UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 4

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73 Employer, and 1199(c), NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME/AFL-CIO Petitioner.	Case No 4-RC-161250

REQUEST FOR REVIEW OF AUGUST 1, 2016 DECISION ON OBJECTIONS TO ELECTION AND CERTIFICATION OF REPRESENTATIVE

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The Employer, SR-73 and Lakeside Avenue Operations LLC d/b/a Powerback Rehabilitation, 113 South Route 73, files this Request for Review from the August 1, 2016 Decision on Objections to Election and Certification of Representative in this case ("Decision"). (A copy of the Decision is appended here as Tab P.) The Decision departed in material part from the June 30, 2016 Hearing Officer's Report on Objections in rejecting the Employer's position that Care Managers are supervisors. (A copy of the Report is appended here as Tab M.) The Decision did not reach the question whether the Care Managers' conduct tainted the outcome of the election because it found that the Care Managers are not supervisors. The Decision did reject the Employer's position that a remark made by Clinical Director Summer Valenti, an undisputed member of management, tainted the outcome of the election.

The Board should grant review for several reasons:

First, the Assistant Regional Director ("ARD") refused to enforce a subpoena that the Employer served upon Summer Valenti. The Employer contends that Valenti promoted the Union and either initiated the Petitioner's organizing drive or, at the very least, meaningfully fueled it. The ARD initially refused enforcement of the subpoena on procedural grounds, but the Decision *sub silentio* abandoned those grounds and purported to deny the subpoena on the merits. The Decision found that there was insufficient basis to justify enforcement of the subpoena because the Employer presented evidence of only a single, mild remark that Valenti made supporting the Union. The Employer submits that the refusal to enforce the subpoena is prejudicial because Valenti was the highest ranking member of management in the facility during the night shift with significant influence over her staff; any remark(s) made by her encouraging staff nurses to consider the Union were quite impactful as a result of her position; she refused to cooperate with the Employer in addressing her involvement with the staff nurses

and Care Managers with regard to the Union, necessitating issuance of the subpoena; the effect of the above justifies the Employer examining her texts, emails, chats, and social media postings pursuant to that subpoena; and the importance of doing so is magnified by the fact that a single vote is determinative of the outcome of this election. Moreover, the refusal to enforce the Valenti subpoena compounded the stifling effect upon the Employer's presentation of its case that resulted from the Hearing Officer's quashing of subpoenas that the Employer served upon in-house organizer Marilyn Viscome as well as Petitioner District 1199, National Union of Hospital and Healthcare Employees, AFSCME, AFL-CIO ("Union") and Union organizer Usamah Abdullah (together "Union"). Board review of the Decision and reversal of these rulings is particularly appropriate and necessary because the Employer sought to minimize any intrusion of these subpoenas upon § 7 rights by agreeing to a redaction procedure that would have maintained the confidentiality of the identities of Care Managers and eligible employees and nothing in the Decision explored use of that (or other) measures in assessing the right of the Employer to such critical information as the subpoenas would have provided. The Employer submits that the cumulative effect of these rulings was undue prejudice to it that necessitates remand with a directive reversing the revocation of the Viscome and Union subpoenas, enforcement of the Valenti subpoena, utilization of such measures as are appropriate and necessary to protect § 7 rights, and resumption of the hearing following production of documents in compliance with the subpoenas.

Second, the Decision made clearly erroneous factual findings with respect to the responsibility of Care Managers to assign and reassign staff nurses and CNAs. In finding that Care Managers do not satisfy the assignment prong of § 2(11) of the Act, the Decision

prejudiced the Employer by overlooking record evidence that establishes that Care Managers regularly assign and reassign the work of staff nurses and CNAs utilizing independent judgment.

Third, the Decision made clearly erroneous factual findings with respect to the role of Care Managers in responsibly delegating work to staff nurses and CNAs. The Decision found (unlike the Report) that Care Managers do delegate work, but it nonetheless found that Care Managers do not satisfy the responsible direction prong of § 2(11) because they do not exercise independent judgment and are not accountable for the performance of their subordinates. The Decision prejudiced the Employer in so finding by overlooking clear evidence to the contrary and adopting a flawed framework for analyzing and assessing the evidence.

Fourth, the Board should reverse the Decision under existing Board precedent. However, to the extent that the Board disagrees and determines that existing precedent forecloses a finding that the Care Managers are supervisors, it should reexamine the case law in the context of an employer such as this one that has two unusual features for which existing case law may not adequately account. One is that the Care Managers at issue function in a short-stay, high patient turnover facility. The second is that the facility does not rely upon traditional discipline and evaluation tools but, rather, has adopted a human resource philosophy that focuses upon contemporaneous feedback, education, and a positive corrective approach to employee relations. The effect of these phenomena in establishing that Care Managers are supervisors cannot be minimized. Extremely high patient turnover necessitates that Care Managers regularly reassign staff nurses and CNAs from their previously planned tasks and utilize independent judgment in doing so. Care Managers are held accountable for their subordinates without imposition of discipline and use of formal evaluations. Assuming, *arguendo*, that the Board cannot find that the Care Managers are supervisors on these facts under its existing precedent, it should consider

whether it needs to modify its test for determining supervisory status in facilities that operate as this one.

Fifth, the Decision did not examine other considerations, such as the supervisor-to-employee ratio and the facility's treatment of Care Managers as part of the facility leadership team, on the ground those are so-called secondary indicia of supervisory status. The Employer submits that the Board should give examine this evidence since, at worst, this is a close case and these facts meaningfully support the Employer's position that the Care Managers are supervisors. To the extent the Board does not examine such evidence under its existing case law, the Board should reexamine that precedent since its failure to do so very well may be outcome determinative in a case such as this one.

The Employer notes that because the Decision did not address the findings of the Report with respect to the conduct of the Care Managers and the impact of that conduct on the outcome of the election (including the cumulative effect of the Care Managers' conduct and Valenti's conduct), it reserves all of its arguments with respect to that issue for such further proceedings as follow disposition of this Request for Review.

The Board should grant the Request for Review, reverse the Decision, and remand the case for further proceedings consistent with the above, including but not limited to enforcement of the subpoenas issued by the Employer.

ARGUMENT

I. THE REFUSAL TO ENFORCE THE VALENTI SUBPOENA COUPLED WITH THE QUASHING OF THE VISCOME, ABDULLAH AND UNION SUBPOENAS PREJUDICED THE COMPANY BY PREVENTING IT FROM SECURING AND THEN INTRODUCING ADDITIONAL EVIDENCE AT TRIAL OF VALENTI'S INSTIGATION OF THE UNION ORGANIZING DRIVE AND OTHER PROMOTION OF THE UNION.

The ARD's refusal to enforce the Valenti subpoena (Employer Exhibit 26: Tab H) during the hearing and adherence to that ruling in the Decision, in conjunction with the quashing of the other subpoenas that the Employer served (Tr. 109:24-111:3), prejudiced the Employer by precluding it from securing and then adducing evidence at hearing that showed that Valenti instigated the Union organizing drive and so aggressively promoted the Union as to taint the election. Initially, the ARD hamstrung the Employer by refusing to enforce the Valenti subpoena on the supposed ground that the Employer's service of the Valenti subpoena was defective (Tr. 698:20-699:2; 710:3-9). However, when the Employer filed its exceptions to the Report, the ARD *sub silentio* abandoned that erroneous rationale and addressed the matter on its merits (Decision at 14-15). The Board should scrutinize the denial of enforcement of the subpoena with particular care in view of the ARD's shifting rationale.

The Decision rationalized the denial of enforcement of the Valenti subpoena on the ground that the Employer failed to show that Valenti had done anything more than state "a mildly pro-union comment well before the start of the organizing campaign" and, accordingly, the subpoena was nothing more than a "fishing expedition" for which the delay resulting from efforts to enforce the subpoena would have been unnecessary and inappropriate (Decision at 14). The "big picture" deficiency in that rationale is that the Employer showed that the highest-ranking member of management on the night shift encouraged her staff to consider bringing in the Union; that, by itself, was sufficient to support the Employer's application requesting

enforcement of the subpoena to ascertain the additional conduct in which Valenti engaged on behalf of and in support of the Union.[1] Beyond that, several more particularized errors infected the ARD's conclusion, demonstrating that it is manifestly erroneous and insupportable[2].

First, the ARD rejected the Report's erroneous finding that there was no evidence of when Valenti made the remark and that the remark even could have been made after the election. However, in searching for a way to overcome that plainly erroneous finding, the ARD overreached in finding that Valenti's remark was stated "well in advance of" and "a substantial…period of time prior to" the organizing drive (Decision at 13 and n. 7). Nothing in the record supports a finding that Valenti's remark so preceded the organizing drive as to render it innocuous. In the absence of any contrary evidence, it appears that Valenti's remark very well may have instigated the organizing drive and, at the very least, was a factor in fueling it. The ARD's finding that Valenti's remark substantially predated the organizing drive is pure speculation wrongly grounded in the rulings quashing and refusing to enforce subpoenas that prevented the Employer from ascertaining and introducing into the record the real facts.

Second, the ARD wrongly concluded that the Employer had a reasonable opportunity to secure and elicit other evidence of supervisory taint arising out of Valenti's conduct because Valenti cooperated with the Company. The finding is outlandish and completely misses the point that the reason the Employer sought enforcement of the Valenti subpoena is that Valenti

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[1] *Laguna College of Art and Design*, 362 NLRB No. 112 (2015), and *Northern Iowa Telephone Co.*, 346 NLRB 465 (2006), upon which the ARD relied, are distinguishable. Valenti was the highest-ranking representative of management on the night shift. In contrast, in *Laguna College* (at n. 3), the Board described the supervisor in issue as "low-level". In *Northern Iowa Telephone*, neither of the supervisors in issue had supervisory authority in numerous respects, 346 NLRB at 466-67, and the higher-ranking supervisor in the facility hierarchy, the Plant Manager, spent 80% of his time performing work similar to that of the eligible voters, supporting the conclusion that he was "low level" too. 346 NLRB at 465.

[2] The last sentence of the "Background" section of the Decision (at 4) stated that the Valenti subpoena sought just "pro-Petitioner social media postings by Valenti". That sentence misstates the scope of the subpoena, which sought texts, chats, emails, and other documents in Valenti's custody as well as social media postings (Employer Exhibit 26).

refused to cooperate. The Decision mistakenly distorts the May 2, 2016 Mendelson Certificate of Service (Employer Exhibit 27: Tab I) to suggest Valenti cooperated with the Employer and that the Employer's failure to elicit evidence of other pro-union conduct by Valenti demonstrates that no finding of supervisory taint can derive from Valenti's conduct. Nothing in the May 2 Mendelson Certificate of Service (Tab I), the May 5, 2016 Motion to Reopen and/or for Reconsideration ("May 5 Motion to Reopen" [Employer Exhibit 28: Tab J]), and accompanying May 5, 2016 Mendelson Certification (Employer Exhibit 29, ¶ 2 [Tab K]), which were filed for the sole purpose of demonstrating that the ARD's denial of enforcement of the subpoena on service grounds was plainly misconceived, support either such inference. That it is "likely" (Decision at 14) that Employer counsel asked Valenti about pro-union comments she might have made has nothing to do with Valenti's willingness to respond, let alone truthfully when not under oath, to such questions. The ARD had no basis for assuming that Valenti even acknowledged voicing the remark that McCarthy ascribed to her.

Nor is it understandable why the ARD believed that certifications submitted solely to address an erroneous and hyper-technical service of process ground for denying enforcement of the subpoena could properly become a basis for substantively denying the subpoena's enforcement. Nothing in the record indicates that the Employer sought to address the substance of interviews and other communications with Valenti prior to the hearing through the May 2, 2016 Mendelson Certificate of Service and the May 5, 2016 Mendelson Certification or, for that matter, that the Employer believed it had a right to do so therein rather than live hearing testimony. Nor does the Employer's May 5 Motion to Reopen indicate such an intention. The sole purpose of the May 5 Motion to Reopen was to overcome the ARD's erroneous procedural rationale for denying enforcement of the Valenti subpoena so that the Company could secure

documents and devices on which it could conduct a forensic search for evidence to present at hearing. The Employer sought to prove supervisory taint through documentary evidence and witness testimony, not statements of counsel in a certification.

Third, the Decision attempts, but fails, to diminish the significance of Valenti's comment. It is of no moment that the remark was stated pre-petition since *Harborside Healthcare, Inc.*, 343 NLRB 906, 912 (2004), holds that comments voiced prior to the critical period are germane and, as noted above, there was no basis for the ARD to conclude that the remark was made long before the critical period commenced. Although the record is devoid of evidence of dissemination and the Decision found Valenti's remark was not coercive, the problem here is one of chicken and egg: the refusal to enforce the subpoena and permit the Employer to collect and elicit evidence necessarily affected the Company's ability to show dissemination and coercion. The ARD's conclusion that the Employer was engaging in a "fishing expedition" also overlooks that the prejudicial effect of the refusal to enforce the Valenti subpoena was compounded by the Hearing Officer's quashing of the subpoenas (Tab N; *see* Decision at 4 n. 2) that the Employer served upon in-house organizer Viscome as well as Union organizer Abdullah and the Union. Nothing in the Decision addresses the Employer's argument that it accommodated the concern over chilling of § 7 rights by agreeing that names of eligible voters and Care Managers, respectively, should be redacted so long as person-specific designations were substituted for each person's name (e.g., individual eligible voters could be designated by specific letters and individual Care Managers could be denoted by specific numbers). *See*, *e.g.*, Tr. 99:22-105:9; 623:13-624:14 and Employer's July 19, 2016 Memorandum at 23-24 (Tab O [pages 23-24 included]). Aside from failing to address the significance of redaction (not to mention other options such as *in camera* review or even testimony by Valenti, Viscome, and Abdullah

preliminary to production of subpoenaed documents), the Decision (at 4) wrongly concluded that the Viscome and Union subpoenas are "mostly irrelevant" because their principal purpose was "to secure additional information regarding pro-Petitioner conduct by Care Managers". Those subpoenas also would have revealed **the extent of Valenti's involvement in the organizing drive**. Accordingly, their revocation compounded the effect of the ARD refusing to enforce the Valenti subpoena and the Board should reverse the Decision in view of its failure to recognize how these rulings unfairly undermined the Employer in seeking to prove that the election was tainted by supervisory conduct. *Ozark Automotive Distributors, Inc. v. NLRB*, 779 F.3d 576, 581-84 (D.C. Cir. 2015)(Court of Appeals refused to enforce Board decision quashing subpoena because Board failed to demonstrate that it had balanced intrusion upon § 7 rights against respondent company's need for documents).

Fourth, the Decision (at 14) mistakenly relied upon Staff RN Stevens and Care Manager McCarthy as barometers of Valenti's comments and conduct:

> If Valenti had been campaigning for Petitioner prior to the vote, it seems likely McCarthy and Stevens would at least have heard of her activities and Employer counsel would have discovered the conduct when interviewing McCarthy and Stevens. Through either Valenti or McCarthy and Stevens, the Employer should have been in a position to discover any pro-Union activity engaged in by Valenti beyond the one comment mentioned at the hearing.

This observation overlooks the fact that Stevens was on the day shift until the second week of October 2015 (Tr. 20:11-21:2). Accordingly, at the time that Valenti made the remark in issue and for several weeks thereafter, Stevens was not on the night shift and was unlikely to have heard anything directly from Valenti. Conversely, while McCarthy was on night shift when Valenti made the remark, she transferred to day shift thereafter and no longer in a position to hear anything further from Valenti since they were not on the same shift (Tr. 112:11-12; 112:20-

113:8). It follows that the Decision's reliance upon Stevens and McCarthy badly misses the mark.

When, as here, the highest-ranking member of management on the night shift advocated that her staff consider bringing in the Union, the Employer should have had an opportunity to develop evidence in support of its objections through the Board's subpoena power. This is particularly so in view of the obstacles, perhaps insurmountable ones, the Employer faced in trying to collect evidence that Valenti's comments and conduct negatively and materially affected the outcome of the election. Without subpoena power, confined by the limitations established by *Johnnie's Poultry Co.*, 146 NLRB 770 (1964), *enforcement denied*, *NLRB v. Johnnie's Poultry Co.*, 344 F.2d 617 (8th Cir. 1965), and hamstrung by the exigencies of operating a rehabilitation facility where personnel are not readily available for meaningful stretches of time to interview when they agree to do so, the Employer nonetheless uncovered Valenti's remark and should have been afforded the opportunity to develop additional evidence of her involvement. Given the additional undeniable reality here that a **single** vote is determinative of the outcome of the election here, the ARD's refusal to enforce the subpoena on the ground that "the waste of time involved clearly outweighs the remote chance that the subpoena will reveal probative material" (Decision at 15) plainly failed to balance appropriately the interests at stake. In view of the D.C. Circuit's admonition that "[w]hen…an appellant has been deprived of the opportunity to summon witnesses, the appellate court can hardly determine what testimony would have materialized but for the error", *Ozark Automotive Distributors,* 779 F.3d at 586, *quoting* Roger J. Traynor, The Riddle of Harmless Error at 68 (1970), the Board cannot countenance the Decision and must remand with a direction that the ARD enforce the Valenti subpoena, reverse the Hearing Officer's rulings quashing the Viscome and Union

subpoenas, direct production of responsive documents redacted as described above, and resume the hearing following production of responsive documents.

II. THE DECISION'S FINDING THAT THE CARE MANAGERS DO NOT ASSIGN WORK IS CLEARLY ERRONEOUS.

The Decision found that Care Managers do not satisfy the assignment prong of § 2(11) for several reasons: in the ordinary course staff nurses and CNAs largely have regular assignments; Staffing Coordinator Melissa Yarnes (rather than anyone else) sets the basic schedule for staff nurses and CNAs; the Clinical Director on the night shift (rather than the Care Managers) handles assignment responsibilities that Yarnes does not perform; and to the extent Care Managers assume the Clinical Directors' assignment responsibilities it is of little significance because they exercise little independent judgment in doing so since schedules are largely pre-determined (Decision at 8). This finding was clearly erroneous and prejudicial to the Employer since it overlooked other record evidence that establishes that Care Managers have the power to assign and do in fact assign staff nurses and CNAs with sufficient regularity that renders them statutory supervisors. This takes place in 3 principal ways: (1) Care Managers on the day and evening shifts reassign staff nurses and CNAs from their initial assignments, (2) when Valenti, the principal night shift Clinical Director, is not present, night shift Care Managers assign day and evening shift personnel either acting as Care Manager while someone else serves as Clinical Director or substituting for the night shift Clinical Director, and (3) day shift Care Managers sometimes substitute as day shift Clinical Directors.

Reassignment Of Staff Nurses And CNAs By Care Managers

Staffing Coordinator Melissa Yarnes testified that Care Managers regularly reassign staff nurses and CNAs in connection with changes in staffing, informing her of staffing changes more frequently than Clinical Directors (Tr. 576:5-14; 577:14-17; 607:9-11). After examining

assignment sheets (Employer Exhibit 22: Tab E) for September 2015 that reflect initial assignment and later reassignment of both staff nurses and CNAs, she confirmed the greater frequency of initial assignments and later reassignments by Care Managers than Clinical Directors based upon both her recollection (Tr. 576:5-577:17) and her recognition of the handwritings on the assignment sheets (Tr. 606:20-608:6).

Care Manager Martha Lake also testified that Care Managers regularly assign staff (Tr. 254:19-21; 255:5-9; 255:17-20; 256:14-257:3; 340:4-23; 258:23-259:10; 314:17-316:22) and have the authority to assign staff as warranted (Tr. 344:12-345:14). Lake related that she has substituted one staff nurse for another to care for a particular patient or administer a specific treatment because the staff nurse assigned to the patient is less proficient or skilled (Tr. 256:14-257:3). Care Manager Kelly McCarthy and RN Kelli Stevens agreed that the Care Managers regularly assign staff (Tr. 38:9-39:12; 47:14-48:23; 135:15-136:4; 224:3-11; 207:22-208:13; 217:18-20). Former Center Nurse Executive Patricia Melora testified that CNAs call out from work, requiring Care Manager reassignment of CNAs, twice a week on each of the 3 shifts (Tr. 385:12-19; *see also* 500:3-504:3).

Admittance of new patients is another principal reason for staff nurse and CNA reassignment. Melora testified that the Care Manager is at the center of the process of admitting new patients, like an air traffic controller, and must decide how to assign personnel to absorb new admissions when a large number arrive at the facility in a limited period (Tr. 364:1-365:1; 380:6-381:2; 494:5-22). When too many new patients are slotted into a single wing, the staff nurses and CNAs assigned those rooms cannot absorb the influx themselves. This is especially true since the facility's protocol requires that a staff nurse must begin assessment of a newly-admitted patient and enter his or her information into the facility's computer system within the

first 30 minutes to one hour following arrival at the facility (Tr. 358:14-19; 267:4-268:8). As a result, Care Managers assign a staff nurse and/or CNA other than those listed on the daily assignment sheet to process that admission.

The Decision analyzed reassignment of staff for new admittances as part of the "responsible direction" prong of § 2(11) of the Act (Decision at 11). While the proper analytical framework in a case such as this is not free from doubt, *Oakwood Healthcare* itself examined assignment of new patients under the "assignment" prong. *Oakwood Healthcare, Inc.*, 348 NLRB 686, 695 (2006). Doing so is appropriate here because there are so many new admittances daily--Melora testified that on a typical day there are between 6 and 15 admissions (Tr. 358:6-9)--and Care Managers so frequently reassign admittance responsibilities for new patients (Tr. 355:15-356:24; 380:7-381:9; 261:24-262:19; 265:11-266:17).[3] While the Decision treated Lake's testimony as indicating that staff are reassigned for the purpose of handling new admittances twice monthly (Decision at 11), she clearly indicated that she herself reassigns staff a minimum of twice monthly and quite probably more often (Tr. 268:6-14). Lake is just one of several Care Managers on the day shift regularly working just 3 days weekly and Melora's testimony underscores that Care Managers generally, not just Lake, regularly reassign staff to process new admittances (Tr. 363:23-364:17; 381:5-9), supporting the conclusion that reassignment of staff for this purpose takes place far more frequently than the Decision recognized.

[3] Powerback Voorhees is a trailblazing, first of its kind **short stay** sub-acute rehabilitation facility unlike any other in the United States, with an unusually high patient turnover rate (Tr. 352:11-12; 352:23-353:2). The average length of stay in this 124 bed facility is 16 to 19 days, which translates into 170 to 180 admissions monthly and a minimum of 6 admissions per day (Tr. 353:4-6). In contrast, the typical facility in the Genesis system of which Powerback Voorhees is part has 20 admissions monthly (Tr. 353:25-354:1; 354:24-355:14), which is akin to no more than one admission per day.

The Decision (at 11) wrongly ignored the evidence set forth above and minimized the importance of reassignments in connection with new admittances on the ground that the record does not show that Care Managers exercise independent judgment this way "on more than a sporadic basis". The independent judgment component is addressed below, but at this juncture the Employer notes that the ARD (like the Hearing Officer before him) very likely discounted the significance of this evidence because McCarthy testified that she only reassigned staff in connection with new admits once and neither Upshur nor St. John indicated that they had ever done so. The defect in that analysis is that admissions take place preponderantly between 2 pm and 8 pm (Tr. 261:16-23) and, therefore, most typically involve Care Managers from the day shift. McCarthy principally worked the night shift until an unspecified date in October 2015 and Upshur and St. John were almost exclusively on the night shift. Accordingly, unless the Employer prolonged the hearing beyond the 4 days it consumed in order to call additional day shift Care Managers, the testimony of Lake and Melora should be taken as representative of that other day shift Care Managers would voice. Even more, it establishes that the night shift Care Managers had the power to reassign staff nurses and CNAs even if they did not typically do so. As such, the record supports the conclusion that Care Managers have assignment authority consistent with supervisory status regardless of the shift on which they regularly work.

Care Managers Acting As Clinical Directors

The record indicates that although Valenti assigns staffs on the night shift, Care Managers do so at night when Valenti is not present 2 nights each week (Tr. 576:15-19; 689:22-690:1; 375:10-12; 375:21-376:2). Although the Decision failed to recognize the importance of this testimony, it establishes that night shift Care Managers prepare 14% of the daily schedules (2 of 14) used each week.

Moreover, the record supports the conclusion that for several months before the November 4 election there was not another night shift Clinical Director: accordingly, during the several months leading up to the election, Care Managers served as Clinical Director on the night shift and assigned staff on the night shift not merely as Care Managers but, instead, as Clinical Director (Tr. 619:8-620:4; 214:24-215:1; 215:14-16).[4] Employer Exhibit 8 (Tab C), which shows instances in which Care Managers served as Clinical Directors, indicates that Care Managers so served 11 times in September 2015 and 9 times in October 2015, a frequency consistent with Care Managers filling in 2 nights weekly as Clinical Directors during each of those months and assuming the assignment responsibilities of the Clinical Director.

The Decision (at 5 n. 3) rejected the Employer's argument that Care Managers are supervisors because they substitute for Clinical Directors generally (as opposed to solely on the night shift) on the ground that these substitutions fail to satisfy the Board's substantiality and regularity requirements. *Oakwood Healthcare*, 348 NLRB at 694. The Decision's substantiality finding is clearly erroneous. Employer Exhibit 8 shows that Care Managers substituted for Clinical Directors on 157 shifts between January 1, 2015 and October 31, 2015 (Tr. 399:17-402:1), which is 304 calendar days. At most, there are 5 Clinical Director shifts daily: 2 Clinical Directors each work the day and evening shifts, respectively, and 1 Clinical Director works the night shift (Tr. 366:15-22). Accordingly, during this period, there were 1,520 Clinical Director shifts (5 Clinical Director shifts multiplied by 304 calendar days)--though this estimate of total shifts worked by actual Clinical Directors is inflated since there are fewer such shifts worked on

[4] Yarnes believed that Margaret Bondo, the night shift Clinical Director who had sometimes filled in for Valenti when she was off, separated from the Employer before the November 4 election (Tr. 611:14-612:1). Bondo was not listed on Employer Exhibit 23, which is a roster of nursing department personnel as of October 2015. Yarnes further testified that Bondo had been on a leave of absence for several months before she separated from employment (Tr. 619:23-620:1).

the weekend (Tr. 136:14-137:18; 684:20-685:4)--and Care Managers worked 10.3% of even this inflated figure (157 Care Manager substitute shifts divided by 1520 Clinical Director shifts). Since *Oakwood Healthcare* holds that the substantiality threshold is satisfied when an individual serves in a supervisory capacity 10%-15% of their total work time, 348 NLRB at 694, Care Managers serving as Clinical Directors in the aggregate satisfy that threshold. The Decision's irregularity finding is clearly erroneous as well. The Decision grounded it in the absence of a clear pattern or schedule under which the facility selected particular Care Managers to serve as Clinical Director on a given shift. However, selection of a specific Care Manager for a particular shift has nothing to do with the larger point that Care Managers served as Clinical Director on more than 10% of all shifts over the 10-month period preceding the election. The record makes clear that Care Managers serve as Clinical Director at least twice weekly when Valenti is not present and in other instances when a Clinical Director is not at work. Although there is not "regularity" with respect to selection of any particular Care Manager as Clinical Director, the Employer satisfied the regularity requirement in demonstrating the circumstances in which Care Managers substitute for and act as Clinical Director.

Although the Employer is confident that it should prevail on the preceding argument, at the very least it established that Care Managers Katrina McNeal and Raymond Twum-Barima are supervisors on the basis of their service as Clinical Director during the 10-month period covered by Employer Exhibit 8. McNeal worked 26 shifts as a Clinical Director. Twum-Barima worked 20 shifts as a Clinical Director. Care Managers work 3 shifts weekly as Care Managers (Tr. 366:24-367:1). Accordingly, during the 10-month period in issue (which consisted of 43 work weeks), McNeal and Twum-Barima would have each been scheduled for approximately 129 shifts as Care Managers. Adding the Clinical Director shifts each worked to that sum, the

Clinical Director shifts worked by McNeal were 16.77% of his total (155 shifts) and the Clinical Director shifts worked by Twum-Barima were 13.42% of his total (149 shifts), respectively. Accordingly, both are supervisors under the *Oakwood Healthcare* substantiality threshold. The regularity threshold is satisfied, as set forth above, based upon the record evidence indicating that they and other Care Managers were selected to fill vacancies resulting from either Valenti on the night shift or any other Care Manager taking time off.[5]

Independent Judgment

The Decision (at 8) is also clearly erroneous in finding that Care Managers do not utilize independent judgment in assigning work. The mere fact that many staff nurses are regularly assigned to the same carts does not nullify the reality that Care Managers and Clinical Directors alike must exercise discretion daily in assigning staff nurses and CNAs without regular assignments and in some instances reassigning staff nurses with regular assignments. Lake testified clearly as to the several variables that influence Care Managers' assignment of work to both staff nurses and CNAs and nothing in her testimony suggested that Care Managers do not give consideration to these variables in those instances in which they complete the assignment sheets. Two critical variables are patient acuity and staff nurse skill and proficiency: Care Managers try to make sure that the staff nurse assigned to a patient has the ability to address the patient's particular health condition and needs (Tr. 255:7-20; 256:15-257:7; 260:14-23; 323:20-324:2). In some instances this involves aligning more senior and experienced staff nurses with patients with more challenging health conditions. In other circumstances this involves assigning a staff nurse to rooms other than are ordinarily associated with a particular cart in order to pair a staff nurse with patients as to whom the staff nurse is better suited to minister in view of his or

[5] The Decision (at 5 n. 3) states erroneously that "most" of McNeal's service as Clinical Director took place in February 2015. In fact, McNeal worked 8 such shifts in February 2015. Accordingly, those shifts constituted less than 31% of her Clinical Director shifts, not "most" of them.

her skill set. By way of example, Lake typically schedules staff nurse Lorraine Nunes so as to ensure that she does not have to care for a patient with wounds. Lake will swap a patient with the need for wound care out of Nunes' assignment to another staff nurse because Nunes does not demonstrate proficiency with wound care. Under *Oakwood Healthcare*, such consideration of patient acuity and staff nurse's overall proficiency and skills constitutes the exercise of independent judgment in assignment of work. 348 NLRB at 697-98.

McCarthy testified that in the ordinary course she considered the above factors as well as others in making sure that the pairing of staff and patients was conducive to maximizing the quality of patient care (Tr. 140:2-13). Lake also testified that Care Managers consider staff nurse personality and demeanor in assessing the ability of a particular staff nurse to jell with a patient (Tr. 261:10-15). *Oakwood Healthcare* recognizes consideration of this factor to constitute the exercise of independent judgment in assignment of work. 348 NLRB at 698. The Decision found, without any basis, that Care Managers gave consideration to these factors infrequently. Full review of the testimony of the witnesses presented by the Employer indicates that when Care Managers assigned staff they were consistently mindful of these variables and relied upon them regularly, whether in completing or revising the assignment sheets, reassigning personnel in connection with newly-admitted patients, or otherwise. In doing so, the Care Managers drew on their training and expertise and exercised independent judgment, in particular, in gauging the relative acuity of patients to ensure that the switching of patients did not result in greater burden upon one nurse than the other. The ARD's failure to recognize that Care Managers exercise independent judgment in constantly making these determinations about acuity is fatal to the Decision.

Lake also testified that Care Managers afford significant consideration to continuity of care in assigning patients (Tr. 256:4-13). This is not a negative. *Oakwood Healthcare* indicates that consideration of continuity of care, which ensures that a staff nurse is familiar with particular patient needs, 348 NLRB at 697, is an exercise of discretion and independent judgment in deciding to whom work is assigned. 348 NLRB at 698. The Decision's finding that Care Managers are not supervisors is clearly erroneous insofar as it ignored Care Managers' consideration of this factor.

The Decision did recognize that in some instances Care Managers gave consideration to a staff nurse's experience and skills, but it found that in the ordinary course staff nurse availability (and, therefore, equalization of work load) was the touchstone for assignment, especially in connection with reassignment of staff nurses for newly-admitted patients (Decision at 11). However, *Oakwood Healthcare* states that equalization of workload is not inconsistent with the exercise of independent judgment when consideration of acuity, employee proficiency and skill, and continuity of care is not premised solely on ensuring that the <u>quantity</u> of work assigned is equalized. 348 NLRB at 697. When, as here, Care Managers assign work on the basis of equalizing workloads <u>along with</u> considering the difficulty of the work and the proficiency of the personnel assigned, *Oakwood Healthcare* recognizes that the equalization of work is part and parcel of a larger process that involves the exercise of independent judgment consistent with a finding that Care Mangers are statutory supervisors.

The Decision's finding (at 8) that "[a]t most" Care Managers decide staffing issues necessitating assignment of staff to patients in 2 different wings or hallways by identifying the employee "located closest to the point at which the hallways intersect" rather than "employee skill or ability" is belied by record evidence clearly to the contrary. In fact, the record shows that

circumstances often necessitate that Care Managers disregard considerations such as proximity (Tr. 260:1-9; 261:24-262:13).

One of the Decision's principal criticisms of the Employer's position is that its evidence of instances in which Care Managers exercised judgment lacked sufficient specificity (Decision at 8). The Employer respectfully submits that its witnesses explained the factors that Care Managers consider in assigning both staff nurses and CNAs with clarity and specifics sufficient under *Oakwood Healthcare* and comparable to the evidence adduced on the record there. *See* 348 NLRB at 696-97 (witnesses testified as to the factors that they considered, the Board majority specifically noted that "[w]itnesses repeatedly testified that the charge nurses' assignments are based on 'informed judgments' about the patients and staff", and the decision did not indicate that specific examples of those "informed judgments" were set forth in the record). The record at bar indicates that the Employer's witnesses endeavored conscientiously to provide an accurate depiction of how Care Managers have addressed every day assignment issues over a couple of years of experience. There are not batches of records that outright denote or are organized in such a way as to confirm the points about which the witnesses in this case testified (i.e., the instances in which newly-admitted patients are reassigned are not separately catalogued (Tr. 608:4-6) and would have to be accessed patient-by-patient in the facility's on-line recordkeeping system [Tr. 307:17-309:9], assuming one recalled the names of patients for whom assignment of staff nurses or CNAs changed). Finally, the high patient turnover at this facility means that the typical Care Manager oversees 240 patients monthly (Tr. 371:1-374:5), most of whom depart the facility within less than one month (Tr. 353:4), meaning there is far less likelihood in the unusual circumstances of this case (compared to the ordinary lower patient turnover facility) that Care Managers are likely to recall a cadre of familiar patients with whom

they have months of consistent experience and to whom they can point in order to provide a plethora of specific examples. Notwithstanding this obstacle, Lake provided numerous examples of specific situations that illustrate instances in which she exercised independent judgment in assigning or reassigning personnel: she mentioned instances involving co-workers Lorraine Nunes (Tr. 271:4-12; 292; 306:25-307:18; 311:9-21; 312:24-314:16), Cynthia Pessoa and Angela Lee (Tr. 300:13-23; 326:-27), Mia Funches (Tr. 312:24-314:16), and Ashley Adams and Ashley Calame (Tr. 314:17-317:12; Employer Exhibit 23). Moreover, the Decision (at 7 and 9) wrongly found that Lake provided no specific examples of instances in which she assigned 2 CNAs to a patient when, in fact, she identified 2 such distinct situations (Tr. 314:17-317:12).

Finally, several of the Decision's findings with respect to the assignment prong are misplaced insofar as they relate to the responsible delegation prong. For example, the criticism of Lake for not providing specific examples of instances in which 2 staff nurses with the same regular assignment are simultaneously scheduled (Decision at 8) is a responsible delegation issue, not an assignment issue. The same is true of the mistaken criticism of Lake for supposedly not providing specific examples of instances in which she directed 2 CNAs to handle certain patient situations (Decision at 9) when, in fact, she did so. Insofar as the ARD sought to "beef up" his rationale that the Employer did not provide sufficient specifics of instances in which Care Managers assigned or reassigned staff, the Decision erroneously referencing "responsible delegation" scenarios in the "assignment" analysis underscores the manifest deficiency in the Decision's rationale.

III. THE DECISION'S FINDING THAT THE CARE MANAGERS DO NOT RESPONSIBLY DIRECT WORK BECAUSE OF AN ABSENCE OF INDEPENDENT JUDGMENT AND ACCOUNTABILITY IS CLEARLY ERRONEOUS.

The Decision found that that Care Managers do not satisfy the responsible direction prong of § 2(11), even though the record establishes that they do direct staff nurses and CNAs, because they do not exercise independent judgment in directing work and they are not accountable for poor performance or derelictions of their staff. These findings are clearly erroneous on the instant record.

Independent Judgment

First, nowhere does the Decision indicate that Care Managers do not exercise independent judgment when they direct staff to perform certain duties, such as changing catheters and turning patients more frequently than protocol requires. The Decision attempts to sidestep this reality with a misplaced finding that no "supervisory judgment is exercised in determining which employee should be assigned to perform the required tasks." (Decision at 11)(emphasis added). The defect in this finding is that the supervisory function at issue in this instance is direction of work, **not** assignment of work. Care Managers are supervisors because, as the Decision recognizes and the record confirms (Decision at 10; e.g., Tr. 272:7-273:24; 271:22-25; 151:7-16; 153:7-9; 137:19-138:21; 357:10-358:5; 38:4-39:12; 40:6-41:12; 682:14-683:8), they regularly monitor and provide direction to their staff regarding duties those employees perform. Direction of work is the essence of being a supervisor at a rehabilitation facility, particularly when patient well-being is its mission. Accordingly, even if, *arguendo*, the Care Managers do not exercise independent judgment in assigning responsibility in these instances, that is of no moment since the issue here is one of providing direction. (It bears note that in view of the Decision's finding that so many staff nurses have regular assignments, in

many instances in which direction is provided--such as changing catheters and turning patients--there is no need for assignment of work because the work is regularly performed by the employees.)

Second, to the extent the Decision finds that Care Managers do not exercise independent judgment in monitoring the work of their staff and providing direction because "tasks performed by staff nurses and assistants appear routine" (at 10), it is also clearly erroneous. The principal responsibility of the Care Manager is to assess the higher risk patients on each shift either when the staff nurse seeks the Care Manager's input or the Care Manager on his or her own discerns that assessment of particular patients is appropriate or necessary (Tr. 271:23-25; 137:19-139:14; *see also* Tr. 357:8-358:5). The aftermath of that assessment often is a directive to the staff nurse or CNA to take certain action. Characterization of such Care Manager intervention as other than "responsible direction" on the ground the underlying work is "routine" misapprehends both the work that is performed and the Care Manager's involvement. During the course of a shift, staff nurses must make several assessments as to each patient (Tr. 460:21-461:1) and a Care Manager fulfilling his/her responsibilities does so for higher risk patients twice each shift (Tr. 461:2-8). The resulting directives that Care Managers issue to their staff often involve important, non-routine judgments (Tr. 138:24-139:24; 140:23-141:10; 324:23-325:9) that derive from the Care Managers' greater experience and training and superior assessment skills (Tr. 356:11-21; 446:16-21). *See also* Tr. 447:16-448:9; 451:23-453:10; 454:1-5 (Melora testified about different situations in which Care Managers exercise independent judgment outside scope of doctors' orders).

Although the Decision found that Care Managers do not exercise independent judgment in connection with delegation of responsibilities during emergencies (such as when patients

code) because such delegation is principally based upon availability of personnel, that finding is clearly erroneous as well. It misses the mark because the key point is that in the ordinary course a Care Manager is the person on the scene in charge during a code or other similar emergency (Tr. 270:18-24; 513:25-514:2) and in the absence of a doctor or other medical professional of higher rank the Care Manager is literally deciding the role of each team member and what is to be done. The finding that this is not indicative of supervisory status because availability of personnel rather than an assessment of their skills determines the composition of the team quite obviously overlooks the common sense point that in exigent circumstances a Care Manager cannot distinguish between employees' respective skill levels or other criteria (Tr. 324:23-24; 329:18-25 [relating to 269:4-270:16]; 141:11-143:9). The independent judgment that Care Managers exercise in these instances derives from them directing the efforts of the personnel who address the emergency and it would be the height of irresponsibility for any fact finder, including the Board, to deem delegation in that context rote or mundane when no doctor or medical director is present. Accordingly, the Employer respectfully submits that the Decision is clearly erroneous insofar as it finds that direction during emergencies is not "responsible" and indicative of supervisory status on the ground that Care Managers do not exercise independent judgment in such settings.[6]

Another instance that the Decision overlooks in which Care Managers exercise independent judgment arises when patients or their families complain about a staff member (nurse or CNA) and the Care Manager must decide whether to reassign personnel. Lake testified

[6] While the Decision recognized (at 10) that in some instances staff nurses may take control in emergency situations, the record reflects that Care Managers ordinarily take control because of their greater expertise and the obligation staff nurses have to other patients under their immediate care (Tr. 324:23-324:9; 141:11-143:9). That Care Managers have the authority to take control of a code, in spite of a staff nurse's capability of running one as a professional nurse, is the key point. *Glenmark Associates, Inc. v. NLRB*, 147 F.3d 333, 345 (4th Cir. 1998)(existence of authority, not exercise of it, is dispositive of whether individual is supervisor).

that Care Managers conduct an investigation (Tr. 257:11-25) and then utilize their training and experience in determining whether reassignment is necessary or appropriate (Tr. 257:24-258:17; 297:15-299:12; 312:24-314:14). The Decision not only failed to address the exercise of independent judgment that this scenario requires in deciding whether to reassign staff but, in addition, overlooked the independent judgment that Care Managers utilize in assessing relative patient acuity when determining which patients to switch. Similarly, the Decision (at 7 and 9) found that the record does not explain how Care Managers exercise independent judgment in assigning 2 CNAs to handle a single patient. In fact, Lake provided detail explaining how she strives not to assign 2 CNAs together when possible but does so in those instances in which her training and experience make clear that there is a safety issue for staff, the patient, or both (Tr. 258:21-259:10; 314:17-317:12).

The Decision completely fails to address the Employer's point that Care Managers are supervisors because they provide direction to employees outside the nursing department (Tr. 378:6-380:5). Care Managers direct physical therapists with respect to the regimen for a specific patient and dietary personnel to restock snacks for diabetics. Care Managers prioritize and order the sequence of events when physical therapists seek to begin a patient's therapy but staff nurses or CNAs need to administer insulin or medication. The Care Manager's direction is "responsible" in these instances involving employees they do not directly supervise because they utilize their knowledge and experience in prioritizing the importance of procedures and treatment and deciding the order in which facility personnel are to proceed with a patient.

Accountability

The Decision is also clearly erroneous in finding that the Care Managers are not accountable for the performance of their subordinates. A critical fallacy underlying that finding

is its failure to recognize that the fundamental premise in the design and opening of this facility was that its new model would succeed in rehabilitating patients consistent with a short length of stay objective that is dependent upon a collaborative work environment grounded in education and immediate feedback rather than discipline. The record demonstrates that that the facility has met the Employer's objective. The average length of stay is well below the average for other Genesis facilities: 16-19 days across approximately 120 patients at Voorhees versus 30 days across 20 short-stay patients at the typical facility (Tr. 355:13-14). Further, the rate of return to hospitals from the Voorhees facility is far below the Genesis average: 10% versus 17% (Tr. 461:9-25). A critical ingredient to this success is a human resource philosophy favoring education and self-improvement over discipline (Tr. 358:24-359:20; 360:14-361:8; 362:5-15; 480:20-481:5). When a staff nurse makes a mistake at the facility, the ordinary response is to explain to the staff nurse why he or she erred, the correct way to perform the function, and how to avoid a recurrence. There is little written discipline. A cooperative, educative approach and eschewing of discipline has yielded successful patient care results. It follows that the absence of discipline is of no moment.

A related critical deficiency in the Decision's analysis is its failure to recognize that the facility relies upon contemporaneous and informal feedback and evaluation: it does not regularly utilize formal evaluations. Lake testified that she knows that senior management, including Melora when she was the head nurse, views her favorably because of regular on-the-job feedback (Tr. 323:3-13). Melora testified that she was actively involved in the administration of patient care, often on the floor side-by-side with her staff, and that she would interact with nursing department personnel and provide feedback and observations on their performance

contemporaneously. That formal evaluations are not utilized does not mean Care Managers are not accountable for their staff.

The only meaningful question is whether Care Managers in fact were held responsible for their subordinates by senior management; disciplinary notices and formal evaluations are merely tools and not the *sine qua non* as to the existence of accountability. The Care Manager job description is clear on this point: the list of 7 administrative and organizational responsibilities is presented under the heading "RESPONSIBILITIES/**ACCOUNTABILITIES**" (Tab B: Employer Exhibit 4)(emphasis added). Record testimony underscores that the Care Managers are responsible and held accountable for the performance of their subordinates (Tr. 272:14-19; 340:4-20). Lake testified that when she was promoted from staff nurse to Care Manager, Melora specifically told her that she was responsible for the work of the staff nurses (Tr. 296:13-22; *see also* Tr. 295:1-297:5). Melora testified that she has spoken to Care Managers because of dissatisfaction over the performance of the personnel that the Care Managers supervise (Tr. 424:1-10). The record further reflects that in every instance other than one related by Upshur, Care Managers secured compliance of their subordinates to their directives (Tr. 683:16-684:5), even in instances in which a staff nurse initially resisted following the Care Manager's order (*E.g.*, Tr. 275:10-20 ["Overall though they do what they're supposed to do"]; 301:2-6 ["Fortunately I have not had to write up anybody"]; 317:20-318:7 and 320:3-321:9 [Lake testified that she has the power to issue written discipline but she has only "had to have verbal conversations"]). Whatever interpersonal conflicts and differences may exist at the facility (as in any setting), the record demonstrates that the facility functions effectively and its personnel overall work together collaboratively.

McCarthy testified extensively about how she understands herself to be responsible for staff nurses and CNAs who report to her (Tr. 151:2-154:11). She believes that she does her job well because she monitors her staff and provides instruction, direction, and feedback to them to ensure that they do their jobs properly. The Decision criticized McCarthy on the ground that she "did not explain the basis for this conclusion" (Decision at 12), but the Decision is deficient because the testimony cited above is self-explanatory and shows that the Care Managers' role and function vis-à-vis their staff is the very essence of accountability.

Notably, Lake related an incident in which a problem arose that at first blush indicated a potentially significant oversight in patient care. Her Clinical Director telephoned her at home on her off day to investigate the matter (Tr. 273:25-275:9; 295:4-25; 297:6-10). It turned out that there had not been a patient care failing, only a documentation error. However, the fact that her Clinical Director phoned Lake on her day off and Lake felt she had to look into the matter then and resolve it unqualifiedly demonstrates the commitment to accountability at the Employer. The Decision's criticism that Lake did not testify that she was told that she would suffer consequences for her subordinate's performance or explain any other basis for her testimony that she could have been disciplined had there in fact been an oversight in patient care completely misses the mark: Lake specifically remarked that she was aware of her responsibility for a subordinate's errors from the Employer's rules (Tr. 295:19-296:25). The Decision's characterization of the testimony upon which the Employer relies as "witness supposition[]" is plainly belied by Lake's testimony.

Labeling of the testimony upon which the Employer relies as "conclusionary" [or conclusory], Decision at 12, emanates out of the Decision's inability to grapple with a non-traditional, educative approach to human resource management. When performance is generally

favorable and feedback is contemporaneous, there is no need for issuance of disciplinary notices or administration of annual performance reviews. The record makes clear that in those instances in which their subordinates do not properly perform their duties, Care Managers provide a prompt explanation that this is the case and that improvement is immediately necessary with an explanation of how the duties should be performed. The Decision's underlying premise that the absence of disciplinary and evaluation paper work indicates that Care Managers are not responsible for the performance of their subordinates speaks to an anachronistic and antedated outlook that bears no relationship to the realities of a cutting-edge facility grounded in a modern, educative approach to management. *See* Tab Q, Elaine D. Pulakos & Ryan S. O'Leary, *Why Is Performance Management Broken?*, 4 INDUS. & ORG. PSYCHOLOGY 146, 147-48, 156-58 (2011). Also pertinent is the decision in *Lakeland Health Care Associates, LLC v. NLRB*, 696 F.3d 1332, 1344-46 (11th Cir. 2012)(reversing Board and finding supervisory status despite absence of actual issuance of discipline for failure of subordinates to comply with facility's standards since *Oakwood Healthcare* holds that "Act requires only a *prospect* of adverse consequences", testimony as to what would happen as opposed to what did happen satisfied facility's burden of proof, and Board wrongly labeled such testimony "conclusory").

IV. THERE ARE COMPELLING REASONS FOR THE BOARD TO RECONSIDER CERTAIN ELEMENTS OF ITS SUPERVISORY STATUS TEST IN A CASE SUCH AS THIS IN WHICH THERE IS ENORMOUSLY HIGH PATIENT TURNOVER AND A COLLABORATIVE WORKPLACE IN WHICH EMPHASIS IS PLACED UPON EDUCATION AND SELF-IMPROVEMENT RATHER THAN DISCIPLINE.

The Board should reconsider certain aspects of its test for determining supervisory status in this case in view of the unusual setting in which the facts arise.

In Point II, the Employer argues that reassignment of patients, particularly in connection with new admissions, supports a finding that Care Managers are supervisors. Assuming,

arguendo, that the Board does not so find, the Employer submits that application of Board precedent from prototypical health care facilities in which patients remain for long stretches of time and there is relatively low patient turnover does not fit this case. Here, Care Managers regularly reassign staff to process newly-admitted patients who are not otherwise assigned to them. The Decision attempted to sidestep this fact on the ground that availability of staff nurses sometimes dictates which staff nurse is so reassigned. However, the record reflects that staff nurse skills, including the ability to process new admittances quickly, also play a role in determining which staff nurses are reassigned. The upshot is that the Board should modify its test for determining supervisory status when, as here, short patient stays and high patient turnover mean that Care Managers rather than the Staffing Coordinator or Clinical Directors reassign staff during the shift. Assignment of personnel is a touchstone of supervisory status and the role of Care Managers in exercising that responsibility in a short stay-high patient turnover facility such as this dictates that the Board modify its test to account for this important factor as an indicia of supervisory status.

The Decision also found that the Care Managers are not accountable because of an anachronistic outlook on human resource management. In Point III, the Employer argues that the instant record justifies reversal of the Decision. To the extent the Board disagrees, it is necessary for it to reexamine and reconsider its case law to hold that accountability consistent with supervisory status can exist in the absence of written discipline and formal evaluations. When, as here, an enterprise operates on the basis of contemporaneous feedback, education, and a positive corrective approach to employee relations, the Board should find that personnel are accountable and that the employer has established supervisory status.

V. THE DECISION'S FAILURE TO EXAMINE OTHER CONSIDERATIONS, SUCH AS THE SUPERVISOR-TO-EMPLOYEE RATIO, WAS ALSO PREJUDICIAL TO THE EMPLOYER.

The Board's general rule is that it does not consider so-called secondary indicia of supervisory status when so-called primary indicia do not support a finding that the employees in dispute are supervisors. However, in this case the Board's application of this principal is prejudicial because, at worst, this is a close case and the compelling reasons for reexamining Board precedent in the unusual circumstances at bar demand that the Board give credence to all applicable considerations in deciding this important question.

Plain common sense dictates that the Board must decide supervisory status issues with an eye toward their practical outcome. Different settings, of course, require different outcomes. However, in the ordinary course, extremely low supervisor-to employee ratios (e.g., 1:10) are often likely to result in operational stresses that cause labor and employee relations stress, whereas extremely high supervisor-to-employee ratios (e.g., 1:2) suggest excessive supervisory oversight and, quite possibly, misclassification of employees and impingement upon employees' statutory rights. Here, the Decision declined to consider the supervisor-to-employee ratio notwithstanding the importance of this factor from a practical standpoint in a rehabilitation facility.

The record makes clear that on a given floor there are typically 2 Care Managers, 4 staff nurses, and 6 CNAs on the day and evening shifts and 2 Care Managers, 4 staff nurses, and 4 CNAs on the night shift (Decision at 2). Further, on the day and evening shifts there is 1 Clinical Director on each floor and on the night shift there is 1 Clinical Director for the entire building (Decision at 2). Accordingly, denial of the instant Request for Review will result in a supervisor-to-employee ratio (Clinical Director to Care Manager/staff nurse/CNA) of 1:12 on the day and evening shifts and 1:20 on the night shift. Plainly, such a low ratio is not consistent with

this rehabilitation facility's focus upon patient care excellence and, concomitantly, short patient stays and high patient turnover. The Board should recognize the impracticality of the Decision and, in response, grant review and afford serious consideration to the Employer's arguments as to why the Decision requires reversal and remand.

Adoption of the Employer's argument that Care Managers are supervisors would yield supervisor-to-employee ratios (Care Manager to staff nurse/CNA, excluding Clinical Directors on the ground they are managers) of 1:5 on the day and evening shifts (2 Care Managers for 10 staff nurses and CNAs on each floor) and 1:4 on the night shift (2 Care Managers for 8 staff nurses and CNAs on each floor)[Tr. 369:24-370:15]. Since the staffing shortage that has afflicted the facility at various times has often resulted in there being just one Care Manager on a floor at any given time, when only one Care Manager is present the supervisor-to-employee ratio falls to 1:10 on the day and evening shifts and 1:8 on the night shift (Tr. 370:16-20). Conversely, if the Clinical Directors are deemed supervisors along with the Care Managers, the ratio increases to 1:3.33 on the day and evening shifts (Tr. 488:13-489:12 [a total of 3 Clinical Directors and Care Managers for 10 staff nurses and CNAs on each floor]) and 1:3.2 on the night shift [one-half of the Clinical Director (there is only one in the facility at night) along with 2 Care Managers, resulting in 2.5 managers-supervisors for 8 staff nurses and CNAs on each floor]. While the latter ratios are relatively low, which is indicative of misclassification, the Employer submits that the record herein--including the Employer's business model with its focus on rapid rehabilitation, short patient stays, and rapid patient turnover--supports the conclusion that Clinical Directors function as managerial employees rather than supervisors and are properly excluded from the supervisor-to-employee ratio (especially since the Care Managers function as supervisors).

The Decision also ignored the evidence that was adduced showing that the Employer treats the Care Managers as part of its leadership team (Tr. 376:10-12; 404:7-9). Care Managers join the Clinical Directors in a monthly leadership meeting (Employer Exhibit 12 (Tab D); Tr. 415:21-416:11) and are part of a set of projects in which both the Clinical Directors and Care Managers are charged with initiating improvements in the Employer's processes and operation (Tr. 376:12-377:14). Care Managers working the day shift in a Clinical Director capacity or otherwise serving as the senior nurse on the shift attend the daily morning meeting held each Monday through Friday with department heads (including managers from outside the nursing department) and accompany the doctor on duty on his rounds (Tr. 504:4-505:16; 149:10-150:19; 220:6-8; 444:6-22). Care Managers, like Clinical Directors and other department heads, are enrolled in Management 101 and expected to complete on line training modules that provide management training (Tr. 405:13-22: 594:23-595:17; 596:7-16; Employer Exhibit 25: Tab G). Although the record indicates that some participants have not completed more than 25% of the courses (last page of Employer Exhibit 25), the Board should not confuse the absence of strict enforcement of the program's completion with the significance of the inclusion of the Care Managers in it. It is indisputable that Care Managers have been part of the program for several years (Employer Exhibit 25 shows that individual Care Managers completed courses as early as 2012), which refutes the Union's suggestion that their inclusion in the program had anything to do with the filing of the petition in this case in 2015. It does not matter, then, that many participants have not completed all of the courses. Inclusion of the Care Managers is notable because it reflects that the Employer has **always** considered them supervisors who are part of the leadership team.

Care Managers are paid approximately $5 per hour more (16%) than staff nurses (Tr. 374:6-10). Conversely, they are paid approximately$3.50 per hour less than Clinical Directors (Tr. 374:11-14), though when Care Managers substitute for Clinical Directors their pay is prorated so that they are paid consistent with the Clinical Director salary for the hours they serve in the Clinical Director capacity (Tr. 155:20-156:5). Employer Exhibit 24 (Tab F) shows mildly greater differences in the hourly rates of the 3 different positions referenced above than those to which Melora testified, but overall the magnitude of the differences is as she indicated.

Finally, the Employer sought to adduce evidence establishing that several Care Managers have been promoted to Clinical Director: as the colloquy on the record demonstrates, the Employer intended to argue that the progression to the management position is probative of the fact that Care Managers are supervisors (Tr. 157:21-158:23). The Hearing Officer sustained the Union's objection, precluding the Employer from eliciting this evidence. The Employer submits that this procedural ruling was prejudicial to the Employer and that on remand the Employer

CONCLUSION

For the reasons set forth herein and the record overall, the Employer respectfully requests that the Board grant this Request for Review, reverse the Decision, direct that the Region enforce the Valenti subpoena and that Viscome, Abdullah, and the Union comply with their respective subpoenas, and remand for further proceedings following the production of documents in compliance with the subpoenas.

Respectfully submitted,

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UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 4

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73 Employer, and 1199(c), NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME/AFL-CIO Petitioner.	Case No 4-RC-161250

APPENDIX IN SUPPORT OF REQUEST FOR REVIEW OF AUGUST 1, 2016 DECISION ON OBJECTIONS TO ELECTION AND CERTIFICATION OF REPRESENTATIVE

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I	Employer Exhibit 27
J	Employer Exhibit 28
K	Employer Exhibit 29
L	Employer Exhibit 30
M	June 30, 2016 Hearing Officer's Report on Objections
N	July 19, 2016 Motion to Reopen Record, with Exhibits A and B (including appended subpoenas served upon Marilyn Viscome, Petitioner, and Usamah Abdullah)
O	Excerpts from Employer's July 19, 2016 Memorandum in Support of Exceptions and Motion to Reopen Record
P	August 1, 2016 Decision on Objections to Election and Certification of Representative
Q	Elaine D. Pulakos & Ryan S. O'Leary, *Why Is Performance Management Broken?*, 4 INDUS. & ORG. PSYCHOLOGY 146, 147-48, 156-58 (2011)

Respectfully submitted,

/s/ Jedd Mendelson

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Dated: August 22, 2016

EXHIBIT A

BEFORE THE

NATIONAL LABOR RELATIONS BOARD

In the Matter of:

SR-73 AND LAKESIDE AVENUE
OPERATIONS, LLC, d/b/a
POWERBACK REHABILITATION,
113 SOUTH ROUTE 73, Case No. 04-RC-161250

Employer,

And

1199C, NATIONAL UNION OF
HOSPITAL AND HEALTH CARE
EMPLOYEES, AFSCME, AFL-CIO,

Petitioner.

The above-entitled matter came on for hearing pursuant to Notice, before ELANA HOLLO, Hearing Officer, at the National Labor Relations Board, Region 4, 615 Chestnut Street, Philadelphia, Pennsylvania, 19106, on Tuesday, April 19, 2016, at 9:30 a.m.

1 Q What position do you hold?
2 A I'm a floor nurse, RN.
3 Q Just keep your voice up, okay?
4 A Um-hum. Floor nurse, RN.
5 Q And you don't want to do uh-huh. You have to use audible
6 words that the reporter can transcribe.
7 A Okay.
8 Q Thank you. To whom do you report? What position do you
9 report to?
10 A I report to the care managers.
11 Q What shift do you work at the present time?
12 A 7p/7a.
13 Q So 7 p.m. to 7 a.m.?
14 A Yes.
15 Q Was there a time when you worked 7 a.m. to 7 p.m.?
16 A Yes, when I first started at the facility.
17 Q When did you begin working at this Voorhees facility?
18 A 27th of August.
19 Q Of what year?
20 A Of 2016 -- '15, sorry.
21 Q When did you start your employment at Voorhees?
22 A 8/27/2015.
23 Q Very good, thank you. At that time, you were working the
24 day shift?
25 A Yes.

1 Q When approximately did you go to the night shift?
2 A Second week of October 2015.
3 Q Just for the benefit of the hearing officer, who I don't
4 think knows much about the operation, tell her what shifts the
5 staff RNs work, the length, how many times a week, that kind of
6 thing.
7 A We're scheduled three days a week. We work 12 1/2 hour
8 shifts, 7p/7a, 7a/7p, with a 1/2 hour overtime.
9 Q And the care managers, what do their shifts look like?
10 A They work the exact shifts we do. They mirror us.
11 Q Did there come a time when you made observations about
12 care managers speaking in favor of having a union?
13 A In October, when I first went from -- it was going on for
14 a while. But in October, when I switched from day shift to
15 night shift, it was more pronounced.
16 Q When you say it, what do you mean by it?
17 A The conversations. They were louder, more boisterous,
18 just more sure like this is what we're going to do, this is
19 what's going to happen.
20 Q When you say the conversations, who were the speakers that
21 you're referring to?
22 A The first big one that I remember was care managers.
23 Q Can you give me specific people?
24 A Katie.
25 Q Let me stop you there. Do you know her last name? If you

1 questions than just general nature of the relationship would be
2 helpful.
3 BY MR. MENDELSON:
4 Q Let's talk about the care managers first, okay. Where at
5 the change of shift are they situated?
6 A Nurse's station.
7 Q What responsibilities if any do you understand the care
8 managers to have at the beginning of their shift?
9 A They get report on their entire unit, find out who is
10 coming in, who is left, who is in crisis, who might be going
11 into crisis, physicians on-calls coming in, making sure staff
12 is where they're supposed to be, changing it if necessary.
13 Q When you say changing it, explain to the hearing officer
14 what you mean by that.
15 A If somebody inadvertently doesn't show up, they have to
16 make the decision on who is going to go to another floor, or
17 who is going to be pulled, or you're taking this many patients
18 versus this many patients, that kind of thing.
19 Q So is there a preexisting assignment sheet that comes to
20 their attention? Does it come to the care manager's attention?
21 A Yes, we have an assignment book that is filled.
22 Q And then if someone doesn't come in, what does the care
23 manager do based on your experience?
24 A They adjust it --
25 Q How do they do that?

1 A -- to fill the gap, to fill the holes.
2 Q And so what do they do? Physically, just what do they do?
3 A Physically, they tell us where we are going to go. They
4 move us from a different, you know, it's usually not nurses
5 that have to be bumped. I mean sometimes it is, but it's
6 usually CNAs, they have to go to a different floor, they have
7 to, you know, they get different patients, more patients.
8 Q Who reassigns them?
9 A Care managers.
10 Q And how often in your experience in a given week does that
11 happen for any given care manager?
12 A At least once a week.
13 HEARING OFFICER HOLLO: Let me just interrupt one moment.
14 Is this once a week that it happens to you, that you were
15 reassigned?
16 THE WITNESS: No, no, no, that the care managers actually
17 have to reassign staff to cover a gap for whatever reason, call
18 out, somebody got sick, somebody went home.
19 HEARING OFFICER HOLLO: Okay. And your testimony about
20 that is just based on your --
21 THE WITNESS: On my own --
22 HEARING OFFICER HOLLO: Your own general observation.
23 THE WITNESS: Correct.
24 HEARING OFFICER HOLLO: You're not testifying about
25 anything that actually happened to you?

1 THE WITNESS: Correct. No, I'm not. Just me.
2 HEARING OFFICER HOLLO: Okay. What do you mean just you?
3 It's just your observation?
4 THE WITNESS: Correct.
5 BY MR. MENDELSON:
6 Q During the course of the shift, tell us if there is any
7 interaction between the care manager and the floor nurse.
8 A There is always interaction.
9 Q Could you explain?
10 A You have to let them know if something is going on with
11 your patient, good or bad. They let the physicians know. They
12 get your orders that you need. They give you direction on how
13 to proceed.
14 Q The they is who?
15 A The care managers.
16 Q And they give you direction, you said?
17 A Direction on how to proceed with your patient.
18 Q Give me an example, if you can, of the kind of direction
19 that they provide, the care managers provide.
20 A A patient starts running a temp. Did you do lung sounds,
21 did you give them Tylenol, are they on antibiotic, what's their
22 diagnosis. They call the physician. They'll relay whatever
23 you've told them to the physician. The physician calls, you
24 know, they'll call you back or they'll come down to your cart
25 and say I talked to the physician, I need you to do this, this,

1 you direction in that context?
2 A In an emergency situation?
3 Q Yes.
4 A No, not me, personally.
5 Q Do you know of other situations?
6 MS. LESHINSKI: I'm going to --
7 THE WITNESS: No.
8 MS. LESHINSKI: -- object to --
9 BY MR. MENDELSON:
10 Q Do you know of other situations where a care manager had
11 not gotten a timely response from a provider and gave direction
12 to the nurses, staff nurses?
13 A No.
14 Q Are you aware of situations where care managers serve as
15 clinical directors?
16 A Yes.
17 Q Let's back up. For the benefit of the hearing officer, to
18 whom do the care managers report?
19 A They report to the clinical directors.
20 Q Tell us to the extent you can of instances that you know
21 of care managers functioning as clinical directors?
22 A I've seen it on occasion on 7p/7a when we don't have one
23 in the building and --
24 Q You don't have one what?
25 A We don't have a clinical director in the building. And a

1 care manager will kind of takeover that spot just to make sure
2 everything flows for the night.
3 Q What kind of things would the care managers serving in the
4 capacity of a clinical director do?
5 A I don't know all that they do. I really have --
6 Q Do you know any of what they do when they serve in that
7 capacity?
8 A I know they check orders. They check the admission
9 assessments to make sure nothing's been missed. I know they do
10 staffing patterns.
11 Q You say they do staffing patterns. What do you mean by
12 that?
13 A They initially will do the assignment sheet to make sure
14 that everybody is where they're supposed to be for the next
15 shift.
16 Q So they'll set the original I'll call it preprinted
17 assignment sheet?
18 A Yeah, yes.
19 Q And then just so I'm clear on this, when the care managers
20 have people reporting, the care managers then make adjustments
21 to that assignment --
22 A As necessary.
23 Q -- assignment sheet.
24 HEARING OFFICER HOLLO: Have you ever served in this
25 position yourself?

1 population that included care managers and care managers
2 commented on it. That was on the posting on Facebook. So by
3 analogy, we're looking for text messages where Ms. Viscome
4 communicated to a population of people including care managers
5 or they responded about the Union.
6 So I want to be clear we're not interested in anything
7 personal to Ms. Viscome or anyone else. And what I indicated
8 in the subpoena, in a narrative letter -- do you have the
9 letter that accompanied it?
10 HEARING OFFICER HOLLO: Yes, I do.
11 MR. MENDELSON: I indicated in the fourth paragraph, the
12 very lengthiest paragraph, that while what I am seeking would
13 identify not just care managers but also eligible voters, I had
14 indicated there that in complying with the subpoena there could
15 not be redaction of the names of the eligible voters because
16 part of my chore in making my burden is showing the extent to
17 which care manager communications about the Union affected
18 eligible voters. But I also recognize, especially after
19 reading the Union's petition, that there are concerns the Board
20 has expressed about Employer knowledge of an eligible voter's
21 sentiments about a union or otherwise.
22 So what I'm prepared to do is to indicate that compliance
23 or order of the hearing officer favoring enforcement of a
24 subpoena involving redaction of eligible voters' names would be
25 acceptable to the Employer. And there's only one caveat to

1 that. In concept, in concept, because the margin of difference
2 in the vote tally is so small here, 16 to 14, it could be that
3 I don't have to even know when an eligible voter's name is
4 redacted from such a communication that it is an eligible
5 voter. Let me explain that. I know this is rambling. I'm
6 sorry about that. I'm doing the best I can. Unfortunately,
7 that's the best.
8 There is a 16 to 14 margin. So if one --well, it's a
9 16/14 margin. There are two challenged ballots. You probably
10 have no knowledge of this. In the challenged ballot
11 proceeding, the Union agreed that one of the challenges was
12 inapt, that that particular voter's eligibility was no longer
13 in dispute. Have I lost you?
14 HEARING OFFICER HOLLO: I think there were --
15 MR. MENDELSON: Sort of.
16 HEARING OFFICER HOLLO: -- too many negatives in that
17 sentence. Try that one again.
18 MR. MENDELSON: There were two challenged ballots the
19 Union challenged.
20 HEARING OFFICER HOLLO: Understood, yes.
21 MR. MENDELSON: One of the two challenges the Union
22 essentially withdrew its challenge.
23 HEARING OFFICER HOLLO: Okay, now I understand.
24 MR. MENDELSON: That person's ballot has never been
25 counted because the other challenged ballot we litigated and

1 the Union has prevailed at this point and that challenge was
2 sustained, and the Board will not count the ballot for which
3 there was no challenge because it takes two to even it up from
4 16/14 to 16/16.
5 However, my understanding of the case law is that for the
6 ballot that the challenge was withdrawn on, for purposes of
7 analysis and deciding the margin of victory in a supervisory
8 taint challenge, the Board assumes for purposes of analysis
9 that the challenged ballot on which the challenge was withdrawn
10 could have been cast or was cast as a no vote. I'll have to
11 find the authority for that, but I believe that's true.
12 HEARING OFFICER HOLLO: Okay.
13 MR. MENDELSON: And that would make it 16/15. That's
14 where I got tongue tied a moment ago. So it's 16/15, 1 vote
15 swing changes the outcome of the election.
16 Now having said that and going back a step, my first
17 reaction was I'm open to redaction of the names of eligible
18 voters in these group texts or Facebook postings or Facebook
19 messages. However, I thought at one time I would still need,
20 when there was a redaction, for there to be an indication that
21 the redaction is of the name of an eligible voter, as opposed
22 to some other reason there's a redaction. And I thought we
23 would need to have any redaction of eligible voters' names
24 being Voter A, Voter B, Voter C. And I reserve my right to
25 state that that's our position.

1 But I have come to believe that if the analysis is as I've
2 described it in my very verbose statement here, and there is a
3 one vote swing, that it's very possible we don't even need to
4 have that kind of designation of eligible voter A, B, or C.
5 All we need to see is that it's a redaction of an eligible
6 voter generically and that as a result a one vote swing would
7 change the outcome of the election. And, therefore, I can
8 accept redaction of that eligible voter's name without any
9 other complication.
10 HEARING OFFICER HOLLO: So is there any other --
11 MS. LESHINSKI: I'm sorry. Can you go back a second? I'm
12 not sure exactly, you're saying you would -- you're suggesting
13 that the Union should comply with your subpoena except redact
14 the names of eligible voters?
15 HEARING OFFICER HOLLO: Correct. If there was a way for
16 me to do it and save you the trouble and difficulty, I would be
17 happy to. But I don't think you'd be amenable to that. So I'm
18 proposing that the subpoena of anyone here, including Ms.
19 Viscome, Mr. Abdullah, or the Union, could be complied with
20 even though it wasn't stated previously through redaction of
21 the names of eligible voters, meaning assuming for argument's
22 sake that there is no other reason to redact the name,
23 strangers are not known to me so why would I care what their
24 name was and why would the Union be concerned about that. If
25 there is a redaction it would indicate it's an eligible voter

1 without regard for how many individuals there are. And the
2 only names that I would be interested in seeing, other than Ms.
3 Viscome as the sender, would be the care managers and care
4 manager responses.
5 HEARING OFFICER HOLLO: Before I ask Ms. Leshinski her
6 position on your proposal, is there anything else you want to
7 argue in opposition to the Union's petitions to revoke?
8 MR. MENDELSON: Yes, I'm sorry. That was my clarification
9 or narrowing of the subpoena. Having glanced at the cases and
10 understanding Ms. Leshinski's argument, and recognizing the
11 sensitivities, and my narrowing of the scope of the subpoena
12 directed toward that, with all due respect to Ms. Leshinski and
13 the Union and to the Board, the Employer believes that the
14 balancing of interests here militates in favor of the subpoena
15 not being revoked and being complied with consistent with the
16 narrowing that I have articulated.
17 The reason is that for the Employer to sustain its burden
18 on the supervisory taint claim, we necessarily have to
19 establish the care manager conduct and its impact on eligible
20 voters. The information we seek has to do precisely with what
21 our burden is, to show the impact of care manager
22 communications or responses to communications upon eligible
23 voters. And so it's a narrowly tailored subpoena. It's not
24 seeking personal information. Response to this by the Union or
25 Ms. Viscome should not -- or Mr. Abdullah should not involve

1 anything personal to somebody involving their personal life.
2 That's of no interest to us. And all we're seeking is
3 information demonstrating communications back and forth between
4 the care managers and eligible voters, with eligible voters
5 other than Ms. Viscome being redacted.
6 Is it possible we can redact Ms. Viscome, too? I suppose.
7 I'm not against that. It's just that she's the person I'm
8 aware of who communicated fairly aggressively and broadly with
9 this stuff. And so even though the Board has weighty concerns
10 about an Employer not being aware of Section 7 rights in their
11 exercise by people privately, we believe that what we're
12 seeking here is narrowly tailored to the evidence that we're
13 required to submit to prove our case and sufficiently narrows
14 the alleged intrusion on Section 7 rights, and therefore is an
15 appropriate subpoena that should be enforced.
16 By the way, I'll also say to you that five to six months
17 after this election, I'm not aware of any unfair labor practice
18 charges having been filed against the Employer. I'm not aware
19 of any allegations of Employer engaging, demonstrating unlawful
20 animus or conduct toward anyone. As you've already heard, this
21 was a fairly aggressive situation where a witness said at some
22 points all people could talk about was the union election.
23 There are some people who, as this witness, who didn't shy away
24 from making known their sentiments. I submit to you there are
25 other people who were proponent of the Union who didn't hide

1 their sentiments.

2 And so in the context where there is no backdrop of any
3 Employer illegality or animus, while the weighty concerns that
4 the case law reflects about not intruding on individual Section
5 7 rights and privacy, I submit to you that those concerns do
6 not overcome the Employer's interest and narrowly secure the
7 evidence it needs to make its case. But, rather, the
8 Employer's needs supplant or outweigh the Union's interest in
9 claiming that the petition should be revoked. Thank you.

10 HEARING OFFICER HOLLO: Ms. Leshinski, before we proceed
11 any further with my consideration of the Union's two pending
12 petitions to revoke subpoena duces tecum and ad testificandum,
13 would the Union withdraw its pending petitions in acceptance of
14 Mr. Mendelson's proffer to redact certain information from the
15 provided information?

16 MS. LESHINSKI: No. And I'd like to give a longer answer,
17 unless you have other things you want to ask. May I explain?

18 HEARING OFFICER HOLLO: Yes, one second. Yes, please
19 provide a more full answer then. I just wanted to find out
20 whether it's a threshold matter we needed to go further if the
21 Union is not in agreement with his proffer or does not want to
22 withdraw in acceptance of his proffer. Then, yes, please
23 explain to the record.

24 MS. LESHINSKI: I don't know that this is totally, I
25 thought it was spelled out in the petitions to revoke, but

1 HEARING OFFICER HOLLO: Thank you. So, Ms. Leshinski, do
2 you have any response before I go off the record? I want to
3 consider this further.
4 MS. LESHINSKI: I mean this is in the petition to revoke,
5 too. I'll be brief but I think that the Veritas Health, it's
6 the 362 NLRB #32, it's a 2015 case, if you look at Footnote 1,
7 I mean the Board really does discuss subpoenas like these. And
8 this is a case where the subpoena was quashed and it was
9 seeking similar communications between employees and the Union,
10 and about authorization cards, and distribution and
11 solicitation of authorization cards. And the Board really
12 says, and it's citing this National Telephone Directory Corp.
13 case from '95 that this is Section 7 activity.
14 To the extent that these care managers, we believe they're
15 not supervisors. Even if we redact off RN and LPN names who
16 aren't care managers, if the care managers are also employees I
17 mean it doesn't cure the problem of not revealing employee
18 union activity because we think the care managers are also
19 employees.
20 HEARING OFFICER HOLLO: Thank you. I think what I'd like
21 to do now is let's go off the record.
22 (Recess from 1:59 p.m. to 2:35 p.m.)
23 HEARING OFFICER HOLLO: We're back on the record.
24 In regard to the two petitions to revoke subpoenas which
25 are filed by the Union on April 18th, I'm going to grant both

1 petitions to revoke. In doing so, the reason for my granting
2 them is that I believe the information sought in each of the
3 subpoena duces tecum is overly broad and it would serve to
4 impinge on the Section 7 rights of employees.
5 I note that the care managers, at this point in time, are
6 considered employees at law. If as the Employer contends they
7 are subsequently found to be Section 2(11) supervisors under
8 the Act, then the Employer will already possess the information
9 from its own supervisors. If they, the care managers, are not
10 found to be statutory supervisors then they will be employees
11 and the Employer will then have subpoenaed Section 7 activity
12 between employees, something which the Board strongly guards
13 against doing.
14 Finally, I find that the information sought in the
15 subpoenas will do little to shed light on the central question
16 here, which is whether the care managers' alleged pro-union
17 conduct would reasonably interfere with the bargaining unit
18 members' freedom of choice in the election.
19 And, finally, again I would direct the parties' attention
20 to Veritas Health Services, 362 NLRB #32, from March 19, 2015,
21 and Footnote 1 where the Board emphasizes it's resistance to
22 subpoenas governing communications between employees and the
23 Union and related topics that would subject Section 7
24 employees' activities to unwarranted investigation and
25 interrogation, and the Board is citing National Telegraph --

1 excuse me, National Telephone Director Corp., 319 NLRB 420, at
2 Page 421, which is a 1995 case. That is my ruling on the
3 petitions to revoke.
4 At this point, you can call your next witness, Mr.
5 Mendelson.
6 MR. MENDELSON: I need Ms. McCarthy.
7 HEARING OFFICER HOLLO: So while Mr. Mendelson is waiting
8 for his witness who is inadvertently stuck in security, we can
9 go off the record.
10 (Recess from 2:38 p.m. to 2:44 p.m.)
11 HEARING OFFICER HOLLO: Mr. Mendelson?
12 MR. MENDELSON: Yes, the Employer calls as its next
13 witness, Kelly McCarthy.
14 HEARING OFFICER HOLLO: Have a seat. Can you please raise
15 your right hand?
16 (Whereupon,
17 KELLY McCARTHY,
18 was called as a witness by and on behalf of the Employer and,
19 after having been duly sworn, was examined and testified as
20 follows:)
21 COURT REPORTER: Say and spell your name.
22 THE WITNESS: Kelly with a Y, K-E-L-L-Y, last name is M-C-
23 C-A-R-T-H-Y.
24 DIRECT EXAMINATION
25 BY MR. MENDELSON:

1 Q Good afternoon, Ms. McCarthy. Why don't you tell us for
2 the record who you are employed by and what your position is.
3 A I'm employed by Genesis Health Care at PowerBack, in
4 Voorhees, and I'm a care manager.
5 Q Okay. Try and keep your voice up, okay?
6 A That's usually not my problem. Okay.
7 Q When did you first come to PowerBack?
8 A August -- no, I'm sorry, the end of June 2014.
9 Q In what capacity were you hired?
10 A I was hired as a care manager.
11 Q In the summer of '15, what shift did you work?
12 A Night shift, 7p to 7a.
13 Q We've heard testimony three days a week?
14 A Yes.
15 Q That's the regular schedule?
16 A My regular schedule is 36 hours, give or take, 3 days a
17 week. We work 7:00a to 7:30. We have the extra half hour at
18 the end of every shift. Or 7:00p to 7:30 a.m.
19 Q And I'm sorry, when you were hired -- not when you were
20 hired. In the summer of '15, you were what shift?
21 A I was on 7:00 p.m. to 7:30 a.m.
22 Q Did there come a time that changed?
23 A Yes.
24 Q When was that?
25 A I'm not sure exactly when I made the shift. I don't

1 remember the exact time. I want to say September, but I'm not
2 sure. I honestly don't remember what month I made the shift
3 over. I was still picking up some night shifts.
4 Q If I represented to you it was in October, in fact I think
5 it may have been the end of October, does that refresh your
6 recollection?
7 A Yes, I believe so. Honestly, I would have to look back at
8 my schedules to remember.
9 Q We'll get a record and we'll introduce it into the
10 evidence. Now did there come a time when you gave
11 authorization cards, union cards to other nurses?
12 A Yes, I gave one authorization card.
13 Q To whom did you give it?
14 A I talked to several nurses. I don't remember the exact
15 person. I talked to two people. One was Lorraine and I know I
16 talked to Robin, two staff nurses, but I don't remember which
17 one filled out the card. I want to say I thought it was
18 Lorraine. Most of the nurses that I had talked to had already
19 been approached.
20 Q How do you know that?
21 A Because they told me they had already filled out a card.
22 Q So you're indicating that you gave a card, you think it's
23 to a woman, a staff nurse named Lorraine, correct?
24 A I know somebody signed one and I gave it back to Marilyn.
25 I just don't remember which one of the ones I talked to filled

1 Q Do they? They don't have to, but do you --
2 A I don't tell them unless I have to. I mean really that's
3 a decision that I'm making. I'm the care manager and I'm
4 managing the flow of the floor. The clinical directors usually
5 have their own duties they have to do. There's things that
6 they do, paperwork and following up on trends, and different
7 things that are specific to that position that the care
8 managers do not do, so they have another workload that no one
9 really, unless you've been a clinical director and have these
10 things assigned to you regularly, you wouldn't know. We just
11 handle it. The care managers on the floor, we just make the
12 choice of how it needs to go and we handle it. If there is a
13 problem or we need assistance with something, then we'll go to
14 the clinical director, but otherwise we just choose.
15 Q What about the assignments, let me just back up into that.
16 My understanding is there is an assignment sheet that someone
17 else prepares but then when your staff comes on and the CNAs
18 come on at the beginning of their shift, the care manager can
19 make adjustments in the assignment sheet.
20 A Sure.
21 Q You've given some testimony about this already. Do you
22 then run those changes in the assignment sheet by the clinical
23 director?
24 A If they require it, but they're usually quite happy to
25 pass that buck. They say fine and handle it.

1 Q So in the ordinary week, how often will you run changes in
2 the assignment sheet by the clinical director?
3 A I've never asked their approval for changes in the
4 assignment. I usually speak to the staff when I'm making an
5 adjustment. Whoever makes it, if the care manager makes the
6 adjustment, they just follow through and talk to the staff, and
7 notify them of the adjustment. If another care manager makes
8 it -- if the clinical director is the one making that because
9 the care manager is not at the desk, then the clinical director
10 will follow up and will tell us, make sure everybody knows. Or
11 we'll tell them themselves. Usually, they'll tell us to tell
12 them. Because it's a change so everyone on the floor has to
13 now know.
14 Q Back before you went to day side and were still on night
15 side, were there instances on night side where a care manager
16 functioned as the clinical director?
17 A Yes.
18 Q When would that happen?
19 A Any time the clinical director is not there. Right now,
20 we lost a night time clinical director. Summer works five
21 nights a week, thank you, schedule. But there's two nights
22 off, so there's a fill-in, part-time, night time clinical
23 director, but she quit some months ago. But there were times
24 when she wasn't scheduled and Summer wasn't scheduled, and I
25 filled in as clinical director on night shift.

1 Q Let me just stop you there. When you filled in as
2 clinical director on night shift, are you talking about before
3 you transferred to the day side?
4 A Yes.
5 Q So this is back in 2015?
6 A Yes.
7 Q How many times would you say you served that function?
8 A Probably at least four or five.
9 Q And what happens on the night side at least when you
10 worked there or if it's still the same today and you know that
11 you can tell us on the weekend in terms of the clinical
12 director being present or not.
13 A Every other weekend Summer has off so there's no clinical
14 director.
15 Q And then who serves in that capacity?
16 A The care managers.
17 Q So that's every other weekend, twice a month.
18 A Yeah, it's frequent.
19 Q During the course of a shift, apart from what you've
20 already told us, do the RNs seek input from the care managers
21 in any instance?
22 A Yes.
23 Q Give us examples of that.
24 A Such and such has a fever of 180 over 70, what do I need
25 to do or can you notify the doctor, make a decision about what

1 to do.
2 Q Are there instances --
3 A Or --
4 Q I'm sorry, go ahead.
5 A Or if someone has a fever or if someone just doesn't look
6 like, or someone is acting different, can you come look at
7 this, I don't know what to do about this.
8 Q And then once you're summoned by the RN, what happens then
9 in terms of your responsibilities? And if you provide
10 direction, tell us.
11 A Well, part of my job is to be a resource for them and as
12 support. So if they don't know what to do, then I will assess
13 it, myself, get some input from them. I'll look at what
14 medications the person is on and I'll try to come up, assess
15 what the problem is with the patient, and then say give him
16 this. Like, for example, somebody can't breathe, do they have
17 PRN nebulizer treatments? Oh, they do, okay, good, give them a
18 nebulizer treatment. Maybe the nurse didn't check. Maybe they
19 were busy.
20 So I assess and figure out what the proper course of
21 action might be. And then if I have to get something new for
22 the patient that requires a physician's authorization then I
23 would contact them and get the authorization.
24 Q Do you always have to get a physician's authorization
25 or --

1 A No.
2 Q There are instances where you do things independently?
3 A Yes.
4 Q And then when you have reassessed the situation, how do
5 you effectuate it? Who does what you then have decided has to
6 be done?
7 A Whoever I choose, either me or the cart nurse. Let's say
8 somebody's blood pressure is really low and I find -- I'm
9 taking to the nurse and she says, yeah, the blood pressure is
10 low, it's in the 80s. All right, did you put them
11 Shandelenberg (ph.), did you put the foot of the bed up, did
12 you do this, did you do this, give them some fluids. I'll
13 direct the nurse, did you try these things already. And if not
14 then I'll say, okay, do that.
15 Q Do you exercise discretion and judgment in performing
16 these activities and giving these directions?
17 MS. LESHINSKI: I'm going to object to that question
18 before this witness answers. I mean he needs to ask -- I
19 object to the form of the question. I think the question needs
20 to be more specific as to what --
21 MR. MENDELSON: I'll withdraw it.
22 MS. LESHINSKI: -- the question means --
23 MR. MENDELSON: I'll withdraw it.
24 HEARING OFFICER HOLLO: I was going to ask the same thing.
25 MR. MENDELSON: I'll withdraw it.

1 BY MR. MENDELSON:
2 Q How do you decide what needs to be done in these variety
3 of instances?
4 A It's based on each cart nurse's individual capabilities.
5 Some nurses might -- are less experienced than others and I
6 might direct them to do certain things that I know they're able
7 to do. But if it's something that they are not familiar with,
8 I might do it myself. It depends on the situation. It also
9 depends on how busy I am. If I have time, I might do it
10 myself. If I'm very busy and dealing with another issue over
11 here, I might direct the cart nurse to do it. Then I'll go
12 back and check on it, and see if it was done and what the
13 results were, and get a follow-up evaluation.
14 Q Apart from what you just said, how do you know what to
15 suggest?
16 A How do I know what to suggest --
17 Q Yes.
18 A -- should be done?
19 Q Yes.
20 A Just the nursing process and experience of what you do for
21 certain things, what the typical protocol is when someone
22 presents with a certain status.
23 Q I heard testimony in this case and elsewhere about
24 doctor's orders. Is what you're doing guided entirely by the
25 doctor's orders?

1 A No.
2 Q Explain to me how it's not guided by a doctor's orders.
3 A Because there are many things that legally a nurse can do
4 without the doctor's order. Like if someone can't breathe, we
5 could give oxygen. Like ultimately we have to save someone's
6 life. We also are able to call 911 without a doctor's order if
7 we feel that something is life-threatening and death might be
8 imminent. So you have the option of stepping outside those
9 rules as authorization because the largest responsibility is to
10 not cause harm and to save someone's life.
11 Q I want to talk for a moment about I'll call them critical
12 events. You mentioned life-saving events. Things like code or
13 chest pain, or GI bleeds, or breathing issues, how do you
14 become aware of those things?
15 A The nurse comes and tells me or I witness them myself if
16 I'm at the hall, down the hall doing rounds.
17 Q Then what do you do upon becoming aware of that?
18 A I assess what's being done so far. I see who is involved
19 and who I can get to help. I decide what part I'm going to
20 play in it, whether I'm going to be active in it or if I'm
21 going to have other people do it and I'm going to be someone
22 that goes and notifies the doctor, or gets a practitioner, or
23 gets the crash cart. The cart nurse usually doesn't do that.
24 In those kinds of instances, as soon as the care manager
25 arrives, most of the cart nurses will immediately like let the

1 care manager take over and make the choices about how we're
2 going to handle this. Like they will attend to the patient,
3 but they won't necessarily attend to all the other details of
4 getting other people and what we do.
5 Q Who decides the allocation of responsibility across the
6 people who are assisting?
7 A I would be the care manager or the clinical director, if
8 they were there. They're usually not there. They'll go get a
9 clinical director if there is no care manager available at that
10 minute. They might run up to the desk. They don't see me or
11 someone else, so they'll get the clinical director instead to
12 handle it.
13 Q So how often in your experience does the clinical director
14 get involved?
15 A Different on different shifts. On the day shift not so
16 much, not often. They're usually busy with other duties. On
17 3:00 to 11:00, clinical directors are more involved. On 11:00
18 to 7:00, I know the clinical director is more involved. But in
19 addition to the care manager, not instead of the care manager.
20 Usually, it's in addition. They're coming, too.
21 Q So when the clinical director is present, are there
22 instances you've been involved in where the care manager is
23 still allocating responsibility to other team members to do
24 things?
25 A Yes, because the clinical director would be new to the

1 scene. They don't know what has already happened. So if the
2 care manager was already there, the care manager would continue
3 to follow-up with whatever she already -- she or he already set
4 in place. The clinical director doesn't even know what has and
5 hasn't been done so they'll just be kind of as an assist,
6 unless they were there first. Whatever supervisor comes there
7 first and knows what's going on usually assumes throughout
8 unless there is a handoff for some reason. It's different for
9 everything. You work hand in hand.
10 Q We've had testimony about incident reports. Walk us
11 through how it's determined who does what in connection with an
12 incident report.
13 A Ultimately, it's the care manager's responsibility.
14 That's what I was -- when I was first trained, I was told it's
15 the care manager's responsibility to make sure that all aspects
16 of an incident are completed from the paperwork that has to be
17 done to the decision about how you're going to stop it from
18 happening again, to the follow-up of making sure that those new
19 interventions to not have -- make sure it doesn't repeat are
20 followed up on and the employees are carrying through with
21 those interventions, like the cart nurse or the CNA.
22 Q So who is determining what --
23 A The care manager.
24 Q The care manager, okay.
25 HEARING OFFICER HOLLO: Wait, wait, I didn't hear the

1 specifically as a care manager, we're responsible for the
2 patients. So we might decide to do something if we feel like
3 the provider is not calling back and in our best judgment we
4 think this person needs it, the care manager would be the one
5 to decide, yes, do it, because there might be some kind of
6 someone coming back over it, because now you've made like an
7 overriding decision. So you're responsible for it. But the
8 cart nurse wouldn't ever do that. That's the care manager
9 would assume that role.
10 Q Has it ever been the case that you're the senior nurse who
11 does a walk around with the doctor?
12 A Yeah.
13 Q What's the normal protocol? Who does the walk around with
14 the doctor?
15 A Someone from therapy, the senior nurse on the floor, and
16 the medical director.
17 Q And so who in the normal course is the senior nurse on the
18 floor?
19 A The clinical director.
20 Q There are instances where someone other than the clinical
21 director is the senior nurse?
22 A Yes, I have been.
23 Q You have been okay. How many times has that happened?
24 A Recently, I had to do the walk around only once. But I've
25 gone to -- morning meeting is another thing that the senior

1 nurse does and I've gone to morning meeting a couple of times
2 when the clinical director was absent on the floor that day.
3 Q How many times have you gone to the morning meeting?
4 A At least twice, maybe more, but I know of two instances
5 that I did.
6 Q When you're there, you're functioning as the senior
7 director?
8 A Yes.
9 Q As the clinical director?
10 A Yes.
11 Q And same as the walk around?
12 A Yes.
13 Q And as a result of being at the morning meeting or doing
14 the walk around, what do you do with the information you've
15 acquired?
16 A I follow up on it if something needs to be done. Like
17 anything else, it's an exchange of information. If I need to
18 do something then I do it myself or make sure whatever
19 instructions I've been given are followed.
20 Q Are you accountable, do you deem yourself accountable for
21 the performance of your team?
22 MS. LESHINSKI: I'm going to object to the question. I
23 think it needs to be more specific about what accountable means
24 rather than use these buzz words like accountable.
25 MR. MENDELSON: I don't think it's a buzz word.

1 BY MR. MENDELSON:
2 Q Have you ever been in your mind held responsible for the
3 performance of your team?
4 A Yes, I am responsible for them. That's part of the job
5 description.
6 Q And so how have you been held responsible for them?
7 A An example would be if a nurse is passing her meds and
8 she's very late because she's overwhelmed and I wasn't aware of
9 it because I didn't check with her, and I didn't offer her help
10 or get her help from someone else, I'm then responsible for
11 that, too, because part of my job is to manage the floor. So
12 if she's not receiving what she needs to get her job done
13 effectively, I'm also responsible for that. One person can
14 only handle so much. And I'm supposed to, as the care manager,
15 be aware, making myself aware of the status of all the nurses
16 to make sure that things are going the way they need to go.
17 Q Have you ever been spoken to by the clinical director
18 because the clinical director thought things had not happened
19 on your team and your shift the way it should have been?
20 A I don't think so. No, I don't think so.
21 Q Are there instances where you speak to your team because
22 you think that they have not executed their responsibilities
23 properly?
24 MS. LESHINSKI: I'm going to again object and ask that
25 this question not be so general that if there is some specific

1 instance that that's what the witness should be testifying
2 about.
3 MR. MENDELSON: I don't understand the objection. I don't
4 think there is anything inappropriate about the question.
5 MS. LESHINSKI: I think it's a vague question.
6 MR. MENDELSON: The witness can answer with all the
7 specifics that she knows.
8 MS. LESHINSKI: I think it's a vague question.
9 HEARING OFFICER HOLLO: It might be vague, but I don't see
10 anything objectionable in it. Overruled.
11 THE WITNESS: One more time?
12 BY MR. MENDELSON:
13 Q Have you communicated with your team members when you felt
14 that they were not executing their responsibilities properly?
15 A Yes.
16 Q What have you done?
17 A I have counselled CNAs that they cannot take a break
18 longer than 30 minutes and they must be on the floor at the end
19 of their break. I have counselled CNAs that they have to come
20 to work on time and they cannot come to work late. I have
21 counselled cart nurses that they did not notify me in a timely
22 manner about a situation that was detrimental to the patient
23 and I should have been told about it so that I could assist.
24 There's been times when the patient got a little bit worse
25 because the nurse didn't alert anyone and didn't tell the care

1 manager so that we could step in and direct and/or help.
2 Sometimes the nurses don't know what to do. I've talked to at
3 least two nurses where they really didn't know what to do in a
4 situation and did nothing. Then I found out about it later on
5 when things were more progressed, so I had to say you have to
6 tell me immediately when these things happen so I can help you.
7 If you don't know how to do something, you have to come to me
8 so I can do it for you, teach you how to do it, or get you the
9 answer. And you also have to notify me if you're overwhelmed.
10 There's times when nurses are very late passing their meds
11 because they just didn't tell someone that too many things were
12 happening at once or that they were overwhelmed. So I'll
13 counsel them what their duties are, which is to pass the meds
14 in a specific period, in a safe manner. And if they are not
15 able to do that, they have to tell someone so we can help them.
16 That's their responsibility.
17 Q Do you initiate this kind of corrective action on your
18 own?
19 A Yes.
20 Q Do you report it to the clinical director?
21 A If I feel they need to know.
22 Q So there are instances where you have not reported it to
23 the clinical director?
24 A No, because it's just an interaction between myself and
25 them.

1 Q And do you understand yourself to have the authority to
2 issue discipline?
3 A Yes. I have issue discipline.
4 Q You have issue discipline?
5 A Um-hum.
6 Q You have to answer audibly.
7 A Yes, I have issued discipline.
8 Q Tell us about that.
9 A Oh, what it was? It was the beginning of a write-up, also
10 known as an IPIP, for someone who was taking very long breaks
11 and disappearing throughout their shift.
12 Q Prior to working at PowerBack, did you work at any other
13 health facility?
14 A Yes.
15 Q At that health facility, what was your position?
16 A I was an RN supervisor. The only RN in the building at
17 the time during my shifts.
18 Q How did your responsibilities in that position compare to
19 your responsibilities at PowerBack?
20 MS. LESHINSKI: I'm going to object to totally irrelevant.
21 HEARING OFFICER HOLLO: Sustained.
22 MR. MENDELSON: Can I make an offer of proof?
23 HEARING OFFICER HOLLO: I don't see how ones
24 responsibilities at a different facility has any bearing on
25 whether or not they're statutory supervisor in the matter

1 before me.
2 MR. MENDELSON: This witness is able to give you testimony
3 comparing a situation where she was the chief nurse on a shift
4 to what happens when she is a care manager at this facility. I
5 think the comparison is quite apt.
6 MS. LESHINSKI: I mean it's just irrelevant. Whether she
7 was supervisor at PowerBack depends upon her responsibilities
8 at PowerBack. Comparing it to some other facility that we
9 don't know about, I don't see how that's helpful.
10 MR. MENDELSON: I have to say we set precedent in this
11 arena. There is a lot of health care industry precedent. And
12 so whether there is a similarity between that facility and
13 PowerBack or a difference, it seems to me it's not really any
14 different than relying on precedent in determining whether
15 these care managers are or are not statutory supervisors in
16 asking this witness that question.
17 HEARING OFFICER HOLLO: I'm going to sustain the
18 objection.
19 BY MR. MENDELSON:
20 Q When you have filled in as the clinical director, are you
21 paid for those hours that you're filling in for the clinical
22 director the same as when you're a care manager?
23 A No.
24 Q What happens?
25 A We get an extra amount of pay, bump up.

1 Q Do you know whether that bump up has any relation in its
2 amount to what the clinical director gets paid?
3 A I think it's supposed to make me equal to what the
4 clinical director gets paid. That's why you get it because
5 there is a base pay that the clinical directors get.
6 Q Have you ever attended something called a leadership
7 meeting?
8 A Yes.
9 Q And what is the leadership meeting?
10 A Leadership meeting was something that Patty held monthly
11 and it was a forum to discuss issues, come up with ideas, offer
12 complaints, problem solve.
13 Q Who attended the leadership meeting?
14 A Care managers and clinical directors. And they were
15 mandatory.
16 HEARING OFFICER HOLLO: Who is Patty?
17 THE WITNESS: Patty Melaura, the former DON, director of
18 nursing, or chief executive nurse.
19 HEARING OFFICER HOLLO: Okay.
20 BY MR. MENDELSON:
21 Q Did you -- have you participated in Management 101 course
22 training?
23 A Yes.
24 Q What is that?
25 A That is online training that is a requirement to complete,

1 which teaches you about leadership. There's some clinical
2 stuff in there. It's just a whole -- it's what Genesis feels
3 as a supervisor, manager, leader, all the above, you should
4 know. That's what they require their employees to complete.
5 Q Do you know are there any clinical directors now or in the
6 past, going back to the summer of 2015, who promoted into
7 clinical director positions on a full-time basis --
8 A Yes.
9 Q -- after having been care managers?
10 HEARING OFFICER HOLLO: Wait, wait, excuse me. You
11 absolutely have to let him ask the question, because I don't
12 know what he's going to ask, so you really need to wait. And
13 once you hear the full question, please answer then.
14 THE WITNESS: Sure.
15 MS. LESHINSKI: Could you repeat the question?
16 MR. MENDELSON: Yeah, of course.
17 HEARING OFFICER HOLLO: Yeah, I was going to say and I
18 don't even know what the question is. You have to stop
19 interrupting each other. Repeat the question.
20 BY MR. MENDELSON:
21 Q Since the summer of 2015 through today, are you aware of
22 any people who have held full-time the clinical director
23 position who got promoted into that position from being care
24 manager?
25 MS. LESHINSKI: I'm going to object. I don't think it's

1 relevant.
2 MR. MENDELSON: We're trying to prove that some of --
3 HEARING OFFICER HOLLO: Hang on one second. Okay, go on.
4 MR. MENDELSON: We're trying to prove at some level the
5 synonimity (ph.) between care managers and clinical directors.
6 They are not obviously identical but they are at some level
7 interchangeable. That's our position.
8 HEARING OFFICER HOLLO: Given the fact that one can be
9 promoted from one position to another just means that one
10 position can be a stepping stone to another. So I don't see
11 the relevancy to the answer to that question. Do you want to
12 try and obtain the information in a different way?
13 MR. MENDELSON: I think with --
14 HEARING OFFICER HOLLO: Lots of people get promoted to
15 positions from positions beneath them. That doesn't mean the
16 positions are synonymous. May actually mean the opposite.
17 MR. MENDELSON: I think we're putting a mosaic together
18 here and it's a fact that I think the evidence is an
19 appropriate part of the record.
20 HEARING OFFICER HOLLO: I'm going to sustain the
21 objection. You might ask it in a different way.
22 MR. MENDELSON: Well, I don't think there is any other way
23 I can ask it. Can I have two minutes so I can talk to my folks
24 and see whether I've covered everything I need to cover? I'd
25 like to step out of the room.

1 Q You're talking about filling out the assignment sheet?
2 A Yeah.
3 Q When you fill out the assignment sheet, we had this
4 conversation about how nurses are assigned to carts and carts
5 are assigned to rooms, so if you're filling out the assignment
6 sheet and you have rooms, I don't remember what rooms Cart 5 is
7 assigned to, but you have those rooms, you would just fill in
8 the name of the person who had Cart 5 that day in the staffing
9 assignment sheet, correct?
10 A If that person is assigned to a cart. If they are not,
11 then I do not.
12 Q If somebody comes in and -- but eventually all the nurses
13 are assigned to carts and the carts are assigned to rooms,
14 correct?
15 A No. There are some nurses that remain floats.
16 Q Okay. So if you have an agency -- so you have all the
17 carts are assigned to nurses except Cart Number 6, and you have
18 an agency nurse come in that day, which cart is she going to go
19 to?
20 A The cart that whoever made the assignment for that
21 morning, which is the clinical director on night shift.
22 Q And if the clinical -- you're saying that you sometimes do
23 the assignment sheets?
24 A Yes. It's different on nights and days.
25 Q If you do the assignment sheet, would you put the agency

1 nurse on Cart 6 because nobody else is on Cart 6?
2 A Or I might put her on Cart 7 if no one else is on Cart 7,
3 yes. I would put it on --
4 Q But she could -- I'm sorry.
5 A I wouldn't automatically -- there might be more than one
6 empty cart, so I would choose.
7 Q And you just stick her on one of the empty carts then?
8 A Yes. We try to put them on the cart they were on
9 previously for continuity of care.
10 Q Then you would fill her name in on the assignment sheet,
11 if you're doing the assignment sheet, that she's on Cart 6 and
12 Cart 6 is assigned to those patient rooms.
13 A Yes.
14 Q I see Number 7, care managers do not interview, hire,
15 fire, perform evaluations, or attend clinical director
16 meetings. Did you write that?
17 A That is true. I have not done those things.
18 Q Your Number 9, any cart nurse can perform care manager
19 duties. There is no special access to the computer system and
20 files allowed only to care managers. Is that correct?
21 A That is true. Except that's not true, I'm sorry, I'm
22 wrong.
23 HEARING OFFICER HOLLO: I believe the question was -- can
24 you repeat your question? Did you ask if she wrote it or if it
25 was true? I thought you asked her if she wrote it.

1 A Yes.
2 Q Do you verbatim tell the nurse who you're giving direction
3 to after that what the doctor said or do you provide any sort
4 of interpretation in terms of what you do?
5 A There's interpretation.
6 Q There were a bunch of questions on cross-examination about
7 what you do in connection with critical events such as a code.
8 Are there instances in which you give direction as to what each
9 person on the team does in handling that situation?
10 A Are there instances when I would or have?
11 Q Have.
12 A When I have? No. But there was -- well, that was it.
13 HEARING OFFICER HOLLO: That's the answer.
14 THE WITNESS: Um-hum.
15 BY MR. MENDELSON:
16 Q Do you have P-12 in front of you?
17 A Yes.
18 Q In Item 6, it says care managers do not decide on staffing
19 assignments. In general, is that true?
20 A That's true on night shift.
21 Q So there has never been an instance on night shift where
22 you had to make an adjustment in the assignment sheet?
23 A Not if I was acting as a clinical director that night.
24 Q I'm sorry. You're saying if you were a clinical director,
25 you would decide on the assignment?

1 A Yes. And very occasionally if the clinical director says
2 -- would say move people around, I have. But that's specific
3 to night shift.
4 Q Let me ask you, so on the night shift when you were care
5 manager, were there ever call-offs?
6 A Yes.
7 Q And when there are call-offs, am I correct that you then
8 have to reassign people to cover the call-off?
9 A It has to be done. But if Summer is there, she prefers to
10 do it.
11 Q You're saying Summer, the clinical director?
12 A That's her preference. Her preference is that she does
13 it.
14 Q And then when Summer is not there and you're acting as the
15 clinical director, then you do it?
16 A Yes.
17 Q Are there instances when someone other than yourself as a
18 care manager serves at the clinical director?
19 A Yeah.
20 Q In those instances where someone other than you served as
21 the clinical director, as the care manager would you then do
22 the reassignments and Summer wasn't there?
23 A Sure.
24 Q To that extent Number 6 is not true because you were the
25 care manager where someone other than you was serving as the

1 manager other than you was serving as the interim clinical
2 director, and you were a care manager therefore.
3 A Yes.
4 Q Were there instances in those circumstances where somebody
5 called off?
6 A Yes.
7 Q In those instances, did you reassign to cover the call-off
8 without getting permission of the interim clinical director?
9 A Not on night shift, no.
10 Q Even when Summer wasn't there?
11 HEARING OFFICER HOLLO: I think you already answered the
12 question.
13 THE WITNESS: Yeah. When Summer wasn't there, on night
14 shift, the clinical director does it unless the care manager is
15 filling in as the clinical director. It's just the habit, so,
16 no, I haven't on night shift.
17 BY MR. MENDELSON:
18 Q Okay. On day shift, is it true that as a care manager you
19 do decide upon reassignments?
20 A Yes. Day shift patterns are different than night shift.
21 Q So Number 6 is not true as to when you're a care manager
22 on the day shift.
23 A Correct.
24 Q When did you write this?
25 A When I was still on night shift. My experiences were

1 Q So let me just ask another question. You talked about
2 also when you've been serving as clinical director attending
3 the morning meeting. Do you consider that a clinical director
4 meeting?
5 A The clinical director habitually goes, yes.
6 Q So in the summer of 2015 or before when you served as a
7 clinical director, did you attend the a.m. meeting?
8 A Yes, I did attend two, I said, unit a.m. meetings.
9 Q So now what clinical director meetings are you talking
10 about other than the leadership meeting and other than the a.m.
11 meeting?
12 A Just private meetings that the DON would have with the
13 clinical directors.
14 Q Number 8 refers to extracurricular projects assigned by
15 the DON. Do you see that?
16 A Um-hum.
17 Q Correct.
18 A Correct.
19 COURT REPORTER: Yes?
20 THE WITNESS: Yes.
21 BY MR. MENDELSON:
22 Q Okay. I understand that you've already explained this was
23 written in the summer of 2015. Today, are you as a care
24 manager a participant in extracurricular projects assigned by
25 the DON?

1 which one.
2 Q What if it's a nurse?
3 A If it's a nurse, how is the person assigned? It depends
4 on when the hole happened. If there was a call-out prior to
5 the shift, the clinical director would try to get someone in.
6 Or if there was extra people, would then just reassign someone.
7 If it's somebody didn't show then whoever is handling it at
8 that time re-arranges it depending on who is there.
9 Q How would it be re-arranged? Has that happened before?
10 A People didn't show? Yeah.
11 Q And what did you do?
12 A As a care manager, when people didn't show for say on 3:00
13 to 11:00, there's a lot of care manager stuff where I'm doing
14 scheduling on 3:00 to 11:00 specifically, the day shift, just
15 move the CNAs around.
16 HEARING OFFICER HOLLO: What about with nurses? We're
17 talking about the nurses.
18 THE WITNESS: Oh, nurses. Have I moved the nurses around
19 according to the pull list? No, I haven't moved nurses around.
20 BY MS. LESHINSKI:
21 Q Do you ever make calls to try to get people to come in?
22 A Yes, I did.
23 Q Can you require them to come in?
24 A No one can be required to come in.
25 Q Can you require them to come in?

BEFORE THE

NATIONAL LABOR RELATIONS BOARD

In the Matter of:

SR-73 AND LAKESIDE AVENUE OPERATIONS, LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73,

Case No. 04-RC-161250

Employer,

And

DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME, AFL-CIO,

Petitioner.

The above-entitled matter came on for hearing pursuant to Notice, before ELANA HOLLO, Hearing Officer, at The National Labor Relations Board, Region Four, 615 Chestnut Street, Philadelphia, Pennsylvania, on Wednesday, April 20, 2016, at 9:30 a.m.

1 Voorhees?
2 A I was hired September of 2013 as a cart nurse and then was
3 promoted to care manager the following year.
4 Q In 2014?
5 A 2014.
6 Q Okay. And what shift do you work?
7 A I work day shift 7:00 A to 7:00 P.
8 Q And has that been consistent?
9 A Yes.
10 Q So since you've been a care manager you've been on the day
11 side?
12 A Correct.
13 Q Had you ever worked on the night side?
14 A I've only stayed until 11:00 p.m. occasionally to help
15 out. I just -- I've never actually worked a full night.
16 Q Okay. How many times would you say you've worked on the
17 night side through 11:00 p.m.?
18 A Maybe six at total throughout my time there.
19 Q Okay. Do you have anything to do with assignment of RNs,
20 LPNs or CNAs?
21 A Yes.
22 Q Tell us what you have to do with that.
23 A We -- for RNs and LPNs they have carts. There's carts per
24 the floor. Cart one, two, three, four, five, six, seven, eight
25 that if you're not a regular nurse, meaning if you haven't been

1 assigned to a cart, you -- the care manager and/or clinical
2 director will decide what cart you go to.
3 So what you do is you look at who you have. Who is your
4 regulars? And then you make a decision on the leftover ones,
5 where they're going to go. And a lot of times if it's --
6 because if you haven't gotten a cart assignment yet, it's
7 usually you're fairly new or you're an agency nurse. So you
8 look at the acuity level of that cart and decide who would be
9 the best fit for each cart. And that's how.
10 Q Okay. When you say you look at the acuity level, explain
11 what you mean by that.
12 A If you have a lot of --
13 Q Who's the you you're talking about?
14 A Oh, if the patients have a lot of tube feeds or wound
15 vacs, IVs, you wouldn't want to put a brand new nurse on that
16 cart. You might want to put a more seasoned nurse on that art.
17 So if you have the option to put the seasoned nurse on the
18 section that has the higher acuity level and then you would put
19 the newer nurse on one that might only have a whole bunch of
20 hips and knees.
21 Q Okay. So I asked who's the you you're talking about, when
22 you're talking about who's assigning the nurse to --
23 A You is the care manager.
24 Q Okay. That's what I was trying to get at.
25 A Yeah, you as the care manager would make that decision.

1 Q Okay. What other factors, besides what you've already
2 discussed, if any do you consider in deciding which nurse goes
3 to which cart?
4 A If -- we have a lot of people picking up overtime. So you
5 make a decision of continuity of care that if -- even though
6 it's a pickup day for one of the nurses, if they might have
7 already been on that cart the past two days and it's another
8 person's regular day to be on that cart, you might make the --
9 or I, the care manager, would make the decision to keep the
10 nurse that picked up an extra day, because she's already been
11 on that cart for three days, and put that other nurse, even
12 though a regular, onto a different cart for that day just to
13 keep up with the -- you know, the care.
14 Q Okay. Any other factors?
15 A It would be more not changing the whole assignment. It
16 would be more selective of I might ask to switch out a
17 particular patient or a particular treatment of that assignment
18 to another nurse.
19 Q And why?
20 A I would have -- if somebody has a wound vac and then I
21 have a nurse on that cart who is not very familiar with wound
22 vac treatments, I would ask another nurse who is could you take
23 room 10, which is a wound vac room and she will -- you know,
24 and she'll switch out another room for you off of your
25 assignment. So they would do an even switch.

1 Q Okay. Now, you said would. Is that something that you're
2 saying hypothetically you would do or you have done?
3 A I have done.
4 Q Okay. So far in testimony is everything you've said
5 something you have done, based on the factors you are
6 articulating?
7 A Yes.
8 Q Okay. What other factors, if any, do you account for in
9 deciding how to assign, whether an entire cart or some part of
10 what that cart does?
11 A I have decided, if there has been a patient complaint or a
12 family complaint of a particular nurse and/or CAN, you -- I
13 have to, as the care manager, change the assignment. Say --
14 same thing, I'm going to use room 10 -- if that family does not
15 want a particular nurse anymore I would have to give that room
16 to another nurse and then they would have to pick up another
17 room from them. So they do like a switch. So it has to be a
18 judgment and I try to make the judgment on somebody of equal
19 acuity level that they're switching off with.
20 Q Do you always yield if a family or patient does not any
21 longer way a nurse or a CNA?
22 A No, I -- you first have to do a thorough investigation
23 with -- speak to the family, speak with the nurse itself, speak
24 with the patient, the aides and kind of make sure that there's
25 not something else you could do first. That's like your last

1 resort is to start switching rooms around. First, you want to
2 try to figure out how we can make this better and to keep the
3 same nurse and/or CNA on the cart.
4 Q Okay. So has it ever happened that in response to a
5 patient or family compliant you have not switched out a nurse
6 or a CNA?
7 A Yes.
8 Q Okay. And has it ever occurred that -- well, when you've
9 decided not to switch out, what if anything do you do in
10 speaking to the nurse or CNA?
11 A I will -- after I've investigated I go back to the nurse
12 or the CNA and discuss where the line of communication went
13 wrong, that the patient perceived this to be a problem. I
14 explain to them why this might have happened and this is how I
15 need you to move forward, based on my explanation to the
16 patient. So then I direct them that this is how we're going to
17 do it from here on out.
18 Q Okay. You mentioned before a specific skill set, for
19 example familiarity with doing wound vacs, are there other
20 instances where you give consideration to the patient -- strike
21 that. Are there other instances where you give consideration
22 to other factors relating to the nurse of CNA?
23 A If -- for CNAs you'll -- there's time that the patient is
24 -- needs to have two CNAs to go in there, more for a safety
25 factor for the patient and for the CNAs. Like occasionally the

1 patient will say oh, I don't like that one or she's too mean to
2 me. So we've made the decision that it should always be two a
3 time going in, so you have somebody to witness and to be there
4 for the care of the patient.
5 Q Has it ever happened, and if it hasn't you'll tell me,
6 that you've explained to the CNAs or the nurses, where there's
7 two at a time, the basis for your decision to do that?
8 A Yes. Yeah, I always give an explanation anytime I tell
9 them. Any change in assignment or care, I try to give an
10 explanation why that is.
11 Q Okay. Are there any other factors you rely upon in
12 pairing a nurse or a CNA with a patient or a room?
13 A Frequently when we have male CNAs we will have to switch
14 out patient rooms, because unfortunately some of females don't
15 want a male CNA. So you'll have to take that into
16 consideration. And it's -- you have delve it out, because you
17 still have to make it equal. So you have to take a room from
18 this one, and give a room to that one and switch it around that
19 way.
20 Q Do you always switch our, based on gender, when a patient
21 or family requests that?
22 A Yes, if they request it we always abide by that, yes.
23 Q Okay. And you've talked here about when you're doing the
24 switching out you try to match up the acuity of the patient?
25 A Correct.

1 Q Is there any other variable that you are considering when
2 you're switching people or even making the decision to switch
3 people? By people I mean nurses or CNAs.
4 A You look at -- one, you wouldn't put them -- I look at
5 location, because if -- you know, we have two hallways, two
6 horizontal hallways. So it's unrealistic to ask a CNA to pick
7 up room one on this side and then room 60 on the other side all
8 the way at the end. That's just -- that would be not care for
9 the patient. So location, you look at that.
10 Big part is acuity. You want -- if you're asking him to
11 pick up -- him/her to pick up, you know, a patient that's an
12 extensive, you want to make sure they're giving up one of their
13 extensive patients to make it fair --
14 Q I'm asking are there other things you look at besides
15 patient acuity, in terms of deciding whether a nurse or a CNA
16 is well equipped to go handle a particular patient?
17 A Their skills.
18 Q Well, that's what I'm after --
19 A Yeah. If -- especially with nurses, the more seasoned
20 ones would be -- you would ask them to do the more skilled jobs
21 than a newer nurse fresh out of school or fresh off of
22 orientation and doesn't know how to use all of our equipment
23 and everything yet.
24 Q Do you factor in your experience with the nurses or the
25 CNAs, in terms of how quickly they handle particular types of

1 problems? The speed with which they can discharge the -- or
2 execute the task?
3 A I would -- that's more so on admissions. You look at
4 speed and that somebody would be able -- one of the nurses
5 who's been there longer and knows how to do the admissions
6 faster, you could give them more tasks than giving a newer
7 person.
8 Q Okay. Is it entirely based upon whether a person is
9 junior or senior, or are there other elements to that judgment?
10 A Well, there's other elements. I mean you know their
11 personalities, you know their -- I mean we have people that
12 have worked there from day one, but they're still one of the
13 slower nurses, and still always running behind and everything
14 like that. So yeah, it really doesn't -- it's not a seniority
15 thing, it's just some get it more and some don't.
16 Q Now, you mentioned admissions. When, in general, if there
17 is a generality to be made, is there the most activity of new
18 admissions into the facility?
19 A New admissions start to come in around 2:00-3:00 O'clock
20 in the afternoon. And that will continue on until 8:00-9:00
21 O'clock at night. Even sometimes we get people at 10:00.
22 That's a little rare. But usually from 2:00 to 8:00 p.m. is
23 your high admission time.
24 Q Okay. And how if at all does the admission of new
25 patients affect the way you manage the staff?

1 A We -- admissions department does the best they can trying
2 to scatter them around the building, but it's all based on how
3 many empty rooms you have anyway. So you could have on a
4 nursing assignment it may have 16 -- 15 to 16 beds. You could
5 have one that has three open rooms. They're going to get three
6 admissions. There's nothing you can do about that.
7 So if that is the case, when you see that this person is
8 getting three admissions, you go to their partners down the
9 hall, or another nurse on the other hall or maybe even somebody
10 from the third floor, if they have extra help or whatever. You
11 know, you find extra hands and then you delegate to them you're
12 going to do admission number two, you're going to do admission
13 number three.
14 Then you tell -- you let the CNAs know hey, we have these
15 admissions coming in. Same thing. While this one is working
16 on this admission, because the CNAs have to get weights and
17 vitals, then I need you -- the second CNA, I need you to go get
18 them out of the car and get them situated in their room, and
19 get their dinner orders in and things like that.
20 Q So when you're making these judgments, am I correct in
21 understanding that even though the admission sheet has nurses
22 and CNAs attached to specific carts and rooms, when these
23 things happen, at least some instances, you're --
24 MS. LESHINSKI: I'm going to object to this question.
25 I'll let Mr. Mendelson finish it, but I would ask the witness

1 MR. MENDELSON: So --
2 HEARING OFFICER HOLLO: Okay.
3 MR. MENDELSON: -- you have an assignment sheet at the
4 beginning of your shift, correct?
5 HEARING OFFICER HOLLO: Okay.
6 THE WITNESS: Correct.
7 CONTINUED DIRECT EXAMINATION
8 BY MR. MENDELSON:
9 Q Now these events you've testified take place.
10 A Correct.
11 Q Is there any circumstance in where -- which the assignment
12 sheet -- the way you deploy the manpower or lady power is
13 different than what's on the assignment sheet?
14 A Yes.
15 Q Okay. How?
16 A There's the basic assignment sheet at the beginning of the
17 shift that comes in. And then as the day is progressing I
18 might ask a CNA who's on assignment one can you please go weigh
19 and get weights on the new admission on assignment three? And
20 they will go down to assignment three and take care of the
21 assignment three patient, new admission that just came in.
22 same thing with a nurse. If she's on assignment one and
23 assignment two is getting three admissions, I would say to the
24 assignment one nurse could you get -- do the second admission
25 on assignment three's admission?

1 Q And the way you've described it, it sounds like you're
2 asking them.
3 A Well, they're not -- I'm asking them, but they can't tell
4 me no.
5 Q Okay.
6 A You know what I mean? Like it's -- you learn that in the
7 management courses that we take. I mean you don't want to go
8 up and be a bear, but it's more of a way politely of saying I
9 need you to do this. I mean --
10 Q Okay. I was --
11 A Yeah.
12 Q I just wanted to clear as to whether it's a directive or
13 it's a request.
14 A No, it's a directive, in a polite way. I mean I've never
15 had anybody question me to the point that I had to, you know,
16 start getting demanding.
17 Q Okay.
18 HEARING OFFICER HOLLO: When you're talking about
19 assignments, for example you just spoke about assignment one
20 and assignment three, is that the same thing as cart one and --
21 THE WITNESS: Yes.
22 HEARING OFFICER HOLLO: -- cart three?
23 THE WITNESS: Yeah.
24 HEARING OFFICER HOLLO: Okay, thank you.
25 THE WITNESS: Yeah. Carts, assignments, they're

1 interchangeable words.
2 HEARING OFFICER HOLLO: Thank you.
3 THE WITNESS: Uh-huh.
4 MR. MENDELSON: By the way when new admits come in, is
5 there a protocol where something has to happen within a certain
6 timeframe?
7 THE WITNESS: When they come in, we -- they have to be put
8 into the computer system immediately. Like as soon as they
9 come into the building. Which the care managers do that.
10 Then they have a window that they need to have their
11 nursing assessment completed and their lift transfer form
12 completed. That's the two parts of a -- an admission that the
13 cart nurse will do. And the window should be within 30 minutes
14 to an hour of them being in the building.
15 We need to make sure that they're fine, that they didn't
16 come in with any wounds. That -- you know, all that has to be
17 documented. So there is a timeframe that needs to be -- it
18 can't just linger.
19 CONTINUED DIRECT EXAMINATION
20 BY MR. MENDELSON:
21 Q And is there a timeframe in which an assessment has to be
22 made of the patient?
23 A Yes, within that first -- like, ideally, first half hour.
24 Q Okay. So that -- I'm trying to understand. So what
25 you're talking about has to be done with a half hour to an hour

1 is the assessment of --
2 A Yes.
3 Q -- the patient?
4 A The assessment of the patient.
5 Q Okay. And does -- and just for clarity -- I thought it
6 was clear, but maybe not. Does the person assigned to the room
7 or the cart on the assignment sheet always do that assessment?
8 A No.
9 Q Okay. And how often would you say, in the course of new
10 admits, do you vary the assignment sheet, in terms of giving
11 someone not on the assignment sheet the responsibility?
12 A I would say at least twice a month.
13 Q Okay.
14 A If not more.
15 Q And I want to shift gears for a moment, without getting
16 too sidetracked. When, during the course of the day, do the
17 CNAs report in?
18 A They are on eight hour shifts. So they report in at 7:00
19 a.m., 3:00 p.m. and 11:00 p.m.
20 Q Okay. So when the 7:00 p.m. nurses come in, they are
21 coming on in the middle of the CNA shift?
22 A Correct, they don't -- when evening shift comes on at 7:00
23 p.m., they are not doing staffing at that time, because it's
24 the middle of the CNA shift.
25 Q Okay. Are there instances in which you can relate to us

1 some kinds of specifics where you gave a directive to a nurse
2 or a CNA to handle a certain situation?
3 A Off of their assignment or just in general?
4 Q Well, I'm not talking about assignment now. I'm talking
5 about direction.
6 A Okay. I've had several crises happen --
7 Q Okay.
8 A -- on the unit where there's one particular the nurse
9 named Linda called out from a room and said Martha, I need help
10 in here. When into the room and the gentleman was
11 hemorrhaging. And at that point I started delegating to
12 everybody what needed to be done.
13 I told the cart nurse to go get the suction machine. I
14 told the CNA to go find the nurse practitioner and call a code
15 blue over our announcement. And I told the unit coordinator or
16 the HUC as -- that -- to call 911, while me --
17 HEARING OFFICER HOLLO: Excuse me. I hate to interrupt
18 you.
19 THE WITNESS: That's okay.
20 HEARING OFFICER HOLLO: Can we just go off the record for
21 one second?
22 (Whereupon, a brief recess was taken)
23 HEARING OFFICER HOLLO: On the record.
24 Okay. Go on. Please continue.
25 BY MR. MENDELSON:

1 Q You said code -- a blue code.
2 A So I had the --
3 HEARING OFFICER HOLLO: They were having -- they were --
4 THE WITNESS: Right.
5 HEARING OFFICER HOLLO: -- called blue over the --
6 THE WITNESS: Right. We had --
7 HEARING OFFICER HOLLO: Yeah.
8 THE WITNESS: We had the -- I told the CNA to get the --
9 it was a weekend. So we only have nurse practitioners on the
10 weekend. To find the nurse practitioner, call the code, the
11 HUC was to call 911.
12 Myself and another care manager were in there and tried to
13 revive the gentleman. As you could see, he started to go
14 south. So we made the decision to start CPA, initiate a line -
15 - an IV line for when -- by then the EMT started to come, but
16 they were able to take over.
17 BY MR. MENDELSON:
18 Q Okay. Did any doctor or other medical professional direct
19 you as to what to do?
20 A No. By the time they got there, EMT was showing up at the
21 same time.
22 Q Okay. But my question is when you initiated these things,
23 did somebody prompt you or were you acting independently?
24 A Acting independently.
25 Q Okay. Now that was a -- an emergency situation?

1 A Uh-huh.
2 Q You have to answer audibly.
3 A Yes, I'm sorry, yeah.
4 Q Are there other instances that are not emergencies where
5 you also act, in your mind, independently, in terms of giving
6 directives to your staff?
7 A Yes, I have -- we frequently have patients that have wound
8 vacs. So I have a nurse Lorraine, who is not very good at
9 wound vacs. She -- her technique -- and she's been educated on
10 it, but her technique is not very well. So when she has a
11 patient, I will direct another nurse or myself to go do the
12 wound vac care for her.
13 There will be situations that a doctor will order to start
14 an IV line. And you have to know who has already been
15 certified or not certified through the Genesis Program to do
16 IVs, because if they're not certified they can't start the IV.
17 So you would have to find somebody who is certified to -- even
18 if it's not on their assignment, to go attempt to star that IV.
19 Q Any other instances where somebody was having a fairly --
20 I don't mean an emergency, but a problem, in terms of blood
21 loss or things like that where you had to act on your own?
22 A I had somebody stop breathing that -- part of when you
23 come in, in the morning as a care manager you find out who --
24 who's your high alerts. Who you're going to be watching
25 patient-wise. And this particular person, she was on the high

1 alert that she was having a rough night.
2 And so myself and the cart nurse were in the room just
3 checking on her. And we happened to be in there when we saw
4 her take her last breath. I did the assessment. No heart
5 sounds. So I initiated to start CPR. And again, had the cart
6 nurse call the code to get all the other help in there.
7 Q Okay. How, if at all, do you view yourself as being
8 responsible for your team?
9 A I'm responsible for the care of at least 30 to 60 patients
10 overall. If we have two care managers it's patients per care
11 manager. If it's only one care manager on, we have 60 patients
12 that we're in charge of the overall outcome of their care for
13 that shift.
14 By doing so we have to keep an eye on the six -- the four
15 cart nurses. And we're responsible that the treatments are
16 done, that their meds are given timely. Any stat medications
17 they got when it was supposed to be received. And with -- and
18 we're responsible of the aid. So, you know, I'm the higher
19 level of all that.
20 Q So you said four cart nurses. How many rooms or patients
21 do those four cart nurses have?
22 A They have 15 to 16.
23 Q Each you're saying?
24 A Each.
25 Q Okay.

1 A Right.
2 Q And so in the ordinary course, if you have another
3 clinical -- another care manager on, how many -- who -- how
4 many employees of different kinds are you responsible for?
5 A If it's -- if I have two care managers on, then one care
6 manager would be overseeing 30 patients, two cart nurses and
7 ideally three aides.
8 Q Okay. And if it's only one care manager?
9 A If it's only one care manager, which more times out of
10 none it's only one care manager, just due to our staffing
11 shortage that we've had for since I've been there --
12 Q Okay.
13 A -- it's one care manager, 60 patients four cart nurses and
14 six CNAS ideally.
15 Q And they report to you?
16 A Yes.
17 Q So when there's only one care manager just how do you
18 explain this? Do you have two wings or do you have --
19 A We have two. Yeah, two halls, two wings. A hall, B hall,
20 C hall, D hall.
21 Q Okay. So when it's one care manager you have two wings --
22 two halls. And when there's two care managers you have one
23 hall?
24 A Correct.
25 Q Has there ever been an instance where you've been

1 contacted because of concerns about your management of the
2 team?
3 A Yes.
4 Q Can you tell us the particulars about that?
5 A There was a situation that involved the medical director
6 Dr. Chack (ph). He had put in an order for a patient to
7 receive IV fluids and I was off that day. I received a phone
8 call from my immediate boss, Cheryl (ph), who is the clinical
9 director, asking me why did this person not get fluids hung?
10 So then I had to look into the cart nurse, who was Robin
11 that day on why -- what happened? Because I was under the
12 impression the fluids -- like I made her aware that the fluids
13 need to be hung. He was supposed to hang the fluids.
14 Now I'm hearing that they were not hung. So it was my
15 responsibility that this didn't happen. So it was -- I had to
16 rectify and do my investigation of the cart nurse to find out
17 what transpired that the person didn't get the fluids.
18 Q Okay. And did you have any further interaction with Robin
19 about what had happened?
20 A Yes. The next day, because it turned out to be a
21 documentation issue. The person did get the fluids. It was
22 more how it was documented, because we have computerized
23 systems. So sometimes things like vanish, get lost.
24 So I had to follow up with Robin. I -- first, I called
25 Robin that day and said did so-and-so get the fluids? Because

1 we both happened to be off. She acknowledged she did.
2 I made Cheryl aware that the fluids were hung. She made
3 Dr. Chack aware. So we all went up our ladder.
4 Then I went back in the very next day with Robin and we
5 went through the computer to find out where it is, so she could
6 show me, so she could change her documentation. Because she
7 had it documented as not documented. I showed her how to
8 change it to administered. And we had to then go in and write
9 a whole note about this situation.
10 Q Okay. Have there been instances, directly or indirectly,
11 where cart nurses have made it known that they're not happy
12 about some way you've deployed them?
13 A Yes. I'm -- I've -- you know, not -- they have not come
14 straight to my face and say, you know, Martha, I'm not happy
15 with you or anything like that. But there -- if I ask them to
16 pick up an extra job, like we'll say -- we'll use the wound vac
17 for instance or starting an IV. It's well, what is she going
18 to do for me or, you know, like expecting me to make deals with
19 them and not just this is what I asked you to do. Overall
20 though they do what they're supposed to do.
21 Q Okay.
22 HEARING OFFICER HOLLO: Can you provide -- you referenced
23 a person named Cheryl who is above you?
24 THE WITNESS: Uh-huh.
25 HEARING OFFICER HOLLO: Could you please tell us her last

1 comes in, who's not an actual employee of the facility, who's
2 just sort of filling in for the shift?
3 A Yes.
4 Q Okay, thank you.
5 A Yeah.
6 Q So if -- so what you're telling me is that if you for
7 instance have Robin on cart two and Robin calls off that day,
8 you would move Lorraine, who always takes cart one, to cart two
9 and you would take Lorraine's assignment?
10 A We have, yes.
11 Q When has that happened?
12 A At least two or three times that --
13 Q Can you --
14 A -- has happened.
15 Q -- give me a specific time?
16 A I can't give you a specific --
17 Q Can you give me a timeframe?
18 A I would say within the last six months to a year that we
19 have had to make adjustments. Maybe the last six months. Our
20 staffing is out of control.
21 Q So you've had that happen within the last six months?
22 A Yes.
23 Q One time?
24 A One time.
25 Q Can you give me all of the circumstances of that time?

1 Q Have you been told that you'll be evaluated based on the
2 work of the cart nurses and CNAs on your floor?
3 A I haven't been told about any evaluation.
4 Q Okay. Have you been disciplined because of the work of
5 the CNAs or cart nurses on your floor?
6 A I was held responsible for, yes.
7 Q Yeah. Let's talk about that conversation. You said that
8 was a conversation with Robin?
9 A No. It was -- started with a conversation from my boss,
10 Cheryl.
11 Q Right. And the cart nurse involved was Robin?
12 A Was Robin.
13 Q Do you know Robin's last name?
14 A Boyer.
15 Q You said that Cheryl called you and asked you about a
16 documentation -- an issue that turned out to be a documentation
17 issue?
18 A Correct.
19 Q Did she write you up?
20 A No, but she could have. If that person did not receive
21 medication, yes, it would be my fault --
22 Q Did --
23 A -- that I did not follow up with --
24 Q Who told you that you could be written up for that?
25 A The PowerBack rules and regulations.

1 A The PowerBack rules and regulations?
2 A Yes.
3 Q Okay. I haven't seen that rule. Where -- is that a
4 handbook?
5 A Yeah. Where I am responsible for them and then, yeah, it
6 --
7 Q I'm just asking --
8 A -- would be a discipline.
9 Q I'm just asking you to identify where that rule exists.
10 A I don't know.
11 Q Did anyone tell you that?
12 A On that specific --
13 Q With respect to that particular rule you're testifying
14 exists that you'll be written up for the work of other staff on
15 your floor.
16 A Yes. When I was being hired as a care manager we were
17 told that we are responsible for the work of the staff nurses.
18 Q Who told you that?
19 A Patty.
20 Q When did she tell you that?
21 A During my interview and hiring process of being care
22 manager.
23 Q Do you know whether Robin was disciplined for what
24 happened with the patient?
25 A There was no need for discipline.

1 Q Can you think of another instance when you were contacted
2 about the work of another nurse or CNA on your floor?
3 A No, that's the only one.
4 Q When did that happen?
5 A Roughly four or five months ago.
6 Q And there was -- was there an incident report filled out?
7 A There would have been, had that patient not received the
8 medication. As I've already said, it was straightened out that
9 the patient did receive the medication. It was a documentation
10 thing.
11 Q So no form was filled out at all regarding this?
12 A There might have been an email from Dr. Chack to Cheryl --
13 Q Okay.
14 A -- about it.
15 Q You testified that you've had a patient complaint and you
16 would change the assignment to give to the room to the -- to
17 another nurse. So tell me when that happened.
18 Q Let's see. We had a patient approximately three months
19 ago who was not happen with Lorraine, last name Nunes, for not
20 washing her hands when she entered the room. She said I do not
21 want to have this nurse anymore. So every day that she worked
22 we would have to reassign that room to another nurse, which was
23 usually on cart two, because Lorraine is usually on cart one.
24 And in essence have to pick a room to give her off of cart
25 two's room that was equal acuity.

1 Q They don't? You called them partners.
2 A Yeah.
3 Q Okay. So --
4 A But they don't call themselves partners.
5 Q Okay.
6 A There are some that don't talk to each other the whole
7 entire day.
8 Q So your testimony is that the nurses wouldn't help each
9 other out?
10 A Not voluntarily. Some will not --
11 Q Okay.
12 A -- no.
13 Q Tell me an instance when this happened when you got a new
14 admission and you had to tell the nurse on one cart on a wing
15 to help the nurse on the other cart on the same wing.
16 A Last week --
17 Q Okay. Who was involved?
18 A Cynthia received three admissions on her cart and she's on
19 cart three. And they came one right after another. So I went
20 to Angela, who was on cart four, and told her that she was
21 going to be doing admission number two. And then I asked
22 Michelle, who is also a care manager, but she was on cart two
23 that day, that could you do admission number three?
24 Q And what if -- you said you asked who, who was on cart
25 four to help her?

1 A Angela.
2 Q And what if Angela refused?
3 A Then I probably would take her into the office and explain
4 to her that she has to. That it needs to be done.
5 Q Have you written up a nurse -- a cart nurse or a CNA?
6 A No. Fortunately I have not had to write up anybody.
7 Q In all your time there you have never written anybody up?
8 A No.
9 Q Okay.
10 A I've had verbal discussions, but no actual write ups.
11 Q So you also testified that sometimes a female patient
12 doesn't want a male CNA. You said there are three CNAs on the
13 wing?
14 A Uh-huh. Yes.
15 Q So who would go help with that female patient?
16 A One of the female CNAs.
17 Q So it's going to be one of either two people, right?
18 Mostly likely?
19 A Most likely. Sometimes --
20 Q Or --
21 A -- we have --
22 Q -- one person, if you have two male CNAs?
23 A Right. It's --
24 Q Okay.
25 A -- a matter of who's available.

1 A Yes.
2 Q Did you have to tell her to put the oxygen on the patient?
3 A I believe I was the one running it. Usually when there's
4 emergency situation you have one runner. That's the person
5 that's dictating to everybody to do -- what to do.
6 You have a recorder, who writes down everything. So yes,
7 I was the first responder. So I probably said let's get oxygen
8 on him. Let's get a line in.
9 Q Is it fair to say that a cart nurse could run a code like
10 that?
11 A Yes, it's fair to say that a cart nurse could run a code
12 like that.
13 Q And a cart nurse could be the runner and tell the other
14 people in the room what they should be doing, during the code?
15 A Yes.
16 Q And you talked about wound vacs. Do you have a wound
17 nurse?
18 A We have -- yes, we have a wound nurse who weekly checks
19 the sizes of wounds.
20 Q And is the wound nurse Ginny Podolak?
21 A Yes.
22 Q And does she go around and see all the patients with
23 wounds?
24 A Yes, once a week.
25 Q Now, you said you had a situation where you asked Lorraine

1 not to take a wound vac patient?
2 A Correct.
3 Q When was that?
4 A We had a patient there for approximately three months.
5 And that was approximately six to seven months ago. Who had a
6 fairly extensive wound on her backside.
7 Q And what room was she assigned to, if you know?
8 A I want to say it was 210.
9 Q And what cart goes to room 210?
10 A Cart one.
11 Q So on the days that Jenny -- that Lorraine was working,
12 who did the -- who took care of this patient?
13 A Usually it would be cart two's patient.
14 Q So what would I -- what would one do to see that cart two
15 took care of this patient six to seven months ago? Would that
16 be reflected on the assignment sheet?
17 A Probably not. You would have to look at -- in SigmaCare
18 and PCC to see the documentation on it.
19 Q So we have to pull the SigmaCare documentation for six to
20 seven months ago for the patient in room 210 with a wound vac?
21 A Yes.
22 HEARING OFFICER HOLLO: Could you please just define for
23 us what SigmaCare and whatever the title with the initials is?
24 THE WITNESS: SigmaCare is where we document all of our
25 medications and treatments.

1 HEARING OFFICER HOLLO: And it --
2 THE WITNESS: It's like where all the medication orders
3 are.
4 HEARING OFFICER HOLLO: And it's an online system?
5 THE WITNESS: It's an online system.
6 HEARING OFFICER HOLLO: Okay. And the second system you
7 mentioned?
8 THE WITNESS: The PCC, that is where we -- it's called
9 PointClickCare.
10 HEARING OFFICER HOLLO: Uh-huh.
11 THE WITNESS: And that where we do all of our
12 documentation.
13 HEARING OFFICER HOLLO: Also an online system?
14 THE WITNESS: Also an online system.
15 HEARING OFFICER HOLLO: And -- I'm sorry. Just so -- I'm
16 trying to -- I can make sure I can follow this. What's the --
17 if they're both online patient documentation systems, what's
18 the difference between the two? Can you explain that?
19 THE WITNESS: They don't jive together. They -- there are
20 two different. One does medication, and treatments and
21 physician orders. The other one is purely just documentation.
22 You go in there to put in their vital signs and any
23 documenting.
24 CONTINUED CROSS EXAMINATION
25 BY MS. LESHINSKI:

1 Q Which one --
2 A But they're --
3 Q -- is which?
4 A -- not --
5 HEARING OFFICER HOLLO: Okay, wait.
6 THE WITNESS: -- interconnected.
7 HEARING OFFICER HOLLO: Okay. Which one is which?
8 THE WITNESS: SigmaCare is for the medications and
9 treatments. PointClickCare is for the documentation.
10 HEARING OFFICER HOLLO: And who utilizes each system?
11 Like SigmaCare, which type of employee -- which like LPN, CNA,
12 whomever, who uses SigmaCare?
13 THE WITNESS: The nurses and the physicians use SigmaCare.
14 HEARING OFFICER HOLLO: So by nurses we mean LPN and RNs?
15 THE WITNESS: Uh-huh.
16 HEARING OFFICER HOLLO: So no CNAs?
17 THE WITNESS: No CNAs --
18 HEARING OFFICER HOLLO: Okay.
19 THE WITNESS: -- on SigmaCare.
20 HEARING OFFICER HOLLO: Okay. And the other system, the
21 PCC?
22 THE WITNESS: Is utilized by everybody.
23 HEARING OFFICER HOLLO: So everybody includes, in this
24 instance, CNA, LPN, RN and physician?
25 THE WITNESS: Yes.

1 MS. LESHINSKI: No.
2 HEARING OFFICER HOLLO: Okay.
3 MS. LESHINSKI: You asked all the questions I was going to
4 ask. So --
5 HEARING OFFICER HOLLO: Okay. Please go on then.
6 MS. LESHINSKI: Okay, thank you.
7 CONTINUED CROSS EXAMINATION
8 BY MS. LESHINSKI:
9 Q So you testified that this incident with the wound vac
10 with nurse Lorraine happened six to seven months ago?
11 A Roughly, yes. Yeah.
12 Q Has that -- and did Lorraine tell you she didn't want that
13 patient?
14 A No, she has said she's not good with a wound vac. She
15 admittedly has said that she is not good with them. So it was
16 -- upon discussion with her, the decision was made for her not
17 to have that patient, because she can't do it effectively.
18 Q So she discussed with you having a different nurse take
19 care of this patient and then the nurse on the other cart took
20 care of the patient?
21 A Correct.
22 Q Okay. Do you have another instance when that's happened?
23 A I've had instances that I have other people do treatments
24 for other people.
25 Q Okay.

1 A Like if it's --
2 Q When was that?
3 A If it's a matter of starting an IV, like I had mentioned
4 before, I might -- not everybody is IV certified in our
5 facility to start IVs. So say a patient on cart five needed an
6 IV and that nurse is not certified to do it, I will have to
7 grab another nurse or myself to do that task.
8 Q So would mostly the nurse on cart six help with the IV
9 line of the nurse -- the patient of the nurse on cart five?
10 A No, it all depends on who's certified. It really all
11 depends on if they -- Genesis has their own IV course and
12 unfortunately we don't have classes very often. So more or
13 less they're not -- aren't trained to do it.
14 Q So would you just grab another nurse who is IV certified -
15 -
16 A Right --
17 Q -- or you would do it yourself?
18 A Right. You would find somebody else that is and have them
19 do it.
20 MS. LESHINSKI: Okay. Can I just have one minute?
21 HEARING OFFICER HOLLO: Yes.
22 MS. LESHINSKI: Thank you.
23 BY MS. LESHINSKI:
24 Q You testified generally that based on acuity you might
25 choose to move a patient assignment to a different nurse. Tell

1 me when that's happened.
2 A Due to acuity I moved a patient's assignment? I --
3 Q What I heard --
4 A When I do switching it's based on acuity. If I have to
5 remove a nurse from one room, I will pick a patient of equal
6 acuity to switch off with.
7 Q Tell me when that's happened.
8 A Just when I gave you the example with Mia, that she wasn't
9 allowed in that patient's room anymore. So then you looked at
10 what that patient is here for, acuity level. And when you're
11 switching rooms you pick somebody that is equal acuity-wise so
12 --
13 Q Okay.
14 A -- it's still a fair --
15 Q Has that happened any other time?
16 A Well, it's happened with Lorraine. It's happened there.
17 And it's happened numerous other times. I can't remember
18 everybody and every time, but it --
19 Q Okay. The time --
20 A -- is a frequent --
21 Q -- with Mia --
22 MR. MENDELSON: Can she --
23 MS. LESHINSKI: The time --
24 MR. MENDELSON: -- finish her answer?
25 THE WITNESS: It's a frequent occurrence.

1 BY MS. LESHINSKI:
2 Q Please finish your answer.
3 A Yeah. It's a frequent occurrence.
4 Q It happened with Mia, it happened Lorraine. Another time?
5 A Yes, it's happened frequently. I cannot pull names and
6 dates out of my head. It's a frequent occurrence.
7 Q Okay. So the incident with Lorraine was the one you
8 testified about how Lorraine said she didn't want the patient?
9 A No. A patient said they didn't want Lorraine.
10 Q Oh, right. Okay. So you switched it with the other cart
11 nurse?
12 A Yes.
13 Q And then the time with Mia was with the patient complaint?
14 A Uh-huh.
15 Q Okay.
16 A Yes.
17 Q Now you said that sometimes a patient may require two CNAs
18 for safety?
19 A Safety of the patient and safety of the CNA.
20 Q When has that happened?
21 A Three, four weeks ago we had a disruptive patient up on
22 the third floor who was supposed to be use -- using a Hoyer
23 Lift. We had a pregnant aide. Her --
24 Q Who was that?
25 A Her name is Ashley. She's very pregnant. And she was

1 going in there and explaining to her you have to use the Hoyer,
2 which is -- a Hoyer, let me -- it's machine to lift and move
3 people from a chair to a bed, when they can't weight bear. The
4 patient did not want the Hoyer and tried to throw herself out
5 of the chair. And so being -- so this patient doesn't fall,
6 Ashley grabbed her, you know, and made sure that she stayed in
7 the chair.
8 Q And then what happened?
9 A So then I -- she came and reported this to me. I went
10 into the room, and talked to the patient and explained to her
11 the purpose of the Hoyer for safety reasons. I understand
12 you're not happy with it, but until therapy clears you --
13 because therapy had to clear them for the next level, you need
14 to do this. And she said okay, okay, okay to me.
15 But then I went out and made the decision. I said from
16 now on anytime you -- even if you just go in to answer the
17 light, I want two CNAs in there at all times, in case she tries
18 to throw herself out of the chair again or -- because she --
19 the patient was saying that the aides weren't being nice to
20 her, that they're coming in here with an attitude. So it was
21 turning into like a he said/she said situation. So I made the
22 decision that at all times two CNAs need to enter and exit that
23 room together.
24 Q So did Ashley grab someone to help her with that patient
25 then?

1 A No, I told her partner, the next one -- sorry, for using
2 the word partner, because not everybody works together. I used
3 her coworker, the one next her, her name is also Ashley and
4 said I need you and -- to go in with the other, the pregnant
5 Ashley, every time you're answering the light.
6 Q So her partner is the other CNA on her wing?
7 A Yes, the one in the assignment --
8 Q Which wing was this?
9 A This would be C hall.
10 Q Okay. Which -- C hall is wing --
11 A C hall is third floor.
12 Q Third floor?
13 A Yeah.
14 Q Okay. So you have wings are C hall and D hall on the
15 third --
16 A On third.
17 Q -- floor?
18 A Yeah.
19 Q Okay. So the two Ashley's were both on the C hall and you
20 grabbed the partner of the first Ashley to help the second
21 Ashley?
22 A Yes.
23 Q Do you know either of their last names?
24 A (No audible answer)
25 MR. MENDELSON: You have to answer orally.

1 THE WITNESS: Oh, no.
2 BY MS. LESHINSKI:
3 Q Okay. Did this happen another time?
4 A yes, we had a person on B hall who was in a -- got hit by
5 a car and was in all kinds of contraptions. And she was
6 complaining that the aides were hurting her when they were
7 turning. So I, during morning meeting that we had, said to
8 each aide there that there has to be two people at all times,
9 be it a nurse and aide, or an aide and an aide, a nurse and a
10 nurse. It just had to be two people at all times to go in
11 there to turn the patient, because of all of her contraptions
12 she needs to be moved that way.
13 Q So with respect to that patient there was a nurse and a
14 CNA assigned to that patient?
15 A Yes, yes.
16 Q And they would just figure out who was helping, that they
17 knew they needed two people?
18 A Right. It was -- she was now deemed a two person for
19 everything.
20 Q Now suppose the CNA -- well, let's go back to the first
21 instance, the one with Ashley. If Ashley, whatever, had said
22 the second person, who -- the second Ashley who you asked to
23 help the first Ashley, if that Ashley had refused what would
24 you have done?
25 A I would have had a private conversation with her in office

1 on why this needs to be and this is what you've been directed
2 to do.
3 Q And then if she refused what would you do?
4 A It would probably be a write up for insubordination.
5 Q Okay. And who would you talk to about a write up?
6 A I would discuss it with the clinical director, but I can
7 do a write up myself.
8 Q Okay. Have you --
9 A It --
10 Q -- been told that you can --
11 MR. MENDELSON: Excuse me. I'm sorry. I'm interrupting
12 because she's interrupting. This is a persistent --
13 MS. LESHINSKI: I think she finished. Mr. Mendelson, she
14 --
15 MR. MENDELSON: I'm sorry.
16 MS. LESHINSKI: -- finished her answer.
17 MR. MENDELSON: There's a pattern here of Ms. Leshinski --
18 MS. LESHINSKI: That's absolutely ridiculous.
19 MR. MENDELSON: -- interrupting the witness. And I ask
20 that you direct her to let the witness finish her answers.
21 HEARING OFFICER HOLLO: Okay. I have to say in this
22 instance I was busy taking notes and I didn't hear what
23 transpired. So Ms. Leshinski, just as a general matter, just
24 remind you please not to interrupt the witness. I don't -- as
25 I said, I was taking notes. I didn't hear whether you did or

1 CONTINUED CROSS EXAMINATION
2 BY MS. LESHINSKI:
3 Q Okay, thank you. Who told you you could write people up?
4 A That was part of the care manager job description. So
5 when I got the job description it's in there.
6 Q Have you ever done it?
7 A I said fortunately I don't -- I have never had to. I have
8 --
9 Q Have you been --
10 A -- never had to get to that point.
11 Q Have you been told that you can report on another
12 employee, but that the decision has to be made by somebody
13 else?
14 A No, I've always been told -- my understanding is I can --
15 write ups are like a two part process. You write up the write
16 up and then it goes to HR and she does what she does with it.
17 Q Okay. And then --
18 A It's not any -- we put down the problem, you know what I
19 mean? And then HR is ultimately the one who does whatever.
20 Q So you could report on something and then HR decides what
21 to do, is that fair to say?
22 A It would still be a write up. It's not a report. It --
23 Q I understand.
24 A It's a disciplinary write up that I could do, send it to
25 HR per the policy and then that's -- I don't know what they do

1 then.
2 Q And then HR takes over?
3 A Yeah. I don't --
4 Q And you wouldn't --
5 A -- know what they do.
6 Q And you don't know what they do with it?
7 A No.
8 Q Okay. But you've never done that yourself?
9 A No, I've had to have verbal conversations.
10 Q Which shift of the clinical -- what's the shift of the
11 clinical directors?
12 A They do eight hours shifts. 7:00 to 3:00, 3:00 to 11:00,
13 11:00 to 7:00.
14 Q If you know, what is the director of nursing's shift?
15 A I don't really know. They're usually there between 8:00
16 and 5:00. I think it's flexible, based on the day.
17 MS. LESHINSKI: Okay. Thank you. I have no other
18 questions.
19 MR. MENDELSON: Just two minutes.
20 (Whereupon, a brief recess was taken)
21 HEARING OFFICER HOLLO: On the record.
22 Mr. Mendelson, do you have any questions on redirect?
23 MR. MENDELSON: Just briefly.
24 HEARING OFFICER HOLLO: Okay. Proceed.
25 REDIRECT EXAMINATION

1 evaluated?
2 A Correct.
3 Q Have you been informally evaluated?
4 A I -- I'm sure like, you know, good job and stuff like
5 that, but we -- I think because there's been so much transition
6 there has not been formal evaluations.
7 Q Okay. So setting aside formal, from time to time has the
8 director of nursing commented to you on the kind of job you're
9 doing?
10 A Yes.
11 Q In your own mind do you believe you know how the senior
12 management of the facility views you?
13 A I do, yes
14 Q Now, at several points during the cross examination you
15 responded to questions by indicating that when you're switching
16 assignments you try to balance the acuity of the patients who
17 you're -- who are being attended to by the nurses or by the
18 nurses you're swapping.
19 A Correct.
20 Q Do you look at any nursing factors relating to nurses
21 themselves, aside from the acuity of the patients?
22 A I look at -- I wouldn't give -- I would switch out like a
23 trach patient with some -- with a nurse that has never had
24 trach experience. So you do have to know their experience on
25 his acuity things, if you're planning on having another nurse

1 from that assignment take that role. That would be the only
2 example I can think of.
3 Q Do you look at speed or competency, in terms of the
4 performance of those nurses, in your experience with --
5 MS. LESHINSKI: I'm going to object to that question. If
6 there's some specific instance? This is such a generalization
7 --
8 MR. MENDELSON: Have there been --
9 MS. LESHINSKI: -- and a leading question I think.
10 MR. MENDELSON: Have there been specific instances, in
11 which you've looked at the speed with which nurses perform
12 certain competencies in deciding on staffing or assignments,
13 shifting assignments?
14 THE WITNESS: I looked at speed and efficiency when doing
15 admissions before asking somebody to pick up or asking somebody
16 to do an admission for that nurse, because she's not caught up.
17 BY MR. MENDELSON:
18 Q Okay.
19 A Pardon me.
20 Q And Ms. Leshinski asked you whether a staff RN had the
21 capability of running the code and you said yes.
22 A Uh-huh.
23 Q When codes occur, who typically runs them?
24 A Care managers.
25 Q And why is that?

1 A My rationalization for it is they have 15 patients. They
2 -- their job is to come to us and let us know when an emergency
3 is happening. We enter the room. So that is now relieving
4 that nurse to go back to her duties of taking care of the other
5 patients. It's just part of our job function as a care manager
6 is to be able to take care of the higher level of needs.
7 Q Okay. So in the event of any emergency, whether coding or
8 other things, in your experience, who typically runs them?
9 A Care managers.
10 MR. MENDELSON: Okay. I have no further questions.
11 MS. LESHINSKI: I have a few questions.
12 RECROSS EXAMINATION
13 BY MS. LESHINSKI:
14 Q You said you wouldn't switch a patient with a trach with a
15 non-trach nurse. When did that happen?
16 A I was using it as an example of skill.
17 Q Have you had a specific instance like that happen?
18 A We have trach patients, yes.
19 Q Oh.
20 A I haven't had to -- that wouldn't be a patient I would
21 pick to switch. That's what I said.
22 Q I guess what I'm looking for is a specific time when
23 that's happened and not just a generalization about not
24 switching a trach patient with a nurse who doesn't have any
25 trach experience. When did that happen specifically?

1 A It couldn't have happened if I would never do it.
2 Q Okay. Was there a time when you had a trach patient, and
3 you had to switch the assignment and you didn't choose a nurse,
4 because she didn't have trach experience?
5 A No.
6 Q You said -- you were asked if you would switch an
7 assignment based on the speed of the staff and you said with an
8 admission. When has that happened?
9 A When we get admissions coming in if the admission is going
10 into room one and that nurse in room one is not able to do the
11 admission, because she's not done what she needs to be doing
12 and another nurse is completed, because she's got it done
13 faster or -- I would have that nurse that is done do that
14 admission.
15 Q Has that happened in -- has there been specific time when
16 that happened?
17 A Yes, that's happened.
18 Q When?
19 A You look for these whens. I need calendars. You know?
20 Q Can --
21 A It happens frequently. I can't give you specific whens.
22 Q Can you give --
23 A It happens frequently.
24 Q Can you give a specific example of when that happened if
25 it happens so frequently?

1 A Cynthia is usually always running behind on her med pass.
2 She gets admissions frequently.
3 Q Cynthia is on cart three?
4 A Yes.
5 Q Okay.
6 A So if she's still in the middle of her med pass and she
7 gets an admission, because they come in on evening med pass,
8 and her cart nurse Angela, who tends to get her meds done
9 faster, then I will have Angela start the admission for
10 Cynthia.
11 Q And Angela would be on cart four. So she'd be on wing B?
12 A Yes.
13 Q Okay. And an admission has to be seen within 30 minutes?
14 A 30 minutes to an hour. I don't know --
15 Q Okay.
16 A -- what the Genesis policy and produce log says. That's
17 just what I've always been told; within 30 minutes to an hour
18 they need to be addressed.
19 Q So Cynthia is doing a med pass. So she's giving
20 medications to all her patients on wing B.
21 A Uh-huh.
22 Q And the other nurse, I'm sorry, what was her name?
23 A Angela.
24 Q And this has specifically happened?
25 A Yes.

1 responses to that.
2 MS. LESHINSKI: Okay. Thank you. I have no other
3 questions.
4 MR. MENDELSON: No questions.
5 THE WITNESS: Okay.
6 HEARING OFFICER HOLLO: Well, just one moment.
7 THE WITNESS: Oh, you've got questions?
8 HEARING OFFICER HOLLO: It's my turn.
9 THE WITNESS: Alright.
10 HEARING OFFICER HOLLO: Yes. I have a number of questions
11 for you. Back when you were testifying the first time on
12 direct questions from Mr. Mendelson, you were describing a
13 scenario where a patient was hemorrhaging, and there were a
14 number of people in the room, because it was a medical
15 emergency and you were, what you later described as running the
16 incident.
17 THE WITNESS: Uh-huh.
18 HEARING OFFICER HOLLO: The time you testified the first
19 time you said we made a decision to start line, that being an
20 IV line. Who -- can you describe to me who the we is?
21 THE WITNESS: The other care manager and I, Megan.
22 HEARING OFFICER HOLLO: Okay, thank you. And did you
23 consult with anybody else before the two of you made that
24 decision?
25 THE WITNESS: No.

1 MR. MENDELSON: -- in response to yours.
2 REDIRECT EXAMINATION
3 BY MR. MENDELSON:
4 Q Just a moment ago you and the Hearing Officer had a
5 colloquy and you said something to the effect of all you do is
6 cover the floor. You know what I'm talking about?
7 A Meaning?
8 Q Well, that's what I wanted to establish. What do you mean
9 by all I do is cover the floor?
10 A Meaning my -- I am responsible to make sure of the staff.
11 We're talking staffing.
12 Q Yes.
13 A So I don't do discipline of staffing, I don't do large
14 grid of staffing.
15 Q Yes.
16 A I do daily staffing making sure the floor is covered with
17 the appropriate amount of staff.
18 Q So how do you make sure the floor is appropriately covered
19 with staff?
20 A I take the staff that arrives and give them assignments.
21 Q Thank you. To whom, if anyone at the site, do the agency
22 nurses report?
23 A To the care manager.
24 Q And the Hearing Officer, in trying to understand this form
25 Petitioner's 16, said to you that the form systemizes and

1 Q And in that case if one of the nurses had already been
2 there for two of the days, she'd just stay on the cart for
3 continuity of care --
4 A Right.
5 Q -- and the other nurse would get reassigned to one of the
6 open slots?
7 A Yes.
8 Q Okay. But otherwise I mean as a rule of thumb if I'm the
9 cart three nurse, I'm going to be on cart three when I go into
10 work, right?
11 A Most likely.
12 Q Okay. And if I'm a CNA, and I'm on wing A and I have a
13 regular assignment of certain rooms on that wing, I'm going to
14 get those rooms when I go into work, right?
15 A Most --
16 Q Or as a rule --
17 A -- likely, but --
18 Q -- of thumb?
19 A -- it's still a decision that's made by the people making
20 the assignment. It's not concrete. It's not -- they don't --
21 they can't say I have to be there. It's not concrete. There's
22 nothing that says you are always on cart three, you are always
23 on cart four, you are always on assignment one. We do do that
24 for continuity of care, but if I wanted to, if I just came in
25 in a bad mood, I could switch them all around.

1 Q Has that --
2 A And I can.
3 Q Has that happened?
4 A No, but I'm just saying --
5 Q Okay.
6 A -- I have the authority to do such.
7 Q I understand what you're saying. I guess --
8 A Right.
9 Q -- I'm asking about specifics of what has actually
10 happened, not a sort of I could make everybody wear blue
11 tomorrow --
12 A Well, I think we're --
13 Q -- if I wanted to.
14 A -- discussing my authority to make decisions. And I could
15 make the decision. This is a guide to make things peaceful.
16 However, it's only a guide.
17 Q I understand that. Okay. So I'm asking you about
18 specifics.
19 A Okay.
20 Q Okay. So I asked you about Ivan and Lorraine. And then
21 you gave this example of Mia. So if Mia is normally on cart
22 four, she just -- and she and -- or excuse me. In the case of
23 Ivan and Lorraine, where they were both there, now you said
24 both on cart two you could put Lorraine. Oh, Ivan -- so Ivan
25 and Lorraine both work cart one. So this --

1 Q Good afternoon, Ms. Melora. By whom are you employed?
2 A PowerBack Rehabilitation.
3 Q And what position do you hold at this time?
4 A I'm the manager of clinical operations for PowerBack.
5 Q And prior to holding that position what position did you
6 hold?
7 A I was the center nurse executive for PowerBack
8 Rehabilitation of Voorhees.
9 Q Okay. When did you change positions?
10 A Mid-October 2015.
11 Q Okay. Briefly, can you describe the facility, it's
12 function, how it works?
13 A Sure. PowerBack Rehabilitation Voorhees was the first
14 purpose built building all short stay sub-acute rehab. It's
15 124 beds. It's a three story building.
16 The first floor is administrative, PT, OT and speech
17 rehabs and dining services in back of the house. The second
18 floor and the third floor are mirror images. They each
19 comprise of 62 patients.
20 There's no distinction between the second and third floor
21 of what types of patients. They're all private rooms. So it's
22 124 private rooms.
23 Q Thank you. And how would you describe the facility? You
24 said it's a sub-acute?
25 A It's all sub-acute rehab. It's really the first -- one of

1 the first of its kind. Definitely the first of its kind in
2 this region of all short stay. No long term care.
3 Q What is the turnover of patients in the facility?
4 A The average PowerBack patient stays about 16-19 days,
5 which is about a 170 to 180 patients per month admissions and
6 then 170 to 180 discharges a month.
7 Q Have you worked with or for other -- well, who's Genesis?
8 A Genesis is our parent company.
9 Q Okay ---
10 A So they own 540 buildings across the nation, PowerBack
11 being a percentage of those.
12 Q Are Genesis buildings all rehab facilities?
13 MS. LESHINSKI: I'm going to object. These are -- that's
14 irrelevant.
15 HEARING OFFICER HOLLO: Well, I'll permit that. It might
16 be useful to me in understanding the general structure of the
17 Employer.
18 MR. MENDELSON: Okay. So --
19 THE WITNESS: There are 11 PowerBack buildings in the
20 company right now, more to come, and the rest are the
21 traditional about 60 to 70% long term care patients and then
22 the other 30 to 40% short stay, sub-acute rehab. And the
23 PowerBacks just have that component of all sub-acute rehab.
24 BY MR. MENDELSON:
25 Q Okay. And in a typical Genesis building, what's the

1 turnover there?
2 MS. LESHINSKI: I'm going to object. That's irrelevant.
3 HEARING OFFICER HOLLO: Where are you going with this --
4 MR. MENDELSON: Well, I --
5 HEARING OFFICER HOLLO: -- Mr. Mendelson?
6 MR. MENDELSON: -- argued to you yesterday that the
7 precedent in the area is healthcare institution precedent. And
8 in applying that precedent, it seems to me you should know how
9 if at all this facility differs from the typical assisted
10 living or nursing home type facility.
11 MS. LESHINSKI: What precedent --
12 HEARING OFFICER HOLLO: And what --
13 MS. LESHINSKI: -- are you talking about?
14 MR. MENDELSON: We've already cited cases -- decisions in
15 this case, Veritas, other decisions. And in terms of deciding
16 the application of the factors, as to who is or is not a
17 supervisor, it seems to me it is important in deciding how to
18 apply that authority -- that case authority, you know how if at
19 all this facility differs from the standard type facility or
20 the facilities discussed there.
21 HEARING OFFICER HOLLO: I think that's -- as I stated
22 yesterday, I think that's largely now how Board law is applied.
23 So I'll permit a few questions and then please on.
24 MR. MENDELSON: Okay. Thank you. So at the typical
25 Genesis facility, what's the turnover of patients?

1 THE WITNESS: I could tell you there were two buildings
2 that I worked at that were typical Genesis buildings. One was
3 Millville Center and one was Kresson View. And they each had
4 maybe 15-20 short stay patients a month. And their long term
5 care patients stayed there. That was their residence now.
6 CONTINUED DIRECT EXAMINATION
7 BY MR. MENDELSON:
8 Q So --
9 A So much less ratio of short stay patients.
10 Q So what would be the turnover? Got to -- you've got to --
11 A Oh.
12 Q -- provide a number.
13 A The short stay patients were maybe there 30 days and maybe
14 they only got 20 of those patients a month.
15 Q Okay. How does the turnover rate at this facility impact
16 the way the management team assigns and directs work?
17 MS. LESHINSKI: I'm going to -- could you repeat the
18 question?
19 MR. MENDELSON: Yes. I suppose I should say how if at all
20 does the turnover rate of patients affect how the management
21 team assigns and directs work?
22 THE WITNESS: The management team from pre-opening knew
23 that there would be a difference. So we added extra management
24 and supervisory levels to assist with this fast pace of
25 patients coming in and patients going out and different acuity

1 levels of the patients.
2 BY MR. MENDELSON:
3 Q Okay. So tell me how it affects that.
4 A So most buildings would have a unit manager, maybe a
5 charge nurse and then staff nurses. PowerBack really came up
6 with a new dimension that they have clinical directors. And
7 the clinical director is a combination of the assistant
8 director of nursing and the off shift supervisor. And they're
9 role was really to run the administrative portion of the shift
10 that they work.
11 We added the care manager level to really handle the --
12 they're the clinical expertise of the floor. So they were in
13 charge of a group of 30 patients. That would be the ideal.
14 Six seal nights (ph).
15 A different staffing pattern, where they would be, you
16 know, really in touch with those staff nurses, being the nurses
17 that had better assessment skills, time management skills,
18 problem solving skills. To be able to help guide the newer
19 nurses, which are your staff nurses or cart nurses. We've
20 given them many different names here. To get through some of
21 the more difficult patients that may come up during their shift
22 --
23 Q Okay.
24 A -- day.
25 Q Now, you say -- well, let me back up. What role if any

1 did you have in the design of the PowerBack model?
2 A We were given a skeleton type of standards and we really
3 had to develop them within certain budget parameters and
4 standards of care parameters.
5 Q When you say we, who's the we?
6 A Oh, it would be myself along with the chief nursing
7 officer and other senior nursing management.
8 Q Okay. Now, I don't want to talk about a model. I want to
9 talk about actual operations from when you were in the
10 facility. When is a care manager, in your experience,
11 responsible for becoming actively involved with the care of a
12 particular patient and the staff nurse?
13 A There's two different avenues. It's when the nurse would
14 come to her. A nurse would come to the care manager and say
15 I'm having a problem with my patient. Can you please come and
16 help me assess? Or let me give you some facts about it and
17 help me figure out what to do next.
18 Or the care manager may go in to check on to see if you're
19 having a problem and get involved that way. So either as a
20 care -- the care manager would initiate it or a staff would
21 come to the care manager and say I'm having issues. Can you
22 please assist me?
23 Q Okay. And how if at all does the turnover rate impact on
24 what you've just described?
25 A With having so many new patients every day and nurses

1 working three days a week, there's a lot of times where nurses
2 just may not know the patients as well and the care manager may
3 have that extra experience of making faster and more thorough
4 assessments. So it would really help them get to the next
5 level and to figure out what the patient needs.
6 Q On average how many new patients arrive each day? And I'm
7 talking about when you were still the head nurse.
8 A Uh-huh. Anywhere between six and 15 patients a day. And
9 the 15 happen more than not.
10 Q And when typically do the patients -- the new patients
11 start arriving?
12 A 3:00-4:00 O'clock on. Very rarely did you get anybody
13 between -- before 3:00 O'clock.
14 Q Okay. And is there something that needs to happen within
15 any certain timeframe when a new patient arrives?
16 A Yes. The nursing standard is that an initial nursing
17 assessment is completed on all new patients within one hour.
18 Q And when you said the nursing standard, who's standard?
19 A It's the PowerBack core standards.
20 Q When you were in charge of the facility, did you -- in
21 your estimation at least, did you convey a attitude or culture
22 about how to handle discipline?
23 MS. LESHINSKI: Could you repeat the question?
24 MR. MENDELSON: Yes. When you were the head nurse, in
25 your estimation did you convey an attitude or culture with the

1 team, the nursing department, as to how to handle discipline?
2 MS. LESHINSKI: I'm going to object. If you -- I think
3 that is a very vague question. Are you asking if she said
4 something? What do you --
5 MR. MENDELSON: Well --
6 MS. LESHINSKI: -- mean convey?
7 MR. MENDELSON: -- I'm trying to not to lead. So what was
8 the practice, with respect to discipline, if there was one,
9 when you were the head nurse?
10 THE WITNESS: We really look at competency and compliance.
11 When somebody does something that you would -- people would
12 consider wrong, my first question is did you know how to do it
13 correctly? So it's a teachable moment.
14 We're not looking to discipline people. We're looking at
15 correcting the process, because nurses there most of the time
16 to do a great job. So if they did something wrong, it's
17 probably because they didn't have the knowledge, or the
18 equipment or what -- the tools they needed, whether it was
19 mental tools or physical tools, to get the job done. So we try
20 go down that track and how could we do it better next time?
21 BY MR. MENDELSON:
22 Q Was there ever issuance of any discipline?
23 A Of course.
24 Q Okay. So tell us how discipline was issued in the
25 department.

1 A Sure. I mean you would --
2 HEARING OFFICER HOLLO: Hang on one -- excuse me one
3 moment. Which department?
4 MR. MENDELSON: Nursing department.
5 HEARING OFFICER HOLLO: Let me ask you a question then.
6 Is there one discipline standard for the entire nursing
7 department?
8 THE WITNESS: Yes.
9 HEARING OFFICER HOLLO: And there is -- okay. Thank you.
10 THE WITNESS: There is -- the practice is set up, you
11 know, they can do a clinical referral. So that's saying that I
12 saw something that wasn't done as per standard policy,
13 procedure. I'm going to educate you.
14 So it could something as simple as printing out the policy
15 and saying this is what you did. Let me show you what the
16 policy is. How come we didn't follow policy, procedure or
17 protocol?
18 BY MR. MENDELSON:
19 Q Now, you're saying me. So I just want to check, are you
20 talking about you would do this or --
21 A I would do this, the educator would do it, the care
22 manager, the clinical director, the nurse practice educator.
23 All those people have the authority to educate nurses about
24 doing something better the next time.
25 Q Okay.

1 A So we would go through and we would say, you know, this is
2 the process. Do you understand it? What didn't you know? Why
3 didn't it happen this way? And you would document it, and
4 would sign it and that would become part of the nurse's
5 education file.
6 If the same issue came up again, you would go back and say
7 okay, we did a clinical referral. You said you understood it.
8 Why did it not go this was this time?
9 You know, and that's when you would make it into a
10 disciplinary. Get to your IPIP, which is the individual
11 performance improvement plan, where you would say, you know,
12 you did it wrong. These are the outcome -- these are the
13 expected outcomes and this is how you need to get it. And you
14 would lay out a plan that says, you know, these are the
15 expected outcomes, this is how you get it and this is when
16 we're going to look at that issue again.
17 Q Okay. I don't want to interrupt you. Just take us
18 through the process.
19 A And there were steps. You know, there's different levels
20 of disciplinary action. So things of call outs. So that's
21 pretty black and white. You call out X amount of times, you go
22 to a level one, which is a verbal.
23 And then there's the next is first written, second and I
24 think it's final warning and then termination. There may be
25 more steps in there, but you would just go through those steps.

1 And there's, for many of these things, written exactly, you
2 know, maybe its six call outs is your first written warning and
3 then it goes from there progressively. And you follow the
4 process.
5 Q Okay. And then what happens if somebody continues to
6 violate?
7 A Well, I mean time you file it you go through human
8 resources to find the last step they were on, because you don't
9 want to say this is your first if they actually got -- if it's
10 their second. Or you don't want to say it's their second if
11 they never had a first. And it's given and you really try to
12 coach the person to better outcomes, because the last thing we
13 want is turnover. That just creates more tension and, you
14 know, doesn't promote our philosophy of giving better patient
15 care.
16 Q Okay. Now, I think you've heard witnesses testify that
17 care managers might initiate something rarely. The testimony
18 seems to be it's very rare. And then it would go to HR. And
19 it sounded like they don't -- the care managers don't seem to
20 know what then happens in the process. Am I understanding that
21 accurately, based on your knowledge?
22 A That's what people said. Remember, care managers are only
23 here three days a week. So if I was the care manager and I
24 wrote up somebody on my second day, it may be several days
25 until I come back. It's given to HR. They do the appropriate

1 investigation and it could be the clinical director or myself
2 that does the actual counseling after that.
3 You know, the whole thing with discipline and performance
4 improvement plans, they should be timely, you know? And I
5 shouldn't have to wait, you know? If I'm off a week and I
6 started it, no one should have to wait a week to hear that
7 something didn't go well. So it's the timeliness.
8 It's getting the right person. Getting the investigation
9 to the plate. And then somebody to give it, so we can improve
10 the process.
11 Q Okay. So does a care manager, in your experience when you
12 headed the facility as the head nurse, have the authority to
13 initiate counseling or discipline?
14 A Yes.
15 Q Okay. Does the care manager have authority to recommend
16 counseling or discipline?
17 A Yes.
18 Q In terms of the way the team operated, when you were the
19 head nurse, how would you describe a philosophy, if there was
20 one, that you tried to impart in the facility through any
21 means, as Ms. Leshinski indicated, verbally, written, however?
22 MS. LESHINSKI: I'm sorry, can you repeat the question?
23 MR. MENDELSON: If there was a philosophy, in terms of how
24 you wanted the department to operate, in terms of the team, and
25 communicated in any possible way, what was it?

1 THE WITNESS: Because this was a new model that we were
2 putting forth, not seen hardly anywhere in The United States,
3 it had to be a model of flexibility, because today you are
4 getting four admissions. And the way you handle four
5 admissions when there's a lot of empty beds is -- the process
6 goes one way. If we're getting 15 admissions and there's only
7 eight nurses, you can't have one nurse three or four
8 admissions. So you're going to divide them up.
9 I mean there was one instance where we were getting 15
10 admissions. I walked on the floor. I saw what's going on? A
11 care manager Sue Henski (ph) handed me a pile of papers and
12 said here's your job. Go sit over there and put these orders
13 in. And I took the orders and I put them in.
14 That's the care manager making the decisions on what the
15 important thing was to do. If I was told, because I'm a nurse
16 first and foremost, to go assess a patient, I could assess a
17 patient. To complete paperwork, to call a doctor. It's what
18 we needed to do in those crisis situations.
19 There are times where I directed someone else to go get
20 the staff from upstairs or downstairs, because they weren't
21 busy. Have a care manager come up and help, because one floor
22 got more admissions than the other because of bed availability.
23 So it was that flexibility of being able to say today
24 we're getting four admissions. We're doing it this way.
25 Tomorrow could be same staff, but if the volume or the types of

1 patients we got differed we're changing the process.
2 CONTINUED DIRECT EXAMINATION
3 BY MR. MENDELSON:
4 Q Okay. Very briefly, because I think the record has it,
5 but the Hearing Officer I think would appreciate it, could you
6 walk us through for each kind of nurse their weekly schedule,
7 in terms of the numbers of days a week and length of the shift?
8 And then just give us the ratios, if you will, however you
9 think it's most effectively communicated, in terms of how the
10 facility operates?
11 A The center nurse executive, there is one in the building,
12 he or she is a salaried supposedly eight hours, five days a
13 week.
14 HEARING OFFICER HOLLO: So this is a CNE?
15 THE WITNESS: Yes.
16 HEARING OFFICER HOLLO: Certified nurse --
17 THE WITNESS: Center nurse executive.
18 HEARING OFFICER HOLLO: Center nurse --
19 THE WITNESS: Yes.
20 HEARING OFFICER HOLLO: -- executive? Is that the same as
21 was referred to yesterday as the DON, director of nursing?
22 THE WITNESS: Correct. It has --
23 HEARING OFFICER HOLLO: Okay.
24 THE WITNESS: -- different connotations to it, but yes,
25 that's the number one --

1 HEARING OFFICER HOLLO: It's the same role?
2 THE WITNESS: -- nurse in the building. Yes.
3 HEARING OFFICER HOLLO: And how about -- I think you --
4 believe you just used a different term. A CNO.
5 THE WITNESS: Chief nursing officer.
6 HEARING OFFICER HOLLO: Is that the same thing?
7 THE WITNESS: No, she's the number one in the whole
8 company. She's the number one nurse in the whole company.
9 HEARING OFFICER HOLLO: Okay. Thank you. Okay. Thank
10 you for clarifying that. Okay. So go on then.
11 THE WITNESS: So the CNE is responsible for all the
12 clinical and some of the financial responsibilities of the
13 building.
14 HEARING OFFICER HOLLO: Okay.
15 THE WITNESS: Under her are clinical directors. Clinical
16 directors work eight hour shifts. And we are budgeted for two
17 in -- two on days. So which would be 7:00 to 3:00.
18 HEARING OFFICER HOLLO: Uh-huh.
19 THE WITNESS: Two on evenings, which would be 3:00 to
20 11:00 and one on nights, which would be 11:00 to 7:00. They
21 are salaried people and they work five shifts a week if they're
22 full time.
23 HEARING OFFICER HOLLO: Okay.
24 THE WITNESS: Then you have care managers. Care manager,
25 we are scheduled -- they're 12 hour shifts. They work three

1 shifts a week. They must be an RN. And so much -- must
2 clinical directors and the CNE. Clinical directors (sic),
3 there should be two on every floor on days and one on each unit
4 on evening -- on nights.
5 CONTINUED DIRECT EXAMINATION
6 BY MR. MENDELSON:
7 Q You said clinical directors.
8 A Care managers.
9 Q Okay --
10 A I'm sorry.
11 MS. LESHINSKI: What was the ratio again? I'm sorry.
12 THE WITNESS: Two on days on each floor. So four in the
13 building from 7:00 A to 7:00 P. And there should be two on
14 nights 7:00 P to 7:00 A, being one on each floor.
15 BY MR. MENDELSON:
16 Q And being clear there, this is the care managers --
17 A Care managers, correct.
18 Q -- you just described??
19 A Yes.
20 Q Okay. Now let me stop you. I know you're helping
21 understand the framework. I heard, I think Ms. Lake say, that
22 often there's only one care manager when there should be two.
23 A We're budgeted for two and if there are call outs the
24 first thing is that the care manager will take the spot of the
25 call out, why we try to replace. We never want to work short.

1 So six, six and four on each floor.
2 BY MR. MENDELSON:
3 Q I don't know if you meant to skip LPNs?
4 A Staff nurses are RNs and LPNs.
5 Q Oh, okay.
6 A Okay. The only other position is we have the health unit
7 coordinator, the HUC. The HUC is an LPN position who does unit
8 clerk plus duties. So the traditional unit clerk would answer
9 the phone, make appointments, non-license acts.
10 We had decided to invent this role as the health unit
11 coordinator and making it an LPN, so they could put orders in,
12 take critical labs, work with the pharmacy, things that a
13 licensed nurse has to do, that traditionally, if I was the unit
14 clerk, and I needed a nurse I would have to yell, and beg and
15 find somebody to sign the meds from the pharmacy, to take
16 critical labs from the lab. This way we have somebody at the
17 desk all the time that can do that. They work 12 hours a day,
18 three days a week. I mean -- yeah, three shifts a week.
19 HEARING OFFICER HOLLO: And how many are there at any
20 given time?
21 THE WITNESS: There's 24 hours scheduled a day. So there
22 should be one on each floor every day, 12 hours a day.
23 BY MR. MENDELSON:
24 Q So what is the budgeted ratio of care managers to staff
25 nurses and CNAs on day shift and then on night shift?

1 A The budgeted -- there should be two care managers, also
2 by the floor. On the second floor there should be two manage -
3 - two care managers, four nurses -- four staff nurses, which
4 could be RNs or LPNs and six CNAs.
5 Q So it should be two to 10?
6 A Correct.
7 Q And what about on -- and that's per floor?
8 A That's per floor.
9 Q And what about on the night shift?
10 A On night shift there's one care manager, four nurses and
11 four CNAs.
12 Q So --
13 A One to eight.
14 Q Okay. Per floor?
15 A Per floor.
16 Q And when -- on day shift, when there's only one care
17 manager, then the ratio is one to 10 rather than two to 10?
18 A Correct.
19 Q Per floor?
20 A Yes.
21 Q I think you've indicated this, but just to be clear, how
22 many beds or patients does a care manager have responsibility
23 for?
24 A Could be one to 31 or one to 62.
25 Q Okay. And this may be a little bit fluid, but in a given

1 week, recognizing that the staff nurse has the principal direct
2 responsibility for the patient, how many patients does the
3 typical care manager have some kind of responsibility over?
4 A In a typical week?
5 Q Yes. If it's a -- if there's an easier unit of time -- if
6 you tell me a month is an easier unit of time -- no?
7 A I mean there's -- if staffing is -- you know, if you have
8 appropriate budgeted staffing on days, she has 31 beds. You
9 have to figure a 25 to 30% of those patients turn over every
10 week. Let me think. If she has one to 31 beds, I would say
11 she has 45 to 60 different patients a week.
12 Q Okay. And I don't mean to be silly, but how would you
13 transpose that into a month?
14 MS. LESHINSKI: I'm going to object. I'm not sure all of
15 these -- is this really --
16 MR. MENDELSON: I think it's pertinent.
17 MS. LESHINSKI: -- necessary? We have the numbers in.
18 Are we going to --
19 HEARING OFFICER HOLLO: Well, where are you --
20 MS. LESHINSKI: Every two months?
21 HEARING OFFICER HOLLO: What --
22 MS. LESHINSKI: Ever quarter? I mean --
23 MR. MENDELSON: Well, --
24 HEARING OFFICER HOLLO: Where are you going with this by
25 the way --

1 MR. MENDELSON: -- I'm trying --
2 HEARING OFFICER HOLLO: -- because --
3 MR. MENDELSON: -- to make a point. I -- there was a lot
4 of requests and questioning about specific examples. And Ms.
5 Lake in particular said there's some instances I just can't
6 tell you a specific name of a patient or a person. I want to
7 show the volume of activity.
8 MS. LESHINSKI: I mean this --
9 HEARING OFFICER HOLLO: To what -- what would --
10 MS. LESHINSKI: -- is a totally --
11 HEARING OFFICER HOLLO: What would my understanding of the
12 volume of activity matter in this context, in terms of you're
13 trying to provide supervisory status?
14 MR. MENDELSON: Yes.
15 HEARING OFFICER HOLLO: Yes. So how would my
16 understanding the ratio over a week versus a month help me make
17 that decision?
18 MR. MENDELSON: Well, the Union, I anticipate, is going to
19 say to you that the record does not have sufficient specificity
20 and depth. And I'm trying to show you the backdrop, as to why
21 a testifying care manager might not be able, given the volume
22 of patients they see, to be able to remember a specific
23 incident. And I think I should have enough latitude to just
24 make that point.
25 MS. LESHINSKI: I mean --

1 HEARING OFFICER HOLLO: Well --
2 MS. LESHINSKI: -- could I respond? Or I'm sorry.
3 HEARING OFFICER HOLLO: I'm not sure that a Hearing
4 Officer's knowledge of the ratios is going to be useful in
5 rendering a decision, but I'll allow you to ask another
6 question or two, then we'll try and move on.
7 MR. MENDELSON: Well, I was really going to conclude
8 there, because --
9 HEARING OFFICER HOLLO: Okay.
10 MR. MENDELSON: -- Ms. Melora was rolling her eyes about
11 the difficulty of doing the arithmetic.
12 HEARING OFFICER HOLLO: Okay.
13 MR. MENDELSON: But --
14 HEARING OFFICER HOLLO: Well, then one --
15 MR. MENDELSON: -- over a month --
16 HEARING OFFICER HOLLO: -- more question and then --
17 MR. MENDELSON: Well, just the month --
18 HEARING OFFICER HOLLO: Okay.
19 MR. MENDELSON: -- how --
20 THE WITNESS: 240.
21 CONTINUED DIRECT EXAMINATION
22 BY MR. MENDELSON:
23 Q 240 patients?
24 A Patients.
25 Q That she has some form of potential --

1 A Contact --
2 Q -- responsibility?
3 A -- with, correct.
4 Q You said contact?
5 A Contact, responsibility.
6 Q Okay. If you know, what is the pay differential between a
7 staff RN and a care manager?
8 A About 16%.
9 Q Okay. And do you have an --
10 A About $5 an hour.
11 Q Okay. And if you know, is there a difference in pay that
12 you can quantify, between a clinical director and a care
13 manager?
14 A Three, 3.50 an hour.
15 Q Okay. We've heard a lot of testimony about care managers
16 being on carts. And so just to be very clear, when is it
17 appropriate for a care manager to be on a cart?
18 A When there's not a staff nurse to fill that cart, to care
19 for those patients and that assignment due to call outs.
20 Q Okay. And just to try to clarify a couple things in the
21 record, are there specific nurses who have come to be known as
22 being either expert or particularly skilled in particular --
23 with particular skill sets?
24 A Yes.
25 Q So give me an example or two.

1 A We've talked about Ginny Podolak. Virginia Podolak is
2 very good at skin and wound care, pressure ulcers. Lee, who --
3 oh, she's not -- she's a clinical director. Mia Funches is
4 very good at IVs. Certain nurses just like certain things and
5 gravitate towards them.
6 Q Okay. There's been some testimony and then some disputing
7 of it about the circumstances if any when a care manager is the
8 senior nurse in the facility. So tell me what you know about
9 specifics where that has happened.
10 A Our goal is to always have clinical directors on every
11 shift, 24/7. That doesn't happen all the time due to several
12 different reasons; calls outs, vacancies, things such as that.
13 So we then always need to have a lead person in the house. So
14 we then assign someone to be the clinical director and they
15 would assume those responsibilities for that shift only and
16 then also be paid the differential for that.
17 Q So they're paid as the clinical director?
18 A Correct.
19 Q Even though they're not the clinical director?
20 A Correct.
21 Q Okay. And so you've explained some of the circumstances
22 where that happens. To your knowledge and only if you have
23 that knowledge, have there been instances where there is a care
24 manager serving as the clinical director and the other care
25 manager, if there is one in the house, who's acting as a care

1 manager gets involved in assignment of staff?
2 A Yes.
3 Q Okay. And has that happened to your knowledge, if you
4 have such knowledge, at night?
5 A Yes.
6 Q To your knowledge have there been extracurricular projects
7 -- and you can define that term if you're able to -- with --
8 where care managers have been involved in performing those
9 projects?
10 A Yes. As part of the -- PowerBack and myself, we've always
11 considered care managers and clinical directors part of the
12 leadership team. And all leaders were asked to take part in
13 one weekly audit, to make sure that the care and services we
14 provide are meetings the standards of not only the state, but
15 of the standards of PowerBack. And they could be -- there is
16 probably six or eight different topics that we've done over
17 time. We also had three different projects going on at once
18 that the nurses were in different teams. There were all
19 assigned to one of the three teams being fall management,
20 incident reports --
21 Q Okay. Say that again --
22 A Fall management and --
23 Q Fall --
24 A -- incident reports.
25 Q Fall management?

1 A Yes. That was one group. There was another group that
2 was annual survey preparation and the third group was looking
3 at nursing morale. I'm not coming up with the right term for
4 it, but nurse engagement.
5 Q And who was doing those things?
6 A It was clinical directors and care managers. I gave them
7 instructions on what I thought I would like to see happen, but
8 how they got to those goals was up to them. They came
9 together. They would have regular meetings and report off to
10 me on their progress on a regular basis.
11 Q Okay. And that was clinical directors and care managers?
12 A Correct.
13 Q For those three endeavors?
14 A Correct.
15 Q And forgive me, there's been an abbreviation used, RMS --
16 A So an incident report is any time there is an adverse
17 outcome on something. It could be a medication error, a fall,
18 skin tear, a loss of an item. An incident report, we used to
19 do it on paper. Now we have an RMS system, Risk Management
20 System. So it's a more in depth type of incident reporting.
21 Q And who has access to the reports to be able to either
22 fill them out or delegate them for filling out?
23 A Staff nurses, care managers and clinical directors all
24 have some access to it. They have access to the entire thing.
25 They've each been assigned different portions to complete and

1 it depends on the type of incident.
2 Q Okay. So are you saying to me that staff nurses can
3 access a portion of the RMS system, but not all of it?
4 A No. Everybody can access all of it, but they've been
5 given education on who should be doing what sections.
6 Q I see. Okay. Now, do care managers only -- strike that.
7 Who if anyone, outside the nursing department, do the care
8 managers have authority to give direction to?
9 A The care managers job is to make sure that care and
10 services are provided. At times care managers will see someone
11 from dining services and say the power bar, which is a
12 refrigerated section of each floor that has snacks and food for
13 patients for either need or desire. So diabetic snacks when
14 they are -- food. And sometimes there's not enough food in
15 there or the wrong types of food. So a care manager can say I
16 need you to go down and get me more protein snacks, or more
17 Jell-O or whatever. So they can give direction.
18 They can give directions to therapists of this patient is
19 looking this way. I need you to do this. I've started
20 education on this. They still be -- still seem to be
21 impulsive. Please review that when you take the patient down
22 today. It's a multi-disciplinary team approach.
23 Q Okay. Have there been instances where employees from
24 different department have conflict?
25 A Yes.

1 Q And what happens in that event?
2 A We always -- like if there's conflict, that the two people
3 in conflict try to handle it themselves. We are adults and
4 professionals. If that is not possible and they have tried
5 that, then it's brought up to the next level.
6 So if it's a CNA and somebody from housekeeping, if they
7 can't work it out then they should go to their care manager or
8 the housekeeper may go to their supervisor. And they get
9 together and say okay, this is the issue. We don't agree on
10 the same thing. Hopefully it's before it gets out of hand.
11 You know, and their -- the supervisor, whether it be the care
12 manager, is supposed to work with them and say this is what the
13 need is.
14 You know, there's been times where the therapist wants to
15 take a patient down to therapy and the nurse is not done giving
16 medications, or hasn't put the compression stockings on or the
17 patient -- the nurse feels that patient is not able to go down
18 to therapy yet, and therapy is trying to wheel the patient out
19 of the room. That's where you get a care manager involved and
20 they -- you know, you could say they're trying to take my
21 patient and the care manager can say okay, what's going on?
22 And the nurse will say I still need to give him their
23 insulin. I still need to give them their pills. They haven't
24 had their hearing aid put in. And the care manager is going
25 have to say therapist, you're going to give them 10 more

1 minutes. They may be a little behind, but they need to have
2 this done before they go to therapy.
3 Q So are you relating to me a hypothetical or a real life
4 situation that you are aware of?
5 A A real life situation that happens several times a day.
6 Q I don't want to detain on this, because I think we've
7 already touched on it earlier in the record, when there are new
8 admission how if at all does that affect the responsibility of
9 the care manager?
10 A The care manager is like the air traffic controller. She
11 has to know what's coming in and how that is going to be
12 divided up. If you want to look at that there is -- if there's
13 10 pieces of an admission. It's just not the physical
14 assessment. There's many other components to it.
15 That care manager has to decide who's going to do what
16 piece. A nurse very rarely does an admission, all those
17 components, from start to finish, just because of the volume
18 and the pace that the patients are coming. So there may be
19 some parts of the admission that are delegated to a CNA, such
20 as getting the patient a shower, taking the shoes off, help
21 inventory the clothes. Other pieces that may be given to the
22 health unit coordinator.
23 And it all depends on the volume of number of patients
24 we're getting and how many each nurse is getting. I'd like to
25 say we divide up one patient on each wing, each time a patient

1 comes in or by each cart. But we assign patients a lot of
2 times by bed availability.
3 Today this -- the census is 121 out of 124. There's not a
4 lot of beds out there. So the admissions director is going to
5 assign them. If all three empty beds are in the same
6 assignment, that's who's getting them. But I can't expect or
7 the care manager can't expect that nurse to complete it all.
8 So we're going to have to assign people depending on the volume
9 and the pace at which they come in.
10 Q When a doctor changes orders, how if at all does that
11 affect the care manager's responsibilities?
12 A There's great communication between care managers and
13 doctors. If a doctor tells the nurse right away that there is
14 something stat that has to be done, he's usually not going to
15 look for the staff nurse caring for that patient, unless she's
16 very visible. A lot of times she'll say I'm putting, you know,
17 an immediate order, do now order, for Ms. Smith. She's going
18 to tell the care manager, the first, you know, charge person he
19 or she finds, in order to get that done.
20 Q And when you say stat that means immediate?
21 A Immediate, correct.
22 Q Okay.
23 A Done now.
24 Q How if at all does something I think that's been referred
25 as UDA affect the responsibilities of the care manager?

1 there's a very difficult assignment. And sometimes people need
2 a break off of that assignment.
3 You hear a lot of times with CNAs that they have a lot of
4 complete patients. And once in a while you get patients that
5 are a little longer and they say I need a break from this
6 patient. And we'll try to switch out that assignment if
7 possible.
8 Or you have patients that -- you know, patients decide I
9 don't like this person. Sometimes we switch it, sometimes we
10 don't. You know, you have to make your judgment on that and
11 that's what the care managers can do.
12 Or if a nurse -- if we think a CNA is going to show up and
13 all of the sudden doesn't show up. You know, somebody made the
14 schedule. It looks all great, but if a person doesn't show up
15 I have five CNAs for six assignments. Somebody has to
16 rearrange that assignment so care gets delivered promptly.
17 Q In a given week, when you were the head nurse, how often
18 would there be a CNA call out?
19 A Way too much. Twice a week per shift.
20 MR. MENDELSON: Okay. Let me introduce some documents.
21 If we could just go off the record for a moment? I think the
22 easiest thing for me to do is to take all of my documents,
23 break them up into a set for each of us and then walk the
24 patient -- walk the witness through them.
25 HEARING OFFICER HOLLO: Well, I think you should be giving

1 A Center nurse executive, yes.
2 Q The center nurse executive, excuse me.
3 MS. LESHINSKI: And it's being offered for what purpose?
4 MR. MENDELSON: Well, from the standpoint of management it
5 defines the management perspective of what the positions should
6 be. We're not representing that it's been circulated to the
7 employees. We're not representing it as that. It has only
8 probative value in terms of what management endeavors to have
9 the positions constitute.
10 MS. LESHINSKI: Okay. I'm not going to object to the
11 document.
12 HEARING OFFICER HOLLO: Okay. E-7 is received into
13 evidence.
14 (Employer's E-7 received in evidence)
15 CONTINUED DIRECT EXAMINATION
16 BY MR. MENDELSON:
17 Q Now Ms. Melora, back at the time of the unit hearing you
18 had engaged in a process, by which you were trying to determine
19 mathematically or objectively, which care managers had
20 functioned as interim clinical directors on a given weekend,
21 night, etc. Do you recall that?
22 A Yes.
23 Q Can you tell the Hearing Officer what you did to try to
24 calculate that data?
25 A We have a system called Kronos and that's our payroll and

1 accounting system. And what we were able to do was look at
2 every care manager in a given time period. And I don't -- so I
3 don't recall which time period it was. And we looked back to
4 see how many times they worked -- that their title was care
5 manager and they worked as clinical director. And since we pay
6 them a differential for that, it was easy to find out how many
7 times everybody worked not as a care manager, but as a clinical
8 director for that shift.
9 Q When you say everybody what population?
10 A All -- any care managers that would have been assigned to
11 be clinical director.
12 Q Okay. And you say you don't remember the timeframe. I'm
13 going to show you a document in a moment and then take a look
14 at it and tell if that helps refresh you as to the time period
15 that you did examine.
16 A Uh-huh.
17 Q You have to answer audibly.
18 A Yes, I will look.
19 Q It's been marked as E-8.
20 HEARING OFFICER HOLLO: I thought we were already looking
21 at E-8?
22 MR. MENDELSON: I think we just looked at E-7.
23 HEARING OFFICER HOLLO: Oh, I'm sorry. I skipped ahead.
24 I was actually looking at it already. Okay. I'm sorry.
25 MS. LESHINSKI: So your representation is that this

1 document shows when a care manager was filling in as clinical
2 director?
3 MR. MENDELSON: Correct.
4 (Employer's E-8 identified)
5 MS. LESHINSKI: Okay.
6 THE WITNESS: It looks like the earliest date was January
7 of 2015.
8 MR. MENDELSON: Well, January what of 2015?
9 THE WITNESS: January -- it looks like the earliest is
10 January 2nd.
11 BY MR. MENDELSON:
12 Q Well, did you look back to January 1?
13 A Oh, wait a minute, wait a minute, wait a minute. Oh,
14 there is a January 1. I'm sorry. There's a January 1, 2015.
15 Q Because under Ms. Podolak's name on the last page it says
16 January 1, correct?
17 A Correct. And the latest looks like -- wait a minute. I'm
18 looking.
19 Q Well, it -- okay, I'm sorry.
20 A It goes to October 10th looks like the latest date I have
21 here.
22 Q Okay. So thinking back, is that approximately the
23 timeframe you were trying to examine, to determine which care
24 managers had functioned on an interim basis as clinical
25 directors?

1 A Yes.
2 Q Okay. And if somebody had not functioned as a clinical
3 director, if you turn to page two, there are instances where
4 you put none.
5 A Correct. That means during that period those people did
6 not get paid a differential, which tells me they did not work
7 as a clinical director during that time.
8 MR. MENDELSON: Okay. I move the admission of E-8.
9 HEARING OFFICER HOLLO: Ms. Leshinski?
10 MS. LESHINSKI: May I ask a few questions?
11 HEARING OFFICER HOLLO: Please.
12 VOIR DIRE EXAMINATION
13 BY MS. LESHINSKI:
14 Q Were you involved in putting together this document?
15 A Yes, I did. I looked up every person --
16 Q Okay.
17 A -- one by one.
18 Q And how did you figure out the date?
19 A I went back from the beginning of the year. It was just a
20 point in time that we picked.
21 Q So if you paid them a differential that's when you put the
22 date down?
23 A Correct.
24 Q Okay.
25 A Because it said -- and besides, it wasn't just a

1 your intent.
2 HEARING OFFICER HOLLO: These months have rolled around
3 again --
4 MR. MENDELSON: Yes. Well --
5 BY MR. MENDELSON:
6 Q I think there's been very brief testimony about this. I
7 just want to touch it again briefly. You've stated that you
8 consider care managers and clinical directors the nursing
9 leadership. What if anything has the department done to
10 cultivate leadership, in terms of meetings or other things of
11 that sort?
12 A Preopening --
13 Q No, no.
14 A -- we had --
15 Q No, no. Well --
16 A Oh.
17 Q I don't think preopening is relevant, but go ahead. Go
18 ahead.
19 A Well, we have monthly leadership meetings. They were held
20 -- maybe it was like the first Wednesday of every month at 6:00
21 O'clock. We did it at 6:00 O'clock at night, so nurses from
22 the day shift or the evening shift had a chance to come in,
23 voice their concerns, hear updates. We always did it at that
24 point, you know, once a month at least.
25 Q Are you talking preopening now or are you talking --

1 A No, I'm talking every month since opening --
2 Q Okay. And so --
3 A -- we had these meetings.
4 Q -- in 2015 in the summer and fall, did you have leadership
5 meetings?
6 A We had leadership -- my last one probably was in September
7 of 2015.
8 Q Okay. And who attended?
9 A Care managers and clinical directors.
10 Q Okay. Let me show you a document that's been marked as
11 Employer exhibit 9 and tell us if you recognize it.
12 A Yes.
13 Q Okay. And I may have asked you a question that was
14 somewhat removed. What is E-9?
15 A E-9 is -- looks like a summary of what we call Genesis
16 leadership essentials, which used to be called management 101.
17 Q Okay. So what is that?
18 A These are anyone at a management level, so it would be
19 from care managers, clinical directors and other department
20 heads, had to complete these courses within a one year
21 timeframe was the suggested timeframe. And this really taught
22 you about the Genesis philosophy on leadership and management.
23 (Employer's E-9 identified)
24 Q Okay. And what does E-9 represent?
25 A All the courses.

1 the time she took them, which long predate the filing of the
2 petition, actually are the same courses required for the care
3 managers.
4 But I'm going to allow in E-11 and accord it the weight
5 that would be appropriate, based on the fact that the emails
6 that were sent and received postdate the filing of the
7 petition. So I'm receiving E-11 into evidence and not E-10.
8 Mr. Mendelson, do you want to withdraw E-10 or --
9 (Employer's E-11 received in evidence)
10 MR. MENDELSON: No, I'd like you to put it in the rejected
11 exhibits file, assuming that that's what has to be created.
12 HEARING OFFICER HOLLO: Yes. I just wanted to know.
13 MR. MENDELSON: Yes.
14 HEARING OFFICER HOLLO: Okay. So we will have a rejected
15 exhibits file or bin and we'll place E-10 in there.
16 (Employer's E-10 rejected)
17 MR. MENDELSON: May I proceed?
18 MS. LESHINSKI: Yes, please do.
19 CONTINUED DIRECT EXAMINATION
20 BY MR. MENDELSON:
21 Q Ms. Melora, I'm going to show you a document that's been
22 marked as E-12 and tell us if you know what these are.
23 A They look like different sign in sheets for nursing
24 leadership meetings that happened in different months in 2015.
25 (Employer's E-12 identified)

1 Q And I had asked you at the outset of this last questioning
2 about leadership training and I think you said it was once a
3 month?
4 A Nursing leadership meeting?
5 Q Yes.
6 A Nursing leadership meeting happens once a month.
7 Q Okay. And who attends those meetings?
8 A Clinical directors and care managers.
9 Q Okay. And these are the sign in sheets from those
10 meetings?
11 A Correct.
12 MR. MENDELSON: Okay. Move the admission of this
13 document.
14 MS. LESHINSKI: No objection.
15 HEARING OFFICER HOLLO: Okay. E-12 is received into
16 evidence.
17 (Employer's E-12 received in evidence)
18 MR. MENDELSON: Okay. Thank you. I'm going to show
19 everyone a document now that was sent here from the facility.
20 I didn't have it. It's been marked as E-13.
21 BY MR. MENDELSON:
22 Q And I only have four of them, Ms. Melora. So I'm going to
23 show it to you in a moment.
24 HEARING OFFICER HOLLO: She can share mine.
25 MR. MENDELSON: Well, I can give it up, then you --

1 BY MR. MENDELSON:
2 Q And how are they accountable?
3 A They are accountable to make sure that work for their team
4 is being completed on a timely manner.
5 Q Are you aware of instances in which care managers have
6 been spoken to or counseled, because there was unhappiness of
7 how their team performed?
8 A Yes.
9 Q Did you ever yourself do that?
10 A Yes.
11 Q And have there been instances in which disciple and/or
12 corrective action has been issued by care managers?
13 A Yes.
14 Q Okay. Do you recall off the top of your head the names of
15 any care managers who initiated discipline?
16 A I think Brielle --
17 Q Okay.
18 A -- wrote a nurse up once. And I think Ray has also
19 initiated disciplinary action.
20 Q Ray who?
21 A Tomba (ph).
22 Q Okay.
23 A Forget how to pronounce his last name.
24 Q Okay. And what shift does he work on?
25 A 7:00 P.

1 Q So on the weekdays who attends the morning meeting?
2 A The senior nurse on the floor. So nine -- you know, 80
3 percent of the time it's the clinical director. If the
4 clinical director is occupied or unavailable then one of the
5 care managers would come down and be that person.
6 Q And what happens when the clinical director is not present
7 and there's an interim care manager -- interim clinical
8 director who's a care manager?
9 A The expectations are the same. They're supposed to come
10 down, give a complete overview of their patients and then be
11 able to take back items that have to be completed throughout
12 the shift and get them completed or delegate them out, and make
13 sure by the end of her time period that those tasks have been
14 completed.
15 Q Is it just the nurses -- nursing -- senior nurses who show
16 up at this meeting or are there other people?
17 A It's a multi-disciplinary meeting. At that morning
18 meeting there are physical -- there's representation from
19 therapy, there's representation from social work, from
20 nutritional services, myself. That's --
21 Q Who from those departments attends?
22 A Department heads.
23 Q Okay. Off the top of your head can be remember any care
24 managers serving as interim clinical directors who attended
25 those meetings?

1 -- I'll use the word run -- run a situation when an emergency
2 appears to exist?
3 MS. LESHINSKI: I'm going to object. Can you repeat the
4 question first? I'm sorry.
5 BY MR. MENDELSON:
6 Q How does a care manager decide that he or she is supposed
7 to run an event or run an episode when he or she decides an
8 emergency exists?
9 MS. LESHINSKI: I'm going to object. I think the question
10 is very confusing. I personally don't understand the question.
11 MR. MENDELSON: Well, I'm trying not to lead the witness.
12 BY MR. MENDELSON:
13 Q Who decides that, whether it's a code or a GI bleed, those
14 kind of things, that somebody has to take charge and begin to
15 handle the situation?
16 A We put the care manager position into place because it's
17 people with better assessment skills, better problem solving
18 skills. They're the ones that can go in, assess the situation
19 the best, and say we should do A, B, and C, or we should do 1,
20 6, and B. They're the ones who will look at that situation and
21 determine what the next step shall be.
22 Q Okay.
23 A And assist that staff nurse. As our standard said it
24 could be a novice nurse, someone new.
25 HEARING OFFICER HOLLO: So the answer to the question is

1 the care manager makes the determination of who should be in
2 charge?
3 THE WITNESS: No, they make the determination of the --
4 they assess the situation and decide what the next step should
5 be. And part of the assessment is --
6 HEARING OFFICER HOLLO: Everybody hang on a second. Is
7 that the question you were asking?
8 MR. MENDELSON: Yes. I was asking who makes the
9 determination that somebody has to take charge and again to
10 address a serious situation.
11 HEARING OFFICER HOLLO: Okay. And so what's the answer,
12 which title is it?
13 THE WITNESS: It's the care manager.
14 HEARING OFFICER HOLLO: Okay. Thank you.
15 BY MR. MENDELSON:
16 Q Is every direction that a care manager gives to a staff
17 nurse after consulting with the doctor prescribed by the
18 doctor's order?
19 A No, there are such things as nursing orders that we can do
20 under our scope of care that we don't have to get a doctor's
21 orders for. So the doctor may say do one, two, and three and
22 we may add don't forget to do these things within our scope of
23 care.
24 Q Okay. When they -- are there instances where a care
25 manager will direct a nurse to change a catheter?

1 A Yes.
2 Q Is a care manager entitled to do that only based upon a
3 doctor's order?
4 A No.
5 Q Are you aware of any situations where a care manager sent
6 a patient to an emergency room outside the facility without
7 consulting a care manager -- I'm sorry -- without consulting a
8 doctor?
9 A There are instances where that happens, yes.
10 Q Okay. And -- strike that.
11 MR. MENDELSON: What number are we up to, 21?
12 THE REPORTER: Yes.
13 BY MR. MENDELSON:
14 Q I'm going show you a document that we're going to mark as
15 Employer 21 that has some redactions on it. Tell me after you
16 look at it if you recognize what it is.
17 (Pause)
18 A It's a patient care plan.
19 Q Okay. So explain for the record what this is.
20 A The way point PointClickCare is set up you think of it as
21 a bunch of filing cabinets, and one drawer of the filing
22 cabinet is care plans. And the first page you see here is the
23 section that basically states whoever this patient is has a
24 care plan, and it was initiated on October 11th and with the
25 next review date of January 9th. It was created by a nurse and

1 HEARING OFFICER HOLLO: No.
2 MR. MENDELSON: No, it's not in the record.
3 MS. LESHINSKI: I mean because if it's in there I would
4 think the reader of the read is going to see it.
5 MR. MENDELSON: No --
6 HEARING OFFICER HOLLO: No, no, it has not been offered
7 nor has it been -- he hasn't offered it.
8 MS. LESHINSKI: Okay. So should he take it back from the
9 court reporter?
10 HEARING OFFICER HOLLO: Oh, you probably should take it
11 back from the court reporter.
12 MR. MENDELSON: Okay.
13 THE REPORTER: So withdrawn?
14 HEARING OFFICER HOLLO: I guess if you want to consider it
15 withdrawn it's withdrawn.
16 THE REPORTER: Thank you.
17 HEARING OFFICER HOLLO: Okay. Different -- sometimes
18 they're just left out there in limbo. But you're direct, Ms.
19 Leshinsk they're not kept with the court reporter then. Thank
20 you.
21 So E-21 is withdrawn.
22 BY MR. MENDELSON:
23 Q Is there a standard, whether generally or in the facility,
24 for how often a CNA should turn a patient or resident?
25 A The sooner it is -- a patient that's unable to turn

1 themselves, are able to move and shift weight should be turned
2 at minimum every two hours. It's up to the people with better
3 assessment skills to determine is it two hours or it could even
4 be less time frame than that.
5 Q Are you aware of instances where care managers have
6 directed CNA or nurses or both to turn patients more frequently
7 than every two hours?
8 A Yes.
9 Q Okay. And is that a function of doctor's orders?
10 A No, it's a nursing assessment and nursing skill.
11 Q Is there -- I gather doctor's orders will specify when
12 medications are to be administered? You have to answer
13 audibly.
14 A Yes.
15 Q Are there circumstances where a -- are you aware of where
16 a care manager will direct a nurse to administer medication
17 other than precisely when the doctor has prescribed it?
18 A You can give medication an hour before or an hour -- up to
19 an hour after the administration time. There's also PRN
20 medication that it says queue four hours PRN pain or nausea or
21 whatever the case may be. So the nurse may remind them, have
22 you given all the medications that you can in a timely basis?
23 Q Okay. And are you aware of instances where a care manager
24 will tell a nurse to administer the medication up to an hour
25 earlier or an hour later than the doctor ordered?

1 A Yes. A nebulizer is a great example.
2 Q Explain that for me.
3 A It's a breathing treatment. So if people are having
4 breathing treatments, you know, you can give it, have you been
5 to the four hours, you can give it now, please remember to give
6 it. So they can do that.
7 Q And what factors would a nurse consider in deciding
8 whether to direct -- I'm sorry -- what factors would a care
9 manager consider in deciding to direct a nurse to do it up to
10 an hour or up to an hour before or after?
11 MS. LESHINSKI: I'm going object. I mean I've let a lot
12 of these questions go, but these are just -- they're
13 generalizations with no reference to any actual time this has
14 ever happened.
15 I would ask that if this witness has some specific
16 knowledge of this situation that perhaps she could testify to
17 that. But a generalization about what care managers are doing
18 I don't think is helpful.
19 BY MR. MENDELSON:
20 Q Ms. Melora, how many patients passed through the facility
21 ballpark while you were the head of nursing?
22 A There have been over 4,600 unique patients, many with
23 multiple, multiple admission. So it's got to be over 5,000
24 individual admissions.
25 Q Okay. And so -- well Ms. Leshinski wants you to identify

1 a specific instance. Can you state to us under oath with
2 certainty that you are aware of instances where care managers
3 have directed a nurse to give medication up to an hour before
4 or an hour after the doctor prescribed it be administered?
5 A Yes.
6 Q Okay. And I was asking what factors do you understand
7 bear on the care manager's decision to do so.
8 HEARING OFFICER HOLLO: Let me ask you a question. If --
9 as I understood it you testified that if a doctor -- a
10 physician prescribes medicine then within the range of an hour
11 before or an hour after the time it's written for that's
12 considered covered by that order?
13 THE WITNESS: Uh-huh. Yes.
14 HEARING OFFICER HOLLO: Okay.
15 THE WITNESS: Yes.
16 HEARING OFFICER HOLLO: So then if it's covered by the
17 order, Mr. Mendelson, I don't understand why we need testimony
18 about what factors are considered. It's considered timely
19 under the doctor's order.
20 MR. MENDELSON: Because I think the --
21 HEARING OFFICER HOLLO: So I don't see how that would show
22 that someone is or is not a supervisor, they're just following
23 the doctor's order.
24 MR. MENDELSON: Well I don't know that they're just
25 following the order. The order is to administer medication at

1 Q So were there instances where care managers would
2 intercede in deciding what CNAs would be sent to the Bistro?
3 A Yes. CNAs are required to go to the Bistro, one from each
4 floor twice a day. Once for the lunch meal and once for the
5 dinner meal. And it's up to the care manager to make that
6 assignment. Even if it was made prior at 7 o'clock things
7 change all the time where I have been a CNA assigned but I am
8 swamped, I had a patient just fall, I had a patient come back
9 from something, and I'm not going to get there. Then the care
10 manager would have to reassign something else to that duty.
11 Q Now there are many instances aren't there where the care
12 manager has nothing to do with the decision about which CNA
13 goes to the Bistro?
14 A Correct.
15 Q Okay. So why would a care manager become involved?
16 A Because the circumstances for that CNA that's supposed to
17 go down changed and that's not the best person to go now. She
18 may be in the middle of showering a patient or changing, doing
19 a full bed change that she just can't stop to go down and help
20 in the Bistro.
21 Q Okay. How often during a shift is a staff RN supposed to
22 assess a patient's condition?
23 A A staff nurse is supposed to round on their patient at a
24 minimum every two hours.
25 Q Okay. And so how many times during a shift?

1 A It should be six times during a shift.
2 Q And how many times during a shift is a care manager
3 supposed to have an assessment of a specific patient?
4 A When a patient is identified twice a shift would go in
5 there and seeing that patient and checking on them. And it's
6 not every patient, it's the patients that have been identified
7 as being at risk for rehospitalization or having a clinical
8 issue at that point.
9 Q By the way, how many patients on average end up being
10 rehospitalized from the Voorhees facility?
11 MS. LESHINSKI: I'm going to object. It's totally
12 irrelevant.
13 MR. MENDELSON: She just testified as to the circumstances
14 in which a staff -- in which a care manager is -- not directed
15 -- is required to see a particular patient, and one of those
16 was the rehospitalization risk.
17 MS. LESHINSKI: The hospital readmission rate? I mean
18 it's totally not relevant.
19 HEARING OFFICER HOLLO: Do you know the hospital
20 readmission rate?
21 THE WITNESS: I do.
22 HEARING OFFICER HOLLO: Okay. What is it?
23 THE WITNESS: It's ten percent. It's more than ten
24 percent, which is about seven percent under the average right
25 now.

1 A I don't remember.
2 Q Okay. And you attended -- you didn't attend any of the
3 other meetings?
4 A I did not give any other information. I was not with her
5 when she gave out any other information, nor did I give out any
6 on my own.
7 Q Did you have any other -- did you have any conversations
8 with staff about the union?
9 A I mean during my normal course of running the building for
10 the couple of last two weeks or so that I was there nurses
11 would come up to me and I would urge them to listen to both
12 sides, gather your information, and make your decision.
13 Q Okay. Did you say anything else?
14 A No.
15 Q Did you see from the flyers that are -- have been marked
16 as Petitioner's 1 through 11, did you see these on the floor?
17 A No, because once this started I was offered my other
18 position, and immediately I think two days later was in Texas
19 working with another building.
20 Q I see. Okay. Now you talked about called a clinical
21 referral. The clinical referrals are disciplinary, correct?
22 A They're educational.
23 Q They're education?
24 A Uh-huh.
25 Q Okay. So they're not disciplinary if they're education;

1 is that right? Is that fair to say?
2 A Correct, we've identified an issue that somebody didn't do
3 something according to policy, protocol, procedure, and we
4 educated them on what didn't go right and how to do it
5 correctly the next time.
6 Q Okay. And then you talked about in IPIP and you mentioned
7 call logs. Care managers aren't keeping track of employee call
8 logs are they?
9 A No, they are not.
10 Q Okay. So -- and then we had a couple of different
11 disciplines. We had one for E-14. Does she have the
12 employer's exhibits?
13 A Those I do have.
14 Q Through E-18. And let's start at E-14. Now you provided
15 a --
16 HEARING OFFICER HOLLO: I don't think she's found it yet.
17 MS. LESHINSKI: Oh, I'm sorry.
18 THE WITNESS: It's okay, I'm just -- I got it.
19 HEARING OFFICER HOLLO: Okay. Okay.
20 BY MS. LESHINSKI:
21 Q E-14, and this is an IPIP for Sekoya Taylor.
22 A Uh-huh.
23 Q Now you testified already that the portion of this form
24 that was filled out by Brelle Cantagalo is just the part at the
25 bottom that says date of event and description of event; is

1 said do this. I said, okay.
2 Q Could she require you to do it?
3 A I'm a nurse, I asked what I can do, she told me what to
4 do.
5 Q Okay. Can she discipline you for not doing it?
6 A Darn right she could. If I -- if it was the most
7 important thing to do for the patient.
8 Q Okay. Now you also talked about how many staff are on --
9 like on days, and you said there are two care managers, four
10 RNs, and six CNAs; is that right?
11 A Per floor, correct.
12 Q And then -- but you failed to mention the clinical
13 directors. How many clinical directors are on days?
14 A No, there's two on days, two on evenings, one on nights.
15 Q Okay. So there are -- on days there'd be two clinical
16 directors, two care managers, four RNs, and six CNAs; is that
17 correct?
18 A No. On days there would be 2 clinical directors, 4 care
19 managers, 8 staff nurse, 12 CNAs for a maximum of 124 patients.
20 Q Okay. So I think I'm looking at the -- for each wing.
21 A Okay.
22 Q So each wing would have one clinical director, two care
23 managers, four RNs, and six CNAs?
24 A Okay. So no --
25 Q Is that right?

1 A No, let's go back.
2 Q Okay.
3 A A wing is 31 patients, a floor is 62 patients, the
4 building is 124. So on a wing, which would be A Hall, by the
5 numbers it would be half a clinical director on days, one care
6 manager, two nurses, three CNAs.
7 Q Let's do the floor.
8 A Okay.
9 Q How many on a floor?
10 A One clinical director, two care managers, four staff
11 nurse, six CNAs.
12 Q Okay. Thank you.
13 Now we saw some -- you mentioned Jenny Permilac as someone
14 who has special skills?
15 A Yes.
16 Q Jenny Permilac is a care manager?
17 A Yes.
18 Q She's also your room nurse though, right?
19 A Yes, that's her special skill.
20 Q That's her -- but she has the title of room nurse, right?
21 A Yes, but she doesn't get separate time for that. She's a
22 care manager.
23 Q Okay. But care manager/room nurse?
24 A Who does wings on part of her shift.
25 Q Have you personally done the scheduling of employees into

1 Q And you've taken vitals and inventory and a welcome packet
2 and toileting a patient, are those job functions that the CNA
3 knows how to do?
4 A Yes.
5 Q And is there some description somewhere of what needs to
6 happen on a patient admission in terms of what the role of the
7 CNA is?
8 A Yes.
9 Q Okay. So they're following the instruction about their
10 role in an admission of the patient, correct?
11 A They are, but sometimes there are numerous requests from
12 the CNA at one time. Patients come in starting about
13 4 o'clock, 3 o'clock in the afternoon, that's when patients
14 coming back from therapy, meals are coming. These all require
15 CNA attention. So the CNA needs direction of what are the
16 priorities and someone has to help them. These are the
17 priorities right now because of this situation.
18 Q And do you have a specific instance of when this happens?
19 A It happens almost every day because you only have six CNAs
20 and you have ten patients that they're caring for and maybe two
21 or three admissions that are coming in to the same assignment
22 segment.
23 Q Okay. So -- but you can't give a specific -- even though
24 it happens frequently you can't give any specific time when
25 that happened?

1 Q Okay. Are you aware that on night shift that clinical
2 director make -- fills out the assignment sheet?
3 A They do that for every shift. It's the care managers that
4 make the adjustments as needed.
5 Q Okay. Are you -- have you witnessed adjustments be made?
6 A Yes.
7 Q When does that happen?
8 A I've been there several mornings where the CNAs are just
9 standing around a desk and I'll go to one of the care managers,
10 why are people standing here, because the assignment wasn't
11 done and someone didn't show up or somebody was assigned to the
12 same room twice, fix it. We are wasting time. The patients
13 aren't being cared for. And I wasn't going to do it. It's the
14 care managers, whoever was at the desk to make that adjustment
15 and --
16 Q Do you know --
17 A -- get the thing started.
18 Q -- how it got fixed?
19 A Somebody took the initiative and fixed it.
20 Q Do you have a specific time when that happened?
21 A It was 7 a.m. in the morning. I can't give you a date.
22 Q Do you know who was involved?
23 A Jenny Permilac was involved one time, Liz was involved one
24 time. I'm trying to think who else was -- these are different
25 instances. I don't remember every one.

1 Q Okay. So take the time with Jenny Permilac. Do you know
2 why the CNAs were standing around the desk?
3 A I think it's because we're supposed to have six CNAs and
4 only five showed up.
5 Q But isn't it true, though, that you have an assignment
6 sheet that will tell you what rooms the CNA is supposed to go
7 based on the number of CNAs who come on that shift?
8 A Correct. So if there's one filled out for six, the CNAs
9 will not take the initiative to say, oh, we're going to a five-
10 man system and we'll just split it up ourselves. They need the
11 redirection of, okay, you're going to take this, you're going
12 to take this, you're going to take this, oh, give me what --
13 you can't take Room 215 because they only request females and
14 the person who called out was a female. So we're going to move
15 you from 15 to assignment 4.
16 Q Okay. So would you agree with me that the CNAs have a
17 regular room assignment?
18 A They don't have a guarantee like the nurses do. They --
19 Q They --
20 A We try to keep them in the general vicinity.
21 Q Okay. And so the CNAs have a general regular assignment,
22 but it's not guaranteed. So they come into work and instead of
23 having six they have five. So you actually keep a grid which
24 shows which CNAs start in what room based on having five CNAs
25 --

1 A No. It doesn't say --
2 Q -- is that correct?
3 A -- what CNAs. It says what room will be a five-man split
4 --
5 Q Right.
6 A -- instead of the six-man split.
7 Q So isn't it true that the CNAs will go to the rooms that
8 they generally get and they will just fill their names in on
9 the assignment sheet based on where the CNAs generally go but
10 for the grid for five CNAs instead of six?
11 A So the CNAs can't change the assignment. It has to be a
12 care manager.
13 Q I understand that. But what I am asking you is whether
14 it's true that when you have five CNAs and these five
15 individuals have a regular assignment, you wouldn't just look
16 at the grid and see what rooms they go to and just slot their
17 names in for the rooms that they would normally have, and they
18 would go and do their job?
19 A That's if all the other stipulations have been made. We
20 don't have a male/female preference. We don't have this. We
21 don't have that. It happens all the time.
22 Q Okay. If we don't have these situations with a
23 male/female preference the CNAs would just get slotted in?
24 A They could.
25 Q Okay. Do you have a specific instance that you know of

1 with a male/female presence where -- preference where the CNAs
2 assignment had to be switched?
3 A I know with -- on 3/11 we had a lot of male CNAs, that
4 just happened to be where they worked, where Andre was asking
5 not to have a certain patient, excellent CNA. The woman did
6 not want a male.
7 Q And how did that come to your attention?
8 A The patient or the family made it very clear that, my
9 mother does not want -- or the patient would say, I don't want
10 a male. Okay.
11 Q So the patient's family went to the center nurse executive
12 to discuss not having a male take care of the patient?
13 A That could be. They could have went to the care manager.
14 Q No. I'm asking you specifically in that situation.
15 A No. That actually went to a care manager.
16 Q And then how did that come to your attention?
17 A First of all, I am on the units all the time so I hear the
18 information. They may just tell me because I may see somebody
19 not in their usual spot and say, hey, why aren't you here.
20 Q I guess I'm asking you to be more specific. Do you
21 remember in this case -- first of all, when did that happen
22 with Andre?
23 A I can't give you dates and times.
24 Q Do you know who the nurse was who was involved?
25 A I do not.

1 Q And do you know how it came to your attention?
2 A From being on the unit, not that I asked, not that someone
3 came to me, but just walking around and doing rounds.
4 Q Are care managers -- so you talked a little bit about the
5 morning meeting. Now for the most part these meetings are
6 attended by clinical directors and not care managers, isn't
7 that right?
8 A Correct. For about the 15 to 20 percent -- well, about 15
9 percent of the time when the care managers are not available or
10 not present, then a care manager will come down and be -- take
11 part in that meeting.
12 Q And is that a meeting where you're discussing patients?
13 A We're discussing patients, processes, and the day and what
14 needs to go on with the patients, and also we look at
15 assessments that didn't get done, weights that aren't done,
16 weights that need monitoring.
17 Q Okay. And would a care manager only attend that meeting
18 if there's no -- if the clinical director is unable to go?
19 A That is what I said. Yes.
20 Q And the reason is just to get an update on the patients
21 and the processes and --
22 A And to get assignments of what are the priorities for the
23 day would have to be done and to make sure that those were
24 delegated and completed.
25 Q Do you know -- so you said that some staff has worked on

1 an interim basis or have you -- I think your testimony was that
2 care managers have done fill-in clinical director work; is that
3 right?
4 A Correct.
5 Q And do you know what -- whether they're fulfilling all of
6 the job duties of the clinical director when they do the fill-
7 in?
8 A They fill in the role of the clinical director and it's
9 pertinent to that day.
10 Q So what would that be?
11 A It could be staffing. It could be patient/family
12 interactions, attending multidisciplinary meetings,
13 multidisciplinary rounds, sitting on different committee
14 meetings that happened that day, just everything is so
15 different in the building so it's such a flexible moving
16 system.
17 Q Anything else that could be included when they do the
18 fill-in role?
19 A Gosh, I guess I would have to go through each response --
20 may I -- would you like me to look at the clinical director job
21 description and go through each one?
22 Q No, not yet.
23 A Okay.
24 Q Do you know off the top of your head without looking at
25 the job description?

1 Q -- there's reporting. But something outside, is there
2 something in -- you mentioned I think CIGNA Care and then
3 there's the other system and whatever other documentation
4 systems exist.
5 A Okay.
6 Q Is there some kind of entry that would memorialize the
7 fact that someone has made you aware of something that happens
8 in the facility?
9 A Usually not.
10 Q Okay. Now you did indicate just now that you would review
11 every code.
12 A Correct.
13 Q I think you've indicated that some -- someone today
14 indicated that when there's a code somebody is memorializing
15 what happened?
16 A Correct. There's an AED code sheet.
17 Q Okay. So in that instance your -- is your -- your
18 testimony is very clear that you would review that
19 memorializing of what happened in the code?
20 A Yes.
21 Q And you would know by virtue of that who it was who ran
22 the code?
23 A Correct, because there's specific spots that say who did
24 what.
25 Q Okay. And so in your experience at the facility in 2015

1 in what portion of those codes was it run by a staff RN?
2 A Minority. The majority was by a care manager.
3 Q And setting aside codes, are there other emergencies where
4 there's that kind of memorializing?
5 A Unless code is called there's not that separate sheet
6 where all of the pieces that fell in before 9-1-1 came in.
7 Q Okay. How about when the facility discharges someone to
8 go back to a hospital? You gave a percentages of instances on
9 average where that happens. Is there something that is
10 memorialized, the process by which that happens that you would
11 review?
12 A we look at -- re-hospitalizations is a very important
13 quality indicator for us. So the medical director and I look
14 at that on a monthly -- we used to look at it on a monthly
15 basis.
16 Q And was there anything to indicate who led that endeavor
17 if there was such a person leading it?
18 A The documentation wasn't as good as with the code, but
19 there was -- we would go and look at all the documentation to
20 see who did what and when to look at a sequencing.
21 Q And so did you make a judgment in the course of your being
22 the head nurse as to the portion of times a staff RN lead that
23 endeavor versus a care manager?
24 A We weren't really looking at that detail. That wasn't the
25 quality indicator parts we were looking at because it's usually

BEFORE THE

NATIONAL LABOR RELATIONS BOARD

In the Matter of:

Case No. 04-RC-161250

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 133 SOUTH ROUTE 73,

Employer,

and

DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTH CARE EMPLOYEES, AFSCME, AFL-CIO

Petitioner.

The above-entitled matter came on for hearing pursuant to Notice, before ELANA HOLLO, Hearing Officer, at One Independence Mall, 615 Chestnut Street, Room 3, Philadelphia, Pennsylvania, on Monday, May 2, 2016, at 9:30 a.m.

1 because there's a, you know, using medical terms maybe I -- I
2 don't know, pick lines or an IV and they know one nurse is
3 better at it than the other, they might go ahead and assign
4 that one patient to somebody else, knowing what their skill
5 levels are. Not saying that one nurse is better than the
6 other, but more experienced than the other.
7 Q Okay. And you're referring to the cross outs. What about
8 where there's no cross out but something is handwritten in?
9 A Well, sure. I mean, that's -- well, the handwriting in is
10 just the daily staffing. It's just -- after -- once it's
11 printed with the typing, then it's -- it's in the book, and
12 then from then on its handwritten in for the rest of the day.
13 So it's always going to be handwritten in from 3 p.m. on.
14 Q Okay. And again, in your experience who is doing the --
15 A More --
16 Q -- preponderance of the --
17 A -- more often it's care managers.
18 Q Okay.
19 MR. MENDELSON: Move the admission of Employer 22.
20 MS. LESHINSKI: No objection.
21 I think we had an Employer 21, though, and it was
22 withdrawn.
23 MR. MENDELSON: Right. But we were holding that space.
24 You said we were not going to put another number -- not use
25 that number again.

1 MS. LESHINSKI: I -- I recall that about Employer's 13.
2 But --
3 HEARING OFFICER HOLLO: If this Employer 22, I guess we
4 can just go with 22. And note for the record that there is no
5 21.
6 MS. LESHINSKI: Okay.
7 (Employer's E-22 received.)
8 HEARING OFFICER HOLLO: Can I ask you a question about
9 this exhibit?
10 THE WITNESS: Yes. Um-hum.
11 HEARING OFFICER HOLLO: I just want to make sure I
12 understand it. It's accepted into evidence, but I note that
13 there are two pages for each day?
14 THE WITNESS: There's two different floors. So --
15 HEARING OFFICER HOLLO: Okay. But can you just explain to
16 me, so the record's clear, I guess the first day here is
17 September 1, 2015. And it's -- their one side. After that, it
18 looks like each day is two-sided. So can you just explain,
19 let's take September 1st then.
20 THE WITNESS: Okay.
21 HEARING OFFICER HOLLO: First day. I'm not exactly sure
22 what I'm looking at from the first page to the second page.
23 What's the difference?
24 THE WITNESS: So the page on your left, starting with 301
25 to 315, would be our hallway, our A/B hallway. And the page to

1 THE WITNESS: I recognize it. It's the -- their courses,
2 our Management 101 courses.
3 BY MR. MENDELSON:
4 Q Okay, do you participate in Management 101?
5 A I do.
6 Q Okay. And have you taken any of the courses?
7 A It -- yes.
8 Q Okay. And if I could direct your attention to the second
9 page, if you look toward the top of the page, in the -- in the
10 line underneath where it says, "Job Title," do you see
11 descriptions of courses?
12 A I do.
13 Q Okay. And if you page from Page 2 through the end, are
14 the descriptions of the courses you see correct descriptions of
15 courses that you either have taken or you understand yourself
16 to be needing to take?
17 A Yes.
18 Q Okay. And do you understand how this document is
19 maintained?
20 A Yes.
21 Q Who maintains it?
22 A Our human resource manager.
23 Q And who's that?
24 A Denise Bullington.
25 Q Okay. And how do you know she maintains this?

1 A Because she's the one that has a tracker so she knows
2 where we are for compliance. So she emails us individually and
3 tells us where we are, what we need to finish.
4 Q Okay. Can you --
5 A But any one of us can access our own and see what we need,
6 too.
7 Q Okay. Now, do you know what this particular document
8 signifies in terms of who it covers?
9 A Yes. This is -- the nursing department would be any of
10 the nurses that are required to take it. So it looks like
11 clinical directors, care managers.
12 Q Okay. And the dates that fall under particular courses,
13 do you know what that signifies?
14 A That would be the date that they completed it.
15 Q Completed what?
16 A Completed these -- the Management 101 courses.
17 MR. MENDELSON: Okay, I would move the admission of this
18 document.
19 HEARING OFFICER HOLLO: Ms. Leshinski?
20 MS. LESHINSKI: May I ask a few questions of this witness
21 about this document?
22 HEARING OFFICER HOLLO: Please.
23 VOIR DIRE EXAMINATION
24 BY MS. LESHINSKI:
25 Q Did you print this?

1 A Did I? No.
2 Q Who printed it?
3 A Denise Bullington.
4 Q Who is Denise Bullington? She's in HR?
5 A She's our human resource manager.
6 Q When did she print it?
7 A I believe last week.
8 Q And it seems like some of the dates are -- is this
9 reflective of what is -- she thinks was completed as of last
10 week? I see some dates in December.
11 A It would be up to date. It's not -- yeah. It's not what
12 she thinks when it's completed. The computer system generates
13 the date.
14 MS. LESHINSKI: I mean, I guess I would give it -- object
15 to putting this document in through this witness since she
16 didn't actually print it.
17 HEARING OFFICER HOLLO: In the course of your duties, Ms.
18 Yarnes, do you -- do you have any oversight responsibility for
19 the completion of Management 101?
20 THE WITNESS: If our human resource manager is not
21 present, it is my responsibility to do what I can of her
22 responsibilities. So I have seen the tracker. I have -- we go
23 over it on a weekly basis in our labor management meetings. So
24 we work hand-in-hand. There's a group of us. It's Natalie
25 Battista, myself, HR, and our nurse practice educator, which is

1 BY MS. LESHINSKI:
2 Q Can you tell me which one is filled out by a care manager?
3 A Sure. Okay, third page, September 2nd, middle section,
4 "Rebecca, Patrick, Jon."
5 Q And how do you know that?
6 A Because it's not Heidi's handwriting. Looks like it's
7 Jamie's handwriting. And like I --
8 Q And you --
9 A -- and like I said, care managers will call down to me
10 directly to ask for their people when they're filling out their
11 assignments.
12 Q So the middle of the third page your guessing that this is
13 the handwriting of a care manager? Or you have some personal
14 knowledge about this 3 to 11 shift with the CNAs?
15 A Well, I have personal knowledge that the first sheet is
16 Heidi's handwriting. And I have personal knowledge that the
17 second sheet is Jamie's handwriting.
18 Q And how is Jamie?
19 A She is a care manager. Last name Dennis.
20 MR. MENDELSON: Second sheet or third sheet?
21 THE WITNESS: Third sheet.
22 BY MS. LESHINSKI:
23 Q For which part?
24 A Middle section, "Rebecca, Patrick and Jon."
25 Q Okay.

1 A First and second page are the same day.
2 Q You think this is Jamie's handwriting?
3 A Yes.
4 Q Nowhere on the sheet does it indicate who fills it out; is
5 that right?
6 A That's right.
7 Q Now, with respect to the CNA assignments, you testified
8 you had worked as a CNA; is that right?
9 A I have, yes.
10 Q And when you were working as a CNA, and I don't know if it
11 has -- has changed, you had a regular assignment of rooms that
12 you would typically take; isn't that true?
13 A I had to work my way up to a -- not a regular assignment,
14 we weren't allowed to call that. It -- Patty Melora, who was
15 the DON at the time, said that we did not have regular
16 assignments as CNAs. I tended to go into the same section
17 because the same group of us would work together, but if they
18 wanted to change it they had every right to.
19 Q Well, you didn't have a guaranteed assignment, but you had
20 a regular set of rooms that you normally worked; isn't that
21 true?
22 A Sometimes, yes.
23 Q And the reason that the facility most likely wanted to do
24 that so that there would be some sort of continuity for the --
25 of care for the patients, right?

1 A That's the hope, yes.
2 Q Okay. So if I go into work -- now, let me ask you another
3 question; there's a sheet -- so there can be as many as six
4 CNAs on a shift?
5 A There can be, yes.
6 Q And is there -- there exists a sheet, and I think it's
7 called -- no, I think it might be called an assignment sheet,
8 where it lists the rooms that the assignment will cover. If
9 there's six CNAs, five CNAs, four CNAs, three CNAs; is that
10 right?
11 A Yes. I actually made that.
12 Q Good for you. So the assignment would tell you if there
13 are four CNAs, for instance, what the room assignment would be
14 for that shift?
15 A It would be how to break up the rooms, yes, so that the
16 clinical directors or care managers shouldn't have to figure
17 out the match in a crunch if the care -- if a CNA called out.
18 Q Okay. And so you would know that this is the breakdown of
19 the rooms if you had four CNAs. And you would take the CNAs
20 and you slot them in for what the -- generally what the regular
21 room assignment would be on the shift?
22 A Correct.
23 Q Now, you talked about getting weight -- weights for
24 patients?
25 A Yes.

1 A Yes.
2 Q Does it indicate her term date or only her entry date?
3 A It wouldn't indicate her -- I'm sorry, which document are
4 we looking at?
5 Q Employer's 25.
6 HEARING OFFICER HOLLO: I didn't --
7 THE WITNESS: They're not numbered, so I don't know which
8 one that is.
9 BY MS. LESHINSKI:
10 Q Oh, it's the last document that --
11 A Thank you.
12 Q -- we went over. I think the --
13 A She's actually not on that one. I apologize; I thought we
14 were looking at the list.
15 HEARING OFFICER HOLLO: I don't see her on Employer's 25,
16 Ms. Leshinski.
17 THE WITNESS: She's not.
18 BY MS. LESHINSKI:
19 Q Margaret Bondo, she was the clinical director?
20 A She was, yes.
21 Q And has she been replaced?
22 A She has not.
23 Q So isn't it -- isn't it true that up until Margaret Bondo
24 left, there was always a clinical director on for every shift
25 at the facility?

1 A As long as nobody called out sick, yes.
2 Q Okay. And you don't know when Margaret Bondo left?
3 A I don't. I don't have her term date.
4 Q How often do care managers work on the carts with the
5 other cart nurses?
6 A It varies. It depends on how our staffing is.
7 Q Is that something you review?
8 A Is what? Is what something that I review? Staffing?
9 Q As the scheduling manager, do you know how often cart
10 nurses -- excuse me, care managers are working the carts?
11 A No. I know that day if they're going to be on a cart. It
12 changes daily.
13 Q Could you guess? Is it once a week?
14 A I couldn't guess.
15 Q Twice a week?
16 A No.
17 Q But you are aware that care managers are working in --
18 with patients?
19 A Of course I am. If you're a nurse, you are required to be
20 able to take a cart if you have to.
21 Q Now, with respect to Employer's 25, and this is the list
22 of -- I guess this is the -- called "Management 101 Courses."
23 A Yes.
24 Q How often are people expected to complete these?
25 A You're actually given a timeframe. You -- you're supposed

1 was, I think she was in a different country.
2 Q Okay. And when the clinical director was not on the
3 property, who served in that role?
4 A A care manager.
5 Q Okay.
6 MR. MENDELSON: No further questions.
7 HEARING OFFICER HOLLO: Ms. Leshinski?
8 MS. LESHINSKI: No questions.
9 HEARING OFFICER HOLLO: Okay, you're excused. Thank you
10 very much.
11 THE WITNESS: Thank you.
12 (Witness excused.)
13 HEARING OFFICER HOLLO: Mr. Mendelson, do you have any
14 further witnesses?
15 MR. MENDELSON: The Employer at this time does not have
16 further witness.
17 HEARING OFFICER HOLLO: Okay.
18 MR. MENDELSON: I do wish to raise one further matter.
19 HEARING OFFICER HOLLO: Okay.
20 MR. MENDELSON: The -- the Employer had issued a Subpoena
21 Duces Tecum to -- to a clinical director, Summer Valenti. Ms.
22 Valenti indicated that she was not going to comply with the
23 subpoena. Unlike a care manager, she is a clinical director
24 and so I don't think there's any dispute as to her management
25 status.

1 The Company wished to secure documents from Ms. Valenti
2 pursuant to the Subpoena Duces Tecum and then on doing so, to
3 elicit testimony from her, if appropriate, because the Employer
4 believes that as clinical director on the night shift, Ms.
5 Valenti had involvement with care managers in promoting and
6 advancing the union and encouraging staff nurses to support and
7 vote for the union.
8 At this time, in view of -- in view of her refusal to
9 comply with the subpoena, I am prepared to mark the subpoena
10 and put it into evidence if you think that appropriate. We
11 wish to ask the Board to take such steps as are appropriate and
12 necessary to compel compliance.
13 I have to confess uncertainty as to what the proper
14 procedure is. And so ultimately I concluded the most
15 appropriate thing for me to do was to make a record here on
16 this transcript, and then subject to any guidance you may
17 provide or any determinations you may make, proceed from there.
18 If -- if you want me to mark the subpoena I would mark it
19 as Employer 26.
20 HEARING OFFICER HOLLO: Okay. Don't -- don't mark it and
21 offer it yet. Let me just ask you several questions.
22 Did you also issue Ms. Valenti a Subpoena Ad
23 Testificandum?
24 MR. MENDELSON: I do not believe so, no.
25 HEARING OFFICER HOLLO: So the only subpoena you would be

1 own voluntarily, we would be agreeable to the redaction of any
2 names of either care managers or eligible voters. And -- and
3 assuming that there was not redaction of people who are
4 strangers to the facility, we would then understand that those
5 redactions were indicative of communication with care managers
6 or eligible voters, and without knowing their identities
7 believe that the documentation would be probative.
8 As I say that, I realize it might be necessary in
9 redacting the names of care managers, to do that in a way that
10 distinguished care managers from eligible voters, but
11 nonetheless we believe that compliance enforcement with the
12 subpoena can be accomplished while still protecting the
13 identifies of specific individuals with respect to exercise of
14 their Section 7 rights.
15 MS. LESHINSKI: May I respond?
16 HEARING OFFICER HOLLO: One moment.
17 Okay. So at this point I had directed you not to mark the
18 subpoena. I'm not certain it will end up being in evidence in
19 the record. So at this point, though, can you please provide
20 me with a copy of the subpoena, because I --
21 MR. MENDELSON: Sure.
22 HEARING OFFICER HOLLO: -- at some point I want to consult
23 with regional management about the issue.
24 MS. LESHINSKI: Thank you.
25 MR. MENDELSON: I can give you a duplicate if you need

1 two. It will be easier.
2 HEARING OFFICER HOLLO: Ms. Leshinski, let me just look at
3 this for one moment.
4 (Pause.)
5 HEARING OFFICER HOLLO: Mr. Mendelson, I don't see proof
6 of service here. Do you have proof of service of that
7 subpoena?
8 MR. MENDELSON: I will have -- I have -- I can generate
9 that. I don't have a copy of that with me. I have to get into
10 my computer and generate the document or an email confirming
11 it. They -- it was handed -- the subpoena was handed to Ms.
12 Valenti. I supposed I could that, as well. I think I sent it
13 to her both by email and hand -- and not "I," but I believe
14 Natalie Battista handed it to her.
15 HEARING OFFICER HOLLO: Okay. Well, I will ask then when
16 we're on break if you can please produce proof of service that
17 complies with the local rules.
18 MR. MENDELSON: Okay.
19 HEARING OFFICER HOLLO: And I note that Ms. Valenti has
20 not file a motion to quash the subpoena; correct?
21 MR. MENDELSON: Correct.
22 HEARING OFFICER HOLLO: Okay. Ms. Leshinski, you wanted
23 to speak on this matter?
24 MS. LESHINSKI: Yeah. I just wanted to say that Summer
25 Valenti is a clinical director. My -- I do believe that

1 walking, I could see what they were doing. But I didn't
2 specifically leave the desk to go observe what each employee
3 was doing, but I did rounds.
4 Q Okay. And if you -- strike that.
5 Were there instances where you would make an observation
6 and check with the staff nurse or CNA to make sure certain
7 things had been done?
8 A Yes.
9 Q Okay. And were there instances where they had not yet
10 been done?
11 A More so with the CNAs. If I observed that there weren't
12 gloves in the room or trash needed to be emptied, yes.
13 Q And would you give direction to them to take care of those
14 things?
15 A I would ask them to empty trash, yes.
16 Q And I think I understood your testimony to be, and forgive
17 me if I'm wrong, that in the normal course when you asked for
18 something to be done, people would do it?
19 A Yes. I was fortunate that way.
20 Q It was a collaborative environment?
21 A Yes.
22 Q Am I correct you had no need to either issue or ask
23 someone else to issue discipline because generally speaking
24 staff nurses and CNAs would -- would do the things that were
25 expected of them?

1 A Yes.
2 Q And if they hadn't done it and you raised it with them,
3 they would then take care of those things and make sure they
4 would -- they got done?
5 A Yes.
6 Q Were there instances where you would talk with the
7 clinical director on the shift about observations you made
8 concerning specific staff nurses or CNAs?
9 A No, because when I went to a clinical director it -- it
10 usually was that there was a family complaint or a family
11 issue, and I would direct that to the clinical director if I
12 had one to go down and mediate.
13 Q Did you yourself intercede with those kind of issues to
14 see if you could resolve them without having to go to the
15 clinical director?
16 A Only if there wasn't a clinical director on while I was on
17 that shift.
18 Q And were there instances where that was the case?
19 A Yes.
20 Q Okay. And who served in the capacity of the clinical
21 director when the clinical director was not present?
22 A If there wasn't one on the third floor where I was
23 assigned, I would see if there was one on the second floor.
24 Q Were there ever instances where neither floor had a
25 clinical director?

1 A Yes.
2 Q And then in that event who served in the capacity of the
3 clinical director?
4 A The care manager.
5 Q Okay. Without -- without, at this point stating the name
6 of anybody else, were there instances in the period from July
7 through early November 2015, where you encouraged others to
8 support or vote for the union?
9 MS. LESHINSKI: I'm going to object. Same objection as
10 before; he's questioning her about Section 7 activity.
11 HEARING OFFICER HOLLO: I'm going to sustain the
12 objection, in this instance is also outside the realm -- the
13 scope of direct.
14 MR. MENDELSON: Okay. No -- no further -- same response
15 as before, but I'm not going to belabor it at this point, at
16 least. No further questions of this witness at this time.
17 MS. LESHINSKI: I just have a couple of follow-ups.
18 REDIRECT EXAMINATION
19 BY MS. LESHINSKI:
20 Q So what was your --what was your authority with respect to
21 running the floor?
22 A As I said, making sure that there was stock. Putting
23 orders in the computer, which any nurse has the ability to do
24 that, but as a care manager, once the orders were approved I
25 would put the orders in the computer, fax the order sheet to

1 the pharmacy. As I said before, calling downstairs to get some
2 food and nourishment up. But HUCs do that. Any nurse could
3 call down if they needed orange juice, apple juice, or
4 whatever.
5 Q Anything else? Unclogging toilets; is that part of
6 running a floor?
7 A Yes. That's an issue, yes.
8 Q Anything else?
9 A As I stated, I've fixed chains on the toilet.
10 Q Could you issue discipline?
11 A I don't believe I could.
12 Q You were asked if there was no clinical director who would
13 serve as clinical director. Did you ever have -- did you ever
14 work a shift with no clinical director?
15 A Yes.
16 Q What jobs of the clinical director would you do?
17 A The 3 to 11 clinical director generated the weight sheet.
18 If for some reason that the 3 to 11 clinical director was busy
19 and didn't do it, I had generated the clinic -- the weight
20 sheet. And each floor has a book called the "Weight Book."
21 When a patient comes into the facility, it is determined when
22 they're going to have a weight. Someone with CHF gets a daily
23 weight; congestive heart failure gets a daily weight, otherwise
24 it's weekly weights. It's a form -- all the patients are
25 listed to the room number and an "X" is put on the day that

1 A Yes.
2 Q Okay. And when you were the clinical director, am I
3 correct that for those hours on that shift where you were
4 functioning as the clinical director, you received an increment
5 in pay relative to your normal pay?
6 A Yes, for three shifts I receive $3 more an hour. And then
7 I decided that I wasn't going to do clinical director any more.
8 That $3 an hour -- that extra $24 was not worth it to me.
9 Q Okay.
10 MR. MENDELSON: Okay, no further questions.
11 MS. LESHINSKI: I just want to clarify.
12 FURTHER REDIRECT EXAMINATION
13 BY MS. LESHINSKI:
14 Q So when you -- when you were saying that you were a care
15 manager with no clinical director in the building, were you
16 still a care manager?
17 A Yes.
18 Q So did some -- on occasion did some care managers do fill
19 in work as a clinical director?
20 A Yes.
21 Q And it -- when you're -- are referring to doing three
22 shifts, is that what you're referring to?
23 A Three shifts? I don't follow your question.
24 Q Did you say you did three shifts as a clinical director?
25 A Oh, there was a period of time where, if I may explain,

1 when we didn't have a clinical director on the weekend that I
2 worked. I worked every other weekend. And then they hired
3 Margaret Bondo. She was there for a short period of time. But
4 before she was hired, care managers, they were doing, as I
5 said, the few jobs that the clinical director did, and the care
6 managers talked about it and said why are we doing this when
7 the clinical directors are getting paid more money?
8 There was a clinical director who, I believe emailed
9 Patty, and it was decided that we would get $3 more an hour
10 when we acted as a clinical director. And as I said, I act --
11 I worked those -- there's three shifts, I believe if you pull
12 my paystubs, that I worked as a clinical director at the $3
13 more an hour and then I decided I'm not doing this anymore.
14 Q Okay. Thank you.
15 Actually, do you know when Margaret Bondo left?
16 A I can't give you the specific day, but it was either the
17 second or third week in December, because she had discussed
18 that she was moving back to Africa and she would be resigning.
19 MS. LESHINSKI: Okay, thank you.
20 MR. MENDELSON: No further questions.
21 HEARING OFFICER HOLLO: I have a question. So I
22 understand. There's been a series of questions about when you
23 were acting as a clinical director. When you were performing
24 that function, were you also acting as a care manager?
25 THE WITNESS: Yes.

1 the acting Regional Director's denying the Employer's request
2 for enforcement of the subpoena.
3 I think at this point, unless the parties have anything
4 they would like to say at this point, we'll -- we will be done
5 for the day.
6 MR. MENDELSON: Was that 5(b)(2)(E) or (C), forgive me I
7 didn't quite catch that.
8 HEARING OFFICER HOLLO: I believe (E).
9 MR. MENDELSON: Could I just have a moment?
10 HEARING OFFICER HOLLO: Sure. Would you like a copy of
11 the rule?
12 MR. MENDELSON: Oh, I was looking it up but sure, if you
13 have one handy I'll take that.
14 HEARING OFFICER HOLLO: I do. Would you like a moment off
15 the record?
16 MR. MENDELSON: Sure.
17 HEARING OFFICER HOLLO: Okay, let's go off the record.
18 (Whereupon, a brief recess was taken.)
19 HEARING OFFICER HOLLO: Back on the record.
20 So before we end for today, is there anything else by Mr.
21 Mendelson?
22 MR. MENDELSON: Nothing further.
23 HEARING OFFICER HOLLO: Ms. Leshinski?
24 MS. LESHINSKI: No, thank you.
25 HEARING OFFICER HOLLO: In that case, we will be back on

1 the record 10:00 May 9th, a week from today at which point each
2 party will have an opportunity to present oral argument. And
3 just to reiterate, can also attach a list of cases if you wish
4 to, to -- you know, for my attention in support of your
5 position. I will not be permitting the filing of briefs.
6 So we will see everybody back on the 9th.
7 Thank you.
8 (Whereupon, at 3:27 p.m., the hearing in the above-entitled
9 matter was adjourned until May 9, 2016 at 10:00 a.m.)

BEFORE THE

NATIONAL LABOR RELATIONS BOARD

In the Matter of:

SR-73, AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 133 SOUTH ROUTE 73,

Case No. 4-RC-161250

Employer,

And

DISTRICT 1199C NATIONAL UNION OF HOSPITAL AND HEALTH CARE EMPLOYEES AFSCME, AFL-CIO,

Petitioner.

The above-entitled matter came on for hearing pursuant to Adjournment, before ELANA HOPPO, Hearing Officer, at One Independence Mall, 615 Chestnut Street, Room 3, Philadelphia, Pennsylvania, on Monday, May 9th, 2016, at 9:30 a.m.

1 believe I had to provide in connection with the initial proof of
2 service. Thank you.
3 HEARING OFFICER: Okay. The Acting Regional Director is
4 denying the motion for reconsideration put forth by the Employer
5 and entered into evidence today for -- on two bases.
6 The first basis is the reasons already stated in his May 2nd
7 denial of the motion to seek subpoena of -- Subpoena Duces Tecum.
8 And the second is because his concern that the bifurcated nature of
9 the service indicates a lack of proper service.
10 At this point we'll be moving on to oral argument
11 MR. MENDELSON: Is R-28 through 30 in evidence?
12 HEARING OFFICER: Yes, Exhibits 28, 29 and 30 are received
13 into evidence. Thank you.
14 (Employer' Exhibits 28, 29 and 30 received.)
15 HEARING OFFICER: 28 was Mr. Mendelson's motion, 29 was Mr.
16 Mendelson's certification and 30 was a two-page certification dated
17 May 5, 2016 executed by Natalie Batista. Okay. Yes, those
18 exhibits are in evidence.
19 At this point, Mr. Mendelson, are you prepared to make oral
20 argument?
21 MR. MENDELSON: I am.
22 HEARING OFFICER: Okay. Are you intending to submit a list
23 of cases as well?
24 MR. MENDELSON: I was going to mention some cases in passing
25 during the course of my oral argument.

EXHIBIT B

GENESIS HEALTHCARE SM
JOB DESCRIPTION: PowerBack Centers

POSITION TITLE: Registered Nurse Care Manager (jobcode NRNC)

OCCUPATIONAL EXPOSURE: Category I

DEPARTMENT: Nursing

REPORTS TO: Nursing Clinical Director

GRADE: 19

FLSA: Non-Exempt

POSITION SUMMARY: This position is responsible for the delivery of high-quality and cost-effective health care while achieving positive clinical outcomes, and patient/family and employee satisfaction. The RN Care Manager leads the Primary Care Teams and is responsible for the care management of the patient's assigned to those teams and for providing the physical care that requires the expertise of a Registered Nurse. Additionally, he/she assumes some administrative functions. As such, the RN Care Manager is required to possess clinical expertise for the patient population, strong communication, mentoring, delegation and coordination skills, and the ability to work with physicians and other medical professionals. The RN Care Manager ensures a high performing team by organizing and prioritizing activities of the members.

RESPONSIBILITIES/ACCOUNTABILITIES:

1. Administrative/Organizational
   - 1.1. Organizes, assigns and delegates aspects of patient care to the team for the assigned group of patients, focusing on the prioritized, individualized needs of the patient and the competencies of the team members.
   - 1.2. Coordinates unit activities (i.e. admissions, discharges etc.) with the Unit Coordinator.
   - 1.3. Identifies staffing needs for next shift and communicates such to the Staffing Coordinator, Administrative Manager (evenings, nights and weekends) and Clinical Director.
   - 1.4. Manages administrative issues and related notifications of the Center Nurse Executive/Director of Nursing and/or Administrator that occur on his/her shift.
   - 1.5. Prioritizes and re-prioritizes the team assignment, including the identification of creative ways to distribute and coordinate care delivery.
   - 1.6. Completes evaluations of his/her team members in collaboration with the Clinical Director.
   - 1.7. Participates in the hiring process as requested.
2. Nursing Process
   - 2.1. Directs delegates and manages the care of his/her assigned patients including assessment, diagnosis, goal identification, care planning, implementation and evaluation.

POSITION TITLE: Registered Nurse Care Manager (jobcode NRNC)

2.2. Provides care to assigned patients, performing skilled interventions that are required by an RN.

2.3. Assesses patients at a minimum twice per shift and as needed based on patient condition; adjusts the plan of care to meet the needs of the patient; directs staff on the shift to ensure that the patient's needs are met.

2.4. Completes scheduled patient assessments (MDS, Risk etc.) based on data collected.

2.5. Coordinates, provides, and delegates as appropriate patient and family education.

2.6. Ensures a safe and effective discharge plan for the patients assigned to his/her team(s).

3. Communication

3.1. Communicates with assigned patients and families to determine patient needs and concerns.

3.2. Communicates at a minimum twice per shift with the team members to the determine status of each patient assigned to the team and for the purposes of prioritization and work distribution.

3.3. Participates in Clinical Stand up Meetings and other clinical meetings as indicated.

3.4. Participates in Patient Conferences

3.5. Communicates identified patient goals and desired outcomes with team members (all disciplines).

3.6. Coordinates with the attending physician to ensure that all care needs are met.

3.7. Consults and collaborates with other members of the care team and interdisciplinary team.

4. Mentoring

4.1. Mentors and assists primary team members providing patient care under his/her direction.

4.2. Guides less experienced RNs, LPNs and CNAs through new experiences/ procedures, optimizing their experience and validating their need for support.

4.3. Models critical thinking and communication skills to less experienced team members.

4.4. Serves as a resource and positive proactive behavioral leader.

5. Performs other related duties as required.

SPECIFIC EDUCATIONAL/VOCATIONAL REQUIREMENTS:

1. Must be a graduate of an accredited school of nursing, college or university with a current registered nurse licensure by the State Board of Nursing.
2. A minimum of two years full-time or equivalent clinical experience is required and a minimum of one years of clinical experience in long-term care nursing is preferred.
3. BSN preferred

POSITION TITLE: Registered Nurse Care Manager (jobcode NRNC)

4. This position requires that the employee is able to read, write, speak and understand the spoken English language to ensure the safety and wellbeing of our patients and visitors at the work site when responding to their medical and physical needs.
5. Must provide verification of TST (tuberculin skin test) as required by state law and in accordance with Company policy. TSTs will be administered at the work site if required.

ESSENTIAL JOB FUNCTIONS:

(a) Physical Demands:

(Answer yes or no)

Reaching (overhead)	yes
Handling	yes
Fingering	yes
Feeling	yes
Talking or Hearing	yes
Seeing	yes

(Answer: 0-33% - Rarely/ 34-66% - Occasionally/67-100% - Frequently)

Standing	34-66%
Walking	34-66%
Sitting	0-33%

(Specify Amount of Weight in Pounds: Sedentary [10 lbs]; Light [20 lbs]; Medium [30-50 lbs]; Heavy [100 lbs]; Very Heavy [>100 lbs])

Pulling	40
Lifting	40
Carrying	40
Pushing	40

(Answer yes or no)

Climbing (stairs)	yes
Balancing	yes
Stooping	yes
Kneeling	yes
Crouching	yes
Crawling	yes
Twisting	yes

(b) Location of Job Activities: (Answer in percent)

Outside	0%
Inside	100%

(c) Environmental Conditions:

POSITION TITLE: Registered Nurse Care Manager (jobcode NRNC)

(Answer yes or no)

Extreme cold with or without temperature changes	no
Extreme heat with or without temperature changes	no
Wet or humid	no
Noise and/or vibrations	yes
Hazards (chemical, mechanical, radiant energy)	no
Explosives, burns, electrical, other	no

Atmospheric conditions -

Fumes, poor ventilation, mists, dust, odors, gas	yes
Unprotected heights	no
Moving machinery	no
Operating automotive equipment	yes
Operating foot controls	no
Uneven ground	no
Protective clothing (list) (gowns, masks, gloves in accordance with policy)	yes

(d) Work Situations:

(Answer yes or no)

Measurable or verifiable criteria	yes
Dealing with people	yes
Repetitive and continuous	no
Performing under stress	yes
Set limits, tolerance or standards	yes
Problem solving	yes
Comparing	yes
Taking instructions	yes

JOB SKILLS:

1. Demonstrates leadership, organizational and critical thinking skills.
2. Strong interpersonal skills.
3. Excellent management skills.
4. Ability to work independently, problem solve and make decisions as necessary.
5. Basic knowledge of computer use.
6. Ability to communicate in English both orally and in writing.
7. Ability to create a patient-centered environment.
8. Knowledgeable of Genesis policies and procedures, MDS process, state nurse practice acts, and state and federal regulations.

GENESIS HEALTHCARE SM
JOB DESCRIPTION: PowerBack Centers

POSITION TITLE: Registered Nurse Care Manager (jobcode NRNC)

PERFORMS RELATED DUTIES:

1. Interacts with residents, families, visitors, center and Genesis subsidiary personnel.
2. Carries out other tasks as requested in situations where hands-on intervention/participation may be required.

If you are under 18 years of age, there may be some essential functions of the job which you are restricted from performing due to regulatory requirements. Please advise your supervisor if you are under 18.

I understand this job description and its requirements; I understand that this is not an exclusive list of the job functions and that I am expected to complete all duties as assigned; I understand the job functions may be altered by management without notice; I understand that this job description in no way constitutes an employment agreement and that I am an at-will employee.

I certify that I am able to perform the essential functions of this position with or without reasonable accommodation.

Employee Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

EXHIBIT C

McNeal, Katrina

January 17, 31

February 1, 14, 15, 19, 20, 23, 24, 28

March 19, 28, 29,

April 3, 11, 12, 21,

May 1, 9, 10,

June 22

July 5, 18, 19

Aug 1, 10,

McCarthy, Kelly

August 24,

Oct 1, 2,

Upshur, Rachel

May 29

St John, Janice

April 24

July 21

Sailor, Donna

January 2, 11, 16,

February 16, 25, 27,

March 15, 20,

July 22,

Torrijos, Bianca

January 9,

August 9,

Twum-Barima, Ray

January 1, 10, 11, 24, 25,

Febuary 7, 8, 21, 26, 27,

March 7,

April 2, 17, 23,

May 5, 8, 24,

June 4, 25,

Sept 6,

Cantagallo, Brielle
None

Boyles, Bethany
None

Springer, Kim

January 31

February 1,

March 28, 29

April 3, 6, 7, 9, 11, 12, 17, 21,

June 20

July 4, 27,

Aug 13, 14, 15,

Dennis, Jamie

October 10

DeJulius, Karina
None

Greene, Lynette
February 14, 15, 28,

July 11, 16

August 28,

October 1, 3, 10/1/15 Also assisted with interviewing staff nurses for open positions

Jackson, Sharon

February 7, 8,

April 19

May 24, 25,

June 13, 14, 19, 21,

July 5, 8, 15, 16, 17, 18, 19, 31

August 2, 8, 10, 11, 12, 14, 15, 22, 29,

September 12, 13, 18, 25, 28, 29, 30,

October 1, 6, 7, 9,

Podolak, Ginny

January 1, 18,
February 28
March 1, 14, 26,
April 18, 19,
May 9, 16, 17, 25, 30, 31
June 17, 18, 27, 28
July 7, 8, 11, 12, 15, 17,
August 8, 28,
Sept 7, 19, 20,
October 4,

EXHIBIT D

2/4/15

Liyuanzhao

Ginny Podolak

Mernito Amasco

Cheryl Manages

Katrina McNeal

Rachel Upshur

Lynette Tilghman

Bethany Boyles

Sharon Jackson

Blanca Torrijos

Ian Lim

Kim Spurgeon

Jamie Clennes

Meghan Hampton

Meritta Lake

Brielle Cantagallo

Summer Valenti

Lily Simuriglio

HUC -

E12

POWERBACK
REHABILITATION

113 South Route 73
Voorhees, NJ 08043

Nursing Leadership
Monthly Meeting

March 4, 2015

Lijuan Chao	
Cheryl Manages	
[illegible]	
Kelly McCarthy RN.	
Ian Lim	
Bethany Bromley RN	
Donna Saifan RN	
Merrito Orasco	
[illegible]	
Martha Sake	
Summer Valentr	

phone (856) 809-3500 ☙ fax (856) 8093572
www.powerbackrehabilitation.com
CareLine: 888-982-2000

Leadership 4/1/15

Pattie Melora CNE

Sharon Jackson

Summer Valenti

Virginia Poddak

Hydei Engel-Perez CD

Lynette Seltzman R

Martha Sale, RN

Karina DeJulius

Kelly McCarthy

Kathy Sougstad

Joan Sovy

POWERBACK
REHABILITATION

113 South Route 73
Voorhees, NJ 08043

Nursing Leadership

6/3/15

Patti Mehr	
Katrina McNeal, RN	
[illegible]	
Sharon Jackson RN	
Summer Valenti	
Kathy Soygstad RN	
Martha Fake RN	
Ian Lim	
Liquan Chen	
Donna Sailor	
O Rodwell	

phone (856) 809-3500 ☙ fax (856) 8093572
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REHABILITATION

113 South Route 73
Voorhees, NJ 08043

Nursing Leadership

7/5/15

Cheryl Manages	
Michelle Croge	
Aydei Angel-Perez	
Kelly McCarthy	
Lignaiz Rivera	
Ian Lin	
Dwaine Podstall	
Lily Simuiglia	
Karina Pellitier	
Delora LaDuca HSKP SUPV.	
Frank Napoli Plant Ops.	
Holly Vizi	
Lynette G. Vilghman RN	
Bethany Fowler	
Martha Fake	
Sunny Valentin	
[illegible]	
Kathy Sangsted	
Merrito Orasco	

phone (856) 809-3500 ☙ fax (856) 8093572
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POWERBACK
REHABILITATION

113 South Route 73
Voorhees, NJ 08043

Nursing Leadership

07/08/15

Karina Defelice	
Summer Valentin	
Cheryl Manages.	
Paula Sulefan	
Kelly McCarthy	
Kathy Sangstad	
Merrita Amasco	

phone (856) 809-3500 ☙ fax (856) 8093572
www.powerbackrehabilitation.com
CareLine: 888-982-2000

EXHIBIT E

Date: 9/1/15 **HUC: Chasity**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Ebony

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Michelle

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Florence	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Monique	301 – 310	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Alexandra	311 – 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany	321 – 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Adele	301-312	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Pat	313- 318	Soiled Linen Room Blanket & Fire Ext	→ BISTRO	17:00 – 17:15 19:30 – 20:00		
Cendre	319 -331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Janice**				
Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Manly	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Sranika	332-347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashonda	348-362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

EK 22

Date: 9/1/15 **HUC: Chasity**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Ebony

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Michelle

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Karina	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	360	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Kimberline	332 – 341	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Suzanne	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy	352 - 362	Shower Room South Door (Fire)	Bistro	09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Steph	332-342	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Pat	343 349	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	350-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager:

Jan	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Kelly	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
June	301-315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Andre	316-331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/2/15 **HUC: Tammy**

****10:3/0 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Kimberline

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Margaret	301 - 315	AED monitor & Code cart check Monitor pt (Fire)	311	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Becky	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	324, 326	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Helema ✓	301-312	Clean Linen Room North Door (Fire)	Bistro	09:00 – 09:15 11:00 – 11:30		
Roseann	313-318 & 346-349	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany	319-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Rebecca	301 – 310	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Patrick	311 – 320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	321 – 331	Shower Room South Door (Fire)	Bistro	17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager: Donna

Rachel	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Sabrina	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Margaret**				
Jakeidy	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Jonathan	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/2/15 **HUC: Tammy**

****10:3/0 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Kimberline

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Kim	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Joan	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Nafesa	332-345	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy	350-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Steph	332 – 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Rosean	342 - 351	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Quetcy	352 - 362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager:

Karen	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Margaret**				
Jamika	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 09/3/15 **Clinical Director 7-3pm:** **Sharon** **HUC: Chantelle**
Huddle: 10:30 AM

7am – 7pm Nurse Care Manager:

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Joan	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	[redacted]	
Jamie	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	[redacted]	
7am- 3pm CNAs		**Transport:**					
Suzanne ~~Chantelle~~	332 – 343	Clean Linen Room North Door (Fire)	[redacted]		09:00 – 09:15 11:00 – 11:30		
Alexandra	313 – 318 344-349	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Roseann	350 – 362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs		**Clinical Director 3pm-11pm:**					
Patrick	332 - 343	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Roseann	350 – 362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		

7pm -7am Nurse Care Manager:

Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	[redacted]	
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	[redacted]	
11pm -7am CNAs		**Clinical Director 11pm – 7am:**					
Patrick	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

Volunteers (CNAs) to CX after all arrived on 2nd & 3rd!

Date: 09/3/15 **Clinical Director 7-3pm: Sharon HUC: Chantelle**
Huddle: 10:30 AM

7am – 7pm Nurse Care Manager:

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Karen	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Rebecca	316-330	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am -3pm CNAs Transport: Dot							
Nancy ~~**Monique**~~ (Stacie)	301 – 312	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
✓ **Alexandra**	313 – 318 344-349	Shower Room Blanket & Fire Ext	Bisho		~~09:30 - 09:45~~ 13:30 – 14:00		
✓ **Tiffany**	319 – 331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm -11pm CNAs Clinical Director 3pm-11pm:							
Sarah	301 – 310	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Otede	313-318 344-349	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Jon	319 – 330	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm - 7am Nurse Care Manager: Rachel							
Julie	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Sabrina	316-330	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am:							
Jawidy	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Andre	316-330	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

Volunteers (CNAs) to CX after all arrived on 2nd & 3rd!

10 am: Huddle/Rounds @ Nurse's Station **Date: 09/4/15**
Clinical Director 7-3pm: Sharon **HUC: Tammy** Ashley

7am-7pm: Nurse Care Manager:

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN
Karen	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	
Margaret	316-331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	
7am -3pm CNAs Transport: Latasha						
Monique	301 – 310	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30	
Candace	311-320	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00	
Tiffany	321-331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00	
3pm -11pm CNAs Clinical Director 3pm-11pm:						
Sarah	301 – 312	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30	
ATeDe	313 – 318 344 – 349	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00	
AndRe	319 – 331	Shower Room South Door (Fire)	BISTRO		17:15 – 17:30 20:00 – 20:30	
7pm - 7am Nurse Care Manager: keoRay						
Julie	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	
Brette	316-331	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	
11pm -7am CNAs Clinical Director 11pm – 7am:						
Simone	301-309 322-331	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30	
	~~316-331~~	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00	

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station **Date: 09/4/15**
Clinical Director 7-3pm: Sharon **HUC: Tammy**

7am – 7pm: Care Manager:

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Tay C Jamie	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Kelly C **Belinda**	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am- 3pm CNAs Transport: Latasha							
✓ **Suzanne**	332 –341	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
✓ **Kimberline**	342-251	Shower Room Blanket & Fire Ext	Bistro		09:30 - 09:45 13:30 – 14:00		
✓ **Quetcy**	352-362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs Clinical Director 3pm-11pm:							
Steph ✓	332 – 243	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Alaina -	250 - 262	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
		Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm -7am Nurse Care Manager:							
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Yemi	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am:							
Tamia	333-343 355-362	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Shamika	310-321 314-353	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/5/15 **HUC: Raniyah**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Clinical Director 7-3pm: Mernito

7am – 7pm Nurse

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Karina	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Monique	301 – 310	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Suzanne	311 - 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Kimberline	321 - 331	Shower Room South Door (Fire)	Bistro	09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Mernito**		
Sarah	301 – 310	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Aede	311 – 320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Lamia	321 – 331	Shower Room South Door (Fire)	Bistro	17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:** Janice				
Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Lamia	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/5/15 **HUC: Raniyah**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Clinical Director 7-3pm: Mernito

7am – 7pm Nurse

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Margaret	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Sara ✓	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Stephanie ✓	332 – 341	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Roseann ✓	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy ✓	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Mernito**		
Stephanie	332 – 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Roseann	342 - 351	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Quetcy	352 - 362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:** Janice				
Ian	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Yemi	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
[illegible]	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
[illegible]	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

9/6/15

Date: ~~08/24/15~~ Clinical Director 7-3pm: Lynette HUC: Raniyah/Ramirez

Huddle: 10:30 AM

7am – 7pm Nurse Care Manager:

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN
Sara ~~Karina~~	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	
7am- 3pm CNAs	**Transport: Quetcy**					
Stephanie	332-341 ~~333 – 347~~	Clean Linen Room North Door (Fire)	Bistro		09:00 – 09:15 11:00 – 11:30	
~~Suzanne~~ ~~Suz~~ roseann	342-5 ~~342 – 818~~ ~~344 – 349~~	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00	
~~Roseann~~ Quetcy	352-362 ~~348 – 362~~	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00	
3pm-11pm CNAs	**Clinical Director 3pm-11pm:** Kathy					
Stephanie	332 – 341	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30	
Roseann	342 – 351	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00	
Quetcy	352 – 362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30	

7pm -7am Nurse Care Manager: Janice / Bethany

Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	
Rachael	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	
11pm -7am CNAs	**Clinical Director 11pm – 7am:** Margaret					
Sheena	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30	
Tashonda	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00	

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

9/6/15

Date: ~~08/24/15~~ Clinical Director 7-3pm: Lynette HUC: Raniyah/Remirez

Huddle: 10:30 AM

7am – 7pm Nurse Care Manager:

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Beth	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Karina ~~Sara~~	316-330	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am -3pm CNAs Transport: Quetcy							
Monique	301-310 ~~[illegible]~~	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Suzanna	~~313 – 318~~ ~~344-349~~ 311-320	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Kimberlin e	321-330 ~~316 – 331~~ ~~[illegible]~~	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm -11pm CNAs Clinical Director 3pm-11pm: Kathy							
Sarah	301 – 310	~~Clean Linen Room~~ North Door (Fire)	Bisho		16:45 – 17:00 19:00 – 19:30		
Rebecca	311 – 320	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Sarah ~~Lamich~~	321 – 330	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm - 7am Nurse Care Manager: Janice / Bethany							
Colleen	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn	316-330	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Margaret							
Shanika	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Simone	316-330	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Dot - transport

10 am: Huddle/Rounds @ Nurse's Station **Date: 09/7/15**
Clinical Director 7-3pm: Peggy **HUC: Raniyah**

7am-7pm: Nurse Care Manager: Joan/~~Belinda~~

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN
Karen	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	
Rebecca	316-331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	
7am -3pm CNAs Transport:						
✓ **Monique**	301-~~312~~ 310	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30	
✓ **Nafesa**	~~313-318~~ 311-320 ~~345~~-350	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00	
✓ **Tiffany**	319-331 321-331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00	
3pm -11pm CNAs		**Clinical Director 3pm-11pm:** Kathy S.				
✓ Sarah	301 – ~~310~~ 311	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30	
✓ Abde	310-316 44-48	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00	
✓ Lamia	~~321~~ 317 – 331	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30	
7pm - 7am Nurse		**Care Manager:** Rachel				
Julie	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	
Sabrina	316-331	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	
11pm -7am CNAs		**Clinical Director 11pm – 7am:** Katie				
Simone	301-310 320-331	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30	
Jareidy	311-319 341-351	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00	

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station Date: 09/7/15
Clinical Director 7-3pm: Peggy HUC: Raniyah

7am – 7pm: Care Manager: Joan/~~Belinda~~

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda ~~Sara~~	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 ~~15:45 – 16:00~~		
7am- 3pm CNAs Transport:							
Candace	332-~~344~~ 341	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Suzanne ~~Nafesa~~ ~~Sherry~~	342-351 313-318 345-350	Shower Room Blanket & Fire Ext	Bistro		09:30 - 09:45 13:30 – 14:00		
Quetcy	352-362 351-362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs Clinical Director 3pm-11pm: Yahira							
[illegible]	332 – ~~341~~ 348	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
[illegible]	313- 318 [illegible]	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
[illegible]	349- ~~352~~ – 362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm -7am Nurse Care Manager: Rachel							
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Yuri							
Andre	332-340 352-362	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
		Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9-8-15 **HUC:** Chantelle E

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION**** Ashley

Transport Dorothy

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Rebecca	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Kimberline	301-~~312~~ 315	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Alexandra	~~313-318 & 344-349~~	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany	~~319~~-331 316-	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**				
Janudy	301 ~~310~~ 312	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Axele	~~311 – 320~~ 313–318	Soiled Linen Room Blanket & Fire Ext	→ BISTRO	17:00 – 17:15 19:30 – 20:00		
Andre	~~321~~ – 331 319	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager: Katie

Julie	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Sabrina	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Jay	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Managers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9-8-15 **HUC:** Chantelle c Ashley

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Margaret	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Kim c Kelli (o)	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Nafesa	347 332-~~343~~	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Roseann	348 ~~350~~-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**				
Steph	343 332 ~~341~~	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Cikede	344-349 ~~342~~ ~~351~~	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	350 ~~352~~ - 362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager: Katie

Rachael	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Shelia	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Managers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/9/15 **HUC: Tammy**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Amber **Wound Rounds: Ginny**

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina & Joan

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)	305, 306, 312	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Becky	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Monique	301-312	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Kimberline	313-318 & 345-350	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
~~Tiffany~~/Fee	319-331	Shower Room South Door (Fire)	Bistro	09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Mernito**		
Adecle	301 - 312	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
June	313 – 318 345 – 350	Soiled Linen Room Blanket & Fire Ext	→ Bistro	17:00 – 17:15 19:30 – 20:00		
Andre	319-331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:** Donna				
Rachel U.	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachel V.	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
June	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/9/15 **HUC: Tammy**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Amber **Wound Rounds: Ginny**

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina & Joan

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Margaret	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda Kelli (O)	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	348	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Roseann	332-344	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy	351-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Mernito**		
Steph	332 – 344	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	35/362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Tashanda	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Jon	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station **Date: 09/10/15**
Clinical Director 7-3pm: Heidi **HUC: Chantelle/Chasity**

7am-7pm: Nurse Care Manager: Joan/Karina

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Karen	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Florence	316-331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am -3pm CNAs Transport: Dot							
Monique	301-310	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Kimberline	311-320	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Latasha	321-331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm -11pm CNAs		**Clinical Director 3pm-11pm: Li**					
Sara	301 – 310	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Afedl	311 – 320	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Jareidy	321 – 331	Shower Room South Door (Fire)	Bistro		17:15 – 17:30 20:00 – 20:30		
7pm - 7am Nurse Care Manager:							
Colleen	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn	316-331	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs		**Clinical Director 11pm – 7am: Summer**					
Simone	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Jareidy	316-331	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

2 Voluntary Cx after all CNAs Arrived

10 am: Huddle/Rounds @ Nurse's Station Date: 09/10/15
Clinical Director 7-3pm: Heidi HUC: Chantelle/ Chasity

7am – 7pm: Care Manager: Joan/Karina

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Belinda	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Sara	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am- 3pm CNAs Transport: Dot							
Nafesa	332-341	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Suzanne	342-351	Shower Room Blanket & Fire Ext	Bistro		09:30 - 09:45 13:30 – 14:00		
Quetcy	352-362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs Clinical Director 3pm-11pm: Li							
Steph	332 – 341	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Pat	342 – 351	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Son	352 – 362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm -7am Nurse Care Manager:							
Jamie	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Ian	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Summer							
Eron	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Jordan	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

2 Voluntary Cx after all CNAs Arrived

Date: 9/11/15 HUC: Chantelle with Ashley

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Ebony

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Becky	301 - 315	AED monitor & Code cart check Monitor pt (Fire)	314	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	[redacted]	
Florence	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	[redacted]	
7am – 3pm CNAs						
Monique ✓	301 – 310	Clean Linen Room North Door (Fire)	Bistro	09:00 – 09:15 11:00 – 11:30		
Latasha ✓	311 – 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany	321 – 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Sharon**		
Sarah ✓	301 – 312	Clean Linen Room North Door (Fire)	301-315 Till 7p	16:45 – 17:00 19:00 – 19:30		
Tashonda At 7p	313-318 345-350	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
andre ✓	319 – 331	Shower Room South Door (Fire)	316-331 Till 7p	17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager:

Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	[redacted]	
Marilyn	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	[redacted]	
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Simone	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Jaeidy	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/11/15 HUC: Chantelle with Ashley

10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION

Transport: Ebony

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)	340	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Margaret	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Suzanne ✓	332 – 341	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Roseann ✓	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy ✓	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Sharon**				
Atede	332 – 344	Clean Linen Room North Door (Fire)	332-348 T.LL 7P	16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Cherylin	351-362	Shower Room South Door (Fire)	349-362 T.LL 7P	17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Jessica Hell 11P (visti at 11P)	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Janice	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:** Summer				
Nicholas	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Emily - Tx

Date: 9/12/15

10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION

Transport: Ebony

Clinical Director 7-3pm: Sharon

7am – 7pm Nurse — Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
✓ Karen	301 - 315	AED monitor & Code cart check Monitor pt (Fire)	309	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	[redacted]	
✓ Tazya (Supervised by Kim)	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	329	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	[redacted]	
7am – 3pm CNAs						
✓ Andre	301 – 310	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
✓ Alexandra	311 – 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
✓ Tiffany	321 – 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
✓ Sarah	301 – 310	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
✓ Atede	311 – 320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
✓ Rachael	321 – 331	Shower Room South Door (Fire)	Bistro	17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Rachael**				
Justice	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	[redacted]	
Yenji ~~Brittany~~	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	[redacted]	
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
~~Tasha~~ Jasmine	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Nicole	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/12/15

10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION

Transport: Ebony

Clinical Director 7-3pm: Sharon

7am – 7pm Nurse — Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Nafesa	332 – 341	Clean Linen Room North Door (Fire)	Bistro	09:00 – 09:15 11:00 – 11:30		
Patrick	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Dianara	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
Rebecca	332 – 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Lamia	342 - 351	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	352 - 362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse — Care Manager:

Mae Grace	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Kati	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Lamia ~~Nicole~~	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Jon	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/13/15

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Clinical Director 7-3pm: Sharon

7am – 7pm Nurse — Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Karen	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Becky	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
✓ Latasha	301-314	Clean Linen Room North Door (Fire)	Bistro	09:00 – 09:15 11:00 – 11:30		
✓ Alexandra	313-318 & 345-350	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
✓ Tiffany	319-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
✓ Cindy	301-312	Clean Linen Room North Door (Fire)	Bistro	16:45 – 17:00 19:00 – 19:30		
✓ Atede	313-318 345-350	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
✓ Rachael	319-331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Rachael**				
Julie	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Olugemi	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Janeidy	301-310 321-331 ~~301-315~~	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Jon	311-320 ~~316-331~~	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/13/15

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Clinical Director 7-3pm: Sharon

7am – 7pm Nurse — Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Nafesa	332-344	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Dianara	351-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Li**		
Rebecca	332 –344	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
	--	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
SARAH	351-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Mae Grace	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Kati	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Andre	332 – 347 348 – 362 ~~332 - 347~~	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Jen	342 – 349 ~~348 - 362~~	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/14/15 **HUC: Chantelle**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Dot

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina & Liz

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Becky	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
✓Monique	301 – 315	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
✓Kimberline	316-319& 346-349	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Suzanne ✓	320-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Kathy**		
Sara	301 ~~310~~ 315	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
	~~311 – 320~~	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Steph	~~321~~ 316 – 331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:** Janice				
Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:** Summer				
Andre	301 – 310 321 – 331	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	311 – 320 342 – 351	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/14/15 **HUC: Chantelle**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Dot

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina & Liz

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Shanna	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	[redacted]	
Sara	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	[redacted]	
7am – 3pm CNAs						
Roseann ✓	332-345	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy ✓	350-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Kathy**				
Rosl	332 – ~~341~~ 347	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
	~~342 - 351~~	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	352 - ~~362~~ 348-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Janice**				
Yemi	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	[redacted]	
Jan	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	[redacted]	
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Tashonda	332-341 352-362	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
		Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/15/15 **HUC: Chantelle**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina **Wound Rounds: Ginny**

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Becky	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Monique ✓	301 – 310	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Kimberline ✓	311 - 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany ✓	321 - 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Mernito**		
Rebecca	301 – 310	~~Clean Linen Room~~ North Door (Fire)	Bistrol	16:45 – 17:00 19:00 – 19:30		
Ptede	311 – 320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Andre	321 – 331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:** Janice				
Rachel	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Rebecca	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/15/15 HUC: Chantelle

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina Wound Rounds: Ginny

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Shanna	332 - 347	AED monitor & Code cart check Monitor pt (Fire)	332, 346	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Sara	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Suzanne ✓	332 – 341	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Latasha ✓	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy ✓	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Mernito**		
Steph	332 – 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Patrick	342 - 351	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	352 - 362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager:

Jan	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nivi	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Shunika	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tokhor Ni	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station **Date: 09/15/15**
Clinical Director 7-3pm: Heidi **HUC: Tammy**

7am-7pm: Nurse Care Manager: Joan

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Kim/ Keli	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Florence	316-331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am -3pm CNAs Transport: Helema							
Ashley	301-310	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Kimberline	311-320	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Tiffany	321-331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm -11pm CNAs Clinical Director 3pm-11pm: Li							
Tamonika	301 – 310	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Cindy	311 – 320	Soiled Linen Room Blanket & Fire Ext	Bistro!		17:00 – 17:15 19:30 – 20:00		
Andre	late 2am 321 – 331	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm - 7am Nurse Care Manager: Donna							
Yemi	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachael	316-331	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Summer							
Simone	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Andre	316-331	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station Date: 09/15/15
Clinical Director 7-3pm: Heidi HUC: Tammy

7am – 7pm: Care Manager: Joan/

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Margaret	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am- 3pm CNAs Transport: Helema							
Nafesa	332-341	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Roseann	342-351	Shower Room Blanket & Fire Ext	Bistro		09:30 - 09:45 13:30 – 14:00		
Quetcy	352-362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs Clinical Director 3pm-11pm: Li							
Stephanie	332 – 341	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Patrick	342 – 351	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Jon	352 – 362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm -7am Nurse Care Manager:							
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Mary	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Summer							
Jacedy	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Tasher M	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station **Date: 09/17/15**
Clinical Director 7-3pm: Heidi **HUC: Tammy**

7am-7pm: Nurse Care Manager: Jamie

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Karen/Kelli	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Florence	316-331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am -3pm CNAs Transport: Helema							
Dot HUC	301-310	Clean Linen Room North Door (Fire)	~~Bare~~		09:00 – 09:15 11:00 – 11:30		
Alexandra	311-320	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Tiffany	321-331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm -11pm CNAs Clinical Director 3pm-11pm: Mernito							
Sarah	301 – 310	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Atede	311 – 320	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Dandy	321 – 331	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm - 7am Nurse Care Manager: Katie							
Julie	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachel	316-331	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Summer							
Ike	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Shamika	316-331	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station Date: 09/17/15
Clinical Director 7-3pm: Heidi HUC: Tammy

7am – 7pm: Care Manager: Jamie

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am- 3pm CNAs Transport: Helema							
Nafessa	332-341	Clean Linen Room North Door (Fire)	Bistro		09:00 – 09:15 11:00 – 11:30		
Suzanne	342-351	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Ashley	352-362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs Clinical Director 3pm-11pm: Mernito							
Cindy	332 – 341	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Patrick	342 – 351	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Jon	352 – 362	Shower Room South Door (Fire)	Bistro		17:15 - 17:30 20:00 – 20:30		
7pm -7am Nurse Care Manager: Katie							
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Kristi	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Summer							
Jay	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/18/15 **HUC: Chantelle/Ashley**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Kimberline

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Liz & Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Karen	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	[redacted]	
Florence	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	321 324	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	[redacted]	
7am – 3pm CNAs						
Candace	301 – 310	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Ashley	311 - 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany	321 - 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Sharon**				
Sara	301 – 310	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Aurede	311 – 320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Andre → 30 min late	321 – 331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Katie**				
Julie	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	[redacted]	
Rachel	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	[redacted]	
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Andre	310-319 341-352	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	301-309 320-331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

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Date: 9/18/15 **HUC: Chantelle/Ashley**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Kimberline

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Liz & Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jamie	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Sara	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Suzanne	332 – 341	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Roseann	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Sharon**				
Steph (late 20 min)	332 – 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Cindy	342 - 351	Soiled Linen Room Blanket & Fire Ext	→ bistro	17:00 – 17:15 19:30 – 20:00		
Jon	352 - 362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager: Katie

Yemi	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Kristi	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Nicole	353 - 362 332 - 340	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
		Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/19/15 **HUC: Raniyah**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Clinical Director 7-3pm: Mernito

7am – 7pm Nurse Care Manager: Karina & Joan

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Florence	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Candace	301 – 310	Clean Linen Room North Door (Fire)	Bistro	09:00 – 09:15 11:00 – 11:30		
Kimberline	311 - 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Stephanie	321 - 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Sarah	301 – 312	Clean Linen Room North Door (Fire)	Bistro	16:45 – 17:00 19:00 – 19:30		
Afede	313 – 318 344 – 349	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Rebecca	319 – 331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager: Janice

Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachael	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Margaret**				
Andre	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/19/15 **HUC: Raniyah**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Clinical Director 7-3pm: Mernito /Stephanie.

7am – 7pm Nurse Care Manager: Karina & Joan

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Shanna	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Suzanne	332 – 341	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Roseann	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Stephanie	332-343	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Cherylin	350-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Ian	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Margaret**				
Nicole	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tishonda	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 09/20/15 **Clinical Director 7-3pm:** **Mernito** **HUC:** **Raniyah**

Huddle: 10:30 AM

7am – 7pm Nurse **Care Manager:** ~~Karina~~ Noam Giz

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Beth	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Terry	316-330	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am -3pm CNAs		**Transport:** Dot					
Candace	301 – 312	Clean Linen Room North Door (Fire)	**Bistro**		09:00 – 09:15 11:00 – 11:30		
Kimberline	313 - 318 ~~213-218~~ ~~244-249~~	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Stephanie	344 - 349 319 ~~311~~ – 331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm -11pm CNAs		**Clinical Director 3pm-11pm: Mernito**					
Sarah	301-312	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
Rachel	313-318 344-349	Soiled Linen Room Blanket & Fire Ext	Bistro		17:00 – 17:15 19:30 – 20:00		
Rebecca	319-331	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm - 7am Nurse		**Care Manager:** Janice					
Colleen	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn	316-330	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs		**Clinical Director 11pm – 7am:**					
Mchol	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Simone	316-330	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 09/20/15 Clinical Director 7-3pm: Mernito HUC: Raniyah

Huddle: 10:30 AM

7am – 7pm Nurse Care Manager: ~~Karina~~ Joan Liz

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Joan	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Shanna	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am- 3pm CNAs		**Transport: Dot**					
Suzanna	332 – 343	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Kimberline	313-318 ~~213-218~~ ~~244-249~~	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Roseann	~~344-349~~ 350 – 362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs		**Clinical Director 3pm-11pm: Mernito**					
Stephanie	332-343	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
	--	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Roseann	350-362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm -7am Nurse		**Care Manager:**					
Jan	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs		**Clinical Director 11pm – 7am:**					
Qwity	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

9/21

Date: 09/2~~0~~1/15 Clinical Director 7-3pm: Heidi HUC: Raniyah
Huddle: 10:30 AM

7am – 7pm Nurse Care Manager: Kim/Jamie

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN
Karen	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45	
Florence	316-330	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00	
7am -3pm CNAs Transport: Tina						
Candace	~~301-3~~ 310	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30	
Nancy	311-317 345-349	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00	
Tiffany	318-331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00	
3pm -11pm CNAs Clinical Director 3pm-11pm: Kathy						
Sara	301-310	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30	
Atede	311-317 345-349	Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00	
Andre	318-331	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30	
7pm - 7am Nurse Care Manager: Katie						
Julie	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15	
Yemi	316-330	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30	
11pm -7am CNAs Clinical Director 11pm – 7am: Summer						
Jon	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30	
Shamika	316-330	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00	

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS 41

Cx 1 Volunteer CNA P all Arrived
on 2nd / 3rd floor

Date: 09/~~20~~ 21/15 Clinical Director 7-3pm: Heidi HUC: Raniyah
Huddle: 10:30 AM

7am – 7pm Nurse Care Manager: Kim/Jamie

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am- 3pm CNAs		**Transport: Tina**					
Roseann Latasha	332 – 343	Clean Linen Room North Door (Fire)	Bistro		09:00 – 09:15 11:00 – 11:30		
Roseann		Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
[redacted]	350 – 362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs		**Clinical Director 3pm-11pm:**					
Jareidy	332-343	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Pat	350-362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm -7am Nurse		**Care Manager:** Katie					
Mia	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Kristi	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs		**Clinical Director 11pm – 7am:** Summer					
Quincy	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Jay	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

Volunteers (CNAs) to CX after all arrived on 2nd & 3rd!

2 CNA sick call!

Date: 9/22/15

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina **Wound rounds: Ginny**

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie, Kim & Joan

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)	308, 315	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Florence	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Kimberline	301-311	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Alexandra	312-317& 344-347	Shower Room Blanket & Fire Ext	Bistro	09:30 - 09:45 13:30 – 14:00		
Tiffany	19+20 am care done 318-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:** Li				
Alecia	301-312 ~~301 – 310~~	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Rebecca	313-318 ~~311 – 320~~ 349-349	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Andre	319-331	Shower Room South Door (Fire)	Bistro	17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:** Rachael				
Julie	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Bethany	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:** Summer				
Jarrelly	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/22/15

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina **Wound rounds: Ginny**

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie, Kim & Joan

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	349	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Suzanne	332-343	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Ashley ~~Roseann~~	348-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**				
Steph	332-343	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Rebecca	313-318 344-349	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Pat	350-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Kati	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Brette	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Nicole	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashanda	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/23/15 **HUC: Chantelle**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Martha & Liz

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)	313	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Becky	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Helena ~~Kimberline~~	301-312	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
~~Ashley~~ ~~Suzanne~~	313-318& 344-347	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Nancy Tiffany	319-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Janeidy	301 – 310	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Adede	311 – 320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Andre	321 – 331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Donna**				
Janice	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachael	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Margaret**				
Shamika	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/23/15

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina **Wound rounds: Ginny**

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Martha & Liz

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Margaret	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Sara	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Suzanne ~~Ashley~~	332-343	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy	348-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Rebecca	332 – 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Cindy	342 - 351	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	~~352 - 362~~	Shower Room ~~South Door (Fire)~~	→ bistro	17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Margaret**				
Nicole	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

10 am: Huddle/Rounds @ Nurse's Station **Date: 09/24/15**
Clinical Director 7-3pm: Heidi **HUC: Chantelle/ Chasity (O)**

7am-7pm: Nurse Care Manager: Karina / Michelle

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Karen	301-315	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Rebecca	316-331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am -3pm CNAs Transport: Dot							
Kimberline/ ~~Helena~~	301-310	Clean Linen Room North Door (Fire)	Bistro		09:00 – 09:15 11:00 – 11:30		
Alexandra	311-320	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Suzanne	321-331	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm -11pm CNAs Clinical Director 3pm-11pm: Mernito							
Sara	301-315	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Rebecca	316-331	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm - 7am Nurse Care Manager: Janice							
Colleen.	301-315	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn.	316-331	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Summer							
Shamika	301-315	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Simone	316-331	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm
Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***
CNAs MUST sign OUT & IN FOR ALL BREAKS

CNAs Voluntary CX after all arrived on each unit

10 am: Huddle/Rounds @ Nurse's Station Date: 09/24/15

Clinical Director 7-3pm: Heidi HUC: Chantelle/ Chasity (O)

7am – 7pm: Care Manager: Karina / Michelle

Nurse	Rooms	Special Duties	Discharge	Appt.	Breaks/Meals	Initial Out / IN	
Sharina	332 - 347	AED monitor & Code cart check Monitor pt (Fire)			10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Sara	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)			10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am- 3pm CNAs Transport: Dot							
Nafesa	332-341	Clean Linen Room North Door (Fire)			09:00 – 09:15 11:00 – 11:30		
Ashley	342-351	Shower Room Blanket & Fire Ext			09:30 - 09:45 13:30 – 14:00		
Quetcy	352-362	Shower Room South Door (Fire)			09:15 – 09:30 11:30 – 12:00		
3pm-11pm CNAs Clinical Director 3pm-11pm: Mernito							
Steph	332-347	Clean Linen Room North Door (Fire)			16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext			17:00 – 17:15 19:30 – 20:00		
Patrick	348-362	Shower Room South Door (Fire)			17:15 – 17:30 20:00 – 20:30		
7pm -7am Nurse Care Manager:							
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)			21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks			21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm -7am CNAs Clinical Director 11pm – 7am: Summer							
Nicole	332 - 347	Soiled Linen Room North Door (Fire)			01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)			01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

CNAs Voluntary CX after all arrived on each

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Date: 9/25/15 **HUC: Tammy**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Cheryl

7am – 7pm Nurse Care Manager: Karina with Shanna

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Florence	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Becky	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Kimberline ~~Pilar~~	301 – 310	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Pilar ~~Kimberline~~	311 - 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany	321 - 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Sharon**				
Sara Tiana	301 -310	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Atede	311-320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Andre	321 - 331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Marilyn	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Lamia	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/25/15 **HUC: Tammy**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: ~~Cheryl~~ Hyeli

7am – 7pm Nurse Care Manager: Karina with Shanna

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica with Chantelle	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Margaret	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Suzanne ✓	332 – 341	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Roseann ✓	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Latasha ✓	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Sharon**				
Stephanie	332 - 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Alaina	342-351	Soiled Linen Room Blanket & Fire Ext	Bistro	17:00 – 17:15 19:30 – 20:00		
Jareidy	352-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Yeimi	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Janice	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Nicole	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Jareidy ~~Tashonda~~	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/26/15 **HUC: Ashley**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Sharon ~~& Stephanie~~

7am – 7pm Nurse Care Manager: Jamie & Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Karen	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Florence	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Ashley	301 – 310	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Alexandra	311 - 320	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany	321 - 331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
Tiana SARAH	301 – 310	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
ATeDe	311 – 320	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Andre	321 – 331	Shower Room South Door (Fire)	Bristo	17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager: Jamie Till 11p

Julie	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachael	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Andre	301-310 323-331	Soiled Linen Room North Door (Fire)	Bryant: 332-341 353-362	01:30 – 01:45 03:00 – 03:30		
Genovia ~~Shamika~~	311-322 342-352	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/26/15 **HUC: Ashley**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

~~Clinical Director 7-3pm: Sharon & Stephanie~~

7am – 7pm Nurse Care Manager: Jamie & Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)	335	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Kim 3-7 Michelle T.T 3P	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	351, 355	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Nafesa ✓	332 – 341	Clean Linen Room North Door (Fire)	Bistro	09:00 – 09:15 11:00 – 11:30		
✓ Roseann	342 - 351	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy ✓	352 - 362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
✓ PATRICK	332 – 341	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
✓ Rebecca	342 - 351	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
✓ Rachael	352 - 362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
KATie	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Brielle	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Andre	301-310 323-331	Soiled Linen Room North Door (Fire)	BOUNTS 332-341	01:30 – 01:45 03:00 – 03:30		
Samuel ~~Shamika~~	311-322 342-352	Clean Linen Room South Door (Fire)	353-362	01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/27/15 **HUC: Tammy**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Sharon

7am – 7pm Nurse — Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Karen	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Kelly	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
✓ Ashely	301-312	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
✓ Alexandra	313-318 344-349	Shower Room Blanket & Fire Ext	Bistro	09:30 - 09:45 13:30 – 14:00		
✓ Tiffany	319-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
~~Joy~~ Rebecca	301 – 312	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Atede	313-318 344-349	Soiled Linen Room Blanket & Fire Ext	Bistro	17:00 – 17:15 19:30 – 20:00		
Andre	319-331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Jamie 7-11P**				
Julie	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachael	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Jareidy	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Andre	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/27/15 HUC: Tammy

10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION

Transport: Tina

Clinical Director 7-3pm: Sharon

7am – 7pm Nurse Care Manager: Kim

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Jessica	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Jamie	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
√ Nafesa	332-343	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
√ Candace	350-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
PATRICK	332-343	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Rachel	350-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager:

KATie	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Brielle	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Jon	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Quetay	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/27/15 **HUC: Ashley**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina ✓

Clinical Director 7-3pm: Stephanie

7am – 7pm Nurse Care Manager: Liz & Michelle

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Ivan	201 - 215	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Shakeaya	216 - 231	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Helema	201-212	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
✓ Regina	213-218 & 246-250	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Latasha	219-231	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
✓ Lashonda	201 – 210	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
✓ Alaina	211 - 220	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
✓ Nicholette	221 - 231	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager: Ray**				
Yemi	201 – 215	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Maria	216 – 231	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Lashand	201 – 210 221 – 231	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Bryant	211 – 220 242 - 250	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/27/15 HUC: Ashley

10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION

Transport: Tina

Clinical Director 7-3pm: Stephanie

7am – 7pm Nurse Care Manager: Liz & Michelle

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Cynthia	232 - 247	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Lynette	248 - 262	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Larry	232-245	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Gerry	261 ~~250~~-261	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
Larry	232 – 241	Clean Linen Room North Door (Fire)	BISTRO	16:45 – 17:00 19:00 – 19:30		
Hilani	242-251	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Veronica	252 – 262	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Cherry	232 – 247	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Bindu	248 – 262	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Lamoy	232-241 251-262	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
		Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/28/15 **HUC: Chasity**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Dot

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie (11-11)

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)	302 (at 3pm)	10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Kelli	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Ashley ✓	301-312	Clean Linen Room North Door (Fire)	302 (at 3pm)	09:00 – 09:15 11:00 – 11:30		
Suzanne ✓	345-346 313-319	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Tiffany ✓	320-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
Sara	301-312	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Jareidy	313-318 344-349	Soiled Linen Room Blanket & Fire Ext	switch 352 for 348 —Bistro!	17:00 – 17:15 19:30 – 20:00		
Aiedl	319-331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		

7pm – 7am Nurse Care Manager: Jamie until 11p

Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Janice	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Jareidy	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/28/15 **HUC: Chasity**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Dot

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Jamie (11-11)

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Tazya	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Karina & Chantelle	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	361	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Kimberline	332-344	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Roseann	347 ~~345~~-362	Shower Room South Door (Fire)	361	09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Li**				
Steph	332-343	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Jarielly	344-347	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Roseanne	350-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Mae Grace	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am: Summer**				
Nicole	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashonda	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/29/15 **HUC: Chasity**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Beth	301 - 315	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Joan	316 - 331	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)	325	10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
✓ Kimberline	301-313	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
✓ Suzanne	314-319 &345 –349	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
✓ Tiffany	320-331	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Alede	301-312	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Pat	313-318 345-349	Soiled Linen Room Blanket & Fire Ext	Bistro	17:00 – 17:15 19:30 – 20:00		
Andre	319-331	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Colleen	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Janice	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
André	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simon	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/29/15 HUC: Chasity

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Hydei

7am – 7pm Nurse Care Manager: Karina

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Sara	332 - 347	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Belinda	348 - 362	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Latasha	332-344	Clean Linen Room North Door (Fire)	Bisto	09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Quetcy	~~350~~ – ~~346~~-362	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Mernito**				
Stephanie	332 - 344	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
		Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	350-362	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Mae	332 - 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Nicole	348 - 362	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
[illegible]	332 - 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
[illegible]	348 - 362	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/30/15 **HUC: Wendy**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Cheryl

7am – 7pm Nurse Care Manager: Michelle & Liz (11a-7p)

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Martha	201 - 215	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Terry	216 - 231	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Cherie	201-214	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
Maggie	215-218 245-250	Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Helema	219-231	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm:**		**Sharon**		
Jareidy	301-310 ~~201 – 210~~	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Cindy	311-320 ~~211 – 220~~	Soiled Linen Room Blanket & Fire Ext	Bistro!	17:00 – 17:15 19:30 – 20:00		
Caitlyn	321-331 ~~221 – 231~~	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**	Donna			
Yeni	301 – 315	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachel	316 – 331	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Shamika	301 – 315	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Simone	316 – 331	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

Date: 9/30/15 **HUC: Wendy**

****10:30 AM - MORNING HUDDLE/ROUNDS AT NURSE'S STATION****

Transport: Tina

Clinical Director 7-3pm: Cheryl

7am – 7pm Nurse Care Manager: Michelle & Liz (11a-7p)

Nurse	Rooms	Special Duties	Discharge	Breaks/Meals	Initial Out / IN	
Margaret	232 - 247	AED monitor & Code cart check Monitor pt (Fire)		10:30 – 10:45 12:00 – 12:30 15:30 – 15:45		
Shanna	248 - 262	Omnicell Narc Ct. Refrigerators -temp Monitor pt (Fire)		10:45 – 11:00 12:30 – 13:00 15:45 – 16:00		
7am – 3pm CNAs						
Larry	232-244	Clean Linen Room North Door (Fire)		09:00 – 09:15 11:00 – 11:30		
		Shower Room Blanket & Fire Ext		09:30 - 09:45 13:30 – 14:00		
Geri	251-262	Shower Room South Door (Fire)		09:15 – 09:30 11:30 – 12:00		
3pm – 11pm CNAs		**Clinical Director 3pm-11pm: Sharon**				
Stephanie	332 ~~232 – 241~~	Clean Linen Room North Door (Fire)		16:45 – 17:00 19:00 – 19:30		
Patrick	342-35 ~~242 – 251~~	Soiled Linen Room Blanket & Fire Ext		17:00 – 17:15 19:30 – 20:00		
Jon	352-362 ~~252 – 262~~	Shower Room South Door (Fire)		17:15 – 17:30 20:00 – 20:30		
7pm – 7am Nurse		**Care Manager:**				
Katie	332 – 347	AED monitor & Code cart check Monitor pts. (Fire)		21:00 – 21:15 23:00 – 23:30 02:00 – 02:15		
Rachel Liz Kathy	248 – 262	Omnicell Narc Ct. Refrigerators -temp checks		21:15 – 21:30 23:30 – 00:00 02:15 – 02:30		
11pm – 7am CNAs		**Clinical Director 11pm – 7am:**				
Nicole	332 – 347	Soiled Linen Room North Door (Fire)		01:30 – 01:45 03:00 – 03:30		
Tashonda	248 – 262	Clean Linen Room South Door (Fire)		01:45 – 02:00 03:30 – 04:00		

Reminders: Nurse/CNA rounds at 6am – 2pm – 10pm

Care Mangers: Ensure all UDAs, charting & logs (ADLs, MARs, & TARs) are signed/completed by end of the shift. ***7pm-7am Care Manager or Clinical Director must print the midnight census at midnight (or anytime thereafter) but not before midnight.***

CNAs MUST sign OUT & IN FOR ALL BREAKS

EXHIBIT F

GHC Payroll, LLC
Payroll Account - Disbursements
101 East State Street
Kennett Square PA 19348

Company:	E09-SR-73 and Lakeside Avenue Oper	Advice #:	**000000006973011**
Pay Group:	293-PowerBack Rehab, Voorhees	Advice Date:	10/30/2015
Business Unit:	55261		
Pay Begin Date:	10/11/2015		
Pay End Date:	10/24/2015		

Cheryl M Manages	Employee ID:	80322151	**TAX DATA:** Federal / NJ State
[redacted]	Department:	552613210-Registered Nurse	[redacted]
	Location:	PowerBack Rehab, Voorhees	
	Job Title:	Nurse-Clinical Director PB RN	
	Pay Rate:	$39.535 Hourly	

HOURS AND EARNINGS

Description	Current Rate	Current Hours	Current Earnings	YTD Hours	YTD Earnings
Regular	39.535	80.00	3,162.82	1,480.00	58,512.15
Holiday			0.00	56.00	2,213.96
Sick			0.00	56.00	2,213.96
Supplemental Staff Bonus Exmpt			0.00		150.00
Vacation			0.00	168.00	6,641.90
TOTAL:		**80.00**	**3,162.82**	**1,760.00**	**69,731.97**

TAXES

Description	Current	YTD
Fed Withholdng	467.37	10,344.34
Fed MED/EE	44.99	991.88
Fed OASDI/EE	192.36	4,241.15
NJ Unempl EE	0.00	122.40
NJ NJ WDPF	0.00	8.00
NJ NJ SWAF	0.00	5.60
NJ FLI/EE	0.00	28.80
NJ Withholdng	118.88	2,625.23
NJ OASDI/EE	0.00	80.00
TOTAL:	**823.60**	**18,447.40**

BEFORE-TAX DEDUCTIONS

Description	Current	YTD
Aetna Basic Medical	25.48	560.56
Aetna Participating PPO	12.36	271.92
Voluntary Vision Plan	3.13	68.86
Personal Accident	19.32	425.04
Expense Ins.		
401K	189.77	4,183.94
TOTAL:	**250.06**	**5,510.32**

AFTER-TAX DEDUCTIONS

Description	Current	YTD
Purchased Meals	0.00	118.75
TOTAL:	**0.00**	**118.75**

ADDITIONS TO TAXABLE GROSS

Description	Current	YTD
*TAXABLE		

	TOTAL GROSS	FED TAXABLE GROSS	TOTAL TAXES	TOTAL DEDUCTIONS	NET PAY
Current	3,162.82	2,912.76	823.60	250.06	2,089.16
YTD	69,731.97	64,221.65	18,447.40	5,629.07	45,655.50

BENEFIT HOURS AVAILABLE

Description	YTD HOURS
Sick	60.68
Vacation	128.00
Personal	16.00

EMPLOYER INFORMATION

SR-73 and Lakeside Avenue Oper
113 South Route 73
Voorhees, NJ 08043

NET PAY DISTRIBUTION

[redacted]

TOTAL: **$2,089.16**

MESSAGE:

ER 24

GHC Payroll, LLC
Payroll Account - Disbursements
101 East State Street
Kennett Square PA 19348

Company:	E09-SR-73 and Lakeside Avenue Oper	Advice #:	000000006973006
Pay Group:	293-PowerBack Rehab, Voorhees	Advice Date:	10/30/2015
Business Unit:	55261		
Pay Begin Date:	10/11/2015		
Pay End Date:	10/24/2015		

Martha Karen Lake
[redacted]

Employee ID:	80382939
Department:	552613210-Registered Nurse
Location:	PowerBack Rehab, Voorhees
Job Title:	Nurse-RN Care Mgr PB
Pay Rate:	$35.000 Hourly

TAX DATA: [redacted]

HOURS AND EARNINGS

Description	Rate	Current Hours	Current Earnings	YTD Hours	YTD Earnings
Regular	35.000	80.00	2,800.00	1,518.40	53,144.00
Overtime	52.500	15.82	830.55	95.31	5,003.79
Bereavement Time			0.00	24.00	840.00
Holiday			0.00	64.00	2,240.00
Personal			0.00	4.00	140.00
Sick			0.00	48.00	1,680.00
Vacation			0.00	65.00	2,275.00
TOTAL:		**95.82**	**3,630.55**	**1,818.71**	**65,322.79**

TAXES

Description	Current	YTD
Fed Withholdng	334.17	5,228.96
Fed MED/EE	52.21	937.63
Fed OASDI/EE	223.24	4,009.19
NJ Unempl EE	0.00	122.40
NJ NJ WDPF	0.00	8.00
NJ NJ SWAF	0.00	5.60
NJ FLI/EE	0.00	28.80
NJ Withholdng	154.29	2,276.66
NJ OASDI/EE	0.00	80.00
TOTAL:	**763.91**	**12,697.24**

BEFORE-TAX DEDUCTIONS

Description	Current	YTD
Aetna Participating PPO	29.93	658.46
401K	36.31	535.37
TOTAL:	**66.24**	**1,193.83**

AFTER-TAX DEDUCTIONS

Description	Current	YTD
Vol Life Employee	0.00	74.00
Vol Life Spouse	0.00	20.80
Purchased Meals	0.00	37.75
TOTAL:	**0.00**	**132.55**

ADDITIONS TO TAXABLE GROSS

Description	Current	YTD
*TAXABLE		

	TOTAL GROSS	FED TAXABLE GROSS	TOTAL TAXES	TOTAL DEDUCTIONS	NET PAY
Current	3,630.55	3,564.31	763.91	66.24	2,800.40
YTD	65,322.79	64,128.96	12,697.24	1,326.38	51,299.17

BENEFIT HOURS AVAILABLE

Description	YTD HOURS
Sick	20.03
Vacation	55.72
Personal	16.00

EMPLOYER INFORMATION

SR-73 and Lakeside Avenue Oper
113 South Route 73
Voorhees, NJ 08043

NET PAY DISTRIBUTION

[redacted]

TOTAL: **$2,800.40**

MESSAGE:

GHC Payroll, LLC
Payroll Account - Disbursements
101 East State Street
Kennett Square PA 19348

Company:	E09-SR-73 and Lakeside Avenue Oper	Advice #:	000000006973014
Pay Group:	293-PowerBack Rehab, Voorhees	Advice Date:	10/30/2015
Business Unit:	55261		
Pay Begin Date:	10/11/2015		
Pay End Date:	10/24/2015		

Jessica G Mociak	Employee ID:	80388303	TAX DATA: NJ State
[redacted]	Department:	552613210-Registered Nurse	[redacted]
	Location:	PowerBack Rehab, Voorhees	
	Job Title:	Nurse-RN	
	Pay Rate:	$28.560 Hourly	

HOURS AND EARNINGS

Description	Rate	Current Hours	Current Earnings	YTD Hours	YTD Earnings
Regular	28.560	48.83	1,394.58	1,270.66	36,262.99
Vacation	28.560	24.00	685.44	93.58	2,672.65
Holiday			0.00	40.00	1,142.40
Orientation-NP			0.00	24.17	676.76
Overtime			0.00	70.77	3,031.79
Personal			0.00	16.00	456.96
Retro Pay			0.00		76.32
Sick			0.00	40.79	1,164.96
Sick Special Reduction			0.00	-0.01	-0.29
Vacation Special Reduction			0.00	-12.00	-342.72
TOTAL:		**72.83**	**2,080.02**	**1,543.96**	**45,141.82**

TAXES

Description	Current	YTD
Fed Withholdng	167.47	3,860.80
Fed MED/EE	26.65	591.80
Fed OASDI/EE	113.93	2,530.44
NJ Unempl EE	0.00	122.40
NJ NJ WDPF	0.00	8.00
NJ NJ SWAF	0.00	5.60
NJ FLI/EE	0.00	28.80
NJ Withholdng	63.61	1,438.77
NJ OASDI/EE	0.00	80.00
TOTAL:	**371.66**	**8,666.61**

BEFORE-TAX DEDUCTIONS

Description	Current	YTD
Aetna Prime Medical	172.48	3,449.60
Aetna Participating PPO	29.93	598.60
Tobacco	40.00	280.00
TOTAL:	**242.41**	**4,328.20**

AFTER-TAX DEDUCTIONS

Description	Current	YTD
Pay Card	0.00	1,082.73
Genesis Employee Foundation	0.00	13.00
Purchased Meals	0.00	66.50
TOTAL:	**0.00**	**1,162.23**

ADDITIONS TO TAXABLE GROSS

Description	Current	YTD
*TAXABLE		

	TOTAL GROSS	FED TAXABLE GROSS	TOTAL TAXES	TOTAL DEDUCTIONS	NET PAY
Current	2,080.02	1,837.61	371.66	242.41	1,465.95
YTD	45,141.82	40,813.62	8,666.61	5,490.43	30,984.78

BENEFIT HOURS AVAILABLE

Description	YTD HOURS
Sick	9.21
Vacation	9.77
Personal	0.00

EMPLOYER INFORMATION

SR-73 and Lakeside Avenue Oper
113 South Route 73
Voorhees, NJ 08043

NET PAY DISTRIBUTION

[redacted]

TOTAL: $1,465.95

MESSAGE:

EXHIBIT G

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Twum-Barima,Raymond A	Raymond.TwumBarima12@GenesisHCC.com
Upshur,Rachel Joan	rachel.upshur@genesishcc.com

Job Title	Job Entry Dt	SP-M00001	SP-M00002	SP-M00003
		Computer Basics	Internet Basics	Central & Sharepoint
Center Sr Nursing Executive	4/4/2014	4/30/2013		
Nurse Practice Educator-RN	9/4/2012			
Nurse-Clinical Director PB RN	7/29/2013	11/21/2014	11/21/2014	8/5/2013
Nurse-Clinical Director PB RN	9/21/2015			
Nurse-Clinical Director PB RN	10/1/2012	3/6/2015	3/6/2015	3/6/2015
Nurse-Clinical Director PB RN	8/24/2015	9/26/2015	9/26/2015	9/26/2015
Nurse-Clinical Director PB RN	9/29/2013	1/18/2013	1/18/2013	1/18/2013
Nurse-Clinical Director PB RN	10/15/2012	12/17/2012	12/17/2012	12/17/2012
Nurse-RN Care Mgr PB	11/9/2014	1/10/2015		
Nurse-RN Care Mgr PB	6/22/2014	4/21/2015	6/14/2015	4/21/2015
Nurse-RN Care Mgr PB	11/9/2014	11/7/2015	11/7/2015	12/7/2014
Nurse-RN Care Mgr PB	9/29/2013	11/16/2015	11/17/2015	11/17/2015
Nurse-RN Care Mgr PB	10/21/2013	6/21/2015	6/29/2014	6/21/2015
Nurse-RN Care Mgr PB	11/9/2014	11/3/2014	11/21/2014	10/16/2014
Nurse-RN Care Mgr PB	11/17/2014	6/29/2015	6/29/2015	6/29/2015
Nurse-RN Care Mgr PB	6/30/2014	4/10/2015	4/10/2015	4/10/2015
Nurse-RN Care Mgr PB	8/4/2013	9/9/2015	9/9/2015	9/9/2015
Nurse-RN Care Mgr PB	10/31/2012	12/20/2012	12/20/2012	12/20/2012
Nurse-RN Care Mgr PB	11/9/2014	9/14/2015	9/14/2015	9/14/2015
Nurse-RN Care Mgr PB	1/4/2015	12/13/2012	12/17/2012	12/13/2012
Nurse-RN Care Mgr PB	11/18/2013	11/23/2014	11/23/2014	11/23/2014
Nurse-RN Care Mgr PB	6/22/2014	12/28/2015		12/28/2015
Nurse-RN Care Mgr PB	9/9/2013	9/17/2015	10/6/2015	9/17/2015
Nurse-RN Care Mgr PB	11/9/2014	10/16/2014	10/16/2014	10/17/2014

SP-M00004	SP-M00005	MP-M00006	MP-M00007	MP-M00008	MP-M00009
GenSTAR	GenServ	Living Core Values	Role of Manager	Role of Manager	Role of Manager
4/30/2013		4/18/2012			
		2/6/2013			
11/21/2014	11/21/2014	4/23/2015	8/5/2013	8/6/2013	8/6/2013
3/6/2015	3/6/2015	4/23/2015	3/6/2015	3/7/2015	3/10/2015
9/26/2015	9/26/2015		9/26/2015	9/26/2015	
1/18/2013	1/18/2013	4/23/2015	1/19/2013	1/19/2013	1/22/2013
12/17/2012	12/17/2012	11/4/2014	12/17/2012	5/26/2013	9/26/2014
		7/28/2015			
6/14/2015	6/14/2015		8/18/2015	8/18/2015	8/18/2015
11/7/2015	11/7/2015				
11/17/2015	11/17/2015		11/16/2015	12/19/2015	12/20/2015
6/21/2015	6/27/2015	10/15/2015	6/27/2015	9/4/2015	7/6/2015
11/21/2014	11/21/2014		12/1/2014	9/16/2015	9/28/2015
6/29/2015	6/29/2015		7/8/2015		
4/10/2015	4/10/2015		10/5/2015		
9/9/2015	9/14/2015		9/14/2015	9/14/2015	9/14/2015
12/20/2012	12/20/2012	4/23/2015	5/21/2013	2/11/2016	2/11/2016
9/14/2015	9/14/2015		9/14/2015		
12/14/2012	12/13/2012	4/23/2015	12/14/2012	9/25/2014	11/16/2014
11/23/2014	11/23/2014	10/15/2015	11/23/2014	9/26/2015	9/26/2015
			4/16/2015		
10/6/2015	10/6/2015				
10/17/2014	10/17/2014		8/27/2015	9/14/2015	9/14/2015

MP-M00010	MP-M00013	MP-M00014	MP-M00015	MP-M00016	MP-M00017
Managing Operations	Managing Operations	Managing Self	Managing Relationships	Managing Relationships	Managing Relationships
8/6/2013	8/6/2013	11/21/2014	11/21/2014	11/21/2014	11/21/2014
3/6/2015	12/20/2012	3/11/2015	3/10/2015	3/10/2015	3/10/2015
9/27/2015	9/27/2015	11/30/2015	11/30/2015		12/1/2015
1/22/2013	1/22/2013	1/22/2013	1/22/2013	1/22/2013	1/22/2013
1/22/2013	12/20/2012	10/6/2014	1/29/2013	1/27/2013	1/26/2013
9/27/2015	1/10/2015		3/25/2015		
5/7/2015	5/7/2015	11/15/2015	6/14/2015	6/14/2015	7/7/2015
9/26/2015	12/7/2014			9/26/2015	9/26/2015
12/20/2015	11/17/2015			12/20/2015	12/21/2015
7/1/2015	7/1/2015	7/1/2015	9/26/2015	9/2/2015	9/2/2015
11/22/2014	11/22/2014	4/22/2015	12/10/2014	12/1/2014	12/1/2014
4/10/2015	4/10/2015		4/15/2015	10/21/2015	4/15/2015
4/10/2015	4/10/2015		11/15/2015		11/15/2015
9/14/2015	9/9/2015	9/14/2015	9/14/2015	9/14/2015	9/14/2015
12/20/2012	12/20/2012	11/14/2015	2/8/2013	5/21/2013	2/8/2013
9/27/2015	9/27/2015			12/19/2015	12/19/2015
12/17/2012	12/17/2012	9/22/2014	1/27/2013	1/28/2013	1/27/2013
11/23/2014	11/23/2014	9/26/2015	9/22/2015	12/7/2014	12/12/2014
	4/16/2015				
10/20/2014	10/17/2014	9/14/2015	10/6/2015	8/27/2015	8/27/2015

MP-M00018	MP-M00019	MP-M00020	MP-M00021	MP-M00022	MP-M00023
Managing Relationships	**Managing Relationships**	**Managing Relationships**	**Managing Relationships**	**Managing Others**	**Managing Others**
11/21/2014	11/21/2014	11/21/2014	11/21/2014	11/21/2014	11/21/2014
	3/8/2016				
3/10/2015	3/14/2015	3/14/2015	3/10/2015	11/5/2012	3/10/2015
12/1/2015	12/1/2015	12/1/2015	12/1/2015	12/1/2015	12/1/2015
1/22/2013	1/22/2013	1/22/2013	1/22/2013	2/8/2013	2/8/2013
1/26/2013	1/27/2013	1/27/2013	1/29/2013	1/23/2013	1/23/2013
				3/25/2015	10/9/2015
6/14/2015	6/14/2015	6/14/2015	7/7/2015	6/14/2015	6/14/2015
9/26/2015	9/26/2015	9/26/2015	9/26/2015	9/26/2015	9/26/2015
12/21/2015	11/27/2015			2/23/2016	
7/1/2015	7/1/2015	9/2/2015	9/2/2015	7/1/2015	7/1/2015
12/1/2014	12/10/2014	12/10/2014	12/10/2014	12/6/2014	12/6/2014
4/14/2015	5/31/2015		6/1/2015	4/14/2015	4/14/2015
11/15/2015				11/15/2015	11/15/2015
9/14/2015	9/14/2015	9/14/2015	9/14/2015	9/14/2015	9/14/2015
2/8/2013	5/21/2013	5/21/2013	5/21/2013	1/28/2013	1/20/2013
10/12/2015	12/19/2015		10/19/2015	10/12/2015	9/27/2015
1/26/2013	1/27/2013	1/27/2013	2/10/2013	1/13/2013	12/17/2012
12/6/2014	12/6/2014	12/6/2014	12/7/2014	12/6/2014	12/2/2014
8/27/2015	11/9/2014	8/27/2015	8/27/2015	10/28/2014	10/26/2014

MP-M00024	MP-M00025	MP-M00026	MP-M00027	MP-M00052	LER-M00028
Managing Others	Managing Others	Managing Others	Managing Others	Managing Others	Labor Relations
			5/16/2012		
11/21/2014	10/9/2014	11/21/2014	5/5/2015	11/21/2014	11/21/2014
				3/8/2016	
3/10/2015	3/10/2015	11/5/2012	5/5/2015	3/10/2015	3/15/2015
9/27/2015	9/27/2015	12/1/2015		9/27/2015	10/10/2015
2/8/2013	2/8/2013	2/8/2013	5/5/2015	2/8/2013	2/9/2013
1/22/2013	12/13/2012	1/24/2013	11/18/2014	1/23/2013	1/29/2013
9/27/2015	9/27/2015	10/9/2015		9/27/2015	
5/7/2015	5/7/2015	7/7/2015	8/18/2015	5/7/2015	8/18/2015
9/26/2015	9/26/2015	9/26/2015		9/26/2015	9/26/2015
7/1/2015	7/1/2015	7/1/2015	1/28/2016	7/1/2015	7/6/2015
12/6/2014	11/22/2014	12/6/2014		12/6/2014	1/19/2015
4/11/2015	4/10/2015	4/14/2015		4/11/2015	
4/10/2015	4/10/2015	11/15/2015	8/18/2015	11/15/2015	
9/14/2015	9/14/2015	9/14/2015		9/14/2015	9/14/2015
12/20/2012	1/4/2013	2/8/2013	8/18/2015	12/20/2012	1/20/2013
9/27/2015	9/27/2015	10/12/2015		9/27/2015	12/19/2015
12/17/2012	12/17/2012	1/13/2013	5/5/2015	12/17/2012	2/11/2013
11/28/2014	11/23/2014	12/6/2014	1/28/2016	12/7/2014	12/20/2014
10/26/2014	10/22/2014	8/27/2015		10/26/2014	9/4/2015

LER-M00029	LER-M00030	LER-M00031	LER-M00032	LER-M00033	LER-M00034
Labor Relations	Legal	Legal	Legal	Legal	Legal
11/21/2014	11/21/2014	11/21/2014	12/11/2014	11/21/2014	11/21/2014
3/11/2015	3/14/2015	11/5/2012	3/14/2015	3/14/2015	3/11/2015
10/10/2015	10/10/2015	10/10/2015	10/10/2015	10/11/2015	10/11/2015
2/9/2013	2/13/2013	2/13/2013	2/13/2013	6/28/2013	8/17/2013
2/4/2013	2/11/2013	2/4/2013	2/11/2013	2/11/2013	2/4/2013
					10/9/2015
8/22/2015	8/18/2015	8/22/2015	8/18/2015	8/22/2015	8/18/2015
9/26/2015	10/11/2015	9/26/2015	10/11/2015	9/26/2015	10/11/2015
			11/27/2015		11/27/2015
9/2/2015	9/2/2015	9/2/2015	7/14/2015	9/2/2015	7/14/2015
1/19/2015	12/29/2014	12/29/2014	12/29/2014	12/29/2014	12/29/2014
9/14/2015	9/14/2015	9/14/2015	9/18/2015	9/14/2015	9/14/2015
12/19/2015	12/19/2015	12/19/2015	12/19/2015	12/19/2015	12/19/2015
11/17/2014	11/17/2014	11/17/2014	11/17/2014	11/17/2014	1/31/2013
12/20/2014	1/3/2015	12/29/2014	12/30/2014	12/21/2014	1/3/2015
11/10/2014	9/4/2015	11/10/2014	9/14/2015	9/4/2015	11/10/2014

LER-M00035	LER-M00036	LER-M00037	TA-M00038	TA-M00039	TA-M00040
Legal	Legal	Legal	Intro to Talent Requisition	Recruiting for Open Positions	Understanding Prescreening
11/21/2014	11/21/2014	11/21/2014	8/9/2013	8/9/2013	8/9/2013
3/8/2016					
11/5/2012	3/11/2015	3/11/2015	11/2/2012	11/2/2012	11/2/2012
10/11/2015	10/11/2015	10/11/2015			
8/17/2013	6/28/2013	6/28/2013	11/6/2013	11/6/2013	11/6/2013
2/4/2013	2/8/2013	2/11/2013	2/13/2013	2/14/2013	2/14/2013
10/9/2015					
8/18/2015	8/18/2015	8/18/2015	8/18/2015	8/18/2015	8/22/2015
10/11/2015	10/11/2015	10/11/2015	10/11/2015	11/7/2015	10/11/2015
11/27/2015					
7/6/2015	9/2/2015	7/14/2015	9/6/2015	9/4/2015	9/2/2015
12/29/2014	12/29/2014	12/29/2014	1/25/2015	1/25/2015	1/25/2015
9/14/2015	9/14/2015	9/14/2015	9/18/2015	9/18/2015	9/18/2015
12/19/2015	12/19/2015	12/19/2015	12/19/2015	12/19/2015	12/19/2015
1/31/2013	11/17/2014	11/17/2014	11/17/2014	11/17/2014	11/17/2014
12/29/2014	1/3/2015	1/3/2015	1/4/2015	1/31/2015	1/31/2015
9/4/2015	11/9/2014	11/14/2014	9/4/2015	9/4/2015	9/4/2015

TA-M00041	TA-M00043	CB-M00044	CB-M00045	CB-M00046	CB-M00047
Conducting Behavioral Interviews	Welcome Program Overview	Coaching Basics Overview	Coaching Basics Overview	When to Coach	Coaching Basics in Performance Management
		1/24/2013		1/24/2013	
	8/9/2013	3/12/2015	12/11/2014	3/12/2015	12/13/2014
	11/5/2012	3/12/2015	11/5/2012	3/12/2015	3/15/2015
5/28/2015	11/6/2013	3/12/2015	7/15/2014	3/12/2015	7/15/2014
10/7/2014	10/6/2014	12/11/2014	12/13/2012	12/11/2014	11/6/2014
	8/22/2015		9/14/2015		11/15/2015
	11/7/2015				
5/28/2015					
5/28/2015	9/2/2015	6/9/2015	9/2/2015	6/9/2015	9/6/2015
	1/25/2015		1/25/2015		1/25/2015
	9/18/2015		9/18/2015		9/18/2015
5/28/2015		6/9/2015	1/20/2013	6/9/2015	
		6/9/2015	12/19/2015	6/9/2015	
5/28/2015	11/17/2014	6/9/2015	12/17/2012	6/9/2015	11/17/2014
	8/30/2015		12/21/2014		9/26/2015
	10/6/2015		10/15/2015		10/6/2015

CB-M00048	CB-M00049	CB-M00050	CB-M00051	OVERALL Course Completion	Overall Completion Date
Practice Coaching Basic Fundamentals	Practice Coaching Basic Fundamentals	Practice Coaching Basic Fundamentals	Reflections on Coaching Basics		
6/5/2013	6/5/2013	6/5/2013		14.29%	
				6.12%	
4/2/2015	4/2/2015	4/2/2015	12/13/2014	97.96%	
				6.12%	
4/2/2015	4/2/2015	4/2/2015	3/15/2015	97.96%	
				65.31%	
6/25/2015	6/25/2015	6/25/2015	7/16/2015	100.00%	7/16/2015
2/27/2013	2/27/2013	2/27/2013	11/10/2014	100.00%	12/11/2014
				26.53%	
			8/22/2015	85.71%	
				67.35%	
				38.78%	
6/25/2015	6/25/2015	6/25/2015	9/6/2015	100.00%	1/28/2016
				81.63%	
				40.82%	
				36.73%	
			10/6/2015	83.67%	
4/2/2015	4/2/2015	4/2/2015		69.39%	
				71.43%	
4/2/2015	4/2/2015	4/2/2015	11/17/2014	100.00%	6/9/2015
			9/26/2015	87.76%	
				8.16%	
				10.20%	
			10/6/2015	83.67%	

EXHIBIT H

FORM NLRB-31

SUBPOENA DUCES TECUM

UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

To Summer Valenti

As requested by Jedd Mendelson

whose address is One Newark Center Newark NJ
(Street) (City) (State) (ZIP)

YOU ARE HEREBY REQUIRED AND DIRECTED TO APPEAR BEFORE A Hearing Officer of the National Labor Relations Board

at 615 Chestnut Street, Suite 710

in the City of Philadelphia

on April 19, 2016 at 10 am or any adjourned

or rescheduled date to testify in SR-73 and Lakeside Avenue Operations LLC d/b/a PowerBack Rehabilitation, 113 South Route 73 Case 04-RC-161250
(Case Name and Number)

And you are hereby required to bring with you and produce at said time and place the following books, records, correspondence, and documents:

SEE ATTACHMENT

If you do not intend to comply with the subpoena, within 5 days (excluding intermediate Saturdays, Sundays, and holidays) after the date the subpoena is received, you must petition in writing to revoke the subpoena. Unless filed through the Board's E-Filing system, the petition to revoke must be received on or before the official closing time of the receiving office on the last day for filing. If filed through the Board's E-Filing system, it may be filed up to 11:59 pm in the local time zone of the receiving office on the last day for filing. Prior to a hearing, the petition to revoke should be filed with the Regional Director; during a hearing, it should be filed with the Hearing Officer or Administrative Law Judge conducting the hearing. See Board's Rules and Regulations, 29 C.F.R Section 102.31(b) (unfair labor practice proceedings) and/or 29 C.F.R. Section 102.66(c) (representation proceedings) and 29 C.F.R Section 102.111(a)(1) and 102.111(b)(3) (time computation). Failure to follow these rules may result in the loss of any ability to raise objections to the subpoena in court.

B-1-R7B3J9

Under the seal of the National Labor Relations Board, and by direction of the Board, this Subpoena is

Issued at Philadelphia, Pennsylvania

Dated: April 11, 2016

Chairman, National Labor Relations Board

NOTICE TO WITNESS. Witness fees for attendance, subsistence, and mileage under this subpoena are payable by the party at whose request the witness is subpoenaed. A witness appearing at the request of the General Counsel of the National Labor Relations Board shall submit this subpoena with the voucher when claiming reimbursement.

PRIVACY ACT STATEMENT

Solicitation of the information on this form is authorized by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* The principal use of the information is to assist the National Labor Relations Board (NLRB) in processing representation and/or unfair labor practice proceedings and related proceedings or litigation. The routine uses for the information are fully set forth in the Federal Register, 71 Fed. Reg. 74942-43 (Dec. 13, 2006). The NLRB will further explain these uses upon request. Disclosure of this information to the NLRB is mandatory in that failure to supply the information may cause the NLRB to seek enforcement of the subpoena in federal court.

ATTACHMENT TO SUBPOENA DUCES TECUM FOR SUMMER VALENTI SERVED BY POWERBACK VOORHEES ("Company")

Definitions:

- "Text Messages" includes but is not limited to: short message service ("SMS"), multimedia message service ("MMS"), iMessage and any other short messaging application.
- "Chat Messages" includes but is not limited to messages sent and/or received via: WhatsApp, Snapchat, Facebook Messenger, QQ Mobile, WeChat, Skype, Viber, LINE, Blackberry Messenger, or any other chat-type of messaging system used via mobile electronic devices.
- "Social Media" refers to any third-party online service provider, including but not limited to Facebook, MySpace, Google+, Twitter, Instagram, Picasa, Tumblr, LinkedIn, Monster, Blogger or any other social networking, career development, or news and commentary sites, services, blogs, or wikis.

Instructions:

- Searches for responsive documents stored in electronic data sources should be conducted across all potential sources of such information to locate non-duplicative content, including any backups made thereof, including those made to physical media (e.g., iTunes backups to a computer or to Apple's Time Capsule, or other external hard drive media) or to the "cloud" (e.g., iCloud, or Amazon Cloud).
- Searches for responsive documents stored within a cellular mobile device **should be conducted by a certified forensic examiner** after making a reasonable effort to complete a full forensic physical image of the device, including but not limited to collection of any SQLite databases contained therein.
- We request that you meet and confer with us regarding the scope of searches to be run in an effort to locate responsive documents stored in any electronic data source.
- Subject to your good faith cooperation with searches for responsive documents and an agreement on a reputable neutral vendor to create forensic images of data sources described herein, **the Company will cover the costs of forensic collection, search, and processing of responsive documents incurred by a neutral vendor**.
- To the extent you contend that responding to any of these requests would be unduly burdensome, we request that you contact us immediately to meet and confer in good faith in an effort to address such burdens.

Document Requests for Subpoena:

1. Produce all Text Messages and Chats that include any Care Manager or Clinical Director concerning the effort to unionize the nurses at the Powerback site in Voorhees, New Jersey (including but not limited to organizing, the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015.

2. Produce all Text Messages and Chats that reference activity by any Care Manager or Clinical Director in connection with the effort to unionize the nurses at the Powerback site in Voorhees,

New Jersey (including but not limited to organizing, the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015.

Electronically stored information ("ESI") responsive to request nos. 1 and 2 should be produced in native format or as Microsoft Excel files, with attachments included, and the following associated metadata provided in Concordance delimited load files along with extracted text:

- FOR TEXT MESSAGES AND CHATS
  - MESSAGE FROM
  - MESSAGE TO
  - MESSAGE CC
  - MESSAGE DATE/TIME SENT
  - MESSAGE DATE/TIME SENT OFFSET
  - MESSAGE DATE/TIME RECEIVED
  - MESSAGE DATE/TIME RECEIVED OFFSET
  - MESSAGE ATTACHMENT COUNT
  - MESSAGE ATTACHMENT NAMES
  - MESSAGE HAS ATTACHMENTS
  - TIME ZONE OFFSET
  - FILE AUTHOR
  - FILE DATE CREATED
  - FILE DATE CREATED OFFSET
  - FILE NAME
  - FILE SIZE
  - FILE EXTENSION
  - MD5 HASH
  - LINK TO NATIVE FILE
  - LINK TO EXTRACTED TEXT

The Concordance .DAT file should contain the following delimiters:

Field Separator	¶	(ASCII:0020)
Quote	þ	(ASCII:0254)
Multi-Entry Delimiter	;	(ASCII:0059)
<Return> Value in Data	®	(ASCII:0174)

For documents that are produced directly from electronic format, the full extracted text should be provided by a link in the main (.DAT) load file.

3. Produce all social media content, including but not limited to communications, posts, writings, comments, entries, electronic contributions, and/or text drafted within or for purposes of submitting to or received via any social media site, as well as any attachments, photos, graphic interchange format ("GIF") images, or videos saved to social media, referencing activity by any Care Manager or Clinical Director in connection with the effort to unionize the nurses at the Powerback site in Voorhees, New Jersey (including but not limited to organizing, the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015.

4. Produce all social media content, including but not limited to communications, posts, writings, comments, entries, electronic contributions, and/or text drafted within or for purposes of submitting to or received via any social media site, as well as any attachments, photos, graphic interchange format ("GIF") images, or videos saved to social media, concerning the effort to unionize the nurses at the Powerback site in Voorhees, New Jersey (including but not limited to organizing, the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015 and which indicates that such content was intended for or accessed by any Care Manager or Clinical Director (including but not limited to any indication that a Care Manager or Clinical Director replied to, "liked", or otherwise acknowledged the content).

ESI responsive to request nos. 3 and 4 should be produced in native format or as TIFF image files (black-and-white) and as JPEG image files (color) with attachments included, and the following associated metadata provided in Concordance delimited load files along with extracted text:

- FOR SOCIAL MEDIA
  - MESSAGE FROM
  - MESSAGE TO
  - MESSAGE CC
  - MESSAGE SUBJECT
  - MESSAGE DATE/TIME SENT
  - MESSAGE DATE/TIME SENT OFFSET
  - MESSAGE DATE/TIME RECEIVED
  - MESSAGE DATE/TIME RECEIVED OFFSET
  - MESSAGE ATTACHMENT COUNT
  - MESSAGE ATTACHMENT NAMES
  - MESSAGE HAS ATTACHMENTS
  - TIME ZONE OFFSET
  - FILE AUTHOR
  - FILE DATE CREATED
  - FILE DATE CREATED OFFSET
  - FILE NAME
  - FILE SIZE
  - FILE EXTENSION
  - ORIGINAL FOLDER NAME
  - PAGE COUNT
  - MD5 HASH
  - LINK TO NATIVE FILE
  - LINK TO EXTRACTED TEXT

The Concordance .DAT file should contain the following delimiters:

Field Separator	¶	(ASCII:0020)
Quote	þ	(ASCII:0254)
Multi-Entry Delimiter	;	(ASCII:0059)
<Return> Value in Data	®	(ASCII:0174)

For documents that are produced directly from electronic format, the full extracted text should be provided by a link in the main (.DAT) load file.

The TIFF images should be produced as single-page Group IV TIFF format with an Opticon image load file. The Opticon image load file should contain the BEGBATES value for each corresponding document and appropriate path or folder information to the corresponding images that comprise each document.

EXHIBIT I

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73, Respondent, and DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME, AFL-CIO, Petitioner	Case: 04-RC-161250 **CERTIFICATE OF SERVICE**

Jedd Mendelson, Esq. certifies as follows:

1. On April 11, 2016, I handed a subpoena *duces tecum* to Summer Valenti at the PowerBack facility in Voorhees, New Jersey. That subpoena *duces tecum* stated that it was returnable April 19, 2016; however, I advised Ms. Valenti that it was very likely that I would not be calling her as a witness on that date and that I would be in touch with respect to when I would call her as a witness. Additionally, on April 11, the attachment to the subpoena *duces tecum* setting forth the documents that the Employer was seeking was not ready and, therefore, not attached to the subpoena. That day I explained to Ms. Valenti what documents I was seeking; on April 15, 2016, I forwarded Ms. Valenti the attachment to the subpoena by email. On April 18, 2016, Ms. Valenti forwarded the facility's Administrator, Natalie Battista, an email stating that Ms. Valenti would not comply with the subpoena. In that email, Ms. Valenti acknowledged receipt of the attachment that I had forwarded to her on April 15.

EXHIBIT NO. E27 RECEIVED ✓ REJECTED ___
CASE NO. 04-RC-161250 CASE NAME PowerBack
NO. OF PAGES ___ DATE 5/5/16 REPORTER JS

ER 27

2. I certify that the statements set forth above are true. I am aware that if any statements made by me are willfully false, I am subject to punishment.

/s/ Jedd Mendelson
Jedd Mendelson, Esq.
Littler Mendelson, PC
One Newark Center, 8th Floor
Newark, New Jersey 07102

Date: May 2, 2016

Firmwide:140230279.1 050738.1217

EXHIBIT J

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73, Respondent, and DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME, AFL-CIO, Petitioner	Case: 04-RC-161250

MOTION TO REOPEN THE RECORD OR FOR RECONSIDERATION OF THE ACTING REGIONAL DIRECTOR'S MAY 2, 2016 REFUSAL TO ENFORCE THE COMPANY'S SUBPOENA OF SUMMER VALENTI

Sr-73 and Lakeside Avenue Operations LLC d/b/a Powerback Rehabilitation, 113 South Route 73 ("Company") files this motion to reopen the record or for reconsideration of the Acting Regional Director's May 2, 2016 refusal to enforce the Company's subpoena served upon Clinical Director Summer Valenti ("Valenti"). The grounds for the motion are as set forth below. The Company also files Certifications of Jedd Mendelson, Esq. ("Company counsel") and Natalie Battista in support of the instant motion.

1. At the conclusion of the objections hearing held on May 2, 2016, the Hearing Officer informed the parties that the Acting Regional Director was denying the Company's request that the Region enforce the subpoena served upon Valenti on the ground that the Company had failed to prove that it had validly served Valenti.

2. The Company is filing the instant motion as promptly as possible following the above-referenced ruling. Among other things, Company counsel needed to examine the rule

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upon which the Acting Regional Director relied and review case law thereunder. Moreover, Company counsel had a previously-scheduled business trip to the western United States that, coupled with the need to research the matter in issue, rendered this morning the earliest that the Company could file the instant motion.

3. The basis for the Acting Regional Director's ruling was that service of the subpoena was improper under Rule 5(b)(2)(E), Fed.R.Civ.P., because the Company served the rider to the subpoena by email and nothing in the Certificate of Service that the Company provided to the Region indicated that Valenti had consented in writing to service by email.

4. The Acting Regional Director's ruling is defective because it fails to account for the fact that **Valenti initiated electronic communication with Company counsel in connection with this case and the subpoena in issue and in doing so indicated in writing that Company counsel should write Valenti at her work email address with regard to the subpoena in issue, which is the email address to which Company counsel forwarded the rider to the subpoena**. Company counsel did not previously relate the facts bearing on these points in his Certificate of Service because his Certificate of Service clearly established proof of service in fact. Since the Acting Regional Director's ruling was predicated upon a principle going beyond the question of whether in fact Valenti had received the rider to the subpoena, Company counsel now provides the relevant facts. The Acting Regional Director should recognize that the Region's reliance upon Rule 5(b)(2)(E) is, in view of these facts, incorrect and deficient and prejudicial to the Company.

5. On both November 5, 2015 and November 10, 2015, Valenti initiated contact with Company counsel by text message concerning this case. On Tuesday, April 12, 2016, Valenti again initiated contact with Company counsel by text message with respect to Company counsel's preparation for the instant hearing and Valenti's anticipated testimony herein pursuant

to subpoena. Valenti forwarded Company counsel a text message from eligible voter Marilyn Valenti and, in relevant part, stated the following: "This is Summer. I received this text from Marilyn and these are the other recipients." On Wednesday, April 13, 2016, Valenti again contacted Company counsel by text message in connection with the above-referenced subpoena. She stated the following:

> (1/2) When I asked for time off to attend court, Natalie indicated that Tuesday April 19 might not be a firm date. I have to schedule an appointment next week a (2/2) nd want to make sure I don't create a conflict. If Tuesday is not firm, can you confirm which days are available?

In response, not recognizing her cell phone number and having subpoenaed other individuals, I wrote back by text "Who is this?" She responded "Summer. Sorry, I thought you had my number since we texted yesterday." I then suggested that she schedule her appointment for Tuesday, April 19 if that opportunity was available to her and she remarked "Yes", which I took to indicate that she would do so.

6. Later that same day (Wednesday, April 13), Valenti texted me again and wrote as follows: "This is Summer. Can you call please call me? I have a question about the search on my phone. *can you pease call me?" Valenti followed up the above text message by texting me another message in which Valenti typed her work email address: summer.Valenti@genesishcc.com ("work email address).

7. On Friday, April 15, 2016, I forwarded the rider to the subpoena to Valenti's work email address, the **very email address to which she had invited me to write her on April 13** as noted in Paragraph 6 above.

8. The email address at which I wrote Valenti on Friday, April 15 was the work email address on and from which Valenti conducts Company-related business. Moreover, when I forwarded the rider to Valenti at that work email address, she and I were engaged in Company-

related business. The accompanying Affidavit of Natalie Battista, the Administrator at the Powerback Voorhees facility, confirms that Valenti routinely conducts Company business on and from the work email address to which I forwarded the rider to the subpoena.

9. The above paragraphs indicate that Valenti **invited me in writing**, as Company counsel, to communicate with her at her work email address about the Company subpoena.

10. In circumstances such as this, the conduct of the recipient of legal process establishes written consent and satisfies the requirements of Rule 5(b)(2)(E), Fed.R.Civ.P. *See Albertson v. Winner Automotive, et al.*, 2004 WL 2435290 at * 4 (D. Del. October 27, 2004)(copy appended). *See also AJ Services Joint Venture I, L.L.P.*, 2013 WL 6731857 n. 2 (December 20, 2013)(rejecting the fact that an employer responded to a subpoena by email as a basis for refusing to enforce it).

11. For these reasons, as well as those stated in the Certificate of Service filed with the Region on May 2, 2016, the Acting Regional Director should reopen the record and/or reconsider and vacate his May 2, 2016 ruling and now rule that the Region will enforce the subpoena.

Respectfully submitted,

/s/Jedd Mendelson
Jedd Mendelson
Littler Mendelson, P.C.
One Newark Center
Newark, New Jersey 07102

Dated: May 5, 2016

EXHIBIT K

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73, Respondent, and DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME, AFL-CIO, Petitioner	Case: 04-RC-161250 Certification of Jedd Mendelson, Esq.

Jedd Mendelson certifies as follows:

1. I am the attorney for SR-73 and Lakeside Avenue Operations, LLC d/b/a Powerback Rehabilitation, 113 South Route 73 ("Company") in this case. I make this Certification in support of the Company's motion for reconsideration of the Acting Regional Director's May 2, 2016 ruling.

2. I certify that the statements of fact set forth in the accompanying Motion for Reconsideration are true and correct. I have included the quoted text messages that are set forth in the accompanying Motion after personally reviewing text messages that are on my iPhone.

I certify under penalty of perjury that the foregoing is true and correct.

Executed on May 5, 2016

/s/Jedd Mendelson
Jedd Mendelson
Littler Mendelson, P.C.
One Newark Center
Newark, New Jersey 07102

Firmwide:140292623.1 050738.1217

EXHIBIT L

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73, Respondent, and DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME, AFL-CIO, Petitioner	Case: 04-RC-161250 Certification of Natalie Battista

Natalie Battista certifies, in accordance with 28 U.S.C. § 1746, as follows:

1. I am the Administrator for the Powerback Rehabilitation facility located in Voorhees, New Jersey.

2. Summer Valenti is a Clinical Director at the Powerback Voorhees site. I have worked with her since I became the Administrator at the site in September 2015. Her work email address is Summer.Valenti@genesishcc.com ("work email address").

3. In the regular course of performing my duties, I have forwarded emails to Summer Valenti at her work email address and received emails from Summer Valenti from her work email address. In the regular course of performing my duties, other personnel at the site have informed me that they forwarded emails to Summer Valenti with regard to Company-related business at her work email address and received emails from Summer Valenti with regard to Company-related business from her work email address.

EC 30

I certify under penalty of perjury that the foregoing is true and correct.

Executed on May 5, 2016

Natalie Battista

Firmwide:140292630.1 050738.1217

EXHIBIT M

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 4

SR-73 AND LAKESIDE AVENUE OPERATIONS
LLC D/B/A POWERBACK REHABILITATION,
113 SOUTH ROUTE 73

Employer

and Case 4-RC-161250

DISTRICT 1199C, NATIONAL UNION OF HOSPITAL
AND HEALTHCARE EMPLOYEES, AFSCME, AFL-CIO

Petitioner

HEARING OFFICER'S REPORT ON OBJECTIONS

I. Summary

On November 4, 2015 an agent of Region 04 conducted an election among certain employees of the Employer. A majority of employees casting ballots in the election voted in favor of representation by the Union. However, the Employer contests the results of the election claiming that its own supervisors and managers engaged in conduct warranting setting aside the election and conducting a new election.[1] Specifically, the Employer contends that during the critical period, supervisors and/or managers interfered with employee free choice by soliciting Union authorization cards and by promoting the Union such that they were conveying to voters that they should vote for the Union in the election.

After conducting the hearing and carefully reviewing the evidence as well as arguments made by the parties, I conclude that the Employer has failed to prove that Care Managers involved in the alleged objectionable conduct are supervisors within the meaning of Section 2(11) of the Act, therefore I conclude the conduct alleged, even if true, cannot be grounds to overturn the election. I also find that even if the Care Managers were statutory supervisors, the conduct they engaged in, along with the conduct of Clinical Director Summer Valenti, does not warrant setting aside the election. I further conclude that the objections should be overruled because the evidence is insufficient to show that the conduct engaged in by the individuals

[1] The Employer failed to present any evidence in support of its Objections #3 and #4, and I therefore overrule these Objections.

involved in the alleged objectionable conduct coerced employees in the exercise of their free choice rendering a free election impossible.

After recounting the procedural history, I provide an overview of the Board standard for setting aside elections. I then discuss the Employer's operation. Next I provide description of the parties' burdens with regard to establishing supervisory status. Finally, I provide my analysis and recommendations regarding the supervisory status and the Employer's election objections.

II. PROCEDURAL HISTORY

The Petitioner filed the petition on October 2, 2015. The parties agreed to the terms of an election and the Region approved their agreement on October 19, 2015. The election was held on November 4, 2015. The employees in the following unit voted on whether they wished to be represented by the Petitioner:

COMBINED UNIT A and B:

INCLUDED: All full-time and regular part-time Staff/Bedside Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) employed by the Employer at its facility located at 113 South Route 73, Voorhees, New Jersey employed by the Employer at its facility located at 113 South Route 73, Voorhees, New Jersey.

EXCLUDED: All other employees, Office Clerical Employees, Clinical Directors, Care Managers, Health Unit Coordinators (HUCS), Clinical Reimbursement Coordinators, Clinical Reimbursement Analysts, Nurse Practice Educator, Managerial Employees, Guards and Supervisors as defined in the Act.

VOTING GROUP - UNIT A (PROFESSIONAL UNIT):

INCLUDED: All full-time and regular part-time Staff/Bedside Registered Nurses (RNs) employed by the Employer at its facility located at 113 South Route 73, Voorhees, New Jersey.

EXCLUDED: All other employees, Licensed Practical Nurses (LPNs), Office Clerical Employees, Clinical Directors, Care Managers, Health Unit Coordinators (HUCS), Clinical Reimbursement Coordinators, Clinical Reimbursement Analysts, Nurse Practice Educator, Managerial Employees, Guards and Supervisors as defined in the Act.

VOTING GROUP - UNIT B (NON-PROFESSIONAL UNIT):

INCLUDED: All full-time and regular part-time Licensed Practical Nurses (LPNs) employed by the Employer at its facility located at 113 South Route 73, Voorhees, New Jersey.

EXCLUDED: All other employees, Staff/Bedside Registered Nurses (RNs), Office Clerical Employees, Health Unit Coordinators (HUCS), Clinical Reimbursement Coordinators, Clinical

Reimbursement Analysts, Nurse Practice Educator, Care Managers, Clinical Directors, Managerial Employees, Guards and Supervisors as defined in the Act.

A majority of professional employees in Voting Group A indicated a desire to be included in the same unit with the non-professional employees in Voting Group B, and the ballots of the two Groups were aggregated for purposes of determining the results of the election in a single unit. Sixteen of the employees in the combined unit voted in favor of represtation by Petitioner. Fourteen employees voted against representation. There were two determinative challenged ballots. On November 11, 2015 the Employer timely filed Objections to the Election.

On November 18, 2015, the Acting Regional Director for Region 4 issued an Order directing a hearing to resolve the eligibility of the two challenged voters — Tazya Wilkes and Angela Lee. The Order indicated that the Objections filed by the parties would be held in abeyance pending the outcome of the challenged ballot hearing. A hearing on challenged ballots was held on November 25, 2015, before Hearing Officer Deena Kobell. At the hearing, the parties agreed that one of the challenged voters — Wilkes — was eligible and that her ballot would be counted if it remained determinative following the resolution of the remaining challenge to the ballot of Angela Lee. Hearing Officer Kobell issued her Report on December 17, 2015, recommending that the challenge to Angela Lee's ballot be sustained on the basis that she did not begin performing bargaining unit work until after the October 10, 2015 eligibility cut-off date. The Employer filed Exceptions to the Hearing Officer's Report. On January 11, 2016, the Acting Regional Director issued his Decision on Challenged Ballot affirming the Hearing Officer's rulings at the hearing and adopting her recommendations. The Employer filed a Request for Review of the Acting Regional Director's Decision on Challenged Ballot. On March 29, 2016, the Board denied the Employer's Request for Review.

A Revised Tally of Ballots issued on March 29, 2016 indicating 16 votes in favor of union representation, 14 votes against representation and 1 non-determinative challenged ballot. Thus, a majority of the valid ballots were cast in favor of representation by the Petitioner.

The Acting Regional Director for Region 4 issued an Order on April 6, 2016 directing that a hearing be conducted to give the parties an opportunity to present evidence regarding the Objections filed by the Employer on November 11, 2015. As the hearing officer designated to conduct the hearing and to recommend whether the Employer's Objections are warranted, I heard testimony and received into evidence relevant documents on April 19 and 20 and May 2 and 9, 2016. The parties presented oral argument in support of their respective positions on the final day of the Hearing.

III. THE BURDEN OF PROOF AND THE BOARD'S STANDARD FOR SETING ASIDE THE ELECITONS

It is well settled that "[r]epresentation elections are not lightly set aside. There is a strong presumption that ballots cast under specific NLRB procedural safeguards reflect the true desires of the employees." *Lockheed Martin Skunk Works*, 331 NLRB 852, 854 (2000), quoting *NLRB v. Hood Furniture Co.*, 941 F.2d 325, 328 (5th Cir. 1991) (internal citation omitted). Therefore, "the burden of proof on parties seeking to have a Board-supervised election set aside is a heavy

one." *Delta Brands, Inc.*, 344 NLRB 252, 253, (2005), citing *Kux Mfg. Co. v. NLRB*, 890 F.2d 804, 808 (6th Cir. 1989). To prevail, the objecting party must establish facts raising a "reasonable doubt as to the fairness and validity of the election." *Patient Care of Pennsylvania*, 360 NLRB No. 76 (2014), citing *Polymers, Inc.*, 174 NLRB 282, 282 (1969), enfd. 414 F.2d 999 (2d Cir. 1969), cert. denied 396 U.S. 1010 (1970). Moreover, to meet its burden the objecting party must show that the conduct in question affected employees in the voting unit. *Avante at Boca Raton*, 323 NLRB 555, 560 (1997) (overruling employer's objection where no evidence that unit employees knew of the alleged coercive incident).

In determining whether to set aside an election, the Board applies an objective test. The test is whether the conduct of a party has "the tendency to interfere with employees' freedom of choice." *Cambridge Tool Pearson Education, Inc.*, 316 NLRB 716 (1995). Thus, under the Board's test the issue is not whether a party's conduct in fact coerced employees, but whether the party's misconduct reasonably tended to interfere with the employees' free and uncoerced choice in the election. *Baja's Place*, 268 NLRB 868 (1984). See also, *Pearson Education, Inc.*, 336 NLRB 979, 983 (2001), citing *Amalgamated Clothing Workers v. NLRB*, 441 F.2d 1027, 1031 (D.C. Cir. 1970).

In determining whether a party's conduct has the tendency to interfere with employee free choice, the Board considers a number of factors: (1) the number of incidents; (2) the severity of the incidents and whether they were likely to cause fear among employees in the voting unit; (3) the number of employees in the voting unit who were subjected to the misconduct; (4) the proximity of the misconduct to the date of the election; (5) the degree to which the misconduct persists in the minds of employees in the voting unit; (6) the extent of dissemination of the misconduct to employees who were not subjected to the misconduct but who are in the voting unit; (7) the effect (if any) of any misconduct by the non-objecting party to cancel out the effects of the misconduct alleged in the objection; (8) the closeness of the vote; and (9) the degree to which the misconduct can be attributed to the party against whom objections are filed. *Taylor Wharton Division*, 336 NLRB 157, 158 (2001), citing *Avis Rent-a-Car*, 280 NLRB 580, 581 (1986).

IV. THE EMPLOYER'S OPERATION

The Employer runs a 124-bed short-stay acute rehabilitation center (herein, the Center) located in Voorhees, New Jersey.[2i] Patients come to the Center from the hospital when they are not ready to go home. The Center receives patients needing cardiac, orthopedic and respiratory care as well as those involved in motor vehicle and motorcycle accidents. Patients range in age from 18 – 100. The Center occupies a three story building. The first floor contains administrative offices, a rehabilitative area for occupational and physical therapy, and a kitchen. The second and third floors are mirror images of one another and each floor serves 62, patients all in private rooms. Each floor has two hallways designated by letter. Floor 2 has hallways A & B, and floor 3 has hallways C & D. The average patient stay at the Center is 16 – 19 days. The Center Nurse Executive (CNE) is responsible for all clinical and certain financial matters at the Center.

[2] Transcript and exhibit citations are to the record of the Objections Hearing in this matter. "T" designates the transcript page number; "PX" designates a Petitioner exhibit, "ERX" designates an Employer exhibit, and "BDX" designates an exhibit of Region 4 of the NLRB.

Reporting to the CNE are the Clinical Directors (CDs) who are salaried employees who work eight hour shifts. Typically there are two CDs on staff for each shift, except overnight, when there is one. It is undisputed that the CDs are supervisors within the meaning of Section 2(11) of the Act. Beneath the CDs are Care Managers (CMs), who work 12-hour shifts and must be RNs. Their shifts are from 7:00 a.m. – 7:30 p.m., or 7:00 p.m. – 7:30 a.m., with the shift overlapping by half an hour on each end for purposes of continuity of care. CMs are paid by the hour. Beneath the CMs are the "cart nurses," also referred to as "floor nurses" who may be either RNs or LPNs, and who work the same 12-hour shifts as the CMs. Beneath the cart nurses are the CNAs, who work 8-hour shifts from 7:00 a.m. – 3:00 p.m., 3:00 p.m. – 11:00 p.m. and 11:00 p.m. – 7:00 a.m. There is also one Health Unit Coordinator (HUC) on duty per 12-hour shift. The HUC is an LPN who performs clerk duties, such as scheduling appointments and entering information into the computer. There is also a CNA who serves as a scheduling coordinator and works weekdays from 9:00 a.m. – 5:00 p.m.

V. THE EMPLOYER'S OBJECTIONS AND MY RECOMMENDATIONS

The order directing hearing in this matter instructs me to resolve the credibility of witnesses testifying at the hearing and to make findings of fact. Unless otherwise specified, my summary of the record evidence is a composite of the testimony of all witnesses, including in particular testimony by witnesses that is consistent with one another, with documentary evidence, or with undisputed evidence, as well as testimony that is uncontested. Omitted testimony or evidence is either irrelevant or cumulative. Credibility resolutions are based on my observations of the testimony and demeanor of witnesses and are more fully discussed within the context of the objection related to the witnesses' testimony.

Objection 1: During the critical period, supervisors and/or managers created a coercive atmosphere and/or interfered with employee free choice by soliciting Union authorization cards and /or creating the impression that they had solicited or were soliciting Union authorization cards.

Objection 2: During the critical period, supervisors and/or managers created a coercive atmosphere and/or interfered with employee free choice by promoting the Union and/or creating the impression that they favored the Union, conveying to voters that they should support the Union and vote for it in the election.

A threshold issue is whether the individuals allegedly engaged in the objectionable conduct were supervisors under the Act at the time the alleged conduct occurred. The two classifications of employees involved in the Employer's objections are Care Manager (CM) and Clinical Director (CD). As noted above, it is undisputed that CDs are supervisors under the Act. I will therefore address the supervisory status of the CMs, as well as the alleged objectionable conduct by the CMs and CDs.

Supervisors are specifically excluded from coverage under the National Labor Relations Act. The burden of establishing supervisory status is on the party asserting that such status exists. *NLRB v. Kentucky River Community Care, Inc*., 532 U.S. 706, 711 (2001); *Shaw Inc*., 350 NLRB 354, 355 (2007); *Croft Metals, Inc.*, 348 NLRB 717, 721 (2006). The party seeking to

prove supervisory status must establish it by a preponderance of the evidence. *Croft Metals, Inc.*, supra; *Oakwood Healthcare, Inc.*, 348 NLRB 686 (2006). Section 2(11) of the Act sets forth a three-part test for determining whether an individual is a supervisor. Pursuant to this test, employees are statutory supervisors if: (1) they hold the authority to engage in any one of the 12 supervisory functions listed in Section 2(11); (2) their exercise of such authority is not of a merely routine or clerical nature but requires the use of independent judgment; and (3) their authority is held in the interest of the employer. See *NLRB v. Kentucky River*, supra at 712-713; *NLRB v. Health Care & Retirement Corp. of America*, 511 U.S. 571, 573-574 (1994).

The statutory criteria for supervisory status set forth in Section 2(11) are read in the disjunctive, and possession of any one of the indicia listed is sufficient to make an individual a supervisor. *NLRB v. Kentucky River*, supra at 713; *Shaw, Inc.*, supra at 355 (2007). The Board analyzes each case in order to differentiate between the exercise of independent judgment and the giving of routine instructions; between effective recommendation and forceful suggestions; and between the appearance of supervision and supervision in fact. The exercise of some supervisory authority in a merely routine, clerical, or perfunctory manner does not confer supervisory status on an employee. See *Oakwood Healthcare, Inc*., supra at 693 (2006); *J.C. Brock Corp*., 314 NLRB 157, 158 (1994). The authority effectively to recommend an action means that the recommended action is taken without independent investigation by supervisors, not simply that the recommendation is ultimately followed. See *DirectTV US*, 357 NLRB No. 149, slip op. at 3 (2011); *Children's Farm Home*, 324 NLRB 61 (1997). The Board has an obligation not to construe the statutory language too broadly because the individual found to be a supervisor is denied the employee rights that are protected under the Act. *Avante at Wilson, Inc*., 348 NLRB 1056, 1057 (2006); *Oakwood Healthcare, Inc*., supra at 687 (2006). Lack of evidence is construed against the party asserting supervisory status. *Dean & Deluca New York, Inc.*, 338 NLRB 1046, 1048 (2003). Where the evidence is in conflict or otherwise inconclusive on particular indicia of supervisory authority, the Board will find that supervisory status has not been established, at least on the basis of those indicia. *Veolia Transportation Services*, 363 NLRB No. 98, slip op. at 7 (2016); *G4S Regulated Security Solutions*, 358 NLRB No. 160, slip op. at 1 (2012); *Dole Fresh Vegetables, Inc*., 339 NLRB 785, 792 (2003). Finally, the sporadic exercise of supervisory authority is not sufficient to transform an employee into a supervisor. See *Shaw, Inc.*, supra at 357, fn. 21; *Oakwood Healthcare, Inc*., supra at 693; *Kanawha Stone Co*., 334 NLRB 235, 237 (2001).

1. RECORD EVIDENCE REGARDING SUPERVISORY STATUS

The highest level nurse at the Center is the CNE. At the time the representation petition was filed, Patricia Melora was the CNE at the Center. She was the sole managerial employee to testify at the proceeding and provided much of the testimony concerning the operational aspects of the Center. Melora ceased to be the CNE sometime in mid-October 2015 and was no longer regularly at the Center in the weeks prior to the November 4, 2015 election. Melora was replaced by Denise Johnson. Natalie Batista began working at Powerback as Executive Director at the end of September 2015.

Beneath the CNE are the CDs. There are two CDs per shift on day and evening shift, one per shift on night shift, except on weekend night shift when sometimes there is none, due to staffing issues. A review of the job description for the CD, which the Employer put into

evidence, shows that the CD participates in staff recruitment, assesses the work performance of nursing staff, implements Individual Performance Improvement Plans (IPIP) for staff whose performance does not meet Center expectations, and when necessary, recommends or initiates disciplinary action. (EX 3). The CD is further expected to ensure patient care assignments are consistent with staff competencies, scope of practice and the needs of the patients, and ensure complete and prompt reporting of incidents, accidents, and adverse events to Administrator and Director of Nursing. (EX 3 Section 2.3, 2.17)

Beneath the CDs are the CMs, who work three days a week in 12-hour shifts, 7:00 a.m. – 7:30 p.m. and 7:00 p.m. – 7:30 a.m.[3] Melora described the CM role as two-fold; nurses can come to the CM and the CM can check on nurse, all for the purpose of patient care. CM Rachel Upshur views her role as a CM as a "go-between" the cart nurses and the physician on call, as well as a resource for cart nurses to help them find an answer to clinical questions. CM McCarthy similarly described the CM role as being a "resource."

The Employer placed the CM job description into evidence.[4] (ERX 4). The document shows the CMs have seven administrative/organizational responsibilities. These include participating in the hiring process as requested, completing evaluations of his/her team members in collaboration with the Clinical Director and organizing and coordinating staff to maximize patient care. Task 1.3 listed on the CM job description specifically requires CMs to identify staffing needs for the next shift and communicate such to the Staffing Coordinator, Administrative Manager (evenings, nights and weekends) and Clinical Director.

Beneath the CMs are "cart nurses," also referred to as "floor nurses" who provide direct nursing care to patients. Cart nurses provide medication to patients, make sure treatments are performed, conduct assessments, and monitor patients during their 12-hour shifts.[5] Beneath the cart nurses are the CNAs who provide less skilled routine patient care. There are eight cart nurses per shift (four per floor, or two per hallway) and 12 CNAs per eight hour shift for day and evening shift, (six per floor, or three per hallway) but only eight CNAs on the night shift (four per floor, two per hallway). Each cart nurse is responsible for 15 – 16 patients. On each shift a CM is responsible for about 30 patients, unless there is only one CM on duty, in which case the CM on duty is responsible for about 60 patients.

At the beginning of her shift, a CM will receive "report" from the outgoing CM or CD on duty.[6] The CM then typically checks on admissions, and enters Doctors' orders and discharge orders in the computer. At the end of their shift, CMs give report to the incoming staff. CMs punch a time clock, as do cart nurses.

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[3] The 12-hour shifts overlap by half an hour to allow for continuity of patient care.

[4] I did not rely on the Powerback Center Standards placed into evidence by the Employer based on testimony that the document was not distributed to employees, as well as Counsel for the Employer's explanation that the document represents the Employer's idea of how it endeavors to have the Center function, not the everyday activity which actually occurs. (T. 398, 399, ER X 7)

[5] This does not include LPNs, who in certain situations are prohibited by their nursing licenses from assessing patients.

[6] "Report" is when the outgoing nursing staff provides updated patient care information incoming nursing staff. The process typically takes 30 minutes.

The CMs are responsible for making sure that all appropriate cart nurses and CNAs are present and where they are assigned to be. The CMs are responsible for making sure the clerical work is completed. The CMs are also responsible for making sure the cart nurses distribute their medications properly. CM McCarthy testified she needs to figure out if the cart nurses need any help from her. Such help typically consists of assisting nurses to assess patients, and if needed. contacting a doctor to find out what to do next. McCarthy stressed she is responsible for a lot of coordinating. One thing she coordinates is the work of the HUC. If the HUC is too busy with clerical work to perform the task of making time sensitive medical appointments, McCarthy has asked her to switch to making appointments. Making appointments is, however, already one of the duties the HUC performs as part of her regular assignment.

Direction

The CMs generally know what needs to be done by the staff on their shift based on their experience as nurses and by following standard protocol for what steps to take when a patient presents with a certain status. Many of the things the CMs do are done a certain way based on what nurses are legally permitted to do. If there is a medical question and the Doctor doesn't respond timely, for example, CM McCarthy will call the medical director. McCarthy testified that there was never an incident in which she gave direction to her team without medical professional input.

The role of the CMs in directing staff during a patient health crisis was the subject of much testimony. Kelly Stevens, an RN cart nurse at the Center, testified that when there is a health crisis the cart nurses get the CM, and the CM assesses the patient, checks the medical orders, and then contacts the physician. Stevens testified, however, that she did not consider directions from CMs in crisis situations to be "orders" but rather the CMs using the skills they have all been taught. Similarly, CM McCarthy testified that when there is a crisis, such as when someone codes, the CM takes notes to give to the EMT, but this is not a CM responsibility per se, but a nursing responsibility. CM Lake testified she directs staff in a health crisis situation, but she also acknowledged that any cart nurse can run a code. Melora testified that during a crisis the CMs determine that somebody has to take charge, but also testified that any RN can run a code and direct people what to do. In contrast, according to CM Rachel Upshur, the CM never takes charge during a code because the nurse of the patient does so because she knows the patient better. Any RN can assess a patient after a code and organize staff, and Powerback has protocols for such situations.

CMs receive instructions from doctors which they pass on to the cart nurses. There was testimony that not everything a CM tells to the staff nurse after consulting with a Doctor is prescribed by the Doctor. Nurses can give a "nursing order" under the scope of their care, including, for example instructing a CNA to turn a patient more frequently than the standard two hour period based on their nursing skill and assessment. No specific testimony was provided as to how often this occurred, or what criteria the CMs used to give such an instruction to the CNA. CMs and cart nurses alike can both decide on their own to administer medicine within the one hour before or after range provided by a Doctor's orders. Melora pointed out that novice nurses

do not always do things on a "functional basis" and it's the CM's job to educate new nurses to look at the whole picture.

The role of the CM in documenting cases of adverse instances was also the subject of much testimony.[7] The Center uses a risk management system (RMS) to create an incident report whenever there is an adverse outcome, such as a patient fall. Cart nurses generally initiate the report, while the CM makes sure that the form is completed. Once the form is completed, it is handed to the CM. The RMS report gets completed during the shift the incident occurs. While the nurse who discovers the incident is supposed to complete the form, often the CMs do because the cart nurses are so busy. CM McCarthy testified that CMs decide who will fill out various sections of an incident report, but the form itself tells you what to write.

Doctors may order a patient's weights be monitored, a task performed by CNAs. Every night there is a "weight list" generated by the CD which is given by the CD to the CNAs at about 6:00 a.m. If there's no CD overnight, the CM will print out the weight list by looking in a book which lists patients' weights each day. The CNAs know how to take weights as part of their training.

The CMs are not evaluated on or otherwise held responsible for the work of cart nurses or CNAs. The CMs each testified that during their tenure as a CM they had not received an evaluation at all. CM Lake was the only CM to testify that she was ever contacted by her management in regard to work performed by employees working on her shift. On one occasion, she was contacted by her CD because the CD was investigating why a patient had not been given proper fluids, as had been ordered by the medical director. Lake looked into the matter and discovered the cart nurse had given proper fluids, but the documentation had been flawed. Lake informed the CD of this and that was the end of her involvement in the matter. There was no evidence that any of the CMs were disciplined for the work of others.

Discipline

The Employer has different levels of discipline for different types of infractions. The Employer uses a document called an Individual Performance Improvement Plan (IPIP) for disciplinary purposes. (ERX 14) CMs may initiate the discipline process by filling out the IPIP, but it is the CD or the CNE who provides the actual counseling. CMs provide a description of events which they report to the Employer's HR department. The evidence did not indicate whether the CMs fill out the "Description of Events" portion of the IPIP itself, or the HR staff does so based on some other form of reporting by the CM. In any event, someone from HR fills out the upper portion of the IPIP which contains information about the employee's past discipline and related information. The CM's role is to report what occurred. The HR staff conducts any subsequent investigation and in conjunction with the CNE, CD, and possibly higher level managers, decides what discipline, if any, is issued. The CM are not informed what, if any, discipline is given to the employees about whom they report.

[7] There was testimony that the nurses, by virtue of their licensing requirement, know what to do in terms of patient care when there is an adverse outcome. The testimony of the Employer focused on the CMs' role in directing the work required to document the event.

CNA Sequuoyah Taylor received an IPIP initiated by CM Brielle Cantagallo after Taylor allegedly fought with another CNA. Taylor provided an explanation of her behavior to Melora and Denise Bullington, an HR manager, but not to the CM. (ERX 15). Cantagallo also provided a statement to Bullington and Melora. (ERX 19) Cantagallo's statement included the facts of what she observed and contained no recommendation regarding the issuance of discipline. (ERX 19). The IPIP is signed by Melora and Bullington. (ERX 14). The decision to terminate Taylor was made by the Melora, a regional HR person and the Center's administrator.

CNA Ashley Almore received an IPIP initiated by CM Katrina McNeal after Almore was found sleeping at the nurses' station while on duty. McNeal subsequently provided a factual response to Bullington's inquiry about what she had observed. McNeal did not provide any recommendation regarding the issuance of discipline. (ERX 17, 18).

CM Upshur testified that when preparing an IPIP she documents what occurred and turns it over to her CD. She does not know what happens after that. In fact, she was told by her CD that it was not her business what happened after she filled out an IPIP (T. 640 – 641) Similarly, CM McCarthy recalled filling out an IPIP only once, about eighteen months prior to the hearing, concerning a night shift CNA who disappeared from the floor during work hours. McCarthy started the IPIP, sent it to HR, and never learned what happened after that.

CMs do not fill out IPIP forms often. CMs Lake St. John never filled out an IPIP.

CMs have no role in the discipline of employees for attendance issues. If someone calls in late or wants to leave early, the CM reports this to Yarnes, the scheduling coordinator. The CM has no responsibility for following up on why someone did not come into work or how many times he or she may have been a no-show.

CM McCarthy provided testimony that she counseled cart nurses regarding several aspects of their job, including telling them quickly if a patient's care is changing and reminding them of their responsibility to pass medication in a timely manner and tell someone, (presumably a CM), if they are not able to do so. McCarthy testified she counseled CNAs on other matters as well, including being on time to work and not taking breaks over 30 minutes in length. McCarthy asserted she would tell her CD about matters requiring counseling if she felt the CD needed to know, but provided no specific example of having done so.

Evaluation of other employees

The CMs do not evaluate cart nurses or CNAs. Although Melora asserted generally that she sought input from the CMs when she was evaluating staff nurses, she provided no specific evidence in support of this assertion, and none of the CMs testified that their input was sought by management in regard to the evaluation of nurses.

Assignment of work

CMs do not have permanently assigned work locations. They arrive each shift to find out where they will be working. Once at the proper locations, they find a schedule for the cart nurses and CNAs that has already been filled out by either the scheduling coordinator or by the CD from the prior night. If there's no CD on duty on a particular night, the CM on duty will do the scheduling.[8] Mellissa Yarnes, the CNA who works weekdays from 9:00 a.m. – 5:00 p.m., serves as the scheduling coordinator for the cart nurses and CNAs. Yarnes maintains a master schedule. She also calls the CMs mid-shift to give the list of the CNAs for the upcoming CNA shift. The CM then puts the information into the assignment board. If someone calls in late, the CM lets Yarnes know.

Cart nurses who have been at the Center for a while have a regular cart assignment. The carts are numbered and assigned to rooms. CMs need to make assignments only for those nurses who lack a regular cart assignment, either because they are new to the Center, or hired temporarily through an outside agency due to staffing shortages. In these situations, according to CM Lake, she uses several factors to assign a particular cart to a nurse. Primarily, Lake looks at the acuity level of the patients, assigning a more seasoned nurse to a patient with a higher acuity level. Another factor Lake considers is continuity of care. If there is a nurse who has been picking up overtime and has already been using a particular cart in the past two days, Lake may want to keep that nurse on the cart and move a regularly assigned nurse in order to provide continuity of care of patients. Finally, Lake testified she may have to consider a patient or family complaint about a particular staff member when making an assignment.

CMs also make assignments when there is a cart nurse call-out, in which case CMs themselves work as carts nurses. If a cart nurse is a no-show, then the first response is for a CM to take that nurse's cart.[9] There is a "pull list" kept which shows which CM is up next for working a cart. CMs work a cart frequently. CM Lake works a cart nurse once out of about every six shifts.

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[8] When there is no CD on duty, one of the CMs on duty assumes some of the work responsibilities of the CD, for which they are paid a differential. The number of times individual CMs filled in as CDs varied by CM and by time of the year. (EX 8) For example, between January 1, 2015 and mid-October 2015, when the Employer's exhibit ends, Katrina McNeal worked as a CD 26 times, Kelly McCarthy 3 times, Rachel Upshur 1 time, and Sharon Jackson 37 times, while Karina DeJulius never worked as a CD. There was no evidence presented to explain why very few CMs acted as CDs following the filing of the Petition in this matter on October 2, 2015. (ERX 8). On night shift when the CM is the highest level person present at the facility there is always a CNE on call. CM Rachel Upshur testified that the only CD duties she performs if she fills in overnight as a CD is to reassign staff if there is a call-out for the upcoming shift and to print a list of patients needing to be weighed, per doctor's orders, in the morning.

[9] Although there was general testimony that CMs will take a lighter duty cart for a nurse and move a nurse away from her usual cart in order to arrange this, no example was provided that this had ever actually occurred. (T. 292).

CMs may also need to reassign nurses on a temporary basis due to the skill level of certain nurses. For example, not all nurses are IV certified, so on occasion a CM may send one nurse to assist another to insert an IV line, or, the CM may perform the work herself. CM Rachel Upshur testified that she has been asked to help others with an IV, and has also asked others to help her. If someone says "no," she just asks someone else. CM Lake may switch a nurse who is not good at wound care with another nurse for the care of a particular patient. Or, Lake testified, she may perform the wound care herself.

The CMs may also need to reassign the CNAs. Most often this occurs due to CNA call out, which occurs about twice per week per shift. In reassigning CNAs, the CMs use a "pull list" which keeps track of which CNA is up next to be pulled to a different floor as needed if there is a call-out. If the CNAs are full-time the CM tries to plug them into the same assignment they had the day before, in order to maintain continuity of care. In re-assigning CNAs, a primary factor is location, as the CM will try to make sure the CNAs have patients whose rooms are near one another. If the staffing is going from 6 CNAs to 5, then one CNA will be split between two hallways on the same floor. CM Upshur typically asks for a volunteer to take this duty, and if no one volunteers, she waits for a CD to arrive. If there was a CNA call out when St. John was a CM, she would first ask any of the CNAs already working if they wanted to stay. If none did, only then she would re-arrange the existing CNAs.

Once the CM determines which CNAs will form the staffing contingent for a given shift, either through use of the "pull list" or the solicitation of volunteers, the CMs use a grid that shows the CNA room assignments if the staffing goes from 6 CNAs to 5 or 4 CNAs per shift. Yarnes created this grid specifically to show the assignment of CNAs when the staffing goes from 6 to 5 or to 4. The purpose of the grid is so the CD or CM won't have to figure out the match.

A CM may need to adjust an assignment in order to assign a second CNA to assist with patient care. This may occur when there is a disruptive patient, and then the CNA from the same wing accompanies the one originally assigned to the disruptive patient. On occasion, CMs may need to reassign CNAs due to patient preference, for example, if a patient only wants a female CNA. This usually means one of the CNAs on the same wing just takes the patient, and the selection is based on which CNA is available. CM St. John would ask CNAs to switch patients in response to a patient or family complaint, and CNAs always did. If no one had, St. John would have contacted the CD.

CNAs are responsible for staffing the common dining room at the Center, which is referred to as the Bistro. One CNA from each floor staffs the Bistro twice during a shift, once for lunch and once for dinner. The CNAs' Bistro assignments are included on the daily schedule. Melora testified generally that there may be times that the CM needs to adjust the CNA assignment regarding the Bistro if a CNA cannot go to the Bistro as assigned due to patient needs.

Not all CMs reassign staff during their own shift. CM Upshur testified she never adjusts the schedule for her own shift, only that for the next shift. The only exception to this is to maintain herself on a cart she worked the day before. However, to switch her own assignment

she would need the approval of the CD. According to Upshur, it is rare for cart nurses to be reassigned during a shift, and when it occurs that two nurses overlap, they usually decide themselves who will move. Usually the decision about which nurse is reassigned is made pre-shift by the prior CD. CMs St. John and Upshur never changed an assignment on their shifts.

CMs may also have to reassign staff based on the arrival of new patients. According to Melora the Center uses a new model for rehabilitation hospitals which involves shorter patient stays and thereby creates a higher level of new patient admissions. The admissions department decides where to place in coming patients. A newly admitted patient needs to be assessed within 30 – 60 minutes of their arrival in their room. Melora described the role of the CM in regard to new admissions as akin to an air traffic controller. Lake testified that at least twice a month she reassigns nurses in order to have admission assessments completed on a timely basis. If one nurse has too many admissions, she finds the nurse's partner or another nurse to help the first nurse out. On one occasion, on Lake's shift, there was a cart nurse who received three new admissions in a row. Lake asked a second nurse to take the second admission, and then asked a third cart nurse, who was actually a CM working as a cart nurse, to take the third admission. In contrast, CM McCarthy could recall only a single instance, over a year ago, when she asked one nurse to help another who had too many admissions. The second nurse declined, saying she was too busy.

It is undisputed that a CM cannot require a cart nurse or CNA to come in to work.

Additional aspects of the duties of the CMs

CMs are expected to participate in the Center's Leadership 101 program (also called the Genesis Leadership Essentials program) and take a number of courses within one year of becoming a CM. No evidence was presented to show the details of the Leadership 101 program. The evidence showed the Employer did not enforce its requirement regarding the completion of the Leadership 101 courses, as its own exhibit showed numerous participants who had completed less than 25% of the program. (ERX 11). The Employer sent email reminders to participants to complete the program, but there was no evidence of any subsequent follow-up. All of the reminder emails were sent after the filing of the Petition in this matter. (ERX 11) CMs also attended monthly leadership meetings with the CDs to discuss issues and problem solve.

On weekday mornings at 8:30 a.m., there are meetings attended by the senior nursing staff. About 80% of the time the CD on duty attends, but if that person is occupied or unavailable, then one of the CMs would come down and substitute for the CD. There was no evidence as to which CMs ever served in this capacity or how frequently it occurred. Since these meetings occur during the day, no night-shift CMs would ever attend.

2. RECORD EVIDENCE REGARDING OBJECTIONABLE CONDUCT

Cart nurse Kellie Stevens testified that after the ballots were already cast, she heard CM Ray Twum-Barima say that it was time for a change and it would be good when the union vote was over. Stevens also testified about a single incident of objectionable conduct which took place during the second week of October 2015 at about 7:30 p.m. during report, when there were about five nurses present. The only nurse Stevens could recall specifically was one named Belinda. Stevens overhead five CMs (Katie McNeal, Jamie Dennis, Rachel Upshur and Breille Cantagallo) "talking about what the Union was going to be able to do." When pressed for details about what the CMs actually said, Stevens stated they were talking about how "the Union was going to be able to get us, the employees, better benefits. We would be paid shift differential. We would be paid for experience versus everybody makes the same across the board whether you're 30 years or 30 days." Stevens could not recall a non-CM making any comments after the CMs spoke. Stevens thought the conversation lasted about 10 minutes. Stevens further testified that "way after the election was over" she heard from someone else that CMs had distributed or taken back Union cards.

CM McCarthy, who worked night shift until around September or October 2015 (although she still picked up some night shifts), testified that she talked to four cart nurses about the Union. One had already signed a card, and one said she would think about it. Of the other two, Lorraine and Robin, one filled out a card, although McCarthy could not remember which one. Lorraine and Robin are both day shift nurses, according to McCarthy. McCarthy gave the signed card to Marilyn Viscomb, a cart nurse. McCarthy did not provide evidence regarding the date she obtained the authorization card.

McCarthy asserted that at some point, over a period of several days, she was part of a group text among about 7 – 8 people, including CMs and one cart nurse. McCarthy remembered CMs Ray Twum-Barima, Bethany Boyles, Brielle Cantagallo and Katie McNeal being part of the texts as well as a cart nurse named Nicole, whose last name she did not remember. McCarthy claimed these texts consisted of Marilyn Viscomb "trying to get people to go to court with her in support of the Union." McCarthy asked to be removed from these texts because her phone was "dinging" all day when she needed to sleep, and Viscomb complied. No date was provided for McCarthy's receipt of these texts. None of the texts themselves were placed into evidence.

McCarthy was "tagged" in a Facebook posting made by Viscomb on August 6, 2015, meaning Facebook made the posting available to those tagged so they could view it. (ERX 1) The Exhibit shows the names of four CMs (including McCarthy) listed at the top as "tagged" and then several blacked-out lines, making it impossible to ascertain the identity of the other people "tagged" by this post. There was no evidence to show who actually viewed the post. (ERX 1) The post consisted of an image of a woman, with the slogan "unions are good for women" on top, and then text along the side stating generally why Unions are good for women. (ERX 1) The text on the top left of the posting reads "Marilyn Viscomb shared AFSCME's photo." The back of the exhibit shows three responses to the post, one of which has the name of the sender blacked- out, but contains the text "I'm still trying to figure out what we're waiting for" followed by McCarthy's response "contact them" and Twum-Barima's response "we need them."

McCarthy testified that she did not know if responses to this post were limited only to those tagged. There was no evidence regarding the identity of the person who sent the first response.

McCarthy testified that Summer Valenti, the night shift CD, commented once about the Union between 1:00 a.m. – 4:00 a.m. during a mid-shift "huddle" to review patient care during the shift. According to McCarthy, during the huddle, in which people expressed frustration over staffing issues at the Center, Valenti said "there's always the Union but I can't be part of that." McCarthy did not provide a date for Valenti's comment. McCarthy further testified that Viscomb told her "well before the petition went to the Union" that CM Cantagallo had distributed union cards. McCarthy admitted on cross examination she had never actually seen Cantagallo with union cards. McCarthy never observed an instance in which a CM other than herself was holding cards, and never saw CMs present when she observed Viscomb with union cards.

McCarthy claimed she was present for conversations when Viscomb was speaking in favor of the Union and thought that "probably" Colleen Kelly had to have been. (T. 120 McCarthy testified very generally that she spoke in favor of the Union based on her prior experience with a union, and Viscomb generally spoke in favor of a union. McCarthy did not provide a date for this conversation. McCarthy also provided general testimony about a conversation she had with a staff nurse named Chantelle. McCarthy did not provide a date for this conversation, or identify anyone who had been present. She just described who was "usually" around during night shift.[10]

The Employer presented Chantelle Corley as a witness. Corley, who always worked day shift, had been a HUC at the Center up until September 24, 2015 when she became a cart nurse. She testified that she heard McCarthy on one occasion "speak in favor of the Union and she was just telling us that we should vote for it."[11] Corley stated she was the only person present when McCarthy made this comment on the second floor, "maybe Hall B", when Corley was going to punch out to go home. No date was provided for this conversation. When asked to convey exactly what McCarthy said, Corley said she couldn't remember, she just recalled McCarthy being in favor of the Union. When Counsel for the Employer asked Corley "did you understand her to be encouraging you to vote for the union in the election?" Corley replied "Yes, well, she was – it wasn't more so that she forcing, like saying that I should vote for the union. It was more so her expressing her feeling that she liked the union." (T. 526). This colloquy then followed between Counsel for the Employer and Corley:

> Q: In your mind when you heard Ms. McCarthy makes such remarks as she relating to the union, did you under – was it your impression that she was urging you to support the union?
>
> A: My impression was that she was angry with the facility and that she wanted – she was expressing her anger to me; that she wanted the union in the building to make changes.

[10] Chantelle Corley provided a more detailed version of the conversation with McCarthy.
[11] Corley's version of her single conversation with McCarthy is consistent with McCarthy's version of the same conversation.

> Q: Okay. And do you – did you at that time understand that her communication was being expressed in the belief that you, too should support the union?
>
> A: No. I believed that she was expressing her – how she felt about the union.
>
> (T. 529)

Corley also testified that she heard CM Elizabeth Sinariglio say once that she wanted the union in the building. Corley could not remember where she was when Sinariglio made this comment, or when it took place. When asked by Counsel for the Employer if Sinariglio indicated that she hoped that Corley would support the Union, Corley replied "no." Corley testified that once, CM Joan Sanford spoke in favor of the Union at the nurse's station on the third floor when just the two of them were present. Sanford said, according to Corley, that her (Sanford's) job was on the line and she was hoping that the Union came in. No date was given for this comment by Sanford, but Corley recalled it was made at the time she was still a HUC, establishing it was made sometime prior to September 24, 2015. On cross-examination, Corley testified that she felt they her words were being "twisted in such a way that it's making it seem like the nurses force to vote a certain way which they didn't."

VI. ANALYSIS

A. The supervisory status of the Care Managers

As the party asserting supervisory status, the burden was on the Employer to produce sufficient evidence to show that its CMs exercise at least one of the supervisory indicia set forth in Section 2(11) of the Act, and that they do so utilizing independent judgment. I will therefore consider each of the indicia on which the Employer presented evidence.

Discipline

To find supervisory status based on disciplinary authority, the exercise of such authority must lead to personnel action without independent investigation by upper management. See *The Republican Co.,* 361 NLRB No 15, slip op. at 8, (2014); *Sheraton Universal Hotel*, 350 NLRB 1114, 1116 (2007); *Beverly Health & Rehabilitation Services, Inc.*, 335 NLRB 635, 669 (2001), enfd. in pertinent part 317 F.3d 316 (D.C. Cir. 2003). A warning may qualify as disciplinary within the meaning of Section 2(11) if it "automatically" or "routinely" leads to job-affecting discipline, by operation of a defined progressive disciplinary system. *Veolia Transportation Services, Inc.,* 363 NLRB No. 98, slip op. at 8 (2016); *Ohio Masonic Home,* 295 NLRB 390, 393–394 (1989); compare *Oak Park Nursing Care Center*, 351 NLRB 27, 30 (2007). Warnings that simply bring the employer's attention to substandard performance without recommendations for future discipline serve a limited *reporting* function, and do not establish that the disputed individual is exercising disciplinary authority. See *Williamette Industries,* 336 NLRB 743, 744 (2001).

When CMs observe rules infractions by cart nurses or CNAs, they prepare only the Description of Events, a portion of the IPIP document, and then send the IPIP directly to HR.[12] CMs do not make recommendations regarding discipline, they merely report facts. CMs Cantagallo and McNeal provided only a recitation of facts to HR as part of the Center's investigation of the discipline each initiated by filling out an IPIP. CMs do not decide on the level of discipline; this decision is made by the CD, the CNE and HR, possibly in conjunction with a higher-ranking official. There is no evidence of any specific instance in which a CM decided independently to impose discipline and then prepared and signed a form memorializing the discipline. Indeed, those CMs who did initiate IPIPs testified that they never recommended discipline and were not even aware of any employee's discipline history. The CMs lack of involvement in the actual imposition of discipline is highlighted by the fact that they are not even informed after the fact what discipline, if any, was imposed based on the IPIP they filled out. The fact that CMs are not the final arbiters of discipline is significant under Board law; when disciplinary actions are independently investigated by other officials, the Board will not conclude that their issuance establishes supervisory status. *Sanctuary at McAuley,* 359 NLRB No. 162, slip op. at 4 (2013); cf. *Mountaineer Park*, 343 NLRB 1473 (2004) (supervisory status found where higher-level management routinely "signed off" on disciplinary recommendations and followed all recommendations without any investigation).

Assignment

As discussed above, in *Oakwood Healthcare, Inc.*, supra, 348 NLRB at 689, the Board stated that the term "assign" refers to "the act of designating an employee to a place (such as a location, department or wing), appointing an employee to a time (such as a shift or overtime period) or giving significant overall duties, i.e., tasks, to an employee." The Board noted that in a health care setting, designating aides to care for particular residents is a form of "assignment."

The CMs in this case do not decide on which hallway or unit cart nurses or CNAs work or determine the shifts to which they are assigned. A full-time scheduler, Melissa Yarnes, performs this function. When Yarnes, who works during the day, is not available, the night shift CD creates the assignments for the morning shift.[13] At most, some CMs may occasionally adjust these assignments to account for employee absences or minor adjustments in the workload, such

[12] I do not credit CM McCarthy's testimony regarding counseling cart nurses and CNAs. McCarthy, a witness for the Employer, admitted she had once been a union supporter and changed her mind. During the summer of 2015, she wrote a document called "Facts about Care Manager" (PX 12) which she gave to fellow CM Ray Twum-Barima. This documents consists of nine enumerated reasons care managers are not supervisors, beginning with #1 "care managers are simply desk nurses with a fancy name." Item #7 reads "care managers do not interview, hire, fire, perform evaluations, or attend Clinical Director meetings." To the extent McCarthy's testimony regarding supervisory status contradicted her "Facts about Care Managers" document (PX 12) and therefore changed to benefit her employer, I do not credit her testimony.

[13] To the extent certain CMs occasionally perform this function when they fill-in as weekend overnight CD, this very occasional routine assignment of work to employees, nearly all of whom have permanent assignments, is insufficient to establish supervisory status.

as new admissions or patient preference.[14] The location of the patient within a hallway or wing was a primary factor considered when adjusting assignments for CNAs, and no independent judgment by the CM was required. A "pull list" showing whose turn was next was used by the CMs in instances when either a cart nurse or a CNA needed to be reassigned, along with a pre-established grid showing the breakdown of patient room assignments when there were fewer CNAs than normal on duty. The purpose of the pull lists and grid was to balance the employee workload. Assignment adjustments, if they occur, are merely designed to adjust cart nurse and CNA workloads, and the Board has repeatedly indicated that assignments made for purposes of equalizing workloads do not involve a sufficient exercise of independent judgment to confer supervisory status. An individual must normally consider relative employee skill and ability when making assignments in order to be deemed a supervisor. *Lynwood Manor,* 350 NLRB 489, 490 (2007); *Golden Crest Healthcare Center,* 348 NLRB 727, 730, fn. 9 (2006).

I therefore find that the Employer has not demonstrated that the CMs exercise supervisory authority in assigning work to cart nurses or CNAs.

Direction

"Direction" encompasses both monitoring employee performance to make certain that tasks are performed correctly, and making discrete assignments of specific jobs. *Golden Crest Healthcare Center,* supra at 730. There is no evidence of CMs making discrete assignments. To the extent the CMs needed to have a properly skilled nurse insert an IV line or provide wound care, the CM directions were based on established criteria, such as being licensed to insert an IV or having a skill with wound care. The directions were for short tasks, limited to a single task for a single patient, and did not affect the nurse's overall assignment. The Employer's claim of direction appeared to be based on CMs' overall monitoring of cart nurse CNA work. To establish that such monitoring involves supervisory authority and constitutes "responsible" direction, the Employer must show that: (1) the CMs exercise independent judgment in deciding whether cart nurse CNA performance meets appropriate standards; (2) the CMs can take corrective action in response to a cart nurse or CNA's deficient performance; and (3) CMs are held accountable for the way in which CNAs perform their jobs and can suffer adverse consequences in the event CNAs perform poorly. *Community Education Centers,* supra, 360 NLRB No. 17, slip op. at 1 (2014).

It is undisputed that part of the CM job is to observe cart nurses and CNAs to make certain they are performing their jobs properly. It is also clear that the CMs primarily serve as educators and resources for clinical information. CMs can initiate the discipline process if they uncover deficiencies in cart nurse or CNA performance. However, the evidence showed that the IPIP initiated by the CMs were for routine matters: fighting on the job and sleeping on the job. The record evidence failed to establish that such disciplines are not covered by the Employer's policies and procedures or involved a degree of discretion above the merely routine. Thus, the Employer failed to established one of the elements required to prove responsible direction. *Community Education Centers,* supra.

[14] There was testimony about CMs asking certain cart nurses to fulfill certain functions on an ad hoc basis, such as inserting an IV line or tending to wound care, in circumstances in which the assigned nurse was not able to do. Such ad hoc assignments are insufficient to establish supervisory status.

I therefore find the Employer has not demonstrated the CMs exercise supervisory authority in directing the work of the cart nurses and CNAs.

The Employer has also failed to demonstrate that CMs are held accountable for cart nurse and CNA performance. The CMs all testified that during their tenure as CMs they never received any evaluations at all. There was no evidence of any informal evaluation of CMs based on the work of others. A single CM testified that on one occasion she was contacted by her manager about a concern that a patient had not received proper fluids. The CM investigated to see what had occurred and reported back to the CD.

Promotions

CMs do not prepare cart nurse or CNA evaluations. Melora testified generally that she sometimes seeks CM input when evaluating staff. Melora's testimony was not accompanied by specific examples and is precisely the sort of conclusory evidence on which the Board refuses to rely when assessing supervisory status. *Lynwood Manor,* supra; *Avante at Wilson, Inc.,* supra, 348 NLRB at 1057.

Job Description

In its oral argument, the Employer relied on the CMs' job description in support of its position that CMs are supervisors. A review of the job description, however, reveals that it fails to demonstrate authority sufficient to establish supervisory status under the Act. The review of the job description of the CDs shows that the CDs actually possess many of the responsibilities the Employer asserts are those of the CMs. In any event, to the extent the Employer relies on the CM job description to support its claim of supervisory status, it is well-settled that job descriptions, job titles, and similar items that constitute "paper authority" do not, without more, demonstrate actual supervisory authority. *Golden Crest Healthcare Center,* supra at 731.

As the Employer has not demonstrated that the CMs possess any of the indicia of Section 2(11) authority, I find that the Employer has failed to show that its CMs are statutory supervisors.

Secondary indicia

Respondent presented evidence regarding several secondary inditia of supervisory status, primarily participation in the Employer's Management 101 program and attending monthly meetings with CDs. I need not address these, however, since absent evidence of the existence of one of the primary indicia of supervisory status, secondary indicia are not dispositive. *Pacific Coast M.S. Industries*, 355 NLRB 1422 at 1423 fn 3(2010); *Central Plumbing Specialties*, 337 NLRB 973, 975 (2002). Since I have found that the Employer has not demonstrated that the CMs exercised any of the primary indicia of supervisory status, the evidence of secondary criteria is not sufficient to meet the Employer's burden that the CMs are supervisors under Section 2(11) of the Act.

Based on all of the above, I find that the Employer has fallen far short in meeting its burden to show that its CMs are statutory supervisors.

B. The Alleged Objectionable Conduct

The Employer's objections assert that objectionable conduct was established by virtue of the prounion conduct of certain CMs and a single CD, Summer Valenti, all of whom the Employer asserts are supervisors and / or managers. Since I have found, as set forth above, that the CMs are not supervisors under Section 2(11) of the Act, I do not need to proceed further and make a recommendation regarding the CMs' role in the these election objections. However, in the event that my conclusion regarding the status of the CMs is reversed, I will make a recommendation regarding whether the conduct of the CMs upset the laboratory conditions for a fair election.

The Board applies a two-part test in determining whether prounion supervisory misconduct should be the basis to overturn election results:

> (1) Whether the supervisor's prounion conduct reasonably tended to coerce or interfere with the employees' exercise of free choice in the election.
>
> This inquiry includes: (a) consideration of the nature and degree of supervisory authority possessed by those who engage in the prounion conduct; and (b) an examination of the nature, extent, and context of the conduct in question.
>
> (2) Whether the conduct interfered with freedom of choice to the extent that it materially affected the outcome of the election, based on factors such as (a) the margin of victory in the election; (b) whether the conduct at issue was widespread or isolated; (c) the timing of the conduct; (d) the extent to which the conduct became known; and (e) the lingering effect of the conduct.

Harborside Healthcare, Inc., 343 NLRB 906, 909 (2004)

In applying the *Harborside* analysis, I need to decide whether the prounion conduct of the CMs Brielle Cantagallo, Bethany Boyles, Raymond Twum-Barima, Kelli McCarthy, Rachel Upshur, Jamie Dennis and Elizabeth Simirglio and Janice St John and CD Summer Valenti reasonably tended to coerce or interfere with employee free choice and whether the conduct interfered with freedom of choice to the extent that it materially affected the outcome of the election. (For reasons of efficiency I will hereto refer to this group of named CMs as "the CMs"). For the reasons set forth below, I find the Employer has failed to meet its burden to show the conduct of the CMs and CD Valetni warrants setting aside the election.

Objection 1

The Employer's Objection 1 alleges objectionable conduct during the critical period by the CMs and CD Valenti by soliciting Union authorization cards and/or creating the impression they had solicited or were soliciting Union authorization cards.[15]

Kellie Stevens testified that "way after the election was over" she heard from someone else that the CMs had distributed or taken back Union cards. This statement is pure hearsay and as such I do not credit it to establish the CMs actually distributed cards. To the extent this statement could be used to show Stevens was coerced in her free choice during the election by her impression that generally speaking CMs had distributed or taken back Union cards, it does not establish this since Stevens heard the comment *after* the election. Thus, any impression Steven's had could not have coerced her or materially affected the outcome of the election since she could not have acquired such an impression until "way after" she voted and the ballots were already cast. Under *Harborside*, Stevens' testimony fails to establish objectionable conduct on the part of the CMs.

McCarthy testified she spoke with four nurses about the Union, and ultimately distributed and received back a single union authorization card to one nurse, although she was unsure which of two possible nurses it was. There was no evidence to show what McCarthy said to the four nurses she spoke to about the Union. In *Harborside* the supervisor repeatedly told employees during the election campaign that they could lose their jobs if the union lost the election, initiated loud and intimidating confrontations with employees to cajole them to support the union, and engaged groups of employees in discussion during which the supervisor made numerous references to the lack of job security. The supervisor also told employees that she was counting on them to vote for the union. In contrast, McCarthy testified that she generally spoke to four cart nurses about the Union. The record evidence does not establish that these general conversations interfered with employee free choice. The nature of the interaction was mild and non-intimidating, there was no evidence the comments extended beyond the four nurses with whom McCarthy spoke, and there was no evidence to show the comments were made in any context other than casual conversation. I conclude the Employer has failed to meet its burden under the first prong of the *Harbroside* test.[16] The Board has made it clear that it is not objectionable for a supervisor to generally express a prounion sentiment, and has found the limited and non-threatening conduct engaged in by McCarthy does not constitute objectionable conduct. *Northeast Iowa Telephone Co.*, 346 NLRB 465 (2006).

As to the nurse from whom McCarthy did obtain a signed card, McCarthy admitted she never told the card signer that if she did not sign the card she would lose her job, or that she would be fired if she did not support the Union, the type of conduct the Board has found coercive. *Harborside*, supra. Either of the two nurses from whom she obtained a a signed card, Lorraine and Robin, worked day shift, while McCarthy worked night shift, only occasionally picking up day shift. McCarthy therefore had no supervisory authority over either of these

[15] The Employer presented no evidence regarding CD Valenti's conduct concerning this Objection.

[16] Having found the Employer failed to meet its burden regarding the first prong of the test, I need not analyze the second prong, which includes the Union's defense that the Employer conducted an aggressive anti-Union campaign. *Laguna College of Art and Design*, 362 NLRB No. 112 (2015) NLRB fn 3.

nurses. The rationale in *Harborside* emphasizes the Board's concern of employees that their responses to the solicitation of a card by a supervisor could lead to rewards or penalties based on a supervisor's direct responsibility over that employee. Based on a lack of evidence that McCarthy had supervisory authority over the nurse to whom she distributed a card, I find McCarthy's conduct not objectionable. *Glens's Market*, 344 NLRB 294 (2005); *Connecticut Humane Society*, 358 NRB 187 (2012).

The only other evidence presented regarding CM involvement in the solicitation and distribution of Union cards also came from McCarthy, who testified that Viscomb told her that CM Cantagallo had distributed cards. McCarthy admitted she did not see Cantagallo (or any other CM for that matter) with union cards. McCarthy's testimony regarding Cantagallo's distribution of cards is hearsay, and I therefore do not credit it. McCarthy, a CM, did not vote in the Union election since the stipulated election agreement specifically excluded CMs from voting. (BDX 1) Thus, McCarthy's testimony about hearing that Cantagallo distributed cards cannot be used to show that a voter was coerced by the impression that CMs were distributing cards in a way that materially affected the outcome of the election. I therefore find that the Employer failed to show that CM Cantagallo's conduct was objectionable. *Harborside*, supra.

Based on the record evidence and my analysis thereof, I conclude the Employer's Objection 1 is without merit. I recommend it be overruled in its entirety.

Objection 2

The Employer's Objection 2 alleges objectionable conduct during the critical period by the CMs and CD Valenti by creating a coercive atmosphere and/or interfering with employee free choice by promoting the Union and/or creating the impression that they favored the Union, conveying to voters that they should support the Union and vote for it in the election.

Kellie Stevens testified that *after* the ballots were already cast, she heard CM Twum-Barima say that it was time for a change and it would be good when the union vote was over. Obviously this comment could not have been coercive in regard to her free choice in the election since she heard it after the ballots were cast. Stevens also testified about an incident which took place during the second week of October 2015 at about 7:30 p.m. during report, and there were about five nurses present, although she could only remember one, Belinda. Stevens overhead five CMs, Katie McNeal, Jamie Dennis, Rachel Upshur and Breille Cantagello… "talking about what the Union was going to be able to do." When pressed for details about what the CMs actually said, she stated they were talking about "the Union was going to be able to get us, the employees, better benefits. We would be paid shift differential. We would be paid for experience versus everybody makes the same across the board whether you're 30 years of 30 days." In regard to this testimony, Stevens was not a credible witness. Although Stevens claimed that five nurses were present to hear the prounion comments of the CMs, her testimony was uncorroborated. Stevens' testimony was general and became more specific only after increased questioning by Employer counsel. I found Stevens' demeanor problematic, as she seemed to be watching Employer's counsel and attempting to mold her response to his question. For these reasons, I decline to credit Stevens' testimony offered in support of Objection 2.

CM McCarthy testified that at some unidentified point in time, over a period of several days, she was part of a group text among about 7 – 8 people, including CMs and cart nurses. McCarthy remembered CMs Ray Twum-Barima, Bethany Boyles, Brielle Cantagallo and Katie McNeall being part of the texts as well as a cart nurse named Nicole, whose last name she did not remember. McCarthy claimed these texts consisted of Marilyn Viscomb "trying to get people to go to court with her in support of the Union." When McCarthy asked to be removed from these texts because her phone was "dinging" all day when she needed to sleep, Viscomb complied. No date was provided for McCarthy's receipt of these texts. McCarthy provided no evidence to establish that she, or any other CM, actively participated in the text exchange. It is certainly possible that like McCarthy, they found the texts unwanted and did not participate. The evidence established only that Viscomb, an eligible voter, sent texts asking other people to go to court in support of the Union. The Employer did not place any of the texts themselves into evidence, although it had the opportunity to do so through McCarthy. At best, McCarthy's testimony established that CMs and a single cart nurse were all recipients of texts about the Union sent by an eligible voter. Applying the *Harborside* analysis, I find that this conduct not objectionable because the Employer failed to show that any CMs actually engaged in any conduct at all. Lacking evidence of actual CM participation in the texts, I conclude this text exchange cannot be found to be coercive or interfere with freedom of choice in an election.

McCarthy further testified that she was "tagged" in a Facebook posting made by Viscomb on August 6, 2015, meaning Facebook sent the posting to those tagged so they could view it. ERX 1 shows the names of four CMs (including McCarthy) listed at the top as "tagged" and then several blacked out lines. It is impossible to know who the other people "tagged" by this post were, or if those tagged even saw the post at all. The post consisted of an image of a woman, with the slogan "Unions are good for women" on top, and then text along the side stating generally why unions are good for women. The text on the top left of the posting reads "Marilyn Viscomb shared AFSCME's photo." The back of the exhibit shows three responses to the post, one of which has the name of the sender blacked out, but contains the text "I'm still trying to figure out what we're waiting for" followed by CM McCarthy's response "contact them" and CM Twum-Barima's response "we need them." McCarthy testified that she did not know if responses to this post were limited only to those tagged. This Facebook posting was made by Viscomb, an eligible voter. The names of those tagged by the post, other than the CMs' were blacked out by the Employer. There was no evidence to establish the identity of the people tagged by the post. The record evidence does not support a finding that those tagged by the post were eligible voters in the election. Moreover, there was no evidence to establish that any eligible voter other than Viscomb (the creator of the post) even viewed this post, or the responses to it. The mere fact that people were tagged for a post does not establish that they viewed it. There were only three responses made to the post, two of them by individuals identified as CMs. The identity of the third individual to post a response is unknown. McCarthy testified that she did not know if responses to a post were even limited to those tagged on it. There is simply no evidence to establish that the unidentified first responder to the post was an eligible voter, who presumably would therefore have seen the subsequent responses by the two CMs. Viewed in its best light, ERX 1 proves that Viscomb, already a Union supporter based on her post, communicated with CMs about her support for Unions, and two CMs provided arguably prounion responses. Applying the *Harborside* analysis, I find nothing coercive about the CMs conduct in this regard. Viscomb had already demonstrated she was in favor of the Union by

sending the post in the first place, so it cannot be concluded that the CMs' responses to her would be coercively prounion.

McCarthy testified that on one occasion she heard Summer Valenti, the night shift CD, make a single comment during a mid-shift "huddle" that occurred between 1:00 –a.m. – 4:00 a.m.. There was no evidence to establish the date of this comment. There was general frustration expressed during huddle, according to McCarthy, and she heard Valenti say "there's always the Union but I can't be part of that." I question the credibility of McCarthy regarding this comment, because there was no corroboration of this testimony even though McCarthy testified it occurred during huddle, when all staff on that shift would have been present. Never the less, applying the *Harborside* analysis, I find nothing objectionable in Valenti's comment. The comment is general in nature, it appears to simply indicate that Valenti, a supervisor, knew she could not be in the Union. The extent of the comment was very limited – Valenti did not voice her sentiment about the Union, or provide any indication that employees should support the Union. The context of the comment was general conversation lacking any other reference to the Union. Since there was no date given for the comment, there was no evidence to show that the comment was made in the context of the union campaign. It could have been made after the election, precluding the comment from affecting the outcome of the election, even if it had been coercive. Thus, I find the employer has failed to meet its burden under the first prong of the *Harborside* analysis in regard to CD Valenti's comment and find Valenti's conduct does not warrant setting aside the election. *Northeast Iowa Telephone Co*. supra.

McCarthy also testified very generally that she and Viscomb talked about the Union being beneficial when they both worked night shift. When asked if there were other persons present when those conversations took place, she testified that "if I had to name names, I would say probably I know Colleen Kelly had to be there just because she was involved with a lot of conversation." McCarthy failed to testify about a single conversation which actually took place, and provided no date for these alleged conversation(s). In fact, McCarthy's testimony was so vague that she did not even testify that Kelly was actually present to hear McCarthy's comments. Rather, McCarthy seemed to have assumed she would have been, but was not sure she *actually* was. The testimony is so vague and general that I conclude it does not provide a basis to find objectionable conduct as alleged by the Employer. *Harborside*, supra.

Finally, in support of its Objection 2 the Employer presented the testimony of Chantelle. Corley, who testified she heard several comments about the Union made by three CMs: McCarthy, Sinariglio and Sanford. Corley was unwavering in her testimony that she did not find any of the comments made by these three to be coercive. She went so far to state on cross-examination that she felt her words were being twisted to make it seem like the CMs were forcing her to vote a certain way when this was not the case. Corley was the only person present to hear the comments about which she testified. I do not credit McCarthy's general speculative testimony that there may have been others present when she spoke with Corley. Corley's version of the conversation between the two is more specific and detailed, and I therefore credit Corley's testimony that the two were alone when McCarthy spoke in favor of the Union. Since Corley was the only eligible voter to hear the comments made by McCarthy, Signariglio and Sanford, only she could have found them coercive. Corely did not, however, find the comments coercive,

as she stated emphatically several times. I therefore conclude that the comments of CMs McCarthy, Signariglio and Sanford do not warrant setting aside the election. *Harborside*, supra.

Based on the record evidence and my analysis thereof, I conclude the Employer's Objection 2 is without merit. I recommend it be overruled in its entirety.

VII. CONCLUSION

I recommend the Employer's Objections be overruled. The Employer has failed to establish that any conduct by supervisors and/or managers reasonably tended to interfere with employee free choice. Therefore, I recommend that an appropriate certification issue.

APPEAL PROCEDURE

Pursuant to Section 102.69(c)(1)(iii) of the Board's Rules and Regulations, any party may file exceptions to this Report, with a supporting brief if desired, with the Regional Director of Region 04 by July 14, 2016. A copy of such exceptions, together with a copy of any brief filed, shall immediately be served on the other parties and a statement of service filed with the Regional Director.

Exceptions may be E-Filed through the Agency's website but may not be filed by facsimile. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number, and follow the detailed instructions. If not E-Filed, the exceptions should be addressed to the Regional Director, National Labor Relations Board, [Regional address].

Pursuant to Sections 102.111 – 102.114 of the Board's Rules, exceptions and any supporting brief must be received by the Regional Director by close of business July 14, 2016 on the due date. If E-Filed, it will be considered timely if the transmission of the entire document through the Agency's website is accomplished by no later than 11:59 p.m. Eastern Time on the due date.

Within 7 days from the last date on which exceptions and any supporting brief may be filed, or such further time as the Regional Director may allow, a party opposing the exceptions may file an answering brief with the Regional Director. An original and one copy shall be submitted. A copy of such answering brief shall immediately be served on the other parties and a statement of service filed with the Regional Director.

Dated: June 30, 2016

/s/ Elana Hollo
Elana Hollo
Hearing Officer, Fourth Region
National Labor Relations Board

EXHIBIT N

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 4

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73 Employer, and 1199(c), NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME/AFL-CIO Petitioner.	Case No 4-RC-161250

MOTION TO REOPEN THE RECORD

SR-73 and Lakeside Avenue Operations LLC d/b/a Powerback Rehabilitation, 113 South Route 73 ("Employer) files this motion to correct and/or reopen the record to ensure that the Hearing Officer's rulings quashing the subpoenas that the Employer served upon Marilyn Viscome, Usamah Abdullah, and the Custodian of Records for District 1199(c), National Union of Hosptial and Healthcare Employees, AFSCME, AFL-CIO ("Union") are part of the formal record along with the subpoenas and petitions to revoke filed by the Union on behalf of the subpoena recipients. Copies of the petitions to revoke, along with the appended subpoenas, are attached to this Motion, respectively, as Attachments A and B.

1. The Hearing Officer's rulings that quashed the above-referenced subpoenas are part of the formal record in that they are reported at the following pages of the transcript: Tr. 109:24-111:3).

2. During the colloquy that led to the Hearing Officer's rulings with respect to those subpoenas (Tr. 92:24-109:21), the parties and Hearing Officer referenced the subpoenas and the petitions to revoke. However, at no time did they mark any of those documents for admission into the record.

3. As is often the case in a proceeding before a Hearing Officer, initial colloquy was conducted off-the-record and the parties and Hearing Officer then went on the record to formalize their arguments and the rulings on the record. However, in this instance, as noted above, the subpoenas and petitions to revoke them were not marked and deemed admitted.

4. Sections 102.26 and 102.31(b) of the Board's Rules and Regulations provide that a petition to revoke a subpoena, any answer to such a petition, and any ruling on such a petition becomes part of the record only upon the request of the aggrieved party. Although there is no express request on the record herein, the Employer understood the petitions to revoke, its defense to them, and the rulings quashing the subpoenas to have been made part of the record by virtue of the Hearing Officer having placed the arguments concerning them and her rulings on the record so that they are reported as part of the transcript. However, in preparing its exceptions to the Hearing Officer's Report on Objections ("Report"), the Employer realized that the subpoenas themselves and petitions to revoke were never marked as exhibits. Accordingly, it now moves to correct and/or reopen the record (a) to ensure that its defense to the petitions to revoke and the rulings with respect to same are part of the formal record as it understood in view of them being reported in the transcript of the hearing and (b) the subpoenas and petitions to revoke are included in the formal record, which makes sense in order for any reader of the record to understand fully the rulings quashing the subpoenas.

5. The Employer believes that the subpoenas and petitions to revoke were not marked as exhibits through oversight following an off-the-record colloquy concerning them. In the interest of economy and efficiency, the parties and Hearing Officer worked through a lunch break taken by witnesses (Tr. 91:17-111:13). The transcript reveals that following completion of the proceedings on the record concerning the petitions to revoke, including the Hearing Officer's rulings, the witnesses were returning from lunch to the hearing room and one of the Employer's witnesses had difficulty regaining access to the building for security reasons (Tr. 111:3-9). It may be that this distraction, including the necessity for Employer counsel to assist in securing reentry of that witness, contributed to the Employer failing to request the marking into evidence and inclusion in the formal record of the petitions to revoke (to which the subpoenas are appended as exhibits). In any event, at this time, the Employer so requests and proposes that the petition to revoke the Viscome subpoena be marked as Employer Exhibit 31, the petition to revoke the subpoenas served upon Mr. Abdullah and the Union be marked as Employer Exhibit 32, and both exhibits be admitted into the formal record to the extent not already done so. Relatedly, although the Employer believes that its defense to the petitions to revoke and the rulings thereon are already part of the formal record, it requests their inclusion in the record as well to the extent not already done so.

6. For the reasons set forth, the Employer believes that the remedy it seeks here is ministerial. However, should the Union or Acting Regional Director disagree, the Employer submits that it has satisfied the requirements of Rules 102.48(d)(1) and 102.65(e)(2) for reopening of the record to admit such portions of the proceeding relating to the above-referenced subpoenas as are not currently part of the record. The documents in issue are not "new" since they were previously presented. They call for a result contrary to that the Hearing Officer

decided for the reasons set forth by the Employer during the argument before the Hearing Officer and in the Employer's Memorandum in support of its Exceptions. The Employer also notes that during the parties' closing arguments on the record, the Employer repeatedly referenced these subpoenas and the Hearing Officer's rulings with respect to them. At that time, neither the Hearing Officer nor the Union objected that the Employer was relying upon documents or rulings that were outside the record. The Employer does not make this statement as a criticism of the Hearing Officer or Union but, rather, to demonstrate that it believes all concerned understood the petitions to revoke and rulings thereon to be part of the record despite the above-referenced oversight with respect to marking the petitions to revoke as exhibits.

7. For these reasons, the Employer respectfully requests that the Acting Regional Director grant the relief requested.

Respectfully submitted,

/s/Jedd Mendelson
Jedd Mendelson
Littler Mendelson, P.C.
One Newark Center
Newark, New Jersey 07102

Dated: July 19, 2016

Firmwide:141596280.1 050738.1217

EXHIBIT A

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

POWERBACK REHABILITATION – GENESIS, Employer, and DISTRICT 1199C, NUHHCE, AFSCME, AFL-CIO Petitioner.	**Case 4-RC-161250**

MARILYN VISCOME'S PETITION TO REVOKE SUBPOENA B-1-R7BBAP

This petition to revoke subpoena *duces tecum* B-1-R7BBAP issued by Powerback Rehabilitation, is submitted on behalf of Marilyn Viscome. A copy of the subpoena is attached.

The subpoena should be revoked in its entirety. It seeks confidential and protected information, communications with the Union and other employees.

I. Subpoena paragraphs 1-4 seek employee communications about the Union. This inquiry has a chilling effect on workers' Section 7 union activity and the Board should revoke the subpoena on this basis.

The interests of workers is an "overriding concern" to the Board and the identity of employees engaged in union activity has been deemed confidential. National Telephone Directory Corp., 319 NLRB 420, 421 (1995). "[W]e find that the breadth of the subpoenas at issue here and the nature of the information requested--encompassing communications between employees and the Union, union authorization and membership cards, and all documents relating to the

distribution and/or solicitation of union authorization and membership cards--would subject employees' Sec. 7 activities to unwarranted investigation and interrogation. Veritas Health Servs., 362 NLRB No. 32, FN1 (2015)(employer subpoena sought communications with charge nurse supervisors and was revoked).[1] Moreover, it has been a long-standing policy of the Board to protect the identities of employees' involved in union activity, particularly those who attend union meetings and sign cards.

> Generally, an employer who seeks to obtain the identities of employees who sign authorization cards and attend union meetings violates the Act. Indeed, an employer may not surveil its employees to obtain such information, and may not give its employees the impression that it has surveilled--or will surveil--them to obtain such information...Further, an employer violates the Act if it questions its employees about this information.

[National Telephone Directory Corp., 319 NLRB 420, 421 (1995).

In National Telephone, the Board revoked a subpoena issued to the Union, seeking *inter alia* the names of employees who had attended union meetings. Id. at 420. The Board acknowledged the Supreme Court's decision in NLRB v. Robbins Tire & Rubber Co., 437 U.S. 214 (1978), holding that disclosure of the statements of affiants who had not testified should not be permitted because of the potential for witness intimidation. In National Telephone, the Board therefore ordered that the names of workers who had attended meetings should not be revealed, and an employer subpoena quashed because, the Board stated, "We conclude that the danger of employee intimidation would be severely heightened if an employer could obtain the names of employees who signed cards or attended meetings...That the Respondent has sought this information through cross-examination, rather than through surveillance or interrogation of employees, does not reduce

[1] In Veritas the Board distinguished the facts from Ozark Automotive, 779 F.3d 576 (DC Cir 2015), because of the breadth of the subpoena in Veritas, seeking all communications (e.g. not just phone records, but copies of the communications themselves).

the potential chilling effect on union activity that could result from employer knowledge of the information." Id. at 421-422. Also see ManorCare Health Services-Easton, 356 NLRB No. 39, 172 (2010) (holding that when worker confidentiality rights are balanced against marginal interests of an employer in learning the identity of employees engaged in union activity – no disclosure). Because the right to confidentiality exists for the protection of employees, it can only be waived by employees. Nat'l Telephone, supra at 422. See also Ampersand Publ'g, LLC d/b/a Santa Barbara News-Press & Graphic Commc'ns Conference, Inter Nat'l Bhd. of Teamsters, 361 NLRB No. 88 (2014)(employer subpoenas to current and former employees, prior to their testimony at a National Labor Relations Board hearing, that sought copies of affidavits the employees had submitted violates 8(a)(1)).[2]

II. Powerback's subpoena also violates 8(a)(1) and should not be enforced as it is coercive and intimidating

The subpoena to Viscome informs her that the Company will have a forensic examiner examine all of her personal devices, "computer, laptop, cell phone etc. and/or through access to [her] accounts on social media sites, email, and other media." To the extent that the Employer has informed Viscome that it intends to scrutinize all of her personal, private communications systems (her private email and private cell phone) it violates the Act. The request itself is intimidating and coercive. It certainly sends a message to employees that they should not

[2] See NLRB Case Handling Manual (Part 1), Unfair Labor Practice Proceedings, Section 10060; see Section 102.118(b) of the Board's Rules and Regulations (affidavit can only be produced upon motion by respondent, after witness has testified in Board proceeding). The Board has said that the purpose of this rule is to ensure that "employee attitudes, activities, and sympathies in connection with the union are 'free of any inquisitive interest by the [e]mployer as are the employees' union activities themselves." Ampersand, supra at 7; Winn-Dixie Stores, Inc., 143 NLRB 848, 849 (1963).

discuss the Union in any way, shape or form, or that the Employer will hire an "expert" to go through all of their communications, including their Facebook accounts. It should not be permitted.

Conclusion

Based on the foregoing reasons, the Employer's subpoena to Viscome must be revoked.

Respectfully submitted,

LISA LESHINSKI
Freedman and Lorry PC

Attorney for Petitioner
District 1199C

Dated: April 18, 2016

Littler
Employment & Labor Law Solutions Worldwide
NEWARK OFFICE
ONE NEWARK CENTER
1085 RAYMOND BLVD., 8TH FLOOR
NEWARK, NJ 07102-5311
(973) 848-4700

UnionBank
Payable at any Union Bank branch including
400 California St., San Francisco, CA 94104
(800) 238-4486 unionbank.com

16-49/1220
7000142586

631265

4/11/2016

PAY TO THE ORDER OF Marilyn Viscome

$ **90.84

Ninety and 84/100******

DOLLARS

103 Ridgewood Ave
Berlin, NJ 08009

LITTLER MENDELSON P.C.
NOT VALID OVER $1,000 - VOID AFTER 90 DAYS

MEMO
witness fee (050738.1217)

⑈631265⑈ ⑆122000496⑆ 7000142586⑈

LITTLER MENDELSON P.C. NEWARK OFFICE

631265

FORM NLRB-31

SUBPOENA DUCES TECUM

UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

To Marilyn Viscome

As requested by Jedd Mendelson

whose address is One Newark Center Newark NJ
(Street) (City) (State) (ZIP)

YOU ARE HEREBY REQUIRED AND DIRECTED TO APPEAR BEFORE A Hearing Officer of the National Labor Relations Board

at 615 Chestnut Street, Suite 710

in the City of Philadelphia

on April 19, 2016 at 10AM or any adjourned or rescheduled date to testify in SR-73 and Lakeside Avenue Operations LLC d/b/a PowerBack Rehabilitation, 113 South Route 73 Case 04-RC-161250
(Case Name and Number)

And you are hereby required to bring with you and produce at said time and place the following books, records, correspondence, and documents:

SEE ATTACHMENT

If you do not intend to comply with the subpoena, within 5 days (excluding intermediate Saturdays, Sundays, and holidays) after the date the subpoena is received, you must petition in writing to revoke the subpoena. Unless filed through the Board's E-Filing system, the petition to revoke must be received on or before the official closing time of the receiving office on the last day for filing. If filed through the Board's E-Filing system, it may be filed up to 11:59 pm in the local time zone of the receiving office on the last day for filing. Prior to a hearing, the petition to revoke should be filed with the Regional Director; during a hearing, it should be filed with the Hearing Officer or Administrative Law Judge conducting the hearing. See Board's Rules and Regulations, 29 C.F.R Section 102.31(b) (unfair labor practice proceedings) and/or 29 C.F.R. Section 102.66(c) (representation proceedings) and 29 C.F.R Section 102.111(a)(1) and 102.111(b)(3) (time computation). Failure to follow these rules may result in the loss of any ability to raise objections to the subpoena in court.

B-1-R7BBAP

Under the seal of the National Labor Relations Board, and by direction of the Board, this Subpoena is

Issued at Philadelphia, Pennsylvania

Dated: April 11, 2016

Chairman, National Labor Relations Board

NOTICE TO WITNESS. Witness fees for attendance, subsistence, and mileage under this subpoena are payable by the party at whose request the witness is subpoenaed. A witness appearing at the request of the General Counsel of the National Labor Relations Board shall submit this subpoena with the voucher when claiming reimbursement.

PRIVACY ACT STATEMENT

Solicitation of the information on this form is authorized by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* The principal use of the information is to assist the National Labor Relations Board (NLRB) in processing representation and/or unfair labor practice proceedings and related proceedings or litigation. The routine uses for the information are fully set forth in the Federal Register, 71 Fed. Reg. 74942-43 (Dec. 13, 2006). The NLRB will further explain these uses upon request. Disclosure of this information to the NLRB is mandatory in that failure to supply the information may cause the NLRB to seek enforcement of the subpoena in federal court.

Littler Mendelson, P.C.
One Newark Center
8th Floor
Newark, NJ 07102

Glenn J. Smith
Office Managing Shareholder

Jedd Mendelson
973.848.4758 direct
973.848.4700 main
973.556.1612 fax
jmendelson@littler.com

April 12, 2016

VIA HAND DELIVERY

Marilyn Viscome
103 Ridgewood Avenue
Berlin, New Jersey 08009

Re: SR-73 and Lakeside Avenue Operations, LLC d/b/a Powerback Rehabilitation, 113 South Route 73 and 1199(c), AFSCME

Dear Ms. Viscome:

This firm represents Powerback Rehabilitation ("Company") in the above-captioned case.

Accompanying this letter is a subpoena duces tecum that demands production of various kinds of electronic data that is or may be accessible from your personal electronic devices (computer, laptop, cell phone, etc.) and/or through access to your accounts on social media sites, email, and other media.

Neither the Company nor Company counsel wish to review any personal information unrelated to the organizing drive, election campaign, or matters related to the pending objections case.

Moreover, the information that the Company seeks is limited to involvement of Care Managers in communications about organizing, the organizing drive, the election campaign, or matters related to the pending objections case. While the Company has no interest in the names of specific employees involved in unionization efforts that has no connection to Care Managers, the Company is entitled to information that indicates, directly or indirectly, that (1) Care Managers and employees who were not Care Managers interacted with one another with respect to communications about organizing, the organizing drive, the election campaign, or matters related to the pending objections case and/or (2) Care Managers and employees who were not Care Managers were included on the same communication or document relating to communications about organizing, the organizing drive, the election campaign, or matters related to the pending objections case. Accordingly, names of employees who were not Care Managers cannot be redacted and must be shown if the communication or document relates to Care Managers or their conduct or otherwise reveals the names of employees who were part of the same communication relating to unionization.

The Company anticipates a neutral forensic examiner assisting in your efforts to comply with the subpoena. If you agree, the Company will pay for the cost of the forensic examiner's work. (The Company will not pay for other expenses you or the Union incur.)

ATTACHMENT TO SUBPOENA DUCES TECUM FOR MARILYN VISCOME SERVED BY POWERBACK VOORHEES ("Company")

Definitions:

- "Text Messages" includes but is not limited to: short message service ("SMS"), multimedia message service ("MMS"), iMessage and any other short messaging application.
- "Chat Messages" includes but is not limited to messages sent and/or received via: WhatsApp, Snapchat, Facebook Messenger, QQ Mobile, WeChat, Skype, Viber, LINE, Blackberry Messenger, or any other chat-type of messaging system used via mobile electronic devices.
- "Social Media" refers to any third-party online service provider, including but not limited to Facebook, MySpace, Google+, Twitter, Instagram, Picasa, Tumblr, LinkedIn, Monster, Blogger or any other social networking, career development, or news and commentary sites, services, blogs, or wikis.

Instructions:

- Searches for responsive documents stored in electronic data sources should be conducted across all potential sources of such information to locate non-duplicative content, including any backups made thereof, including those made to physical media (e.g., iTunes backups to a computer or to Apple's Time Capsule, or other external hard drive media) or to the "cloud" (e.g., iCloud, or Amazon Cloud).
- Searches for responsive documents stored within a cellular mobile device **should be conducted by a certified forensic examiner** after making a reasonable effort to complete a full forensic physical image of the device, including but not limited to collection of any SQLite databases contained therein.
- We request that you meet and confer with us regarding the scope of searches to be run in an effort to locate responsive documents stored in any electronic data source.
- Subject to your good faith cooperation with searches for responsive documents and an agreement on a reputable neutral vendor to create forensic images of data sources described herein, **the Company will cover the costs of forensic collection, search, and processing of responsive documents incurred by a neutral vendor.**
- To the extent you contend that responding to any of these requests would be unduly burdensome, we request that you contact us immediately to meet and confer in good faith in an effort to address such burdens.

Document Requests for Subpoena:

1. Produce all Text Messages and Chats exchanged between yourself and any Care Manager or Clinical Director concerning the effort to unionize the nurses at the Powerback site in Voorhees, New Jersey (including but not limited to organizing, the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015.

2. Produce all Text Messages and Chats exchanged between yourself and anyone else referencing activity by any Care Manager or Clinical Director in connection with the effort to unionize the nurses at the Powerback site in Voorhees, New Jersey (including but not limited to organizing,

4. Produce all social media content, including but not limited to communications, posts, writings, comments, entries, electronic contributions, and/or text drafted within or for purposes of submitting to or received via any social media site, as well as any attachments, photos, graphic interchange format ("GIF") images, or videos saved to social media, concerning the effort to unionize the nurses at the Powerback site in Voorhees, New Jersey (including but not limited to organizing, the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015 and which indicates that such content was intended for or accessed by any Care Manager or Clinical Director (including but not limited to any indication that a Care Manager or Clinical Director replied to, "liked", or otherwise acknowledged the content).

ESI responsive to request nos. 3 and 4 should be produced in native format or as TIFF image files (black-and-white) and as JPEG image files (color) with attachments included, and the following associated metadata provided in Concordance delimited load files along with extracted text:

- FOR SOCIAL MEDIA
  - MESSAGE FROM
  - MESSAGE TO
  - MESSAGE CC
  - MESSAGE SUBJECT
  - MESSAGE DATE/TIME SENT
  - MESSAGE DATE/TIME SENT OFFSET
  - MESSAGE DATE/TIME RECEIVED
  - MESSAGE DATE/TIME RECEIVED OFFSET
  - MESSAGE ATTACHMENT COUNT
  - MESSAGE ATTACHMENT NAMES
  - MESSAGE HAS ATTACHMENTS
  - TIME ZONE OFFSET
  - FILE AUTHOR
  - FILE DATE CREATED
  - FILE DATE CREATED OFFSET
  - FILE NAME
  - FILE SIZE
  - FILE EXTENSION
  - ORIGINAL FOLDER NAME
  - PAGE COUNT
  - MD5 HASH
  - LINK TO NATIVE FILE
  - LINK TO EXTRACTED TEXT

The Concordance .DAT file should contain the following delimiters:

Field Separator	¶	(ASCII:0020)
Quote	þ	(ASCII:0254)
Multi-Entry Delimiter	;	(ASCII:0059)
<Return> Value in Data	®	(ASCII:0174)

the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015.

Electronically stored information ("ESI") responsive to request nos. 1 and 2 should be produced in native format or as Microsoft Excel files, with attachments included, and the following associated metadata provided in Concordance delimited load files along with extracted text:

- FOR TEXT MESSAGES AND CHATS
  - MESSAGE FROM
  - MESSAGE TO
  - MESSAGE CC
  - MESSAGE DATE/TIME SENT
  - MESSAGE DATE/TIME SENT OFFSET
  - MESSAGE DATE/TIME RECEIVED
  - MESSAGE DATE/TIME RECEIVED OFFSET
  - MESSAGE ATTACHMENT COUNT
  - MESSAGE ATTACHMENT NAMES
  - MESSAGE HAS ATTACHMENTS
  - TIME ZONE OFFSET
  - FILE AUTHOR
  - FILE DATE CREATED
  - FILE DATE CREATED OFFSET
  - FILE NAME
  - FILE SIZE
  - FILE EXTENSION
  - MD5 HASH
  - LINK TO NATIVE FILE
  - LINK TO EXTRACTED TEXT

The Concordance .DAT file should contain the following delimiters:

Field Separator	¶	(ASCII:0020)
Quote	þ	(ASCII:0254)
Multi-Entry Delimiter	;	(ASCII:0059)
<Return> Value in Data	®	(ASCII:0174)

For documents that are produced directly from electronic format, the full extracted text should be provided by a link in the main (.DAT) load file.

3. Produce all social media content, including but not limited to communications, posts, writings, comments, entries, electronic contributions, and/or text drafted within or for purposes of submitting to or received via any social media site, as well as any attachments, photos, graphic interchange format ("GIF") images, or videos saved to social media, referencing activity by any Care Manager or Clinical Director in connection with the effort to unionize the nurses at the Powerback site in Voorhees, New Jersey (including but not limited to organizing, the organizing drive, the election campaign, and the election) during the period June 2015 through November 2015.

For documents that are produced directly from electronic format, the full extracted text should be provided by a link in the main (.DAT) load file.

The TIFF images should be produced as single-page Group IV TIFF format with an Opticon image load file. The Opticon image load file should contain the BEGBATES value for each corresponding document and appropriate path or folder information to the corresponding images that comprise each document.

EXHIBIT B

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

POWERBACK REHABILITATION – GENESIS, Employer, and DISTRICT 1199C, NUHHCE, AFSCME, AFL-CIO Petitioner.	**Case 4-RC-161250** **HEARING- OBJECTIONS**

PETITIONER DISTRICT 1199C'S PETITION TO REVOKE SUBPOENAS B-1-R7A61P, B-1-R7A8KT, A-1-R75GF1, A-1-R73Y9B

In accordance with § 102.66(f) of the NLRB's Rules and Regulations, Petitioner District 1199C, NUHHCE, AFSCME, AFL-CIO ("Union") hereby petitions to revoke subpoenas *duces tecum* B-1-R7A61P and B-1-R7A8KT, and subpoenas *ad testificandum* A-1-R75GF1, A-1-R73Y9B, served by the Employer, Powerback Rehabilitation, 113 South Route 73, Voorhees ("Powerback"), seeking certain information and testimony from the Union.[1] Copies of the subpoenas are attached hereto as Exhibit A.

The subpoenas should be revoked in their entirety. They seeks confidential and protected information, and privilege information. The subpoenas are intended to and do harass the Union and intimidate employees.[2] To the extent that the Employer seeks to question Union

[1] B-1-R7A61P was addressed to the Union's Custodian of Records. B-1-R7A8KT was addressed to union representative Usamah Abdullah. The subpoenas seek identical information.
[2] See Veritas Health Inc. d/b/a/ Chino Valley Med. Ctr., 362 NLRB No. 32 (2015) finding the employer violated 8(a)(1) of the Act by issuing subpoenas to employees seeking information regarding Section 7 activities.

representatives about their communications with employees, such an inquiry should not be permitted.

I. Subpoenas may be quashed, which are unreasonable, oppressive, or seek information obtainable from other sources. The Board does not permit the misuse of its processes for "fishing expeditions."

Section 11(1) of the National Labor Relations Act provides that the Board may revoke a subpoena. 29 CFR §102.31 (emphasis added); see also FRCP 26(b)(1); NLRB Rules and Regulations § 102.66(c); Brink's Incorporated, 281 NLRB 468 (1986) (Board partially upheld a subpoena revocation, relying on FRCP 26(b)(1)). FRCP 26(b)(1)(i) provides that discovery shall be limited if it is determined that the discovery is "obtainable from some other source that is more convenient, less burdensome, or less expensive." FRCP 45(b) states that a subpoena may be quashed or modified if it is unreasonable or oppressive.

The Board's procedures do not permit a "fishing expedition." Interstate Builders, 334 NLRB 835, 842 (2001); see also 800 River Road Operating Co., 359 NLRB No. 48, slip op at 2 (2013)(enf'd at 784 F.3d 902, 917 (3d Cir. 2015))(halting employer's fishing expedition into Union's organizing campaign to support its election objections). Further, Section 8(a)(1) prohibits employers from giving the "impression of surveillance if doing so reasonably tends to interfere with, restrain, or coerce employees in the exercise of their section 7 rights." 800 River Rd., 784 F.3d 902, 917 (3d Cir. 2015).

II. Powerback's efforts to obtain union authorization cards, meeting sign-in sheets, and communications between the Union and workers should not be permitted because of the chilling effect it would have on Section 7 activity.

The subpoena should be revoked inasmuch as it seeks union authorization cards and information about employees' Section 7 activities. This subpoena is nothing more than a fishing expedition. The interests of workers is an "overriding concern" to the Board and the identity of employees engaged in union activity has been deemed confidential. National Telephone Directory Corp., 319 NLRB 420, 421 (1995).

In a case with similar facts (employer filed objections based on alleged involvement of charge nurses in union activity) The Board found the subpoena constituted an unwarranted invasion of Section 7 rights. The Board held that communications between employees and the union relating to union authorization cards should not be permitted.

> [W]e find that the breadth of the subpoenas at issue here and the nature of the information requested--encompassing communications between employees and the Union, union authorization and membership cards, and all documents relating to the distribution and/or solicitation of union authorization and membership cards--would subject employees' Sec. 7 activities to unwarranted investigation and interrogation. See, e.g., National Telephone Directory Corp., 319 NLRB 420, 421 (1995) (recognizing "the importance of an employee's ability to sign an authorization card with confidence that the card will not be presented to the employer, because it is entirely plausible that employees would be chilled when asked to sign a union card if they knew the employer could see who signed"). Although the Respondent maintains it was willing to allow the documents to be produced to the hearing officer for an in-camera inspection, we find that under these facts, the harm is in the very request itself, which would have a chilling effect on employees' willingness to engage in (or refrain from) protected activities. See, e.g., Pacific Molasses Co. v. NLRB, 577 F.2d 1172, 1182 (5th Cir. 1978) ("[I]t is impossible to minimize the seriousness of the threatened [disclosure of authorization cards]. We would be naive to disregard the abuse which could potentially occur if employers and other employees were armed with this information. The inevitable result of the availability of this information would be to chill the right of employees to express their favorable union sentiments. Such a chilling effect would undermine the rights guaranteed by the [Act],

> and, for all intents and purposes, would make meaningless those provisions of the [Act], which guarantee secrecy in union elections.").
>
> [Veritas Health Servs., 362 NLRB No. 32, FN1 (2015).][3]

Moreover, it has been a long-standing policy of the Board to protect the identities of employees who attend union meetings.

> Generally, an employer who seeks to obtain the identities of employees who sign authorization cards and attend union meetings violates the Act. Indeed, an employer may not surveil its employees to obtain such information, and may not give its employees the impression that it has surveilled--or will surveil--them to obtain such information...Further, an employer violates the Act if it questions its employees about this information.
>
> [National Telephone Directory Corp., 319 NLRB 420, 421 (1995).

In National Telephone, the Board revoked a subpoena issued to the Union, seeking *inter alia* the names of employees who had attended union meetings. Id. at 420. The Board acknowledged the Supreme Court's decision in NLRB v. Robbins Tire & Rubber Co., 437 U.S. 214 (1978), holding that disclosure of the statements of affiants who had not testified should not be permitted because of the potential for witness intimidation. In National Telephone, the Board therefore ordered that the names of workers who had attended meetings should not be revealed, and an employer subpoena quashed because, the Board stated, "We conclude that the danger of employee intimidation would be severely heightened if an employer could obtain the names of employees who signed cards or attended meetings...That the Respondent has sought this information through cross-examination, rather than through surveillance or interrogation of employees, does not reduce the potential chilling effect on union activity that could result from employer knowledge of the

[3] In Veritas the Board distinguished the facts from Ozark Automotive, 779 F.3d 576 (DC Cir 2015), because of the breadth of the subpoena in Veritas, seeking all communications (e.g. not just phone records, but copies of the communications themselves)..

information." Id. at 421-422. Also see ManorCare Health Services-Easton, 356 NLRB No. 39, 172 (2010) (holding that when worker confidentiality rights are balanced against marginal interests of an employer in learning the identity of employees engaged in union activity – no disclosure).[4] Because the right to confidentiality exists for the protection of employees, it can only be waived by employees. Nat'l Telephone, supra at 422.

III. Powerback's subpoena should be revoked to the extent that it seeks documents that would disclose the Union's organizing strategy and impinge on the labor relations privilege.

Internal union documents should not be revealed pursuant to this subpoena. See Berbiglia, Inc., 233 NLRB 1476, 1495 (1977). In Berbiglia, the Board affirmed an ALJ finding that revoked most of a subpoena *duces tecum*, issued by the employer, seeking to review communications between the union and its members and other organizations. The main reason for revocation was held to be that

> ...[R]equiring the Union to open its files to Respondent would be inconsistent with and subversive of the very essence of collective bargaining and the quasi-fiduciary relationship between a union and its members. If collective bargaining is to work, the parties must be able to formulate their positions and devise their strategies without fear of exposure. This necessity is so self-evident as apparently never to have been questioned. The policy was recently adhered to by the Court of Appeals for the Ninth Circuit in Harvey's Wagon Whell, Inc. v. N.L.R.B., 93 LRRM 3068, 3070, 78 LC P11,268 (1976), an action under the Freedom of Information Act. The court there said:

---

[4] See also the cases protecting affiant statements from disclosure, under a similar principle, to protect against witness intimidation: Ampersand Publishing, LLC d/b/a Santa Barbara News-Press and Graphic Communications Conference, International Brotherhood of Teamsters, 358 NLRB No. 155 (2012) (decision affirmed at 361 NLRB No. 88 (2014)); and see NLRB Case Handling Manual (Part 1), Unfair Labor Practice Proceedings, Section 10060; see Section 102.118(b) of the Board's Rules and Regulations (affidavit can only be produced upon motion by respondent, after witness has testified in Board proceeding). The Board has said that the purpose of this rule is to ensure that "employee attitudes, activities, and sympathies in connection with the union are 'free of any inquisitive interest by the [e]mployer as are the employees' union activities themselves." Ampersand, supra at 7; Winn-Dixie Stores, Inc., 143 NLRB 848, 849 (1963).

> 'Statements of union representatives and agents of the employee, for example, should normally be protected from disclosure as a matter of law. Otherwise, the danger of their withholding relevant information for fear of exposing crucial material regarding pending union negotiations would be manifest.'
>
> [Berbiglia, Inc., 233 NLRB 1476, 1495 (1977).]

Conclusion

Based on the foregoing reasons, the Employer's subpoena must be revoked.

Respectfully submitted,

LISA LESHINSKI
Freedman and Lorry PC

Attorney for Petitioner
District 1199C

Dated: April 18, 2016

EXHIBIT A

FORM NLRB-31

SUBPOENA DUCES TECUM

UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

To 1199(c), AFSCME - Custodian of Records

As requested by Jedd Mendelson

whose address is One Newark Center Newark NJ
(Street) (City) (State) (ZIP)

YOU ARE HEREBY REQUIRED AND DIRECTED TO APPEAR BEFORE A Hearing Officer of the National Labor Relations Board

at 615 Chestnut Street, Suite 710

in the City of Philadelphia

on April 19, 2016 at 10 am or any adjourned

or rescheduled date to testify in SR-73 and Lakeside Avenue Operations LLC d/b/a PowerBack Rehabilitation, 113 South Route 73 Case 04-RC-161250
(Case Name and Number)

And you are hereby required to bring with you and produce at said time and place the following books, records, correspondence, and documents:

SEE ATTACHMENT

If you do not intend to comply with the subpoena, within 5 days (excluding intermediate Saturdays, Sundays, and holidays) after the date the subpoena is received, you must petition in writing to revoke the subpoena. Unless filed through the Board's E-Filing system, the petition to revoke must be received on or before the official closing time of the receiving office on the last day for filing. If filed through the Board's E-Filing system, it may be filed up to 11:59 pm in the local time zone of the receiving office on the last day for filing. Prior to a hearing, the petition to revoke should be filed with the Regional Director; during a hearing, it should be filed with the Hearing Officer or Administrative Law Judge conducting the hearing. See Board's Rules and Regulations, 29 C.F.R Section 102.31(b) (unfair labor practice proceedings) and/or 29 C.F.R. Section 102.66(c) (representation proceedings) and 29 C.F.R Section 102.111(a)(1) and 102.111(b)(3) (time computation). Failure to follow these rules may result in the loss of any ability to raise objections to the subpoena in court.

B-1-R7A61P

Under the seal of the National Labor Relations Board, and by direction of the Board, this Subpoena is

Issued at Philadelphia, Pennsylvania

Dated: April 11, 2016

Chairman, National Labor Relations Board

NOTICE TO WITNESS. Witness fees for attendance, subsistence, and mileage under this subpoena are payable by the party at whose request the witness is subpoenaed. A witness appearing at the request of the General Counsel of the National Labor Relations Board shall submit this subpoena with the voucher when claiming reimbursement.

PRIVACY ACT STATEMENT

Solicitation of the information on this form is authorized by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* The principal use of the information is to assist the National Labor Relations Board (NLRB) in processing representation and/or unfair labor practice proceedings and related proceedings or litigation. The routine uses for the information are fully set forth in the Federal Register, 71 Fed. Reg. 74942-43 (Dec. 13, 2006). The NLRB will further explain these uses upon request. Disclosure of this information to the NLRB is mandatory in that failure to supply the information may cause the NLRB to seek enforcement of the subpoena in federal court.

SR-73 and Lakeside Avenue Operations LLC d/b/a/ PowerBack Rehabilitation, 113 South Route 73
Case No. 04-RC-161250

Attachment to Subpoena Duces Tecum for Petitioner 1199(c), AFSCME-Custodian of Records

You are required to bring with you and produce at said time and place the following records and documents in hard copy form, including but not limited to emails, text messages, and social media postings:

Any communication or other document that itself indicates, or references anything else that indicates, that any Care Manager supported the effort to unionize the PowerBack facility at Voorhees in 2015, including but not limited to

(a) a Care Manager encouraging any employee to sign an authorization card,

(b) a Care Manager collecting an authorization card,

(c) a Care Manager encouraging an employee to attend a meeting at which there would be or was discussion about having a union at the Voorhees facility,

(d) a Care Manager himself/herself attending a meeting at which there would be or was discussion about having a union at the Voorhees facility or communicating about what happened at a meeting at which there would be or was discussion about having a union at the Voorhees facility,

(e) a Care Manager distributing any leaflet, text message, or email supporting unionization,

(f) a Care Manager posting or responding to any posting that concerned having a union at the Voorhees facility,

(g) a Care Manager reporting upon an employee's sentiment about having a union at the Voorhees facility,

(h) a Care Manager encouraging an employee to vote "yes" or for unionization during the election,

(i) a Care Manager communicating with anyone about what was taking place in connection with the voting on the day of the election at the Voorhees facility, and/or

(j) any other document that itself shows or relates to Care Manager involvement in the effort to have a union at the Voorhees facility.

FORM NLRB-32

SUBPOENA

UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

To 1199(c), AFSCME - Custodian of Records

As requested by Jedd Mendelson

whose address is One Newark Center Newark NJ
(Street) (City) (State) (ZIP)

YOU ARE HEREBY REQUIRED AND DIRECTED TO APPEAR BEFORE A Hearing Officer

of the National Labor Relations Board

at 615 Chestnut Street, Suite 710

in the City of Philadelphia

on April 19, 2016 at 10 am or any adjourned

or rescheduled date to testify in SR-73 and Lakeside Avenue Operations LLC d/b/a PowerBack Rehabilitation, 113 South Route 73 Case 04-RC-161250
(Case Name and Number)

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A-1-R75GF1

Under the seal of the National Labor Relations Board, and by direction of the Board, this Subpoena is

Issued at Philadelphia, Pennsylvania

Dated: April 11, 2016

Chairman, National Labor Relations Board

NOTICE TO WITNESS. Witness fees for attendance, subsistence, and mileage under this subpoena are payable by the party at whose request the witness is subpoenaed. A witness appearing at the request of the General Counsel of the National Labor Relations Board shall submit this subpoena with the voucher when claiming reimbursement.

PRIVACY ACT STATEMENT

Solicitation of the information on this form is authorized by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* The principal use of the information is to assist the National Labor Relations Board (NLRB) in processing representation and/or unfair labor practice proceedings and related proceedings or litigation. The routine uses for the information are fully set forth in the Federal Register, 71 Fed. Reg. 74942-43 (Dec. 13, 2006). The NLRB will further explain these uses upon request. Disclosure of this information to the NLRB is mandatory in that failure to supply the information may cause the NLRB to seek enforcement of the subpoena in federal court.

FORM NLRB-31

SUBPOENA DUCES TECUM

UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

To Usamah Abdullah

As requested by Jedd Mendelson

whose address is One Newark Center Newark NJ
(Street) (City) (State) (ZIP)

YOU ARE HEREBY REQUIRED AND DIRECTED TO APPEAR BEFORE A Hearing Officer of the National Labor Relations Board

at 615 Chestnut Street, Suite 710

in the City of Philadelphia

on April 19, 2016 at 10 am or any adjourned

or rescheduled date to testify in SR-73 and Lakeside Avenue Operations LLC d/b/a PowerBack Rehabilitation, 113 South Route 73 Case 04-RC-161250
(Case Name and Number)

And you are hereby required to bring with you and produce at said time and place the following books, records, correspondence, and documents:

SEE ATTACHMENT

If you do not intend to comply with the subpoena, within 5 days (excluding intermediate Saturdays, Sundays, and holidays) after the date the subpoena is received, you must petition in writing to revoke the subpoena. Unless filed through the Board's E-Filing system, the petition to revoke must be received on or before the official closing time of the receiving office on the last day for filing. If filed through the Board's E-Filing system, it may be filed up to 11:59 pm in the local time zone of the receiving office on the last day for filing. Prior to a hearing, the petition to revoke should be filed with the Regional Director; during a hearing, it should be filed with the Hearing Officer or Administrative Law Judge conducting the hearing. See Board's Rules and Regulations, 29 C.F.R Section 102.31(b) (unfair labor practice proceedings) and/or 29 C.F.R. Section 102.66(c) (representation proceedings) and 29 C.F.R Section 102.111(a)(1) and 102.111(b)(3) (time computation). Failure to follow these rules may result in the loss of any ability to raise objections to the subpoena in court.

B-1-R7A8KT

Under the seal of the National Labor Relations Board, and by direction of the Board, this Subpoena is

Issued at Philadelphia, Pennsylvania

Dated: April 11, 2016

Chairman, National Labor Relations Board

NOTICE TO WITNESS. Witness fees for attendance, subsistence, and mileage under this subpoena are payable by the party at whose request the witness is subpoenaed. A witness appearing at the request of the General Counsel of the National Labor Relations Board shall submit this subpoena with the voucher when claiming reimbursement.

PRIVACY ACT STATEMENT

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SR-73 and Lakeside Avenue Operations LLC d/b/a/ PowerBack Rehabilitation, 113 South Route 73
Case No. 04-RC-161250

Attachment to Subpoena Duces Tecum for Usamah Abdullah

You are required to bring with you and produce at said time and place the following records and documents in hard copy form, including but not limited to emails, text messages, and social media postings:

Any communication or other document that itself indicates, or references anything else that indicates, that any Care Manager supported the effort to unionize the PowerBack facility at Voorhees in 2015, including but not limited to

(a) a Care Manager encouraging any employee to sign an authorization card,

(b) a Care Manager collecting an authorization card,

(c) a Care Manager encouraging an employee to attend a meeting at which there would be or was discussion about having a union at the Voorhees facility,

(d) a Care Manager himself/herself attending a meeting at which there would be or was discussion about having a union at the Voorhees facility or communicating about what happened at a meeting at which there would be or was discussion about having a union at the Voorhees facility,

(e) a Care Manager distributing any leaflet, text message, or email supporting unionization,

(f) a Care Manager posting or responding to any posting that concerned having a union at the Voorhees facility,

(g) a Care Manager reporting upon an employee's sentiment about having a union at the Voorhees facility,

(h) a Care Manager encouraging an employee to vote "yes" or for unionization during the election,

(i) a Care Manager communicating with anyone about what was taking place in connection with the voting on the day of the election at the Voorhees facility, and/or

(j) any other document that itself shows or relates to Care Manager involvement in the effort to have a union at the Voorhees facility.

FORM NLRB-32

SUBPOENA

UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

To Usamah Abdullah

As requested by Jedd Mendelson

whose address is One Newark Center Newark NJ
(Street) (City) (State) (ZIP)

YOU ARE HEREBY REQUIRED AND DIRECTED TO APPEAR BEFORE A Hearing Officer

of the National Labor Relations Board

at 615 Chestnut Street, Suite 710

in the City of Philadelphia

on April 19, 2016 at 10 am or any adjourned

or rescheduled date to testify in SR-73 and Lakeside Avenue Operations LLC d/b/a PowerBack Rehabilitation, 113 South Route 73 Case 04-RC-161250
(Case Name and Number)

If you do not intend to comply with the subpoena, within 5 days (excluding intermediate Saturdays, Sundays, and holidays) after the date the subpoena is received, you must petition in writing to revoke the subpoena. Unless filed through the Board's E-Filing system, the petition to revoke must be received on or before the official closing time of the receiving office on the last day for filing. If filed through the Board's E-Filing system, it may be filed up to 11:59 pm in the local time zone of the receiving office on the last day for filing. Prior to a hearing, the petition to revoke should be filed with the Regional Director; during a hearing, it should be filed with the Hearing Officer or Administrative Law Judge conducting the hearing. See Board's Rules and Regulations, 29 C.F.R Section 102.31(b) (unfair labor practice proceedings) and/or 29 C.F.R. Section 102.66(c) (representation proceedings) and 29 C.F.R Section 102.111(a)(1) and 102.111(b)(3) (time computation). Failure to follow these rules may result in the loss of any ability to raise objections to the subpoena in court.

A-1-R73Y9B

Under the seal of the National Labor Relations Board, and by direction of the Board, this Subpoena is

Issued at Philadelphia, Pennsylvania

Dated: April 11, 2016

Chairman, National Labor Relations Board

NOTICE TO WITNESS. Witness fees for attendance, subsistence, and mileage under this subpoena are payable by the party at whose request the witness is subpoenaed. A witness appearing at the request of the General Counsel of the National Labor Relations Board shall submit this subpoena with the voucher when claiming reimbursement.

PRIVACY ACT STATEMENT

Solicitation of the information on this form is authorized by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* The principal use of the information is to assist the National Labor Relations Board (NLRB) in processing representation and/or unfair labor practice proceedings and related proceedings or litigation. The routine uses for the information are fully set forth in the Federal Register, 71 Fed. Reg. 74942-43 (Dec. 13, 2006). The NLRB will further explain these uses upon request. Disclosure of this information to the NLRB is mandatory in that failure to supply the information may cause the NLRB to seek enforcement of the subpoena in federal court.

EXHIBIT O

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 4

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC d/b/a POWERBACK REHABILITATION, 113 SOUTH ROUTE 73 Employer, and 1199(c), NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME/AFL-CIO Petitioner.	Case No 4-RC-161250

MEMORANDUM IN SUPPORT OF EMPLOYER'S EXCEPTIONS AND MOTION TO REOPEN RECORD

Jedd Mendelson
Littler Mendelson, P.C.
One Newark Center
Newark, New Jersey 07102-5311
(973) 848-4758
jmendelson@littler.com

Attorneys for Employer

unjustifiably denied the Employer appropriate recourse to that instrument for securing plainly relevant information.

Third, the Hearing Officer erred in finding that she had to quash the subpoenas because compelling production of the requested information would chill § 7 rights. Her ruling failed to account for the Employer having **narrowed the subpoenas to redact the names of eligible voters** (Tr. 99:22-105:9; 623:13-624:14). The Employer explained that because analytically a single ballot is outcome- determinative, production of documents that redacted the names of eligible voters would suffice so long as such redaction made clear that an eligible voter's name had been removed. Even though this narrowing of the subpoenas removed the intrusion upon § 7 rights with respect to eligible voters, neither the Hearing Officer's ruling during the hearing nor her Report even mentions, let alone assesses the impact of, the effect of this reduction in subpoena breadth. In *Ozark Automotive Distributors, Inc. v. NLRB*, 779 F.3d 576, 581-584 (D.C. Cir. 2015), the District of Columbia Court of Appeals refused to enforce a Board decision quashing a subpoena precisely because the Board, like the Hearing Officer here, failed to demonstrate that it had balanced the intrusion upon § 7 rights against the respondent company's need for documents.

The Hearing Officer also failed to balance the Employer's needs herein against the § 7 intrusion by ordering other possible measures. She could have ordered Viscome and the Union to testify preliminarily, without producing documents, to explore (1) their knowledge of Care Manager involvement with authorization cards, the Union organizing drive, and the election campaign as well as (2) their knowledge of the documents within or possibly within their custody. Indeed, *Ozark Automotive* underscores the importance of ensuring that a party has a full and fair opportunity to examine witnesses: "[w]hen...an appellant has been deprived of the

opportunity to summon witnesses, the appellate court can hardly determine what testimony would have materialized but for the error." 779 F.3d at 586, *quoting* Roger J. Traynor, The Riddle of Harmless Error at 68 (1970).

Alternatively, the Hearing Officer could have ordered *in camera* production of the documents. The Hearing Officer's failure to order, let alone propose, these possible measures as a means of balancing the Employer's needs in presenting and proving its case against the intrusion upon § 7 rights its subpoenas presented requires reversal of the Report's recommendation and remand for further proceedings.

To the extent an issue also existed with respect to disclosure of the Care Managers' sentiments regarding the Union, the Employer submits that concern is overcome by a finding that the Care Managers are supervisors. If, *arguendo*, the Board finds that the Care Managers are not supervisors, the Employer still had a right to secure the information sought in order to permit it to prosecute its objections and make a record for appellate review. Redaction measures like that the Employer proposed for staff nurses were equally available with respect to the Care Managers, i.e., names could have been redacted provided the redaction was coded to reflect that particular Care Managers (A, B, C, etc.) were involved in a communication. Undoubtedly, such measures would have made the mechanics of the Employer proving its case difficult. For example, it would have been necessary to denote information about Care Manager X consistently across different documents and communications so that the Employer could establish a clear record of instances in which Care Manager X (or any other Care Manager) distributed and collected authorization cards or otherwise promoted the Union. Such measures would have been superior, however, to outright denying the Employer the information it sought.

EXHIBIT P

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

SR-73 AND LAKESIDE AVENUE OPERATIONS LLC D/B/A POWERBACK REHABILITATION, 133 SOUTH ROUTE 73 Employer and DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTH CARE EMPLOYEES, AFSCME, AFL-CIO Petitioner	Case 04-RC-161250

DECISION ON OBJECTIONS TO ELECTION AND CERTIFICATION OF REPRESENTATIVE

Pursuant to a Stipulated Election Agreement, a representation election was held in this case on November 4, 2015, in a unit consisting of the Employer's registered and licensed practice nurses. The final tally showed 16 votes for and 14 votes against Petitioner with one non-determinative challenged ballot.[1] The Employer filed timely objections, and a hearing regarding the objections was conducted before Hearing Officer Elana Hollo. On June 30, 2016, the Hearing Officer issued a Report recommending that the objections be overruled and that Petitioner be certified as the representative for unit employees.

The Employer has filed Exceptions to the Hearing Officer's Report. Having reviewed the record, the Employer's Exceptions and supporting Memoranda and Petitioner's Opposition, I have decided to affirm the rulings made by the Hearing

[1] The registered nurses voted for inclusion in the same unit as the licensed practical nurses. The initial tally of ballots showed two determinative challenged ballots, but a hearing was held to determine the status of one of these voters, and the Hearing Officer concluded that the voter, Angela Lee, was not eligible. I adopted the Hearing Officer's conclusions in a Decision issued on January 11, 2016. The Board denied the Employer's Request for Review on March 29, 2016.

Officer at the hearing and, for the reasons set out below, to adopt her recommendations.

A. BACKGROUND

The Employer operates a 124-bed acute rehabilitation center in Voorhees, New Jersey. The first floor of the three story facility contains administrative offices, a kitchen and areas in which therapy is performed. Patients are housed on the second and third floors with each of these floors consisting of two hallways. Each hallway can accommodate 31 patients.

A Center Nurse Executive has overall responsibility for the nursing care provided to patients at the Employer's facility. Denise Johnson currently serves as Center Nurse Executive. Patricia Melora occupied the Nurse Executive position prior to mid-October 2015.

Reporting to the Nurse Executive are Clinical Directors. Clinical Directors work eight hour shifts – 7 a.m. to 3 p.m., 3 p. m. to 11 p.m., and 11 p.m. to 7 a.m. Two Clinical Directors are normally present on the day and evening shifts, one for each floor. There is only one Clinical Director present on the 11 p.m. to 7 a.m. shift.

Beneath the Clinical Directors are Care Managers, cart nurses and certified nursing assistants. Care Managers and cart nurses work 12½-hour shifts, either 7 a.m. to 7:30 p.m. or 7 p.m. to 7:30 a.m. The certified nursing assistants work the same eight-hour shifts as the Clinical Directors.

Care Managers must be registered nurses. There are typically four Care Managers present on each shift. Reporting to the Care Managers are the cart nurses and nursing assistants. Cart nurses can be either registered or licensed practical nurses. Eight cart nurses are assigned to each 12½-hour shift, four per floor. Twelve nursing assistants are assigned on the day and evening shifts with six assistants allocated to each floor. There are eight nursing assistants on the 11 p.m. to 7 a.m. shift, four on each floor. In addition to the Care Managers, cart nurses and nursing assistants, a Health Unit Coordinator is assigned to each twelve hour shift. The Unit Coordinators are nurses who perform clerical duties such as scheduling appointments and entering information into the facility's computer system.

The election in this case was held in a unit consisting of the Employer's cart nurses. Clinical Directors, Care Managers and Health Unit Coordinators were specifically excluded. The parties agree that Clinical Directors are supervisors within the meaning of Section 2(11) of the Act. They disagree on the status of the Care Managers. The Employer maintains that the Care Managers are statutory supervisors. Although Petitioner agreed to exclude them from the bargaining unit, it insists they do not possess supervisory authority.

The Employer initially filed four election objections, but failed to produce evidence at the hearing to support two of the objections. The Hearing Officer dismissed these objections for lack of proof, and the Employer has not excepted to this portion of her Report.

The two remaining objections focus on the conduct of Care Managers and Clinical Director Summer Valenti. The Employer contends that Care Managers interfered with the election by soliciting other employees to sign authorization cards and by expressing support for Petitioner during the critical period preceding the election. As for Valenti, the Employer produced evidence of a single arguably pro-union remark which she made prior to the filing of the petition and contends this comment also tainted the vote.

In her Report, the Hearing Officer found the Employer had failed to demonstrate that the Care Managers possessed supervisory authority within the meaning of Section 2(11) of the Act. As a consequence, she found that any pro-Petitioner comments made by the Care Managers were not objectionable. Alternatively, she concluded that, even assuming the Care Managers were statutory supervisors, the evidence produced by the Employer of pro-Petitioner remarks by Care Managers was not sufficient to overturn the results of the election. As for the single arguably pro-union remark made by Clinical Director Valenti, the Hearing Officer decided it was also insufficient to require a second election.

The Employer objects to both the Hearing Officer's conclusion that its Care Managers are not statutory supervisors and to her refusal to find that the conduct by Care Managers shown at the hearing was sufficient to require a second election. Similarly, it argues that Valenti's pro-Petitioner remark was enough to taint the election and excepts to the Hearing Officer's failure to adopt this position. Finally, the Employer objects to the quashing of subpoenas which it served on the Union and cart nurse Marilyn Viscome seeking social media, texts and chats regarding the Union campaign involving Care Managers and Clinical Directors. It also excepts

to my refusal to delay the hearing so that a subpoena seeking similar information from Clinical Director Valenti could be enforced.

As I explain below, I agree with the Hearing Officer that the Employer failed to demonstrate that the Care Managers exercise powers sufficient to make them supervisors within the meaning of the NLRA. Given this conclusion, I find it unnecessary to reach the question of whether the pro-union comments by Care Managers found by the Hearing Officer are sufficient to justify overturning the election.[2] As for the single pro-union remark attributed to Valenti by the Employer, I agree with the Hearing Officer that it is not enough to warrant a second election. Further, I reaffirm my decision made during the hearing that it is not appropriate to delay this proceeding to enforce a subpoena seeking possible pro-Petitioner social media postings by Valenti.

B. <u>The Status of the Employer's Care Managers</u>

At the hearing, the Employer argued that the Care Managers exercised supervisory authority in disciplining, assigning and directing cart nurses and certified nursing assistants (Tr. 731-42). In the area of discipline, the Hearing Officer properly concluded that the Care Managers' role is limited to reporting possible infractions. Care Manager reports are independently investigated by the Employer's Human Resources Department which is responsible for determining what, if any, discipline is appropriate (Tr. 183-185, 320, 360-61, 483, 498, 641-42). The Board has, as the Hearing Officer correctly noted, found that individuals who merely report possible infractions are not exercising the power to discipline within the meaning of Section 2(11) of the Act. Disciplinary authority will be found only where the putative supervisors can impose discipline without investigation by higher level managers. See, e.g., *The Republican Company,* 361 NLRB No. 15, at slip op. 5 (2014). Given this standard, I find the Hearing Officer appropriately decided that the Employer failed to prove the Care Managers have the power to discipline other workers, and I adopt her conclusion on this point.

I also adopt the Hearing Officer's refusal to find supervisory status on the basis of the Care Managers' job description. The Board has made clear its refusal

[2] Since the quashed subpoenas were designed principally to secure additional information regarding pro-Petitioner conduct by Care Managers and I am concluding that the Case Managers have not been shown to be statutory supervisors, I find that the information sought by the subpoenas is mostly irrelevant and that the subpoenas were properly quashed. See, *Veritas Health Services,* 362 NLRB No. 32, at fn. 1 (2015). The Employer has moved to reopen the record to include documents related to Petitioner's Petition to Revoke the subpoenas served on Petitioner and Ms. Viscome. The Motion is granted, and the documents attached to the Employer's Motion are hereby made part of the record in this case.

to rely on paper authority in assessing whether individuals should be deemed statutory supervisors. See, e.g., *Golden Crest Healthcare Center,* 348 NLRB 727, 731 (2006). Similarly, the Hearing Officer properly refused to consider secondary indicia such as the supervisor-to-employee ratio in determining whether the Employer established the Care Managers as supervisors. See, e.g, *Buchanan Marine, L.P.,* 363 NLRB No. 58 (2015) and *Modesto Radiology Imaging, Inc.,* 361 NLRB No. 24, at slip op. 3 (2014).[3]

This leaves the Employer's claim that the Care Managers exercise supervisory powers in assigning and directing subordinates. Although I agree with the Hearing Officer that the Employer failed to prove that the Care Managers exercise supervisory authority in these areas, I do so for the reasons set out below.

1. **Assignment**

According to the Board, the term "assign" as used in Section 2(11) refers to "the act of designating an employee to a place (such as a location, department or wing), appointing an employee to a time (such as a shift or overtime period) or giving significant overall duties, i.e., tasks, to an employee." *Oakwood Healthcare, Inc.*, supra., 348 NLRB at 689. The Care Managers' role in these areas is quite limited.

Scheduling Manager Melissa Yarnes determines the days, shifts and floors to which employees will be assigned. The Employer has created pre-printed forms which divide floors for purposes of cart nurse and nursing assistant assignments into equal groups of patient rooms. Cart nurses working on the third floor of the Employer's facility, for instance, will be assigned to either rooms 301-15, rooms

[3] The Employer argued at the hearing that Care Managers should be deemed supervisors because they are in some cases occasionally asked to substitute for Clinical Directors (Tr. 743-46). To support this claim, it produced a summary showing the number of times each Care Manager acted as a Clinical Director during the period from January to October 2015 (Er-8). This summary showed a wide range in the frequency with which individual Care Managers served in the Clinical Director position with most Care Managers substituting on relatively few occasions. Of the 15 Care Mangers shown on the exhibit, 10 acted in the Director position less than 10 times and 3 did not act at all. Some Care Managers did act more frequently but there did not appear to be any discernible pattern to their service as Clinical Directors. Katrina McNeal, for instance, served as a substitute Clinical Director on 26 occasions during the period shown on the Employer's exhibit, but most of that service occurred during the month of February 2015, and McNeal did not act at all in the months of September or October 2015. Further, former Center Nurse Executive Patricia Melora indicated that Care Managers do not necessarily exercise all of the authority associated with the Clinical Director position when acting as substitutes (Tr. 443, 505-06). To establish supervisory status based on substitution, the Employer was obliged to show that the Care Managers as a group spent a regular and substantial portion of their time acting in the Clinical Director position. *Oakwood Healthcare, Inc.,* 348 NLRB 686, 698-99 (2006). In view of the limited substitution by many Care Managers and the absence of any regular substitution pattern, I find the Employer failed to meet this burden.

316-31, rooms 332-47 or rooms 348-62. The forms also show the break times for each nurse and assistant and indicate ancillary duties associated with each set of rooms. The nurse designated to work rooms 301-15, for example, is also supposed to handle "AED monitor & Code cart check Monitor pt (Fire)." (Er-22; Tr. 575-82).

Clinical Directors or Care Managers fill in the assignment sheets. The sheets are normally completed by the Director or Care Managers on preceding shifts. Night shift Director Summer Valenti, for instance, completes the assignment sheets for the day shift cart nurses and nursing assistants. Valenti always fills out the sheets when she is present. Night shift Care Managers only do the day shift assignments on nights when Valenti is out. (Tr. 384, 687-89, 206). Care Managers on day shift do sometimes fill out assignment sheets even if Clinical Directors are present. Scheduling Manager Yarnes testified to her impression that Care Managers on day shift contacted her about the sheets more often than Directors. Beyond this, the record does not indicate how frequently day shift Care Managers are asked to fill out the sheets. (Tr. 500, 576, 206).

Most cart nurses have permanent room assignments – i.e., they are assigned to work the same group of rooms on every shift they work. Nursing assistants are not officially given permanent assignments but are also normally assigned to work the same group of rooms whenever they work. In filling out assignment sheets, the Directors and Care Managers begin by penciling cart nurses and nursing assistants into their permanent assignments. Floaters or agency nurses are then assigned to open slots. If more than one employee without a permanent assignment is present, Care Manager Marsha Lake reported considering employee skill level and patient acuity in deciding on the open slot into which the non-permanent employees should be placed. She did not say how often this occurred (Tr. 289-90, 344, 608, 640, 687, 191, 208, 254-55).

If a cart nurse is absent, a Care Manager will handle her patients. A rotation is used to determine which Care Manager will take the assignment. Care Manager Martha Lake reported that normal assignments might be shifted when a Care Manager is obliged to fill in so that the Care Manager has the easiest patients and will be able to also perform her Care Manager functions. Lake did not provide specific examples of such assignment shifts or indicate how often they take place. (Tr. 287, 291-92, 374, 633)

The Employer has developed revised assignment sheets which are used if nursing assistants call off. Like the normal sheets, the revised sheets divide a floor

into an equal number of rooms so that each assistant has a roughly equal assignment. As I noted above, each floor is divided into two hallways. When an odd number of assistants is present, one of the assistants is obliged to handle patients in both hallways. Care Managers may ask for a volunteer in this situation or assign the assistant whose normal room assignments are closest to the other hall. (Tr. 501-02, 609, 634-36, 673-74, 132)

Normal room assignments are occasionally altered for reasons other than employee absences. Two nurses with same permanent room assignment will sometimes be assigned to the same shift. Care Manager Marsha Lake indicated that in this situation she will typically have the nurse who most recently worked handle her usual assignment and reassign the other nurse. (Tr. 256, 343, 346). Care Manager Rachel Upshur reported that the nurses themselves usually decide who will switch in this situation (Tr. 640-41). Neither Lake nor Upshur indicated how often this problem comes up.

Patients sometimes object to particular cart nurses or nursing assistants, and a Care Manager or Clinical Director will have the nurse or assistant trade patients with another employee to resolve the problem. Care Manager Lake was able to recall two occasions on which she made such switches. Care Manager Kelly McCarthy remembered being involved in one change due to a patient complaint. (Tr. 257-59, 297-99, 192, 314-17).

Lake also testified that she will sometimes have a second nursing assistant assist with particular patients if the patient has a history of being difficult or has a condition which would make it unsafe for just one employee to provide care. She did not provide specific examples of situations in which this has occurred or indicate how often it takes place (Tr. 259).

One of the nurses assigned to Lake's area has difficulty providing wound care, and Lake indicated that she might switch patients if a patient requiring wound care was admitted to this nurse's regularly assigned area. She was able to cite one example of this taking place. When a patient with a particularly serious wound was assigned to the nurse's area, the nurse confessed that she was not good at wound care. According to Lake, this confession prompted a decision to switch patients with another nurse. (Tr. 256, 306-07, 311).[4]

[4] Lake generally asserted that she would also switch assignments if a nurse with no "trach" experience was assigned to a "trach" patient. She conceded, however, that this has never happened (Tr. 323-24, 326).

Beyond the examples cited above, the record does not contain evidence of Care Managers making changes in the overall employee assignments set out in the Employer's assignment sheets.[5] In fact, Care Manager Upshur testified that the only time she alters assignments is when there is a call out. (Tr. 656).

Analysis

As I noted above, the role of Care Managers in the assignment of subordinate employees is limited. Scheduling Manager Yarnes decides the days, shifts and floors on which employees will work. Pre-printed forms determine how patients on a particular floor will be divided among the employees. Clinical Directors frequently fill out the pre-printed forms. And, to the extent Care Managers complete the assignment sheets, they merely pencil employees into their normal spots and slot extra workers into any remaining openings. This process does not appear to involve any exercise of significant judgment.

Care Managers do become involved if assignments have to be shifted due to employee absences, but there is, once again, little evidence that much judgment is involved. A Care Manager will substitute if a cart nurse calls off, and the selection of the substitute is determined by a rotation. Pre-printed forms determine how work is to be divided if nursing assistants are absent. At most, a Care Manager might be required to determine which assistant will have to handle patients on two hallways, and this determination appears to be made by either soliciting volunteers or designating the assistant whose normal assignment is located closest to the point at which the hallways intersect. There is no indication employee skill or ability is considered.

In some situations, Care Managers do appear to exercise judgment in adjusting overall patient assignments, but much of the Employer's evidence regarding such situations lacked specificity. Care Manager Lake reported considering employee skills when she is obliged to fill more than one open slot in a schedule and claimed continuity of care governed when two employees with the same permanent assignment turned up on the same shift and one had to be moved. But, Lake did not describe any specific examples of these situations or suggest how often they arose. Further, Care Manager Rachel Upshur testified that cart

[5] In its Memorandum in support of Exceptions, the Employer cites as evidence of assignment power some examples which are more appropriately considered as "direction." For instance, Care Managers will sometimes ask employees to assist with particular admissions, to start IVs if the employee assigned to a patient is not certified for IVs or to handle a specific treatment if the nurse assigned to a patient lacks experience. In the Board's view, such individual assignments are part of directing work and do not involve the overall designation of tasks which it regards as "assignment" within the meaning of Section 2(11). *Oakwood Heathcare, Inc.*, supra at 689.

nurses often decide on their own who will move if two nurses with the same permanent assignment are scheduled together.

Lake also claimed she will sometimes have two assistants handle a patient jointly, but she did not describe specific examples of this taking place or indicate that relative employee skill and ability determines which assistant will be asked to help in this situation. Lake did generally say that she will reassign patients if employees have difficulty performing treatments the patients require, but she could cite only one example in which such a switch was made and the switch was instigated by the employee rather than Lake. Lake and fellow Care Manager Kelly McCarthy testified to changing assignments due to patient complaints, but could only identify three situations in which such reassignments were made.

In short, the evidence of Care Managers making adjustments in assignments which at least arguably required some level of judgment was either lacking in specificity or involved just a handful of incidents. As the proponent of supervisory status, the burden was on the Employer to prove that the Care Managers used independent judgment in making overall assignments of work. *NLRB v. Kentucky River Community Care, Inc.,* 532 U.S. 717, 721 (2006). And, the Board will not find supervisory status absent specific evidence that an individual has exercised supervisory authority on a more than occasional or sporadic basis. *Cook Inlet Tug & Barge, Inc.,* 362 NLRB No. 111, at slip op. 2-3; *Modesto Radiology Imaging, Inc.,* supra. at slip op. 3; *The Republican Company,* supra. at slip op. 8; *Lynwood Manor,* 350 NLRB 489, 490 (2007). To the extent the Employer provided specific evidence, it shows Care Managers either making routine assignments or exercising judgment in altering assignments on rare occasions. Agreeing with the Hearing Officer, I find that the Employer failed to prove that the Care Managers "assign" work within the meaning of Section 2(11).

2. **Responsible Direction**

Direction as defined by the Board includes making discrete assignments and monitoring the performance of subordinates. See, *Golden Crest Healthcare Center,* supra. at 730. To establish supervisory status under this criteria, a party is obliged to demonstrate that the alleged supervisors used independent judgment in providing direction, had the ability to take corrective action in the event subordinates failed to follow their instructions and could suffer consequences, negative or positive, as a result of their subordinates' performance. *Community Education Centers,* 360 NLRB No. 17, at slip op. fn. 1 (2014).

It seems clear from the record that Care Managers do direct the work of the cart nurses and nursing assistants. Care Managers Lake and McCarthy testified that they monitor cart nurses to make certain proper treatments are being given, prescribed medications are being dispensed and reports are being completed (Tr. 132, 272). Similarly, former Care Manager Janice St. John indicated that she spoke to employees if she noticed they had not completed tasks and cart nurse Kellie Stevens reported having Care Managers talk to her about her failure to finish work in a timely manner (Tr. 50, 683).

There is also evidence of Care Managers making discrete assignments. If multiple patients are admitted to an area assigned to a particular cart nurse, Care Managers will assign another nurse to handle one of the admissions (Tr. 262, 300, 188). Care Managers direct assistants and cart nurses to change catheters or turn patients more frequently than required by Employer protocols (Tr. 447-48, 452-54). If an emergency arises with a patient, the Care Manager may direct employees to perform particular tasks in connection with the emergency although there is also evidence that cart nurses sometimes take control in this situation (Tr. 642-45, 661, 141-43, 269, 272. Care Managers may ask employees to assist other workers who have fallen behind in distributing medications. On occasion, Care Managers have nurses handle treatments on another nurse's patients if the nurse assigned to the patient is inexperienced or has trouble performing particular treatments (Tr. 188-89, 140, 256). When IVs must be started, Care Managers make certain the employee handling the task has the necessary certifications (Tr. 271).

The record also shows that Care Managers can take corrective action if assignments are not handled properly. Care Manager McCarthy reported counseling employees about taking overlong breaks or failing to inform her of changes in a patient's conditions (Tr. 152). Care Manager Upshur indicated that she informs a Clinical Director if she receives reports of employees failing to perform assigned tasks (Tr. 663-64). And, the Employer produced evidence of two occasions on which employees were disciplined as a result of incidents reported by Care Managers (Er-14 to 19).

As the Hearing Officer correctly noted in her Report, however, there is not much evidence that Care Managers exercise independent judgment in monitoring and assigning work. The tasks performed by cart nurses and assistants appear routine, and none of the witnesses explained how independent judgment is required to make certain that medications or treatments have been given or reports filled out. Care Managers do exercise medical judgment in deciding that catheters

should be changed or patients turned more frequently, but there is no evidence supervisory judgment is exercised in determining which employee should be assigned to perform the required tasks. Making certain employees are certified to insert IVs requires Care Managers to simply check for the required certification and does not require any independent evaluation of employee skills and abilities. Assignments in emergencies appear to be based mostly on availability as do adjustments made when an employee falls behind in her work (Tr. 302). Further, emergencies are not regular occurrences. Former Center Executive Melora testified that there were only four or five emergencies between January and November 2015 (Tr. 508).

Care Manager Lake did testify that she sometimes considers experience and ability in deciding which cart nurse to ask to assist with admissions (Tr. 260-61). But, Lake also made clear that availability is a critical factor in deciding who to have assist. If the nurse assigned to the area to which a patient is to be admitted is not done with her regular assignments and another nurse is finished, then Lake will assign the admission to the nurse who is free (Tr. 326-27). The Board has indicated that this sort of reassignment to equalize workloads does not require independent judgment and is not evidence of supervisory authority. *Golden Crest Healthcare Center,* supra. at 730, fn. 9. Lake reported that she makes reassignments related to admissions at least twice per month (Tr. 268), but she did not indicate how many of these reassignments involve considerations of relative skill as opposed to availability. As a consequence, it is not clear assignments based on skill and experience take place on more than a sporadic basis.

To the extent Care Managers shift treatments because of cart nurses' experience levels or ability to perform tasks, independent judgment is plainly involved. But, the Employer did not establish that such reassignments take place with sufficient frequency to support a finding of supervisory status. Lake reported reassigning wound care away from a particular nurse, but did not say how often she made such reassignments beyond recounting one specific example (Tr. 271, 306-07, 311).

Other than Lake, Care Manager McCarthy was the only witness to testify about shifting specific assignments based on concerns about the ability of employees to handle tasks. According to McCarthy, she will perform a task if she is concerned that the cart nurse assigned to a patient does not have sufficient experience (Tr. 140). She did not say how often she steps in and did not report reassigning tasks to other nurses. In short, agreeing with the Hearing Officer, I

find the evidence insufficient to show that Care Managers exercise independent judgment on more than a sporadic basis in directing the work of subordinates.

I also find that the Employer failed to demonstrate that Care Managers are held accountable for the performance of the cart nurses and nursing assistants. Most of the testimony presented by the Employer on this point was conclusionary. Former Center Executive Melora, for instance, declared that Care Managers are accountable for making certain the work of subordinates is completed in a timely manner and claimed she had spoken with Care Managers about subordinate performance but did not offer specific examples (Tr. 423-24). Care Manager McCarthy testified that she considers herself responsible for the performance of subordinates, but did not explain the basis for this conclusion. Further McCarthy admitted that none of her superiors have ever spoken to her about a subordinate's failure to perform as expected (Tr. 151). Care Manager Upshur and former Care Manager St. John concurred with McCarthy on this latter point, testifying that they were never disciplined or held responsible for subordinate performance (Tr. 645, 675).

Care Manager Marsha Lake was the only witness to offer more specific testimony on the issue of accountability. Lake reported that Melora stated when Lake was hired as a Care Manager that Lake would be responsible for the work of cart nurses. Lake also described an incident in which she was questioned by a Clinical Director as to why a nurse did not appear to have given a patient required fluids (Tr. 274, 295-96).[6] Although Lake believed she could have been disciplined if the nurse had neglected to provide fluids, she did not say she had been told this. In fact, Lake did not report ever actually being told she would suffer consequences as a result of subordinate performance.

The Board has made it clear that conclusionary testimony and witness suppositions are not sufficient to establish that an alleged supervisor is held accountable for subordinate performance. To establish supervisory status under the responsible direction criteria, a party must demonstrate by specific evidence that the alleged supervisors have suffered, or at least have been told they will suffer, consequences if the employees they supposedly supervise fail to perform. *Community Education Centers, Inc.,* supra. slip op. 1-2; *Lynwood Manor,* supra. at 490-91. Such evidence is completely lacking here, and I find, as did the Hearing

[6] An investigation disclosed that fluids had actually been given and that the nurse had simply failed to complete the appropriate records.

Officer, that the Employer has failed to demonstrate that its Care Managers responsibly direct other workers.

In sum, I adopt the Hearing Officer's conclusion that the evidence produced by the Employer is insufficient to demonstrate that Care Managers are statutory supervisors. And, lacking evidence that the Care Managers are supervisors, I find that pro-Petitioner remarks they made in the period leading up to the election did not taint the result. To the extent the Employer's objections are based on the conduct of the Care Managers, I agree with the Hearing Officer that they should be overruled.

C. The Conduct of Clinical Director Summer Valenti

In addition to relying on the behavior of its Care Managers, the Employer contends that Clinical Director Summer Valenti engaged in objectionable conduct during the period leading up to the representation election in this case. To support this claim, it introduced testimony by Care Manager Kelly McCarthy regarding a single arguably pro-union comment made by Valenti.

Referring to Petitioner's organizing campaign, McCarthy indicated that the remark in question had been made "well before all this was put into place."[7] Employees at the Employer's facility conduct mid-shift "huddles" to review the status of patients. During a huddle, employees complained about staffing. Valenti responded by saying, "Well there's always the Union, but I can't be part of that." (Tr. 127-29). McCarthy did not report any other pro-union comments by Valenti, and the Employer did not present evidence of additional pro-union remarks by Valenti or any other Clinical Director. The Employer's claim of taint rests entirely on the lone remark reported by McCarthy.

Applying the standards set out by the Board in *Harborside Healthcare, Inc.*, 343 NLRB 906, 909 (2004), I have no difficulty in finding Valenti's one comment insufficient to justify overturning the election. The remark was made well in advance of the organizing campaign and outside the critical period between the filing of the petition and the election. Moreover, it was an isolated comment. Although Valenti had authority over the employees who heard the remark, the comment was not accompanied by any hint of coercion and Valenti specifically indicated that she would not be involved in any organizing campaign. Further,

[7] The Hearing Officer mistakenly found in her Report that McCarthy did not place Valenti's comment in time. Correcting this error, I find the remark was described by McCarthy as having been uttered a substantial, but unspecified, period of time prior to the start of the organizing effort.

there is no evidence of Valenti's comment being disseminated beyond the individuals present when she made the remark or of employees commenting on Valenti's statement after it was made.

At most, Valenti made a mildly pro-union comment well before the start of the organizing campaign. The Board has refused to overturn elections despite far more extensive pro-union conduct by supervisors. See, *Laguna College of Art and Design,* 362 NLRB No. 112, at slip op. *fn. 3 (2015); Northern Iowa Telephone Co.,* 346 NLRB 465 (2006). I find that Valenti's comment did not taint the election.

The Employer argues in its Memorandum in Support of Exceptions that I should reconsider a ruling I made during the hearing denying the Employer's request that I enforce a subpoena requiring Valenti to produce texts, e-mails and other social media postings in her possession regarding Petitioner's campaign. Having reconsidered the matter, I adhere to my original decision.

Valenti remained employed by the Employer at the time of the hearing in a supervisory Clinical Director position. The Employer introduced into evidence during the hearing an affidavit signed by its counsel describing contacts he had with Valenti. The affidavit portrays Valenti as mostly cooperative. She initiated contact with counsel shortly after the election, discussed dates for her appearance as a witness at the hearing and forwarded documents to counsel (Er-27). Given Valenti's position and her apparent willingness to cooperate, it seems likely counsel asked her about any pro-union comments she might have made beyond the single remark reported by McCarthy.

Further, the Employer called as witnesses both McCarthy and another employee, Kelli Stevens, who worked with Valenti on the night shift during the lead up to the representation election. If Valenti had been campaigning for Petitioner prior to the vote, it seems likely McCarthy and Stevens would at least have heard of her activities and Employer counsel would have discovered the conduct when interviewing McCarthy and Stevens. Through either Valenti or McCarthy and Stevens, the Employer should have been in position to discover any pro-Union activity engaged in by Valenti beyond the one comment mentioned at the hearing.

The Employer did not, however, allude at the hearing to any concrete evidence of additional pro-Union conduct by Valenti, and it does not make reference to such evidence in arguing now that the hearing should be reopened to allow it to examine Valenti's personal electronic devices. And, the Employer's

failure to refer to any evidence suggesting additional conduct by Valenti makes it reasonable to infer that it has not been able to uncover such evidence despite having a more than reasonable opportunity to do so.

Given the circumstances, the Employer's subpoena to Valenti is, at best, a fishing expedition. The Employer may hope the subpoena will turn up objectionable conduct but has offered no particular reason to think that it will. In this situation, I find that delaying the proceedings to enforce the Employer's subpoena would be inappropriate. The waste of time involved clearly outweighs the remote chance that the subpoena will reveal probative material. I reaffirm my original decision and deny the Employer's request to reopen to record so that the Valenti subpoena can be enforced. And, in the absence of evidence of conduct in addition to Valenti's lone pro-union remark, I shall overrule the Employer's objections.

D. Conclusion

Based on the above, I find that the Employer's objections do not constitute grounds for setting aside the election. The objections are hereby overruled. Accordingly, I am issuing a Certification of Representative.

CERTIFICATION OF REPRESENTATIVE

IT IS CERTIFIED that a majority of the valid votes counted have been cast for District 1199C, National Union of Hospital and Healthcare Employees, AFSCME, AFL-CIO and that it is the exclusive collective-bargaining representative of the employees in the following appropriate unit:

All full-time and regular part-time Staff/Bedside Registered Nurses (RN) and Licensed Practical Nurses (LPN) employed by the Employer at its facility located at 113 South Route 73, Voorhees, New Jersey; excluding all other employees, Office Clerical Employees, Clinical Directors, Care Managers, Health Unit Coordinators (HUCS), Clinical Reimbursement Coordinators, Clinical Reimbursement Analysts, Nurse Practice Educator, Managerial Employees, Guards and Supervisors as defined in the Act.

REQUEST FOR REVIEW

Pursuant to the provisions of Section 102.69(c)(2) of the Board's Rules and Regulations, any party may file with the Board in Washington, D.C., a request for review of this decision. This request for review must conform with the requirements of Sections 102.67(e) and (i)(1) of the Board's Rules and must be received by Washington by **August 15, 2016**. If no request for review is filed, the decision will be final and shall have the same effect as if issued by the Board.

A request for review may be E-Filed through the Agency's website but may not be filed by facsimile transmission. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number and follow the detailed instructions. If not E-Filed, the request for review should be addressed to the Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570-0001. A party filing a request for review must serve a copy on the other parties and file a copy with the undersigned. A certificate of service must be filed with the Board along with the request for review.

Dated August 1, 2016:

Harold A. Maier

Harold A. Maier
Acting Regional Director,[8] Region 4
National Labor Relations Board
615 Chestnut Street, 7th Floor
Philadelphia, PA 19106-4404

[8] Regional Director Dennis P. Walsh is recused from this matter.

EXHIBIT Q

Industrial and Organizational Psychology, **4** (2011), 146–164.
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FOCAL ARTICLE

Why Is Performance Management Broken?

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PDRI, an SHL Company

Abstract

Although extensive research and practice have focused on understanding and improving performance management systems in organizations, the formula for effective performance management remains elusive. We propose that a significant part of the problem is that performance management has been reduced to prescribed steps within formal administrative systems that are disconnected from the day-to-day activities that determine performance management effectiveness (e.g., communicating clear work expectations, setting short-term objectives and deadlines, and providing continual guidance). We argue that interventions to improve performance management should cease their exclusive focus on reinventing formal system features. Although well-developed tools and systems can facilitate performance management, these alone do not yield effective performance management. In lieu of making further changes to formal performance management systems, we argue for devoting more attention to improving manager–employee communication and aspects of the manager–employee relationship and propose an approach we believe holds promise for improving performance management processes in organizations.

For over 30 years, extensive research and practice have focused on understanding and improving performance management systems in organizations. Some research has examined the effects of various factors on ratings, including format (Bernardin, 1977; Borman, 1979; Landy & Farr, 1980); rater and ratee characteristics, such as gender, race, liking, and so forth (Landy, 2010; Pulakos & Wexley, 1983); and rater cognitive processes (DeNisi, Cafferty, & Meglino, 1984; Feldman, 1986), among others. Yet, other work has examined what features lead to successful system implementation, such as automation to improve efficiency (Pulakos, 2009) and leadership support and employee buy-in (Rodgers, Hunter, & Rogers, 1993). Finally, several large-scale survey studies have examined what performance management features are most related to employee engagement and performance outcomes (Corporate Leadership Council, 2004; Creative Metrics, 2008; Harter, Schmidt, & Hayes, 2002; Office of Personnel Management, 2007).

Although the cumulative research and practice have yielded performance management methods, tools, and processes that should work well, operational implementations have proven disappointing. This is consistent with what we have experienced

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This article was based on Elaine Pulakos' Distinguished Professional Practice Award address at the 2010 SIOP conference in Atlanta, GA. The authors would like to thank Thomas K. Coghlan and Edward K. Moe for providing insightful comments on an earlier draft of this article. These individuals bring valuable perspectives based on their roles leading to large, complex, and challenging performance management interventions in major organizations. We also thank Rose A. Mueller-Hanson and Anne M. Hansen of PDRI for their helpful reviews of this article.

as we implemented many large-scale performance management systems over the past 15 years. For example, no solution has been found to ameliorate the seemingly intractable problem of leniency in ratings, which at the extreme renders performance evaluations of little value for decision making (e.g., pay, promotion, etc.) or validation research. Although implementation of a new performance management system is usually accompanied by decreased leniency during the initial rating cycle, rating levels creep up again over time. As another example, survey data consistently show poor attitudes toward performance management, with many employees reporting that their system fails to provide useful feedback and establish clear expectations. Thus, after extensive analysis and study, the formula for effective performance management remains elusive.

It is perhaps for this reason that performance management has been characterized by innumerable attempts to improve it, more so than it seems to be the case with other human capital systems. In the last 20 years, recommendations have been made to evaluate results, competencies, behaviors, and contributions; to rate performance using highly differentiated 5-, 7-, or 9-point scales, much simpler pass–fail scales, strictly developmental scales, or no scales and instead prepare written narratives; to collect ratings from supervisors, peers, customers, or the employees themselves; to cascade goals from the highest organizational level to individual employees, to establish individual's objectives that are rated directly, or not to include goals; and the list goes on. As long as a new approach holds promise for increasing performance management effectiveness, organizational members from top-level leaders to human resource professionals seem to flock to it. What happens so often, however, is that new performance management practices are enthusiastically and readily adopted, without sufficient consideration of what it takes to implement them effectively or how they will fit within an organization's culture (Pulakos, 2009). This has led to vicious cycles of organizations reinventing their performance management systems every few years only to suffer implementation failures that necessitate reinventing the system again, and the cycle continues.

The challenges inherent in performance management are well known. It has rightly earned its distinction as the ''Achilles Heel'' of human capital management, rarely working well irrespective of the time, effort, and resources that are devoted to it. Yet, communicating what employees are expected to do, providing feedback, and helping employees contribute the most they can are essential behaviors managers must engage in to accomplish work through others. Done effectively, performance management communicates what's important to the organization, drives employees to achieve results, and implements the organization's strategy. Done poorly, performance management not only fails to achieve these benefits but can also undermine employee confidence and damage relationships. The extremely large number of unsuccessful attempts to improve performance management speaks volumes about its inherent difficulties.

We believe that a significant part of the problem is that performance management has been reduced to prescribed, often discrete steps within formal administrative systems, the results of which are highly scrutinized. Although formal performance management systems are intended to drive and reinforce the day-to-day activities of communicating ongoing expectations, setting short-term objectives, and giving continual guidance as work is planned and executed, these behaviors seem to have become largely disconnected from the formal systems. For example, effective managers regularly provide informal feedback to employees on specific tasks, but the same managers are often reluctant to formally document less-than-stellar performance for fear of damaging relationships with the very individuals they count on to get the work done. Similarly, many employees want guidance from their managers about how to accomplish work, yet they do not want documented examples of them needing

guidance for fear that these will undermine their pay or advancement. These concerns on the part of managers and employees prevent formal performance management systems from working well and have turned them into largely administrative drills that add little value. Contributing to this is the fact that performance management implementations tend to focus on rolling out formal administrative processes and tools (e.g., competency models, rating scales, and automated systems) rather than training managers and employees how to engage in effective performance management behavior (e.g., setting expectations, providing feedback, and helping staff solve problems). However, it is the informal process of engaging in these behaviors day-to-day that determines performance management effectiveness, not the tools and steps that comprise the formal system.

In this article, we argue for a shift in the focus of performance management interventions in two important ways. First, we believe unbridled implementation of performance management system changes should cease. This is because making changes to the formal performance management system has not been shown to improve performance management effectiveness. Further, implementing new practices that seem compelling but are difficult or impractical to sustain can cause negative consequences, such as eroded credibility and increasingly negative attitudes towards performance management. To illustrate these points, we provide examples of the difficulties involved in implementing four popular performance management practices below. The second shift we propose is to devote more attention to improving manager–employee communication and aspects of the manager–employee relationship that are foundational for effective performance management. Although well-developed tools and systems can facilitate performance management, these alone do not yield effective performance management, as this can only occur between people. We thus propose an approach for enhancing manager–employee communication and relationships that we believe holds promise for yielding sustainable performance management improvement.

What It Takes to Implement Four Popular Performance Management Practices

Popular Practice 1: Cascade Organizational Goals to Individual Employees

One of today's popular performance management practices is to cascade organizational goals from the top and refine them through each level until they reach individual employees. The idea of linking objectives across organizational levels dates back many decades to discussions of managing by objectives (Rodgers & Hunter, 1991). Proponents of cascading goals argue that they help everyone understand how work is related across organizational units and levels, and they also align the work of individuals and units with the organization's direction and priorities (Hillgren & Cheatham, 2000; Schneier, Shaw, & Beatty, 1991). Although understanding these relationships is important and helps to avoid confusion, redundancy, and turf battles, there are questions as to whether or not a formal process of cascading goals is the most effective way to achieve this.

Although the rationale underlying cascaded goals makes sense, creating the cascade itself is extremely challenging operationally. First, high-level organizational goals are often lofty and broad, which often causes confusion and frustration when managers attempt to cascade them. Second, the process of cascading goals through multiple levels necessitates many meetings that are contingent on the previous level completing their cascade. As a practical matter, although the organization and perhaps its largest divisions may have goals, it has been our experience that cascaded goals rarely reach past the highest few levels. Thus, it can take months of work well into the performance management cycle

Table 1. *Popular Practice 1: Cascade Organizational Goals to Individual Employees*

Proponents advocate	Reality
• Cascade goals so that each level supports goals relevant to the prior higher level • Help employees gain an understanding of how their work relates to higher levels • Align the employee's activities with the organization's strategic direction and goals	• Organizational goals can be lofty and difficult to cascade down to individuals • It is time consuming and difficult to cascade goals, especially the first time • Considerable consultant or HR time is needed to facilitate the cascade • If employees do not attach a high value to cascaded goals, the burdensome process will be frustrating and yield negative attitudes • The advantages associated with cascading goals can be achieved through more informal and simpler communication processes

before individual objectives can be written, although the process becomes more efficient after it has been completed once.

Given that less than 10 hours per year, on average, is devoted to performance management activities per employee (Brentz, Milkovich, & Read, 1992), the decision to implement a formal cascade must be made with a corresponding commitment to devote significantly more time to performance management activities. Because the process of cascading goals is difficult and burdensome to execute well, it often collapses under its own weight. Although training managers how to cascade goals is helpful, facilitated sessions with trained professionals yield higher quality cascades with less frustration and wheel spinning than when organizational members attempt to cascade goals on their own. In lieu of a formal cascade, informal discussions among leaders, managers, and employees can be equally useful in gaining a common understanding of direction, roles, and boundaries so that work can proceed in an organized manner.

Bottom line recommendation regarding cascaded goals. In light of the complexity, practical implementation challenges, and potential risk for failure, we do not recommend that cascaded goals be implemented in the vast majority of organizations. If the practitioner or organizational decision makers believe that there is an organizational issue or problem that is best addressed by cascaded goals, they should be implemented only if commitment to the resources and time that are necessary to achieve quality results can be secured from all involved parties (Table 1).

Popular Practice 2: Set SMART Performance Goals

A popular practice today is to evaluate performance based on whether employees meet SMART (specific, measurable, attainable, relevant, time-bound) goals developed at the beginning of the rating cycle. The stated advantages of the goals are to (a) provide customized performance expectations and criteria based on the employee's specific job, (b) drive employees to achieve important results, and (c) remove unfair subjectivity from the evaluation process. Although it is certainly important for managers to communicate what they expect each employee to achieve, it is not clear that setting formal goals for each employee is the most effective way to accomplish this or that this is even viable for all jobs. Even when well-researched guidelines (Locke & Latham, 1990) for setting goals have been used, significant challenges have

been reported (e.g., Government Accountability Office, 2008).

Jobs that lend themselves best to setting goals have relatively static performance requirements and defined productivity metrics, for example, many manufacturing jobs. However, setting goals for today's increasingly knowledge and service-based jobs is more challenging. The fluid and unpredictable nature of these jobs means that one's objectives can change frequently, necessitating continual revision and increasing the work associated with performance goals (Cascio, 1998; Pulakos, Mueller-Hanson, & O'Leary, 2008; Pulakos & O'Leary, 2010). Even when jobs are relatively predictable, goals set at the start of the performance cycle often cannot account for special assignments or other duties that may arise during the year. Goals also do not work well when goal attainment is dependent on factors outside the employee's control or that are team oriented (Lawler, 1994; Locke & Latham, 1990; Ployhart & Weekley 2009). Some jobs do not lend themselves to setting objectives at all, such as many R&D jobs in which it is impossible to predict when and what discoveries will occur.

Assuming that goals are practical in a given situation, evaluations have consistently found poor quality goals, even after training. They often read like generic task statements rather than goals with measurable outcomes, and the specificity, complexity, and difficulty of the objectives vary considerably for employees occupying identical jobs (e.g., Government Accountability Office, 2008). Especially during initial implementation, it helps to have coaches available to provide feedback on the relevance, clarity, and equivalence of the goals for similarly situated employees, as this both improves the quality of the goals and further trains managers and employees to write better ones. Other strategies to enhance the quality and fairness of goals include (a) implementing a process similar to frame-of-reference training (Bernardin & Buckley, 1981), in which managers review and discuss goals to ensure that they are sufficiently specified, consistent, and fair; (b) collecting and storing high-quality goals in a searchable database organized by job and level so they are accessible and can be used as a starting point to develop goals for others; and (c) evaluating employees not only on whether they achieved their goals, but also on the difficulty and complexity of what they contributed. Although evaluations of difficulty and complexity introduce subjective judgments and thus the need for subjective criteria against which to make such evaluations, we have found that incorporating these factors provides a much fairer and more accurate assessment of contributions.

One final issue with goal-based performance management systems is that the recommended number of objectives per employee is usually three to five per year. What this means is that the goals will necessarily represent major projects or pieces of work and thus be at a fairly high level. It is a mistake to assume that high-level goals, even with associated measurable criteria, will be sufficient to ensure the desired outcomes. This is because higher level goals need to be translated into more specific plans, activities, milestones, and interim deliverables that employees will accomplish day-to-day to meet their larger objectives over the course of a year. Managers have an important ongoing role in monitoring how goals are being translated into daily work activities and helping employees identify and remediate gaps that may cause short falls in their performance.

Although managers need to tell employees what they are expected to achieve, the issue is whether this is best accomplished through setting formal goals at the beginning of the rating period or engaging in more informal and ongoing manager–employee discussions in which expected results are communicated and adjusted as circumstances unfold. Even in relatively stable jobs with reasonably defined outcomes, developing effective and fair goals can be challenging and require considerable time from both managers and employees. However, even after extensive guidance and

training, the quality of goals is often still poor, leading some to suggest that writing effective objectives is simply too hard and not worth the effort. It is certainly not realistic to expect goal-based systems to work well immediately following implementation because it takes experience to develop good goals, deliver on them, and put the infrastructure in place that is needed to support an effective system.

Bottom line recommendation regarding SMART goals. In the vast majority of work situations, especially those characterized by knowledge and service work, the complexity, practical implementation challenges, and potential risk for failure are too great to recommend formal goal setting and evaluation against those goals for individual employees. Formal individual goals should be considered only in those rare jobs and situations in which they can be easily established and aligned with the work (i.e., performance is not affected by factors outside the employee's control, goals and performance measurement are clear-cut and objective, etc.). However, team or unit goals can be practical to develop and evaluate in many of today's organizations. Although we recommend limited and prudent use of individual goals overall, clearly communicating expectations and providing on-going feedback as the work progresses is essential for effective performance management (Table 2).

Popular Practice 3: Rating Competencies

Although goals that are purported to drive results are popular today, an exclusive focus on results can yield deficient performance measurement because little or no consideration is given to *how* employees go about accomplishing work (Borman, 1991). Although one might achieve impressive results, overall performance is not effective if individuals are extremely difficult to work with or otherwise exhibit ineffective behavior. Performance that reflects how an employee accomplishes work is typically evaluated by rating their competencies (e.g., communication, critical thinking, managing resources, etc.). When competencies were first introduced, there was no

Table 2. *Popular Practice 2: Set SMART Performance Objectives*

Proponents advocate	Reality
• Managers and employees collaboratively identify performance objectives specific to the employee's job • Use of objectives communicates and clarifies what employees are accountable for delivering • SMART objectives drive employees to achieve important results	• Writing good performance objectives is very difficult; considerable training and facilitation are needed; examples help • Ensuring objectives are fair for similarly situated employees requires review and monitoring across employees • Some jobs are too volatile for objectives to be practical • Individual objectives do not work well when the work is team based or dependent on factors outside the employee's control • Objectives must be translated into specific work plans and deliverables in which managers have a significant ongoing role • The difficulties, complexities, and time associated with objectives-based systems yield high implementation risk • The advantages of setting formal goals can be achieved through more informal discussion

Note. SMART = specific, measurable, attainable, relevant, time-bound.

agreed-upon definitions or procedures for developing them. As a result, there is a great deal of variability in the quality of the competencies that appear in different organizations' performance management systems.

An important step forward in developing competencies was to define them in terms of performance standards that describe different levels of effectiveness. In spite of the fact that no one rating format has been shown to be superior to others in terms of rating errors or accuracy (Landy & Farr, 1980), one advantage of performance standards is that they communicate what is expected of employees, thereby increasing the transparency of the evaluation process. Standards also provide uniform criteria against which managers evaluate performance, thus enhancing fairness. It is important to note that behavioral rating standards have been extensively researched and used operationally for decades. However, the widespread development of competency models defined by behavioral performance standards and their prominent use in performance management systems is a relatively recent popular practice.

Although managers and employees have generally reacted positively to performance standards overall, they also present implementation challenges that need to be addressed. The most critical and persistent problem is inconsistency in ratings across managers. Employees want to be treated consistently and fairly, and a key indicator of this is whether or not they receive the same ratings as others who are similarly situated and perform equivalently. The problem is that managers interpret any rating scale or set of rating standards from their own viewpoints (Jamieson, 1973; Strauss, 1972). For example, one manager may believe that a relatively simple information cataloging project is difficult and complex, whereas another manager may feel that the design and implementation of a customized information management system is only somewhat complex. One manager may think that technical expertise is most important, whereas another may feel that being a team player is what matters. If there is no mechanism in place for addressing these differences, employees will be held to inconsistent standards across different managers, in spite of the fact that all employees are supposedly rated against common standards. Managers' use of their own idiosyncratic rating standards not only undermines the accuracy of performance measurement but can also lead to perceptions of unfairness, with consequential negative impacts on employee attitudes and motivation (Dipboye & de Pontbraind, 1981; Greenberg, 1986).

Another issue is that there are strong outside factors that influence the ratings managers provide, which is why rating format has likely accounted for little variance in ratings. For example, leniency is a chronic problem that results from managers rating most of their employees at the high end of the scale. Because most employees do not want to hear that they are merely meeting expectations for the job, managers feel pressured to rate everyone above the midpoint of the scale. In addition, managers generally want to send encouraging messages to employees to protect their relationships with them and avoid unnecessary motivational problems. As a result of these influences, managers often shift their ratings to the higher end of the scale and compress them within a more limited range of ratings.

Rating calibration is a process in which managers within a unit discuss their ratings of employees to identify where they may have inadvertently applied different standards or rated too leniently. Discussing specific examples of performance helps managers align their views of how to interpret and apply standards, which increases rating consistency across employees (McIntyre, Smith, & Hassett, 1984; Pulakos, 1984, 1986). An interesting aspect of the calibration process is that it makes managers more accountable for the ratings they provide. This is because they have to justify their ratings to other managers, who can be as knowledgeable as the manager about how employees perform. Fellow managers do not usually let each

Table 3. *Popular Practice 3: Use Rating Standards to Evaluate Employee Behavior*

Proponents advocate	Reality
• Use of predefined, job-relevant rating standards to rate employee behavior • Behavioral standards facilitate communicating expectations and transparency • Rating standards improve the consistency and accuracy of ratings across managers	• There are significant outside forces operating in organizations that yield inaccurate ratings • Even with defined rating standards, managers interpret them from their own viewpoints and apply them differently • Obtaining more accurate and consistent ratings from managers requires calibration and monitoring • Failure to calibrate ratings can result in use of idiosyncratic standards across managers, unfair treatment of employees, and consequential dissatisfaction with the system

other off easily if they believe an employee has been rated unfairly, creating peer pressure that provides a powerful incentive to make accurate ratings. Initially, calibration sessions take time, but once managers develop a shared frame-of-reference for evaluating performance, calibration discussions require much less time and effort. Investing in trained facilitators for the initial process helps managers illuminate areas of agreement and disagreement more quickly.

Bottom line recommendation regarding rating standards. In many if not most work situations, a formal evaluation will be needed for administrative purposes, and this is usually some form of defined numerical rating. Although implementation of rating standards is more complex than may be apparent and is often underestimated, assigning numerical ratings based on standards has been shown to have merit and is generally well received, although not entirely devoid of challenges. Calibration helps to ensure that rewards associated with the ratings are more fairly and uniformly distributed across similarly performing employees, and this is thus important to mitigate perceptions of unfairness and actual unfairness that can undermine confidence in the performance management system. Accordingly, implementation of numerical performance ratings based on performance standards that are assigned via a calibration process is recommended (Table 3).

Popular Practice 4: Gather Performance Information From Multiple Sources

As managers, peers, direct reports, and customers see different aspects of a person's performance, multisource assessments enable a more complete assessment of performance. Collecting performance information from multiple sources can be done informally or formally. If done informally, managers simply ask those with different relationships to the employee for feedback on the person's performance, and they incorporate this into their ratings. If done formally, a more complex process is required. First, with the exception of supervisors, multisource ratings are usually collected from at least three raters per source (e.g., peers, customers, etc.) to protect the anonymity of individual raters and increase the reliability and accuracy of the feedback obtained (Ghorpade, 2000; Waldman & Atwater, 1998). Because ratings are usually reported separately by rating source, automated tools to collect, analyze, and properly integrate them are also needed to efficiently manage the process.

Multisource ratings are usually used strictly for development. If ratings are to be used for decision making, it

Table 4. *Popular Practice 4: Gather Performance Information From Multiple Sources*

Proponents advocate	Reality
• Multisource rating information provides a more complete picture of the employee's performance • Performance information from different rating sources should be collected	• Collecting multisource information formally requires automated tools to handle more complex data collection and reporting requirements • When ratings are tied to rewards, multisource rating quality decreases; managers should consider multisource information but must decide on the final ratings • Use of multisource ratings for decision making risks integrity, fairness, and confidence in the system

is recommended that managers serve as gate keepers, gathering and combining information from the different rating sources, judging its credibility and quality, and balancing it against other available information. The reason more control and proper integration of information is important for decision-making purposes is because direct reports, peers, and customers often do not have the qualifications, perspective, or motivation to make accurate and effective ratings. Evaluation studies of multisource ratings we have performed have revealed some instances of peers colluding to rate each other effectively when ratings are tied to outcomes. Research has also shown decrements in the quality of multisource ratings for decision making compared to development (Greguras, Robie, Schleicher, & Goff, 2003), raising further questions about the accuracy and integrity of multisource ratings that are tied to the outcomes.

Bottom-line recommendation regarding multisource ratings. Multisource ratings offer significant potential value, especially for developmental purposes. If they are implemented following the guidelines that have evolved based on research and practice, they can add important and useful information to the performance management process. However, whether or not their cost and complexity provide a sufficient return to justify their use needs to be evaluated on a case by case basis (Table 4).

Summary

Performance management strategies and practices run rampant, and there always seems to be a new twist that promises improved results. For example, it has recently been argued that SMART goals are ineffective and need to be replaced with HARD (heartfelt, animated, required, difficult) goals (Leadership IQ, 2005). New approaches like this are readily implemented, only to frequently result in disappointing outcomes, particularly in the early years of the change management process. This, in turn, leads to frustration and negative attitudes that increasingly alienate managers and employees from engaging in formal performance management activities. Given that many changes to performance management tools and systems over decades of practice have proven ineffective for addressing the problems that plague performance management, there is little reason to believe that further tool or system modifications will prove fruitful. Instead, we believe that fundamental change is needed in how performance management is implemented and viewed, from an administrative exercise to the most important tool managers have to help them accomplish work through others.

In our experience, this occurs only when managers and employees see value in the performance management system for themselves rather than something that is imposed from HR. Engaging these stakeholders in discussions about the philosophy and use of performance management as well as design,

policy, and implementation decisions builds ownership in and value for the system. We believe that implementing a system that users value needs to be coupled with interventions that focus on improving manager–employee communication and those aspects of the manager–employee relationship that are essential for effective performance management. Although some might view these types of interventions as simply the next ''new approach,'' there is extensive research and numerous real-world evaluation studies (discussed below) that show the importance of effective communication and relationships for effective performance management. Yet, addressing these factors directly in performance management implementation has been relatively rare.

Interventions to Improve Manager–Employee Communication and Relationships

The effectiveness of the relationship between a manager and an employee has a profound effect on how they engage in the performance management process and the outcomes they experience (Daniels, 2000). In fact, it has been argued for many years that one of the most important determinants of whether or not performance management will achieve its maximum benefit is the quality of the manager–employee relationship (Beer, 1981; Pulakos & Wexley, 1983; Wexley & Pulakos, 1983). Peterson and Hicks (1996) have supported this notion in discussing trust as an essential prerequisite for effective development and coaching. These authors report that employees who have solid, trusting relationships with their managers are more willing to follow the manager's lead and more confident they will be treated fairly. Effective manager–employee relationships have also been associated with perceptions of performance management fairness and procedural justice (Beer, 1981; DeCotiis & Petit, 1978; Wexley & Klimoski, 1984). Trust, effective communication, and good manager–employee relationships were also recurring themes in the attitude survey studies discussed earlier in this article as well as important engagement levers (Corporate Leadership Council, 2004; Creative Metrics, 2008; Harter, Schmidt, & Hayes, 2002; Office of Personnel Management, 2007).

Developing interventions to impact communication and relationships requires understanding what these things mean in the context of performance management. This is a criterion definition problem like many others we confront in which models are needed that specify the critical behaviors that lead to desired outcomes. Toward this end, the Corporate Leadership Council (2002) conducted a large-scale, cross-organizational study to investigate factors that lead to higher levels of performance effectiveness and more favorable attitudes. The study examined many variables, such as features of the performance management system itself, the organization's culture, and the existence of formal and informal review processes, among others. The results revealed that specific manager behaviors are some of the most important drivers of performance. These include (a) helping employees understand what they are expected to do in sufficient detail to deliver it, (b) supporting and helping employees find solutions to problems, (c) playing to employees' strengths rather than their weaknesses by giving them assignments they can do well, (d) developing employees productively by finding a balance between acknowledging strengths and contributions and addressing development needs, and (e) engaging in regular, informal performance conversations in which managers provide feedback that is fair, accurate, and helps employees do a better job. Although formal performance management systems attempt to drive these manager behaviors through the use of formal tools and processes, this approach has not proven effective and has led to our contention that interventions should more directly target manager behaviors that lead to effective performance and employee attitudes.

Although not specifically addressed in previous research, we also believe that there are key behaviors exhibited by employees that facilitate or impede effective relationships and communication with managers, as these are two-way processes rather than something the manager does to the employee. For example, employees cannot assume managers are mind readers, and they need to be accountable for initiating performance conversations when they encounter difficulties or want to learn more about the manager's views. Employees also need to react well to the feedback they receive, so managers will be motivated to continue providing it. Finally, for relationships to work best there needs to be mutual trust such that managers can count on their employees as much as employees need to count on their managers.

Although some managers naturally create high-trust relationships with their employees, a frequent finding in attitude surveys is that many employees report poor communication and low trust with their managers (Mercer Human Resource Consulting, 2005; Office of Personnel Management, 2005, n.d.). Whether these views result from poor relationships or contribute to them, effective performance management is inhibited. When managers do not have open relationships with employees, they are reluctant to provide candid feedback and have honest discussions for fear of reprisal or damaging relationships. Employees who do not trust their managers are reluctant to engage in open dialogue with them for fear that the managers will use this information to deny them rewards or otherwise retaliate against them. The dysfunctional behavior and attitudes that result from poor communication and lack of trust are so derailing that performance management cannot be effective until intentional action is taken to address these issues.

We believe that an important first step in maximizing performance is to help managers and employees understand the critical role that performance management plays in enabling work to be performed. An issue that needs to be addressed, especially in the first-line supervisor ranks where strong technical skills are prevalent, is that managers often do not understand the role of a manager and what is expected of them. For example, managers who complain that they are too busy to spend time on performance management are likely spending too much time performing technical work rather than using performance management to accomplish work through their staff. Thus, effective performance management begins by ensuring that managers and employees understand their respective roles and the benefits each receives when performance management is done well, thereby answering the question, ''What's in it for me?''

In addition to changing how performance management is viewed, we believe that training is needed to facilitate acquiring the skills and driving the behavioral changes that are foundational for effective performance management, such as learning how to (a) build trust through creating supportive and open relationships, (b) engage in continuous informal performance conversations, (c) diagnose and productively address performance issues, and (d) deliver and react to feedback conversations constructively. In addition to training, posttraining interventions are needed to solidify attitudinal and behavioral changes and to promote training transfer to the work context. We discuss each of these topics next.

Building Trust

Without a basic level of trust, it is unlikely that communication and engagement between a manager and employee will be productive or lead to positive outcomes. Alternatively, when there is a high level of trust between managers and employees, they are more comfortable with each other and more willing and able to engage in effective performance management. Peterson and Hicks (1996) provide a set of behaviors that help managers build trust with their employees, along with rationales for why these are important. Example behaviors include making realistic commitments and following

through on what is promised, keeping employees informed, showing support and not blaming when something goes wrong, helping employees solve work problems, protecting people who are not present, sharing information even handedly and openly, and communicating consistent principles, among others. To develop a solid relationship, managers also need to get to know their employees and what is going on in their lives inside and outside of work. This is important so that they can better understand and effectively deal with circumstances that may be affecting the employee's work. We would expect training that increases awareness and helps managers engage in relationship-building behaviors to have direct effects on performance and attitudinal outcomes as well as indirect effects on these variables through facilitating more effective performance conversations.

Conducting Effective Performance Conversations

The importance of feedback to the performance management process has been consistently acknowledged for decades in the research literature (Bernardin & Beatty, 1984; Ilgen, Fisher, and Taylor, 1979; Lawler, 1994; Maier, 1958; Murphy & Cleveland, 1995). The effects of feedback have the potential to be profound, influencing both future performance (Ilgen et al., 1979; Kluger & DeNisi, 1996) and job and organizational attitudes (Ilgen, Peterson, Martin & Boeschen, 1981; Pearson, 1991). Given the criticality of feedback, numerous researchers have investigated how to most effectively conduct performance feedback review sessions (e.g., Burke, Weitzel, & Weir, 1978; Cederblom, 1982; Nathan, Mohrman, & Milliman, 1991; Nemeroff & Wexley, 1979; Pearce & Porter, 1986), the models and principles from which have been widely incorporated into standard performance management training for managers.

Although at least one or two formal feedback reviews are usually required in the formal performance management process, the reality is that informal, continuous feedback is the most important and powerful feedback that can be given. Both the research and practice literatures have advocated that feedback be provided immediately following effective or ineffective performance (e.g., Gregory, Levy, and Jeffers, 2008; Kirkland & Manoogian, 2007; Wexley, 1986). The Gregory et al. (2008) literature review specifically highlights the importance of continuous feedback to help employees make real-time alterations in their behavior, enabling them to perform their work more efficiently and effectively. In addition to the research literature, effective performance conversations and continuous feedbacks have also been shown to relate to higher levels of performance and engagement in the field survey research studies cited earlier (Corporate Leadership Council, 2002; Creative Metrics, 2008; Harter, Schmidt, & Hayes, 2002; Office of Personnel Management, 2007). Informal feedback discussions were also one of the top-five factors associated with high performing teams in the Corporate Leadership Council study (2002).

Informal feedback is different in nature than formal feedback. First, it typically deals with a specific matter rather than a broader evaluation over time and multiple competencies. It can include strategizing what to do, deciding next steps, analyzing what went right or wrong, and/or discussing what to do differently next time. Formal feedback tends to be initiated, led, and controlled by the manager, whereas informal feedback relies more heavily on two-way accountability and interaction. Both employees and managers initiate informal feedback discussions, and employees are usually fully engaged in these with their managers. Although the importance of two-way participative engagement is a common theme in discussions of formal feedback, it is more characteristic of informal than formal feedback.

Many managers and employees naturally engage in informal feedback conversations, but these are likely more intuitive than intentional. By understanding

the value of informal feedback and recognizing opportunities for it, both managers and employees can take better advantage of these to enhance learning and performance outcomes. Compared to the prevalence of training on conducting formal feedback review sessions, training on how to conduct informal feedback conversations is rare. For managers, training should include learning about the concept of informal feedback, its contributions to effective performance management, and how to communicate with employees in a constructive, candid, and timely manner so employees are open to hearing their messages. One caveat and something that should be included in training is the difference between conducting performance conversations with inexperienced versus experienced employees: The former are generally open to and looking for feedback because they are in a learning mode, whereas the latter tend to be more confident in their capabilities and approaches.

Finally, manager training should also include the importance of providing positive feedback. Recognizing effective performance is easy, but many managers neglect to do this to the extent they should, perhaps because they expect effective performance. However, positive feedback for a job done well is desired by most people, and giving such feedback can improve both employee attitudes and subsequent performance outcomes. Feedback that acknowledges contributions also paves the way for more productive and credible discussions about areas for improvement because these are balanced by recognizing areas in which the employee does well.

Diagnosing the Cause of Performance Problems

Managers need to be able to diagnose why an employee is experiencing a performance problem. This is important because what the manager should do to address a performance problem varies based on its underlying causes. Peterson and Hicks (1996) cite several potential causes for performance problems. One frequent cause is simply that the employee lacks clear expectations, which are generally easy to clarify. In other cases, the employee may lack the skills to perform and need formal training or further job experience. Lack of motivation is another source of performance problems, which can be because of the circumstances at work or home. Environment or work process factors are yet other reasons for performance problems. For example, the employee may not have the tools that are needed to perform work or may be reliant on others who are not delivering, in which case additional resources or other interventions may be necessary to address the issue. The bottom line is that managers need to understand that performance problems exist for different reasons, and they need to be able to diagnose these accurately to address them effectively.

Delivering and Reacting to Feedback

Most employees want to do a good job and are appreciative of ideas for improving their work products or outcomes, when feedback is delivered in an appropriate and helpful manner. This does not happen to the extent that it should, however, because many managers do not always deliver feedback productively and in a way that mitigates defensive reactions from employees. However, even if managers deliver feedback effectively, employees do not always react to feedback effectively. Depending on employees' personalities, they will be more or less open to feedback and more or less willing to accept it, with numerous potential reactions varying from appreciation to depression and anger. Managers thus benefit from training to recognize and effectively manage different reactions to feedback, whereas employees benefit from training on how to effectively and constructively receive feedback.

Posttraining Interventions

One important caveat regarding the overall strategy and training suggested here

is that it is important not to oversimplify what is required to achieve sustainable changes in perceptions, attitudes, and behavior that will enhance performance management effectiveness. Certainly training is a reasonable first step, but this will serve as an introduction, at most, that needs to be followed up with additional interventions to promote training transfer and ongoing evaluation to assess whether or not manager–employee relationships and communication and their hypothesized consequences—performance and attitudes—are improving. We acknowledge the possibility that the training and training transfer strategies proposed here may prove to be just as difficult, frustrating, and ineffective as those that have been aimed at making changes to the formal system itself, and they will certainly require resources and commitment to implement well. However, given the number of different system changes that have been tried and proven unsuccessful, we feel that there is merit in attempting a wholesale different approach to improving performance management. We certainly do not expect that training will address performance management ineffectiveness to a person, but even modest improvements may have meaningful positive impacts on employee attitudes, engagement, and performance overall. At least, organizations may avoid investing significant resources in changing their performance management systems yet again, which is virtually guaranteed to produce no results.

Regarding posttraining interventions, employee surveys are used to collect information on the extent to which managers are exhibiting effective performance management behaviors. Providing individualized feedback to managers based on responses of their direct reports pinpoints areas where the managers may need to adjust their behavior and reinforces the need to engage in effective performance management more generally. Another strategy to reinforce training is to provide simple job aids to managers to encourage them to engage in effective performance management behaviors on an ongoing basis. For example, managers can periodically be asked by their managers to jot down and communicate one or two particular strengths and areas to work on for each employee. Informing employees that managers are doing this practically ensures subsequent performance conversations. Another aid is to provide a list of trust-building behaviors taped to the manager's computer monitor, a constant reminder to engage in these. To the extent feasible, demonstrating the impact of interventions on important performance metrics at local levels is a powerful way to build the business case for and reinforce effective performance management. A further step is to implement more individualized programs or processes for situations in which standard training interventions do not produce the desired results. These could include but may not be limited to individual coaching or employee reassignment programs.

The posttraining interventions described above are largely behavioral in nature, implying the key issue is that managers and employees lack the knowledge and skills they need to engage in effective performance management. We believe that lack of knowledge and skills associated with effective performance management is in fact a significant problem that needs to be addressed. However, in addition to the strategies discussed above, additional interventions will likely be required to motivate and solidify behavioral change, such as rewarding effective managerial behavior, making managers accountable for effective behavior, and providing leadership and peer models of effective behavior. Although such ongoing interventions to facilitate training transfer are costly to implement and maintain, one of the key reasons employees' leave a job is because of ineffective managers (Harvey, Stoner, Hochwarter, & Kacmar, 2007). When the high costs that are associated with turnover (i.e., hiring, training, and productivity loss associated with onboarding new staff) are considered, training and related interventions that reduce unwanted turnover typically produce compelling ROI, and this is especially true if they

are accompanied by improved performance outcomes and attitudes.

Summary and Conclusions

There is strong agreement that performance management is the most difficult human capital system to implement successfully and have work effectively over time. The inherent difficulties that plague performance management have commanded an enormous amount of attention from researchers and practitioners. Most of the many attempts to improve performance management have focused on operationalizing different approaches to it (e.g., ratings based on achieving goals vs. ratings based on job-relevant behavior) within formal systems that prescribe specific steps, tools, and processes. Unfortunately, this focus has yielded largely disappointing results and the formula for effective performance management is yet to be discovered. Nevertheless, declining to assess performance and provide feedback is neither a viable nor acceptable strategy to achieve effective management, meaning that we must continue attempting to improve how performance management is conducted in organizations. A golf analogy helps illustrate our view of performance management.[1] The game of golf is a particularly difficult skill to acquire. Most golfers fail to break a score of 100. Adding to the complexity of the sport is the fact that improvement is often elusive. Sometimes the answers to problems are counterintuitive. For example, at times the best way to improve your shot distance may be to slow down your swing. Only the very best golfers are able to consistently score par or better. However, we know that golfers who play frequently typically improve their game and that repetition and refinement lead to better results. The focus isn't on redefining the game of golf but improving one's skill in executing the various demands of the game.

We have argued here that interventions to improve performance management should cease their almost exclusive focus on reinventing formal systems. Using examples of four popular practices, we demonstrated how implementing approaches that make sense in theory can result in significant cost and resource requirements that are often not apparent initially. When these new approaches then fail to work well, the unintended consequences are that performance management loses credibility and is devalued by both managers and employees. In lieu of making further changes to formal performance management systems, we believe that attention needs to be devoted to training managers and employees about the benefits of effective performance management and how to engage in this as a day-to-day means of accomplishing work. Previous research has shown that important performance and attitudinal outcomes are at least partly a function of manager–employee communication and relationships. Specific behaviors on the part of both managers and employees were hypothesized as important contributors to these, and training and training transfer interventions were recommended as the primary strategies to teach, reinforce, and further motivate these critical behaviors.

Although the results of prior research indicate that effective manager–employee communication and relationships positively impact important outcomes, additional research that directly examines the causal effects of performance management behaviors on proximal (e.g., frequency and effectiveness of performance conversations, continuous feedback) and distal outcomes (e.g., performance effectiveness, turnover) is needed. Understanding such causal relationships will not only help build the case for investing in the types of interventions we are proposing, but it will also help in designing those interventions to be maximally effective. For example, knowing that certain behaviors have the strongest

1. The golf analogy was provided by our colleague, Thomas K. Coghlan, who has extensive experience and insight into what it takes to successfully implement performance management processes in organizations and with whom we have been fortunate to collaborate on a highly complex, large-scale performance management intervention.

impact on important proximal and distal outcomes facilitates decisions about the relative amount of training that should be devoted to different topics and what behaviors should be the focus of posttraining accountability and reward systems. Thus, shifting the focus of our interventions to directly target and reward effective performance management behavior needs to be accompanied by more field research like the Corporate Leadership Council study that identifies what matters most in driving important outcomes.

Although we have argued that attention should be directed away from the formal system, this leaves open the question of whether a formal system is needed and if so, what that system should contain. Some have suggested eliminating performance management processes entirely (Culbert, 2010), and this may be viable when there are no ties between ratings and outcomes, such as pay. When pay or other outcomes are tied to performance, however, there is usually a perceived if not actual need for a formal system and administrative rating of record. Having a formal system also provides a safety net of sorts because it helps ensure at least some performance information is communicated to employees from managers who may otherwise grossly neglect their performance management responsibilities. For these reasons, decision makers usually opt to have a formal performance management system in place in most situations.

In designing the formal system, it is prudent to consider organizational members' appetite and tolerance for formal performance management requirements. For example, if informal feedback is regularly provided as a natural course of events, requiring managers to schedule feedback sessions at specific points in the year will likely be seen as burdensome and unnecessary. Similarly, if an organization is a pure sales organization and goals come down to revenue and profit targets, an elaborate and time-consuming process to cascade goals will not likely be credible or well received. It is important to realistically assess what performance management features organizational members will value and use in their particular context. Even if tools and processes are embraced initially, organizational members will not comply with burdensome requirements over time that do not add value.

In our own work, we have learned the value of implementing straightforward and simple formal appraisal systems rather than burdensome ones that often come with high costs and can collapse from their own weight. We recommend keeping complex processes, formal requirements, and administrative demands to a minimum so that managers and employees can spend their time focusing on the more important aspects of performance management—communicating where the group and each employee fit within the larger organizational context, setting behavioral and results expectations, and providing ongoing coaching and feedback. Although we argue for a simple approach to the formal system overall, we have found that numerical ratings that are based on well-defined performance standards and manager calibration are uniformly well received and useful in practice. Performance standards provide a structure and context that helps managers communicate expectations and organize their feedback. Importantly, standards can be written to incorporate results expectations, thus marrying evaluation of *what* was achieved with *how* it was achieved. This provides a more straightforward, integrated evaluation that represents the sum total of performance effectiveness and avoids many of the problems we discussed previously that plague goal-based systems. Performance standards have the final added benefit of helping employees understand the different aspects of performance on which they will be evaluated and what differentiates the different levels of performance effectiveness. Adding manager calibration to the use of numerical ratings based on performance standards helps standardize interpretation and application of the standards across employees, thereby

increasing the likelihood that rewards will be distributed fairly.

In conclusion, we have argued here that the combination of documented performance standards to support ratings, formal manager calibration, and training and training transfer strategies to improve manager–employee relationships and communication will be optimal practices in many situations. This is because this combination provides managers and employees with straightforward tools that facilitate performance management, while training and reinforcing them to exhibit behaviors that are essential for effective performance management outcomes. Alternatively, the complexity involved in practices like cascaded goals or SMART goals limits their applicability and potential effectiveness. We acknowledge that the training and training transfer strategies suggested here are neither inconsequential nor easy to implement, but we feel based on our experience and the research evidence that they have sufficient potential to produce more significant and sustainable performance management improvements that they warrant further exploration and research.

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