LakeWood Health Center d/b/a Chi LakeWood Health *and* Minnesota Nurses Association. Case 18–RC–177139

December 28, 2016

ORDER

BY CHAIRMAN PEARCE AND MEMBERS MISCIMARRA AND MCFERRAN

The Employer's Request for Review of the Regional Director's Decision and Direction of Election, which is attached as an appendix, is denied as it raises no substantial issues warranting review.[1]

Dated, Washington, D.C. December 28, 2016

Mark Gaston Pearce, Chairman

Lauren McFerran, Member

(SEAL) NATIONAL LABOR RELATIONS BOARD

MEMBER MISCIMARRA, dissenting.

My colleagues deny the Employer's Request for Review and affirm the Regional Director's determination that the Employer's Patient Care Coordinators (PCCs) are not statutory supervisors. I disagree with the majority's finding and believe that substantial questions exist regarding whether the PCCs possess authority to assign and responsibly direct other employees, which constitutes supervisory authority under Section 2(11) of the Act.

The Employer is an extremely small rural hospital located in Baudette, Minnesota that draws patients from a

[1] In affirming the Regional Director's finding that the patient care coordinators (PCCs) do not exercise the supervisory function of making hiring recommendations, we do not rely on his citation to *Connecticut Humane Society*, 358 NLRB 187 (2012). Instead, we rely on *Republican Co*., 361 NLRB No. 15 (2014).

Contrary to the dissent, review is not warranted based on job descriptions for the newly-created PCC position which state that PCCs possess supervisory authority to assign and responsibly direct nursing department employees, or the testimony of Vice-President of Patient Care Danielle Abel that PCCs exercise that authority. The Board has consistently held that Sec. 2(11) supervisory status cannot be established merely by "paper" authority or conclusory testimony. *Peacock Productions*, 364 NLRB No. 104, slip op. at 2–3 and fn. 6 (2016); *G4S Regulated Security Solutions*, 362 NLRB No. 134, slip op. at 2–3 (2015), and cases cited therein. Rather, "what the statute requires is evidence of actual supervisory authority visibly translated into tangible examples demonstrating the existence of such authority." Id. citing *Oil Chemical & Atomic Workers v. NLRB*, 445 F.2d 237, 243 (D.C. Cir. 1971), cert. denied 404 U.S. 1039 (1972).

As the Regional Director found, Abel's testimony on the asserted supervisory indicia was "general and conclusionary and at times contradicted by documentary evidence." Thus, with respect to assignment authority, Abel's testimony that PCCs exercise independent judgment in assigning a particular nurse to a patient based on an assessment of the nurse's skills and abilities was not supported by any record evidence that the skills and abilities of the staff nurses differ. Abel's conclusory testimony was further undermined by documentary evidence showing that for most of the shifts in evidence, the patient census was so low that there was only one nurse on duty for the PCC to assign. As the Board explained in *Oakwood Healthcare, Inc*., 348 NLRB 686, 693 (2006), and reiterated in *Cook Inlet Tug & Barge, Inc*., 362 NLRB No. 111, slip op. at 1 (2015), assignment authority is not established if there is "only one obvious choice." We also reject, as contrary to the statutory language of 2(11), our colleague's assertion that the PCCs have more than one obvious assignment choice in these situations—themselves or the other nurse. Sec. 2(11) clearly defines a supervisor as one who assigns "other employees," not themselves.

We also reject the dissent's contention that, with respect to responsible direction, review is warranted to determine whether the Regional Director's finding that the PCCs do not exercise independent judgment in exercising this function runs afoul of *NLRB v. Kentucky River Community Care*, 532 U.S. 706 (2001). As in *Peacock Productions*, supra, 364 NLRB No. 104, slip op. at 4, we do not reach this issue because "[e]ven assuming that [PCCs] use independent judgment in directing other employees, the Regional Director correctly found that the record does not establish that the Employer holds [PCCs] accountable for their direction of others." Contrary to the dissent, accountability was not established by Abel's affirmative response to the leading question whether "it would be correct to say that the PCC will be held accountable for the performance, or lack thereof, of her subordinate." Abel's testimony is "simply a conclusion without evidentiary value," *Peacock Production*, slip op. at 4, citing *NLRB v. NSTAR Electric Co*., 798 F.3d 1, 18 (1st Cir. 2015), and is irrelevant in any event as it references only the future prospect of accountability.

Finally, our colleague contends that the potential existence of the PCC's supervisory authority is evident from the three-factor "guide" that he has proposed in prior dissents for determining supervisory status. See *Cook Inlet*, supra, 362 NLRB No. 111, slip op. at 5 fn. 9. We reject this proposal for the reasons we have previously stated. See *Buchanan Marine*, *L.P.*, 363 NLRB No. 58, slip op. 2–3 (2015) and *WSI Savannah River Site*, 363 NLRB No. 113, slip op. 2–3 (2016). As in those cases, the dissent's standard relies principally on the fact that the PCCs are the highest authority in the nursing department on weeknights and weekends. However, "highest authority" is a secondary indicium of supervisory status which does not confer 2(11) status where, as here, the putative supervisors are not shown to possess any of the primary indicia of supervisory status. *Golden Crest Healthcare Center*, 348 NLRB 727, 730 fn. 10 (2006).

In sum, for the reasons set forth by the Regional Director and as discussed above, the Employer has failed to meet its burden to demonstrate that PCCs are statutory supervisors. Nevertheless, we observe that our precedent does not necessarily foreclose the Employer, which never stipulated to the inclusion of the patient care coordinators, from raising their supervisory status in a future unit clarification proceeding in the event the Employer establishes the existence of newly discovered and previously unavailable evidence bearing on that issue. See generally *Premier Living Center*, 331 NLRB 123, 123–124 (2000).

30–40 mile radius around Baudette.[1] Although small, the hospital is a full-fledged acute care medical facility. It operates 24 hours a day, 7 days a week with 15 in-patient beds and a nursing staff that includes 6 PCCs—who are registered nurses—and their subordinates: 8–9 registered nurses (RNs), three licensed practical nurses (LPNs) and one certified nurse assistant (CNA). During each shift, the PCC is responsible for overseeing all RNs, LPNs, and the CNA. The PCC, in turn, reports to Acute Care Nursing Manager Joan Baade, who reports to Vice-President of Patient Care Danielle Abel. The senior-most hospital official is President Ben Koppelman. Significantly, *the PCC is the only person present* most of the time—i.e., from 7 p.m. to 8 a.m. Monday through Friday, and every weekend from 5 p.m. Friday through 8 a.m. Monday—who can give directions and assignments.[2]

It is undisputed that the PCC position was created on February 28, 2016, only 4 months before the hearing in this case. The record establishes that the PCC position replaced a "charge nurse" system, and this change was made for a specific purpose: to ensure that the PCC would be accountable "for the shift-by-shift work flow of the department. . . ."[3] Accountability did not exist with the charge nurse system, under which charge nurses' "sole duty was to look at staffing for the day and for the next shift."[4]

According to Abel's uncontradicted testimony, prior to the creation of the PCC position

> [t]here was never anything formally designated to them for accountability of the department. Their sole duty was to look at staffing for the day and for the next shift. The charge nurses included all of the RNs, so you can imagine how difficult it is having—at the time, there was probably about 20 RNs, and trying to get all of those 20 individuals to focus on the goals and priorities of the department was essentially a moot point. It was difficult for the manager to have any accountability or any effectiveness on delegating work flows to them that needed to be maintained.[5]

When Abel was asked *why* the PCC position was created, she answered:

> *Accountability for the shift-by-shift work flow* of the department, with having six individuals who are knowledgeable about the goals and strategic initiatives for the department, in addition to *supervising the employees on their shift*.
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> * * *
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> And so the [prior] model, as it was, again, having about 20 RNs who would rotate in and out of a charge nurse position on a shift-by-shift daily, monthly, yearly, whatever, basis—there was no formal accountability for them, and they were not ever delegated any of the work of a manager, because the follow-through wasn't there. The [charge nurse] position was never created in that light by the previous director.[6]

Accordingly, the PCC job description states that PCCs have the following authority and responsibilities:

- Responsible for Daily Nursing *Assignments*—assesses, identifies and communicates *unit staffing needs for current and oncoming shifts and assigns admissions and/or transfers based on patient acuity level, nurse/patient ratio, and nursing skill levels*.
- Coordinates *daily patient care activities* with acute care nursing staff and other related services.
- Provides, maintains, and coordinates effective communications between nursing, medical staff, and ancillary departments.
- Ensures patient specific nursing care plans are developed, updated, and evaluated for effectiveness.
- Initiates problem-solving processes with nursing staff as patient care concerns arise on a daily basis.
- Communicates with staff to assure *assignment* made is appropriate to promote team building and cohesiveness.
- Knowledgeable and competent to care for patients in the emergency room and outpatient setting.
- *Retains overall accountability for the work-flow* for their shift, and *remains accountable if duties are delegated to another qualified staff member*.

In addition, PCCs "[p]rovide[] *overall supervision* of staff and patient care during shift and serve[] as the bedside leader for the nursing team during shift" (emphasis added).

In finding the PCCs are not supervisors, the Regional Director properly took into account that the position had only been in existence for 4 months at the time of the

[1] The facility is also referred to as a "critical access hospital."
[2] Transcript at 68–69.
[3] Transcript at 49.
[4] Transcript at 30.
[5] Transcript at 30–31.
[6] Transcript at 49–50 (emphasis added).

hearing, and accordingly gave "little or no weight to the fact that the Employer failed to provide examples of PCCs exercising their ostensible supervisory authority." Nevertheless, for several reasons, I believe that the Request for Review raises substantial issues regarding the Regional Director's conclusion that the PCCs lack the authority to assign or responsibly direct.

First, the PCC position description quoted above clearly indicates that they do have the authority to make "daily nurse assignments." Abel testified that in making these assignments, PCCs take into account the needs of the patient and the skill of the nurses, but the Regional Director dismissed this testimony because no one specifically testified that nurses have differing levels of skill and ability. The Regional Director also found that assignment authority was negated by evidence that PCCs made assignments with input from their supervisees and that at times there was only one other RN on shift to be assigned. I do not believe that specific testimony is needed to establish the commonsense fact that some employees are more skilled than others, which in any event is implied by the undisputed testimony that skill level is taken into account. As I have previously explained, the Board should not disregard unrebutted evidence "merely because it could have been stronger, more detailed, or supported by more specific examples." *Buchanan Marine, LP*, 363 NLRB No. 58, slip op. at 9 (2015) (Member Miscimarra, dissenting) (internal quotation and citation omitted). Nor is the PCCs' assignment authority negated by the fact that they may accept input from nurses before making assignments or that only one other nurse may work under them on some shifts. The Act does not limit supervisory authority to dictators, and even if there is only one other nurse on a shift, PCCs still have the authority to assign a patient to the other nurse or to themselves.

Second, the Regional Director found that PCCs have, and exercise, the authority to direct nurses, but found that they do not use independent judgment in doing so because "[t]hey assess patients' medical conditions, and according to the testimony of one PCC, alter the care plan of patients utilizing their skills as RNs. However, this exercise of independent judgment relates not to how employees perform their jobs, but to how patients are cared for." I believe review is warranted to determine whether the Regional Director improperly invoked the discredited notion that the exercise of "professional judgment" when rendering patient care means a supervisor is not exercising independent judgment "in the interest of the employer." See *NLRB v. Kentucky River Community Care*, 532 U.S. 706, 719 (2001) (rejecting Board's holding that exercise of professional judgment does not constitute independent judgment within the meaning of Sec. 2(11)); *NLRB v. Health Care & Retirement Corp.*, 511 U.S. 571 (1994) (rejecting Board's holding that professional employees exercising professional judgment do not act "in the interest of the employer" within the meaning of Sec. 2(11)).

Third, the Regional Director also found no evidence that the PCCs were accountable for the performance of patient-care tasks by the nurses they direct because there was insufficient evidence that they would face adverse consequences directly as a result of others' poor performance. For the reasons stated in my separate opinion in *Community Education Centers, Inc.*, 360 NLRB No. 17 (2014), I believe that "[t]his restrictive interpretation improperly fails to recognize that 'accountability' can exist based on 'the supervisor's own conduct and judgment in exercising oversight and direction of employees in order to accomplish the work.'" Id., slip op. at 2 (quoting *Entergy Mississippi, Inc.*, 357 NLRB 2150, 2158 (2011) (Member Hayes, dissenting)). Neither can the Board ignore the fact that the "no accountability" finding by the Regional Director is contradicted by the position description quoted above, which states that the PCC "remains accountable if duties are delegated to another qualified staff member"; Abel's undisputed testimony that "it would be correct to say that the PCC will be held accountable for the performance, or lack thereof, of her subordinate";[7] and the equally undisputed evidence that the Employer created the PCC position to impose accountability in the first place.

Finally, I believe the potential existence of supervisory authority here, as defined in Section 2(11) of the Act, is evident from the framework that I have stated the Board and the courts should utilize in every case involving disputed supervisor status. This framework incorporates commonsense principles guiding the application of the factors set forth in Section 2(11) and is based on my observation that many of the Board's supervisor determinations have become increasingly abstract and out of touch with practical realities of the workplace. *Buchanan Marine, L.P.*, above, slip op. at 3–10 (Member Miscimarra, dissenting); *Veolia Transportation Services, Inc.*, 363 NLRB No. 98, slip op. at 13–14 (2016) (*Veolia I*) (Member Miscimarra, dissenting); *WSI Savannah River Site*, 363 NLRB No. 113, slip op. at 6–7 (2016) (Member Miscimarra, dissenting); *Veolia Transportation Services, Inc.*, 363 NLRB No. 188, slip op. at 14–15 (2016) (*Veolia II*). As indicated in *Buchanan Marine* and other cases, when applying the factors outlined in Section 2(11), I believe the Board in every situation should take into ac-

[7] Tr. at 102.

count the following considerations: (i) the nature of the employer's operations, (ii) the work performed by undisputed statutory employees, and (iii) whether it is plausible to conclude that all supervisory authority is vested in persons other than those whose supervisory status is in dispute.[8]

The first factor—the nature of the Employer's operation—strongly favors a finding that the PCCs are supervisors. The Employer operates an acute care hospital that serves up to 15 acute care in-patients at a time and includes an emergency department that operates 24/7, where the PCCs and one or two nurses are the *only* nursing personnel in the facility on evenings and weekends. If a critically ill patient arrives at the facility any time after 7 p.m. during the week or any time during the weekend, he or she will be received by the PCC or a nurse on duty at that time. The Regional Director determined that the PCCs are not supervisors, so the question arises, who is in charge in this life-or-death situation? If there are four acute in-patients at the time a critical patient arrives and two nurses on duty, who decides which nurse will take care of which patient? Who decides what treatment to begin? Who evaluates the condition of the patients and the abilities of each nurse? To state the obvious, these are not appropriate judgments to resolve by a coin toss or drawing straws. Someone has to be in charge at this facility at all times, including times when no manager and perhaps no physician is present.[9] Moreover, the record reveals that the Employer's primary purpose when creating this new position was to make sure that everyone understood that a single person—the PCC—had the authority to address these issues and would be accountable for them.[10]

The second factor—the nature of the work performed by undisputed statutory employees (in this case, the Employer's subordinate nurses)—also supports a finding that the PCCs have supervisory authority. The subordinate nurses are responsible for patient care, the patients may be acutely ill, and the hospital has 15 beds. Certainly, the treatments for patients' predictable medical needs are prescribed in patient care plans, but the ebb and flow of patient health and the difficulty of cases and emergency care cannot be predicted in advance. Each day at the facility requires the careful assignment and direction by each PCC, who is the *only* person present the majority of the time—evenings, nights and weekends—to assign and direct the subordinate nurses on each shift.

The third factor—whether it is plausible to conclude that all supervisory authority is vested in persons other than those whose supervisory status is in dispute—similarly favors a finding of supervisory status. As noted above, the PCC is the only person present the majority of the time who can direct and assign the subordinate nurses. Thus, the record reveals that for approximately 13 hours of each day and approximately 63 hours straight each weekend, the PCC is the highest-level official at the hospital. Similar to the captains on the tugboats in *Buchanan Marine* (which were at sea for 24 hours per day up to seven days at a time), the PCC is the *only* person on the "boat" with authority to give assignments and direction in situations that literally may involve life or death.[11]

Here as in *Buchanan Marine* (and other similar cases), the notion that nobody exercises "supervisory" authority in this type of work setting for such extended periods of

[8] I first articulated these factors in *Cook Inlet Tug & Barge, Inc.*, 362 NLRB No. 111, slip op. at 5 fn. 9 (2015) (Member Miscimarra, dissenting), in which the Board majority held, over my dissent, that tugboat captains failed to qualify as statutory supervisors. As I explained in my dissent in *Buchanan Marine*, these factors do not comprise a new test for supervisory status, but rather constitute a guide to how the Board should apply the indicia of supervisory status that Congress listed in Sec. 2(11). *Buchanan Marine*, above, 363 NLRB No. 58, slip op. at 10 (Member Miscimarra, dissenting) (emphasis in original). See also *Veolia I*, above, 363 NLRB No. 98, slip op. at 13–14 (Member Miscimarra, dissenting); *G4S Government Solutions, Inc.*, above, 363 NLRB No. 113, slip op. at 6–7 (Member Miscimarra, dissenting).

[9] The record establishes that there are times when no manager is present at the hospital, and it suggests there are also times when no physician is present, either. Vice-President of Patient Care Abel testified that evenings, nights, and weekends, "the PCC would be the highest ranking person present" (Tr. 68–69). Moreover, the record establishes that the Employer is a critical access hospital (CAH), and it is not required that a physician be on-site at a CAH at all times. "CAHs must provide 24-hour emergency services, with medical staff on-site, *or on-call and available on-site within 30 minutes, 60 minutes if certain frontier area criteria are met*." https://www.ruralhealthinfo.org/topics/critical-access-hospitals (last visited Oct. 27, 2016) (emphasis added).

[10] It is true that PCCs make initial staffing decisions based on a formula that is contained in staffing documents. However, once the nurses are all on shift, the PCCs are the ones who monitor patients and make decisions as to where RNs, LPNs, and the CNA need to be assigned based on the PCC's assessment of the patients' needs and the fluctuation of the work. The PCCs are exclusively responsible for the day-to-day and shift-to-shift coordination of care and daily assignments for the nursing staff. PCCs have the authority to send staff home if the patient census is low and call staff in if the census is higher than anticipated or the number of emergency or outpatient clinic patients increases. Just because the PCCs have not yet had the opportunity, on a regular recurring basis, to adjust staffing levels should not preclude a finding of supervisory status. As the Employer noted in its Request for Review, "It would be nonsensical to conclude that a position created on day one is nonsupervisory and the party asserting supervisory status has failed in its burden when the only available information about it is based on day one." Request for Review at 17.

[11] While finding the PCCs to be supervisors would result in a ratio of supervisors to employees of 1:1 or 1:2 on many shifts, this fact is immaterial in the context of the small size of the hospital and the other factors discussed above.

time fails the "test of common sense."[12] The Regional Director and my colleagues endeavor in this case to ensure that the Board's supervisory determinations are consistent with our statute. However, I believe the finding that PCCs are not supervisors under Section 2(11) provides yet another illustration of the principle that "common sense" is not so common.[13]

For the reasons stated above, I believe the Request for Review raises substantial questions about whether the PCCs possess supervisory authority as defined in Section 2(11) of the Act. Accordingly, I respectfully dissent from my colleagues' denial of the Request for Review.

Dated, Washington, D.C. December 28, 2016

Philip A. Miscimarra, Member

NATIONAL LABOR RELATIONS BOARD

APPENDIX

DECISION AND DIRECTION OF ELECTION

Petitioner seeks to represent two units of employees employed by the Employer at its Baudette, Minnesota facility and asks that the Board conduct a *Sonotone* election.

Petitioner seeks to represent all full-time and regular part-time staff registered nurses employed by the Employer at its acute care hospital located at 600 Main Avenue South, Baudette, Minnesota; excluding all other professional employees, physicians, technical employees, non-professional employees, business office clerical employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center. The Employer stipulated to the appropriateness of this unit, but contrary to Petitioner, contends that the registered nurses employed as patient care coordinators (PCCs) are supervisors within the meaning of Section 2(11) of the Act.

The Employer and Petitioner also stipulated to the appropriateness of the following unit of technical employees: All full-time and regular part-time technical employees, including licensed practical nurses (LPNs), radiologic technologists, pharmacy techs, multi-modality technologists and medical laboratory technicians, employed by the Employer at its acute care hospital located at 600 Main Avenue, Baudette, Minnesota; excluding all other technical employees, professional employees, non-professional employees, business office clerical employees, skilled maintenance employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center. No issues exist with regard to this unit.

In essence, Petitioner seeks a unit of hospital-based registered nurses and a unit of hospital-based technical employees. The Employer agrees that the units sought are appropriate but contends that the registered nurses employed as PCCs in the acute care hospital are 2(11) supervisors. After carefully reviewing the record evidence and Board law, I conclude that the Employer has failed to establish that the PCCs are supervisors within the meaning of Section 2(11) of the Act.

Under Section 3(b) of the Act, I have the authority to hear and decide this matter on behalf of the National Labor Relations Board. Upon the entire record in this proceeding, I find:

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

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction herein.[1]

3. The labor organization involved claims to represent certain employees of the Employer.

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

5. This decision begins with an overview of the Employer's operation and supervisory hierarchy, insofar as the record establishes the hierarchy. The second section summarizes the unit of registered nurses sought by Petitioner. Third is a detailed description of the job duties of the PCCs based on documents in the record, submitted by the Employer. I then discuss in detail the testimony of the vice president of patient care regarding the supervisory indicia the Employer claims establishes that the nurses sought by Petitioner are supervisors, including comparing that testimony to the documentary evidence. In the next two sections I provide an overview of Board law and I apply Board law to the facts of this case. Finally, I briefly explain why I affirm the hearing officer's refusal to accept into evidence documents related to a charge and complaint involving the same parties and Region 18.

[12] *Buchanan Marine*, supra, slip op. at 10 (Member Miscimarra, dissenting).

[13] Departures from common sense occur with sufficient frequency to have given rise to the phrase "common sense is not so common," which is often referred to using its Latin counterpart, "*rarus enim ferme sensus communis*." The origin of this phrase is the subject of some debate. It has been attributed variously to Voltaire, Will Rogers, and Mark Twain (whose version was "I've found that common sense ain't so common"). See https://idiomation.wordpress.com/2015/09/01/common-sense-is-not-so-common/ (last visited Oct. 20, 2016). However, long before these persons were born—and roughly 1800 years before Congress enacted the National Labor Relations Act—the Roman poet Decimus Junius Juvenalis (known in English as Juvenal) wrote, "*Rarus enim ferme sensus communis*" *(meaning "common sense is generally rare")*, which appeared in Book III of his "Satires." Id.

[1] The Employer, LakeWood Health Center d/b/a CHI LakeWood Health, maintains an office and place of business in Baudette, Minnesota, where it is engaged in the operation of a health care facility and in providing health care services. During the 12-month period ending December 31, 2015, a representative period, the Employer derived gross revenues in excess of $250,000 and purchased goods and supplies valued in excess of $50,000 directly from suppliers located outside the State of Minnesota.

The Employer's Operation and Supervisory Hierarchy

The Employer is a small rural hospital designated a "critical access hospital." The designation as a critical access hospital is certified by Medicare, and any hospital so certified must meet the following requirements: (1) licensed for 25 patient beds or less; (2) have an average stay for in-patients of 96 hours or less; (3) be separated from a similar facility or other acute care hospital by at least 35 miles; and (4) operate an emergency room 24 hours per day/7 days per week. Facilities designated as critical access hospitals are funded on a cost-based reimbursement by Medicare, and not by fixed rates depending on the procedure or medical care.

The Employer is owned and operated by Catholic Health Initiatives. CHI also operates other health care institutions in Minnesota, as well as other states. The Employer's Baudette hospital has 15 in–patient beds and draws patients from a 30–40 mile radius of Baudette. Baudette is a community of about 1000 people, and close to the United States/Canadian border. The nearest hospital to the Employer's Baudette operation is 50–60 miles away.

In addition to the hospital, the Employer operates a ten-bed assisted living facility, a 36-bed nursing home, an ambulance service, and medical clinic and a public health area. The 36-bed nursing home is in the same building as the hospital, and connected to the hospital by two hallways. The ambulance service (EMT department) is 3–4 blocks northwest of the hospital. The public health area provides grant-related work for the State of Minnesota, community outreach and education, child and teen checkups, behavioral health services, a flu clinic, other vaccinations, and a foot care clinic for diabetics. None of these ancillary operations is involved in this matter.

The Employer's president is Ben Koppelman. Reporting to Koppelman is Danielle Abel, vice president of patient care. Abel's position requires her to oversee all departments involved in patient care, and therefore, Abel supervises the department directors. However, the record does not reveal who reports to Abel, other than Joan Baade, acute care nursing manager. According to the Employer, the PCCs in issue report to Baade, and staff registered nurses, licensed practical nurses and the single certified nursing assistants report to the PCCs.

According to the Employer, until February 28, 2016, the position of PCC did not exist. Rather, the Employer operated with charge nurses. However, Abel was dissatisfied with the charge nurse model because she did not feel the charge nurses were (or perhaps could be) held accountable. Starting in the spring of 2015, Abel began considering a different staffing management plan, which included the concept of PCCs. In October 2016, the Employer began sharing the staffing management plan with employees, and over the course of the three months repeatedly met with staff to discuss the concept and ideas for the position. After a great deal of back and forth, the Employer moved forward with the plan, and effective February 28, 2016, six PCCs began working for the Employer, and the Employer no longer utilized charge nurses. The six PCCs hired were all previously employed by the Employer as nurses.

The Employer provided almost no record evidence about the job responsibilities of the vice president of patient care and the acute care nursing manager. What little evidence is in the record is specified in the context of discussing the supervisory indicia the Employer claims establishes the 2(11) supervisory status of the PCCs. The acute care nursing manager did not testify at the hearing; the Employer's case relies solely on the testimony of the vice president of patient care, and extensive documentary evidence.

While the hospital is a 24 hour/7 day a week operation, neither the vice president of patient care nor the acute care nursing manager work hours other than Monday through Friday, during the day. Thus, according to the Employer, PCCs are the persons of highest authority at the facility evenings, nights and weekends. However, the significance of this fact is unclear—there is no record evidence regarding what (if any) extra authority PCCs have during the times the vice president and manager are not working. At one point in her testimony, the vice president described a telephone conversation she had with a PCC when the vice president was not working, but the content of this conversation reveals little as the PCC merely reported to the vice president an incident that occurred while the PCC was working.

Finally, it is important to note that the vice president of patient care emphasized that the Employer operates under a primary care model, which means everyone who is working shares in the workload and tasks. Because of the Employer's low patient census, "everyone has to pitch in, including myself." Thus, when necessary, the vice president performs patient care duties. In fact, she estimated that she spends 15 percent of her time providing patient care.

The Unit of Registered Nurses Sought by Petitioner

The unit of registered nurses sought by Petitioner consists of eight or nine employees, depending on whether one of the PCCs is counted as a PCC or an RN.[2]
There are a total of five or six PCCs, depending on whether the one employee is a PCC or RN. In addition to the eight or nine RNs, there are three LPNs and one CNA in the patient care area. Thus, in terms of direct patient care, there are a total of 12 or at most 13 employees, excluding of course the PCCs.

The Employer acknowledges that if its position is upheld, there are seven or eight supervisors for 12 or 13 employees. The supervisors are the vice president of patient care, the acute care nursing manager, and the PCCs. Thus, according to the Employer, the ratio of employees to supervisors is greater than 2:1.

Prior to the creation of the PCCs, apparently all of the RNs (the record is not clear with regard to the LPNs) served as charge nurses. When the Employer created the PCC position and selected from among the nurses to fill the PCC positions, it did not backfill and hire replacement employees for the nurses selected to fill the PCC positions. The vice president of patient care emphasized that given the small size of the hospital, the Employer simply could not afford to have five or six PCCs *and* around 20 RNs providing patient care. In fact, according to the vice president of patient care, in the last year the average cen-

[2] There is no explanation in the record as to why the one employee's status as a PCC is in question.

sus of the hospital has been 3.4 – 4 patients. Even with the current staffing model, the Employer is frequently in a position of "calling off" employees, which means employees shifts are cancelled and they are not paid because of low patient census.

The job duties of RNs and LPNs are not exactly the same because of their different licensing and the requirements to obtain their licenses. While both classifications are involved in patient care, LPNs cannot do anything with a central line (no port-a-cath or tunneled central line, no flushes, meds, not even dressing changes); they cannot mix a drug; and they cannot administer blood products, IV chemo medications or any medication the first time a patient receives it.

The Job Duties of the Patient Care Coordinators

The record is replete with documents put in evidence by the Employer purportedly explaining the responsibilities of the PCCs. In addition, the vice president of patient care testified—mostly in general terms—about the supervisory duties of the PCCs. In this section of the decision, I describe the job duties of the PCCs as set forth in the documents, including any suggestion in the documents of 2(11) responsibilities of the PCCs. In the next session, I summarize the testimony of the vice president of patient care about the supervisory duties of the PCCs.

The PCCs' Job Description

The job description is a 6-page, mostly single-spaced document, outlining numerous responsibilities of the PCCs, as well as core expectations, accountabilities, and job requirements. While the testimony of the vice president of patient care was unclear on the point, the job description of the PCC makes clear that PCCs are involved in direct patient care, although they are not necessarily assigned to specific patients. Rather, according to the job description: PCCs assess patients; intervene in their care and implement care plans; make daily patient rounds; ensure PCC daily checklists are completed and that the next shift is aware of any outstanding items requiring follow-up; initiate and participate in patient education and discharge planning; deliver "accountable, high quality, and person-centered care;" and complete or delegate the completion of follow-up calls to patients who are discharged. According to a PCC who testified, 50–75 percent of her time is spent in direct patient care, depending on how busy the emergency room is. The same PCC also testified that she is expected to and does assist staff with the care of patients assigned to staff. Under key responsibilities are the following "supervisory" duties:

- Provides overall supervision of staff and patient care during shift and serves as bedside leader for the nursing team during the shift;
- Participates in the hiring and performance evaluation processes of the acute care nursing staff;
- Initiates disciplinary action when appropriate up to and including termination; and
- Attends departmental and PCC specific meetings (as requested).

Under Job Summary/Job Purpose are the following duties which implicate supervisory status:

- Responsible for Daily Nursing Assignments – assesses, identifies and communicates unit staffing needs for current and oncoming shifts and assigns admissions and/or transfers based on patient acuity level, nurse patient ratio, and nursing skill levels;
- Coordinates daily patient care activities with acute care nursing staff . . .
- Retains overall accountability for the workflow for their shift, and remains accountable if duties are delegated to another qualified staff member.

At other points in the job description, it emphasizes the responsibility of PCCs to collaborate with others, to build teams and engage in teamwork and to recognize "peers when they are providing excellent care."

Minutes of Meetings Involving the PCCs and Vice President of Patient Care and Acute Care Manager[3]

The Employer also put in evidence minutes from two meetings held with PCCs on February 18 and 24, 2016. Present were only the PCCs and two managers in the patient care area. Nothing discussed in the February 18 meeting implicates the PCCs' alleged supervisory status; the closest subject was a discussion about "brainstorming" whether to return to rotating shifts. On the other hand, the February 24, 2016 meeting focused on a key aspect of the PCCs' alleged supervisory status – corrective actions. The February 24 minutes state:

> Lakewood's corrective action policy was reviewed and scenarios discussed along with the use of corrective action form. Determination made that PCC staff can initiate a verbal warning if warranted. Written warnings, Suspensions, Terminations should be discussed with Acute Care Manager, VP Patient Care and/or HR prior to moving forward.

In the February 24 meeting, there was also discussion of HR policies related to premium pay, attendance, employee badge and lanyards, as well as when staffing decisions should be completed.

Also in evidence are minutes of PCC meetings held on April 8, 13 and 28 and May 19, 2016. Some of the minutes do not reflect who was present; and those that do reveal that the vice president of patient care was not present. In addition, not all PCCs were present at all the meetings. It is unclear who drafted the minutes (except one where the author is the acute care manager), although the "voice" of the minutes suggests that they were not drafted by PCCs. The subjects covered in these meetings largely relate to various aspects of patient care. In addition, however, they reveal that the Employer is very con-

[3] Also in the record are numerous interview sheets, setting forth the questions asked of employees who applied for PCC positions, as well as each employee's responses. Apparently the Employer believes that the fact the interview sheets ask a variety of questions about managing employees, leadership and communication with staff members is relevant to a determination of the PCC's supervisory status. While the interview sheets certainly reflect what the applicants were asked and how they responded, they have little relevance as to the actual duties performed by PCCs. The minutes of meetings held with staff prior to the creation of the PCC position to discuss the position and its potential role is similarly irrelevant.

cerned about call offs, including ensuring that call offs are recorded accurately. The April 28 minutes also have great detail about delegating work to LPNs and what work LPNs cannot do. The minutes make clear the "delegation is decided by each RN delegating any task that requires licensure. Essentially the LPN is working under your licensure. Delegation should occur if an RN is immediately available. You are responsible for the assessment and any adverse response to this task." Unclear is why the minutes refer to delegation by an RN and not a PCC.

A somewhat common theme in the minutes (not all but most) is the importance of leadership and being a change agent.

The Staffing Management Plan

The Staffing Management Plan is an 8-page document that provides acute care nursing guidelines, and according to the vice president of patient care, was the genesis for phasing out charge nurses and creating the PCC positions. It is dated February 28, 2016. The Plan contains a detailed description of various aspects of caring for patients, including at times the specific roles of the PCCs. With regard to PCCs, it states that they "coordinate" daily patient care activities with acute care nursing staff while also caring for patients in the Emergency Room and outpatient area. It also states that PCCs "assist" the acute care nurse manager in establishing goals and objectives that enhance the department's competencies. PCCs retain "overall accountability for the workflow for their shift and remain accountable if duties are delegated to another qualified staff member."

The Staffing Management Plan states that staffing a unit appropriately is essential and that "clear guidelines will be developed and maintained." It therefore provides guidelines for the licensed staff to patient ratios for various areas. As to assignments of patients to staff, the plan states: "Patient assignments are made by the PCC with input from nursing team members." The plan also has detailed instructions for orientation of new staff and states that preceptors (the person doing the orientation) will be selected by the acute care nursing manager "with input from the nursing staff." The section does not suggest that only PCCs will be selected to orient new staff.

Shifts worked by nursing staff are set forth in the Staffing Management Plan. According to the plan, "Scheduling is the responsibility of the Acute Care Nursing Manager with the assistance from the Acute Care Nursing Scheduler." Shift trades must be approved by the PCC or Acute Care Nursing Manager, who are to take into account whether as a result of the trade unscheduled overtime will result. The plan also explains who is eligible (and in what order) to pick up open shifts, how staff is to be rotated for holiday shifts, and how holiday call offs will occur. The plan limits the number of staff allowed to be out on PTO, with deviations to be determined by the Acute Care Nurse Manager. Breaks are assigned by the PCC "after seeking input from the nursing staff on expected flow of the shift." (the length and number of breaks are set out in the plan).

According to the Staffing Management Plan, at all times (even with a patient census of zero), two licensed staff are to be on duty, one being the PCC. The plan contains detailed instructions on calling off employees, including the order of call off. With regard to staff being on call, according to the plan, the third individual on the shift, if called off, is automatically placed on call. Use of the employee time clock is also governed by the plan.

Emails from PCCs to Staff

The Employer believes that emails sent to the acute nursing staff from PCCs are relevant to a determination whether they are supervisors within the meaning of the Act. None of the emails is directed to a particular individual, and none deals with supervisory issues as described in the Act. Rather, all relate to reminding the entire staff to do certain tasks, to have certain equipment in place where needed, or summarizing tasks the sender has completed. One concerns a "night shift chart checklist" that "PCCs can be responsible for" to "make sure that orders are getting put in that documentation is getting done."

Testimony Regarding the Patient Care Coordinators and Section 2(11) Indicia

There is no record evidence, and the Employer does not contend, that charge nurses permanently transfer, lay off, recall, promote, or adjust the grievances of employees, or effectively recommend any of the foregoing actions. In fact the Employer contends that it never lays off, and therefore never has to recall, employees. In this section of the decision, I consider testimony regarding each of the remaining indicia.

Those employees who were selected to be PCCs received a 5 percent wage increase. A PCC who testified explained that she has been allowed to trade shifts with a staff nurse and work as a staff nurse in order to get a shift off. When she works as a staff nurse, she does not receive the extra 5 percent in wages. If a staff nurse works for a PCC, the staff nurse does not receive extra remuneration.

Assignment of Work

In *Oakwood Healthcare, Inc.*, 348 NLRB 686, 689 (2006), the Board interpreted the term "assign" as referring 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."

Scheduling of employees is accomplished by the acute care nursing manager with regard to hours of work and apparently their locations of work (no evidence in the record specifically addresses this latter matter). According to the vice president of patient care, paid time off requests go to the acute care nursing manager, who builds the requests into the work schedule and has the authority to deny requests. While nursing staff call the PCCs when they will be absent due to illness, PCCs do not have the authority to deny the absence. The Employer takes employees at their word that they are sick. While the record testimony does not address how open shifts are staffed, the Staffing Management Plan addresses this.

PCCs have the authority to approve nurses trading shifts, and the PCCs initial off on shift trades. However, the Staffing Management Plan states that the acute care nursing manager can also approve shift trades. The reason the Employer requires approval of shift trades is in the past there were staff "improperly trading," that is sometimes a trade involved a licensed staff employee trading with the CNA, but the shift the

CNA was then scheduled to work did not have the requisite two licensed nurses required by the staffing management plan. In addition, PCCs or the acute care nursing manager are to take into account whether overtime will be required as a result of the trade, according to the Staffing Management Plan. The vice president for patient care further testified that in examining shift trades, the PCCs should take into account the abilities and experience of the individuals involved compared to the patient census and level of patient care required. However, the vice president did not cite any specific examples of shift trades where it was clear the PCC took into account abilities or experience, and she did not explain the circumstances when a PCC, rather than the acute care nursing manager, would approve shift trades. She also did not explain how the PCC takes into account abilities and experience for shift trades requested well in advance of when the PCCs (or the Employer for that matter) have any idea who will be patients or what the census will be in the hospital. Finally, the frequency of shift trades approved by PCCs is not in the record.

PCCs also have the authority to call off employees. This means when there are too many employees scheduled for the patient census, an employee or employees are to be cancelled and not paid. The Staffing Management Plan has detailed instructions who is to be called off, and the vice president of patient care emphasized in her testimony the importance of PCCs carefully recording who is called off to ensure the process is fair (and presumably in accordance with the Staffing Management Plan). Whether to call off an employee or employees is determined by staffing calculations, described below.

In the record are examples of staffing calculations. Part of the calculation is filled out by a PCC who classifies each patient in one of three categories of acuity. Each classification is assigned a certain number of hours of care for each shift; the number of hours of care is not determined by the PCC but by a formula derived by the Employer. Therefore, the PCC determines how many patients there are in each category, multiplies the number of patients by the hours of care needed, and then divides the total by seven to determine how much staffing is required for the shift. The staffing calculation allows for the PCC to enter variances, and as a result increase staffing if in the PCC's view the variances are medically necessary.

Staffing calculations are in the record for May 3, 5, 10, 11 and 17, and 24, 2016. They reveal that for each date,the shifts from 7 pm to 7 am were calculated to need one or less employees, and no more than one employee actually worked. Thus, the minimum number of two employees worked (the PCC and one other nurse). During the shift from 7 a.m. to 7 p.m. on May 3, the calculation was that .64 staff was needed, and therefore one nurse worked, and similarly on May 11 zero staff was needed so only one nurse worked. During the remaining dates on the 7 a.m. to 7 p.m. shifts, while the calculations were that anywhere from .32 to 1.11 staff were needed, in fact two registered nurses worked due to variances such as new employees were orienting, the possibility of admissions, or patients required extra care.

According to the vice president of patient care, the PCCs assign patients to particular nurses, taking into account the nurses' skills and abilities. However, she provided no examples or specifics, and acknowledged that she neither reviews assignment sheets nor uses them to evaluate the performance of the PCCs. In addition, other evidence indicates that the PCCs are somewhat constrained by a number of factors. First, as the vice president made clear, the patient census has been particularly low, testimony borne out by the staffing calculations in evidence. In any shift where a PCC and one nurse is working, including all of the 7 p.m. to 7 a.m. shifts in the staffing calculations in evidence, the PCC had no choice—there was one nurse to assign to the patients. Even when two members of the staff are working, unless they are both registered nurses, the PCC is constrained by the fact that the CNA can only be responsible for daily cares. Therefore, on those dates where a CNA and nurse are working, presumably the CNA and nurse are assigned to the same patients—with the CNA providing the daily cares. The PCC is also somewhat constrained in assigning patients when an LPN and RN are working due to their different licensures. Thus, only when there are two RNs working does it appear that the PCC has possible discretion in assigning patients.

The Employer also contends that PCCs have the authority to approve premium pay, which is not the same as overtime pay. It is given to an employee when the Employer is having problems with staffing and is used to encourage an employee to work an extra shift. In the record are two examples in May 2016 of where a nurse was paid premium pay and the initials of a PCC appear next to the notation for premium pay. The Employer also introduced into evidence its premium pay policy which states that premium pay must be approved by the department director or supervisor. The vice president for patient care indicated that one cannot determine from the exhibits why premium pay was authorized. One PCC who testified explained that the Employer's policy on premium pay is that if an employee is needed for a shift and it is 12 hours or less prior to the start of the shift, she can offer premium pay.

The vice president also testified that PCCs "could approve" overtime. However, there are no examples in the record where a PCC has done so. According to a PCC who testified, she cannot require an employee to work beyond the shift ending time.

Responsible Direction of Work

For direction to be responsible under the Act, "the person directing and performing the oversight must be accountable *for the performance of the task of the other,* such that some adverse consequence may befall the one providing the oversight if the tasks are not performed properly." Id. at 695 (emphasis added).

There is minimal record testimony regarding PCCs directing the work of RNs, LPNs and the CNA, but the evidence suggests that in fact at times PCCs do direct work. Two specific examples provided by the vice president of patient care were provided in the context of discussing discipline. On May 5, 2016, a PCC instructed an LPN to stop completing discharge paperwork and to instead restart a patient's IV. The LPN came to the vice president, upset about the instruction. The vice president asked the LPN further questions, and then interviewed the PCC. The vice president concluded that the PCC's instructions were correct, and noted that had the LPN not followed the PCC's

instructions (in fact she had but was upset by them) "she probably would have ended up with a more formal disciplinary process for insubordination."

A second example occurred on May 29, 2016 when a PCC telephoned the vice president at home to relate a situation between the PCC and another staff nurse, involving a disagreement on how to manage an outpatient who had come in that day. The PCC explained that the two had worked it out and ultimately made "amends."

Less clear is whether PCCs are held accountable for the work of those employees they direct. In evidence is an email to a PCC from the vice president of patient care inquiring about a failure to adequately clean up and attentiveness to patient needs. However, the email is an inquiry and expression of hope the PCC will help improve processes, and it does not make clear who was responsible for the perceived problems. The only other evidence that PCCs are held accountable for the work of those they direct is when the vice president responded "yes" to a leading question whether PCCs will be accountable for the performance of their subordinates.

The Power to Discipline, Suspend, and Terminate

The vice president of patient care provided detailed testimony related to the power of the PCCs to discipline, suspend, or terminate employees, or to recommend these actions. However, she also pointed out that because the position is relatively new, the PCCs have had little opportunity to exercise these powers, and she also testified that in fact the Employer has few disciplinary issues. Thus, to the extent the Employer did not provide specific examples of PCCs exercising these powers, it is because the situations have not arisen.

There appears to be no dispute that PCCs can verbally coach employees. Coaching is not viewed as discipline, and in fact is not recorded. According to the vice president of patient care, PCCs were told at the February 24, 2016 meeting that they could independently discipline, including suspending and discharging employees, but the vice president testified that she also told them that even she does not suspend or discharge without consulting with HR or the president, so therefore they should also consult. However, this testimony is not entirely consistent with the minutes of the meeting, which clearly state PCCs should not move forward with written warnings, suspensions or terminations without consulting with higher-level managers or HR. A PCC who testified stated that her understanding of her ability to discipline was consistent with what is written in the minutes of the meeting. The precise roles played by PCCs, upper level managers, or HR are not delineated in the minutes or any testimony.

There are no written warnings, suspensions, or discharges in the record that were initiated or independently issued by a PCC—but the Employer emphasizes that is because there was no need to issue such discipline. The vice president of patient care described one suspension of an LPN—but it was a suspension that was the result of a report to the vice president by a staff nurse—not a PCC. As a result, the PCC was coached verbally by the vice president that her actions in the situation were not consistent with how the Employer wanted her to manage the situation.

Preparing and Issuing Performance Evaluations (Rewarding Employees)

The authority to evaluate employees is not one of the indicia of supervisory status set out in Section 2(11) of the Act. *Elmhurst Extended Care Facilities*, 329 NLRB 535, 536 (1999). Rather, the question is whether the evaluations are "effective recommendations" of promotion, wage increase, or discipline." *Phelps Community Medical Center*, 295 NLRB 486, 490 (1989). If the evaluation does not, *by itself*, directly affect wages and/or job status of the individual being evaluated, the Board will not find the individual performing the evaluations to be a statutory supervisor. *Williamette Industries, Inc.*, 336 NLRB 743, 743 (2001) (emphasis added).

PCCs have not written performance evaluations of their subordinates. However, according to the Employer, performance evaluations occur in September of each year and since the PCC position was created only a few months ago, PCCs have not been in the position yet to write performance evaluations. Once again the vice president of patient care testified in general terms that the PCCs' assessment of performance will determine wage increases that employees receive. In evidence is a performance evaluation from the year 2015 – thus before the creation of the PCC position. While not explicitly stated on the record, apparently it is the Employer's position that this form will be used by PCCs to evaluate employees. The evaluation includes a section which weighs various performance goals and then results in a rating score. However, nothing on the form suggests that the rating score results in a particular wage increase, or any wage increase at all. Moreover, there is no testimony regarding the Employer's historical practice.

The Authority to Recommend Hiring

The Employer contends that PCCs will be involved in the hiring of staff, but like so many of the other indicia, in fact at this point the PCCs have not exercised this authority. And like the other indicia, the Employer's evidence is the generalized testimony of the vice president of patient care. According to her, PCCs will be involved in hiring in that they will participate in interviewing applicants as part of a panel consisting of "two or three members of leadership" (which is not further explained). According to the vice president: "Our practice is to have panel interviews, and we will meet right after the interview or after we're done with all the interviews, if there is more than one candidate, and we listen to each other's feedback." According to the vice president, in response to a leading question, the PCC's recommendation will count. However, the vice president was clear that the panel will not include every PCC, and that probably one will be asked to participate.

Overview of Board Law

The party asserting supervisory status, in this case the Employer, has the burden of establishing such status. See e.g., *NLRB v. Kentucky River Community Care*, 532 U.S. 706, 711–712 (2001). Conclusionary evidence does not satisfy that burden. See e.g., *Lynwood Manor*, 350 NLRB 489, 490 (2007). Thus evidence of supervisory status must be specific. *Brusco Tug & Barge, Inc.*, 359 NLRB No. 43, slip op. at 5 (2012), *Avante at Wilson, Inc.*, 348 NLRB 1056, 1057 (2006).

Application of Board Law to Facts in this Case

In reaching the conclusion that the Employer has failed to meet its burden of proof establishing the 2(11) status of charge nurses, I emphasize that I have taken into account the fact that the PCC position has existed for less than four months, and therefore the Employer is not in a position to provide examples of where PCCs have exercised the Section 2(11) authority that the Employer contends the PCCs possess. Thus, while in a different context I would rely on the failure to provide examples in finding that an employer failed to meet its burden, in the context of this case, I give little or no weight to the fact that the Employer failed to provide examples of PCCs exercising their ostensible supervisory authority. Rather, I conclude that the Employer has failed to meet its burden of proof because the testimony of the vice president of patient care is general and conclusionary, and at times contradicted by documentary evidence.

I begin with the PCCs' alleged authority to assign work. First, and importantly, the Employer's evidence clearly establishes that PCCs have no role in assigning hours of work, creating work schedules, or assigning locations of work. On the other hand, PCCs do assign staff to the patients they will care for. However, the record is clear that the PCCs are constrained by a number of factors in assigning staff to patients. First, the staffing calculations in evidence establish that for eight of the twelve shifts covered by the calculations, one staff nurse worked. Obviously, when there is one staff nurse (and of course the PCC) working a shift, the PCC is not deciding to assign one staff nurse over another to certain patients. Second, the PCCs are constrained by the job classifications of the employees working. If a staff nurse and CNA are working, the PCC has no discretion in assigning patients, because the CNA is qualified to perform daily cares only. If an LPN and RN are working, the PCC is at least partly constrained by the qualifications of the two in assigning patients.

Obviously there are shifts where two RNs work (and even times when three RNs work), and in that situation PCCs decide which patients to assign to which RN. Equally clear is that it is the view of the vice president of patient care that the PCCs are supervisors because when they assign patients between two RNs, they are making assignments based on the cares required by the patients, and the skills and abilities of the RNs. However, there is no record evidence making clear that the skills and abilities of the staff nurse RNs differ significantly, and the vice president of patient care acknowledged that she does not review patient assignments and that she does not rely on them in assessing PCC performance. The summary testimony of the vice president of patient care is also of concern in view of the Staffing Management Plan, which suggests that the PCC's role is to "coordinate" daily patient care activities, and that patient assignments *are to be made with input from nursing team members*. Thus, the Staffing Management Plan and the testimony of the vice president of patient services are not consistent with one another, and in my view, the Employer has failed to meet its burden to establish that when assigning patients to two (or possibly three) RNs, that the PCCs exercise independent judgment. *Lynwood Manor,* 350 NLRB 489, 490 (2007).

While PCCs can call off employees (requiring them not to work or get paid), when PCCs do so, it is the result of applying a mathematical formula taking into account patient acuity levels resulting in how many hours of care that will be required – but the hours of care required has been developed by the Employer. PCCs literally perform math—they multiply the number of patients in each acuity level by the hours of care therefore required, and divide by 7—the resulting number tells the PCC how many staff are needed for each shift. The staffing calculations in evidence are remarkable in that they consistently apply this formula. I am unable to conclude that the PCCs exercise any discretion in using the formula. The record does establish that PCCs can decide that in spite of the resulting number, they can retain additional staff due to variances, which include that a patient or patients are particularly challenging or that a nurse will be involved in training a new employee. However, any variances in the staffing calculations in evidence that result in deciding to have one staff member on the shift are irrelevant as the Employer's policy is every shift will have a PCC and one other staff nurse. Given the testimony of the vice president of patient care that the average census in the last year has been 3.4–4 patients, the record fails to establish that the variances occur frequently enough to establish supervisory status, and there is little evidence of how much independent judgment is exercised. Id.

There is little or no record evidence establishing that PCCs utilize independent judgment in approving shift changes or offering employees premium pay. The Employer has clear guidelines when shift changes are to be denied, and there is no evidence that a PCC has denied a shift change for reasons other than set forth by the Employer. While the PCC can and does offer premium pay to induce employees to work extra, in effect the PCC is merely committing that the Employer will pay the employee additional amounts of money for the hours worked. The PCCs cannot require employees to work extra—with or without premium pay. In similar circumstances, the Board has concluded that the ability to call and request employees to work, absent an ability to require them to work, is insufficient to establish 2(11) status. *Lakeview Health Center*, 308 NLRB 75, 79 (1992). While the vice president of patient care also testified that PCCs could approve overtime, there is no evidence establishing that PCCs have done so, and I would expect that at least overtime would occur in the last 4 months.

With regard to the fact that PCCs direct the work of nursing assistants, the record is inadequate to support a conclusion that the PCCs either use independent judgment or are held responsible for the work of their alleged subordinates. There is record evidence that PCCs have the ability, and exercise the ability, to direct the work of staff working with them on their shifts. Moreover, there is evidence that PCCs exercise independent judgment with regard to the care of patients. They assess patients' medical conditions, and according to the testimony of one PCC, alter the care plan of patients utilizing their skills as RNs. However, this exercise of independent judgment relates not to how employees perform their jobs, but to how patients are cared for. What is lacking is specific and detailed evidence that PCCs exercise independent judgment when directing staff, given the fact that patient care is governed by patient care

plans. *Community Education Centers, Inc.*, 360 NLRB No. 17 (2014).

Just as significant, the Employer has not satisfied its burden of proof that PCC nurses are accountable, and therefore "responsibly direct" nursing assistants. Certainly the vice president of patient care summarily testified that PCCs are accountable. On the other hand, the PCC's job description suggests otherwise. It states that PCCs are accountable for how they make assignments and "for the workflow for their shift," and they retain accountability even "if duties are delegated to another qualified staff member." Clearly the language of the job description establishes that PCCs are accountable for their actions, and remain accountable for the actions of others, to the extent the PCCs delegate PCC tasks to others. Nothing in the job description states that PCCs are accountable for the work of staff on their shifts. However, the standard for finding supervisory status based on direction of work is whether the PCCs suffer adverse consequences if staff on their shifts performs poorly. Except for the summary testimony of the vice president of patient care, which is contradicted by documentary evidence, there is no evidence in this record that the Employer holds PCCs accountable, and issues adverse action, for the actions of the staff on their shifts.

The Employer's failure to meet its burden to prove that charge nurses discipline, suspend, or terminate employees and are therefore 2(11) supervisors is largely due to the inconsistency between the testimony of the vice president of patient care and documentary evidence. The vice president testified that on February 24, 2016, in a meeting with PCCs, she told them they had the authority to issue written warnings, to suspend, and to terminate employees, with a cautionary note that it is always better to check with HR or the Employer's president before doing so. On the other hand, the minutes of the same meeting reflect that written warnings, suspensions and terminations "should be discussed" with the acute care manager, vice president of patient care and/or HR "*prior to moving forward.*" (emphasis added). This contradictory evidence, offered by the Employer, leads me to conclude that the Employer has failed to meet its burden of proof.

To be clear, the record establishes that PCCs can verbally correct, including verbally warn employees. However, verbal correction/warnings are not considered discipline and they are not recorded.

The Board has also made clear that the fact that individuals complete performance evaluations for other employees is insufficient to establish 2(11) status, unless there is evidence that the performance evaluations lead to rewards or discipline. It appears from this record that the Employer intends for PCCs to complete performance evaluations. What the Employer failed to do is create sufficient record testimony that performance evaluations lead to rewards or discipline, other than a summary statement to that effect from the vice president of patient care. While I acknowledge that the Employer cannot provide examples of PCCs completing evaluations that led to rewards or discipline because PCCs have not had the opportunity to complete evaluations yet, on the other hand the Employer introduced into evidence an example of a performance evaluation given before the creation of the PCC position to prove what is in the evaluations. Yet the Employer made no effort to prove that historically the evaluations issued prior to the creation of the PCC position resulted in wage increases or discipline. This failure is further compounded by the fact that the Employer's witness obliquely referenced the fact that HR can overrule any recommendation for a wage increase, without any further explanation.

The fact that the Employer will have PCCs participate in panel interviews of applicants for patient care positions, and that (according to the vice president of patient care) the Employer will consider their recommendations is not sufficient to establish that PCCs effectively recommend the hiring of applicants for employment. *Connecticut Humane Society*, 358 NLRB 187, 206 (2012), and cases cited therein.

Finally, I note that the Employer relies significantly on the job descriptions and numerous other documents that refer to PCCs as supervisors or refer to their performance of supervisory functions. It is well settled, however, that an employee "cannot be transformed into a supervisor by the vesting of a title and the theoretical power to perform one or more of the enumerated functions in Section 2(11) of the Act." *Lakeview Health Center*, supra at 78, and case cited therein.

The Employer's Contention that Petitioner Is Precluded from Arguing, and that I Am Precluded from Finding, that the PCCs are Employees

Petitioner and the Employer are no strangers to one another. Until the Employer withdrew recognition of the Union in the fall of 2015, the Union represented a group of employees at the Employer that included most of the employees the Petitioner now seeks to represent, as well as other employees. The withdrawal of recognition was the subject of a complaint issued by the undersigned in Cases 18–CA–161872 and 18–CA–170429. The complaint included allegations that the Employer unilaterally implemented a new staffing plan, including the creation of a new supervisory position of PCC; dealt directly with unit employees in order to fill the new PCC positions; and unilaterally removed work from the unit when it implemented the new staffing plan and assigned unit work to non-unit employees. It appears to be the Employer's position that the issuance of this complaint, and the fact that it issued based on charges filed by Petitioner, suggests that both Petitioner and the undersigned viewed the PCCs as 2(11) supervisors, and therefore both are precluded from taking a contrary position in this matter.[4]

The Employer, which waived the filing of a post-hearing brief, did not provide case support for its view during the hearing. I reject the Employer's position for a number of reasons. First, the allegations of the complaint are precisely that—allegations—which to quote Webster's definition of the word means "assertions that must be proved or supported with evidence." Second, the consolidated complaint was dismissed pursuant to a motion by Counsel for the General Counsel shortly after the completion of the hearing held to present evidence on the allegations of the consolidated complaint. Thus, there

[4] The hearing office correctly rejected as exhibits the formal papers and transcript of the proceeding involving the consolidated complaint. Obviously, however, I am able to take judicial notice of the facts surrounding the proceeding and the formal papers.

are no findings, and will be no findings, on the allegations of the complaint. Finally, the allegations of the complaint are not inconsistent with a conclusion that the PCCs are not 2(11) supervisors (or more accurately that the Employer has failed to meet its burden of establishing their 2(11) status). The allegations do not allege that the PCCs are in fact supervisors; rather, they allege that the Employer *unilaterally* announced an intention, and then created a new supervisory position, and in doing so assigned unit work to non-unit employees.[5]

In view of the foregoing and the record as a whole, I reject the Employer's contention that its PCCs are supervisors within the meaning of Section 2(11) of the Act, and I conclude that it is appropriate to hold an election which includes the PCCs in the unit.

Under Section 9(b)(1) of the Act, the Board is prohibited from including professional employees in a unit with employees who are not professional, unless a majority of the professional employees vote for inclusion in such a unit. To carry out the statutory requirement, the Board has adopted a special type of self-determination procedure in such an election known as a *Sonotone* election. Under this procedure, a separate voting group encompassing all professionals would elect whether to constitute a separate appropriate bargaining unit or be included in the larger unit with non-professionals. Accordingly, I find that all registered nurses, who are professional employees, constitute a separate voting group which, depending on the outcome of the election, may constitute either a separate appropriate bargaining unit, or be included in the unit with the non-professional employees.

I therefore find that the following employees of the Employer may constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> All full-time and regular part-time registered nurses, including the patient care coordinators, technical employees, including licensed practical nurses (LPNs), radiologic technologists, pharmacy techs, multi-modality technologists and medical laboratory technicians, employed by the Employer at its acute care hospital located at 600 Main Avenue South, Baudette, Minnesota; excluding all other professional employees, physicians, all other technical employees, all other non-professional employees, business office clerical employees, skilled maintenance employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center.

In order to ascertain the desires of the professional employees as to their inclusion in the unit with the non-professional employees, I shall direct separate elections in the following groups:

> (a) All full-time and regular part-time registered nurses, including the patient care coordinators, employed by the Employer at its acute care hospital located at 600 Main Avenue South, Baudette, Minnesota; excluding all other professional employees, physicians, technical employees, non-professional employees, business office clerical employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center.
>
> (b) All full-time and regular part-time technical employees, including licensed practical nurses (LPNs), radiologic technologists, pharmacy techs, multi-modality technologists and medical laboratory technicians, employed by the Employer at its acute care hospital located at 600 Main Avenue, Baudette, Minnesota; excluding all other technical employees, professional employees, non-professional employees, business office clerical employees, skilled maintenance employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center.

The employees in the professional group (a) will be asked two questions on their ballots:

> (1) Do you wish to be included in a unit with non-professional employees for purposes of collective bargaining?
>
> (2) Do you wish to be represented for the purposes of collective bargaining by Minnesota Nurses Association?

If a majority of the professional employees in voting group (a) vote "yes" to the first question, indicating their wish to be included in the unit with non-professional employees (voting group b), they will be so included. Their votes on the second question will then be counted together with the votes of the non-professional employees to determine whether or not the employees in the combined professional and non-professional unit wish to be represented by Minnesota Nurses Association. If, on the other hand, a majority of the professional employees in voting group (a) vote against such inclusion, they will not be included with the non-professional employees. Their votes on the second question will then be separately counted to determine whether or not they wish to be represented by Minnesota Nurses Association.

The non-professional employees comprising voting group (b) will be polled to determine whether or not they wish to be represented by Minnesota Nurses Association.

The unit determination is based, in part, on the results of the election among the professional employees. However, the following findings in regard to the appropriate unit are now made:

(1) If a majority of the professional employees vote for inclusion in the unit with the non-professional employees, I find that the following will constitute a unit appropriate for purposes of collective bargaining within the meaning of Section 9(b) of the Act:

[5] I note that much of the testimony offered by Petitioner suffers the same infirmity. Petitioner had witnesses it presented compare the job duties of the PCCs to the job duties of charge nurses, implicitly suggesting that if the charge nurses performed the duty, therefore 2(11) status did not exist. However, there is no basis for me to know whether charge nurses met or did not meet the Board's definition of a supervisor. The fact they were in the previous unit represented by Petitioner does not mean they therefore did not exercise 2(11) authority. Thus, I do not consider relevant, and did not consider probative, testimony by Petitioner witnesses to the extent it was that charge nurses performed some or all of the same job duties that PCCs currently perform.

All full-time and regular part-time registered nurses, including the patient care coordinators, technical employees, including licensed practical nurses (LPNs), radiologic technologists, pharmacy techs, multi-modality technologists and medical laboratory technicians, employed by the Employer at its acute care hospital located at 600 Main Avenue South, Baudette, Minnesota; excluding all other professional employees, physicians, all other technical employees, all other non-professional employees, business office clerical employees, skilled maintenance employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center.

(2) If a majority of the professional employees do not vote for inclusion in the unit with the non-professional employees, but do vote for representation apart from them, I find that the following two groups of employees will constitute separate units appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

All full-time and regular part-time registered nurses, including the patient care coordinators, employed by the Employer at its acute care hospital located at 600 Main Avenue South, Baudette, Minnesota; excluding all other professional employees, physicians, technical employees, non-professional employees, business office clerical employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center.

All full-time and regular part-time technical employees, including licensed practical nurses (LPNs), radiologic technologists, pharmacy techs, multi-modality technologists and medical laboratory technicians, employed by the Employer at its acute care hospital located at 600 Main Avenue, Baudette, Minnesota; excluding all other technical employees, professional employees, non-professional employees, business office clerical employees, skilled maintenance employees, managerial employees, guards and supervisors as defined in the Act, and all other employees employed by the Employer at either its acute care hospital or at the adjacent care center.

DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the units found appropriate above. Employees will vote whether or not they wish to be represented for purposes of collective bargaining by Minnesota Nurses Association.

A. Election Details

In view of the fact that Petitioner waived its right to have the Voter List for 6 of the 10 days normally required, the election will be held on **June 30, 2016** from 6:30 a.m. to 8:30 a.m. and 4:30 p.m. to 6:30 p.m. in Conference Room 4 at the Employer's Baudette, Minnesota facility.

B. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending **June 4, 2016,** including employees who did not work during that period because they were ill, on vacation, or temporarily laid off.

Employees engaged in an economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike that commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Unit employees in the military services of the United States may vote if they appear in person at the polls.

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

C. Voter List

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names, work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters.

To be timely filed and served, the list must be *received* by the Regional Director and the parties by **June 21, 2016**. The list must be accompanied by a certificate of service showing service on all parties. **The Region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the list in the required form, the list must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the list will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the list shall be filed electronically with the Region and served electronically on the other parties named in this decision. The list may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the detailed instructions.

Failure to comply with the above requirements will be grounds for setting aside the election whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election accompanying this Decision in conspicuous places, including all places where notices to employees in the unit found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In addition, if the Employer customarily communicates electronically with some or all of the employees in the unit found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the election and copies must remain posted until the end of the election. For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution.

Failure to follow the posting requirements set forth above will be grounds for setting aside the election if proper and timely objections are filed.

RIGHT TO REQUEST REVIEW

Pursuant to Section 102.67 of the Board's Rules and Regulations, a request for review may be filed with the Board at any time following the issuance of this Decision until 14 days after a final disposition of the proceeding by the Regional Director. Accordingly, a party is not precluded from filing a request for review of this decision after the election on the grounds that it did not file a request for review of this Decision prior to the election. The request for review must conform to the requirements of Section 102.67 of the Board's Rules and Regulations.

A request for review 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 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 of the request on the other parties and file a copy with the Regional Director. A certificate of service must be filed with the Board together with the request for review.

Neither the filing of a request for review nor the Board's granting a request for review will stay the election in this matter unless specifically ordered by the Board.