United States Government

NATIONAL LABOR RELATIONS BOARD

Region 22

20 Washington Place - 5th Floor

Newark, NJ 07102-3110

January 23, 2018

National Labor Relations Board
Office of the Executive Secretary
Attn: Roxanne Rothschild
1015 Half Street SE
Washington, DC 20570

Re: New Vista Nursing & Rehabilitation
Cases 22-RC-013204
22-CA-029988

Dear Ms. Rothschild:

Please accept this letter brief as the Counsel for the General Counsel's statement of position concerning the Third Circuit's remand of the above-referenced cases. As outlined below, it is the undersigned's position that under the test set forth by the Third Circuit in *NLRB v. New Vista Nursing and Rehabilitation*, 870 F.3d 113 (2017), the Employer has not carried its evidentiary burden to establish that its LPNs are supervisors as defined by Section 2(11) of the Act.[1]

Recent Procedural History

On March 9, 2011, the Regional Director for Region 22 of the Board issued a decision and direction of election finding that New Vista's licensed practical nurses (LPNs) were not supervisors as defined by Section 2(11) of the Act. Thereafter, the

[1] The General Counsel does not necessarily agree with the Board's current standards for determining supervisory status, but takes no position in the posture of this case where it can be decided under the Third Circuit's standard as law of the case.

Petitioner decisively won the representation election held on April 8, 2011. A certification of representative issued on April 18, 2011 for the following bargaining unit:

> All full-time and regular part-time Licensed Practical Nurses employed by the Employer at its Newark, New Jersey facility, excluding all other employees, guards, and supervisors as defined by the Act.

The Employer tested the certification of the newly elected bargaining unit and on August 26, 2011, the Board found that the Employer violated Section 8(a)(5) of the Act by refusing to bargain with the Petitioner. Over the next six years, the above cases pended before and then were remanded by the Third Circuit. Ultimately, on August 29, 2017, the Third Circuit in *NLRB v. New Vista Nursing and Rehabilitation*, remanded to the Board the sole issue of whether the Employer's LPNs effectively recommend discipline. On November 28, 2017, the Board notified all involved parties that it had accepted the Third Circuit's remand of the case and that it was soliciting statements of positions with respect to the issue raised by the remand.

Relevant Facts[2]

Background

The Employer operates a 340-bed nursing and sub-acute care facility in Newark, New Jersey. Administrator Newt Weinberger oversees the entire facility. Victoria Alfeche is the Director of Nursing[3] (DON) and Catherine Carido is the Assistant Director of Nursing (ADON).

The facility operates 24-hours a day, seven days a week, utilizing day, evening, and overnight work shifts. The record indicates that the day shift runs from 7:00 a.m. to 3:00 p.m., the evening shift is from 3:00 p.m. to 11:00 p.m., and the overnight shift is from 11:00 p.m. to 7:00 a.m. Alfeche, who oversees the entire nursing department,

[2] These facts were generated from the RC-hearing held on February 14, 17, and 18, 2011.
[3] Alfeche has served as the Employer's Director of Nursing since 2005. From 2002-2005, Alfeche served as the Employer's Assistant Director of Nursing.

generally works from about 8:00 a.m. until about 6:00 p.m., making her physically present for most of the day shift and part of the evening shift. Reporting to Alfeche are two nursing supervisors and three unit managers. One nursing supervisor works on the evening shift and one nursing supervisor works on the overnight shift, each responsible for supervising the entire 340-bed facility during their respective shifts. The record reflects that Alma Isip, a registered nurse, is the Nursing Supervisor on the overnight shift and Grace Tumamak, an LPN, is the unit manager for the 3rd floor on the day shift. Thelma Ibanga and Leonita Fernandez are nursing supervisors for the Employer, but it is unclear from the record what shifts they work. During the day shift, there are three unit managers, one for each of the floors where residents are housed.

Residents are housed on floors 3, 4, and 5 of the Employer's six-story facility. Each residential floor is divided into east and west units, and the staffing quotient for each floor turns on the type of care provided, the time of day, and the resident census. For example, on the day shift, Grace Tumamak is the unit manager for the third floor. One nurse (either an RN or an LPN) is assigned to each unit on the floor, with 4 or 5 CNAs assisting the nurses to meet all resident care needs. Nurses give medications and perform treatments (e.g. splints) on residents while ensuring that CNAs have performed their resident care responsibilities. CNA duties include basic care of residents and assistance with daily living functions, such as feeding, bathing, grooming, dressing, and hygiene.

The Employer employs 42 LPNs. Significantly more CNAs work at the Employer's facility, but the record does not reflect an exact number or an approximation. Petitioner represents the Employer's CNAs for collective-bargaining purposes, but it is unclear from the record when this relationship began or what other classifications of the Employer's employees are included in this bargaining unit.

Discipline of CNAs

Notice of Corrective Action forms[4] are the official disciplinary forms used for CNAs and nurses. They are kept at the nurses' station on each floor. These forms contain space for a recitation of the facts, boxes to check the degree of discipline meted out, information about the offending party, room for a response from the offending party, and signature lines for the department head, administrator, union delegate, and offending employee. The LPN job description states that nurses may "initiate appropriate action as necessary" and can "recommend disciplinary action to the Director of Nursing…"

Employer's progressive discipline procedure is set forth in its employee handbook for all employees. There are two groups of work rule offenses in the progressive discipline procedure. These rules cover a wide variety of employee misconduct, including attendance, attitude, appearance, work performance, insubordination, theft, intoxication, and violation of resident rights.

The procedure for initiating discipline is laid out on page 42 of the employee handbook (Employer Exhibit 7). It specifically states that "Whenever an employee commits an offense warranting disciplinary action, his **supervisor** (emphasis added) may begin disciplinary action in any of the steps listed below, depending on the nature of the offense committed (See Rules and Regulations)." The second step of the procedure states that the Administrator must be notified prior to a discharge recommendation.

Although not defined in the employee handbook, the term "supervisor" is used in other portions of the handbook. For instance, on page 43 of the handbook, one of the Group 1 level offenses listed is "failure to notify supervisor of change of address or other

[4] The record also contains employee warning notice forms, which predate the notice of corrective action.

change of personal data essential for current records." Furthermore, on page 49 of the handbook, under the time/records heading, the handbook states that "All employees are required to punch in and out and keep their immediate supervisor advised of their departures from and returns to the premises during the work day." Additionally, on page 50 of the handbook, under the absence/lateness section, the handbook reads "In the rare instances when employees cannot avoid being late to work or are unable to work as scheduled, they should notify their direct supervisor and or staffing coordinator of the anticipated tardiness or absence at least 2 hours prior to start of shift."

If a nurse believes that a CNA has violated the Employer's work rules, the nurse has the discretion to (1) do nothing; (2) verbally counsel the employee without issuing any write-up; or (3) report misconduct to either the nursing supervisor or unit manager.

LPN Witness Testimony

LPN witnesses presented conflicting testimony regarding the extent of their authority to address and remedy violations of the Employer's work rules.

Marisol Roldan, a 15-year employee, testified that she would fill out an employee warning notice if she observed a CNA doing something he wasn't supposed to do. She testified that she didn't need permission to complete this form and that she would speak to the CNA before completing the form. If she had personal knowledge of the CNA's disciplinary history, she would fill this part of the form out- otherwise, this portion would be completed by the nursing supervisor or DON. Roldan would forward her write-up to a supervisor without suggesting or identifying the type of warning the CNA should receive.

Roldan testified that she has completed warning notices for CNAs who were insubordinate or who failed to properly position their residents. Roldan did not issue either discipline to the employees in question. Only the latter discipline has been supplied by the Employer as part of this record. A review of this discipline (ER Exhibit 4, page 4)

shows that Roldan filled out the top portion of the employee warning notice, including the offending employee's name (Stella Ighasa), department, position, shift, and date of the warning. Nothing is checked in the section detailing prior warnings for this employee. Roldan then wrote the date of the violation, the place, the nature of the violation (neglect), she filled out the narrative section and signed her name (mistakenly) on the employee signature line. DON Alfeche then filled out the remarks section and wrote the following in the "action to be taken" section: "next offense is suspension or as the case maybe." It is unclear from the notice itself, or from Roldan and Alfeche's testimony, as to whether Ighasa was actually disciplined in this case.

Roldan also testified that she wrote a statement recommending the termination of an insubordinate CNA after directing him to leave the floor, but Roldan acknowledged that this incident took place about 10 years prior to the 2011 hearing (prior to the current owners purchasing the facility). The Employer supplied no written documentation corroborating Roldan's testimony regarding this episode.

Simon Ramirez, an LPN for 4 years, testified that if he observed a CNA failing to perform her duties, he would speak to her the first time. If the performance issues continued, he and a co-worker would administer a verbal counseling, which he did not consider part of the Employer's progressive discipline policy. A third occurrence would lead Ramirez to issue a discipline. Ramirez asserts that he does not need permission to use the Employer's discipline forms, which are located by the nurses' station. He fills out the top portion of the form (outlining the facts, who committed the infraction, the shift and date of the occurrence) and gives it to either the nursing supervisor or unit manager. Ramirez does not speak to the CNA again after forwarding this paperwork to the supervisor and does not fill out the corrective action portion of the warning notice. Ramirez cited a December 2007 incident in which he initiated discipline against a CNA

for taking extended breaks as one of the two times he disciplined or recommended discipline of a CNA. This discipline is part of the record as Employer Exhibit 11. On this notice of corrective action, Ramirez filled out the name of the offending employee, department, and date of violation. He then filled out the section entitled "It has been brought to our attention…that you have violated the Institution Rules and Regulations in the following manner."[5] Nothing is filled out in the section that says: "This corrective action has generated a," but there is a handwritten notation at the bottom of this section that says "as per DON's discretion." It is unclear who signed his/her name next to this notation.

In the second incident, which occurred in either 2008 or 2009, Ramirez recommended to the Employer that CNA Darlene Williams be discharged for taking excessive breaks and for insubordination. The Employer failed to supply any written documentary evidence of the Williams incident for the record.

Agnes Ramirez, an LPN at the Employer's facility for 25 years, testified that if a CNA continuously failed to perform a task or endangered a resident, she had no choice but to give a write-up. When pressed for specifics, Ramirez recalled an incident (with no timeframe provided) in which she filled out an investigation report sheet to document a non-compliant CNA's performance. She described what happened on the form and furnished it to her unit manager. Ramirez has never filled out a notice of corrective action nor has she filled out an employee warning notice.

Wendy Thompson, an LPN who has worked for the Employer for 3 ½ years, testified that she has never issued a discipline to a CNA and is not aware of other LPNs issuing disciplines. She explained that if she had a concern about a resident not receiving

[5] This notice of corrective action pre-dates, by over a year, the employee handbook labeled Employer Exhibit 7.

the proper care, she would speak to Tumamak, who would indicate that she would handle the situation. Tumamak has twice requested that Thompson fill out an investigation report sheet- reporting what she observed. Thompson did not recommend to Tumamak what discipline should be meted out and she did not know whether any discipline resulted from her investigation report submissions. Thompson testified that these two incidents involved male CNAs who allegedly did not wash their patients well and provided inadequate care.

The Employer supplied as part of the record a resident concern form filled out by Thompson in April 2010 (Employer Exhibit 4, page 17). Thompson testified that a resident's family member told her about an incident with the CNA caring for her mother, Thompson reported to Tumamak what happened, and Tumamak requested that Thompson fill out the resident concern form. Thompson filled out the first 6 lines of the "Concern" section and then Tumamak filled out the remainder of the form. Thompson never spoke to the CNA and does not know whether this CNA was disciplined as a result of this report.[6] Thompson further testified that anybody (a CNA, nurse, etc.) can fill out a resident concern form, which is located near the nurses' station.

Abosede Adekanmbi has worked for the Employer as an LPN since 2000. Adekanmbi testified about the discipline form in the record that she initiated in September 2010. (Employer Exhibit 4, page 102). She says that while working in 3 East, a resident told her that she wanted to get out of bed. Adekanmbi relayed the resident's wish to the CNA assigned to her room. Later that day, the resident's daughter complained to Adekanmbi about her mother not getting out of bed that day. The next day, Adekanmbi called Tumamak to report this incident and Tumamak instructed her to write a statement, which is found on the top of the discipline form. Adekanmbi did not check "verbal

[6] It is unclear from the document itself as to whether the CNA involved was disciplined.

warning" or write "counseling" on the form and nobody asked her opinion regarding the severity of the discipline appropriate to remedy this matter. Tumamak supplied her with the form and Adekanmbi says that this is the only time in her career that she had written on one of these forms.

Unit Manager and Director of Nursing Testimony

Grace Tumamak has worked for the Employer for 23 years. She started working as a unit manager in about 2002 or 2003 (preceding all of the disciplines entered into the record). From her appointment as unit manager until about December 2009, Tumamak worked as a unit manager on the day shift and worked as a regular LPN on the overnight shift. In about December 2009, Tumamak started working exclusively as a unit manager. Tumamak issued 19 of the 33 disciplines entered into the record by the Employer. Five of these disciplines occurred on about the same date (9/1/09) after Tumamak, as a unit manager, reviewed the CNA accountability book and discovered several transgressions. On all but one of the disciplines Tumamak initiated, she did not mark the discipline the offending employee should receive[7].

Tumamak testified that she writes up nurses that work in her unit, as well as CNAs. For CNA write-ups, normally nurses will let her know what happened and she will investigate by asking the nurse to give her a statement, and soliciting statements from the CNA and any eyewitnesses. Tumamak follows the same protocol for write-ups that originate on other shifts but are forwarded to her for processing.

Tumamak further testified that for disciplines on her shift, she simply fills out the top part of the discipline form (reporting the facts underlying the infraction) and submits the discipline form to the DON. Tumamak never actually issues disciplines to employees

[7] Tumamak testified that she will only check this box if she is certain that the CNA has not previously been warned for this infraction.

and never sits in on meetings between the accused, the CNA union representative, and a member of upper management (usually the DON).

Director of Nursing Victoria Alfeche contends that LPNs have the authority to issue disciplines to CNAs on their own and to also effectively recommend discipline of their subordinates. She asserts that she determines the severity of the punishment but that LPNs can offer a specific discipline recommendation. No record documentary evidence was offered by the Employer to support the latter conclusionary statement.

Alfeche further testified that once a corrective action form is filled out and a nurse determines that a rule violation has occurred, a discipline action will issue. This is regardless whether eyewitnesses present contradictory statements during the investigation or other exculpatory evidence is presented. Alfeche asserts that the offending employee can grieve the discipline if he or she believes it is improper. When pressed on cross-examination, Alfeche admitted that she speaks to the offending party, his or her union representatives, and any eyewitnesses volunteered by the parties as part of the Employer's investigation into the incident. But Alfeche insists that any information obtained would only impact the severity of the discipline issued, not the discipline itself.

The Employer points to 33 examples of such action in the record covering a period of approximately 6 1/2 years. This evidence is summarized as follows:

Date	**Issuing LPN**	**Exh. pg #**	**Signed**	**Reason**
7/21/04	Maggie Dempaire	ER 18	Yes	Insubordination
12/13/06	Marivic Palacios	ER 4, 110	No	Poor Performance
5/22/07	Joyce Silva	ER 4, 92	Yes	Insubordination
12/29/07	Simon Ramirez	ER 11	Yes	Poor Performance
2/22/08	Joyce Silva	ER 4, 93	No	Poor Performance
6/26/08	Grace Tumamak	ER 4, 66	No	Poor Performance
6/30/08	Grace Tumamak	ER 4, 91	No	AWOL on Unit
9/3/08	Rolando P.	ER 4, 13	Yes	Insubordination
10/14/08	Marisol Roldan	ER 4, 4	Yes	Poor Performance
3/1/09	Grace Tumamak	ER 4, 79	No	Sfty rounds not done
5/4/09	Mati Mompus	ER 17	Yes	AWOL on Unit

7/27/09	Angel Medina	ER 4, 62	No	Poor Performance
8/21/09	Grace Tumamak	ER 4, 33	No	Account. Book Check
8/21/09	Grace Tumamak	ER 4, 68	No	Account. Book Check
8/21/09	Grace Tumamak	ER 4, 47	No	Account. Book Check
8/21/09	Grace Tumamak	ER 4, 95	No	Account. Book Check
8/22/09	Grace Tumamak	ER 4, 86	No	Account. Book Check
9/1/09	Grace Tumamak	ER 4, 85	No	Poor Performance
9/1/09	Grace Tumamak	ER 4, 105	No	Poor Performance
9/1/09	Grace Tumamak	ER 4, 46	No	Poor Performance
1/6/10	Grace Tumamak	ER 4, 106	No	Poor Performance
1/18/10	Donna Willis	ER 4, 2	Yes	Insubordination
4/23/10	Grace Tumamak	ER 4, 104	No	Resident Concern
5/24/10	Joyce Silva	ER 4, 73	No	Poor Performance
5/27/10	Recel Ybanez	ER 4, 5	Yes	Poor Performance
6/20/10	Grace Tumamak	ER 4, 83	No	Poor Performance
6/21/10	Grace Tumamak	ER 4, 22	No	Sfty rounds not done
6/29/10	Grace Tumamak	ER 4, 25	No	Poor Performance
8/9/10	Grace Tumamak	ER 4, 27	No	Poor Performance
9/16/10	Abosede Adekanmbi	ER 4, 102	No	Poor Performance
10/15/10	Grace Tumamak	ER 4, 20	No	Poor Performance
11/5/10	Grace Tumamak	ER 4, 28	No	Harassment/Threats
1/31/11	Alycia Reese	ER 4, 1	Yes	Insubordination

In the preponderance of cases, discipline issued to a CNA is investigated by unit managers or upper management. The LPN becomes involved only as a fact witness to the underlying incident. After the LPN submits a factual report to the unit manager or other supervisor, he or she has no further role in the investigation or determination of discipline. The LPN is not routinely given notice of the outcome of a disciplinary matter, and is never present if discipline is served. LPNs are absent from such meetings even when their signatures appear on the discipline form being issued.[8] The DON or other upper management officials make all final disciplinary decisions. There is no evidence that the DON or other stipulated supervisors completing the disciplinary write-ups consult with any LPNs regarding any aspect of the discipline.

[8] The LPNs' signatures only appear on the notices of corrective action next to their handwritten recitation of facts or if they mistakenly wrote their names on the employee signature line (as Simon Ramirez did). There is no dedicated line for LPNs to sign their names on the form and on many of the discipline forms, the LPNs did not write their names.

Caselaw Relevant to the Remand

The sole issue in the remand is whether the Employer's LPNs effectively recommend discipline of other employees. In analyzing this issue in 2011, the Region applied a four factor test that an Employer must satisfy to prove supervisory status: 1) LPNs submit actual recommendations, and not merely anecdotal reports; 2) their recommendations are followed on a regular basis; 3) the triggering disciplinary incidents are not independently investigated by superiors; and 4) the recommendations result from the LPNs' own independent judgment. *ITT Lighting Fixtures,* 265 NLRB 1480 (1982).

In its August 2017 opinion, the Third Circuit rejected the four-factor *ITT* test. In remanding the case, the Third Circuit set forth the important legal factors that the Board must follow in analyzing LPNs' supervisory status. Applying *NLRB v. Attleboro Associates, Ltd.,* 176 F. 3d 154 (1999), the Third Circuit recognized three facts that together may show an employee is a statutory supervisor: 1) the employee has the discretion to take different actions, including verbally counseling the misbehaving employee or taking more formal action; 2) the employee's actions "initiate" the disciplinary process; and 3) the employee's action functions like discipline because it increases severity of the consequences of a future rule violation. *NLRB v. New Vista,* 870 F.3d at 132. Additionally, the Third Circuit stated that the following two facts do not disprove supervisory status: 1) whether a nurse's supervisor undertakes an independent investigation and 2) whether the employees exercise their supervisory authority only a few times or even just one time. *NLRB v. New Vista,* 870 F.3d at 132-133.

After identifying the factors that support a finding of 2(11) status, the Third Circuit identified certain circumstances that would defeat a finding of 2(11) status. The Third

Circuit said that "it may well be that the notices issued by nurses do not become permanent parts of the CNAs' files and are not used to increase the severity of the discipline." The Third Circuit additionally stated that "we are not unmindful of other circuits' 'reportorial' cases holding that where nurses merely report factual information without actually recommending discipline, the employer fails to show that the nurses have the authority to recommend discipline." *NLRB v. New Vista,* Id. at 135, citing *Schnurmacher Nursing Home,* 214 F.3d at 265-266 ("In actual practice, the charge nurses appear not to have formally disciplined CNAs or even to have recommended discipline, albeit, the charge nurses did, from time to time, refer CNA misconduct to a nurse manager but without recommendation"). The Third Circuit went on to say that "any finding that the nurses here were merely "reportorial" must be reconciled with the demands of *Attleboro*. *NLRB v. New Vista,* 870 F.3d at 135.[9]

Analysis

The Employer Has Not Carried Its Burden of Proof to Establish That Its LPNs Effectively Recommend Discipline.

Applying the factors laid out by the Third Circuit, the Board should find that the Employer has not satisfied its burden to prove that its LPNs are supervisors as defined by the Act. In this regard, the record evidence shows that LPNs' role in the disciplining of CNAs is to merely report factual information to their supervisors and otherwise, they are uninvolved in the discipline process. These facts make the instant case distinguishable from *Attleboro,* and therefore, the Board should find that the New Vista LPNs are not supervisors as defined by the Act.

In *Attleboro*, the LPN charge nurses were authorized to issue "employee disciplinary notices" to CNAs. These notices contained signature lines for the

[9] The Third Circuit confirmed that the burden remains on the Employer to establish that these nurses should not enjoy the Act's protection.

"supervisor" who prepared the form and for the "department head." LPN charge nurses completed the disciplinary notices, meaning that they filled out the notices, selected a level of discipline to be meted out (oral warning, 1st written warning, or 2nd written warning), and signed (some of) the forms. The LPNs then forwarded the disciplinary notices to the DON for the DON to ensure that the discipline selected comported with the offending employee's previous disciplinary record. The DON may also direct the LPN charge nurse to conduct further investigation, and the LPN and DON sometimes met with the offending employee as part of this supplemental investigation. But after the DON signed off on the discipline, the discipline form was returned to the LPN who prepared it, who then physically issued the disciplinary notice to the offending CNA.

The Third Circuit in *Attleboro* found that the LPN charge nurses were supervisors under the Act because their authority and practice of orally counseling and writing up CNAs for other infractions was undisputed. *NLRB v. Attleboro*, 176 F.3d at 165. In this regard, the Third Circuit found that Attleboro's charge nurses initiated a progressive disciplinary process and their decisions to write up a CNA became a permanent part of the CNAs' personnel file, which could lead to the employees' termination. The Third Circuit based this finding on the Regional Director's recognition (in the underlying DD&E) that "the record shows that disciplinary notices were, at least in part, filled out and, in some instances, signed by LPN charge nurses" and that some of these notices "contained recommended corrective action or indicated that the employees received oral counseling." *Id.* at 165. In summation, the Third Circuit in *Attleboro* held that "because Attleboro's LPN charge nurses make a decision to counsel an offending CNA directly, or initiate a progressive disciplinary process that becomes part of a CNA's permanent personnel file and could lead to her termination, the charge nurses effectively recommend discipline using independent judgment within the meaning of Section 2(11)." *Id.*

Unlike in *Attleboro*, the LPNs here do not issue disciplines to other CNAs. At most, these LPNs report misconduct to their unit manager or other department head. These misconduct reports are placed in the narrative section of the notice of corrective action. But that is the end of the LPNs' involvement. Unlike in *Attleboro*, New Vista's LPNs do not select the level of discipline to be meted out, participate in any further investigations conducted regarding the incident, receive a copy of the discipline back from the unit manager or director of nursing, nor do they meet with the offending CNA to present the discipline.

Furthermore, the documentary evidence entered into the record by the Employer is insufficient to support a finding of supervisory status on the basis of effective recommendation of discipline. Three LPN witnesses testified about the disciplines they initiated. For Simon Ramirez, the Employer only entered one of the disciplines he spoke of into the record. On this discipline, Ramirez filled out the narrative section and had no further involvement in the investigation or issuance of this discipline. In the corrective action section of this discipline, there is a handwritten notation that says "as per DON's discretion," leaving the record unclear as to what level of discipline was meted out, or whether any formal discipline was even issued. For Marisol Roldan, the only discipline of hers entered into the record revealed that Roldan filled out the narrative section of the warning notice and that she had no further involvement. No boxes were checked indicating that the offending CNA had previously been disciplined and the handwritten notation under the corrective action section said "next offense is suspension or as the case may be." Therefore, it is unclear from the testimony and the documentary evidence itself as to what, if any, discipline was issued as a result of Roldan's reporting. Additionally, Abosede Adekanmbi testified that on the only discipline in which she played a role, she had reported the incident to unit manager Grace Tumamuk, who then instructed

Adekanmbi to fill out the narrative section. This was the extent of Adekanmbi's involvement. Finally, Wendy Thompson testified that the only times she filled out one of the narrative sections on the discipline form was at Tumamuk's behest and that she had no idea as to whether a discipline even issued to the offending CNA. The paucity of documentation as well as the witness' lack of knowledge as to whether offending employees were even penalized for their infractions cannot support a finding of supervisory status here. Therefore, the Board should find that New Vista's LPNs' peripheral involvement in initiating discipline is distinguishable from *Attleboro* and more akin to the charge nurses in *NLRB v. Schnurmacher Nursing Home*, 214 F.3d at 260 (2nd Cir. 1999) because the record here shows that, from time to time, LPNs have referred CNA misconduct to the unit manager but without recommendation. Based on the above, the Board should find that the Employer has not carried its burden of establishing that its LPNs effectively recommended discipline.

The Employer's Handbook Does Not Support the Employer's Contention that its LPNs Initiate or Effectively Recommend Discipline

As noted above, it is the Employer's burden to establish that its LPNs possess indicia of 2(11) status. The Employer's handbook, however, does not advance the Employer's position. The handbook clearly states that "whenever an employee commits an offense warranting disciplinary action, his supervisor may begin disciplinary action…" Although the term supervisor is not defined in the handbook, other uses of the term throughout the book suggest that the reference to "supervisor" refers to either a unit manager, shift supervisor, or department head (all of whom are admitted 2(11) supervisors). For example, one of the Group I violations listed in the handbook is "Failure to notify supervisor of change of address or other change(s) in personal data essential for

record keeping." There is no record evidence demonstrating that CNAs are required to report changes of addresses to LPNs. Furthermore, it is illogical for LPNs, who have no access to employees' personnel files, to be the designated receptacle for CNAs' changes of address.

Another handbook provision, this time focusing on time and attendance, disproves the Employer's contention that its LPNs are supervisors. The handbook states that "In the rare instances when employees cannot avoid being late to work or are unable to work as scheduled, they should notify their direct supervisor and or staffing coordinator of the anticipated tardiness or absence at least 2 hours prior to start of shift." DON Alfeche's record testimony made clear that when a CNA called out sick, the unit manager or staffing coordinator was entrusted to find replacements. Therefore, it makes sense that the reference to a supervisor in the aforementioned rule related to a unit manager instead of an LPN floor nurse.[10] Based on the above, the Employer has failed to carry its burden of establishing that LPN floor nurses possess indicia of supervisory status.

The Record Evidence also Fails to Establish that the Employer Actually Operates a Progressive Discipline System.

Although DON Alfeche testified that the Employer uses a progressive discipline system to mete out more severe punishment to recidivist offenders, the documentary evidence belies the Employer's contention. Therefore, the Employer has failed to establish the requirement set forth in *New Vista* that an LPN's "action functions like discipline because it increases severity of the consequences of a future rule violation."

My position is based on a review of the disciplinary actions the Employer entered into the evidentiary record. There are about 33 disciplines of CNAs in the record, with about 24 different CNAs receiving discipline over a 6-year period. Of these 24 different

[10] There is no record testimony indicating that CNAs call their floor nurses to report their absences.

CNAs, only 4 CNAs received multiple disciplinary notices- Riskat Lawall, Roberta Drayton, Dana Grubbs, and Mimose Moizil. A review of Lawall, Drayton, Grubbs, and Moizil's disciplinary notices reveals haphazard and seemingly random application of the progressive discipline system set forth in the handbook, along with a clear failure to account for previous disciplines when issuing successive write-ups.

The record evidence shows that Riskat Lawall received a verbal warning in September 2009. (ER Exhibit 4, page 105). Grace Tumamak issued this warning for Lawall's asserted failure to provide ice and water to bed-ridden residents. Approximately four months later, Tumamak again wrote up Lawall. (ER Exhibit 4, page 106). This time, Lawall failed to answer a resident's call bell, which resulted in the resident urinating in bed. Nothing in the warning notice indicates that Lawall had previously been disciplined and there is no indication on this warning notice as to what specific discipline Lawall received. It should be noted that nursing supervisor Alma Isip signed both disciplinary notices.

About a week after Lawall received the 2nd disciplinary notice, she received another one. (ER Exhibit 4, page 2). This time, Lawall was accused of not doing her rounds before she left her unit, interrupting the nurse during a shift change debriefing, and exhibiting a lack of self-control. Nothing is checked in the section of the warning documenting Lawall's previous disciplinary history. Furthermore, the disciplinary notice does not indicate what type of discipline, if any, Lawall received for these offenses. Isip again signed the bottom of this warning notice.

Three months later, in April 2010, Lawall received another notice of corrective action. (ER Exhibit 4, page 104). This notice refers to a resident concern form, which was not included in the evidentiary record. On this notice, there is nothing written in the section that documents whether previous warnings were issued, and there is no box

checked indicating what corrective action this notice generated. The handwritten notation in the notice says "move out of 3W- will flag," but it is unclear what this notation means and Tumamak did not address this subject during her testimony. In sum, Lawall received four disciplinary notices within seven months, but the last three notices failed to indicate what discipline, if any, Lawall received, and also failed to list any of her previous warnings. Based on Lawall's record, it is clear that the Employer has failed to establish that it has implemented and utilized a progressive discipline system. Therefore, the Employer has not established the requirement set forth in *New Vista* that such notices are used to increase the severity of discipline that employees receive.

The record evidence also indicates that CNA Roberta Drayton received two disciplinary actions in June 2010. Like with Lawall, the evidence fails to show that the Employer engaged in progressive discipline. In this regard, Drayton received a verbal warning from Tumamak on about June 25, 2010. (Employer Exhibit 4, page 22). The notice of corrective action asserts that Drayton failed to perform required safety monitoring of residents. Two weeks later, Tumamak issued Drayton another notice of corrective action for failing to wash a resident properly in preparation for a doctor's visit. (ER Exhibit 4, page 25). Despite Tumamak issuing a similar warning just weeks earlier, the second notice does not indicate that any previous warnings were issued. Furthermore, no box is checked indicating what corrective action the second notice generated. Based on the above, it is clear that the Employer did not employ a progressive discipline system with Drayton. Therefore, the Employer has failed to carry its burden of proof in establishing indicia of supervisory status.

Additionally, CNA Dana Grubbs received three warning notices over a two-year window, but the notices do not follow the suggested disciplinary path set forth in the employee handbook. In June 2008, Grubbs received a second written warning because

one of his residents had wet clothes and urine dripping on the floor. (ER Exhibit 4, page 66). Although Grubbs received a second written warning for this offense, the notice of corrective action does not indicate that Grubbs had previously received any write-ups. Over a year later, in August 2009, Grubbs received a verbal warning for not properly initialing the facility's accountability book (confirming that certain care was provided). (ER Exhibit 4, page 68). This notice of corrective action does not reference Grubbs' discipline from the previous year. Finally, in May 2010, Grubbs received a suspension for committing multiple infractions on two separate shifts. The infractions included failing to give a resident a shower, not changing a resident who was wet, and failing to start rounds until near the end of his shift. (ER Exhibit 4, pages 5 and 73). There is no indication on either of the two May 2010 notices that Grubbs had been previously disciplined. It is also unclear from the notices as to why Grubbs received a suspension here because the Employer's progressive discipline policy specifically states that "in cases of single violations of rules in groups 1 and 2, which do not reoccur within one (1) year from the date of violation, they will no longer be considered in combination with other violations." Since Grubbs' 2008 infraction yielded a second written warning and he did not receive a similar infraction within a year, this infraction should not have been relied on when Grubbs was suspended in 2010.

For Moizil, the Employer issued her a 2-day suspension in May 2009. (ER Exhibit 17). About three months later, Moizil received only a verbal warning for failing to properly initial the facility's accountability book. (ER Exhibit 4, page 95). But on this August notice of corrective action, there is nothing noted in the section addressing previous warnings. Therefore, it cannot be shown that Moizil's May 2009 discipline was used as part of a progressive discipline system.

Because the above evidence from Lawall, Drayton, Grubbs, and Moizil shows a haphazard application of the Employer's written progressive discipline system (if it was applied at all), the Employer has failed to carry its burden to establish that notices of corrective actions initiated by its LPNs are used to increase the severity of discipline meted out.

Conclusion

For all of the reasons listed above, the Counsel for the General Counsel urges the Board to find that the Employer has failed to carry its burden of establishing that its LPNs effectively recommend discipline. Consequently, the Employer's LPNs are employees who enjoy the Act's protection, and any failure to bargain with the LPNs' designated collective bargaining representative violates Section 8(a)(5) of the Act.

Dated at Newark, New Jersey this 23rd day of January 2018

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CERTIFICATION OF SERVICE

This is to certify that the Counsel for the General Counsel's Statement of Position has been served on this date as follows:

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