JD(ATL)–38–08
Oak Lawn, IL

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
DIVISION OF JUDGES
ATLANTA BRANCH OFFICE

REGAL HEALTH AND REHAB CENTER, INC.

and **CASES 13–CA–44481**
13–CA–44482
13–CA–44619

SERVICE EMPLOYEES INTERNATIONAL UNION HEALTHCARE, LOCAL 4

Sylvia L. Taylor, Esq., for the General Counsel
Margaret A. Angelucci, Esq., for the Charging Party.
Michael Lerner, President, *Pro Se* for the Respondent.

DECISION

Statement of the Case

MARGARET G. BRAKEBUSCH, Administrative Law Judge. This case was tried in Chicago, Illinois, on May 27, 2008 through May 30, 2008, and on June 25 and 26, 2008. The charge in Case 13-CA-44481 was filed by the Service Employees International Union Healthcare, Local 4 (Union) on January 8, 2008. The charge in Case 13-CA-44482 was filed by the Union on January 8, 2008, and amended on February 25, 2008. The charge in Case 13-CA-44619 was filed by the Union on March 27, 2008, and amended on March 28, 2008, and on May 5, 2008.

On May 5, 2008, the Regional Director for Region 13 of the National Labor Relations Board (Board) issued a Second Order Consolidating Cases, Consolidated Complaint and Notice of Hearing based upon the allegations contained in Cases 13-CA-44481, 13-CA-44482, and 13-CA-44619. The consolidated complaint alleges that Respondent issued a disciplinary write up to employee Kalea Williams on March 20, 2008. The consolidated complaint further alleges that on various dates in January and March 2008, Respondent terminated employees Lavern Harper, Diane Rounds, Michael Thurmond, and Kalea Williams because of their support for, and assistance to, the Union in violation of Section 8(a)(3) of the Act. The consolidated complaint also alleges that Respondent further violated Section 8(a)(3) by altering the working conditions of its employees in mid-December 2007 and about December 20, 2007. Finally, the consolidated complaint alleges that on various dates

between November 2007 and January 2008, Respondent's Director of Nursing, Durodola Adewolu engaged in 17 independent violations of Section 8(a)(1) of the Act.

The General Counsel further alleges that a majority of Respondent's full-time and regular part-time Licensed Practice Nurses (LPNs) designated and selected the Union as their collective bargaining representative on or about November 18, 2007. The General Counsel seeks a bargaining order as a part of the remedy for Respondent's alleged unfair labor practices.

On the entire record[1], including my observation of the demeanor of the witnesses, and after considering the briefs filed by the General Counsel, Union, and Respondent, I make the following:

Findings of Fact

I. Jurisdiction

Respondent, an Illinois corporation, with an office and place of business in Oak Lawn, Illinois, has been engaged in the business of providing skilled nursing care. During the past twelve months, Respondent purchased and received goods, products, materials and/or services valued in excess of $3,000 from other enterprises including public utilities located within the State of Illinois, each of which public utility had received the goods, products, materials and/or services directly from points outside the State of Illinois. The Respondent admits and I find that it is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act and that the Union is a labor organization within the meaning of Section 2(5) of the Act.

II. Alleged Unfair Labor Practices

A. Issues

1. Whether the Licensed Practical Nurses employed at Respondent's facility are supervisors within the meaning of Section 2(11) of the Act?

2. Whether Respondent, acting through its Director of Nursing, engaged in multiple violations of 8(a)(1) of the Act as alleged in the complaint?

3. Whether Respondent issued a verbal warning to employee Kalea Williams in violation of Sections 8(a)(3) and (1) of the Act?

4. Whether Respondent terminated the employment of employees Lavern Harper,

[1] The consolidated complaint initially alleged that Food Services Supervisor Derrick Hawkins unlawfully threatened employees with discharge on or about March 26, 2008. During the course of the hearing, however, General Counsel moved to withdraw the complaint allegation.

Diane Rounds, Michael Thurmond, and Kalea Williams in violation of Sections 8(a)(3) and (1) of the Act?

5. Whether a Gissel Bargaining Order is warranted?

B. Respondent's Facility and Operation

Respondent operates a long-term healthcare facility in Oak Lawn, Illinois. Healthcare to patients is primarily administered by Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs). The facility is composed of two floors providing full-time health care to approximately 90 to 95 patients. There are usually 40 to 45 patients on the second floor who require more skilled nursing care. There are approximately 50 patients on the first floor who require less skilled care. For purposes of this decision, the individuals who receive nursing care at the facility are referenced as either patients or residents. There are three scheduled shifts for employees; 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7 a.m. The LPNs provide nursing care to the patients, administer medications, and are responsible for completing the requisite nursing care documentation. The CNAs are responsible for assisting patients with activities of daily living; such as turning, bathing, clothing, and feeding. The CNAs also check the patients' vital signs and report any changes in the residents' condition to the LPN on duty. For each shift, there is one LPN on the first floor and two LPN's on the second floor. There are normally three CNAs assigned to the second floor and two CNAs assigned to the first floor. The Union represents 80 percent of Respondent's employees. The Union represents not only the CNAs, but also the employees in Housekeeping, Laundry, and Dietary. CNA Jeraldine Cheatem (Cheatem) is a Union steward for the bargaining unit. The LPNs are essentially the only group of employees at Respondent's facility, who were not represented by the Union prior to November, 2007.

Michael Learner is not only the owner, but also the administrator of the facility. He appeared as *pro se* representative for the Respondent during the hearing. Deborah Kipp is Director of Operations and Sanuelle Williams is Assistant Administrator. During the period in issue, the LPNs were directly supervised by Respondent's Director of Nursing (DON); Durodola Adewolu (Adewolu). Adewolu came to the United States from Nigeria and he assumed the position of DON at Respondent's facility in August 2007. Adewolu is the direct supervisor for the LPNs and he prepares their monthly work schedule. In November 2007, there were 13 LPNs. Rhonda White has been the Quality Assurance Nurse since October 25, 2007. White supervises approximately 22 CNAs and prepares their monthly work schedule.

C. Terms and Definitions

Because of the nature of the employees' work, this record contains a number of medical, nursing, and specialized industry terms that are generally unfamiliar. In some instances, these terms were specifically defined by the witnesses. In other instances, the term definitions became apparent after multiple witness testimony. For purposes of clarification, such industry and nursing terms are described below:

1. "G-Tube" describes a gastrointestinal feeding tube that is inserted directly into a patient's stomach for patients who are unable to orally ingest food

2. "MAR" is the Medication Administration Record in a patient's file.

3. "PICC line" is an intravenous line that is inserted to allow a patient to receive medicines and fluids.

4. "POS" is a physician order sheet contained in the patient file that lists the medications to be administered to the patient.

5. "Trach" refers to an artificial breathing tube inserted in a patient's trachea.

6. For purposes of this record, the terms "charge nurse" and "LPN" are used interchangeably.

7. "Write-up" refers to employee discipline that is reduced to written form.

8. "In-service" is a term that is applied by witnesses to include more than one situation. In-Service may apply to a meeting where employees are brought together for training in a specific area. In-service may also apply to one individual providing training to an employee concerning a specific nursing task. Respondent also uses the term in-service to apply to a disciplinary step preceding a written warning.

9. "Call-off" is a term used to describe an employee's notifying the facility that the employee is not reporting for a scheduled shift.

D. Employee's Organizing Efforts

Kalea Williams[2] (Williams) worked as an LPN at Respondent's Oak Lawn facility from July 7, 2007, until her termination on March 27, 2008. Based upon information that she received from Union Steward Gerri Cheatem, Williams contacted a representative from the Union in approximately mid-November, 2007. Williams testified[3] that she contacted the

[2] For purposes of this decision, Kalea Williams is referred as either Kalea Williams or "Williams." Kalea Williams is distinguished from Assistant Administrator Sanuelle Williams, who is always referenced as Administrator Williams and from Omolo Williams who is also an LPN and who was called to testify on behalf of Respondent.

[3] During the hearing, Respondent moved to have all of Kalea Williams' testimony stricken from the record, asserting that General Counsel tried to withhold evidence regarding Kalea Williams. Respondent renewed the motion in post-hearing brief and asserts: "During Williams' testimony, when Respondent was collecting an exhibit that wasn't yet entered into evidence, General Counsel slipped evidence under her papers in

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Union about representation for the LPNs because of her concerns about working conditions and pay. Within a couple of days of talking with the Union's representative, Williams received union authorization cards to distribute to other LPNs. The union representative instructed her to tell the other nurses about the benefits of unionization and to ask them to sign the authorization cards. Williams signed an authorization card on November 15, 2007. She then collected signed authorization cards from 10 other nurses. The 11 authorization cards were signed and collected over the period of time between November 15 and 18. Williams submitted the cards to the Union in November.

On December 6, 2007, Williams attended a union meeting for employees at the McDonald's restaurant located approximately two-tenths of a mile from Respondent's facility. The meeting was attended by employees Diane Rounds, Michael Thurmond, Shanina Mitchell, Diane Gavin, Williams, and the union representative. The meeting lasted for approximately an hour. During the meeting, the employees not only talked about the benefits of having a union and scheduling issues, they also discussed a prior sexual harassment charge involving Adewolu.

Williams reported to work at approximately 4:00 p.m. on December 14, 2007. Williams testified that almost immediately after reporting to work, she spoke with Adewolu in his office. She recalled that he told her that he had heard that he had been discussed at the union meeting. He asked her why she had accused him of sexual harassment. Williams told him that it had not been personal, she had simply let the Union know the kinds of issues that employees faced at the facility and he had been one of the issues.

Approximately a week after the December 14, 2007 conversation, Williams again spoke with Adewolu in his office. Williams testified that when Adewolu asked her if it was true that the LPNs were trying to get a union, she had confirmed that they were. She recalled that he told her that they could not have a union because LPNs were supervisors. Williams responded that they were not supervisors and had no authority to discipline other employees.

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an attempt to keep it, and thereby deceive Respondent." The record reflects, however, that Respondent attempted to submit a document into evidence that was covered by General Counsel's subpoena and not produced in response to the subpoena. When Counsel for the General Counsel raised this issue, Respondent sought to retrieve the document from distribution to the parties. Respondent also asserts that the testimony should be stricken because General Counsel failed to provide all of Kalea Williams' affidavits to Respondent for cross-examination. The record reflects however, that upon Respondent's first opportunity to cross-examine Williams, General Counsel provided two affidavits (General Counsel Exhibits 33 and 34) for Respondent's review. Later in the hearing, General Counsel discovered that Williams had given an additional affidavit that had not been made available to Respondent for cross-examination. General Counsel provided the additional affidavit to Respondent and Kalea Williams was recalled by Respondent for cross-examination concerning the additional affidavit. Because Respondent appeared *pro se*, it is understandable that some procedural matters may have been confusing for Respondent. I do not find, however, that General Counsel "hide" Respondent's documents or failed to turn over all of the requisite affidavits to Respondent. While Respondent did not produce all of the books and records subpoenaed by General Counsel, Respondent was not precluded from offering relevant documents. Additionally, Respondent was given the opportunity to recall Williams for additional cross-examination concerning the additional affidavit. Accordingly, I deny Respondent's motion to strike the testimony of Kalea Williams.

Adewolu told her that Lerner would fire all of them if they continued with the same action. Williams told Adewolu that if Lerner fired her, she would be sitting at home at Lerner's expense.

Kalea Williams also attended a second meeting with the union representative on December 19 at the Dunkin Donuts restaurant near the facility. Williams told other employees about the meeting in person and by telephone. Only Kalea Williams and Lavern Harper attended the meeting with the union representative. Williams recalled that as she and Lavern Harper were leaving the building, Adewolu asked her if she were taking Harper to another one of her union meetings. Williams simply responded that they were going to lunch. Harper corroborated that Adewolu made this remark to them as they were leaving the building. Kalea Williams also testified that prior to her discharge; she distributed union handbills to the other nurses. While she asserted that Adewolu saw her doing so, she did not identify the date or circumstances in which she did so.

On January 8, 2008, the Union filed a petition with the Board, seeking to represent all full-time and part-time LPNs. Respondent denies knowledge of the Union's organizing before receiving written notice from the Board on January 10, 2008.

E. Whether LPNs are Statutory Supervisors

Perhaps the most pivotal issue in this case involves the issue of whether the LPNs are supervisors as defined by the National Labor Relations Act (the Act). All of the alleged discriminatees in this case are LPNs and all of the alleged 8(a)(1) statements were made to alleged discriminatees. Respondent maintains that the LPNs are supervisors and are thus outside the protection of the Act. General Counsel and the Charging Party submit that these employees are not supervisors and are well within the protection of the Act.

Under Section 2(11) of the Act, a supervisor "means any individual having authority, in the interest of the employer, to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them or to adjust their grievances, or effectively to recommend such action, in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment." The enumerated powers in Section 2(11) are to be read in the disjunctive. However, possession of one or more of the stated powers does not convert an employee into a 2(11) supervisor unless the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment. *Adco Electric Inc.*, 307 NLRB 1113, 1120 (1992). The Board does not construe supervisory status too broadly because the employee who is deemed a supervisor loses his protected right to organize. Therefore, the burden of proving that an individual is a supervisor is placed on the party alleging that supervisory status exists. *Masterform Tool Company*, 327 NLRB 1071, 1071 (1999).

There is no record evidence that the LPNs have the authority to hire, fire, promote, transfer, layoff, recall, reward, set wage rates, evaluate employees or to make effective

recommendations regarding any of these actions. Respondent, nevertheless asserts that LPNs meet at least 6 of the criteria of supervision discussed in the Board's decision in *Oakwood Healthcare, Inc*., 348 NLRB No. 37 (2006). Specifically, Respondent asserts that LPNs use independent judgment in CNA staffing, scheduling, assignment of duties, and monitoring of work. Respondent further asserts that the LPNs have the authority to discipline, suspend employees, adjust grievances, and to responsibly direct the work of CNAs.

In its recent decision in *Oakwood Healthcare, Inc*., above, the Board found that the employer failed to establish that rotating charge nurses exercised supervisory authority for a substantial part of their work time. In its decision, the Board sought to clarify its interpretation of the terms "independent judgment" as well as the terms "assign" and "responsibly direct." Specifically, the Board defined assign as the act of designating an employee to a place (such as a location, department or wing), appointing an individual to a time (such as a shift or overtime period), or giving significant overall duties or tasks to an employee. For purposes of the Act, the assignment must be a designation of significant overall duties and not simply an *ad hoc* instruction that the employee perform a discrete function. *Id* at 4. In defining the term "responsibly direct," the Board pointed out that an individual may be a supervisor if that individual determines what job will be undertaken next and who will perform the job. Supervisory status is conditioned, however, on the accompanying accountability for such decisions. It must also be shown that the employer delegated to the putative supervisor the authority to direct the work and the authority to take corrective action if necessary. *Id* at 8. Additionally, it must be shown that there is the prospect of adverse consequences for the putative supervisor arising from this discretion in directing the work of employees. Finally, the Board defined independent judgment as judgment that is not effectively controlled by another authority and the exercise of which must rise above merely routine or clerical discretion. *Id* at 9.

In support of its assertion that LPNs possess and exercise various indicia of supervisory status, Respondent relies in part upon the testimony of admitted supervisor Rhonda White, who began working at the facility on October 8, 2007. She testified concerning various areas of authority based upon her work at Respondent's facility as an LPN floor nurse. She initially testified that she worked as a floor nurse from October 8, 2007 to November 26, 2008. She maintained that during this period of time, she worked two to three times each week as a floor nurse on the second floor. When shown the November 2007 LPN schedules, she acknowledged that she worked as an infection control nurse rather than a floor nurse during November 2007. Later in her testimony, she further acknowledged that she was promoted to the Quality Assurance position on October 25, 2007. Interestingly, however, Administrator Williams testified that White was actually hired into the facility as a Quality Assurance nurse. Thus, while White gave extensive testimony about her exercise of supervisory authority as a floor nurse, the record reflects that her work as a floor nurse was quite limited or perhaps even non existent. At best, White may have worked as a floor nurse for only about three weeks. Accordingly, her testimony in this regard is given little weight.

Additionally, Respondent presented the testimony of LPNs Genette Clay, Oluyemi Agunbiade, Gal Vandusn, and Omolo Williams. While they all testified concerning different

aspects of exercising supervisory authority, they were hired in January and February 2008 and only after the LPNs began organizing. Although LPN Vandusn previously worked for Respondent for a period of time prior to November 2006, she held supervisory roles as the MDS Coordinator and a wound care nurse during the last year of her employment. She is not currently a floor nurse and was promoted to the supervisory position of MDS Coordinator two months after she again began working for Respondent in February 2008.

The remaining evidence concerning each area of alleged authority and my conclusions are discussed as follows:

1. Calling in CNAs for additional work and scheduling breaks and lunches

Respondent asserts that LPNs can call in additional CNAs to work if needed and they have the authority to ask employees to stay over for the next shift. Although LPN Genett Clay testified that she could call in employees to work, she admitted that she has never done so. It is also significant that Clay has only been employed at Respondent's facility since January 4, 2008 and after the Union began organizing the LPNs. Although CNAs Eusdace Dwiei and David Carey testified that LPNs have called employees in to work, they acknowledged that they did not know whether the LPNs obtained the approval of management before doing so. LPN Gal Vandusn testified that if she found that she needed additional CNAs, she would "make a phone call to try to get another CNA to come in." Vandusn, however, has only recently worked as a floor nurse from February to April 2008. She now holds a supervisory position as the MDS Coordinator.

LPN Angela Hicks has worked at Respondent's facility for eight years. She testified that if there is only one CNA working on the floor, she can call to the other floor and ask for a CNA to come to her floor to assist with the patients. She testified that if there is not another CNA available on the other floor, she consults a list of CNA names and numbers and calls to see if a CNA can come in early for their shift or if they are available even if not on the schedule. She estimated that within the past year, she may only have done so four times. CNA Debra Rais testified that while she has never been called in to work by an LPN, she has been called to come in to work by another CNA.

Administrator Williams testified that there are a specific number of CNAs assigned to each floor for each shift. She explained that if the CNAs call off and do not report to work, the LPN on duty can call in CNAs to fill those empty spaces. Administrator Williams also asserted that an LPN has authority to call in extra CNAs even if there are no shortages of CNAs on the floor. She contends that the LPN can do so without getting permission from either her or from the Director of Nursing. Adewolu testified, however, that because there are a specific number of hours allowed for nurses each week, management employees work on the floor in order to contain costs.

The overall evidence does not reflect that LPNs use independent judgment in determining when additional CNAs are needed or in selecting the CNAs who will be called in for additional work. To the contrary, the record reflects that when there is a shortage of

CNAs on the floor, the LPN consults a list containing the names and telephone numbers of current CNAs to find a CNA who is available to come in to cover for the shortage. There was no testimony by any LPN or management witness to indicate that LPNs evaluate the skill level of CNAs in determining who they will call. The only criterion appears to be the CNA's availability and willingness to come in for additional work. It is undisputed that CNAs themselves have assisted the LPNs in finding available CNAs. While Respondent asserts in brief that LPNs can use independent judgment in calling in additional help even if the floor is completely staffed, the overall record does not support this assertion. If LPNs possessed and exercised this kind of authority, they would be able to augment the staff at any time without consultation with the administrator or the director of nursing. Respondent's daily expenditures for nursing staff would then be totally at the whim of the LPNs without any limitation. It is simply not credible that the facility could operate within budgetary guidelines with such alleged independence in personnel expenditures. Additionally, both the staffing records and Adewolu's testimony reflect that management personnel work on the floor to contain costs. I also note that Respondent provided no documentary evidence in support of Williams' testimony. If LPNs are permitted to call in CNAs in excess of those already scheduled, it is reasonable that Respondent's daily staffing sheets or payroll records would substantiate this assertion. Accordingly, I find Administrator Williams' testimony in this regard to lack credibility.

Respondent also asserts that LPNs completely and independently schedule the breaks and lunches of CNAs. Respondent's witness LPN Hicks testified, however, that both lunches and breaks are scheduled at set times on each shift. She explained that the breaks are simply alternated between CNAs. Additionally, CNA Rais confirmed that the breaks are at predetermined times each day and are not assigned by the LPNs.

Thus, I do not find that LPNs possess or exercise independent judgment in calling in CNAs to work or in scheduling CNAs for breaks and lunches within the meaning of Section 2(11) of the Act. While the record may reflect that LPNs may contact CNAs in order to fill a shift vacancy, they do so by simply going through the list of CNAs listed in a register at the nurse's desk. Additionally, the overall record evidence reflects that standard times set aside for CNA breaks are alternated by the CNAs and modified by patient needs, rather than a specific directive or determination of the LPN on duty.

2. Assignment of CNA duties and monitoring of work

Respondent also maintains that LPNs use independent judgment in assigning and transferring CNAs to different patients, to different units, and to different floors. CNA Cheatem testified that from approximately mid-2003 until November 2007, she prepared the monthly staffing schedule for the other CNAs. In November 2007, Rhonda White assumed that responsibility. Cheatem also testified that prior to November 2007, she compiled the room assignment sheets for her shift and other CNAs designated as "team leaders" completed the rooms assignment sheets for other shifts. In support of its assertion that LPNs assign CNAs to specific rooms, Respondent submitted into evidence a compilation of four daily assignment sheets. Each of these four sheets identified the rooms assigned to the CNAs.

Each form submitted by Respondent also contained a date and the name of the LPN on that shift. The respective dates for these assignment sheets were shown to be February 8, 2007, April 25, 2007, May 8, 2007, and November 9, 2007. Counsel for the Union asserts that the General Counsel subpoenaed all documentation showing room assignments to CNAs made and/or signed by LPNs for the period of November 1, 2006 to the present. The Union's counsel argues that if LPNs completed the daily room assignment sheets as argued by Respondent, there should have been approximately 1800 examples of these assignment sheets. Administrator Williams acknowledged that in reviewing the assignment sheets back to February 2007, she only found these four daily assignment sheets containing the names of LPNs.

Although these four daily assignment sheets contain the names of LPNs who were on duty for those specific shifts, there is no evidence that the LPNs actually made the assignments rather than simply signing their names on the sheets. CNA Teresa Tovler testified that while she has seen the daily assignment sheets on other shifts, the sheets are not used on her shift. She has observed LPNs signing their names to assignment sheets completed by the CNAs and she has observed CNAs writing the LPNs name on other sheets. Although Debra Rais has worked as a CNA at the facility since May 2004, she has only seen the daily assignment sheets a few times prior to 2008.

Despite the question of whether LPNs actually complete or sign the daily assignment sheets, there remains the issue of whether independent judgment must be used in the assignment of CNAs to the different patients. The overall record reflects that for the most part, the patient rooms are allocated to CNAs in a standardized and established pattern. There was no evidence to reflect that each day the LPN specifically assessed the CNAs to determine those patients to whom they were best suited or even to assess the patients to determine which CNA was best suited to care for the patients' needs. The record reflects that most of the time, the CNAs are responsible for a block or set of rooms in a specific section. CNA Eustace Dwiei testified that although different LPNs were assigned to his floor, he has been responsible for the same set of rooms for 17 years. Debra Rais testified that prior to April, 2008; she worked the 3:00 to 11:00 p.m. shift for almost four years. During that time, she was assigned to the same block of patient rooms. CNA Tovler has been assigned to the same set of patient rooms since she began working at the facility ten years ago. Although LPN Vandusn asserts that she makes assignments to the CNAs on her shift, she also acknowledges that she simply divides the patients among the number of CNAs on duty. She also admits that the CNAs can refuse the assignments if her division is not fair.

Respondent further maintains that LPNs use independent judgment in moving CNAs to different floors. Both LPNs and CNAs testified that on occasion, a CNA may be needed to assist or fill in on another floor when CNAs call off or are otherwise absent from work. While the LPN may request that a CNA temporarily move to a different floor to assist on a particular shift, there is no evidence that CNAs are disciplined if they decline to move during a shift. CNA Rais confirmed that she has refused such a request to change floors during a shift and she suffered no adverse action.

Thus, the overall evidence does not reflect that LPNs use independent judgment in assigning CNAs to patients or in temporarily transferring them to help on a different floor during their shift. As discussed above, any alleged patient assignments by LPNs involved only a routine division of patients among the CNAs. Any temporary transfer of a CNA to other work on a different floor is initiated because of a staffing shortage or specific need that arises on the other floor. As the Board has determined, assignments made solely on the basis of equalizing workloads are routine or clerical in nature and do not establish the use of independent judgment. *Oakwood Healthcare Inc*., at 9.

Respondent also asserts that LPNs "use their nursing expertise to decide which CNA is best suited for each specific patient, based on the skills of the CNA and based on the specific care needs of the patient." The record reflects that on occasion, LPNs may request a CNA to work with a particular patient because of the patient's size, the patient's preference for a specific CNA gender, or because of a patient's family request. Because of the working relationship between the LPNs and the CNAs, there are also instances when LPNs ask CNAs to additionally clean a patient who is soiled or to perform a specific task for the patient. While the LPNs may sporadically request CNAs to provide additional assistance to certain patients, there is insufficient evidence that the LPNs exercise the degree of judgment necessary to establish 2(11) supervisory status.

3. The authority to discipline CNAs

There is no dispute that Quality Assurance Nurse White, Administrator Williams, and Director of Nursing Adewolu have the authority to discipline employees. Respondent asserts LPNs share this authority and in fact have total discretion in how to discipline a CNA. Respondent asserts that the LPN has the authority to give an in-service training, a verbal warning, a written warning, or suspension. In addition to management officials White, Adewolu, and Administrator Williams, Respondent also presented the testimony of employees Clay, Dwiei, Vandusn, Carey, and Hicks to confirm this purported authority. Although CNA Dwiei has been employed at Respondent's facility for 17 years, he was able to relate only one incident in which a CNA was sent home by an LPN. He did not identify either the name of the nurse or the CNA and he did not indicate the year in which the incident occurred. His testimony, however, indicated that the employee was sent home in conjunction with patient abuse and the employee's arrest at the facility. Although LPN Vandusn testified that she issued a written discipline to an employee when she was employed at Respondent's facility prior to November 2006, she did not identify the employee, the date, or the circumstances. Additionally, she did not identify if the prior discipline occurred during the time that she served as a wound care nurse or MDS coordinator from January to November 2006. Wound Care Technician David Carey has only been employed at the facility since October 7, 2007. In January 2008, he was promoted from CNA to Wound Care Technician and given a raise. The only incident that he related in which a CNA received discipline from an LPN occurred in January 2008 and only after the Union's organizing. While Carey asserts that a nurse gave a CNA a write-up for not bathing a patient, he did not testify as to whether the LPN independently issued the write-up or at the direction of management. LPN Angela Hicks also testified that when a CNA is disciplined, the charge nurse writes up the discipline.

She also asserted that the charge nurse decides what discipline is appropriate and that the administrator is not involved at all in the decision. Although Hicks has been employed at the facility for eight years, she gave only one example of issuing a write-up to a CNA. She testified that in January 2008, she wrote-up a CNA because a patient was soiled when the family came to visit. She could not recall the CNA's last name and she did not identify the kind of discipline administered. She also testified that she gave an in-service to a CNA by instructing her to strip the entire bed if a patient's bed became soiled.

In support of its assertion that LPNs have the authority to discipline, Respondent submitted six disciplinary forms. Respondent asserts that each document represents discipline issued by an LPN to a CNA. Administrator Williams confirmed that in order to find these examples of discipline, she went through records preceding 2005. There was no record of Hicks' discipline to any CNA included in the six documents. Additionally, three of the disciplinary notices contain issuance dates after January 10, 2008 and after Respondent's admitted knowledge of Union organizing. One of the three disciplines that were alleged to have occurred after January 10, 2008 involves LPN Joanne Harris and CNA Debra Rais. Harris did not testify. Rais, however, testified that she had never seen this document prior to the hearing and was unaware of any warning or resulting impact upon her employment. One of the six documents is dated December 17, 2007 and contains no signature of anyone other than the employee. One of the disciplinary notices dated after January 10, 2008 involved an LPN and White's investigation of a theft. The LPN notified White that she observed a CNA throwing something into the garbage. Both the LPN and White searched the garbage and found a patient's wallet. While the reason for the discipline was shown to be felony theft, there was no indication as to what discipline was imposed and there was nothing to indicate that the LPN did anything more than report the theft and investigate the theft along with White.

One of the disciplines submitted by Respondent involved LPN Michael Thurmond and CNA Teresa Tovler. The alleged infraction involved Tovler's refusal to clean a patient before the patient's discharge to the hospital. Thurmond testified that he reported the incident to Administrator Williams and she directed him to prepare the form documenting what occurred. Thurmond denied that he made any kind of recommendation as to what discipline Tovler should receive. Tovler testified that she never received this warning or even saw it prior to preparation for the hearing.

The remaining document purporting to show a disciplinary action by an LPN involved LPN Harper and CNA Rashida Stewart. The document reflects that in September 2007, Stewart was assigned to work with CNA Dwiei in caring for a particular patient. Stewart refused the assignment and went to lunch instead. Harper testified that she reported the incident to Administrator Williams and was told to document the incident. Harper testified that after she documented the incident, she did not discuss the incident with Stewart and made no recommendation as to the level of discipline to be issued.

As discussed above, there is very little documentation to show the LPNs' involvement with discipline notices. Although five of the six disciplinary notices contain the signature of a

charge nurse, the overall record evidence reflects that the LPN's involvement is limited to documenting the incident without input or a recommendation as to what discipline is given. Both Rais and Tovler denied that Respondent ever notified them of the alleged discipline or that they suffered any adverse impact from the warnings. Recently hired LPN Omolo Williams acknowledged that the write-ups given by LPNs were simply a description of the incident that was passed along to White or Adewolu. She explained that she documents what the employee has done and then it is up to the discretion of Adewolu to take whatever action is necessary. She also explained that it was not in her jurisdiction to know how the write-up affects the job of the recipient. Administrator Williams further confirmed that while the write-ups contained a description of the incident, there is nothing in the description concerning the discipline to be given. While there is a grievance procedure in place for the CNAs, there is no evidence that any discipline issued by an LPN has been the subject of a grievance under the collective bargaining agreement.

In asserting that LPNs exercise independent judgment in issuing discipline, Respondent maintains that the LPNs have the discretion to conduct an "in-service" training with the CNA rather than issue discipline to the employee. There is, however, no documentation of these discretionary "in-service" training sessions. At best, such interactions appear to be occasions when LPNs demonstrate how to perform a task. There is also record evidence that such instruction is given by more experienced CNAs to lesser experienced CNAs and by LPNs to other LPNs. The authority to "point out and correct deficiencies in the job performance of other employees does not establish the authority to discipline." *Franklin Hospital Medical Center*, 337 NLRB 826, 830 (2002); *Crittenton Hospital,* 328 NLRB 879 (1999).

Thus, the overall record evidence does not support a finding that LPNs possess or exercise authority to discipline employees as defined by Section 2(11) of the Act. The alleged discipline initiated by LPNs appear to be a written documentation of a CNA's substandard performance without recommendations for further action. *Passavant Health Center*, 284 NLRB 887, 889 (1987).

4. Adjustment of grievances

Respondent argues that the grievance procedure in its bargaining agreement with the Union covering CNAs does not relate to any issues involving patient care or differences between employees and that those issues are resolved by the LPNs using independent judgment. In brief, Respondent cites the testimony of a number of witnesses. The record reflects that while witnesses Dwiei, Vandusn, and Clay stated that nurses could resolve differences between CNAs, they could recall no incidents in which this occurred. Administrator Williams testified that "most" of the time the CNAs look to the LPN to resolve disagreements about work. As an example she cited an incident in which a CNA became involved in a verbal altercation with a co-worker and the charge nurse "put the fire out." She did not identify the nurse or what in fact the nurse did to "put the fire out." The only other example of a CNA dispute was a situation in which the matter was brought to Administrator Williams' attention and she settled the dispute. White recalled that when she worked on the

floor and the CNAs had a dispute about the number of patients to which they were assigned, she just counted out the patients and evenly divided the patients between the CNAs.

The other incidents that were identified as CNA disputes also involved the distribution of patients among the CNAs. In each situation, the LPN resolved the issue by equalizing the room assignments. There is no evidence to indicate that the LPN did anything other than simply to redistribute the patients to even out the workload. This situation is really no different than those occasions when the CNAs were temporarily moved from one floor to another in order to alleviate understaffing in a designated area. Such reassignments appear to be no more than merely equalizing the workload and do not necessitate independent judgment. *Lynwood Manor*, 350 NLRB No. 44, slip op. at 2 (2007); *Oakwood Healthcare*, 348 NLRB No. 37, slip op. at 8-9, 12 (2007). I also note that although there is a grievance procedure in the existing collective bargaining agreement covering the CNAs, there is no evidence that the LPNs perform any role in the formal grievance procedure. *Illinois Veterans Home at Anna, L.P.*, 323 NLRB 890, 891 (1997).

At best, the LPNs appear to function more as mediators in CNA disputes than authoritative decisionmakers. Accordingly, even if the LPNs provide some assistance to CNAs in resolving work load distribution matters, such limited authority to resolve minor disputes is insufficient to establish supervisory status. *Ken-Crest Services*, 335 NLRB 777, 779 (2001). The resolution of "minor employee complaints regarding workload, lunch and break schedule conflicts, or personality conflicts" has not been found to be sufficient to establish supervisory status. *Beverly Enterprises*, 304 NLRB 862, 865 (1991); *Ohio Masonic Home*, 295 NLRB 390 (1989).

5. Responsibly direct employees

In its recent decision in *Oakwood Healthcare, supra,* at 8, the Board found that for direction to be "responsible," the person "directing and performing the oversight of the employee must be accountable for the performance of the task by the other, such that some adverse consequence may befall the one providing the oversight if the tasks performed by the employee are not performed properly." The Board went on to explain that "to establish accountability for purposes of responsible direction, it must be shown that the employer delegated to the putative supervisor the authority to direct the work and the authority to take corrective action, if necessary. It must also be shown that there is a prospect of adverse consequences for the putative supervisor if he/she does not take these steps."

Respondent submits that LPNs responsibly direct the work of the CNAs and are disciplined for CNAs poor work performance. White testified that LPNs can be written up, suspended, or even terminated for CNAs' work performance. She identified no circumstances, however, when this had occurred. LPN Omolo Williams testified that she had received a verbal warning from Administrator Williams for a CNA work performance. Although she has only been employed at the facility since February 8, 2008, she could not recall the date when this occurred. LPN Hicks testified that she was written up by the Director of Nursing in November 2007 because a patient's G-tube leaked; causing distress for

the patient's family. Adewolu also testified that he disciplined an LPN in November or December 2007 because of a CNA's work. He could not recall, however, the name of the LPN who received the warning. Administrator Williams testified that she gave a verbal counseling to an LPN when she found CNAs sleeping in the dining room.

Despite the testimony described above, Respondent submitted no supporting documentation to substantiate that any of the alleged discipline was given. Although the record reflects that Respondent has a practice of documenting verbal warnings, there was no documentation submitted to show that LPNs have been disciplined as Respondent asserts. Additionally, there is no written documentation to show that LPNs have received in-service instructions from management because of CNAs' work performance.

In a case that was decided after *Oakwood*, the Board dealt with the employer's assertion that charge nurses were statutory supervisors based upon their alleged authority to responsibly direct the work of CNAs. *Golden Crest Healthcare Center*, 348 NLRB No. 39 (2006). In that case, there was no dispute that the LPNs in question oversaw the work performance of the CNAs and corrected the CNAs when they were not providing adequate care to the patients. Additionally, the LPNs were even rated concerning their direction of the CNAs in providing quality care. The Board, however, noted that there was no evidence that any action had been taken as a result of the LPN's rating in this regard. There was no evidence that any LPN had ever been rewarded for the CNA's work performance or that any adverse action had ever been taken against an LPN for their rating on directing the CNAs' performance. *Id* at 7. In the instant case, there is no documentation to substantiate Respondent's assertions that LPNs have been disciplined for the work performance of CNAs. Unlike the circumstances in *Golden Crest Healthcare Center*, there is no evidence that LPNs are evaluated at all; much less evaluated because of the CNAs' work performance.

6. Authority to suspend

There was a great deal of testimony in this hearing devoted to how LPNs are to handle a report of abuse of a patient. Respondent asserts that when an allegation of abuse to a resident by a CNA becomes known to an LPN, the LPN must asses the credibility of the allegation, and if credible must suspend the CNA, and bar them from further resident contact. Respondent asserts that such discretion supports a finding of the LPN's supervisory status.

LPN Clay confirmed that if she were aware of someone abusing a patient, she would do the same thing whether the abuser was a CNA, an LPN, or the Director of Nursing. She asserted that after investigating the allegation, she would report it to her supervisor. LPN Vandusn also testified that whether the allegation involved a CNA or an LPN, she would follow similar steps when there was a report of patient abuse. She confirmed that she would file a report, notify administration, and do what she needed to do to protect the patient. In both instances, she would get the abuser out of the building. LPN Omolo Williams explained that if she were to receive a report that a staff member was abusing a patient, she would remove the staff member from the resident, instruct the staff member to go home, and notify administration. She clarified that if it were another LPN who was reported to have abused a

patient, she would also make the LPN leave the facility.

Section 300.3240 of the Illinois Administrative Code provides that if a facility employee of a long term care facility becomes aware of abuse or neglect of a patient, the employee is to report the matter immediately to the facility administrator. If an employee is the perpetrator of the abuse, the employee "shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee." Director Nursing Adewolu confirmed that the state regulation does not specifically address CNAs and applies to anyone. He explained that under the Code anyone suspected of abuse is barred from the building, regardless of whether the individual is a nurse or a physician.

Thus, the total record evidence reflects that LPNs have no greater discretion than any other employee when they are confronted with patient abuse. Sending a CNA home because of a patient abuse is not a matter of supervisory discretion; but an exercise of authority that is mandated by state law. Authority that is limited to situations involving flagrant and egregious conduct does not normally constitute statutory supervisory authority. *Vencor Hospital-Los Angeles*, 328 NLRB 1136, 1139 (1999). The Board has specifically noted that sending an employee home because of patient abuse is not an indicium of supervisory status. The Board has reasoned that there is no independent judgment involved because the offenses are "obvious violations of the employer's policies and speak for themselves." *Children's Farm Home*, 324 NLRB 61, 67 (1997).

7. Changes in LPN duties

Paragraph VI (a) and (b) of the complaint alleged that about mid-December 2007 and about December 20, 2007, Respondent altered the working conditions of its employees by requiring the LPNs to issue disciplinary write-ups to CNAs. General Counsel argues that all write-ups issued after that time are "just manifestations of Respondent's unlawful action in changing the LPN's duties to confer supervisory indicia and therefore cannot be properly relied upon to establish such indicia in the first instance."

CNA Cheatem was a team leader on the 11:00 p.m. to 7:00 a.m. shift for the five years prior to the Union campaign. She testified that part of her duties included preparing the monthly CNA schedule and dispersing daily room assignments for the CNAs. On December 20, 2007, Administrator Williams told Cheatem that Rhonda White would take over the responsibility of preparing the monthly schedule for the CNAs and that the LPNs would assume responsibility for preparing the daily staffing sheets.

Administrator Williams and Adewolu conducted a staff meeting with employees on December 20, 2007. Approximately 60 to 75 employees attended the meeting. Kalea Williams testified that during the meeting, Administrator Williams announced that Cheatem would no longer prepare the CNA schedule and that Rhonda White would assume that responsibility. Administrator Williams also told the employees that the LPNs were required to begin making out the work schedules and patient assignments for the CNAs. Administrator

Williams testified that while she mentioned these duties to the LPNs, she was only reminding them to do what they were already responsible for doing. Kalea Williams testified that she believed that Respondent was trying to make the LPNs supervisors and therefore she never began making out the schedules for the CNAs as Administrator Williams instructed. No one in management spoke with her about her failure to do so and she was not disciplined for her failure to do so.

Kalea Williams also recalled that at some time after the December 20, 2007 meeting, she had occasion to speak privately with Administrator Williams. While standing near the elevator on the second floor, Administrator Williams told Kalea Williams that because the LPNs were going to be responsible for what the CNAs did or did not do, the LPNs would need to start writing them up. Administrator Williams cautioned that the LPNs' licensees would be jeopardized if they did not do so. Kalea Williams did not initiate any discipline for CNAs and was not disciplined for her failure to do so.

8. Conclusions concerning the LPNs' supervisory status

It is "well settled that the burden of proving supervisory status rests on the party asserting that such status exists." *Freeman Decorating Co*., 330 NLRB 1143, 1143 (2000), citing *Ohio Masonic Home*, 295 NLRB 390, 393 (1989). Additionally, the party asserting such status must establish the supervisory status by a preponderance of the evidence. *Bethany Medical Center*, 328 NLRB 1094, 1103 (1999). The Board has also noted that any lack of evidence in the record is construed against the party asserting supervisory status. *Elmhurst Extended Care Facilities, Inc*., 329 NLRB 535, 536 fn. 8 (1999). As discussed above, a large portion of Respondent's evidence concerning LPN supervisory status was presented through the testimony of Adewolu, Administrator Williams, and Quality Assurance Nurse Rhonda White; all members of management. Additional testimony was presented through a number of CNAs and LPNs. A significant number of LPNs who testified on Respondent's behalf were nurses who were hired after the Union's organizing campaign began and after the changes in LPN duties that are alleged to violate the Act. Although there was testimony that LPNs issue discipline to CNAs, there was scant documentation in support of the testimony. As discussed above, even though Administrator Williams reviewed records dating back to before 2005, she was able to find only six disciplinary notices that were alleged to have been issued by LPNs to CNAs and three of those disciplines were administered after the Union filed its petition to represent the LPNs. For those disciplines dating prior to the filing of the petition, one did not even identify the name of the nurse who was alleged to have given the discipline. The remaining disciplinary notices were alleged to have been issued by Thurmond and Harper. Both testified that while they used the notice to record what occurred with the respective CNAs, they made no recommendation as to what discipline should be taken and they had no further involvement in the disciplinary process.

There is no dispute that during certain periods of the evening and night, LPNs perform their job functions without the presence of Adewolu, Administrator Williams, or White at the facility. I do not find, however, that such circumstances demonstrate that LPNs possess or exercise supervisory authority. The absence of statutory supervisors in the facility does not

confer any greater authority on the LPNs for those particular periods. The overall testimony in this case indicates that Adewolu, White, and Administrator Williams are available by telephone if needed by the LPNs on duty. The testimony of both Administrator Williams and Thurmond confirm that Thurmond telephoned Administrator Williams at home early on a Saturday morning after the incident with LPN Harris. Thus, statutory supervisors are available for consultation even if they are not physically present at the facility. See *Chevron U.S. A.,* 309 NLRB 59, 71 (1992).

Therefore the overall record evidence is not sufficient to corroborate the conclusionary testimony offered to establish that LPNs are statutory supervisors. Accordingly, I do not find that Respondent has met is burden of showing that the LPNs possessed or exercised authority that establishes their supervisory status under the Act.

9. Conclusions concerning changes in LPN duties

Citing the Board's decision in a number of cases[4], Counsel for the General Counsel submits that the Board has "consistently held that altering the duties of employees to convert them into supervisory employees in the face of a union organizing campaign violates Section 8(a)(3) of the Act."

Respondent maintains that LPNs had the authority to make CNA daily room assignments and to discipline CNAs prior to December 2007 and that Administrator Williams' comments to Harper and to the employees in the meeting simply reminded LPNs of their existent authority. I do not find, however, that the overall record supports this premise. As the above discussion indicates, the evidence reflects that LPNs were not responsible for disciplining CNAs prior to December 2007 and were only tangentially involved in CNA room assignments. Within only a matter of days after the first Union meeting, Respondent attempted to shift these responsibilities to the LPNs. As discussed later in this decision, the altering of responsibilities also came during a period when Adewolu was engaged in unlawful interrogation, threats, promises, and other actions violative of 8(a)(1) of the Act. Clearly, the timing of this altering of LPN duties demonstrates both an illegal motive and animus.[5] It is undisputed that White relieved Cheatem of the responsibility for the monthly scheduling for CNAs in December 2007. Although Respondent asserts that the LPNs were responsible for the daily room assignments for CNAs prior to December, 2007, the record evidence does not support this assertion. The credible record evidence indicates that Cheatem and other CNA team leaders were responsible for CNAs room assignments prior to December 2007. Additionally, as discussed above, the evidence is insufficient to show that LPNs were responsible for the discipline of CNAs prior to the Union's organizing efforts. Accordingly, I do not find that Respondent has met its burden in showing that LPNs had these same duties prior to December 2007 and I find that Respondent altered the working conditions by

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[4] *Matson Terminals, Inc*., 321 NLRB 879, 879 (1996), enfd. 114 F.3d 300 (D.C. Cir. 1997); *Dickerson-Chapman, Inc*., 313 NLRB 907, 930-40 (1994); *Venture Packaging, Inc*., 294 NLRB 544, 551-553 (1989), enfd. mem. 923 F.2d 855 (6th Cir. 1991).

[5] *Regency Manor Nursing Home*, 275 NLRB 1261 (1985).

requiring[6] LPNs to discipline employees and to make room assignments as alleged in complaint paragraphs VI (a) and (b) in violation of Section 8(a)(3) and (1) of the Act. *A.M.F.M. of Summers County, Inc.,* 315 NLRB 727, 731 (1994).

F. The Discharges of Harper, Rounds, and Thurmond

General Counsel has alleged that Respondent violated Section 8(a)(1) and (3) of the Act by its discharge of employees Harper, Rounds, and Thurmond. There is no dispute that Harper and Rounds were terminated on January 2 and January 3, respectively. Thurmond was terminated only four days later. In order to determine whether these employees were unlawfully terminated, the Board has established a specific framework for analysis. Under the principles of *Wright Line*, 251 NLRB 1083, 1089 (1980), enfd. on other grounds, 662 F.2d 899 (1st. Cir. 1981), cert. denied 455 U.S. 989 (1982), and approved by the United States Supreme Court in *NLRB v. Transportation Management Corp*., 462 U.S. 393, 401-402 (1983), the General Counsel must establish that union activity was a motivating factor in the action taken against these employees. Once the General Counsel has met this burden, the burden shifts to the Respondent to establish, by a preponderance of the evidence, that it would have taken the action even in the absence of the employees' union activity. *Wright Line*, 251 NLRB at 1089. The burden shifts only if the General Counsel establishes that protected conduct was a "substantial or motivating factor in the employer's decision." *Budrovich Contracting Co*., 331 NLRB 1333 (2000). Union activity, employer knowledge, and employer animus are the essential elements to show discriminatory motivation. *Farmer Bros. Co*., 303 NLRB 638, 649 (1991). As discussed more fully below, the total record evidence reflects that General Counsel has met its burden in demonstrating Respondent's discriminatory motive in terminating Harper, Rounds, and Thurmond. As I have also discussed below, the record does not support a finding that the Respondent would have terminated these employees in the absence of their union activity. I find that Respondent discharged each of these employees because of their union activity and in violation of Section 8(a)(3) of the Act.

In support of its position that all of the alleged discriminatees were lawfully terminated; Respondent presented the testimony of Alan J. Litwiller; a consultant with Omni Care Pharmacies of the Midwest. Respondent asserts that after consultation, Litwiller gave an opinion that supported Respondent's decision to terminate the employees. Respondent does not assert that it relied upon Litwiller's opinion prior to the discharge of the employees in issue.

There is no dispute that Respondent is a customer of Omni Care. Prior to 1984, Litwiller was employed with the Illinois Department of Public Health for approximately four and a half or five years. In his position with the State of Illinois, Litwiller was involved in the regulation of long term care facilities in the northern half of Illinois. For the past 10 years, however, Litwiller has conducted training seminars for long term care facilities on State and

[6] Although the testimony of discriminatees Kalea Williams, Harper, and Thurmond indicates that they declined to exercise the authority that was thrust upon them, the attempt to alter their duties is no less violative.

Federal regulation compliance. He acknowledged that his last visit to the Respondent's facility may have been a year and a half or two years prior to his testimony. He opined that his last visit to the facility may have been a nurse's training program, however, he could not specifically recall the details. I did not find Litwiller's testimony persuasive with respect to the alleged discriminatory discharges. Respondent does not assert that it relied upon or was even aware of Litwiller's opinions and observations prior to the terminations of Harper, Thurmond, and Rounds. Accordingly, I have given little, if any, weight to his testimony.

1. The discharge of Lavern Harper

Lavern Harper (Harper) worked for Respondent as an LPN from January 1, 2007 until her discharge on January 2, 2008. She normally worked the 7:00 a.m. to 3:00 p.m. shift for the skilled care patients on the second floor.

(a) Harper's union activity

Harper signed a union authorization card on November 17, 2007. She recalled that one day during the latter part of November, she and LPN Angela Bibbs were standing at the nursing station. Adewolu approached them and made the statement that he liked them and he did not want them to lose their jobs. He told them that he did not want them to join the Union and if they did so, they would be terminated. When Harper tried to pretend that she did not know what he was talking about, Adewolu added that he was aware of the Union and that Lerner would not tolerate the Union and that anyone involved in the Union would be terminated.

Harper recalled that when she and Bibbs asked him if he wanted them to be spies, he told them yes and assured them that there would be "something in it" for them. When Harper and Bibbs asked if their compensation would be another 16 straight hours, Adewolu walked away. Harper testified that she asked this question because the nurses had been working 16-hour shifts without overtime pay.

Harper spoke again with Adewolu during the week of December 6, 2007. Adewolu approached her about 6:00 p.m. while she and LPN Joanne Harris were working at the nurse's station. Adewolu told her that he knew about the Union and he knew that "you guys" were out to get him. He also told her not to play dumb with him and he knew that she was aware of the Union meeting. Harper admitted to Adewolu that she knew about the meeting but assured him that she had not attended. Adewolu then told her that he knew that Kalea Williams, Michael Thurmond, and Diane Rounds attended the meeting and he threatened that he would terminate them all for attending the meeting.

When Harper responded: "They have a right to have a union," Adewolu replied; "Not in Illinois." Harper acknowledged that might be true in his home country, but not in the United States. When she asked him if it were not true that he had come to the United States for equality, he had simply looked at her. He again repeated his earlier comment that Lerner would not tolerate anyone being in a union and they would be terminated.

Harper recalled that she had another conversation with Adewolu sometime toward the end of December. Both of them had worked late and they were in his car, driving to a restaurant. During the drive, they talked about the facility and the things that they would like to see changed there. Adewolu told her that the "union thing" was "pretty bad" and that they needed to get it out of the way before anything else. Adewolu told her that employees should not be involved with the Union because Lerner would fire people if they became involved. Harper again told Adewolu that employees have a right to have a union. He responded: "No, this is just really bad. It needs to end."

(b) Notice of termination

On January 2, 2008 Harper met with Restorative Nurse Betty Arnold and Rhonda White in Adewolu's office. Harper was given a notice of termination. The discharge notice references four reasons for Harper's discharge. The bases listed include: (1) Failure to give proper medication dosage; (2) Improper patient discharge documentation; (3) Failure to document a patient's refusal of treatment; and (4) medication left on medication cart unattended. White testified that although Harper was terminated by the Adewolu, she had been the one who had brought each of these concerns to his attention.

Administrator Williams testified that she was involved in the decision to terminate Harper and that her decision was based upon information provided to her by Adewolu and White.

(c) The four incidents reported in Harper's termination notice

(1) Alleged medication dosage error

White testified at length about an alleged medication error committed by Harper. Respondent asserts that when a patient was transferred to the facility from the hospital, Harper neglected to correctly document the correct medication dosages from the hospital to the patient's chart at the facility.

The only record that Respondent presented in support of this medication error was a compilation of four pages that were pulled from the chart of a patient who was admitted to the facility at 1:00 p.m. on December 12, 2007. (Respondent's Exhibit No. 3) Administrator Williams confirmed that when she made the decision to terminate Harper, she reviewed only these four pages from the patient's chart in determining that Harper made a medication dosage error. The first page of the exhibit contained the nursing notes showing the time and condition of the patient upon admission on December 12, 2007. The page also contained notes made by nurses on the 11:00 p.m. to 7:00 a.m. shift on December 12, 2007, and the 11:00 p.m. to 7:00 a.m. shift on December 13, 2007.

The second page of Respondent's exhibit is a document generated by Advocate Christ Medical Center entitled: "Medication Reconciliation Report – as of 12/11/07 16:20." The

document includes the specific language: "This is not a physician order form. Do not use this form as a medication administration record." The document also reflects that it is page 2 of a 4 page document from the hospital. The other three pages from the hospital report were never submitted into evidence. The one-page document from the hospital contains a listing of 9 medications with dosage descriptions, the date and time of the last dosage, and whether the medications are to be converted to prescription. For each medication listed, there is a check mark showing that the medication is not to be converted to prescription. The document also contains a section that designates whether the medication reconciliation is for a patient's discharge. The form does not reflect that it has been completed for discharge.

The third and fourth pages of Respondent's compilation exhibit are medication record sheets generated after the patient's admission to the facility on December 12, 2007. The hospital's medication reconciliation sheet shows that the patient received 100 milligrams of Docusate sodium at 11:00 p.m. on December 10, 2007, at the hospital. The facility's medication record of December 12, 2007, and completed by Harper shows that the patient was scheduled to receive 150 milligrams of Docusate sodium at 9:00 p.m. daily. A medication identified as metoclopramide is also listed on the hospital's Medication Reconciliation Report, showing that the patient received a daily dosage at 9:00 p.m. on December 11, 2007 at the hospital. Respondent's medication record, however, reflects that the patient was scheduled to receive the medication three times daily. The hospital Medication Reconciliation Report also lists insulin as a medication to be given every six hours. Rhonda White testified that the facility's medication record showed that the insulin was to be given at 6:00 a.m., 12:00 p.m., and 6:00 p.m., but did not list 12:00 a.m. as well. White acknowledged, however, that when a nurse looks at the medication record, the nurse will read beyond the name of the medication and also read the additional description and she acknowledged that the description provides for the insulin to be given every six hours.

White also admitted that the medication record in the patient's chart usually contains the nurse's initials to indicate that the medication has been given to the patient. She acknowledged that because there are no nurse's initials on the medication record included in Respondent's Exhibit No. 3, these particular medications that are listed were not actually given to the patient. She also acknowledged that the medication record submitted into evidence can not confirm what medications were actually given to the patient.

Harper agreed that while there is a difference between some of the medication dosages at the hospital and what was listed in the facility's medication record introduced by Respondent, there are also normally more than one copy of a medication reconciliation report sent to the facility from the hospital. She testified that the total paperwork from the hospital may often include as many as 20 to 30 pages. Rhonda White also admitted that hospitals may send two sets of medication orders to a nursing home. White confirmed that the medication reconciliation report is only one of the many forms that the hospital sends to the nursing home. Administrator Williams admits, however, that in making her decision to terminate Harper, she reviewed no other hospital records other than the one page that is included in Respondent's Exhibit No. 3.

Harper testified that once a patient is admitted from the hospital, the nurse will talk with the doctor and verify if he wants to modify the orders for the patient in the nursing home. If the doctor changes the orders, the medication record is prepared to comply with the doctor's verbal orders. Administrator Williams also admits that the nurse confirms the medication orders with the doctor by telephone and that the doctor can change the orders by phone.

(2) Factual conclusion concerning the alleged medication dosage error

Respondent contends that Harper was discharged in part because of a serious medication error. In support of this position, Respondent relied upon the testimony of White and four pages taken from a patient's chart. There is no dispute that the Medication Reconciliation Report relied upon by the Respondent is incomplete and is only one page of a four page document. The Medication Reconciliation Report states on its face in the bottom right hand corner that it is the second of four pages. The remaining three pages of the hospital report were not provided.

In asserting that Harper erred in charting the correct medication dosage from the hospital orders to the nursing facility's medication record, White compared the dosage amounts on the hospital's Medication Reconciliation Report to the dosage amounts documented in the facility's Medication Administration Record (MAR), asserting that there were demonstrable variances in the dosages. Interestingly, however, a comparison of the two documents shows that there were only three medications that are contained on both forms. The facility's MAR reflects seven entirely different medications that were not listed on the hospital's form. As the Charging Party points out in brief, these medications certainly came from somewhere and presumably from the missing pages of the hospital's Medication Reconciliation Report. Thus, it is apparent that during the transfer process from the hospital to the facility, changes were made in not only the dosage amounts for three medications, but also in the medications that were ordered for this patient. The Medication Reconciliation Report taken from the hospital records simply appears to document the medications that the patient was receiving while in the hospital and the time and date of the last dosage received.

The wording on Harper's termination notice reflects that she was discharged because a specific patient "was not given" the "proper dose of medication." I note, however, that the documentation allegedly relied upon by Respondent does not reflect that Harper or any other nurse gave the medications listed. Again, the document appears to be incomplete because there are no nurses' initials to show that any of the listed medications were those actually administered by Harper or any other nurse. The document provided by Respondent was actually a blank and incomplete medical record without the requisite nursing signatures to show that the medications had been given. Thus, the very document upon which Respondent allegedly relies contradicts Respondent's notice of termination stating that the patient was not given the proper medication dosage. Respondent's assertion that it relied upon an obviously incomplete document supports an inference that the alleged medication dosage error was not the real reason for Harper's discipline, but was fabricated to support Harper's unlawful termination.

(3) Alleged failure to document patient's refusal for treatment

White initially testified that on December 22, 2007, she specifically told Harper to document a patient's refusal for medication during the 3:00 p.m. to 11:00 p.m. shift. She testified that Harper failed to do so and she cites this omission as an additional basis for Harper's discharge. In support of this discipline, Respondent initially submitted a one-page document from a patient's file. The first four lines on the page were undated and White identified the handwriting in those lines to be her own. White testified that the notes referred to a patient for whom antibiotics had been ordered by the physician and the patient refused to have an intravenous (PICC) line inserted for the administration of the antibiotics. White explained that because there were also some issues with this patient's family, management had emphasized the documentation of the patient's refusal to allow the PICC line. White's notes included the following:

> Will try again and this behavior has been endorse[d] to oncoming nurse 3-ll

White asserted that this language demonstrated that she had directed Harper as the incoming nurse on the 3:00 p.m. to 11:00 p.m. shift to document the patient's refusal of treatment. The first new nursing note after White's note was identified as a note by LPN Shanina Mitchell and is dated December 23, 2007. Mitchell documented that she had been unable to give the patient the intraveneous treatment because there was no PICC line. The next entry in the nurses' notes was made on December 25, when Mitchell documented that the physician had been paged and she was awaiting his call. White testified that because Harper worked on December 22, 2007, she should have documented the patient's refusal of the medication in her notes for that shift. The one-page nursing note was not initially received into evidence as it appeared to contain a continuation of White's note and was thus an incomplete document. The Respondent was allowed to resubmit the exhibit with the addition of the nursing notes that preceded those contained in the original one-page document. The preceding nursing notes were added to the Respondent's exhibit and the complete document was received into evidence as Respondent's Exhibit No. 4. The additional page for Respondent's Exhibit No. 4 and the preceding nursing note reflected that White's note was actually made on December 18 rather than December 22.

(4) Conclusions concerning the alleged documentation error

As discussed above, Respondent initially offered a nursing note to show that in response to White's directive, Harper failed to properly document a patient's refusal of medication on December 22, 2007. White asserted that she had been present on the 7:00 a.m. to 3:00 p.m. shift and she had directed Harper to additionally document the patient's refusal of medication on the 3:00 p.m. to 11:00 a.m. shift. In her initial testimony, White testified without hesitation that Harper worked the 3:00 p.m. to 11:00 p.m. shift on December 22 and identified Harper's error as not including a note on December 22 about the patient's refusal to allow the insertion of the intravenous line. General Counsel, however, offered into evidence Respondent's Daily Staffing sheet that showed that while Harper worked on December 22,

2007, she worked on the 7:00 a.m. to 3:00 p.m. shift; the same shift with White. Additionally, the staffing sheet showed that Harper worked on the first floor on December 22, although it is undisputed that the patient in issue was a patient receiving skilled care on the second floor.

When the Respondent submitted the preceding nurses' notes to supplement its original exhibit, the notes reflect that White had actually written her directive to document the patient's refusal on December 18 rather than December 22. When asked about the discrepancy on cross-examination, White then asserted that the date of the documentation error was December 18 rather than December 22. Respondent's daily staffing pattern sheet for December 18, however, reflects that Harper was not on the schedule at all for December 18, 2007.

Additionally, White acknowledged that the requirement for the nurses to document the patient's refusal to allow the PICC line applied to all nurses and not just to Harper. She also acknowledged that while LPN Mitchell documented that she could not administer the antibiotic because there was no line, she did not document the patient's refusal to allow the PICC line in her December 23, 2007 nursing note. White did not dispute that the physician's order not only required that the patient receive the PICC line on December 18, but for each day continuing thereafter. She acknowledged that there were no notes from any other nurses to confirm the patient's refusal of the PICC line on December 19, 20, 21, or 22. Despite the fact that other nurses did not document the patient's refusal to accept the medication, White contended that it was Harper's responsibility to document the refusal on December 18, 2007 because White endorsed this behavior to Harper as the oncoming 3:00 p.m. to 1:00 p.m. nurse. Although White also asserted that she personally told Harper to document the refusal at the beginning of Harper's shift on December 18, White admitted that the daily staffing sheet for December 18 did not have Harper scheduled for the 3:00 p.m. to 11:00 p.m. shift or for any other shift that day.

On redirect examination, White opined that it is possible that Harper may have filled in for someone at the last minute on December 18. The December 18, 2007 staffing sheet, however, shows that LPN Mitchell was scheduled to work the 3:00 p.m. to 11:00 p.m. shift on the first floor. Nurses "Joanne" and "Mary" were also scheduled to work the 3:00 p.m. to 11:00 p.m. shift on the second floor. While the staffing sheet shows that Mitchell called off, the sheet also reflects that Adewolu filled in and worked the shift on the first floor in her place. There is nothing to indicate that either of the other two nurses who were scheduled to work that shift did not work as scheduled. Thus, there is no credible evidence that Harper worked at all on December 18.

During Respondent's direct examination, Adewolu was shown the nursing notes for December 15 through December 26, 2007 and asked to identify what Harper erroneously failed to document. Contrary to White, Adewolu asserted that Harper's error had been her failure to comply with the 72-hour hour rule on documenting antibiotics and she failed to document the time that the IV treatment began. He initially asserted that the patient had a PICC line and then finally admitted that he was confusing the patient with another patient.

As with the alleged failure to correctly chart the medications, Respondent's evidence concerning Harper's alleged failure to chart a patient's refusal for treatment is suspect. Respondent initially submitted an incomplete document to support White's testimony. When confronted with contradictory documents, White's recall changed as well. White's testimony concerning Harper's documentation errors was then totally contradicted by Adewolu. Inasmuch as White's testimony is contradictory and unsupported by either Respondent's own records or the Adewolu's testimony, I find no basis to credit her testimony that Harper was discharged because of a valid documentation error. I must infer that this alleged error is a pretext to hide an underlying discriminatory motive.

(5) Improper discharge documentation allegation and conclusion

Harper testified that Adewolu has always told the nurses to use a separate note to document a patient's discharge or readmission, rather than using the next line available in the nurses' notes. Harper recalled the circumstances involved with the patient in question. Harper spoke with the patient's doctor at approximately 7:30 a.m. and he told her that the patient would be discharged to the hospital. Harper began documenting the physician's orders for discharge. She called the hospital, spoke with the admitting nurse, and informed the nurse of the patient's impending transfer to the hospital. Harper then contacted the ambulance service that was to transport the patient to the hospital and the patient's family to inform them of the transfer. Harper testified that she documented all of these discharge procedures in a separate discharge note. She also documented her attempt to reach the patient's family and she documented when the patient left the facility. Respondent simply submitted into evidence a sheet from the patient's file, and asserted that there was no discharge note on that specific page of the chart. Harper asserts that since she placed the discharge notes in the patient's chart, someone must have removed the separate note from the chart. Although White testified that there was no policy of starting a new sheet for a discharge, she gave no other information about the chart for which Harper was disciplined. Although Respondent submitted portions of other patients' medical records concerning other matters in issue, Respondent did not submit any other documentary evidence to support the allegation that Harper failed to chart this patient's discharge. I found Harper to be a credible witness. I credit her testimony that she made the discharge contacts as alleged and that she added her documentation in the file as she asserted. Crediting Harper's testimony that she placed her notes separately in the file, I find the timing of the disappearance of the notes to be questionable. Based upon the overall evidence, it appears that this basis for discharge was added to bolster Respondent's pretextual assertions.

(6) Medication cart unattended

The final reason noted on Harper's termination notice was "Meds left on Medication cart unattended." White testified that because patients are often confused, it is dangerous to leave a medication cart unattended and she asserts that such action is a Public Health violation. Although this violation is specifically included in Harper's discharge notice, White did not recall the date when this occurred. She estimated that it may have been in December, 2007. Although White asserted that she observed the incident, she acknowledged that no one

else was present at the time. Administrator Williams testified that she was aware of the unattended medication cart because it was brought to her attention by a second floor patient.

(7) Conclusions concerning the medication cart incident

Neither White nor Administrator Williams provided any other details concerning how this matter was dealt with by either of them or by any other management official. No evidence was given as to whether there was an investigation to determine how long the cart was unattended or whether any medication was taken from the cart. Neither witness testified as to whether they addressed this matter with Harper. Neither witness could even recall when the incident actually occurred. The brevity of the evidence concerning this alleged incident brings into question whether such incident occurred at all. Certainly, the serious nature of such an infraction would reasonably have resulted in some kind of investigation or at least a confrontation with Harper. Inasmuch as there was apparently no such response by management, it appears more likely that this infraction was added as an additional basis for discharge to strengthen Respondent's alleged basis for firing Harper.

Accordingly, as discussed above, I find that Respondent has not demonstrated that it would have discharged Harper in the absence of her union activity and her discharge constitutes a violation of Section 8(a)(3) and (1) of the Act.

2. The discharge of Diane Rounds

(a) Facts presented

Diane Rounds (Rounds) was employed as an LPN at Respondent's facility from August 17, 2006 until her discharge on January 3, 2008. Rounds normally worked the 11:00 p.m. to 7:00 a.m. shift and she rotated between first and second floor. There is no dispute that prior to Rounds' discharge, she received no prior discipline.

On November 16, 2007, Rounds signed a union authorization card given to her by Kalea Williams. On December 6, Rounds attended the Union meeting at the McDonald's restaurant near the facility.

Rounds was scheduled to work the 11:00 p.m. to 7:00 a.m. shift on January 1, 2008. Because of a death in her family, Rounds' brother notified the facility that she was unable to come into work. Rounds was also scheduled to work on January 2, 2008. Prior to her reporting to work, another nurse called her to let her know that her name was no longer on the work schedule. Rounds contacted Adewolu and asked why she had been removed from the schedule. He told her that the matter was out of his hands and that she should contact Administrator Williams. When Rounds spoke with Administrator Williams, she was told to come in the next day to collect her check. When Rounds came into the facility on January 3, 2008, Administrator Williams told her that she had "called off" on a holiday and that was unacceptable and therefore her services were no longer needed.

Rounds explained that based upon Respondent's policy, if an employee called off the day before or the day after a holiday, the employee would not get holiday pay. When Rounds was hired in August 2006, she received and signed a copy of Respondent's absence policy. The policy provides that except in cases of emergency, serious illness, or accident, an employee is required to notify their supervisor at least four hours in advance of his or her inability to report for work on any regularly scheduled work day. The policy does not reference any different requirement for scheduled work days that occur on holidays.

Rounds testified that she was personally unaware of any employee who has been terminated for calling off on a holiday or even terminated as a "no show" for work. Rounds also testified that she has never previously received any discipline for attendance or for any other conduct. Prior to her discharge, no one in supervision or management ever spoke with her about her attendance.

In responding to the initial charge filed concerning Rounds, Respondent asserted in its statement of position that Rounds was terminated for calling off on New Year's Day; which was unacceptable behavior on a day when the facility was short staffed. During the hearing, Administrator Williams testified that Rounds was terminated because she "called off" on a holiday after having a history of calling off. Williams identified a grouping of staffing sheets that were marked and received into evidence as Respondent's Exhibit No. 11. Administrator Williams explained that the staffing sheets reflect that between February 24, 2007 and June 1, 2007, Rounds called off seven times on days that she was scheduled to work. Administrator Williams admitted that Rounds was never disciplined for any of these seven incidents when she "called off." To demonstrate that Respondent has terminated employees for calling off, Respondent submitted into evidence two prior discharge actions. One discharge involved an employee who began employment on December 6, 2000 and then called off on Christmas Day; December 25, 2000. Respondent's absence policy provides that all employees are hired with a 30-day probationary period. Administrator Williams also acknowledged that if a probationary employee has an unexcused absence during the 30-day period, the employee will be terminated under the absence policy. The second discharge occurred on April 29, 2001, and involved a housekeeping employee who was previously warned that his absences would result in termination.

(b) Conclusions concerning Rounds' discharge

In post-hearing brief, Respondent argues that Rounds was terminated because she violated the facility attendance policy and called off seven times in a six-month period. Respondent asserts that her calling off on January 1, 2008 was "the straw that broke the camel's back" and required her termination. Additionally, Respondent denies any knowledge of her union activity prior to her discharge.

As discussed above, it is fundamental that General Counsel establish that Rounds was engaged in union activity and that Respondent had knowledge of that union activity in order to establish that Rounds was unlawfully terminated. *Wright Line*, 251 NLRB 1083, 1089 (1980), enfd. on other grounds, 662 F.2d 899 (lst. Cir. 1981), cert. denied 455 U.S. 989

(1982), and approved by the United States Supreme Court in *NLRB v. Transportation Management Corp*., 462 U.S. 393, 401-2 (1983).

There is no dispute that Rounds' total union activity was limited to attending a Union meeting and signing a Union authorization card. Despite the fact that she may not have been a vocal Union supporter, the overall evidence, however, demonstrates that her involvement in the Union's organizing effort was a motivating factor in Respondent's decision to terminate her. *Webco Industries*, 334 NLRB 608, fn. 3 (2001); *Manno Electric*, 321 NLRB 278, 280 fn. 12 (1996).

Respondent argues that Rounds never told management that she was involved in the Union's campaign and that management never said anything to her about the Union. As discussed above, however, Harper credibly testified that within a week of the December 6, 2007 Union meeting, Adewolu told her that he knew about the meeting and he knew that Rounds attended the meeting. Even though Harper did not attend the meeting, Adewolu warned her that Learner would terminate those nurses involved with the Union. As of January 2, 2008, Rounds was one of the few LPNs whose interest in the Union was clearly known to Adewolu.

Additionally, the Board has found that under similar circumstances knowledge of union activity may be implied from the circumstances surrounding the discharge. *A to Z Portion Meats*, 238 NLRB 643 (1978). Even where employees have sought to conceal their activity from management in a small work force, the Board has inferred employer knowledge in the absence of direct proof. *A to Z Portion Meats, Inc.,* at 643. *Wiese Plow Welding Co. Inc.,* 123 NLRB 616 (1959). Certainly, the Board has previously relied upon timing and the advancement of a false reason for a discharge as indicating employer knowledge of the employee's union activity. *Avery Leasing, Inc*., 315 NLRB 576, 581 (1994). In this case, Respondent asserts that Rounds' discharge was based upon her violation of the attendance policy and because she previously called off seven times within a six-month period. As discussed above, however, Respondent presented no evidence that Rounds failed to give the four hours notice of her inability to report to work as required by the attendance policy. Additionally, the last call off for Rounds presented by Respondent occurred on June 1, 2007; seven months prior to the call-off which allegedly caused her discharge. Administrator Williams testified that while she never previously disciplined Rounds for her absences, the call-off on January 1, 2008 was the "tip of the iceberg." As noted by the Court of Appeals for the Ninth Circuit in *Shattuck Mining Corp. v. NLRB*, 362 F.2d 466, 470 (9th Cir. 1966), when the stated motive for a discharge is found to be false, the trier of fact may infer that there is another motive. Moreover, it can be inferred that the motive is one that the employer desires to conceal and further would be an unlawful motive where the surroundings facts tend to reinforce that inference.

Accordingly, I find that General Counsel has made out a *prima facie* case under *Wright Line.* The record supports a finding that Respondent had knowledge of Rounds' union activity as well as animus toward the activity. I also infer discriminatory motive from the pretextual nature of the discharge and the obvious falsity of Respondent's stated reason for

the discharge. *Fast Food Merchandisers*, 291 NLRB 897, 898 (1988).

Under the *Wright Line* analysis, once the General Counsel has shown that union activity was a motivating factor in the action taken against the employee, the burden shifts to the Respondent to establish, by a preponderance of the evidence, that it would have taken the action even in the absence of the employee's union activity. *Wright Line*, above at 1089. Williams acknowledged that Rounds did not receive any written warning prior to her discharge and that the progressive discipline policy was not followed in Rounds' discharge. Although Respondent's attendance policy requires only that an employee call off at least four hours before the start of his or her shift, Respondent does not assert that Rounds' failed to comply with the four-hour reporting requirement. Although Respondent maintains that it was significant that Rounds called off on a holiday, there is nothing in the attendance policy that requires an employee to follow a different procedure for holidays or otherwise sets additional restrictions for call-offs on holidays.

Respondent presented only two incidents of prior discipline involving employees' calling off on a holiday. Neither circumstance was comparable to Rounds. While one employee was terminated for calling off on a holiday, the employee was only 19 days into employment and clearly within the probationary period specifically addressed in the attendance policy. The other termination occurred almost seven years earlier after the employee had been specifically warned that additional attendance infractions would result in discharge.

Under *Wright Line*, "an employer cannot carry its burden of persuasion by merely showing that it had a legitimate reason for imposing discipline against an employee, but must show by a preponderance of the evidence that the action would not have taken place even without the protected activity." *Hicks Oils & Hicksgas, Inc*., 293 NLRB 84, 85 (1989), enfd. 942 F.2d 1140 (7th Cir. 1991). If the evidence shows that the proffered reason for the discharge did not exist, or was not in fact relied upon, the Respondent's reason is pretextual. *La Gloria, Oil and Gas Co*., 337 NLRB 1120, 1123 (2002). Having rejected as false Respondent's explanation for the Rounds' discharge, it follows that Respondent has not met its burden of showing that it would otherwise have terminated Rounds. Accordingly, I find that Respondent terminated Rounds in violation of Section 8(a)(1) and (3) of the Act.

3. The discharge of Michael Thurmond

(a) The events in November and December 2007

Michael Thurmond worked as an LPN at Respondent's facility from January 7, 2007 until his discharge on January 7, 2008. His normal work shift was from 11:00 p.m. to 7:00 a.m. Thurmond initially learned about the Union organizing from Kalea Williams. On December 6, 2007, Thurmond attended the union meeting at the McDonald's restaurant near the facility. Thurmond testified that the employees and the union representative discussed things that needed to be changed at the facility. Thurmond also recalled that he mentioned at the meeting that Adewolu didn't like male employees. On November 18, 2007, Thurmond

signed a Union authorization card given to him by Kalea Williams.

On December 11, 2007, Thurmond telephone Adewolu to ask if he could work overtime. During the conversation Adewolu asked Thurmond "What's this I hear about your going to McDonald's and [told] the Union rep that I don't like male workers?" When Thurmond laughed in response, Adewolu went on to say that he didn't understand why the employees wanted the Union and that it was just a waste of time. He ended by telling Thurmond that he (Adewolu) didn't have any overtime available at that time. Thurmond testified that he noticed that his relationship with Adewolu changed during December, 2007 because they no longer talked with each other.

Thurmond recalled that during the period between December 25, 2007 and the end of the year, he asked three newly hired nurses if they wanted to sign union authorization cards. Thurmond told them some of the problems at the facility and how the Union could help employees with those problems. Although the nurses agreed to sign the cards, he did not have the cards with him at the time that he spoke with the nurses.

(b) The events of January 2, 2008

Prior to working for Respondent, Thurmond worked with LPN Joanne Harris at another facility eight years earlier. Thurmond testified that while employed at the previous facility, Harris was physically attacked by another employee. He opined that Harris harbored bad feelings toward him because he and other employees at the former facility had not stopped the fight. When Thurmond reported to work on January 2, 2008, he received his daily report on the patients from Harris who had worked the previous shift. After Harris left and during his patient rounds, he noticed a patient who had perspiration bubbles all over her face and increased respiration. When he examined her, he found that her stomach was bloated and that she was covered in loose stools from diarrhea. He also noticed that the patient's G-tube was leaking into the patient. He immediately called in a CNA and the respiratory nurse to help him. He stopped the G-tube feeding, pumped the patient's stomach, and induced the patient's vomiting. Thurmond made a note of what occurred. The other nursing personnel who had witnessed the incident signed the note as well. Thurmond placed the nursing note under Adewolu's door. After Thurmond called the patient's doctor, the patient was sent to the hospital.

CNA Cheatem corroborated Thurmond's account of the January 2, 2008 incident. She confirmed that at approximately 11:30 p.m. on January 2, Thurmond called her to come to a patient's room and told her that the patient was in distress and breathing with difficulty. Cheatem observed that the patient was profusely perspiring and there were feces from the head to the foot of her bed. Cheatem assisted Thurmond in pumping the feeding solution from the patient's stomach. She testified that the feeding tube had been hung for the patient without the required measured drip. Cheatem recalled that the situation required the efforts of Thurmond, herself, and another CNA to clean the patient completely to prepare the patient for transport to the hospital. Cheatem confirmed that she read the statement prepared by Thurmond. Because she agreed with what he included in the statement, she signed it along

with two other CNAs. Cheatem testified that no one from management ever spoke with her about the written statement.

(c) Thurmond's conversation with Adewolu on January 4, 2008

Thurmond reported to work at 11:00 p.m. on January 4, 2008. Shortly after arriving at work, Adewolu asked Thurmond to come into his office. When Adewolu asked him if he wanted to do some overtime, Thurmond told him that he did not. Adewolu asked why he did not. Thurmond explained that he was declining because Respondent did not pay time and a half for overtime. Adewolu began laughing and asked Thurmond why employees were crying for the Union as though a union would make any difference. During the conversation, Adewolu also asked Thurmond if he knew that he could be blackballed. Adewolu went on to state that because 90 percent of the nursing homes were Jewish owned, Thurmond could be blackballed. When Thurmond responded that he would just work for the county jail, Adewolu again laughed. Adewolu left the facility approximately 20 minutes after speaking with Thurmond.

(d) The altercation with Harris on January 5, 2008

Thurmond's shift was scheduled to end at 7:30 a.m. on the morning of Saturday, January 5, 2008. LPN Harris arrived at approximately 6:50 a.m. while Thurmond was sitting at the nurse's desk finishing his charting. He testified that Harris "marched" off the elevator, threw her personal bag next to him, and proceeded to collect the keys from the nurse that she was relieving. As she slammed the door to the medicine room, she exclaimed: "Let me do my mother-fucking rounds, Boo-boo, let me do my mother-fucking rounds, there's some trick bitches around here." CNA Cheatem testified that when she heard Harris' comment, she told Harris that she could not use profanity on the floor. Harris responded: "Like I said, I'm going to go do my mother fucking rounds, especially on 11:00 to 7:00 because we got trick bitches on this shift.". Thurmond testified that he understood that a "trick bitch" as a woman who tells everything. After going into a patient's room, Harris came out waving her hand as though she had an empty G-tube bottle. She looked at Thurmond saying: "G-tube empty, ha-ha, go tell that shit, sissy boy. Dola's right, you're a sissy boy." Cheatem testified that she told Harris to please quiet down because there were residents who were still resting. Cheatem told Harris that there was no need to scream. Thurmond then asked Cheatem to get him Administrator Williams' telephone number. While he was in the process of making the call, Harris stated: "Oh, look at trick boy, you're a trick boy, go ahead. Sissy boy, go tell, sissy boy, tell, sissy boy." Thurmond testified that during this time, Harris also made the comment that Thurmond "knew her history." Thurmond told Harris that he knew her history with not hanging a G-tube properly and with not knowing patient medication. Cheatem testified that during the conversation with Harris, Thurmond did not yell and his demeanor was not oppressive. Cheatem described Harris, however, as loud and very aggressive.

When he reached Administrator Williams he told her that Harris was "flipping on the floor" and cursing him. Williams told him to give the phone to Harris. Thurmond heard Harris tell Williams some of the same things that she had said to him about his being a "trick

bitch" and that Adewolu was right that Thurmond was a sissy boy. After speaking with Harris, Williams again spoke with Thurmond. She told him that she would handle the matter when she got back to work on Monday. She also told Thurmond that Harris had accused him of threatening her. Thurmond denied that he threatened Harris and told Williams that Harris started the cursing and that Harris brought up the fact that he knew Harris' history. Thurmond told Williams that the only history that he had discussed with Harris was the history of her failure to correctly hang the G-tube for the patient the previous day. He told Williams that he had not said anything to Harris about her incident 8 years before. He also told Williams that Harris had alleged the threat just to cover up her behavior on the floor.

Cheatem also spoke with Administrator Williams. She told Williams what had occurred and told Williams that the situation needed to be dealt with. Williams suggested to Cheatem that she and Thurmond leave the building as scheduled at the end of their shift. Williams also told Cheatem to obtain statements of the incident. Cheatem requested employee Leisha Gardner and Thurmond to prepare statements for her. Later that day, Cheatem obtained the written statements from Gardner and Thurmond. Thurmond also prepared a separate written statement of what occurred with Harris and left it under Adewolu's door that same day.

Administrator Williams recalled that she spoke with both Harris and Thurmond around 7:00 a.m. on January 5, 2008. She asserts that at approximately 9:00 a.m., Harris called her again to tell her that she (Harris) had contacted the police. Harris told Williams that she filed charges with the police because Thurmond made the comment: "history repeats itself." Williams testified that Harris explained that because some nurses physically attacked her in the past, she believed that Thurmond's comment was a threat. Williams recalled that later that same afternoon, Thurmond again called her at home and talked with her about Harris' police report. In her testimony, Williams maintained that in her conversation with Thurmond, he indicated that his comment about history repeating itself was linked to Harris' previous altercation with other nurses.

(e) Thurmond's contacts with management on January 6, 2008

Williams recalled that when Thurmond called her again on Sunday and asked what she was going to do about the situation, she told him that she would handle it once she returned to work on Monday. There is no dispute, however, that later in the day, Thurmond telephoned Director of Operations; Deborah Kipp. He told Kipp what occurred and how Harris had cursed him and had been aggressive toward him. He also told Kipp that he understood that Harris had also called the police after he had left the facility on the 5th. He told Kipp that he didn't want to be arrested when he returned to work on Monday. Kipp assured him that the matter would be resolved.

(f) The events of January 7, 2008

Shortly after arriving at work on Monday morning, January 7, Williams received a telephone call from Kipp. When Kipp told Williams about her call from Thurmond the

previous day, Williams attempted to explain what occurred over the weekend.

Cheatem called Administrator Williams from her home shortly before 10:00 a.m. on Monday morning, January 7. Cheatem explained that she had three statements concerning the incident and that she would bring them to the facility later that same morning. Williams told her that she could do so.

When Cheatem arrived at the facility at approximately noon, Williams told her that she had already made a decision to terminate Thurmond. Cheatem asked Williams how she could have already made the decision when she had not spoken with anyone or even read the statements of what occurred. Williams told her that she had spoken with "people" and she knew that he was the one who had caused the problem. Cheatem's three-page written statement that she prepared and left with Williams outlined the conversation between Thurmond and Harris and confirmed that there had been no threats or physical contact.

Thurmond explained that there had been a meeting scheduled on January 7, 2008 to discuss the incident. He had not attended the meeting, however, because he did not have a witness available. He said that his attorney advised him not to be in the room with Adewolu, Administrator Williams, and Harris without a witness. Later in the day, Administrator Williams telephoned him and told him that she was terminating him. Williams went on to explain to Thurmond that she had previously told him never to call her boss and he had done so. Williams reminded Thurmond that she had told him that she would handle the situation when she returned on Monday and yet he had contacted her boss. Thurmond testified that Williams added that she had heard that he was "nothing but problems, anyway." She said that she had heard that he had been complaining about the facility and "hollering" about the Union. Williams then added: "Let me tell you something Michael, you go and tell the Union to get your job back."

Williams testified that she made the decision to terminate Thurmond because she believed that his comment to Harris about history repeating itself was a threat. Williams acknowledged that Cheatem's letter reported that Thurmond did not threaten Harris and that it had been Harris who cursed and used vulgar language on the floor. Williams acknowledged that she had confirmed that Cheatem's letter was accurate about Harris' use of vulgarity. Despite doing so, however, she still decided that it was appropriate to terminate Thurmond. She also contended that his calling her boss and failing to follow the chain of command was a factor in her decision to terminate him. Respondent submitted into evidence copies of two disciplinary discharge forms to document that other employees have been discharged for fighting. One discharge involved an employee who put patients in harm's way when he attempted to physically injure another employee in the presence of patients on November 25, 2007. The second discharge resulted from an employee's involvement in a fighting incident on November 27, 2000. The discharge notice documents that the employees were screaming, yelling, fist-fighting, and using brooms and dust pans and other housekeeping items in the fight. Police were called to the facility because of a 911 request. The employee was both terminated and arrested. The documented reasons for the employee's termination were fighting on the job, procedure/rule violation, battery to another employee, and felony theft.

Administrator Williams admitted that while employees have been fired from the facility for physical fights and assaults, no employees have been fired for verbal threats. She also confirmed that no other employee had ever been fired for "breaking the chain of command." There is no dispute that prior to his discharge; Thurmond had never received any prior discipline.

(g) Alleged 8(a)(1) involving Adewolu and Thurmond

The Board has opined that "employees should be free to participate in union organizing campaigns without the fear that members of management are peering over their shoulders, taking note of who is involved in union activities, and in what particular ways." *Flexsteel Industries*, 311 NLRB 257 (1993). General Counsel alleges that on December 11, Adewolu not only informed Thurmond that he knew about the Union meeting at McDonald's, he also knew the subjects discussed at the meeting. The Board's test for determining whether an employer has created an impression of surveillance is whether the employee would reasonably assume from the employer's statement in question that his or her union activities have been the subject of surveillance. *United Charter Service*, 306 NLRB 150, 151 (1992). As the Board has found: "When an employer creates the impression among its employees that it is watching or spying on their union activities, employees' future union activities, their future exercise of Section 7 rights tend to be inhibited." *Robert F. Kennedy Medical Center*, 332 NLRB 1536, 1539 (2000).

In response to Thurmond's testimony, Adewolu simply denied that he told Thurmond that he was aware of the Union meeting at McDonald's restaurant. He gave no testimony as to whether he had telephone or personal conversations with Thurmond during this same period of time. He denied that he knew anything about the Union's organizing efforts before January 10, 2008 when he received written notice from the Board. In contrast to Adewolu's generalized denial, Thurmond provided a detailed and specific account of his conversation with Adewolu after the December 11, 2007 Union meeting. Based upon the overall testimony and demeanor of the witnesses, I found Thurmond's testimony to be more credible. Accordingly, crediting the testimony of Thurmond, I find that Adewolu's statement created an impression of unlawful surveillance in violation of Section 8(a)(1) of the Act as alleged in complaint paragraph V (c).

During his conversation with Thurmond on January 4, 2008, Adewolu again brought up the subject of the employees' union organizing. Adewolu not only questioned why the nurses would want the Union, but also asserted that it would gain them nothing. Adewolu warned Thurmond that his union support could result in retaliation and his being blackballed by other employers and specifically by Jewish-owned facilities. During his testimony, Adewolu simply stated that he had not told Thurmond that he should not cry for the Union because he could be blackballed by the Jewish nursing home owners. Adewolu did not confirm or deny that he spoke with Thurmond on January 4, 2008 or otherwise talked with him about whether he wanted to work additional overtime. For the reasons that I have discussed more fully below, I do not credit the testimony of Adewolu. Crediting Thurmond's testimony, I find that Respondent, acting through Adewolu, unlawfully threatened to blackball

employees because they engaged in Union activities as alleged in complaint paragraph V (h).

(h) Whether respondent unlawfully terminated Thurmond

(1) Respondent's asserted reasons for Thurmond's discharge

Respondent documented the basis for Thurmond's discharge in two separate termination notices; both of which are dated January 7, 2008. There is no evidence that either form was ever issued to Thurmond. Both notices list 13 potential reasons for which an employee may be disciplined. None of the boxes are checked on either document and the only information concerning the basis for the discharge is included in a segment of the form entitled: "Describe what happened." One form contains the following handwritten section:

> Michael made a comment to a co-worker "History will repeat itself." He and his co-worker used to work together at another facility and due to this history, she felt threatened by his statement and called the police. He admitted to administrator that he made the comment but he was talking about patient care. He is being discharged for threatening a co-worker.

The second form containing a separate handwritten note includes the following:

> Michael Thurmond has been instructed on several occasions to follow the proper chain of command. He was asked by Administrator to allow her the opportunity to complete an investigation regarding a conflict with a co-worker. He failed to allow her the opportunity to complete investigation. He instead called the Director of Operations on Sunday January 6, 2007. He is being discharged for failure to follow reasonable instructions.

(2) General Counsel's *prima facie* case

The record evidence reflects that Thurmond engaged in activities in support of the Union and that his support was known to Respondent prior to his discharge. Although Adewolu and Administrator Williams allege that they were unaware of any Union organizing prior to January 10, 2008, their testimony is contradicted by credible record evidence. Harper credibly testified that only a day after the December 6, 2007 Union meeting, Adewolu confirmed that he knew that Thurmond attended the meeting and threatened Thurmond's termination. Later on December 11, 2007, Adewolu specifically confronted Thurmond with his attendance at the meeting and told Thurmond that he knew what had been discussed at the meeting. Finally, on January 4, and only three days before Thurmond's discharge, Adewolu threatened Thurmond that he could be blackballed by other Jewish-owned nursing homes. Clearly, not only did Adewolu establish Respondent's knowledge of Thurmond's Union activities, but also animus toward those activities.

Further evidence of Respondent's discriminatory motive in terminating Thurmond is found in the timing of his discharge as well as the pretextual and shifting reasons for his

discharge. When Respondent submitted a position statement in response to the Union's initial charge, Respondent asserted that Thurmond was discharged for threatening to harm another employee. There was no reference to his failure to follow the chain of command. At hearing, however, Administrator Williams asserted that his failure to follow the chain of command was also a basis for his discharge. She acknowledged that she had prepared the second disciplinary notice in an attempt to "be thorough."

The discharge notice relating to the alleged threat to another employee describes Thurmond's threat as telling Harris that "history will repeat itself." In testimony, however, Administrator Williams expanded the alleged threat in describing her telephone conversation with Thurmond. Administrator Williams testified that during her conversation with Thurmond, she asked Thurmond what he had meant by telling Harris that history would repeat itself. She alleged that Thurmond explained: "That means she got her ass kicked at Gallesburg Terrace[7] and she's going to get her ass kicked again here." Administrator Williams acknowledged that she had not included this additional statement by Thurmond in her affidavit given to the Board during the investigation of the case. Later in her testimony in describing her conversation with Thurmond, Administrator Williams contradicted her earlier testimony and admitted: "History will repeat itself is exactly the term that he kept using. As far as the part about getting her ass kicked, I don't know where that came from. He said he told her history will repeat itself." Although Administrator Williams ultimately corrected her testimony, her temporary embellishment must be considered in evaluating the validity of Respondent's asserted reasons for terminating Thurmond.

The Board and the Courts have previously found that an employer's shifting reasons for discharge may provide evidence of an unlawful motivation. *NLRB v. Henry Colder Co*., 907 F.2d 765, 769 (7th Cir. 1990); *Abbey's Transportation Services v. NLRB*, 837 F.2d 575, 581 (2d Cir. 1988). In this case, Williams' creation of two discharge notices and her attempt to expand Thurmond's alleged threat during her testimony indicate just such a "shifting of reasons" from which discriminatory motive may be inferred.

Administrator Williams asserts that Thurmond was discharged in part because of his failure to follow the chain of command and to give her an opportunity to investigate the incident. Ironically, however, there is no evidence that Administrator Williams made any attempt to investigate what really occurred on January 5. Cheatem credibly testified that when she presented Administrator Williams with the employee statements concerning the January 5, 2008 incident, Administrator Williams confirmed that she had already decided to terminate Thurmond. During her testimony, however, Williams alleged that she reviewed those notes before she made the decision to terminate Thurmond. While she claims that she read the statements, there is no evidence that she spoke with any of the employees about the incident after reading such statements. Even without further investigation, Administrator Williams was aware that Harris cursed on the floor and was not blameless in the incident. Although she asserts that she gave Harris a verbal warning for having cursed on the floor, no other evidence was submitted in support of this assertion. Harris did not testify and no written

[7] Granting Respondent's motion to correct, the transcript is corrected to "Halsted Terrace."

documentation of the warning was provided.

Accordingly, Administrator Williams' failure to investigate the alleged reasons for Thurmond's discharge demonstrate that those reasons were not determinative in the decision and indicates that the discharge would have occurred regardless of the truthfulness of Thurmond and Cheatem's account. The failure to conduct a meaningful investigation and to give an employee the opportunity to explain has been found to be clear indicia of discriminatory intent. *K & M Electronics*, 283 NLRB 279, 291 (1987). An employer may not assert a reasonable belief that an employee has engaged in misconduct based upon an unfair investigation. *Midnight Rose Hotel & Casino*, 343 NLRB 1003, 1004 (2004). In this case, it is apparent that Respondent seized the opportunity to rid itself of one of the employees who had shown interest in the Union. There is no evidence that Williams attempted to obtain any further information from either Thurmond or any of the other employees who witnessed the incident. She admitted that she did not see Harris's police report until after Thurmond's termination. Interestingly, although Respondent submitted a copy of the police report into evidence, there is no evidence that the police took any further action or even talked with Thurmond about the incident.

Furthermore, Respondent has not shown that it would have terminated Thurmond in the absence of his union activity. Although Respondent claims that Thurmond was discharged in part for his failure to follow the chain of command, Williams admits that no other employee has ever been terminated for "breaking" the chain of command. She also admitted that while other employees had been terminated for physical fights at the facility, no other employee had ever been terminated for a verbal threat.

Although Respondent has presented an otherwise legitimate basis for Thurmond's discharge, the total record supports a finding that Respondent's explanation for the discharge is pretextual. I therefore may not only infer that there is another motive for the discharge, but that the real motive is one that Respondent seeks to conceal. *Laro Maintenance Corp. v. NLRB,* 56 F.3d 224, 229 (D.C. Cir. 1995); *Shattuck Denn Mining Corp. v. NLRB*, 362 F.2d 466, 470 (9th Cir. 1966). Accordingly, I find that Respondent terminated Michael Thurmond in violation of Section 8(a)(1) and (3) of the Act.

G. The Discipline and Discharge of Kalea Williams

The complaint alleges that Respondent unlawfully issued a disciplinary warning to Kalea Williams on March 20, 2008, and then unlawfully terminated her on March 27, 2008. Counsel for the General Counsel asserts that Respondent issued the disciplinary warning and the discharge because of Williams' protected and union activity.

1. Williams' union activity

As discussed above, Williams contacted the Union in mid-November 2007 concerning representation for the nurses at Respondent's facility. It is undisputed that she collected signed union authorization cards from 10 other nurses. She attended two union meetings at

restaurants within the vicinity of Respondent's facility. As discussed above, Adewolu engaged in multiple conversations in which he interrogated Williams about her union activity and threatened employees with reprisals for their union and protected activity. Additionally, during these conversations he also let her know that he was aware of the union meetings and the subjects being discussed. Williams testified that Adewolu treated her differently after December 6, 2007. She recalled that there were times when he passed her in the halls that he would refer to her as the union organizer or the union leader. No witnesses corroborated her testimony.

2. Kalea Williams' disciplinary warning

On March 20, 2008, Kalea Williams was given a verbal warning for leaving the facility on March 14 at approximately 8:15 p.m. and not returning to the facility until approximately 11:30 p.m. Williams was also warned because she failed to punch out when she left the facility. There is no dispute that during Williams' absence from the facility, a patient under her responsibility pulled out his G-tube; requiring his transfer to the hospital.

On March 14, 2008, LPN Oluyemi Agunbiade (Agunbiade) and Kalea Williams were working both the 3:00 p.m. to11:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift on the second floor. At that time, Agunbiade had only been an employee at the facility for approximately three months. Agunbiade recalled that she finished her medication rounds at approximately 7:30 p.m. She was in the dinning room eating at approximately 7:45 or 8:00 p.m. when CNA Tameka Hoggas reported to her that a patient had pulled out his feeding tube. Hoggas also told Agunbiade that Kalea Williams was out of the building on break. Agunbiade contacted the patient's doctor. Although she paged Williams, there was no response. Betty Wilkes, the nurse assigned to the first floor, came to help her with the patient. When Wilkes came to the second floor to assist Agunbiade, she was talking with Kalea Williams on her cell phone. Wilkes told Agunbiade that Williams would soon be on her way back to the building. Agunbiade testified that she did not see Kalea Williams, however, until sometime after 10:45 p.m. She estimated that it may have been as late as 11:30 p.m. Prior to Williams' leaving, Williams had not told her that she was going on break or even that she was leaving the second floor.

Kalea Williams does not dispute that she took a two-hour break and that she left the facility without notifying Agunbiade that she was doing so. She asserts that prior to leaving for break at approximately 8:15 to 8:30 p.m.; she gave her keys to the narcotics box to Wilkes who was working on the first floor. She asserts that she asked Wilkes to cover for her because she trusted Wilkes with her patients. Williams testified that she returned to the facility after her break at approximately 10:30 or 10:45 p.m. Williams explained that when she first returned after her break, she had to first deal with the patient who had pulled out the G-tube before she could retrieve her keys from Wilkes. She estimated that she retrieved the keys after 11:00 p.m. She asserted, however, that she saw Wilkes when she first returned from her break and that it had been Wilkes who had informed her of the problem with the patient's G-tube. Williams admits that she did not, however, see Agunbiade until approximately 12:30 to 1:00 p.m.

Kalea Williams denied knowing whether Respondent had a policy about employee breaks. She also testified that she had no assigned time to take a break and that she did not have a practice of clocking out for breaks. Williams admits that she took a two-hour break on March 14, 2007 and asserts that nurses are allowed to do so when they work double shifts. She also admitted on cross-examination, however, that no one has ever told her that if she worked a double shift, she could take two hours of break time. Administrator Williams testified that because Kalea Williams works double shifts on March 14, 2008, she was entitled to an hour break for each shift based upon a half hour for lunch and two 15-minutes breaks. Administrator Williams denied, however, that Kalea Williams was allowed to combine all the breaks into one two-hour break. She pointed out that this was especially true for a nurse working on the skilled floor of the nursing care facility.

3. Conclusions concerning Williams' disciplinary warning

General Counsel asserts that there is no record evidence that any other nurse has ever been disciplined for combining all his or her breaks when working a double shift. Thurmond testified that while he had never combined his breaks in such a manner, he believed that other nurses had done so. He testified that he had seen nurses come in for their shift and then leave for breakfast. He identified Shanina Mitchell and Lavern Harper as nurses who had taken extended breaks. Harper recalled that she had once taken an extended break and had told Adewolu that she was going to do so before leaving the building. This testimony would certainly indicate that there have been some instances when nurses have taken extended breaks and even with management knowledge. Nevertheless, there is no evidence that Respondent has tolerated conduct comparable to that demonstrated by Williams in this instance. There is no dispute that she had joint responsibility for the skilled care patients on the second floor on March 14, 2008. She left the facility for at least two hours without notifying the other nurse who was also caring for these patients. While she asserts that she informed Wilkes on the first floor that she was leaving, Wilkes did not testify or corroborate her testimony. Although Williams asserts that she did not leave the facility until 8:15 or 8:30, there are no other witnesses who corroborate her testimony. Agunbiade credibly testified that she was unable to find Williams prior to 8:00 p.m. Although Williams asserts that she returned to the facility at 10:30 or 10:45 p.m., she admits that she did not see Agunbiade until 12:30 p.m. or 1:00 a.m. Inasmuch as they shared a common nursing desk and all their patients were located on the same floor, it is surprising that Williams would not have seen Agunbiade earlier, had she actually been back in the facility.

I also note that while Agunbiade also worked double shifts, there is no evidence that she took a two-hour break. Although Williams may have worked double shifts, her leaving her patients unattended for at least a two-hour period is unconscionable. By March 14, 2008, there is no question that Respondent was aware of the Union's organizing efforts. As discussed above, Respondent had already unlawfully terminated Harper, Rounds, and Thurmond. Even with Respondent's knowledge of Williams' union activity, her conduct was such that she would have been disciplined even in the absence of any union activity. Respondent, in fact, could have reasonably terminated her on the basis of her abandonment of

patients. Respondent did not do so, however, and simply issued her a verbal warning. Accordingly, I find that even though Respondent had knowledge and demonstrated animus, Respondent has met its burden of showing that it would have disciplined Williams in the absence of any union or protected activity.

4. Kalea Williams' termination

(a) Williams' protected activity

Not only does General Counsel assert that Williams engaged in union activity, but also that she engaged in protected concerted activity prior to her discharge. Kalea Williams testified that prior to March 25, 2008; a high-risk patient was admitted to the facility that appeared to have an infectious disease. Williams discussed her concerns with nurses Bell and Wilkes as well as CNA Cheatem. On March 25, 2008, Williams then wrote letters to both Adewolu and Administrator Williams concerning the patient's condition and the potential risk to the staff. In her letter to the Administrator and the Director of Nursing, Williams explained that the patient's respiratory condition would inevitably bring a risk of infection to not only other patients but also the staff and the staff's families. William also emphasized that the nurses did not have proper equipment to care for a patient in such condition. In a March 26 nurses' meeting, Rhonda White accused Kalea Williams of showing the letters to other staff members. During her testimony, Williams conceded that while the colonized infection must be treated as though it is contagious, the condition may not be contagious[8] and the need for the patient's isolation may not be clear-cut. White denied that she took any adverse action toward Williams for having written the letter to management. There was no evidence presented that either White, Adewolu, or Administrator Williams made any comments to Williams because of this letter.

(b) Respondent's basis for terminating Williams

Administrator Williams confirmed that she made the decision to terminate Kalea Williams based upon three reasons. On March 27, 2008 Administrator Williams, Adewolu, and Rhonda White met with Kalea Williams to inform her of her discharge. Administrator Williams read through two separate discharge notices that listed three separate bases for the discharge. Kalea Williams refused to sign the notice of discharge forms and denied any misconduct. The following reasons were given for Williams' discharge:

(1) Failure to properly transfer a patient to the hospital

The disciplinary action report included the allegation that on March 17, 2008, Williams failed to properly transfer a patient to the hospital. The document specified that no nursing note was written by Williams regarding the patient's transfer to the hospital.

[8] White testified that she was actually the nurse who had admitted the patient to the facility. She confirmed that before she admitted the hospital, she had verified with the hospital nurses that the patient did not require isolation.

Williams asserts that on that day, one of her patients was scheduled to leave the facility and a new patient was scheduled to come into the facility to occupy the departing patient's bed. When the newly admitted patient arrived at the facility, Williams transferred the patient awaiting discharge across the hall to an area under another nurse's responsibility. Adewolu testified that he told Williams to move the patient across the hall to free up the room for an incoming patient. Williams estimates that the patient remained in the facility for approximately two more hours before discharge. Williams asserts that she did not complete the charting of the patient's discharge to the hospital because the patient became the responsibility of the other nurse. On either March 18th or 19th, Adewolu asked Williams why she had not completed the discharge paperwork for the transferred patient. Williams told him that the transferred patient was no longer "her" patient at the time that the patient left the building. Adewolu told her that the patient was still her responsibility even though the patient was moved across the hall and he directed her to write a discharge note for the chart. Administrator Williams testified that she spoke with Kalea Williams about her failure to add the transfer documentation to the nurse's notes. Administrator Williams explained that initially, Kalea Williams asserted that another nurse transferred the patient to the hospital. Administrator Williams then asked if that was correct, why did Kalea Williams sign the patient information and transfer form. Administrator Williams recalled that Kalea Williams then acknowledged that technically the transferred patient remained as her patient, however, another nurse had helped her finish the transfer. The copy of the March 17, 2008 patient information and transfer form that was admitted into evidence as Respondent's Exhibit No. 17 does not contain a full copy of the original full page. The bottom of page contains a portion of the date and a portion of the signature. While Kalea Williams' name is not fully identifiable at the bottom of the page, Kalea Williams did not deny that it was her signature or contradict Administrator Williams in rebuttal testimony. Adewolu testified that it is important that there is documentation about the patient's condition prior to the patient leaving the facility. He explained that even if another nurse gives the patient to the ambulance driver, it is the responsibility of the patient's primary nurse to document the doctor's orders and the patient's condition. Williams admitted that while Adewolu told her to move the patient across the hall, he had not told her that the patient was no longer her responsibility.

(2) Failure to start a G-tube feeding at the proper time

Kalea Williams' discharge documentation also included an allegation that Williams failed to start a patient's G-tube feeding at the proper time as well as a complaint by the patient's family. Williams recalled that the patient in question was scheduled for her G-Tube feeding at 4:00 p.m. on March 14, 2008. The tube feeding schedule for patients provides that 16-hour feedings are to start at 4:00 p.m. daily and run until 8:00 a.m. the next day. Respondent submitted into evidence the visitor sign-in sheet showing that the patient's husband arrived at the facility at 5:30 p.m. When he discovered that his wife's feeding tube had not been started, the patient's husband complained to Adewolu. Adewolu was making rounds when the patient's husband found him and asked him to come to the patient's room. Adewolu recalled that it was 6:30 and the patient was not receiving the G-tube feeding. Adewolu explained that this particular patient was diabetic and that there was the risk that the patient might go into a diabetic coma without timely feeding. He recalled that he immediately

paged Kalea Williams to come to the floor. When she arrived, she told him that it was very rude of him to page her as he had. Adewolu questioned how he could be rude when she had starved a patient for two and a half hours with no feeding. Kalea Williams' only explanation for her failure to start the G-tube feeding was the tour that she was giving to a potential patient's family. Adewolu testified that Williams did not have permission to leave the floor to conduct such a tour.

While Williams asserts that there is a time window before and after the scheduled feeding time, she admits that she did not start the patient's gastrointestinal feeding during the allowed window period. She asserts that she did not start the feeding because she was checking other patients and giving a tour of the facility to a potential patient's family. She acknowledges that because there was not an Admissions Director, she "took it upon" herself to give the tour to the facility visitors. In contrast to Williams, Adewolu testified that there is no policy that allows a window in which the feeding can be started. He explained that if the feeding is scheduled at 4:00, it is to be started at 4:00.

(3) Failure to carry-out admission process for re-admitted patient

Williams' discipline notice also documents that she failed to carry out the admission process on a re-admitted patient and that the patient did not receive the medications that were ordered by the physician. Administrator Williams confirmed that Kalea Williams' discharge was based in part upon her failure to complete the physician's orders sheet on March 17, 2008 when the patient was admitted to the nursing care facility.

Williams confirmed that when a new patient is admitted to the nursing home from the hospital, the nurse contacts the physician for the patient's orders. The orders are written on the physician order sheet and the medication orders are faxed to the facility's pharmacy. She acknowledged that if the medication order is not on the physician's order sheet (POS), the patient will not receive the medication. Williams testified that when the patient in issue arrived at the facility at approximately 10:00 to 10:30 p.m., she contacted the primary physician to let him know that the patient was in the facility with new medication orders from the hospital. Her admission note in the patient's file, however, indicates that the patient was admitted at 8:45 p.m. on March 17, 2008. Williams testified that the doctor told her that he planned to come to the facility the next morning and instructed her to suspend the orders until he arrived. She acknowledged, however, that the doctor gave her orders to give the patient the antibiotic therapy because the medication accompanied him from the hospital. She does not dispute that she did not document the patient's medication orders on the POS upon the patient's admission on March 17. She denied that the doctor told her to continue the hospital orders until he visited the facility. While she asserts that she later completed a POS for this patient, she did not indicate when she did so. Williams acknowledged that the POS submitted into evidence by Respondent is not in her handwriting.

Administrator Williams testified that in her investigation of the matter, she personally spoke with the physician. She asserts that the doctor confirmed that he spoke with Kalea Williams and told her that he would be in the facility on March 18, 2008 to verify the orders.

Administrator Williams explained that based upon her discussion with the doctor, it was her understanding that the doctor meant for the hospital orders to be carried out. Administrator Williams also pointed out that Kalea Williams' admission notes on March 17, 2008 confirm that she received orders from the doctor because of Williams' reference to performing a procedure pursuant to the doctor's order. She asserts that the note verifies that Kalea Williams carried out some of the doctor's order and yet failed to complete the POS as required on March 17, 2008. Adewolu also testified that he spoke personally with the doctor and confirmed that the doctor instructed Williams to continue the medication orders that came with the patient from the hospital. Adewolu confirmed that the patient in question was seriously ill and was on a ventilator and had a G-tube for feeding. Respondent submitted personnel records to demonstrate that other nurses had been terminated for similar offenses. The records show that an employee was terminated in September 2007 for failing to maintain a feeding pump and thus starved a resident for two hours before the error was detected. The employee had previously been suspended for negligence. Another employee was terminated in June 2005 for allowing a patient's tube feeding to run continuously for the entire shift. A third employee was terminated in August 2005 for also failing to start the tube feeding properly. A fourth employee was terminated in June 2005 for failing to order a patient's medication upon admission. In August 2000, a respiratory therapist was suspended for two days for giving a medication without a physician's order.

(4) Failure to comply with the 72-hour documentation policy

The discharge documentation also charges Williams with a failure to follow the 72-hour charting policy for a newly admitted patient. Williams explained that the policy requires charting every 8 hours for the first 72 hours after a patient is admitted to the facility. Williams asserts that while she did not chart in the patient's file, she made anecdotal notes on the patient. She asserts that she had not made the regular charting notes because the admission notes were in error and the chart was going to be destroyed and redone. To show that other nurses have failed to properly chart within the 72-hour period, General Counsel submitted into evidence a page from the chart of a patient who was newly admitted on February 2, 2008. Williams pointed out that although the patient was admitted at 10:00 p.m., there was no nurse's documentation for the subsequent 7:00 a.m. to 3:00 p.m. shift and the 11:00 p.m. t0 7:00 p.m. shift.

(5) Failure to give insulin to a patient

The discharge notice also reflects that there is no documentation to show that Williams gave insulin to a patient on March 25, 2008 as ordered by the doctor. Williams does not deny that she failed to give the patient the insulin. She testified that frozen insulin was the only insulin available at the facility pharmacy. She said that she had not given it to the patient because she understood that the properties of insulin are changed after freezing. Williams testified that she documented the problem with the insulin and asked fellow LPN Shanina Mitchell to witness her documentation. In contrast, White testified that Respondent did not store frozen insulin.

(c) Conclusions concerning Kalea Williams' termination

There is no dispute that Kalea Williams was terminated after Respondent had clear knowledge of the Union's organizing efforts. Having credited Kalea Williams concerning her conversations with Adewolu, I have also found that Adewolu knew about the Union's organizing efforts prior to January 10, 2008. Respondent made good on Adewolu's threats to Williams, Harper, and Thurmond and terminated employees Rounds, Harper, and Thurmond within days of threats to terminate employees involved in the Union's organizing efforts. Thus, at the time of Kalea Williams' discharge, there was sufficient evidence of knowledge and animus to create an inference of discriminatory motive in Respondent's termination of Williams. By March, Respondent would reasonably have known that Williams was instrumental in contacting the Union and setting up contacts for the Union with interested employees. Crediting her testimony concerning the early threats by Adewolu, there is no doubt that Respondent likely welcomed the opportunity to rid itself of Kalea Williams. The remaining issue, however, is whether Respondent would have retained her even in the absence of her protected[9] and union activity.

As discussed above, the record indicates that Respondent's reasons for discharging Rounds, Harper, and Thurmond were pretextual. In terminating Thurmond, Respondent rejected the information provided by other employees and quickly terminated him without any attempt to ascertain the facts. Harper's discharge was based in large part on incomplete and erroneous records. In discharging Rounds, Respondent claimed to rely upon Rounds' call-off's that occurred over six months before her discharge and fired her for her actions that were permissible under Respondent's own attendance policy. Thus, the pretextual nature of those three discharges is readily apparent and supported by the record evidence. Unlike the circumstances with Rounds, Harper, and Thurmond, Respondent asserts reasons for Williams' discharge that do not appear to be pretextual.

Williams was terminated in part because of her failure to complete the paperwork that is required by the nurse when a patient is discharged to the hospital. As Adewolu explained in his testimony, it is important that there is documentation about a patient's condition prior to the patient's discharge and transfer to the hospital. The undisputed evidence reflects that Williams began the discharge paperwork for the patient in question. She does not dispute, however, that she never completed the discharge summary. She maintains that she did not have to do so because the patient was moved across the hall for a few hours before leaving the facility. Williams admits that while Adewolu told her to move the patient across the hall, he did not tell her that the patient was no longer her responsibility. Williams' argument that she

[9] Although General Counsel submits that Williams' letter to Adewolu concerning the potentially infectious patient was also protected concerted activity, the overall evidence does not demonstrate a nexus between her discharge and the letter. White admitted the patient to the facility and is the only member of management alleged to have even mentioned the letter to Williams. Although White may have harbored some resentment toward Williams for questioning her judgment in admitting the patient, there is insufficient evidence to show that the letter was a motivating force in Williams' discharge. Additionally, as discussed further, Respondent has demonstrated that it would have terminated Williams even in the absence of her protected concerted activity or her union activity.

was no longer responsible for documenting the patient's condition because she was not the nurse who actually released the patient to the ambulance service is somewhat insincere. Certainly, it is reasonable that it would be the patient's condition necessitating the transfer to the hospital that required documentation. It is logical that Williams would have been far more knowledgeable about the patient's condition in this regard than the nurse who simply released the patient to the ambulance service. The overall record supports an inference that Williams simply avoided documenting the discharge information by relying upon a technicality as to where the patient was situated while awaiting discharge.

A second basis for her discharge was her failure to start a patient's G-tube feeding at the proper time. Williams does not dispute that she failed to do so. The record reflects that the patient's husband came to the facility and found that his wife's scheduled feeding had been delayed by as much as an hour and a half. He sought out the Director of Nurses to complain about the lack of attention to his wife. When Adewolu checked into the situation, he found that Williams was not even on the skilled care floor, but was giving a tour of the facility to a prospective family. Williams did not assert that giving a tour was part of her responsibility or that any member of management asked her to leave her patients and duties to conduct such a tour.

Williams asserts that there is a "window" of time in which a patient may be given their G-tube feeding and that it is not unusual for a nurse to feed the patient outside the feeding schedule window. In support of Williams' testimony, General Counsel submitted into evidence a portion of another patient's medication record that reflected a schedule for daily gastrointestinal feeding at 4:00 p.m. The particular page that listed the scheduled gastrointestinal feedings did not have any nurses' initials to show that the feeding was administered to the patient on March 12, 16, and 18. Williams was not the nurse who was responsible for the patient on March 12, 16, and 18. Counsel for the General Counsel asserts that there is no evidence that the nurse or nurses who were responsible were terminated or otherwise disciplined for not giving this scheduled feeding. General Counsel urges that this disparate treatment is evidence of discriminatory motive in terminating Williams.

Certainly, the one-page document from the patient's MAR raises a question as to whether the patient was erroneously denied the scheduled feeding on March 12, 16, and 18. Because there is no other documentation from this patient's record, there is no way to determine whether these feedings may have been intentionally omitted because of the patient's medical condition on those days or based upon a physician's consultation that is documented elsewhere in the patient's record. Even if the patient was erroneously denied the G-tube feeding for those dates in issue, there is no evidence that anyone in management was aware of this medication error. These circumstances are easily distinguished from the existent facts in this case. There is no dispute that Adewolu was well aware that the patient did not receive her scheduled G-tube feeding because he was specifically alerted to the fact by the patient's husband. Without question, the failure to administer a patient's gastrointestinal feeding appropriately is a serious mistake for any nurse. The only evidence reflecting management's knowledge of such an error, however, involved Kalea Williams. There is no record evidence to show that management had knowledge or in any way tolerated other nurses

in neglecting the timely administration of the G-tube feedings. In fact, Respondent submitted into evidence records to show that other nurses have been terminated for improperly administering the gastrointestinal feeding procedure for patients. Accordingly, the overall record evidence supports a finding that Kalea Williams would have been disciplined for the G-tube feeding error, even if she had not engaged in any union or protected activity.

A third reason for Williams' termination involved a failure to carry out admission progress on a readmitted patient. Respondent asserts that Williams was terminated in part because she did not implement or document a doctor's medication orders. Williams acknowledged that when a patient is admitted to Respondent's facility from a hospital, the patient will arrive with orders. According to procedure, the nurse contacts the physician and verifies the orders. The nurse is then responsible for copying those orders to a physician order sheet and including the document in the patient's file. Williams acknowledged that this document is the facility's record of what medication the patient is to receive. She admitted that if the medication is not included on the physician order sheet, the patient will not receive the medication. Although she acknowledged that the patient had a very high acuity level with G-tube feedings, vent, trach, PICC line, and decubitus ulcers, she confirms that she did not record the patient's medications on the POS. She explained that when she spoke with the doctor on the evening of the patient's admission, he told her that he would be in the facility the next morning and to suspend the medications in the interim. Both Adewolu and Administrator Williams testified that during their investigation of this incident that they spoke with the doctor and found that he had not ordered the suspension of the patients' medications until he physically came to the facility. The physician did not testify and therefore provided no direct corroboration of Adewolu's and Administrator Williams assertions. Likewise, there was no physician testimony to corroborate Williams' testimony. Accordingly, without corroboration of either Williams or Respondent's witnesses in this regard, credibility may only be determined by looking at the reasonableness of the testimony given.

There is no dispute that the patient in issue required skilled care attention and was acutely ill. There is also no dispute that the admitting nurse is responsible for documenting the medication orders in order that medications can be ordered and administered to the patient. Williams justifies her failure to do so on the basis that the patient would not have needed the medications over the course of the night and that the medications could have been changed by the physician when he came to the facility. Although that might well have been the case, it was also a possibility that those medications may have been needed prior to the doctor's visit. It is feasible that the physician's visit may have been delayed for hours or even days. Nurses other than Williams may have needed a complete POS in the patient's record. With the possibility of varying circumstances and the patient's skilled care needs, it is inconceivable that a treating physician would have taken this kind of risk and authorized Williams to suspend the orders until he came to the facility. What appears more likely is that this was a task that Williams chose to omit. In fact, Williams demonstrated this same conduct in September 2007 and prior to engaging in any union activity. The record reflects that Williams received a warning on September 28, 2007 for failing to carry out the admission process on a re-admitted patient, which caused the patient to do without medication. Respondent also presented evidence that in June 2005, a nurse was terminated for failing to

order a patient's medication upon the patient's admission. Thus, not only has Respondent demonstrated that it has disciplined other nurses for engaging in similar conduct, but Respondent has previously disciplined Williams for engaging in the same conduct in the absence of any union activity.

Respondent has a policy that upon admission or readmission, a patient's vital signs should be checked during each shift for the first 72 hours. As one of the reasons for Williams discharge, Respondent asserts that Williams failed to comply with the 72-hour policy by documenting that she checked the patient's vital signs on her shift within the 72-hour period. Williams acknowledges that she did not record the vital signs in the patient's chart, because she anticipated that the patient's record would have to be corrected later. She asserts that she was waiting for the correction to be made before she recorded the vital signs so that she would not have to do the charting twice. On the face of this explanation, Williams' rationale seems quite similar to her asserted reason for not completing the POS upon the patient's admission. In both instances, Williams chose not to include documentation in a patient's file because she might have to duplicate her efforts at a later time.

Finally, Respondent bases its termination of Williams upon her failure to administer insulin to a diabetic patient. Williams asserts that she could not do so because the only insulin in the facility at the time was frozen and the drug properties of insulin are altered after freezing. Williams testified that she documented on the MAR that she had not given the insulin and why she did not do so. Although Williams asserts that CNA Shanina Mitchell observed this documentation, Mitchell did not testify. Even though Williams asserts that freezing insulin changes the effectiveness of the drug, she provided no explanation as to how or why the only insulin in the facility was frozen. Additionally, White testified without contradiction that Respondent does not store frozen insulin.

In summary, I have considered each reason given by Respondent for its termination of Williams. As discussed above, Williams does not dispute that she engaged in the conduct relied upon by Respondent. In each instance, she provides a rationale to explain why she did not follow the required nursing procedures. Respondent has provided evidence to show that Williams was previously disciplined for engaging in similar conduct and that other nurses have been disciplined for engaging in similar conduct. I do not find any of the stated reasons for her discharge to be pretextual. Using a dual motive analysis, the record supports a finding that Respondent would have terminated Williams even in the absence of union activity.

In reaching this decision, I am mindful of the fact that Williams professed to be the most active employee in the Union organizing efforts. I have credited her testimony in finding that Adewolu was aware of her activities and that she was the recipient of various statements that were violative of Section 8(a)(1) of the Act. My finding that she was a known union supporter and the target for Adewolu's unlawful statements may initially appear to be at odds with a finding that she was lawfully discharged. A closer analysis, however, suggests that Respondent's knowledge of her support for the Union actually diminishes the basis for finding a discriminatory discharge. As discussed above, Respondent's reasons for discharging Rounds, Thurmond, and Harper all appear to be pretextual. The timing and lack

of sound basis for their discharges indicates that the discharges were more likely a knee-jerk reaction to the Union's organizing and motivated by Respondent's desire to diminish the Union's support base within this 13-person bargaining unit.

On January 8, 2008, the Union filed a charge with the Board alleging five separate violations of the Act. Included in those allegations was the allegation that Respondent threatened Williams with discharge on December 14, 2008. Had there been any prior doubt by Respondent, the January 8, 2008 charge demonstrated that Williams was communicating with the Union. Thus, her ultimate discharge on March 27, 2008 occurred after the Union had already filed two initial charges and two amended charges. While the earlier discharges may have been impetuous and without foundation, Williams' discharge was based upon admitted conduct. Because of the Union's previous charges, Respondent must have known that Williams' discharge would also result in a charge by the Union. The very fact that Respondent terminated her despite the risk of an additional charge, lends support to a finding that Respondent did so based upon conduct that would otherwise result in discipline even in the absence of union activity.

Accordingly, I find that the General Counsel has failed to sustain the requisite burden of proof with respect to the discharge of Kalea Williams and I recommend dismissal of that allegation.

H. Credibility Determinations Concerning Alleged 8(a)(1)

The complaint alleges that during a period between November 2007 and January 4, 2008, Adewolu engaged in seventeen separate violations of Section 8(a)(1) of the Act. The complaint alleges that he repeatedly interrogated employees about their union activities, threatened employees with reprisals because of the union activities, and told employees that it would be futile for them to select the Union as their collective bargaining representative. He is also alleged to have said things to employees that created the impression that their union activities were under surveillance and to have promised employees rewards if they engaged in surveillance of other employees.

Respondent defends these allegations in part through the testimony of Rhonda White. White testified that Adewolu almost never talks with the LPNs without her presence. She explained that after a sexual harassment charge was brought against Adewolu, she was assigned to make sure that he did not have any one-on-one meetings or "hands-on" activities with the nurses. She asserted that because of her assignment, she was with him approximately 90 percent of the time. She denied that she ever heard him make any of the comments that are the subject of the 8(a)(1) allegations.

Adewolu denied that he had any knowledge of the union organizing prior to January 10, 2008 when he received written notice from the Board. When asked by the Respondent's representative (Learner) if he had told Kalea Williams that Lerner would fire anyone pushing for a union, he responded that he did not talk with Learner and didn't have Learner's number. Based upon questions from Respondent's representative, Adewolu went on to give blanket

denials for each alleged 8(a)(1) violation. When he was asked if he ever spoke with Learner about the Union, he again asserted: "No, I don't talk with you."

The record contains the testimony of employees Kalea Williams, Lavern Harper, and Michael Thurmond who described the various conversations with Adewolu in which he allegedly engaged in conduct violative of Section 8(a)(1) of the Act. Each of these witnesses described Adewolu's statements with specificity and detail. Despite his denials of the alleged violative statements, Adewolu never confirmed nor denied that he had conversations with those employees on the dates or in the circumstances they identified. For instance, Lavern Harper testified that Adewolu made some of the unlawful statements in late December when she was in the car with him driving to a restaurant after they had both worked late. Adewolu neither confirmed nor denied that the two of them went out to eat that day or worked late as she recalled. Michael Thurmond testified that Adewolu made the alleged statements to him during a telephone call concerning overtime and during a personal conversation in which Adewolu talked with him about overtime. Adewolu did not even address these conversations in his testimony. Overall, I found Kalea Williams, Harper, and Thurmond's testimony to be far more credible with respect to these alleged conversations. Adewolu's assertion that he could not have made these statements to employees about the Union and about Learner's response to the Union because he does not talk with Learner appears disingenuous. There is no dispute that during this time period; Learner functioned as the administrator for the facility. To assert that there was no communication between Learner and Adewolu is not credible. The overall record would lead me to conclude that Adewolu was very much aware that the Union was trying to organize the last group of unrepresented employees at Respondent's facility. It is reasonable that Adewolu sought to discourage the LPNs, telling them that they were not eligible to be in the Union and cautioning them as to what he believed that Learner would do in response to their organizing efforts. Within a month of his telling employees that Learner would not tolerate their Union activity, three of Respondent's 13 LPNs who had attended union meetings and signed union authorization cards were fired without warning. Accordingly, I do not credit Adewolu's denials and I find merit to each of the alleged 8(a)(1)[10] violations that are described in greater detail in this decision. Specifically, I find that during conversations with Williams, Thurmond, and Harper, Adewolu threatened employees with discharge and other unspecified reprisals if they engaged in union activity[11] and created an impression that employees' union activities were under surveillance[12]. He interrogated[13] employees about their union activity and informed employees that it would be futile for them to select the union as their bargaining representative[14]. In one instance he promised employees a reward if they engaged in surveillance of employees engaged in union activity.

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[10] Complaint paragraph V(d)(i) alleges that about December 14, 2007, Adewolu threatened employees with a lawsuit for engaging in union and/or protected concerted activities. There was no evidence in support of this allegation.

[11] *Regency Manor Nursing Home*, 275 NLRB 1261 (1985).

[12] *Tres Estrellas de Oro*, 329 NLRB 50 (1999).

[13] *P.B. & S. Chemical Co.*, 300 NLRB 764, 769 (1990).

[14] *Shane Felter Industries*, 314 NLRB 339 (1994).

I. Whether a *Gissel* Bargaining Order is Warranted

There is no dispute that as of November 18, 2007, 11 of the 13 LPNs had signed Union authorization cards authorizing the Union as their sole representative for purposes of collective bargaining with Respondent. The complaint alleges that at all times since November 18, 2007, based upon Section 9(a) of the Act; the Union has been the exclusive bargaining representative of the Unit employees. The complaint also alleges that the conduct alleged in the complaint is so serious and substantial in character that the possibility of erasing the effects of the unfair labor practices and of conducting a fair election by the use of traditional remedies is slight. The complaint further alleges that the employees' sentiments regarding representation, having been expressed through authorization cards would, on balance, be protected better by issuance of a bargaining order than by traditional remedies alone.

Under *NLRB v. Gissel Packing Co.,* 395 U.S. 575 (1969), the Board will issue a remedial bargaining order, absent an election, in two categories of cases. The first category is "exceptional" cases that involve unfair labor practices so "outrageous" and "pervasive" that traditional remedies cannot erase their coercive effects, and thus rendering it impossible to conduct a fair election. *Id*. at 613-614. The second category is "less extraordinary cases marked by less pervasive practices which nonetheless still have a tendency to undermine the majority strength and impede election processes." *Id*. at 614.

Without doubt, a *Gissel* bargaining order is an extraordinary remedy. The preferred course is to remedy the unfair labor practices with an election, once the atmosphere has been cleansed by traditional remedies. *Hialeah Hospital*, 343 NLRB 391 (2004); *The Jewish Home for the Elderly of Fairfield County*, 343 NLRB 1069 (2004). In determining whether a bargaining order is appropriate, "the Board examines the seriousness of the violations and the pervasive nature of the conduct, considering such factors as the number of employees directly affected by the violations, the size of the unit, the extent of dissemination among employees, and the identity and position of the individuals committing the unfair labor practices." *Abramson,* 345 NLRB 171, 176 (2006).

The Respondent's pattern of unfair labor practices as discussed above, by their nature and extent, had a strong tendency to undermine the Union's majority support, especially in a Unit as small as the 13 employees here. Beginning immediately after employees attended the first Union meeting, Respondent's Director of Nursing initiated an intensive effort to discourage employees from further support or interest in the Union. He interrogated employees about their Union support and he implied that their activities were under surveillance. He promised rewards if they would spy on their fellow employees' union activities. He continued to tell employees that it would be futile for them to organize, reminding them that the owner of the facility would not tolerate their attempt to organize. He not only threatened to discharge employees but also to blackball them in finding jobs elsewhere. Finally, as a further attempt to dissuade employees, Respondent then fired three of the Union supporters within a five day period without any warning. In doing so, Respondent rid itself of almost 25% of the Unit. Such egregious conduct was not lost on this small Unit

of employees and it is conduct that is likely to linger in the memories of all the employees who were spared discharge. In its recent decision in *Concrete Form Walls, Inc*., 346 NLRB 831 (2006), the Board found that a bargaining order was warranted after the employer's unlawful discharges affected 16 percent of the overall unit. In *Michael's Painting, Inc*., 337 NLRB 860, 861 (2002), a bargaining order was based in part on the employer's discharge of 5 employees in a 34-person unit.

The facts of this case reflect that all of the 8(a)(1) statements were made only by the Director of Nursing and were made during the period of time between November and the first few days of January, 2008. The discriminatory discharges occurred between January 2 and January 7, 2008. Thus, it is apparent that at the very least, Respondent engaged in conduct that has a tendency to undermine majority strength and impede an election process. The Board has found that "threats of job loss and the actual discharge of union adherents are 'hallmark' violations, which are highly coercive because of their potentially long-lasting impact." *National Steel Supply, Inc.,* 344 NLRB 973, 976-977 (2005). For the reasons cited above, I find that Respondent's conduct is such that it warrants a bargaining order under Category II of the *Gissel* standard. Therefore, to protect the sentiment of a majority of employees in favor of the Union as of November 18, 2007, as demonstrated by their authorization cards, a bargaining order is appropriate in this case. *NLRB v. Gissel Packing Co*., 395 U.S. 575 (1969); *Flexsteel Industries*, 316 NLRB 745 (1995).

J. Motions to Correct Transcript

Respondent's unopposed motion to correct the transcript, dated August 3, 2008, is granted and received into evidence as Respondent Exhibit 34. General Counsel's unopposed motion to correct the transcript, dated August 8, 2008, is granted and received into evidence as G.C. Exhibit 54.

Conclusions of Law

1. Regal Health and Rehab Center, Inc., Respondent, is an employer engaged in commerce within the meaning of Section 2 (2), (6) and (7) of the Act.

2. Service Employees International Union Healthcare, Local 4, is a labor organization within the meaning of Section 2(5) of the Act.

3. By threatening its employees with discharge and other unspecified reprisals for engaging in union activity, the Respondent violated Section 8(a)(1) of the Act.

4. By promising its employees that they would receive a reward if the employees engaged in surveillance of employees engaged in concerted activities, Respondent violated Section 8(a)(1) of the Act.

5. By telling employees that it would be futile for them to select the Union as their bargaining representative, Respondent violated Section 8(a)(1) of the Act.

6. By creating an impression among its employees that their union activities were under surveillance, Respondent violated Section 8(a)(1) of the Act.

7. By interrogating employees about their union membership, activities, and sympathies, Respondent violated section 8(a)(1) of the Act.

8. By threatening to blackball employees because they engaged in union activities, Respondent violated Section 8(a)(1) of the Act.

9. By discharging Lavern Harper, Diane Rounds, and Michael Thurmond, Respondent violated Sections 8(a)(1) and (3) of the Act.

10. By altering the working conditions of its employees by requiring that Licensed Practical Nurses issue disciplinary write-ups to Certified Nursing Assistants and to make room assignments for Certified Nursing Assistants, Respondent violated Sections 8(a)(1) and (3) of the Act.

Remedy

Having found that the Respondent has engaged in certain unfair labor practices, I find that it must be ordered to cease and desist and to take certain affirmative action designed to effectuate the policies of the Act.

The Respondent having discriminatorily discharged Lavern Harper, Diane Rounds, and Michael Thurmond, it must offer them reinstatement and make them whole for any loss of earnings and other benefits, computed on a quarterly basis from date of discharge to date of proper offer of reinstatement, less any net interim earnings, as prescribed in *F. W. Woolworth Co.*, 90 NLRB 289 (1950), plus interest, as computed in *New Horizons for the Retarded*, 283 NLRB 1173 (1987). General Counsel seeks compound interest computed on a quarterly basis for the discriminatees. Although the Board at one time referenced[15] its consideration of modifying its interest calculation procedures, there is no existing Board authority to deviate from the past practice of ordering the award of simple interest. *Rogers Corp.*, 344 NLRB No. 60, slip op. at 1 (2005). Accordingly, I do not recommend the award of compounded interest as requested by General Counsel.

Because I have determined that traditional remedies cannot erase the coercive effects of Respondent's unfair labor practices, I recommend that a bargaining order be granted.

On these findings of fact and conclusions of law, and on the entire record, I issue the following recommended:[16]

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[15] *Alaska Pulp Corporation*, 300 NLRB 232, fn. 4 (1990).

[16] If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the

Continued

ORDER

The Respondent, Regal Health and Rehab Center, Inc., Oak Lawn, Illinois, its officers, agents, successors, and assigns, shall:

1. Cease and desist from:

(a) Threatening employees with discharge and other unspecified reprisals for engaging in union activity.

(b) Promising employees that they would receive a reward if the employees engaged in surveillance of employees engaged in concerted activities.

(c) Telling its employees that it would be futile for them to select the Union as their bargaining representative.

(d) Creating an impression among its employees that their union activities are under surveillance.

(e) Interrogating employees about their union membership, activities, and sympathies.

(f) Threatening to blackball employees because they engaged in union activities.

(g) Discharging employees because they engage in union activities.

(h) Altering the working conditions of its employees in order to prevent employees from selecting the Union as their collective bargaining representative.

(i) In any like or related manner interfering with, restraining, or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act.

2. Take the following affirmative action necessary to effectuate the policies of the Act:

(a) Within 14 days from the date of this Order, remove from its files any reference to the unlawful discharges of Lavern Harper, Diane Rounds, and Michael Thurmond, and within 3 days thereafter notify the employees in writing that this has been done and that the discharges will not be used against them in any way.

(b) Within 14 days from the date of this Order, offer Lavern Harper, Diane

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Board and all objections to them shall be deemed waived for all purposes.

Rounds, and Michael Thurmond full reinstatement to their former jobs, or if those jobs no longer exists to substantially equivalent positions, without prejudice to their seniority or any other rights and privileges previously enjoyed. Make whole Lavern Harper, Diane Rounds, and Michael Thurmond for any loss of earnings suffered as a result of the discriminatory discharges in the manner set forth in the Remedy section of this decision.

(c) Preserve and, within 14 days of a request, or such additional time as the Regional Director may allow for good cause shown, provide at a reasonable place designated by the Board or its agents, all payroll records, social security payment records, timecards, personnel records and reports, and all other records, including an electronic copy of such records if stored in electronic form, necessary to analyze the amount of backpay due under the terms of this Order.

(d) Recognize, and on request, bargain with the Service Employees International Union Healthcare, Local 4, as the exclusive representative of the employees in an appropriate unit of Licensed Practical Nurses[17] concerning terms and conditions of employment and, if an understanding is reached, embody the understanding in a signed agreement:

(e) Within 14 days after service by the Region, post at its Oak Lawn, Illinois, facility copies of the attached notice marked "Appendix."[18] Copies of the notice, on forms provided by the Regional Director for Region 13, after being signed by the Respondent's authorized representative, shall be posted by the Respondent immediately upon receipt and maintained for 60 consecutive days in conspicuous places including all places where notices to employees are customarily posted. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. In the event that, during the pendency of these proceedings, the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent at any time since on or about November 1, 2007.

(f) Within 21 days after service by the Region, file with the Regional Director a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

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[17] The Union's petition filed on January 8, 2008, seeks to represent all full-time and part-time Licensed Practical Nurses (LPNs), excluding all other casual, full-time and part-time employees.

[18] If this Order is enforced by a Judgment of the United States Court of Appeals, the words in the notice reading "POSTED BY ORDER OF THE NATIONAL LABOR RELATIONS BOARD" shall read "POSTED PURSUANT TO A JUDGMENT OF THE UNITED STATES COURT OF APPEALS ENFORCING AN ORDER OF THE NATIONAL LABOR RELATIONS BOARD."

Dated, Washington, D.C.

Margaret G. Brakebusch
Administrative Law Judge

APPENDIX

NOTICE TO EMPLOYEES

Posted by Order of the
National Labor Relations Board
An Agency of the United States Government

The National Labor Relations Board has found that we violated Federal labor law and has ordered us to post and obey this notice.

FEDERAL LAW GIVES YOU THE RIGHT TO

Form, join, or assist a union
Choose representatives to bargain with us on your behalf
Act together with other employees for your benefit and protection
Choose not to engage in any of these protected activities

WE WILL NOT discharge or otherwise discriminate against any of you for supporting Service Employees International Union Healthcare, Local 4, or any other union.

WE WILL NOT threaten you with discharge or other unspecified reprisals because you engaged in union activity.

WE WILL NOT promise you rewards if you engage in surveillance of other employees' union activity.

WE WILL NOT tell you that it is futile for you to select the Service Employees International Union Healthcare, Local 4, or any other union.

WE WILL NOT create an impression that your union activities are under surveillance.

WE WILL NOT coercively question you about your union support or activities.

WE WILL NOT threaten to blackball you because you engaged in union activities.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights guaranteed you by Section 7 of the Act.

WE WILL, on request, bargain with the Union and put in writing and sign any agreement reached on terms and conditions of employment for our employees in an appropriate unit of Licensed Practical Nurses.

WE WILL, within 14 days of the Board's Order, offer Lavern Harper, Diane Rounds, and Michael Thurmond immediate and full reinstatement to their former jobs, or, if those jobs no longer exists, to substantially equivalent jobs, without prejudice to their seniority or any other

rights or privileges previously enjoyed.

WE WILL, within 14 days of the Board's Order, make Lavern Harper, Diane Rounds, and Michael Thurmond whole for any lost wages because of their discriminatory discharges.

WE WILL, within 14 days from the date of the Board's Order, remove from our files any reference to the unlawful discharges of Lavern Harper, Diane Rounds, and Michael Thurmond and **WE WILL**, within 3 days thereafter, notify them in writing that this has been done and that the discharges will not be used against them in any way.

REGAL HEALTH AND REHAB CENTER, INC.
(Employer)

Dated _____ By _____
(Representative) (Title)

The National Labor Relations Board is an independent Federal Agency created in 1935 to enforce the National Labor Relations Act. It conducts secret-ballot elections to determine whether employees want union representation and it investigates and remedies unfair labor practices by employers and unions. To find out more about your rights under the Act and how to file a charge or election petition, you may speak confidentially to an agent with the Board's Regional Office set forth below. You may also obtain information from the Board's website: www.nlrb.gov

The Rookery Building, 209 South LaSalle Street, Suite 900, Chicago, Illinois, 60604-1219
(312) 353-7570, Hours: 9:30 a.m. to 6:00 p.m.

THIS IS AN OFFICAL NOTICE AND MUST NOT BE DEFACED BY ANYONE

THIS NOTICE MUST REMAIN POSTED FOR 60 CONSECUTIVE DAYS FROM THE DATE OF POSTING AND MUST NOT BE ALTERED, DEFACED, OR COVERED BY ANY OTHER MATERIAL. ANY QUESTIONS CONCERNING THIS NOTICE OR COMPLIANCE WITH ITS PROVISIONS MAY BE DIRECTED TO THE ABOVE REGIONAL OFFICE'S COMPLIANCE OFFICER. (312) 353-7170.