

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD

SPECIALTY HEALTHCARE AND  
REHABILITATION CENTER OF MOBILE,

*Employer*

and

UNITED STEELWORKERS, DISTRICT 9,

*Petitioner*

CASE NO. 15-RC-8773

BRIEF AMICUS CURIAE ON BEHALF OF

AMERICAN HEALTH CARE ASSOCIATION &  
NATIONAL CENTER FOR ASSISTED LIVING

*and their Affiliates*

Alabama Nursing Home Association	Missouri Health Care Association
Alaska State Hospital and Nursing Home Association	Nebraska Health Care Association
Arizona Health Care Association	Nevada Health Care Association
Arkansas Health Care Association	New Hampshire Health Care Association
California Association of Health Facilities	New Mexico Health Care Association
Care Providers of Minnesota	New York State Health Facilities Association
Colorado Health Care Association	North Carolina Health Care Facilities Association
Connecticut Association of Health Care Facilities	North Dakota Long Term Care Association
Delaware Health Care Facilities Association	Ohio Health Care Association
District of Columbia Health Care Association	Oklahoma Association of Health Care Providers
Florida Health Care Association	Oregon Health Care Association
Georgia Health Care Association	Pennsylvania Health Care Association
Health Care Association of Michigan	Rhode Island Health Care Association
Health Care Association of New Jersey	South Carolina Health Care Association
Health Facilities Association of Maryland	South Dakota Health Care Association
Healthcare Association of Hawaii	Tennessee Health Care Association
Idaho Health Care Association	Texas Health Care Association
Indiana Health Care Association	Utah Health Care Association
Iowa Health Care Association	Vermont Health Care Association
Kansas Health Care Association	Virginia Health Care Association
Kentucky Association of Health Care Facilities	Washington Health Care Association
Louisiana Nursing Home Association	West Virginia Health Care Association
Maine Health Care Association	Wisconsin Health Care Association
Massachusetts Senior Care Association	Wyoming Health Care Association

AND

**ASSISTED LIVING FEDERATION OF AMERICA**  
*and its Affiliates*

Texas Assisted Living Association  
New York ALFA  
Michigan Assisted Living Association  
Tennessee ALFA  
South Carolina ALFA

**AMERICAN SENIORS HOUSING ASSOCIATION**

**LEADINGAGE**

**AND**

**THE ALLIANCE FOR QUALITY NURSING HOME CARE**



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## INTRODUCTION

Bert Lance, a native Georgian, was President Jimmy Carter's Director of Office and Management and Budget when in May 1977 he was quoted in Nation's Business:

Bert Lance believes he can save Uncle Sam billions if he can get the government to adopt a single motto: "If it isn't broken, don't fix it." He explains: "That's the trouble with government: fixing things that aren't broken and not fixing things that are broken."<sup>1</sup>

Thus did a homespun aphorism find its way into our national conversation. It has become, according to the late William Safire, "a source of inspiration to anti-activists."<sup>2</sup>

The signatories to this Amicus Brief, the American Health Care Association and National Center for Assisted Living (and its listed affiliate organizations), the Assisted Living Federation of America (and specified state chapters), the American Seniors Housing Association, and the Alliance for Quality Nursing Home Care, commend this "source of inspiration" to the National Labor Relations Board in reassessing Park Manor Care Center, 305 NLRB 872 (1992). Park Manor has well served employees, labor organizations, employers and—they should not be forgotten—long-term care facility residents. It has furthered the statutory purposes of the National Labor Relations Act. Park Manor has permitted employees to organize with reasonable ease, enabled unions and management to bargain collectively and administer day-to-day labor relations issues efficiently and has limited the risk of disruption to residents in their homes occasioned by labor disputes. While the amici have no quarrel with the review of Park Manor called for in Specialty Healthcare and Rehabilitation Center of Mobile, 356 NLRB No. 56

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<sup>1</sup> U.S. Chamber of Commerce, Nation's Business, May 27, 1977, attributed to Thomas Bertram (Bert) Lance in the Phrase Finder, <http://www.phrases.org.uk/meanings/if.it.ain't.broke.dont.fix.it.html>; Answers.com, <http://www.answers.com/topic/if.it.ain.t.broke.don.t.fix.it>; Wikipedia, <http://en.wikipedia.org/wiki/if.it.ain%27t.broke.don%27t.fix.it>. Mr. Lance also was quoted as having said this in the *Washington Post*, on December 23, 1976. See The Big Apple: "If it ain't broke, don't fix it," <http://www.barrypopik.com/index.php/new.york.city/entry/if.it/aint/broke.dont.fix.it>.

<sup>2</sup> Gregory I. Teitelman, "Random House dictionary of Popular Proverbs and Sayings," (Random House New York, 1996), quoted in Wikipedia, supra n. 1.

(December 22, 2010), that exercise should persuade the Board to preserve the salutary conditions and predictability that Park Manor has set in place. No provision of the National Labor Relations Act requires change.

The Board should leave well enough alone.

### **INTEREST OF THE AMICI CURIAE**

The American Health Care Association (AHCA) is the national representative of nearly 11,000 non-profit and proprietary facilities dedicated to improving the delivery of professional and compassionate care to more than 1.5 million citizens who live in skilled nursing facilities, subacute centers and homes for persons with developmental disabilities. The National Center for Assisted Living (NCAL) is a federation of state affiliates representing more than 2,700 non-profit and for-profit assisted living and residential care communities nationwide. NCAL is dedicated to promoting high-quality, principle-driven assisted living care and services with a steadfast commitment to excellence, innovation and the advancement of person-centered care. AHCA/NCAL's advocacy has caused these associations to participate as amicus curiae in court and administrative agency cases with significant and wide-ranging consequences for its members. Specialty Healthcare is such a case.

The Assisted Living Federation of America (ALFA) is the largest national trade association representing owners and operators of assisted living communities and the residents they serve. A primary function of the Assisted Living Federation of America and its state affiliates is to represent the interests of its members on issues of vital concern to the senior living community before Congress, the Executive Branch, state legislatures, and state regulatory agencies.

The Alliance for Quality Nursing Home Care (the "Alliance"), based on Washington, D.C., represents sixteen of the largest providers of post-acute and skilled nursing services in the United States. Its members own and operate approximately eighteen percent of the nation's nursing facilities, including facilities in 47 states. The Alliance focuses its efforts on advancing the quality of care and services in nursing facilities and assuring the government funding for those services is appropriate to meet the needs of those who require those services.

The American Seniors Housing Association (ASHA) is an independent non-profit organization based in Washington, D.C.. Members of ASHA are executives involved in the operation, development, and finance of the entire spectrum of seniors housing, including senior apartments, independent living communities, assisted living residences, and continuing care communities. ASHA's membership is both for-profit and not-for-profit operators. The Association's membership owns and/or manages an estimated 600,000 units of seniors housing in the U.S., with communities located in virtually all 50 states and Canada.

LeadingAge is an association of 5,500 not-for-profit organizations dedicated to expanding the world of possibilities for aging. These organizations, many of which have served their communities for generations, offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes. Together, LeadingAge and its members advance policies, promote practices and conduct research that supports, enables and empowers people to live fully as they age. As part of LeadingAge's advocacy, it participates as amicus in issues of concern to its members.

Because these organizations believe a change in the law as it has developed under Park Manor could adversely affect members, their employees and residents, they join with AHCA/NCAL in filing this brief amicus curiae.

### **SUMMARY OF ARGUMENT**

The Board today invites input on several questions. The Board majority suggests that experience under Park Manor Care Center, Inc., 305 NLRB 872 (1991) demonstrates some need to abandon the so-called “empirical” community of interest standard articulated there in determining bargaining unit composition. The NLRB proposes to replace this time-tested analysis with a bargaining unit rule, akin to the acute care hospital rule, section 103.30. However, the Board majority offers to adopt such a rule without benefit of Section 6 formal rulemaking. Alternatively, the Board suggests that single-job title units may be presumptively appropriate in long-term healthcare, and possibly all industries.

The organizations filing this amicus brief assert that the rule of Park Manor, and the traditional community of interest standard in general, provides a sound basis for unit determinations, and one that benefits purposes of the Act. Rejection of these criteria in favor of single-job unit determinations would result in wholesale proliferation of units and fragmentation of workplaces – consequences that Congress specifically sought to avoid. Similarly, there is no need for rulemaking; to the extent any rigid pattern should be deemed appropriate, formal rulemaking under the Administrative Procedure Act is the appropriate vehicle. The decision in Park Manor, and the case-by-case adjudication it prescribes, should be retained.

## POINT I

### THE BOARD FAILS TO SHOW GOOD CAUSE FOR ABANDONING THE PRAGMATIC COMMUNITY OF INTEREST TEST FOR LONG-TERM HEALTHCARE BARGAINING UNITS IN CALLING FOR A RE-EXAMINATION OF PARK MANOR

In 1991, the Board decided unanimously that in cases involving nursing homes and other non-acute (long-term) care facilities, it would henceforth follow an approach to determining bargaining units “utilizing not only ‘community of interest’ factors but also background information gathered during [the Board’s acute care hospital] rulemaking and prior precedent.” Park Manor Care Center, Inc., 305 NLRB 872, 875 (1991).<sup>3</sup> The Board reversed and remanded a decision by its regional director to exclude from a petitioned-for unit of service and maintenance workers the nursing home’s four licensed practical nurses (LPNs) whom the regional director, applying only a community of interest analyses, had found (appropriately) to be technical employees and separable.

The Board in Park Manor reviewed at length the 1987–1989 acute care hospital rulemaking proceedings. 305 NLRB at 874-876.<sup>4</sup> It observed that the rulemaking proceedings

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<sup>3</sup> The United States Court of Appeals for the Second Circuit has explained:

Under the community of interests standard, the NLRB finds that a bargaining unit is appropriate if the employees in the proposed unit are an “identifiable group with a community of interest that is sufficiently separate or distinct” from other employees to warrant separate representation. Allegheny General Hospital, 239 N.L.R.B. 872, 878 (1978), enforcement denied, 608 F.2d 965, 971 (3d Cir. 1979). See also Garden City Hospital (Osteopathic), 244 N.L.R.B. 778, 778 (1979) (the Board weighs such factors as “mutuality of interest in wages, benefits and working conditions; commonality of skills and supervision; frequency of contact with other employees; lack of interchange and functional integration; and area practice and patterns of bargaining.”)

N.L.R.B. v. The Long Island College Hospital, 20 F.3d 76, 78, n. 3 (2d Cir. 1994). See St. Francis Hospital, 265 NLRB 1025, 1029 (1982), a case anticipating the Board’s acute care hospital bargaining unit rule, 29 CFR 103.30 (“In cases arising outside the healthcare industry, the Board applies only a community-of-interest test, in which we examine the petitioned-for unit for shared job characteristics and common workplace concerns to determine whether that group of employees comprises an appropriate unit for bargaining.”).

<sup>4</sup> See 29 CFR Part 103; 52 Fed. Reg. 25142, 284 NLRB 1516 (July 2, 1987); 53 Fed. Reg. 33900, 284 NLRB 1527 (Sept. 1, 1988); 54 Fed. Reg. 16336, 284 NLRB 1579 (April 21, 1989).

identified certain similarities between acute care employment and employment in long-term healthcare establishments, but it also drew comparisons and contrasts. This examination, as well as the Board's consideration of earlier agency precedent abjuring the automatic exclusion of LPN technical employees from broader units, *id.* at 876-877, led the NLRB in Park Manor to conclude that its decision makers needed to avoid bargaining unit proliferation among long-term healthcare workers, even where a customary community of interest analysis might permit it. Its bargaining unit decisions for such workers, it announced, would follow this "pragmatic" or "empirical" community of interest approach. *Id.* at 875, 877.

For two decades, Park Manor has served the long-term healthcare industry well. Employers, unions and employees alike have adapted to it readily. Thousands of representation cases have been resolved in its wake without difficulty. No cry has been raised that Park Manor has unduly inhibited employees from organizing. Renewed rulemaking to address industry bargaining was not sought; and the Board has never instituted such proceedings. None of the parties in Specialty Healthcare called for an overhaul of Park Manor. Indeed, the only issue here appears to be whether Park Manor was properly applied by the Regional Director in directing an election only among certified nurses aides, and whether a corrective, if needed, should be administered by the Regional Director upon remand or by the Board itself. *Id.*, 356 NLRB No. 56 (Dec. 22, 2010), slip op. at 4 (Member Hayes, dissenting). Neither has any interested employer association or labor organization, as far as we know, called for change.

A "pragmatic" or "empirical" community-of-interest test that is accepted and workable has much to recommend it. Why, then, does the Board invite possible change? There does not seem to be any good answer.

The Board majority's expressed reasons for suggesting change are at odds with Park Manor, whose language it invokes in justification of possible change. The Board cites concern that a "special industry" rule for long-term healthcare is contrary to the "most basic principle of treating like cases alike in adjudication." Id. 356 NLRB No. 56, slip op. at 3. Further, it observes that the Board's standards for making unit determinations "have long been criticized as a source of unnecessary litigation," and not just for healthcare issues alone. Id. It floats a proposal for appropriate units based on a solitary job title. Citing American Cyanamid, 131 NLRB 909, 910 (1961), it also suggests the possibility of an adjudicated rule approving units that are "readily identifiable as a group whose similarity of function and skills creates a community of interest." 356 NLRB No. 56, slip op. at 2. Cf. Wheeling Island Gaming, Inc., 355 NLRB No. 127 (Aug. 27, 2010), slip op. at 1 (Member Becker, dissenting from the dismissal of a petition seeking a unit limited to casino poker dealers on the ground that "employees who do the same job at the same location" from the employees' perspective constitute "one of the most logical and appropriate units within which to organize for the purpose of engaging in collective bargaining.").

The majority in Specialty Healthcare notes correctly that the Board in Park Manor contemplated the possibility of future unit rulemaking. It would be based on the agency's decision-making experience and, if they arose, the emergence of "certain recurring factual patterns . . . [that] illustrate which units are typically appropriate." 305 NLRB at 875 (footnote omitted). This "contingent desire," however, did not contemplate the majority's proposed action here. First, it plainly contemplated deliberative, Section 6<sup>5</sup> formal rulemaking—not hasty rule-

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<sup>5</sup> Section 6 of the National Labor Relations Act provides: "The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of this Act." 28 U.S.C. Sec. 156.

by-adjudication. Second, consideration of the Board's experience under Park Manor meant that any rulemaking would necessarily reflect the Congressional mandate and the case law's underlying recognition of the need to avoid proliferation of units in the healthcare industry. It would not raise the prospect of smaller units based on job title or a particular skill. Healthcare, in this regard, differs from other industries in its greater need for stable labor relations and the avoidance of workplace disruption; and that need is just as pronounced in long-term care, if not more so, than elsewhere in the industry.

Third, the Board in Park Manor anticipated a rule that would formalize existing case law—reflecting the patterns and typicalities revealed by its subsequent decisions and influenced by that case. Proper rulemaking, then, would adopt Park Manor or something like it as a substantive regulation. A rule establishing a unit-by-title, or one akin to American Cyanamid, we are sure, was never contemplated in 1991; small, fragmented units were just the opposite of what Congress preferred for healthcare labor relations. It would undermine the very reason for the Board's actions in Park Manor.<sup>6</sup>

The concerns articulated by Congress are serious and reflect the profound national impact Board action in this case may have. Moreover, as the express intent of the legislature, these concerns should inform and direct the Board's interpretation of the Act. When enacting the 1974 amendments the Act, it is incontrovertible that Congress understood that NLRB unit determinations would have an impact upon the potential for labor disputes in healthcare institutions, and thus upon the interruption of vital services. Congress also understood that number and scope of such units could reasonably be expected to affect the cost and quality of

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<sup>6</sup> Moreover, the number of staff employed in long-term care facilities is generally far less than that of acute care hospitals. Proliferation of units in a long-term care facility would be expected to result in a single nursing home or assisted living center with multiple units of very few employees. Collective bargaining obligations for multiple small units present significant burdens for the healthcare employer, both in the costs of negotiations and in management's time. Further, multiple small units fragments employees' bargaining leverage.

healthcare services, the administrative burdens of facility management, as well as the representation efforts of labor organizations and the effectiveness of the collective bargaining process.

The reports of both the Senate and House committees on the amending bills included the identical Congressional directive: “Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry.” S. Rep. No. 766, 93rd Cong., 2d Sess., H.R. Rep. No. 1051, 93rd Cong., 2d Sess.

The House and Senate Committees expressed their approval of three contemporary Board decisions in which the NLRB avoided unit fragmentation: Four Seasons Nursing Center, 208 NLRB 403 (1974) (refusing to find a maintenance-only unit appropriate), Woodland Park Hospital, 205 NLRB 888 (1973) (unit solely comprised of X-ray technicians not appropriate), and Extendicare of West Virginia, 203 NLRB 1232 (1973) (finding a broad service and maintenance unit appropriate). *Id.*, see also T. Merritt Bumpass Jr., *Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and Its Implementation by the National Labor Relations Board*, 20 B.C.L. Rev. 867 (1979). Senators Robert Taft and Harrison Williams both indicated that the committee reports reflected the intent of Congress. 120 Cong. Rec. 13560, 9145 (May 7, 1974).

Taft, a co-manager of the bill, said that a “multiplicity” of bargaining units would cause administrative problems such as jurisdictional disputes, work stoppages, and increased costs of care due to wage competition between units. 120 Cong. Rec. 12944-45 (May 2, 1974). The Senator continued, “[i]f each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care.” *Id.* In a passage which is perhaps even more true today

than it was in 1974, Taft said

In analyzing the issue of bargaining units, the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage “leapfrogging” and “whipsawing.” The cost of medical care in this country has already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

Id. Senator Taft specifically warned against “unit fragmentation” which would devolve into the Balkanization of the health care workplace; “[h]ealth-care institutions must not be permitted to go the route of... the construction trades, in this regard.” Id.<sup>7</sup> It is clear from the legislative history that Congress intended the Board not use its authority to determine bargaining units in a manner to create multiple units in long-term care facilities.

Beyond the procedural difficulty attending a proposed rule-by-adjudication under Park Manor, the majority in Specialty Healthcare suggests no pressing need for its undertaking. It cites only a 17-year-old Dunlop Commission study reporting that parties engage in litigation for tactical purposes such as to delay an election, 356 NLRB No. 56, slip op. at 3<sup>8</sup> and the observation that Park Manor’s “pragmatic” and “empirical” qualifiers “cannot possibly be described as a model of clarity ...” Id., at 2 n. 8. The Dunlop Commission’s 1994 report did not address long-term healthcare specifically and it was issued less than three years after the decision in Park Manor. It hardly warrants Board action in 2011. The Specialty Healthcare majority’s

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<sup>7</sup> Although Senator Taft’s admonishments were made almost 40 years ago, the dynamic of collective bargaining has not changed. The healthcare employer and the public would face increased upward pressure on healthcare costs arising from the threat of multiple strikes, friction between bargaining units and potentially different unions under the same roof, as well as the expenses in time and resources for multiple contract bargaining. This would be of particularly harsh impact in rural areas in which there are a limited number of skilled nursing beds. Moreover, the contemporary multi-disciplinary approach to care is especially suited to a broad bargaining unit, avoiding the potential for infighting which could arise from competing units – which would drive quality down, and costs up. Today, when the cost of healthcare is a raging national debate, implementation of an unnecessary new labor policy which is sure to exacerbate the problem is particularly inappropriate.

<sup>8</sup> Citing Commission on Justice Worker-Management Relations, U.S. “The Dunlop Commission is the future of Worker-Management Relations Final Report” at 18-19 (1994).

semantic squabbling is even wider of the mark. The Board in Park Manor dubbed its approach “pragmatic” or “empirical” simply to satisfy “those most comfortable with verbal formulas . . .” 305 NLRB at 875 n. 16. No great import was attached to the nomenclature. This is hardly the stuff of serious criticism, let alone justification for undoing twenty years of precedent.

Any implication that Park Manor has unduly delayed the resolution of representation cases involving long-term healthcare service and maintenance units, such as Specialty Healthcare, is not borne out by experience. The appropriateness of a service and maintenance unit including various classifications of employees not unlike those involved here is generally accepted and seldom, if ever, has been questioned. Laurel Associates d/b/a Jersey Shore Nursing & Rehabilitation Center, 325 NLRB 603 (1998) (nursing home) (unit of all service and maintenance employees appropriate under Park Manor); Marian Manor for the Aged and Infirm, 333 NLRB 1084, 1094-1095 (2001) (nursing home) (a service and maintenance unit in a nursing home is presumptively appropriate); The Holliswood Hospital, 312 NLRB 1185, 1195 (1993) (psychiatric hospital) (separate unit of all non-professional employees found appropriate under Park Manor). See CGE Corporations, Inc., 328 NLRB 748 (1999) (medical equipment and clerical services facility). See also HRC Manor Care d/b/a Arden Courts of Whippany, Case No. 22-RC-12444 (2004) (assisted living facility); Hospice of Michigan, Case No. 7-RC-22100 (2001); Glenview Senior Living Center LLC, Case No. 8-RC-16806 (2006). The general acceptance of service and maintenance units as furthering the intent of Park Manor (sometimes including technical employees as well, see Brattleboro Retreat, 310 NLRB 615, 617 (1993)), renders it unnecessary to revamp the rules of decision. A new rule would not eliminate Section 9 contentiousness. Certain classifications or individuals inevitably would remain in dispute depending on the circumstances of the operations involved. The Board would still have

to render a decision in these cases. “The Board may use classifications, rules, principles and precedents in order to regularize the process, but absent a stipulation, it must still determine the appropriateness of the unit in every case.” Health Acquisition Corp. d/b/a Allen Health Care Services, 332 NLRB 1308, 1309 (2000). There is no need for change.

We would not fault the Board in general for reflecting upon its experience from time to time. Reassessment can be beneficial. As the Supreme Court has said:

“Cumulative experience” begets understanding and insight by which judgments... are validated or qualified or invalidated. The constant process of trial and error, on a wider and fuller scale than a single adversary litigation permits, differentiates perhaps more than anything else the administrative from the judicial process.

NLRB v. Weingarten, 420 U.S. 251, 265-266 (1975), quoting NLRB v. Seven-Up Co., 344 U.S. 344, 349 (1953). Just as this review may cause the Board to change course when it believes it has erred, see e.g., IBM Corporation, 341 NLRB 1288 (2004) (holding that Weingarten rights do not apply to unrepresented employees, overruling Epilepsy Foundation of Northeast Ohio, 331 NLRB 676 (2000), enf'd in relevant part, 268 F.3d 1095 (D.C. Cir. 2001), cert. denied, 536 U.S. 904 (2002), it should also lead to the validation of past judgments where they are shown to be correct. That would be the case with Park Manor. Here, however, there is no compelling reason for change or need for re-examination. Relying on language in Park Manor to instigate a review whose suggested purpose is to strip the case of meaning does not exemplify good faith. Rulemaking once contemplated in furtherance of Park Manor does not justify adjudication today in derogation of it.

As we show below, the Board should have made public meaningful information in its possession that might have affected any action here. As matters stand, any developments in the long-term care industry do not disturb our conclusion that Park Manor should be retained as law.

## POINT II

### THE BOARD SHOULD HAVE PRESENTED DATA AVAILABLE TO IT THAT COULD INFORM ANY DECISION IN THIS CASE, INSTEAD OF CALLING ON PRIVATE PARTIES TO OFFER ANECDOTAL EVIDENCE

The Board in Specialty Healthcare calls upon the parties to offer anecdotal evidence that, in its view, bears upon a decision whether to continue applying Park Manor, and perhaps, the community of interest test generally. 356 NLRB No. 56, slip op. at 1-2. Thus, among other things, it asks for “the experience” of correspondents under the “pragmatic” or “empirical” community-of-interest approach of Park Manor. It also inquires about examples of factual patterns that have emerged at various kinds of non-acute care facilities illustrating the type of units that may be appropriate, and instances illustrating how Park Manor has hindered or encouraged employee free choice and collective bargaining in these facilities. Id.

Anecdotal evidence is unreliable as a basis for making a significant policy change in bargaining unit standards. It weighs disproportionately in favor of those who sought unsuccessfully to organize. Petitioners seeking to represent a narrow subset of employees, few in number and inappropriate for bargaining, surely will claim Park Manor was an obstacle to employees’ exercise of Section 7 rights. After all, their attempts were thwarted. They ignore, of course, other compelling interests. These countervailing interests inveigh against fragmented units and collective bargaining especially in healthcare institutions, and favor labor relations conducted on a more comprehensive basis. Board data, we believe, would provide a more accurate picture – one that shows statutory rights are vigorously exercised under “pragmatic” community-of-interest standards.

The Board itself, however, has not presented data on agency experience under Park Manor. It has not offered information, for example, on: the number of representation petitions that have been filed in long-term care facilities in the past two decades; what units were

sought by the petitions; how many petitions sought units limited to a single job title (e.g., CNA only) where a service and maintenance unit was shown to include others; how many petitioned-for units were stipulated to and how many of those were limited to a single classification; how many petitioned-for units were contested with regard to included titles or classifications; and of those, how many directions of election permitted balloting only within a single title or classification within a service and maintenance unit.<sup>9</sup>

This data, we believe, could be gleaned from Board statistical information. Obtaining it would involve considerable effort, to be sure. But if the Board wishes to examine Park Manor's efficacy, it is incumbent upon the agency to make available to the parties and the public, in meaningful form, a distillation of its experience under that case. It has not done so.

Based on data obtained privately, it appears there have been 4,004 representation petitions (RC and RM) filed with the NLRB since January 1, 1991 (the year in which Park Manor was decided) through mid-January 2011, in the long-term healthcare industry (NAICS 623). During the same period, 2,707 Board-conducted elections were conducted, of which, it appears, unions won at least 60 percent. In a large majority of the cases, elections were conducted in units that had been agreed to by the parties.<sup>10</sup>

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<sup>9</sup> Board data specific as to unit composition in the long-term care industry is not published. Pursuant to a Freedom of Information Act (FOIA) request filed by the authors of this Brief, the Board provided limited information; specifically, a listing of certain representation case data within the industrial classification encompassing long term care. Within this list the full panoply of relevant information is not provided. Moreover, information for some petitions is incomplete. The available records only begin with the 4th Quarter of 1999. The information provided reveals that in only four cases (not including the case at bar) a regional director approved or directed an election in a unit limited to a single job title ("certified nursing assistants," "nurses aides," or "nursing assistants").

<sup>10</sup> Because of the limited information made available under the Freedom of Information Act, information here was gathered from private industry sources and databases, most significantly the Labor Relations Institute. We note that the Board majority in Specialty Healthcare, presumably relying on the agency's own (and also the most reliable) data, stated that "almost 3,000 petitions" were filed for representation elections in this industry in just the last decade. 356 NLRB No. 56, slip op. at 2.

While limited, this information nevertheless demonstrates that successful union organizing has not been inhibited by Park Manor. Thousands of petitions have been filed and thousands of Board elections have been conducted. Unions have won most elections. Of course, nothing prevents a long-term healthcare employer and a petitioning union from agreeing to recognition or an election in a unit smaller than one that might be approved under Park Manor. If an employer is content to deal with a union representative on behalf of only its CNAs, for example, it may do so.<sup>11</sup> Parties may still order their affairs voluntarily. The amici do not argue for any changes in this regard. However, even where employers have invoked the “pragmatic” community-of-interest standard, it cannot be said that organizing has been encumbered. Indeed, by conforming organizing efforts and expectations to healthcare’s non-proliferation standards, most unions have petitioned only for service and maintenance units or other bargaining units that fall comfortably within Park Manor’s “broader approach.”

One point remains to be made. That unions cannot gain a showing of interest or achieve victory in an NLRB election does not mean employees are prevented from exercising their Section 7 rights. Union success is not the measure of statutory vindication. Employees have the right to refrain from engaging in union activity. And in exercising their statutory rights, they may reject a union at the polls. The problem for unions may lie with the message or the messenger, and not with the ability of employees to enjoy Section 7 rights.

In the absence of comprehensive Board data for the period following Park Manor, it is inappropriate to proceed further.

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<sup>11</sup> An informal survey conducted among member healthcare organizations by AHCA indicates that, of over 400 unionized long-term healthcare facilities in which non-professional employees are represented, only two have bargaining units that include the single job title of nursing assistants alone. The FOIA information provided reveals that (not including the case at bar), since 1999, only four such cases exist.

### POINT III

#### CHANGES IN LONG-TERM HEALTHCARE SINCE PARK MANOR DO NOT INDICATE THE NEED FOR ABANDONING THE PRAGMATIC COMMUNITY OF INTEREST STANDARD IN FAVOR OF AN ADJUDICATED RULE

The Board's invitation for briefing in Specialty Healthcare relies substantially on its suggestion that rapid and significant changes in long-term care may have affected the industry's labor relations. Id., 356 NLRB No. 56 slip op. at 2. While there has been considerable evolution within the industry, nothing points to the need to jettison Park Manor as a standard for resolving representation disputes. While the field has grown and options for resident care have expanded, these changes are not of a qualitative nature affecting the goals of the National Labor Relations Act. On the contrary, the emerging changes point forcefully to the conclusion that mandating partial, fragmentary units of service and maintenance workers, e.g., CNAs alone, is not appropriate.

Long-term healthcare has expanded and diversified greatly since the Board's rulemaking and the decision in Park Manor. While the Board's rulemaking for a time was concerned with nursing homes (as distinguished from hospitals), 53 Fed. Reg. 33927-33929 (1988), the industry has grown to include (depending on one's definitions of long-term care) Independent Living, Assisted Living, Intermediate Care, Congregate Care, Skilled Nursing, Continuing Care Retirement Communities (CCRC) or Life Care Communities (LCC), Hospice Care, Adult Day Care and Respite Care.<sup>12</sup> An estimated 4.7 million workers were employed in the long-term care industry in 2009 (including nursing homes, assisted living and home health) representing more than 29 percent of employment in the U.S. healthcare sector and 3.6 percent of

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<sup>12</sup> See <http://www.nursinghomerank.com/nursing-home-care>. Medicare lists the types of long-term care as including Community-based services, home healthcare, in-law apartments, housing for aging and disabled individuals, board and care homes, assisted living, continuing care retirement communities and nursing homes. <http://www.medicare.gov/longtermcare/static/typesoverview.asp>. See, also, University of Rochester, "Levels of nursing home care," <http://www.stronghealth.com/services/seniors/caring/levelsofcare.cfm>.

total U.S. jobs.<sup>13</sup> Direct care workers in the industry numbered 2.9 million, of whom almost 645,000 were RNs or LPNs, and 2.2 million were nursing aides, orderlies and attendants and home health aides.<sup>14</sup> Over 50,000 industry jobs were added in 2009, despite adverse economic conditions.<sup>15</sup> There are approximately 17,000 total nursing facilities in the United States, as compared to approximately 4,900 hospitals.<sup>16</sup>

The Board finds it “important” that the number of residents in long term care has increased as the population has aged, and as the length of stays in acute care hospitals has decreased. 356 NLRB No. 56 slip op. at 2. While these facts are, indeed, very important developments for the healthcare industry, there is no reason to believe that the industry, the public, or the statutory goals of the Act would be benefitted by the fundamental changes now contemplated by the Board.

In traditional nursing homes, the structure of employee functions has remained largely similar to the typical arrangement in place at the time of Park Manor. However, the trend is clearly toward a *less* compartmentalized approach:

The industry as a whole is moving toward a more “holistic” approach to care in which the “universal worker” attends to all the daily living needs of their residents: assistance with ADLs, meal service, light housekeeping, laundry, programming, etc. Rather than dealing with four or five different people to have their needs met, residents are able to relate to one or two staff members who actually know them and are familiar with their needs, their

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<sup>13</sup> AHCA and NCAL, “2010 U.S. Long-Term Care Workforce at a Glance,” Data based on a national survey conducted by Hospital & Healthcare Compensation Service (HCS). <http://www.ahcancal.org>.

<sup>14</sup> Id. In 2004, according to the Centers for Disease Control, approximately 936,000 persons were employed as RNs, LPNs, CNAs, nurses aides and orderlies in nursing homes, CNAs represented a majority of all nursing staff employed in nursing homes. U.S. Dept. of Health & Human Services, CDC, “The National Nursing Home Survey.” 2004 (Series 13, No. 167 June 2009) at p. 3.

<sup>15</sup> Id.

<sup>16</sup> <http://www.therubins.com/homes/stathome.htm>, based on data obtained from Centers for Medicare and Medicaid Services (data are for community hospitals, which represent 85 percent of all hospitals, federal hospitals, long-term care hospitals, psychiatric hospitals, institutions for the mentally retarded and alcoholism and other chemical dependency hospitals are not included. Id.)

routines, their likes and dislikes. The result is care that is more personal, customized and consistent.

An additional benefit is increased efficiency in staffing, i.e., while the caregiver is assisting a resident with his bathing, dressing and so on, he or she may also be able to perform other duties, rather than having someone to dust off a countertop or clean a bathroom. Ultimately, this approach can result in staffing efficiencies.<sup>17</sup>

The advent of the interdisciplinary team model as a way of providing better care for the patient or resident breaks down historical barriers between job functions: “when a team of several physicians, physical therapists, respiratory therapists, nutritionists, nurses, social workers, occupational therapists, chaplains and counselors is working on one case, each member has to talk to one another to know exactly where he or she fits into the overall care model.”<sup>18</sup>

See U.S. Dept. of Health & Human Services Office of the Inspector General, OIG Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56832, 56837 (Sept. 30, 2008) (“Medicare and Medicaid regulations require nursing facilities to develop a comprehensive care plan for each resident that addresses the medical, nursing and mental and psycho-social needs for each resident and includes reasonable objectives and timetables [citing 42 CFR 483, 20(k)]. . . . To reduce risks, nursing facilities should design measures to ensure an interdisciplinary and comprehensive approach to developing care plans.”) (footnote omitted).<sup>19</sup>

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<sup>17</sup> Widdes, “Assisted Living’s Universal Worker,” Nursing Homes, April 1996, republished at [http://findarticles.com/p/articles/mi\\_m3830/is\\_n4\\_v45/ai\\_18335705/](http://findarticles.com/p/articles/mi_m3830/is_n4_v45/ai_18335705/)

<sup>18</sup> Alaniz, Jose, “The Med Squad: Interdisciplinary team model brings well-rounded care to patients,” Nurse Week (Aug. 14, 2001) [http://nurseweek.com/news/features/01-08/medsquad\\_print.html](http://nurseweek.com/news/features/01-08/medsquad_print.html).

<sup>19</sup> See also Kryzs, Timothy M., “Building teams for today’s nursing home care: A guide to creating interdisciplinary teams—cover story,” Nursing Homes (March 1996) [http://findarticles.com/p/articles/mi\\_m3830](http://findarticles.com/p/articles/mi_m3830); Dellafield, Mary Ellen, PhD, RN, “Interdisciplinary Care Planning and the Written Care Plan in Nursing Homes: A Critical Review,” 48 The Gerontologist 128-133 (2006).

A proliferation of bargaining units in a facility employing the “holistic” approach would defeat the very purpose of an interdisciplinary approach. Nursing homes utilizing a traditional structure have not experienced any substantive change in employee configuration since Park Manor which would warrant discarding the long-standing community of interests principles.

The evolution in healthcare has perhaps been most extensive in the expansion of assisted living communities which are today estimated at more than 36,000.<sup>20</sup> However, this development only further supports retention of the case-by-case community of interest analysis which has typically been shown to yield a broader unit. “A relatively new concept twenty-five years ago, today assisted living is the most preferred and fastest growing long-term care option for seniors.”<sup>21</sup> It provides “personalized, resident centered care in order to meet individual preferences and needs.”<sup>22</sup> Regulated by the states, “[a]ll settings offer 24-hour care and supervision for those who need assistance.”<sup>23</sup> “They offer a less-expensive, residential approach to delivering many of the services available in skilled nursing, either by employing personal care staff or contracting with home health agencies and other outside professionals.”<sup>24</sup> In addition to providing amenities of daily living, such as their meals served daily in a common dining area, housekeeping services, transportation, 24-hour security, exercise and wellness programs, personal laundry services, social and recreational activities, they offer personal care: staff availability to respond to scheduled and unscheduled needs, assistance with eating, bathing,

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<sup>20</sup> Assisted Living Federation of America, “Assisted Living,” [http://www.alfa.org/alfa/assisted\\_living\\_information.asp?snid=996944813](http://www.alfa.org/alfa/assisted_living_information.asp?snid=996944813).

<sup>21</sup> Id.

<sup>22</sup> Id.

<sup>23</sup> Id.

<sup>24</sup> Id.

dressings, toiletry and walking; access to health and medical services, such as physical therapy and hospice, emergency call systems for each resident's apartment, medication management, and care for residents with cognitive impairments (e.g., Alzheimer's).<sup>25</sup> These facilities "are designed to bridge the gap between independent living and nursing home facilities."<sup>26</sup>

Because of lower acuity levels, these assisted living communities are less heavily staffed and need employ fewer professional and technical employees. This enables them to maintain affordable cost structures.

With smaller assisted living staffs—consisting of employees who, in the main, are not technical or professional employees—performing greater varieties of tasks, and with more traditional facilities requiring greater interaction among patient/resident direct care providers to meet acceptable treatment standards—which inevitably affects workers in facility service and maintenance jobs—there is even less justification today than there was two decades ago for making community of interest decisions in long-term healthcare based on narrow job classifications as they exist at an isolated and random point in time. At a minimum, the Park Manor standard could reasonably be expected to result in the inclusion of all service and maintenance employees in the unit found appropriate. Thus, while times have changed, as we show next, the fundamental analysis of Park Manor holds true, and its prescribed approach remains valid.

The Board in Park Manor recognized that during the NLRB's rulemaking, it observed:

[T]here is less diversity in nursing homes among professional, technical and service employees, and the staff is more functionally integrated [cites to testimony omitted]. Generally, nurses provide

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<sup>25</sup> Id.

<sup>26</sup> <http://www.nursinghomerank.com>, supra.

a less intensive, lower level of care to patients in skilled and extended care facilities, and thus receive lower salaries than that paid in acute care hospitals [cites to testimony omitted] . . . [T]here is for the most part little difference in the duties of LPNs and nurses aides [cites to testimony omitted]. Both are primarily responsible for providing nursing care to patients.

305 NLRB at 876, citing 53 Fed. Reg. 33928, 284 NLRB 1567 (1988). This tendency to push down levels of skilled care has accelerated with the growth of assisted living facilities. Assisted living facilities have few LPNs and RNs; they function mainly using employees traditionally included in service and maintenance units, including dining services workers, food service assistants, housekeeping/maintenance, nursing assistants/care managers, program service associates and concierge. See e.g., Sunrise Senior Living, Inc., Case No. 8-RC-16609 (2004). While there may be issues concerning supervisory status, or whether an employee is more aligned with business office clericals, or whether the bargaining unit should include more than one location, few petitioners, if any, question the inclusion of CNAs (or similar positions) in an overall service and maintenance unit. See e.g., Jersey Shore Nursing & Rehab Center, supra; Marian Manor for the Aged and Infirm, supra; Bethany Nursing Home and HRF, Case No. 3-RC-11603 (2005); Talmadge Park, Inc., 34-RC-2140 (2005); Glenview Senior Living Center LLC, Case No. 8-RC-16806 (2006); Britthaven of Edenton Inc., Case No. 11-RC-6587 (2004); cf. Community Living Association, Case No. 1-RC-21862 (2005) (intermediate care facility).

Of course, the facts in specific cases will vary. The Board's case-by-case assessment according to its long-standing principles may result in differing unit inclusions, as appropriate. The *amici* herein do not contend otherwise, nor do they dispute the ability of parties in representation cases to stipulate unit composition. Nonetheless, it is inescapable that the most commonly found appropriate unit is an overall service and maintenance unit. Changes in the industry make such a unit even more likely than before. The Board in 1988 noted that:

[C]ase by case determinations of appropriate units for nursing homes have not caused undue litigation . . . In fact, to the best of our knowledge there is not a single published case since the [1974] health care amendments in which the Board had to decide appropriate impacts in nursing homes and no party has testified that it had experienced problems with case-by-case determinations as to the issue.

53 Fed. Reg. 1568. While the Board may have decided some unit issues in the interim, as the dissent in Specialty Healthcare notes, “under Park Manor, the Board has consistently found non-professional service and maintenance employees a separate appropriate unit in nursing homes,” citing CGE CareSystems, 328 NLRB 748 (1999); Jersey Shore Nursing & Rehab Ctr., *supra*, Lincoln Park Nursing Home, 318 NLRB 1160 (1995); and Hillhaven Convalescent Ctr., 318 NLRB 1017 (1995). 356 NLRB No. 56, slip op. at 5 and n. 10 (Member Hayes, dissenting). The dissent observed, too, “that CNAs have traditionally been considered with this group, although, significantly, their inclusion in an overall unit has rarely been questioned,” citing Jersey Shore, *supra*; Lincoln Park, *supra*; and Hillhaven, *supra*, *id.* at n. 11. Member Hayes further noted that even prior to the 1974 amendments, “CNAs were similarly included in broad non-professional units in nursing homes without dispute.” *E.g.*, Laurel Hill Health Centers, 203 NLRB 326 (1973); Madeira Nursing Center, 203 NLRB 323 (1973). *Id.*

Accordingly, despite the growth of the long-term healthcare industry, the law has remained constant and predictable. Evolution of the industry has only reinforced the validity of the Park Manor test and its common result: an inclusive service and maintenance unit, including CNAs, among others. Nothing that has happened since Park Manor impels the creation of an adjudicated rule that changes the *status quo*.

As we consider next, if any rule were to be devised, the Board would be obliged to invoke rulemaking, for to do otherwise would abuse its discretion.

## POINT IV

### THE BOARD WOULD ABUSE ITS DISCRETION BY ABANDONING CASE-BY-CASE DETERMINATIONS OF APPROPRIATE UNITS IN LONG-TERM HEALTHCARE IN THE ABSENCE OF FORMAL RULEMAKING

The majority in Specialty Healthcare maintains the agency has the right to determine whether its reassessment of Park Manor should proceed by adjudication or rulemaking. 356 NLRB No. 56, slip op. at 3. For now, it opts for the former. “[I]f, at any time,” it adds, “we are convinced that rulemaking would be a fairer or otherwise more appropriate means to address the questions raised in this case, we shall initiate that process.” Id.

The Board’s bias for rulemaking by adjudication is incorrect. If the NLRB contemplates new rules for an industry that “has undergone a radical transformation” in the face of “dramatic growth in the last 20 years . . . [which is] projected to continue,” a “proliferation of facility-like residential alternatives to nursing homes,” and “a persistent interest [by long-term care employees] in invoking the statutory process for obtaining representation,” then formal rulemaking under the Administrative Procedure Act is needed. With its more deliberate legislative approach, and its opportunity for public hearings, testimony, the presentation of data, and written comment, it affords the only sound basis for considering major changes in the law or the way the law is to be administered.

There is “near unanimity” among judges and academics in “extolling the virtues of the rulemaking process over the process of making ‘rules’ through case-by-case adjudication.” 1 Pierce, Administrative Law Treatise (4<sup>th</sup> Ed. 2002), §6.8 at p. 368, quoted in Wright, “Rulemaking versus adjudication in federal courts,” Mackinac Center for Public Policy, <http://www.mackinac.org/article.aspx?ID=9845&print=yes> (July 23, 2008). Those virtues include: (1) often higher quality rules, since the agency receives greater input than in

adjudication involving particular parties; (2) enhanced political oversight, since the notice period allows potentially affected parties to notify politicians, while adjudications often provide no warning about the rules being set forth until after the fact;<sup>27</sup> (3) rulemaking is less costly over time than case-by-case adjudication (see discussion below); (4) rules are clearer than agency opinions; (5) adjudication focuses the cost of an adverse decision on a particular party, while others learn of the outcome without cost to themselves; and (6) adjudication leads to more disparate action by the agency which can pick and choose its targets. Pierce, *id.* at 368-73.

When the Board undertook its examination of healthcare bargaining units nearly a quarter century ago, it recognized that rulemaking was an appropriate method for doing so. Its action was particularly significant, for the agency had cleaved to adjudication exclusively as a means of deciding substantive issues. Although the Board eventually abandoned its effort to regulate healthcare broadly and focused instead on acute care hospitals, 29 CFR §103.30; Park Manor, 305 NLRB at 872; see Specialty Healthcare, 356 NLRB No. 56, slip op. at 4-5 (Member Hayes dissenting), it made clear that “rulemaking, though perhaps time consuming at the outset, will be a valuable long-term investment, paying dividends in the form of predictability, efficiency and more enlightened determinations as to viable appropriate units, ultimately leading to better judicial and public acceptance.” 52 Fed. Reg. 25144 (July 2, 1987) (First Notice of Proposed Rulemaking on Collective Bargaining Units in the Healthcare Industry) 284 NLRB 1515, 1519. The Board, therefore, has recognized the virtues of and employed rulemaking on this very subject.

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<sup>27</sup> In rulemaking, political appeals can be made to members of Congress who can exert pressure indirectly on the agency, thereby increasing the likelihood of a decision that weighs all societal interests. This is at least a partial reason for according deference to agency determinations. See Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984); see also American Hospital Association v. NLRB, 499 U.S. at 606 (1991). While the Board’s invitation in Specialty Healthcare arguably affords some notice of a possible change in the law, it falls well short of an express proposed rule with detailed justification, as would be expected in a notice of proposed rulemaking published in the Federal Register.

To be sure, as a general proposition, “the Board is not precluded from announcing new principles in an adjudication proceeding” and in the first instance, may select whether it wishes to proceed by rulemaking or adjudication. NLRB v. Bell Aerospace Co., 416 U.S. 267, 294 (1974), cited approvingly in Specialty Healthcare, *id.*, slip op. at 3, n. 11; see NLRB v. Wyman-Gordon Co., 394 U.S. 759, 765-766 (1969) (plurality opinion) (“[a]djudicated cases may and do . . . serve as vehicles for the formulation of agency policies, which are applied and announced therein” and “generally provide a guide to action that the agency may be expected to take in future cases.”); see also American Hospital Ass’n v. NLRB, 499 U.S. at 611-612 (“In resolving . . . a [representation] dispute, the Board’s decision is presumably guided not simply by the basic policy of the Act but also by rules that the Board develops to circumscribe and to guide its discretion either in the process of case-by-case adjudication or by the exercise of its rulemaking authority.”).

That having been said, the question remains whether any limits exist on the Board’s use of adjudication to promulgate *de facto* rules of future general applicability. This is a question expressly left unresolved by the Court in Bell Aerospace, 416 U.S. at 291, and, of course, not presented by the Board’s regulation in American Hospital Association. The issue is particularly worrisome where, as here, the Board raises the possibility not only of altering the rules of decision for representation cases in long-term healthcare, but of casting aside its community of interest standard, which has been a bedrock criterion for bargaining unit decisions generally for many years. Here, indeed, we believe Board discretion would be abused by evading the rulemaking process. As the Ninth Circuit has observed:

when the new standard, adopted by adjudication, departs radically from the agency’s previous interpretation of the law, where the public has relied substantially and in good faith on the previous

interpretation, . . . and where the new standard is very broad and general in scope and prospective in application.

Pfaff v. U.S. Dept. of Housing & Urban Development, 88 F.3d 739, 748 (1996), quoted approvingly in Specialty Healthcare, *id.*, slip op. at 6 (Member Hayes, dissenting). Such is the case with the Park Manor reassessment.

If the time is ripe for a long-term healthcare bargaining unit rule, why not continue the rulemaking begun in 1987-1989? If it was necessary for establishing healthcare bargaining units then—at least in acute care hospitals—why should it not be needed now for an even wider array of healthcare employers and employees? Put another way, why revert to adjudication?

The Board in Specialty Healthcare makes no attempt to explain why it chooses a different course this time. *Id.*, slip op. at 3. No persuasive reason is apparent. If a bargaining unit rule must be promulgated for long-term healthcare, the Board abuses its discretion by adjudicating one.

### CONCLUSION

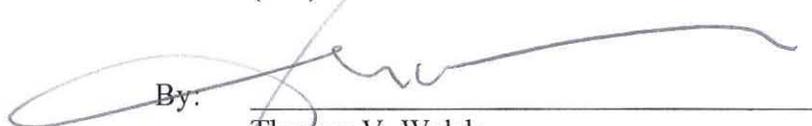
Park Manor is a sound decision offering a workable means for resolving representation issues in long-term healthcare. The majority in Specialty Healthcare has not shown reason to disturb the case-by-case approach it announced in 1991 in favor of an adjudicated rule. Neither has it supplied relevant information based on its experience in deciding representation cases in the industry that might inform the parties and members of the public respecting the issues it raises. While the long-term care industry has grown in the past two decades, Park Manor still provides an effective tool for considering representation case issues generally, let alone the rare case that questions propriety of service and maintenance units. Even

if the Board were to undertake a possible change in law, it would have to proceed by rulemaking; and adjudicated rule in these circumstances would result in an abuse of discretion.

The decision in Park Manor, and the case-by-case adjudication it prescribes, should be retained.

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I certify that on March 8, 2011, a true and accurate copy of the foregoing Amicus Curiae Brief was served by e-mail on the following:

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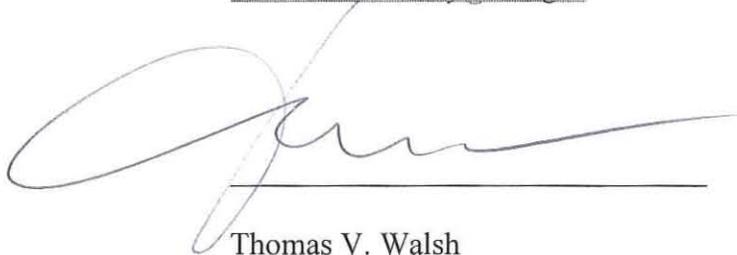
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