

**UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
WASHINGTON, DC**

SPECIALTY HEALTHCARE AND)
REHABILITATION CENTER OF MOBILE)

Employer,)

and)

Case No. 15-RC-8773

UNITED STEEL, PAPER AND FORESTRY,)
RUBBER, MANUFACTURING, ENERGY,)
ALLIED INDUSTRIAL AND SERVICE)
WORKERS INTERNATIONAL UNION)

Petitioner)

EMPLOYER'S RESPONSE TO NOTICE AND INVITATION TO FILE BRIEFS

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TABLE OF CONTENTS

STATEMENT OF THE CASE.....1

STATEMENT OF FACTS.....3

A. Nursing Home Bargaining Units3

B. The Mobile Facility4

ARGUMENT.....9

A. Legal And Decisional Background.....9

 1. **The Statute**10

 2. **The Healthcare Amendments And The Intent Of Congress**.....11

 3. **The 1989 Rulemaking**.....15

 4. **The Board’s 1991 *Park Manor* Decision**18

 5. **The Impact Of Section 9(c)(5)**.....19

B. Experience Under *Park Manor* Has Been Positive20

C. *Park Manor* Represents The Appropriate Legal Analysis In Non-Acute Care Facilities. A Single Job Classification Is Not A Presumptively Appropriate Unit21

D. The Unit Sought By The Union Is Inappropriate Under *Park Manor*26

E. *American Cyanamid* Has No Application27

F. Rulemaking Versus Adjudication.....30

CONCLUSION31

TABLE OF AUTHORITIES

National Labor Relations Board Cases

<i>American Cyanamid Co.,</i> 131 NLRB 909, 910 (1961)	3; 28-30
<i>Buckhorn, Inc.,</i> 343 NLRB 201 (2004)	28-29
<i>CGE Caresystems, Inc.,</i> 328 NLRB 748 (1999)	19; 22
<i>Charter Hospital of St. Louis, Inc.,</i> 313 NLRB 951 (1994)	22
<i>Don Lee Distributor, Inc.,</i> 322 NLRB 470 (1996)	25
<i>Extendicare of West Virginia, Inc.,</i> 203 NLRB 1232 (1973)	11; 14
<i>Four Seasons Nursing Center,</i> 208 NLRB 403 (1974)	11; 13
<i>Hillhaven Convalescent Center,</i> 318 NLRB 1017 (1995)	22-23
<i>Holliswood Hospital,</i> 312 NLRB 1185 (1993)	21
<i>Home Depot USA Inc.,</i> 331 NLRB 1289 (2000)	10
<i>Jefferson Health System,</i> 330 NLRB 653 (2000)	21
<i>Kalamazoo Paper Box Corp.,</i> 136 NLRB 134 (1962)	10
<i>Laurel Associates, Inc. d/b/a Jersey Shore Nursing and Rehabilitation Center,</i> 325 NLRB 603 (1998)	22
<i>Lifeline Mobile Medics, Inc.,</i> 308 NLRB 1068 (1992)	23

<i>Lincoln Park Nursing and Convalescent Home, Inc.</i> , 318 NLRB 1160 (1995)	23; 26
<i>Manor Healthcare Corp.</i> , 285 NLRB 224 (1987)	14-15
<i>Marian Manor for the Aged and Infirm, Inc.</i> , 333 NLRB 1084 (2001)	22; 23; 26-27
<i>McLean Hospital</i> , 331 NLRB 1100 (1993)	21
<i>Mercy Hospitals of Sacramento, Inc.</i> , 217 NLRB 765 (1975)	14
<i>Park Manor Care Center</i> , 305 NLRB 872 (1991)	<i>passim</i>
<i>TDK Ferrites Corp.</i> , 342 NLRB 1006 (2004)	29
<i>Virtua Health</i> , 334 NLRB 484 (2005)	19; 23
<i>Woodland Park Hospital</i> , 205 NLRB 888 (1973)	11; 13-14

U.S. Supreme Court Cases

<i>American Hospital Association v. NLRB</i> , 499 U.S. 606 (1991)	18
<i>NLRB v. Yeshiva University</i> , 444 U.S. 672 (1980)	10

Circuit Court Cases

<i>IBEW, Local 474 v. NLRB</i> , 814 F.2d 697 (D.C. Cir. 1987)	30
<i>Laidlaw Waste Systems, Inc. v. NLRB.</i> , 934 F.2d 898 (7th Cir. 1991)	20
<i>Lundy Packing</i> , 68 F.3d 1577 (4th Cir. 1995)	19-20
<i>Sandvik Rock Tools, Inc. v. NLRB</i> , 194 F.3d 531 (4th Cir. 1999)	20
<i>Singer Sewing Machine Co. v NLRB</i> , 329 F.2d 200, 205 (4th Cir. 1964)	20
<i>Uyeda v. Brooks</i> , 365 F.2d 326 (6th Cir. 1966)	10

Code of Federal Regulations

29 C.F.R. § 103.30 16; 17

Federal Reports

S. Rep. No. 93-766, p. 5 (1974) 11

H.R. Rep. No. 93-1051, pp. 6-7 (1974) 11

Federal Bills

120 Cong. Rec. 12944-45 (May 2, 1974) 12-13

120 Cong. Rec. 22949 (July 11, 1974) 13

Federal Register

52 FR 25142-01 17

53 FR 33900-01 16

53 FR 33928..... 17

53 FR 33933..... 16-17

STATEMENT OF THE CASE

On December 18, 2008, the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (“Union”) filed a petition seeking to represent the Employer’s employees in the following bargaining unit:

Included: All CNAs employed at the Mobile, AL facility;

Excluded: All Office/Clerical employees, all Dietary employees, professional employees, guards and supervisors as defined by the Act.

A Hearing was conducted on December 30, 2008, before Hearing Officer Charles Rogers in Mobile, Alabama, at which time the Employer argued that the CNA-only unit proposed by the Union was inappropriate as a matter of law, and that the only appropriate unit would include all non-professional service and maintenance employees. The unit, as proposed by the Employer, would include all certified nursing assistants (“CNAs”), activity assistants, dietary aides, cooks, the social services assistant, the staffing coordinator, the maintenance assistant, the central supply clerk, the medical records clerk, the data entry clerk, the business office clerical, and the receptionist.¹ The Employer’s proposed unit contained 86 employees; the Union’s petitioned-for unit contained 53 employees.

In opposing the unit requested by the Union, the Employer noted that this narrow unit was contrary to both the Board’s well-established rule of *Park Manor Care Center*, 305 NLRB 872 (1991), as well as Congress’ admonition against a proliferation of units in a health care setting. Nevertheless, the Regional Director issued a Decision and Direction of Election finding that “[d]istinct training, certification, supervision, uniforms, pay rates, work assignments, shifts,

¹ Laundry staff was contracted out by the Employer at the time of the Hearing.

and work areas all demonstrate that the CNAs share a community of interest and form an appropriate bargaining unit.” (D&D, 11). The Employer filed a timely Request for Review.

On February 19, 2009, the Board granted the Employer’s Request for Review, and on August 27, 2010, the Board affirmed the grant of review.² On December 22, 2010, the Board issued a Notice and Invitation to File Briefs in the matter. In its Notice and Invitation, a majority of the Board announced its intention to revisit *Park Manor*, asserting that reconsideration of the standard was necessary due to “dramatic” changes in the long-term care industry within the last two decades, as well as the high number of representation petitions (3,000, according to the Board’s records) that had been filed within such facilities. Accordingly, the Board posed the following questions to “the parties and interested amici:”

- (1) What has been their experience applying the “pragmatic or empirical community of interests approach” of *Park Manor* and subsequent cases.
- (2) What factual patterns have emerged in the various types of nonacute health care facilities that illustrate what units are typically appropriate.
- (3) In what way has the application of *Park Manor* hindered or encouraged employee free choice and collective bargaining in nonacute health care facilities.
- (4) How should the rules for appropriate units in acute health care facilities set forth in Section 103.30 be used in determining the appropriateness of proposed units in nonacute health care facilities.
- (5) Would the proposed unit of CNAs be appropriate under *Park Manor*.
- (6) If such a unit is not appropriate under *Park Manor*, should the Board reconsider the test set forth in *Park Manor*.
- (7) Where there is no history of collective bargaining, should the Board hold that a unit of all employees performing the same job at a single facility is presumptively appropriate in nonacute health

² The election was conducted, and the ballots were impounded.

care facilities. Should such a unit be presumptively appropriate as a general matter.

(8) Should the Board find a proposed unit appropriate if, as found in *American Cyanamid Co.*, 131 NLRB 909, 910 (1961), the employees in the proposed unit are “readily identifiable as a group whose similarity of function and skills create a community of interest.”

Member Hayes dissented from the Notice and Invitation. He observed that the majority had turned a simple case into a highly complex matter of law, and that such a comprehensive policy change would better be effectuated by following the procedures articulated within the Administrative Procedures Act (APA). Member Hayes also expressed concern that the majority was ignoring Congress’ clear intention in enacting the Healthcare Amendments, and that the majority’s statements regarding nursing homes contradicted the findings of the Board’s 1989 Rulemaking. Finally, Hayes noted that the majority’s actions constituted a dangerous shift, in both policy and procedure, which opened the door to highly specialized units, as well as permitting units based upon the extent of organization.

STATEMENT OF FACTS

A. Nursing Home Bargaining Units

Although the Employer’s Mobile facility does not have a specific bargaining history, both its parent company (Kindred Healthcare) and the nursing home industry at large do have a well-established pattern of collective-bargaining units. At the hearing, Kindred’s Vice President of Labor Relations, Edward Goddard, testified that Kindred operates twenty-seven nursing homes at which employees are represented by unions and covered by collective bargaining agreements. (Tr. 22). None of these represented facilities has a bargaining unit or a labor agreement that covers only CNAs. (Tr. 22). Rather, all twenty-seven units are comprehensive

service and maintenance units, which at a *minimum* include dietary, housekeeping, and laundry, to the extent housekeeping and laundry are not outsourced.

Goddard further testified that he has worked in the nursing home industry in a labor relations capacity for ten years. He serves as the Chair of a long-term care industry labor relations group and, as a result, is very familiar with industry patterns with respect to bargaining units in this field. (Tr. 21). Goddard testified that he is not aware of any bargaining units in the industry comprised solely of CNAs, unless agreed to as a result of a stipulated unit.

B. The Mobile Facility

Turning to the Employer's Mobile facility, the record reflects a substantial community of interest between the CNAs and the other classifications that the Employer seeks to include. The CNA position does not require a notably different background, experience or education level than other positions at the Mobile facility. Thus, like the CNAs, the maintenance assistant, staffing coordinator, medical records clerk, central supply clerk, and data entry clerk positions all require a high school degree or equivalent. Only the dietary aide and cook positions have lower educational requirements (10th grade and above). (Emp. Exhs. 8, 9). And, while CNAs are required to be certified, this certification requires no more than 16 hours of classroom training and approximately 72 hours of general education. (Tr. 132).

The record also revealed significant evidence of functional interchange, job functions, and basic contact and interaction among all employees. Indeed, the operation of a nursing home inherently involves a high level of functional integration and interchange. The facility's Executive Director testified that, in the nursing home setting, the main goal and focus is on quality patient care, and this effort necessarily "entails a collaborative effort with all departments meeting nutritional needs, psychological needs, the activity needs...[and] the clinical needs" of

the residents. (Tr. 125). The Employer's collaborative approach to total quality care dictates that, while all employees in the facility must perform their primary job, they must also be able to identify the needs of the resident under all circumstances. As a result, "there's no department that could truly take care of these residents independent of the other departments." (Tr. 125). Instead, all departments must work together to provide the necessary degree of care, and this collaborative method, involving each employee, is critical to the success of the facility. (Tr. 128).

As a result of this holistic approach to patient care, the duties and functions of the non-supervisory employees overlap in many ways. One obvious example involves the development and application of each resident's "care plan." Upon the admittance of a new resident, the facility immediately performs an assessment of the individual's dietary, social, and clinical needs. Following this assessment, a formal care plan is developed; this plan acts as a blueprint for the needs of each resident. All jobs and departments – activities, social, nursing, and dietary – are involved in the development of a resident's care plan. (Tr. 127). After the initial care plan is developed, the different disciplines meet at least quarterly to determine whether the existing care plan must be updated or modified because of a resident's changing condition or needs. (Tr. 127). The different disciplines also participate in regular employee meetings and training functions. (Tr. 150; Emp. Exh. 7(a), (b)). Moreover, the Employer also conducts daily "stand up" meetings where representatives from each department receive a general overview of everything that happened in the facility during the course of the previous day and/or shift. (Tr. 151). Although the participants are usually supervisors, they are expected to pass details of the meeting along to their respective teams.

The CNAs are not "the only employees assigned to work the floors and tend to the designated residents." (D&D at 5, 11). The activity assistants work with certain residents

throughout the facility, including inside patient rooms. (Tr. 116). The maintenance assistant also performs work throughout the entire facility, working wherever maintenance is required. (Tr. 130). The staffing coordinator spends as much as three to four hours a day working “on the floor” with CNAs and other employees, and the medical records clerk is frequently “out on the floors” retrieving medical records, setting up patient charts, retrieving patient records, and working with Activities of Daily Living (ADL) charts. (Tr. 135, E Exh. 9(b)). The central supply clerk moves throughout the building as well, as she maintains and stocks supply closets located at the nursing stations on each floor. Indeed, one CNA testified that she saw the central supply clerk every day or every other day, for anywhere from 20 to 30 minutes. (Tr. 139-140).

Moreover, the interaction is not limited to employees simply working in the same area at the same time; every employee in the Employer’s proposed unit is required to interact with other nonsupervisory employees, from other departments, in the course of performing their jobs. CNAs must work closely with the activity assistants to understand residents’ activity needs, and to ensure that each resident’s needs are, in fact, being met. (Tr. 119-120). Activity assistants, in turn, must coordinate patient activities with all staff, including the CNAs. (Tr. 117). CNAs must also work with the staffing coordinator in order to locate replacement personnel to cover shifts of employees who have called off work. (Tr. 136). One CNA testified that the disciplines must work together whenever there is a call-off or a need for leave. (Tr. 58, 75). CNAs and the staffing coordinator must also work together in arranging which CNA will take patients to doctors’ appointments, as the staffing coordinator prepares those schedules. (Tr. 78). The medical records clerk interacts with the CNA in compiling the data recorded by CNAs on the ADL flow charts; as a result, the clerk is frequently “out on the floors” retrieving ADL charts and other documents maintained at the nursing stations. (E. Exh. 9(b); Tr. 137). Similarly, the

central supply clerk – who is responsible for stocking and maintaining supply closets located at the nursing stations on each floor of the facility – also works with CNAs to ascertain special needs or supply requirements of the residents. (Tr. 140). Indeed, the supply clerk is often told directly by CNAs of the need for various supplies.

Additionally, even employees who are not usually out on the floors have demonstrated interaction with nonsupervisory employees from different departments. For example, CNAs are not permitted to receive phone calls while working; it is the receptionist who receives these calls, and takes messages for the CNAs. (Tr. 76). The CNAs and dietary employees are also in contact on a daily basis, as the CNA must communicate a resident's dietary need to the cooks or to a dietary aide in order to ensure that the resident's request is met; the same interaction occurs if a resident receives the wrong food, or if a meal is missing. (Tr. 123). CNAs often come into contact with dietary aides when CNAs accompany residents to the dining room to assist them with eating. (Tr. 72). Finally, the record evidence shows that dietary aides and cooks both work together to cook meals for the CNAs when they request to purchase a meal. (Tr. 156).

The record further establishes numerous instances of employees transferring from one position to another. In October 2007, a receptionist was promoted to the position of unit clerk. In June 2007, a CNA was promoted into a unit clerk position. In 2000, a dietary worker moved into a data entry clerk position. In April 2008, an employee was promoted from cook to central supply clerk. (Emp. Exh. 10).

Although the different job classifications have separate immediate supervision, there is common supervision at higher levels, most notably the Director of Nursing (DON) and the Administrator. (Tr. 161). Indeed, even the CNAs do not all share the same supervisor or unit

manager; they report to different charge nurses on different units. And, like everyone else in the Employer's proposed unit, the CNAs answer ultimately to the Director. (Tr. 88).

With respect to wages, hours, and benefits, the record indicates that the employees in the Employer's proposed unit share very similar pay, identical benefits, and common terms and conditions of employment. The starting hourly pay rates are as follows: dietary aides: \$7.00 per hour; CNAs: \$8.50; cooks: \$9.00; receptionist: \$9.00 to \$10.00; central supply clerk: \$10; medical records clerk: \$10; scheduling/staffing clerk: \$10; and data entry clerk: \$15-16. (D&D, 8). Further, "CNAs, Dietary Aides, and Cooks all receive an additional 10 cents per hour based on years of experience up to fifteen years." (D&D, 8). All employees in the Employer's proposed unit are subject to the same annual evaluation process, and are evaluated on or around their anniversary date by their immediate supervisor. (Tr. 114). Based on the annual evaluation, the immediate supervisor makes a recommendation as to the annual increase (if any) an employee will receive. All recommendations of this nature are then approved or modified by the Executive Director. (Tr. 115). All benefits are completely identical. (Tr. 24-29, E Exh. 1).

While it is true that the CNAs work on one of three shifts—6 a.m. to 2 p.m., 2 p.m. to 10 p.m., and 10 p.m. to 6 a.m.—other employees also work shifts. For example, the activities assistants cover two shifts per day, one of which is staggered to accommodate the residents' needs in the evening hours; their shifts can start at 8, and the second shift can run as late as 7:00 or 8:00 p.m. (Tr. 120-121). All dietary employees are normally scheduled over two shifts in order to cover three meals; the first shift begins as early as 5:00 or 6:00 a.m., with the later shift scheduled to cover the evening meal and typically ending around 10:00 p.m. (Tr. 124). The maintenance assistant is typically scheduled to work a shift beginning at 7:00 a.m. and ending at 3:00 p.m., quite similar to a 1st shift CNA. (Tr. 130).

All nonsupervisory employees at the Employer's Mobile facility are subject to the same policies and procedures. (Emp. Exh. 1; Tr. 18-19). All employees in the Employer's proposed unit complete the same application for hire, and undergo the same hiring process. They all receive the same "new employee orientation." (Tr. 109-110). All employees are paid on a bi-weekly basis. They all use the same parking lot, time clock, break room, smoking area, and bulletin boards (Tr. 98). They are all required to attend regular monthly meetings and occasional group meetings regarding matters of special interest. (D&D, 4). All employees are required to wear an identical name badge and closed-toe shoes (Tr. 102). All employees have the option of purchasing meals through the dietary department, all are eligible for PEAK program bonuses, and all can receive a \$100 bonus if the facility receives zero areas of deficiency in state inspections. All employees are also eligible for special recognition and monetary rewards for exceptional performance. (D&D, 9).

ARGUMENT

The Employer will attempt to address each of the questions, although not in precisely the manner set out, in the Board's invitation. In summary, the Employer contends that (1) *Park Manor* represents the legally appropriate analysis, and should continue to be applied, in the non-acute care setting; (2) experience with *Park Manor* has been positive; (3) a single classification is not a presumptively appropriate unit, particularly in health care institutions; and (4) under *Park Manor*, the petitioned-for unit is clearly inappropriate.

A. Legal And Decisional Background

Before addressing the propriety of *Park Manor*, it is necessary to examine the legal and decisional background that preceded it. Viewed against this history, it becomes apparent that the *Park Manor* analysis remains the appropriate one for non-acute care facilities.

1. The Statute

Section 9(b) of the Act provides, with certain express limitations, that the “Board shall decide in each case whether, in order to assure employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof.” Section 9(c)(5) provides that in making unit determinations, “the extent to which employees have organized shall not be controlling.”

The three specific units set out in § 9(b) – employer, craft, and plant – are presumptively appropriate. In determining whether subdivisions of these statutorily recognized units are appropriate, the Board historically has applied a “community of interest” test, which considers a number of factors relevant to the employment relationship. These factors include the degree of functional integration between employees; employee skills and job functions; contact and interchange; common supervision; similarities in wages, hours, benefits; and other terms and conditions of employment. *Home Depot USA Inc.*, 331 NLRB 1289, 1290 (2000). In addition to these factors, the Board will also consider bargaining history, traditional unit compositions, and the extent of organization. *Kalamazoo Paper Box Corp.*, 136 NLRB 134, 137-139 (1962). The community of interest standard is consistent with the language of the Act, which provides that the Board must make determinations in “each case.” It is also consistent with the rulings of the Supreme Court, which require the Board to make unit determinations based on an “examination of the facts of each case,” rather than “on the basis of conclusory rationales.” *NLRB v. Yeshiva University*, 444 U.S. 672, 691 (1980). For over fifty years, the community of interest standard has been applied by every circuit court in the United States, and has been called the “touchstone” of appropriate unit determinations. *Uyeda v. Brooks*, 365 F.2d 326, 329 (6th Cir. 1966).

2. The Healthcare Amendments And The Intent Of Congress

In 1974, Congress undertook to amend the Act in order to extend coverage to employees of non-profit hospitals. In doing so, however, Congress recognized that it was facing “twin objectives” in the form of competing public interests: the workers’ interest in organizing versus the public interest in preventing a proliferation of bargaining units in health care facilities.

With respect to unit proliferation, Congress recognized numerous potential dangers to which a health care employer was particularly vulnerable. These concerns included the potential for jurisdictional disputes and work stoppages in an industry that requires uninterrupted work from its employees. Congress also recognized the administrative difficulties that would be involved in negotiating and administering multiple contracts, as well as the cost associated with such administration. Finally, Congress acknowledged that undue unit proliferation could result in wage “leapfrogging” and “whipsawing” – something which could ultimately affect the average citizen’s ability to pay for medical care.

In an effort to strike a balance between the interests of the workers and the interests of the public, both the Senate and House Committees’ Reports contained the following admonition:

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).¹

¹ By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

S. Rep. No. 93-766, p. 5 (1974); H.R. Rep. No. 93-1051, pp. 6-7 (1974).

While relatively brief, this language represented the outcome of extensive and controversial debate. Senator Taft, a co-manager of the Senate bill, observed that the problem of unit proliferation was one of the “central issues” faced by the Committee in drafting the amendments, and that he could not “stress enough” the importance of using restraint in bargaining unit determinations. For example, Senator Taft made the following remarks on May 2, 1974, describing the nature of the potential problems, as well as the importance of Congress’ mandate to the Board:

The issue of proliferation of bargaining units in health care institutions has also greatly concerned me during consideration of legislation in this area. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If 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. . . .

. . . I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdiction disputes and work stoppages must be prevented.

The administrative problems from a practical operation viewpoint and labor relations viewpoint must be considered by the Board on this issue. Health care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.

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.³

The committee, in recognizing these issues with regard to bargaining unit determination, took a significant step forward in establishing the factor of public interest to be considered by the Board in unit cases.

³ The escalating costs that Senator Taft referenced in 1974 pale in comparison to the health care cost escalation that has occurred over the last two decades.

120 Cong. Rec. 12944-45 (May 2, 1974).

Senator Taft's concerns were echoed by other members of Congress. Senator Williams, who noted that "sometimes circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly where there is such a history in the area or a notable disparity of interests between employees in different job classifications," nevertheless explained that, while the Board had discretion to exercise its specialized experience in this area, "the committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in health care industry[.]" 120 Cong. Rec. 22949 (July 11, 1974). Similarly, Congressman Ashbrook observed that "the Committee was quite concerned with the issue of undue proliferation of bargaining units and by language in the committee report has stressed the need for the Board to curtail such proliferation in health care institutions." Congressman Ashbrook further noted that, although the Board had previously acted in a Congressionally-approved manner, he "would expect the Board to be cognizant of the concerns for patient care and employee rights in the Board's continuing review of bargaining unit questions in the health care institutions." 120 Cong. Rec. 22949 (July 11, 1974).

Further indications of Congressional intent can be inferred from the three cases cited by the Committees. The first of these decisions, *Four Seasons Nursing Center of Joliet*, involved a petition for a unit of 2 maintenance employees out of a work force of 143 employees. The Board dismissed the petition, finding "that the maintenance unit sought herein is not composed of a distinct and homogeneous group of employees with interests separate from those of other employees, and therefore is not an appropriate unit." *Four Seasons Nursing Center*, 208 NLRB 403, 403 (1974).

In the second decision referenced by the Committee, *Woodland Park Hospital, Inc.*, the Board found a that a unit composed solely of x-ray technicians in a general hospital was

inappropriate, because they were not sufficiently distinct from other technical employees. In dismissing the petition, the Board acknowledged its own concerns with proliferation, concluding that a unit comprised solely of x-ray techs would “lead to severe fragmentation of units in the health care industry.” By contrast, the Board found that a “broad unit” at the same hospital – a unit which included all hospital employees except professional and confidential personnel, registered nurses, dietitians, pharmacists, guards, and supervisors – did constitute an appropriate unit, as those employees shared a sufficient community of interest. 205 NLRB 888, 889 (1973).

Finally, in the *Extendicare* case, the Union proposed three separate units: (1) all LPNs, (2) all technical employees, and (3) all service and maintenance employees. The employer, however, argued for a single unit, with the addition of employees in the business office and medical records department. The Board disagreed with both parties, and ultimately determined that two units were appropriate in the facility – one LPN unit, and one combined unit of service, maintenance, and technical employees. In arriving at this conclusion, the Board noted the small number of technical employees in the facility (seven), and found that allowing them a separate unit would result in “unwarranted unit fragmentation.” *St. Luke's Hosp. (Extendicare of West Virginia, Inc.)*, 203 NLRB 1232, 1233 (1973).

Since the 1974 amendments, the Board itself has recognized that its consideration of all unit issues in the health care industry “must necessarily take place against this background of avoidance of undue proliferation.” *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765, 766 (1975). And, in *Manor Healthcare Corp.*, 285 NLRB 224, 226-227 (1987), the Board explicitly approved consideration of these concerns in deciding whether a single-facility or a multi-facility unit is appropriate:

[W]e are aware of the seriousness of Congress' concern that in making unit determinations we seek to avoid a unit structure that poses a real threat of disruptions to the continuity of patient care through the spread of work stoppages and other adverse effects of labor disputes. We think we can best accommodate this concern with the mandate of Section 9(b) by retaining the single-facility presumption and, in any particular health care industry case, allowing the party opposing such a unit to rebut the presumption by a showing of circumstances that militate against its appropriateness, including an increased risk of work disruption or other adverse consequences that the 1974 Congress appears to have wanted to minimize in this industry. Rebuttal on such grounds requires providing a reasonable basis for finding an increased risk that is substantial, but not necessarily overwhelming.

3. The 1989 Rulemaking

On July 2, 1987, for the first time in its history, the Board announced its intention to engage in rulemaking by publishing a "Notice of Proposed Rulemaking on Collective-Bargaining Units in the Health Care Industry." What followed included 14 days of hearings, 144 witnesses, and over 1800 commentators. The Board reviewed the information, and ultimately issued its final rule on April 21, 1989.

At the heart of the 1989 Rulemaking was an attempt to formulate standard, appropriate units within the health care industry; early in the process, however, the Board found itself facing the same competing interests Congress encountered in enacting the Healthcare Amendments — namely, the interest of employees to organize, versus the interest in preventing unit proliferation:

It has been observed that, in exercising its discretion to determine appropriate units, the Board must steer a careful course between two undesirable extremes: If the unit is too large, it may be difficult to organize, and, when organized, will contain too diversified a constituency which may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent; on the other hand, if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage whipsawing, and may even be deleterious for the union by too severely limiting its constituency and hence its bargaining strength. The Board's goal is to find a middle-ground

position, to allocate power between labor and management by “striking the balance” in the appropriate place, with units that are neither too large nor too small.

53 FR 33900-01.

Conducting an “analysis of the empirical evidence and comments received during the rulemaking proceeding,” the Board concluded that, except in “extraordinary circumstances,” a maximum of eight bargaining units would be appropriate: (1) all registered nurses; (2) all physicians; (3) all professionals other than registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all non-professional employees other than those categories already specified. 29 C.F.R. § 103.30(a); 53 FR 33900-01. In the Board’s view, these units would avoid undue proliferation:

As set forth in considerable detail, supra, the evidence taken during the rulemaking proceeding has convinced the Board, contrary to its earlier belief, that eight possible units (seven plus guards) should be found appropriate in acute care hospitals. In reaching this conclusion, the Board has carefully considered the Congressional admonition against proliferation set forth in the legislative history of the 1974 health care amendments as well as its own strongly-held view that the number of units found appropriate should not be so many as to lead to a splintering of the workforce into the myriad of occupations and professions found within the industry. The Board has examined the units found appropriate to ensure they are not so numerous as to create a never-ending round of bargaining sessions, and that each unit represents truly distinctive interests and concerns. A number of groups of employees found appropriate have separate labor markets. A thorough examination of the record in this rulemaking proceeding has satisfied us that the health care units established by the Board do not constitute proliferation either in terms of the legislative history of the amendments or in the context of the history or realities of the industry.

We believe that Congressional and industry concern with proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately.

53 F.R. 33933.

Still, while the Board entered the Rulemaking with the intention of including long-term health care facilities, it did so while recognizing that fewer units would probably be appropriate in such facilities, observing that “we think that in smaller facilities there will be found less division of labor and specialization, and thus more functional integration of employees’ services ... we also expect that there are far fewer professionals other than physicians and nurses in the smaller facilities (especially in nursing homes), and therefore that separate units of ‘other professionals’ are less likely to be appropriate.” 52 FR 25142-01. Ultimately, however, the Board determined that its Rulemaking would not extend to long-term care, and decided to leave these other facilities – including nursing homes – to be determined “by adjudication.” 29 C.F.R. §103.30(g). The Board explained that this exclusion was necessary, because nursing homes were inherently different operations; specifically, the Board noted that:

[T]here is less diversity in nursing homes among professional, technical and service employees, and the staff is more functionally integrated. Generally, nurses provide 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. In addition, RNs in most nursing homes never administer oxygen or assist in surgery, and therefore generally have no interest in or need for acute care pay differentials or for specialization. Also, there is for the most part little difference in the duties of LPNs and nurses’ aides. Both are primarily responsible for providing nursing care to patients. Indeed, almost no aspect of nursing home care is in the exclusive domain of any one group of employees. Thus, there appears to be a greater overlap of functions as well as greater work contact between the various nursing home non-professionals.

Skilled care homes also differ from hospitals in that a ratio of 50 patients per nurses’ station is ideal for nursing homes, whereas the typical ratio for acute care units is half that number.

53 FR 33928.

In *American Hospital Association v. NLRB*, 499 U.S. 606 (1991), the Supreme Court upheld the Board's acute care hospital rule. The Court, however, noted that the Healthcare Amendments were controversial, in that they were undertaken amid concerns "that labor unrest in the health care industry might be especially harmful to the public ... [and] the fact that so many specialists are employed in the industry created the potential for a large number of bargaining units, in each of which separate union representation might multiply management's burden in negotiation and might also increase the risk of strikes." Thus, the Court noted, Congress had admonished the Board that "[d]ue consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry." *Id.* at 615 (quoting S. Rep. No. 93-766, p. 5 (1974) and H.R. Rep. No. 93-1051, pp. 6-7 (1974)).

4. The Board's 1991 *Park Manor* Decision

The opportunity for the Board to consider appropriate units in non-acute care facilities arose shortly after the Supreme Court issued its decision in *American Hospital*. In *Park Manor*, a union sought to represent a service and maintenance unit in a nursing home, while excluding four LPNs as technical employees. The Regional Director initially determined that the LPNs enjoyed a separate community of interest from the service and maintenance employees; upon review, however, the Board remanded the issue, instructing the Director to take into account several additional factors. And so, as a result of the Board's order in *Park Manor*, a modified community of interest standard emerged. While the traditional community of interest test considered five fact-intensive categories – (1) similarity in skills, interests, duties, and working conditions; (2) functional integration of the plant, including interchange and contact among the employees; (3) the employer's organizational and supervisory structure; (4) the bargaining history; and (5) the extent of union organization among the employees – *Park Manor* provided

for an additional step, requiring the factfinder to also consider the unit in a broader context, taking into account the information gathered during the Board's health care rulemaking efforts, as well as the Congressional mandates regarding units in such facilities. *Id.* at 875; *see also Virtua Health*, 334 NLRB 484 (2005). In all, this expanded inquiry requires consideration of general community-of-interest factors, the factors and evidence considered relevant by the Board during the rulemaking process with regard to acute care hospitals, and prior decisions of the Board involving either the type of unit sought or the type of health care facility in dispute. *CGE CareSystems, Inc.*, 328 NLRB 748 (1999). And, since *Park Manor*, this test has served as the consistent standard for unit determinations in non-acute care facilities for two decades.

5. The Impact Of Section 9(c)(5).

Finally, in addition to the information above background, consideration must be taken of an additional provision within the Act itself. To this end, section 9(c)(5) of the Act expressly prohibits the extent of union organization from being considered as a controlling factor in determining appropriate units for collective bargaining. The Fourth Circuit addressed the impact of § 9(c)(5) in *Lundy Packing*, 68 F.3d 1577 (4th Cir. 1995). There, the Board certified a bargaining unit consisting of production and maintenance employees, but excluded the quality control employees, who spent a large percentage of their working time on the production floor alongside the production and maintenance employees. On review, however, the Fourth Circuit concluded that the distinguishing factors relied upon by the Board did not, in fact, create any meaningful delineation, and instead amounted to "meager differences." *Id.* at 1581. The court also noted that, by excluding the quality control employees, the Board's certification was inconsistent with its precedent, and the Board offered no justification for its deviation. In light of these factors, the court concluded that, by presuming the union-proposed unit proper unless there

was “an overwhelming community of interest” with excluded employees, the Board had effectively accorded controlling weight to the extent of union organization. *Id.* This is because “the union will propose the unit it has organized.” *Laidlaw Waste Systems, Inc. v. NLRB*, 934 F.2d 898, 900 (7th Cir. 1991); *see also Sandvik Rock Tools, Inc. v. N.L.R.B.*, 194 F.3d 531, 534 - 535 (4th Cir. 1999); *Singer Sewing Machine Co. v. NLRB*, 329 F.2d 200, 205 (4th Cir. 1964) (“[I]f the evidence establishes that the extent of union organization was the controlling factor in the selection of the Pittsburgh City District as the appropriate unit, the resulting order finding the refusal to bargain to be an unfair labor practice is invalid”). Thus, because the Board’s holding was inconsistent with §9(c)(5), the unit was inappropriate as a matter of law.

B. Experience Under *Park Manor* Has Been Positive.

Turning to empirical evidence, no compelling reason exists for revising the *Park Manor* analysis. Unions have not encountered great difficulty in organizing nursing homes, as evidenced by the Board’s annual reports [Table 16]. In fiscal year 2009, the Board conducted 88 elections in nursing homes and residential facilities, of which unions won 58 elections. In fiscal year 2008, the Board conducted 164 elections in nursing homes and residential facilities, and unions won 110 elections. In fiscal year 2007, the Board conducted 129 elections in nursing homes and residential facilities, of which unions won 89 elections. In 2006, unions won 100 of 165 elections; in 2005, unions won 122 of 192; in 2004, 120 out of 190; in 2003, 138 out of 194; in 2002, 96 out of 173; in 2001, 132 out of 203; and in 2000, 132 out of 204.⁴ With unions clearly winning the majority of elections in nursing homes, there is simply no evidence that any great difficulty exists here.

⁴ The Board did not publish election statistics for Nursing and Residential Care Facilities in its Annual Reports prior to 2000.

Similarly, there is little support for the notion that the Board's current unit determination precedents result in excessive litigation. Although not specific to health care, the Board's annual reports [Table 11] indicate that only a small percentage of elections are directed after a hearing and that the vast majority of elections are held pursuant to a stipulation or consent agreement. In fiscal year 2009, only 147 of 1321 RC petitions resulted in directed elections. In fiscal year 2008, only 189 of 1585 RC petitions resulted in directed elections. In fiscal year 2007, only 192 of 1500 RC petitions resulted in directed elections. In 2006, 308 out of 1736 petitions resulted in directed elections; in 2005, 313 out of 2180; in 2004, 341 out of 2240; in 2003, 378 out of 2435; in 2002, 404 out of 2538; in 2001, 456 out of 2631; and in 2000, 410 out of 2894.

C. **Park Manor Represents The Appropriate Legal Analysis In Non-Acute Care Facilities. A Single Job Classification Is Not A Presumptively Appropriate Unit.**

Viewed against this background, for several reasons, *Park Manor* clearly represents the appropriate legal analysis in non-acute care facilities. First, although the results are not rigidly ordained, the *Park Manor* analysis typically results in decisions that vary only in slight degree from the eight units established for acute care hospitals. Thus, the Board has frequently approved a unit limited solely to registered nurses, if requested by the Union. *Jefferson Health System*, 330 NLRB 653 (2000); *Charter Hospital of St. Louis, Inc.*, 313 NLRB 951 (1994); *Holliswood Hospital*, 312 NLRB 1185 (1993); *McLean Hospital*, 311 NLRB 1100 (1993). Although employers often argue that such units must include all other professional employees, the Board usually rejects such contentions. The most likely exceptions are where exclusion of other professionals would leave a residual "other professional" unit of five or fewer employees, or where other professionals perform the same functions as registered nurses.

With respect to nonprofessional employees, the Board has approved a unit of all nonprofessional employees. *Holliswood Hospital*, 312 NLRB 1185 (1992). It also has approved

a unit of all nonprofessional employees, excluding business office clericals (a service and maintenance unit). *CGE CareSystems, Inc.*, 328 NLRB 748 (1999). [An exception may exist if there are five or fewer business office clericals. In such cases, the Board is more likely to include the business office clericals in a unit of all nonprofessionals. *Charter Hospital of St. Louis, Inc.*, 313 NLRB 951 (1994).] Indeed, a unit composed of service and maintenance employees has become standard, and the Board has held that a service and maintenance unit in a nursing home is presumptively appropriate. *Laurel Associates, Inc. d/b/a Jersey Shore Nursing and Rehabilitation Center*, 325 NLRB 603 (1998); *Marian Manor*, 333 NLRB 1084, 1094 (2001)(since rulemaking, “the Board has held that a service and maintenance unit in a nursing home is *presumptively* appropriate,” and including into this unit maintenance department employees, medical secretary, and switchboard operator). Receptionists, customer service agents, and other clericals are often included in the service and maintenance units. *Lincoln Park Nursing Home*, 318 NLRB 1160 (1995)(including receptionist and other clericals in the service and maintenance unit); *CGE CareSystems, Inc.*, 328 NLRB 748 (1999)(reversing the Regional Director, applying *Park Manor*, and finding that customer service representatives could not be excluded from the petitioned-for unit).

If requested by the Union, the Board sometimes, but not invariably, will approve a unit of all nonprofessional employees excluding technical employees, or a unit limited solely to technical employees. To this end, the Board has noted that in non-acute care facilities such as nursing homes, “there is generally less diversity among technical employees and service employees, and the staff as a whole is more integrated than in acute care hospitals,” and that “whether or not technical employees may constitute a separate appropriate unit depends on their relationship to other nonprofessional employees.” *Hillhaven Convalescent Center*, 318 NLRB

1017, 1017-1018 (1995); *see also Lincoln Park Nursing & Convalescent Home, Inc.*, 318 NLRB 1160 (1995); *Lifeline Mobile Medics, Inc.*, 308 NLRB 1068 (1992). The Board typically does not approve units limited to a single job classification of technical employees. Thus, in *Virtua Health, Inc.*, 344 NLRB 484 (2005), the Board dismissed a union's petition seeking a unit limited to paramedics, but excluding all other technical employees.

Second, *Park Manor* is consistent with the Board's observations during the rulemaking process. The Board clearly was of the opinion that there was more overlap between jobs in nursing homes than in acute care facilities, and that fewer units would likely be appropriate in nursing homes. It is beyond dispute that a unit limited to CNAs would never be found appropriate under the acute care rule. Given the greater community of interest among all nonprofessionals in nursing homes, it follows that a unit limited to CNAs is even less appropriate in a nursing home.

Third, *Park Manor* is not only largely consistent with the rule for acute care hospitals, but it also is consistent with the Congressional admonition that there not be undue proliferation of bargaining units in health care institutions. As seen above, it allows a union reasonable flexibility in selecting the unit that it wishes to represent without opening the door to a hodgepodge of units based solely on individual job classifications. For if CNAs can constitute an appropriate unit, there is nothing that would prevent the Board from approving a unit of cooks or a unit of activity assistants in this case – the extent of proliferation is boundless. For example, in *Marian Manor For The Aged And Infirm, Inc.*, 333 NLRB 1084 (2001), the service and maintenance unit included “nursing assistants, senior nursing assistants, cooks, dietary aides, food service workers, bakers, laundry workers, activities leaders, office assistants, porters, housekeepers, resident care techs, rehab aides, stock clerks, storeroom clerks, unit assistants, unit secretaries, hairdressers,

and clinic coordinators,” as well as “the positions of assistant cook and kitchen porter.” Under a job classification analysis, each of these classifications could have constituted a separate appropriate unit.

Fourth, *Park Manor* is consistent with the clear Congressional mandate that the Board adopt a unit analysis that does not unduly increase the cost of health care. To be sure, health care costs have risen dramatically over the last two decades, but this trend has not been caused by *Park Manor* or the Board’s unit determinations, which have produced a manageable number of bargaining units for most employers. Any effort, however, to expand the number of appropriate units in nursing homes will inevitably lead to excessive fragmentation and increased administrative costs for employers. Currently, most nursing homes where unions have achieved representation rights have either one or two bargaining units. This has worked well. But if the Board were to adopt a job classification analysis, there is the clear potential for many other bargaining units. The administrative cost of dealing with a multitude of bargaining units would be substantial. Further, the threat of strikes would increase. And because of the integrated nature of the services provided, a strike in one unit would undoubtedly affect employees in other units. The overall impact would be an increase in health care costs for the ultimate consumers.

The problem of proliferation is not limited to administrative and economic consequences; numerous other concerns, including jurisdictional work disputes, work stoppages, and infighting among separate units within one facility, must also be considered. Given the integrated and overlapping nature of the duties of each job classification, an increased number of bargaining units will inevitably lead to work jurisdiction disputes. For example, as the Board noted in rulemaking, there is often little difference in the duties of LPNs and CNAs: both provide patient care, although LPNs, unlike CNAs, can administer medications and treatments. But if a patient

needs turning and a CNA is unavailable, the LPN can turn the patient. If, however, LPNs and CNAs are invariably in separate bargaining units, jurisdictional disputes will arise, particularly where different bargaining representatives are involved. The needs of the residents are paramount, and patient care will suffer if each job classification is limited in the duties that employees are permitted to perform. Nursing homes cannot wait to decide whether a CNA or an LPN turns a patient, or whether a CNA or a dietary employee delivers trays to patients.

Multiple bargaining units with separate collective bargaining agreements create a strong likelihood of multiple strikes, whipsawing, disrupted patient care, and internal conflict among employees and bargaining units. Whipsawing has been defined as “[a] union stratagem seeking to obtain benefits from a number or group of employers by applying pressure to one, the objective being to win favorable terms from the one employer and then use this as a pattern, or perhaps a base, to obtain the same or greater benefits from the other employers, under the same threat of pressure (including a strike) used against the first one.” *Don Lee Distributor, Inc.*, 322 NLRB 470, 486 n. 7 (1996). But this strategy can also be applied against a single employer with multiple bargaining units. A strike by CNAs could be followed by a strike of LPNs, followed by a strike of cooks, followed by a strike of housekeepers. The more units, the greater the impact. The consequence, of course, is total chaos, and a decline in the quality of patient care. Under *Park Manor*, such problems have been held in abeyance.⁵

Fifth, a job classification analysis would inevitably make the extent of organization controlling. In the instant case, for example, other than their common job title and duties, the CNAs have no compelling community of interest separate and apart from other employees.

⁵ It should also be noted that *Park Manor* does not prevent management and unions from stipulating to smaller units where they agree that such composition would not have detrimental effects on the quality of care.

Nothing else binds them together other than the fact that the Union's organizing efforts have failed to bear fruit outside the CNAs. Finding such a unit appropriate would therefore run counter to §9(c)(5).

Finally, as Congress recognized, there is an overriding public interest in preventing labor disputes from impacting the quality of care received by individuals in nursing homes. Indeed, the recognition of these dangers have led to the creation of particular rules for strikes and window periods in health care settings. Thus, under § 8(g), unions must provide ten days notice before striking a health care provider, and under § 8(d), extended notice periods are required for terminating or modifying a collective bargaining agreement. Whatever merits there may be to functional units in general – the Employer does not see any – they are both impracticable and potentially dangerous within the health care field.

For all of these reasons, the Board should refrain from any attempt to alter the *Park Manor* analysis. And, it most certainly should not adopt a job classification analysis.

D. The Unit Sought By The Union Is Inappropriate Under *Park Manor*.

If *Park Manor* is correctly applied, it is clear that the Regional Director erred in finding the petitioned-for unit appropriate. Throughout her Decision, it is apparent that the Director has consistently tailored her findings to reach a conclusion in favor of the Petitioner. In doing so, her Decision hinges on her findings of small, frequently semantic differences between the CNAs and the other nonsupervisory employees. These differences are strictly minor, however, and the distinctions she draws – for example, that \$8.50 an hour is not comparable to \$9.00 – often border on the ludicrous. In any event, the Board has never required every employee within a bargaining unit to be precisely the same, and this is particularly true in service and maintenance units. See, e.g., *Marian Manor*, 333 NLRB 1084, 1094 (2001)(since rulemaking, “the Board has

held that a service and maintenance unit in a nursing home is *presumptively* appropriate"...where the Board included into this unit maintenance department employees, medical secretary, and switchboard operator (emphasis supplied); *Lincoln Park Nursing Home*, 318 NLRB 1160 (1995)(including receptionist and other clericals in the service and maintenance unit).

The record here demonstrates that the education, training, and skills of a CNA are not remarkably different than the other jobs in the Employer's proposed unit. Their wages are substantially similar, and fall comfortably within the range of those performing other jobs in the Employer's proposed unit. Their supervision is generally the same, as most report ultimately to the DON. They enjoy identical benefits, and they share in the same terms and conditions of employment as other employees. Finally the evidence shows that the CNAs at the Mobile facility have frequent, if not daily, contact with other employees in the Employer's proposed unit, and that all of these employees work together in a well-established "collaborative effort" to provide resident care. Thus, the CNAs are not separate and distinct from the other non-professional employees in the Employer's facility, and would certainly not constitute an appropriate unit by themselves.

Further, approving a unit of CNAs would inevitably lead to unit fragmentation among all other nonprofessional employees. Activity assistants would constitute a separate unit, as would the dietary employees. As for the clerical employees, most are the only employee within his/her classification. As a single-employee unit is inappropriate as a matter of law, these employees would either be denied any opportunity to be represented, or would have to be grouped together in a very small clerical unit that would have no inherent bargaining strength.

The only appropriate unit in this case is a comprehensive service and maintenance unit, as proposed by the Employer. Thus, the Employer requests that the Board dismiss the petition unless the Union is willing to proceed in the larger unit.

E. American Cyanamid Has No Application.

In *American Cyanamid Co.*, 131 NLRB 909 (1961), the Board found that maintenance employees could, under the facts presented therein, constitute an appropriate bargaining unit. According to the Board, “[t]he record in this case fails to establish that the Employer's operation is so integrated, as alleged herein, that maintenance has lost its identity as a function separate from production, and that maintenance employees are not separately identifiable.” *Id.* at 910. The Board, however, disavowed any intent to establish any rule of general application as to the appropriateness of either departmental or classification units: “Thus we shall continue to examine on a case-by-case basis the appropriateness of separate maintenance department units, fully cognizant that homogeneity, cohesiveness, and other factors of separate identity are being affected by automation and technological changes and other forms of industrial advancement.” *Id.* at 911-912.

Subsequent Board decisions demonstrate that *American Cyanamid* did not establish a broad principle that any “readily identifiable” group of employees with “similarity of function and skills” would constitute a separate appropriate unit. For example, in *Buckhorn, Inc.*, 343 NLRB 201, 202 (2004), the Board cited *American Cyanamid* for the long-standing practice of finding “petitioned-for separate maintenance department units appropriate where the facts of the case demonstrate the absence of a more comprehensive bargaining history and the petitioned-for maintenance employees have a community of interest separate and distinct from other employees.” Nevertheless, the Board concluded, on the facts of the case, that a separate

maintenance unit was inappropriate; it “reach[ed] this conclusion based on the highly integrated nature of the Employer’s production process during which maintenance and production employees interact and interchange frequently; the shared supervision among employees, including the split supervision within the group of maintenance employees; and working conditions and terms and conditions of employment common to all employees.” *Id.* at 204.

Similarly, in *TDK Ferrites Corp.*, 342 NLRB 1006 (2004), the Board concluded, despite citing *American Cyanamid*, “that a unit limited to maintenance department employees, production technicians, tooling specialists, and set-up specialists is not appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act.” *Id.* at 1009. To this end, the Board explained:

At the Employer’s facility, the petitioned-for employees are not organized in a separate department and most work side-by-side with and share immediate supervision with production employees. Moreover, the employees in the petitioned-for unit are not traditional craft employees and are not required to participate in a formal apprenticeship program. In fact, almost all of the employees in the petitioned-for unit have previously worked as production employees and many regularly perform production work even though they are classified as maintenance employees.

Despite the foregoing, we are not unmindful that there are some factors favoring finding the petitioned-for unit to be an appropriate unit. Maintenance department employees, production technicians, tooling specialists, and set-up specialists are paid on the higher end of the pay scale and, while the positions they fill do not require any traditional craft skills, they generally possess greater skills than the production employees. Nevertheless, we find that, under these circumstances, the production and maintenance employees share a broad community of interest that outweighs any nominal community of interest that may be enjoyed solely by the petitioned-for employees. Because of the highly integrated nature of the Employer’s production process, the production and maintenance employees interact and interchange frequently, share common supervision, are functionally integrated, and have common working conditions and terms and conditions of employment.

Id.

American Cyanamid has never been viewed as establishing any broad unit principles. While it permits, in appropriate circumstances, a separate maintenance unit, it has no application outside of the production and maintenance context and does not alter the Board's long-standing community of interest standards. It is wholly inapplicable to the health care industry, where unit proliferation concerns are paramount. The Board should not extrapolate *American Cyanamid* into any new type of unit analysis focusing on common job duties.

Indeed, “[f]or over forty [now sixty] years, the Board has consistently read the definition of a ‘unit appropriate for the purposes of collective bargaining’ under section 9 to embody community-of-interest criteria.” *IBEW, Local 474 v. NLRB*, 814 F.2d 697, 708 (D.C. Cir. 1987). While the Board may not be prohibited from changing such a long-standing interpretation of the Act, it certainly should take a deep breath before doing so, and it must advance rational, cogent reasons for undertaking such a change. The Employer is unaware of any supportable rationale that would justify a departure from this long-standing precedent that has withstood numerous changes in administrations and Board members, and which has served as the consistent test of unit determinations for half a century.

F. Rulemaking Versus Adjudication

There are substantial reasons why the Board should utilize rulemaking if it is seriously considering making dramatic changes to its methods of determining appropriate bargaining units. Inasmuch as the Board has already addressed the units in acute care hospitals through rulemaking and initially considered – but later rejected – applying the rule to nursing homes, it makes sense that any reversal of course at this time be done through the same process that led to the rule. Indeed, the Board obtained extensive empirical data regarding nursing homes during the

rulemaking process, which could be built upon if rulemaking were once again pursued. Further, the information that is likely to be gathered through rulemaking is likely to be greater and of higher quality than can be obtained through the solicitation of amicus briefs. Finally, given the historical significance of the community-of-interests standard and its long acceptance by the parties, the public, and the courts, the Board should make sure that it has the most complete information possible before making any major changes in its approach to determining bargaining units. Similarly, the Board should also make available its own information pursuant to the request filed jointly by the House Committee on Education and the Workforce and the House Committee on Oversight and Government Reform, as this data would surely be critical to any argument regarding the ongoing effectiveness of Park Manor. For these reasons, the Board would abuse its discretion by making major changes without engaging in rulemaking.

CONCLUSION

The Employer respectfully requests that the Board apply *Park Manor* to this case, as well as to future cases, and that it dismiss the petition.

Respectfully submitted this 8th day of March, 2011.



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**UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
WASHINGTON, DC**

SPECIALTY HEALTHCARE AND)
REHABILITATION CENTER OF MOBILE)

Employer,)

and)

Case No. 15-RC-8773

UNITED STEEL, PAPER AND FORESTRY,)
RUBBER, MANUFACTURING, ENERGY,)
ALLIED INDUSTRIAL AND SERVICE)
WORKERS INTERNATIONAL UNION)

Petitioner)

CERTIFICATE OF SERVICE

I certify I have filed one electronic copy of the Employer's Response to Notice and Invitation to File Briefs with the Executive Secretary's Office via the NLRB e-filing system. In addition, I certify that I have served a copy via electronic delivery or facsimile, as well as a hard copy via UPS Overnight Delivery, to the following parties:

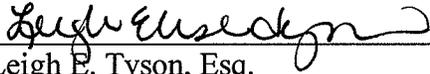
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This 8th day of March , 2011.



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