

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

In the Matter of)	
)	
1621 ROUTE 22 WEST OPERATING)	
COMPANY, LLC D/B/A SOMERSET)	
VALLEY REHABILITATION AND)	
NURSING CENTER)	
)	Case No. 22-CA-29599
Respondent)	22-CA-29628
)	22-CA-29868
and)	
)	
1199 SEIU UNITED HEALTHCARE)	
WORKERS EAST, NEW JERSEY)	
REGION)	
)	
Charging Party)	

RESPONDENT'S BRIEF IN SUPPORT OF ITS EXCEPTIONS TO THE
ADMINISTRATIVE LAW JUDGE'S DECISION

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Complaint, as amended, alleged that Somerset Valley interrogated employees about their union membership and solicited employee grievances in violation of Section 8(a)(1) of the Act and reduced the hours of, disciplined, and/or terminated employees in violation of Sections 8(a)(1) and 8(a)(3) of the Act. Somerset Valley denied the allegations of the Complaint. The Hearing in this case before Administrative Law Judge Steven Davis (the “Judge” or the “ALJ”) began on April 27, 2011, and included a total of 19 days of hearing through June 28, 2011. On November 21, 2011, the ALJ issued a Decision and Order in favor of the Acting General Counsel on every count alleged in the Complaint.

For all the reasons set forth below, the Judge’s findings of fact and conclusions of law are not supported by a preponderance of all of the relevant evidence in the record and/or are contrary to established Board law or policy. Accordingly, the Judge’s Decision and Order should be reversed, Judgment should be entered in favor of Somerset Valley on all counts, and the Complaint should be dismissed in its entirety.

II. STATEMENT OF THE CASE

Somerset Valley is a 64-bed skilled nursing, rehabilitation, and long term care center in Bound Brook, New Jersey. (Tr. 1404, 2664).¹ In 2009, Somerset Valley first learned of a series of operational and clinical issues which were hindering its performance. Thereafter, and over the course of the following two years, Somerset Valley implemented and effectuated a series of operational changes—with regard to both policy and personnel—to transform its culture and ultimately improve the quality of

¹ The ALJ’s decision is cited as “(ALJD __),” the hearing transcript as “(Tr. __),” the Respondent’s exhibits as “(R-1, R-2, etc.),” the Acting General Counsel’s exhibits as “(GC-1, GC-2, etc.),” and the Charging Party’s exhibits as “(CP-1, CP-2, etc.).”

its patient care. This case arises out of the business decisions underlying those changes.

A. Somerset Valley's Business Concerns and Management Overhaul

The quality of Somerset Valley's operations began to decline in 2009. In January 2009, Caroline Allen, Somerset Valley's Administrator of nineteen years, retired. (Tr. 1420). She was replaced by Elizabeth Heedles, who had not worked as an Administrator previously.² (Tr. 1420-21). Heedles' inexperience showed. As early as the spring of 2009, Jason Hutchens, the Regional Director of Operations responsible for overseeing Somerset Valley's operations and Heedles' direct supervisor, began to question Heedles' ability to manage the Center. (Tr. 1422). Hutchens' concerns were based primarily on Heedles' inability to staff the Center appropriately in her first several months as an Administrator. (Tr. 1422).

Heedles' leadership issues became glaringly apparent in December 2009, when the Center failed its annual recertification survey conducted by the New Jersey Department of Health and Senior Services. (Tr. 1423, 1847). The Center received multiple "G" level deficiencies³ for pain assessment and care planning in the 2009 survey, and, as a result, was in danger of losing its entitlement to Medicare funding, and/or its license to operate, in addition to facing possible monetary penalties. (Tr. 1423-25, 1847).

² The ALJ erroneously found that Heedles was Somerset Valley's Director of Nursing. (ALJD 7:44-45).

³ "G" level deficiencies mean that there was actual harm to the patient. (Tr. 1424-25). This level of deficiency is serious and is not common. (Tr. 1428-29, 1680, 1904). Critical survey deficiencies such as these can result in a center being forced to stop accepting new admissions and/or stop receiving Medicare funding. (Tr. 1425-26). An administrator with repeated problem surveys also is at risk of losing his or her license to operate a center. (Tr. 1443).

To avoid losing its certification following this failed 2009 survey, the Center immediately implemented a Plan of Correction approved by the State and the State surveyors returned to the Center in January 2010 to conduct a resurvey. (Tr. 1426-27, 1435; R-33, R-34). Although the ALJ found that Somerset Valley took no affirmative steps relating to changes in its administration or increased oversight of employee performance immediately following the failed survey in December 2009, this erroneous finding is directly contradicted by the undisputed fact that in preparation for the resurvey, Somerset Valley brought in its Regional Clinical Nurse Specialist, Jessica Arroyo, and Vice President of Clinical Operations, Jackie Engram, to audit the Center's nursing protocols and ensure that the Center was maintaining compliance with the necessary standards. (Tr. 1436, 1479). As a result of the State's resurvey process in January 2010, the Center was declared to be back in substantial compliance. (Tr. 1437; R-35). Thus, the Center had recovered from its brush with disaster, but the December 2009 survey served as a wakeup call to Hutchens that Somerset Valley's operations needed to be closely monitored going forward. (Tr. 1437, 1449; R-35).

In the spring of 2010, Hutchens began to hold Heedles and DON Eileen Meyer more accountable for their performance.⁴ (Tr. 1449). In April, Meyer resigned as a result of heightened scrutiny, and she was replaced by Kamala Kovacs. (Tr. 1449-50, 1512, 1995, 2678). Following Meyer's resignation, Hutchens learned that systemic scheduling and staffing issues continued to plague the Center and that employee

⁴ The ALJ found it "inconceivable" that "Hutchens' attention would have been brought to bear on the allegedly worsening situation for the first time in the spring of 2010." (ALJD 16:49-52). As set forth above, however, it is undisputed that Hutchens' attention clearly had been brought to bear on the situation when the Center failed the 2009 state survey. Hutchens simply failed to act as swiftly as he should or could have to remedy the situation. This failure was not unlawful.

morale had begun to deteriorate. (Tr. 1451-52). Unfortunately, it soon became apparent to Hutchens that hiring Kovacs was a mistake, as she did not have the respect of the nursing staff and had not moved the clinical department forward in preparation for the 2010 state recertification survey. (Tr. 2668). At about the same time, Hutchens concluded that Heedles was in over her head and that the Center needed to get an experienced Administrator with a proven track record. (Tr. 1451-52, 1454-55). In short, Hutchens decided that a significant management change was necessary to improve the Center's performance.

Accordingly, in early August 2010, Hutchens replaced Heedles with Doreen Illis, a 10-year veteran Administrator who had turned around a center of an affiliated company. (Tr. 1456, 1994-95, 2663), and replaced Kovacs with Inez Konjoh, a respected Assistant Director of Nursing at another center of an affiliated company. (Tr. 1457, 1620, 1993, 2323, 2535, 2669). Additionally, Jacquie Southgate was promoted and replaced the Unit Manager over the Nursing Department.⁵ (Tr. 2000-02, 2683).

B. New Management's Efforts to Transform Somerset Valley's Culture

Illis spoke with the Center's employees informally upon her arrival at the Center to assess the Center's business and culture and to understand the Center's day-to-day

⁵ Southgate was not continuously employed in a supervisory position from August 2008 through August 2010 as the ALJ erroneously implied. (Tr. 900, 1077). To the contrary, she became a statutory supervisor in August 2010, and any knowledge she had prior to that time regarding the employees' support for or interest in the Union cannot be imputed to Somerset Valley. (Tr. 900, 1077). Ultimately, Southgate proved to be an ineffective leader and later was terminated for performance issues after repeated counseling. (Tr. 2002, 2271-73, 2683-84). She failed to exercise authority and direction over the staff, had a difficult time communicating and giving directions, did not have a good rapport with patients and their families, and could not properly manage the nursing unit. (Tr. 2002, 2683-84).

operations.⁶ (Tr. 3078). Illis' initial impression was that the Center needed a lot of improvement; the clinical environment appeared to be very chaotic and disorganized, and there was an absence of effective leadership. (Tr. 2676).

Hutchens and Illis held another round of meetings with employees in mid-August, after Illis had been in her new role for a couple of weeks.⁷ (Tr. 103, 2325, 2690). During these meetings, Hutchens apologized to employees for not having identified certain problems with the Center's operations sooner. (Tr. 104-05, 1469, 1649). In response to Hutchens' comments and observations, employees interrupted him and volunteered that he was not "seeing the entire picture" at the Center. (Tr. 1470, 1650). Employees told Hutchens that the issues at Somerset Valley were more widespread than he understood them to be. (Tr. 104-05, 1650-51, 3096). Although entirely unsolicited, employees expressed dissatisfaction with the schedule changes announced by Heedles and with how Heedles spoke to them.⁸ (Tr. 3096). Hutchens apologized because he felt responsible for many of the issues the employees were discussing as a result of his placement of Heedles in the Administrator position and his failure to pay close enough attention to what was happening at the Center. (Tr. 1471).

In this meeting, Illis indicated to employees that she did not realize things were so bad at the Center when she first got there and she could understand why employees were upset. (Tr. 105, 514). In response to questions by employees regarding why

⁶ Illis was involved in meetings with employees where the topic of the Union was discussed, but she did not discuss the Union or the NLRB election with individual employees, nor did she ask any employee if he or she was going to vote for or against the Union. (Tr. 2691, 2692). Illis also did not ask employees individually or in groups what they did not like about their jobs. (Tr. 2691).

⁷ These meetings also were not about the Union's organizing campaign. (Tr. 342).

⁸ Employees also shared their concerns about the proposed scheduling changes with Andrea Lee ("Lee"), the Vice President of Human Resources, in the spring of 2010.

Heedles was involved with the nursing scheduling, Illis responded that she did not know because as Administrator she did not create the nursing schedule, but she wanted to “get a handle on” what was going on at the Center to better understand the situation. (Tr. 513-14). Neither Hutchens nor Illis stated or implied to employees what, if anything, they would do with any information provided to them – rather, they just listened to the employees and tried to understand the issues the employees voluntarily were bringing to their attention. (Tr. 1471).

Neither Hutchens nor Illis told employees that the terms and conditions of their employment would improve if they refrained from Union organizing activities or support. (Tr. 1473, 2691). Furthermore, neither Hutchens nor Illis ever told employees that they were there to remedy employee problems or asked employees about their grievances or complaints at the Center, or gave any indication to employees that they wanted to fix things if the employees did not vote for the Union. (Tr. 1474, 2690). To the contrary, in response to employees’ voluntary identification of perceived issues, Hutchens told employees that he *could not* make any promises to remedy any issues or concerns. (Tr. 343, 1474-75). In fact, several employees who were called to testify by the Acting General Counsel admitted that Hutchens not only did not make any promises to employees or tell them he would fix anything, but that he told employees that it would not be legal for him to make any changes at that time. (Tr. 105, 343). Similarly, Annie Stubbs, another witness for the Acting General Counsel, repeatedly testified that Hutchens *did not* ask the employees to voice their concerns or otherwise tell him why they wanted a union. (Tr. 876-77). According to these employees, Hutchens and Illis simply asked for a chance. (Tr. 105, 343, 515, 1021).

During the course of the meeting, Stubbs volunteered that she did not have access to sufficient trash bags for soiled linens and patient diapers to care for the patients. (Tr. 876, 885, 1472, 1556, 1684). According to Stubbs, employees were talking to Hutchens in the meeting and that is how the mention of trash bags came up. (Tr. 876). As Regional Director of Operations, Hutchens made sure employees had appropriate access to trash bags so they could do their jobs and remove the soiled linens and diapers and reduce the risk of possible spread of infection to patients.⁹ (Tr. 1472, 1556-57, 1685, 2911-12).

By early September, following Illis' evaluation of the Center's operations, Illis and Konjoh had identified a series of operational and clinical issues that were hindering the Center's performance. (Tr. 2676). The most significant of these issues included poor scheduling and staffing decisions (Tr. 2008-09, 2093, 2097, 2746; R-108, R-109), the misuse of per diem (as-needed) employees (Tr. 1406, 1410, 1540-41, 2005, 2500, 2885), excessive employee absenteeism and tardiness (Tr. 2034-36), and a general lackadaisical and haphazard approach to clinical nursing procedures, including the administration of medication and documentation of patient records (Tr. 1996, 2688).

1. Scheduling and Staffing Issues

The first significant issue Illis and Konjoh identified upon their arrival was that Valarie Wells, Somerset Valley's Staffing Coordinator, was not properly staffing the

⁹ Stubbs never approached Illis or Konjoh regarding insufficient trash bags and Hutchens never told them that Stubbs made this complaint. (Tr. 2326, 2911-12). Konjoh recalled that employees made some complaints to her about insufficient trash bags, but did not recall Stubbs discussing the issue with her. (Tr. 2326). Konjoh believes this issue was brought to her attention by the evening shift CNAs and Konjoh talked to the individual in maintenance responsible for distribution so that employees had access to needed trash bags. (Tr. 2326).

Center. Wells was not using the Center's scheduling program, SmartLinx,¹⁰ as she was required to do, but was instead relying on her own system of spreadsheets to manage the Center's staffing needs. (Tr. 2008-09, 2093, 2097, 2746; R-108, R-109). Wells' refusal to use the SmartLinx system had resulted in a number of staffing deficiencies and mistakes. (Tr. 2008-09, 2093). Accordingly, Illis and Konjoh devised a plan to assist Wells in developing the skills necessary to properly staff the Center. Beginning in or around August 2010, Konjoh began having regular meetings with Wells to discuss the problems with the schedule. (Tr. 2744, 2809-11). Wells acknowledged that she was making mistakes and vowed to correct the problems she was having. (Tr. 2100). Unfortunately, despite the additional oversight from Konjoh, the discrepancies and confusion with the schedules continued. (Tr. 2100).

In early September 2010, Konjoh and Illis developed a set of written guidelines to assist Wells in performing her job. (Tr. 2101, 2751-52; GC-70). On September 7, 2010,¹¹ they met with Wells in Konjoh's office and informally counseled Wells regarding her job performance and recent scheduling deficiencies, provided a copy of the written guidelines to her and reviewed them with her. (Tr. 2101-04, 2751-55, 2759-66; GC-70). The written guidelines in no way changed Wells' job duties; they simply set forth her existing duties in writing for Wells' use as a reference. (Tr. 2101, 2104, 2762, 2765, 2783, 2785). Among other things, Wells was required to provide Konjoh with a

¹⁰ The scheduling portion of SmartLinx is tied into the time and attendance (payroll) programs. The data in the SmartLinx programs is used to generate reports used by management for budgeting and planning purposes. (Tr. 1694-95).

¹¹ This meeting was held after the Labor Day weekend because many scheduling problems occurred over the Labor Day weekend and Illis had received calls about staffing problems at the Center and the hectic nature of the schedule. (Tr. 2752).

SmartLinx¹² attendance schedule on a daily basis, (Tr. 2104, 2760-61), promptly communicate schedule vacancies, rely solely on the SmartLinx system to develop the schedule, and reconcile the schedule in SmartLinx on a regular basis.¹³ (Tr. 2752-53, 2757-61; GC-70).

Contrary to the ALJ's erroneous finding, this meeting with Wells was not intended to be a disciplinary meeting, and Konjoh and Illis hoped that the written guidelines would preclude the need for future discipline by clearly conveying their expectations to Wells.¹⁴ (Tr. 2101-02, 2752, 2755, 2758; GC-70). Wells again acknowledged the errors she had made as set forth in the written document and agreed with the guidelines and expectations presented to her and signed off on them. (Tr. 2103-04, 2753, 2758-59, 2785; GC-70).

Unfortunately, staffing and scheduling problems persisted. On September 15, 2010, Konjoh and Illis met with Wells again, not to discipline her, but to assist her in entering the master schedule into SmartLinx. (Tr. 2106-07, 2821). In this meeting, Konjoh, Illis, and Wells sat together for approximately two hours and worked through the

¹² Illis asked that the daily attendance schedule be printed in Format 6, as that was the format with which she was most familiar. (Tr. 2756). To generate this schedule, Wells needed only to click on a button in the SmartLinx system and the computer would generate the daily schedule. (Tr. 2756). Konjoh did not have access to SmartLinx and could not access the schedule herself. (Tr. 2104, 2760-61).

¹³ While Wells may have been recording some information on her own Excel spreadsheet, this was not acceptable, as no one but Wells could access that information. (Tr. 2757-58). Thus, it was critical for Wells to enter the accurate information into the SmartLinx system where it could be accessed by Illis and other managers at the Center or at home, or by regional management outside of the Center. (Tr. 1477-79, 1541-42, 1695, 2757-58, 2787, 2792).

¹⁴ The ALJ seized on the fact that Wells was not "disciplined" for her performance prior to the election, (ALJD 29:33-34), without acknowledging the undisputed fact that she was verbally counseled in August 2010 (prior to the September 2nd election), concerning the same performance issues for which she received discipline following the election. (Tr. 2744, 2809-11). The ALJ's reasoning in this regard effectually punishes Somerset Valley for following a progressive discipline policy rather than taking a hard line with employees following the first instance of subpar performance.

entire process of inputting all the employees' schedules into the SmartLinx system. (Tr. 2107-09, 2821-22). After Konjoh left the meeting, Illis spent some additional time with Wells reviewing her expectations and discussing some recent scheduling errors Wells had made. (Tr. 2823-24). At that time, Wells acted as if she really did not care about the two hour process that they had just completed or about ensuring the accuracy of the schedule moving forward. (Tr. 2824). Accordingly, Illis issued Wells a formal disciplinary notice to convey to her the seriousness of her errors and the significance of her role in proper operation of the Center. (Tr. 2824). Unfortunately, Wells failed to modify her behavior. (Tr. 2765). Thus, on September 16, 2010, Konjoh gave Wells a second written warning for failing to provide Konjoh with a daily schedule and inform her of certain changes to the September 15 schedule. (Tr. 2113). Wells admitted in this meeting that she had failed to provide Konjoh with the daily schedule, claiming she had forgotten to do so. (Tr. 2115).

Konjoh gave Wells a third and final written warning for continued performance deficiencies on September 20, 2010. (Tr. 2117; GC-75, GC-81). Konjoh typed up a bullet point list of errors, and reviewed those errors with Wells. (Tr. 2117-19, 2124). The list included several instances in which Wells had failed to reconcile the schedule for employees who were cancelled from a shift or did not come to work, or for employees who had been included on the daily assignment sheet but not on the schedule, and all of which resulted in short-staffing. (Tr. 2125-33; R-81). While Wells offered explanations at that time for certain of the issues identified, and Konjoh accepted those explanations, Wells offered no objection or complaint for the other items listed in the write-up. (Tr. 2118-19, 2122, 2123; GC-76; R-81). Following receipt of this

third and final warning on September 20, 2010, Wells' performance still did not improve, (Tr. 2137-38). Accordingly, Wells' employment was terminated on September 20, 2010.¹⁵ (Tr. 2139; R-113).

Neither Illis nor Konjoh knew Wells supported the Union and no managers or employees ever told them that Wells had any involvement with the Union or the Union's organizing campaign.¹⁶ (Tr. 2140, 2848). Wells was expressly excluded from the bargaining unit and was not eligible to vote. (GC-4). Konjoh saw Wells come in to vote on election day but did not know how Wells voted.¹⁷ (Tr. 2141). The fact that Wells may or may not have participated in any Union activity did not enter into the decision to discipline Wells or terminate her employment.¹⁸ (Tr. 2849).

2. The Misuse of Per Diem Employees

The second significant operational issue identified by Konjoh and Illis was the misuse of per diem employees. By definition, a "per diem" employee is used only as

¹⁵ While still employed at the Center, Wells violated Center policy by forwarding a series of emails containing confidential Center information from her work computer to her home email address, without permission. (Tr. 2867-70; R-30). Wells previously had received, via email, a copy of the Use of Technology Policy applicable to the Center from Chief Information Officer, Richard Entrup. (Tr. 1778-79, 2862-66; R-55, R-56, R-114). The Policy was distributed by email to everyone at the Center and its affiliated companies with an email account. (Tr. 1779). The Policy specifically prohibits forwarding emails to a home email address. (Tr. 2862-66; R-55, R-114). Wells also had never been approved to conduct Center business on her personal email account or to send emails to her personal email address. (Tr. 1319, 2870). These repeated Policy violations by Wells were a terminable offense. (Tr. 2871; R-55). Had management known about this behavior at the time that it occurred, Wells would have been terminated for her actions. (Tr. 2871). Despite this undisputed evidence and the undisputed consequences of Wells' actions, the ALJ inexplicably found that the issue was "not fully litigated."

¹⁶ No one (including Mary Apgar, Heidi Neer, Southgate, Irene D'Ovidio, or Sheena Orozco) ever told Illis about any involvement Wells may have had with the Union or the Union's organizing campaign. (Tr. 2851).

¹⁷ Wells' vote was challenged. (Tr. 1196; GC-4).

¹⁸ Wells also never accused Illis of disciplining her because of her alleged Union sympathies or support. (Tr. 2849).

needed. (Tr. 1406, 1408, 2005). They do not have a regular or fixed schedule. (Tr. 2005-06). According to Somerset Valley's policy, per diem employees should have been used only to fill unexpected vacancies in the schedule caused by last minute absences, etc. (Tr. 1406, 1540, 2005-06, 2885-86, R-32). However, upon the arrival of Illis and Konjoh at the Center, per diem employees were being used on a regular schedule. (Tr. 1410, 1540-41, 2005, 2500, 2885). This misuse of per diem employees created problems for the Center. (Tr. 2008, 2887). First, because per diem employees are expected to maintain very flexible schedules to fill in as needed, even on weekends, they earn at least \$2.00 more per hour than full-time and part-time employees and often \$4.00-\$5.00 more per hour based on shift and weekend differentials.¹⁹ (Tr. 1407, 2006). Second, having regular full-time and part-time employees work the same shifts, as opposed to per diem employees, makes a significant difference in the quality and consistency of care provided to patients and further aids in establishing patient routines. (Tr. 2007).

Accordingly, after learning about this misuse of per diem employees, Konjoh and Illis took steps to conform the Center's use of per diem employees to the Center's policy.²⁰ (Tr. 2887). First, Illis and Konjoh offered full-time and/or part-time status to some of the per diem employees who had been working regularly scheduled days and

¹⁹ Indeed, even former Administrator Heedles did not like the overuse of per diem employees at the Center. (Tr. 1114). However, it was an issue that she was apparently unable to correct. The ALJ erroneously failed to consider the evidence of this failed attempt by Heedles in finding that "no correction" was made to the improper practice in scheduling per diems until after the election. (ALJD 32:38).

²⁰ This review of per diem staff usage also was consistent with Illis' past practice of looking at a list of all employees approximately every 30-45 days and ensuring they were all active employees. (Tr. 2887). If particular employees had not worked in recent weeks, they would be removed from the system. (Tr. 2887).

began filling the regularly scheduled jobs with full-time and part-time employees. (Tr. 831, 1410, 2305-06, 2910; R-27). They also determined the degree of availability and schedule flexibility of the current complement of per diem employees for use on a last minute, on-call basis, and to cover both days of a weekend schedule, if necessary.²¹ (Tr. 2888-93). Over time, the per diem employees who did not have the flexibility to work on an on-call basis proved to be undependable, ended up not working at all, and eventually were dropped from the per diem list.²² (Tr. 2890, 2892-93; R-117).

From September 2010 to April 2011, approximately 26-29 per diem employees were dropped from the rolls, including five per diem employees who are alleged discriminatees in this matter. (Tr. 2890, 2892-93; R-117). Significantly, these five per diem employees were treated exactly the same as the others and two of the five were offered part-time or full-time positions, which they turned down.²³ Today, per diem employees are being scheduled properly, and Somerset Valley is not only operating more efficiently, but the continuity and quality of its patient care has improved significantly. (Tr. 1406, 2887-88).

The five alleged discriminatees dropped from the per diem rolls from September 2010 to March 2011 were Rita Onyeike, Annie Stubbs, Daysi Aguilar, Dominique Joseph, and Gertrudis Rodriguez-Arias. All of them were dropped because they were

²¹ Having the same employee cover both weekend days improves the continuity of care for the patients, which is an important aspect of providing for the patients' needs. (Tr. 2309).

²² New per diem employees who were hired had to demonstrate that they had the flexibility to work as needed by the Center. (Tr. 2886, 2991-93).

²³ Neither Illis nor Konjoh knew whether any of these five per diem employees was a Union supporter. (Tr. 2311, 2899, 2912-16). Indeed, because some rarely worked, Illis and Konjoh didn't even know some of them as employees beyond seeing their names on a schedule now and then. Moreover, no consideration of the Union ever entered into any decision to change the utilization of per diem employees or to not use these employees as "per diems." (Tr. 2311, 2899, 2912-16).

unable to provide the flexibility needed from per diem employees. (Tr. 806-07, 811-12, 2307, 2894-97, 2911, 2913-14; R-119). In September 2010, Illis ran punch detail reports and reviewed the hours worked of the employees. (Tr. 2035, 2894-96; R-119). As a result of this review, Illis determined that Onyeike's hours were erratic and she was not working sufficient hours to qualify for part-time with benefits status.²⁴ (Tr. 2894-97; R-119). Illis then sent a letter to Onyeike informing her of management's decision to change her status from part-time with benefits to per diem because Onyeike was not working the requisite number of hours.²⁵ (Tr. 2420-2421; GC-53). Once advised that she could still earn a shift differential, Onyeike was agreeable to this change in status, and did not voice any complaint about it. (Tr. 2895-96). Onyeike was subsequently removed from the system in January 2011 for no active hours. (Tr. 2898; R-117).

Konjoh had conversations with Stubbs about her availability to work in September 2010 after the election. (Tr. 2307). Konjoh talked to Stubbs on the telephone and Stubbs informed Konjoh that she was only available to work the morning shift until 2 p.m., not the entire shift which ended at 3 p.m., because she had another job in the evening. (Tr. 2307, 2911). Unfortunately, Stubbs' lack of flexibility meant that she was ill-suited to serve Somerset Valley in a traditional per diem role, and in January 2011, Stubbs was removed from the system for no active hours. (Tr. 2911).

²⁴ Onyeike only started working at Somerset Valley in July 2010. (Tr. 697). Illis was not aware of Onyeike working any hours other than what was in the punch report. (Tr. 2897; R-119).

²⁵ Konjoh did not ask Illis to write a letter to Onyeike regarding her availability and work status at the Center. (Tr. 2299-2300). Also, Konjoh did not confirm how many shifts Onyeike had worked when she reviewed the status letter prepared by Illis. (Tr. 2436-37). However, shifts worked when Onyeike was still an orientee were not counted in a review of the total shifts that Onyeike had worked and the daily assignment sheets do not reflect the actual days that Onyeike worked at the Center, rather, the punch report reflects the days and times Onyeike worked. (Tr. 2439, 2443, 2897; GC-107; R-119).

Significantly, before she was removed from the per diem system, Stubbs was offered a part time position so she could have regular hours at Somerset Valley. (Tr. 2910). Stubbs, however, declined the offer. (Tr. 2910-2911). Further, Illis was not aware of whether Stubbs was a Union supporter or whether she engaged in Union activity, and any Union activity or support played no role in decisions made about scheduling Stubbs to work. (Tr. 2912).

Likewise, Aguilar indicated to Konjoh that she only had specific dates that she could work and specific shifts that she was available to work on those particular dates. (Tr. 2308). Aguilar also indicated that she had time constraints on the weekend hours she was available to work, which created a burden for the nursing department. (Tr. 2913-14). Significantly, she could not work the entire second shift schedule, which ended at 11 p.m., because she could not work past 8 p.m. on Sundays due to child care issues. (Tr. 2913-14). Aguilar never told Konjoh that she was available to work any other days in September or October 2010 beyond what was included in her note. (Tr. 2309). Konjoh did not schedule Aguilar for these days because Aguilar was not available to work the same shift on both weekend days on any weekend. (Tr. 2309). It was important for Konjoh to try to have the same person cover both weekend days for continuity of care to the patients. (Tr. 2309-10, 3126-27). Aguilar later was removed from the system for no active hours. (Tr. 2912-13). Neither Konjoh nor Illis had knowledge of whether Aguilar supported the Union or engaged in Union activity. (Tr. 2309, 2913). Moreover, Konjoh did not witness any interaction between Aguilar and Jillian Jacques (the Union's roving observer) on election day that might have indicated whether Aguilar supported the Union. (Tr. 2309). Whether or not Aguilar was a Union

supporter did not impact whether Aguilar was scheduled to work at the Center. (Tr. 2311, 2913).

Dominique Joseph also was removed from the per diem roll for inactive hours. (Tr. 2916). About one week after the election, Joseph told Konjoh that her car was broken and that she needed to be taken off the schedule. (Tr. 774-75). Konjoh did as requested and told Joseph to let her know if anything changed. (Tr. 775). Joseph later called and spoke to Illis about being put on the schedule and Illis told Joseph to call Konjoh back on Monday but Joseph failed to do so. (Tr. 777-78, 804-05). The ALJ erred in failing to acknowledge that Joseph admittedly never contacted Konjoh to advise that her car was fixed, or that she was available to work. (ALJD 35:18). Without such information, Konjoh had no reason to know that the status of Joseph's inability to work had changed. Additionally, Joseph had a job at another company and could not work the hours of a regular shift at Somerset Valley. (Tr. 806-07). Instead of starting the shift when it began at 3 p.m., Joseph testified that she could not start working until 4 p.m. and never told anyone that she could do otherwise. (Tr. 806-07, 811-12). As a result, Joseph ultimately was not scheduled for per diem shifts and was removed from the system for inactive hours. (Tr. 2916). Illis did not know whether Joseph supported the Union or not²⁶ and this did not factor into any decisions regarding Joseph being placed on the schedule. (Tr. 2916).

²⁶ Joseph's testimony about a conversation she had with Hutchens about the Union is not credible. According to Joseph, she told Hutchens in a one-on-one conversation that she only worked 13 hours every two weeks so she did not have enough money for Union dues. (Tr. 772). She alleged that Hutchens did not respond to her statement. (Tr. 772). When prompted by the Acting General Counsel whether "anything else" was discussed between Hutchens and her, Joseph stated, "It was about the Union dues." (Tr. 772). Finally, after additional, specific prompting by the Acting General Counsel regarding whether "the subject of the Union vote [came] up in conversation," Joseph responded, "He asked me if I'm going to vote," to which

Finally, Gertrudis Rodriguez-Arias also was removed from the per diem roll for lack of active hours. (Tr. 2914). Significantly, however, management offered Rodriguez-Arias a full-time position. (Tr. 831, 2305-06; R-27). Rodriguez-Arias initially accepted the full-time position, but then turned it down about a week later because of child care responsibilities. (Tr. 2305, 2633-34). Illis was not aware of whether Rodriguez-Arias was a Union supporter or whether she engaged in Union activity. (Tr. 2914-15). Rodriguez-Arias' feelings about the Union played no role in any decisions regarding her employment. (Tr. 2914-15).

As a result of the changes made by Illis and Konjoh to the Center's staffing practices, Somerset Valley is in a much better position today than it was in the Summer and Fall of 2010. (Tr. 1486-87, 1768-70; R-52). Staffing and scheduling are more reliable and more predictable, per diems are being used appropriately, there is transparency in the Center's labor metrics to the regional management team, and there is greater continuity and consistency in patient care. (Tr. 1486-87; 1768-75, R-52, R-53, R-55).

3. Attendance and Tardiness Issues

The third significant operational issue identified by Illis and Konjoh upon their arrival at Somerset Valley was excessive tardiness and absenteeism. Employees at Somerset Valley are told about the expectations regarding attendance during their employee orientation. (Tr. 2047). The Center has a policy prohibiting excessive

Joseph allegedly stated that she did not know. (Tr. 773). Contrary to her initial testimony that this was a one-on-one conversation, Joseph later changed her testimony and alleged that two other women were present who stated that they were going to vote and Hutchens responded that they were not eligible to vote. (Tr. 773-74). According to Joseph, it was in the context of Hutchens allegedly telling the other two women that they were not eligible to vote that he allegedly asked Joseph if she was going to vote. (Tr. 773-74). The ALJ failed entirely to reconcile this internally inconsistent, leading testimony in finding Joseph credible.

absenteeism, tardiness, and/or a pattern of absenteeism, all of which may result in disciplinary action, up to and including termination of employment. (Tr. 2060; R-79). Nevertheless, absenteeism and tardiness was rampant among employees upon Illis and Konjoh's arrival at the Center. (Tr. 2034-36). Illis and Konjoh addressed the issue by identifying the worst offenders²⁷ and issuing those offenders "warning notices."²⁸ (Tr. 2035-73, 2713).

In mid-September 2010 Illis and Konjoh issued 13 warning notices for absenteeism and/or tardiness to 11 employees. Jillian Jacques (109 tardies in approximately 8 months and 11 within the preceding 30 days), Shannon Napolitano (93 tardies in approximately 8 months and 9 within the preceding 30 days), and Sheena Claudio (64 tardies in approximately 8 months and 16 within the preceding 30 days) were included in this group of "worst offenders."²⁹ Konjoh, either alone or with Illis, made the decision to discipline Jacques, Napolitano, and Claudio. (Tr. 2055-56, 2057, 2064, 2071, 2737). The issuance and level of discipline was based on the severity of

²⁷ While the ALJ relied upon his finding that following Illis' arrival, "no action was taken against anyone for 6 weeks" to conclude that Somerset Valley sought to retaliate against employees for the Union's election victory, it was undisputed that Illis needed time in the Center to evaluate the attendance and tardiness situation before she could determine the necessary action to take. (Tr. 2034, 2036, 2713).

²⁸ Illis had a practice as an Administrator of ensuring compliance with the prevailing absenteeism and tardiness policies. (Tr. 2742). Approximately every 30-45 days, Illis reviewed employees' absences and tardies through the SmartLinx system, where all of the instances of absenteeism and tardiness are automatically calculated and can be generated into summaries and reports. (Tr. 1765, 2742, 3015-19; R-44). After reviewing the records, she analyzed the results to see if there are repeated problem areas and then forwarded the results to the employees' individual managers if there were concerns. (Tr. 2742-43). Illis followed this same practice when she was previously the Administrator at another center. (Tr. 2743).

²⁹ While Illis and Konjoh were aware that Napolitano and Jacques had served as Union observers at the election, they were unaware of any other Union activities by these employees. (Tr. 2174, 2947-48, 2952). In addition, they did not know whether Claudio was a Union supporter. (Tr. 2220, 2943). Moreover, no consideration of the Union ever entered into any decision to issue these attendance warning notices to Napolitano, Jacques, or Claudio. (Tr. 2174, 2220, 2943, 2947-48, 2952).

the attendance issues, and the employees' Union support, if any, was not considered in Somerset Valley's decision to discipline Jacques, Napolitano, and Claudio for these issues.³⁰ (Tr. 2056, 2065, 2733-34, 2076, 2737-39).

The other employees who were considered "worst offenders" and received warning notices were Beatrice Beauvoir (Tr. 2036, 2399; R-71), Lusette Ceus (Tr. 2038-40; R-72, R-73), Soledad Guillaume (Tr. 2041-42, 2052; R-74), Dominique Joseph (Tr. 2042-43, 2916; R-75), May Novelette (Tr. 2043-45; R-76, R-77), Jennifer McAuley (Tr. 2715-16, 2718-19; R-103, R-104), Patsy Benimadho (Tr. 2723-25; R-105), and Kassandra Burke. (Tr. 2715-16, 2726-28, 2958-59; R-106, R-134). The purpose of the attendance discipline was to change employee behavior with regard to absenteeism, call-outs, and tardiness, to improve staffing and patient care. (Tr. 2036).

Following the issuance of attendance discipline to these numerous employees in September 2010, there was a significant improvement in employees coming to work on time and not calling out. (Tr. 2083-85, 2743). The discipline meted out had its intended effect, and attendance improved across the board, not only for those who had received discipline. (Tr. 2084-85). Indeed, Jacques and Napolitano both demonstrated improvement in their attendance. (Tr. 2084, 2740-41). Management personally thanked some employees for the improvement in their attendance. (Tr. 2084, 2740-41). Illis even sent a card to Jacques' home congratulating and thanking her for her significantly improved attendance – an undisputed fact the ALJ failed to acknowledge. (ALJD 14:40-15:17; Tr. 604-05, 2084, 2741).

³⁰ Significantly, whether an individual was a Union supporter never was considered in deciding whether to issue discipline to an employee or in determining the level of discipline to be issued. (Tr. 2293).

4. Clinical and Patient Care Issues

Finally, Illis and Konjoh identified numerous serious clinical issues affecting patient care at the Center. (Tr. 1996, 2688). Upon her arrival at the Center, Illis discovered that there were no systems in place to manage clinical information, no audits of records and procedures were being conducted, there was no protocol for conducting audits, and information was not being managed properly. (Tr. 2688-89). Illis concluded that nursing leadership needed to be strengthened and the nursing department needed to set up systems to manage information, audits needed to be completed, and nursing leadership needed to be out on the patient floors talking to patients and reviewing medical records.³¹ (Tr. 2689).

When Konjoh assumed the DON position at Somerset Valley, she met with Illis and Regional Director of Operations, Jason Hutchens, and the two informed her that the Center was expecting a state survey to commence at any time. (Tr. 2009, 2323-24, 2342, 2687-88). Illis and Hutchens further explained to Konjoh that the Center had received "G" level deficiencies in the 2009 survey.³² (Tr. 1903, 2009, 2324, 2687-88; R-57).

During her first couple of weeks as the DON at Somerset Valley, Konjoh conducted a comprehensive clinical review of the Center, during which she discovered serious documentation issues, identified problems with patient care, and learned of past

³¹ Southgate acknowledged that Illis had a different leadership style from Heedles, and that Heedles had a different leadership style than her predecessor, Caroline Allen. (Tr. 1129-32).

³² Near the end of their conversation, Illis and Hutchens also informed Konjoh that the employees had petitioned for a union election and that the election would be occurring in a couple of weeks. (Tr. 2010, 2324, 2342). Illis and Hutchens told Konjoh that they wanted the Center to stay union-free, but did not tell her that they were unhappy that employees had petitioned for a union. (Tr. 2343).

complaints from patients and their family members. (Tr. 1996). The ALJ's finding that the timing of the increased monitoring and review of records and increased accountability coincided with the timing of the election is erroneous as he blatantly ignored clear evidence that the timing coincided with new management with different leadership styles taking responsibility for operation of the Center. (ALJD 16:32-35, 16:35-26, 17:2-4, 17:44-47). Moreover, the ALJ's reliance on the testimony of Jacques and Claudio in this regard is misplaced as both testified that the infrequent review of records took place during a time when the Center undisputedly was being poorly managed and had performed poorly on its State survey. (ALJD 18:19-22, 18:26-30).

As a result of Konjoh's review, she found instances where nursing protocols and/or policies were not being enforced.³³ (Tr. 1998-99). For example, patients were sometimes admitted to the Center and nurses failed to properly carry out physicians' orders or failed to properly document the patient's assessment. (Tr. 1998-99, 2013, 2544). A critical part of a nurse's job is to properly document patient care and a patient's condition. (Tr. 1998). The nurse is required to initial on the date of the Medication Administration Records ("MARs") or Treatment Administration Records ("TARs") immediately after the medication is administered or the treatment is rendered.³⁴ (Tr. 2014). The MARs and TARs at Somerset Valley are kept in a binder on one of three med carts. (Tr. 2017-18).

³³ Nurses are subject to Somerset Valley's Nursing Code of Conduct and all employees are subject to the Code of Conduct that is distributed to employees during orientation, and employees sign acknowledgements for the Code of Conduct. (Tr. 656-58, 1312, 1487-88; R-5, R-12, R-13, R-29, R-39, R-40).

³⁴ It was never brought to Konjoh's attention that there were any repeated issues of nurses not completing their MARs or TARs. (Tr. 2548). As such, Konjoh did not have any regular procedure in place for reviewing the MARs or TARs. (Tr. 2548).

It is not permissible for nurses to wait until the end of their shift to complete the MARs or TARs, for the simple reason that if the record was not made immediately, someone else looking at the patient's chart would have no way of knowing whether the medication was administered or whether the treatment was provided. (Tr. 2014-17). Furthermore, failure to immediately document medication or treatment is a violation of state and federal guidelines. (Tr. 2016-17). It also is not permissible to record medication administration or patient treatment in an employee's own personal notebook, and Konjoh was not aware of any nurses doing so. (Tr. 2015, 2409). Moreover, making personal recordings of patient medical or healthcare information that are then taken outside the Center would constitute a violation of the Health Insurance Portability and Accountability Act ("HIPAA"). (Tr. 2015, 2540).

Nurses at Somerset Valley similarly are required to complete incident/accident reports whenever there is an incident or accident involving a patient, employee, or visitor. (Tr. 2018). The Center has a policy requiring that all such incidents be reported by the nursing supervisor and appropriate documentation be completed on the shift during which the incident occurred. (Tr. 1870, 1985; R-62).

The failure to properly document the administration of medication, patient treatments, or a patient's condition adversely affects patient care,³⁵ (Tr. 1998), because the prior documentation is used by physicians and nurses to determine how patients will be evaluated and cared for in the future. (Tr. 1998, 2185). For example, if a patient falls and hits his or her head and the nurse fails to document the fall, the nurse on the next shift would not know how to assess any neurological changes for that patient and

³⁵ Disciplinary action for failing to properly complete an incident report is based on the severity of the infraction. (Tr. 2470-71).

would, therefore, not be able to treat the patient appropriately. (Tr. 1998). When Konjoh arrived at Somerset Valley, she learned that nurses were failing to document patient falls and skin tears. (Tr. 1998-99). She also learned that the administration of medication was not always properly documented, which was a significant patient care issue.³⁶ (Tr. 1998-99).

Because the 2010 recertification survey was imminent at the time of Konjoh's arrival at Somerset Valley, Konjoh began auditing patient charts immediately to get ready for the survey.³⁷ (Tr. 2010-11). She also began by working on new patient admissions to the Center to ensure smooth transitions for all new patients. (Tr. 2011). During this period of time, Konjoh examined the admission paperwork for all new admissions to the Center. (Tr. 2011, 2370, 2486, 2547). She examined the hospital records, the MARs, and the TARs, both before the patient arrived and again approximately 24-48 hours after the patient's arrival.³⁸ (Tr. 2012, 2486-87). In reviewing the MARs and TARs in preparation for the state survey, Konjoh reviewed hospital transfer records, patient assessments, and the patient records for patients for

³⁶ The Somerset Valley Code of Conduct sets forth a number of fundamental principles by which employees at the Center are expected to conduct themselves. (R-39, R-40). Among other things, the Code of Conduct informs employees that they must comply with professional standards of practice, maintain accurate and reliable documents during the course of day-to-day activities, and complete or be subject to internal audits to ensure no false claims are generated to Medicare or Medicaid. (R-39, R-40). Significantly, the Code notifies employees that failure to comply with the principles set forth within the Code will subject the employee to discipline, including termination. (R-39, R-40).

³⁷ Southgate admitted that there usually is closer review of the MARs, TARs, admission records, and other admissions documentation in preparation for the State survey. (Tr. 1072). The ALJ erroneously failed to acknowledge the testimony by Konjoh regarding review of documentation in preparation for the survey in finding that she reviewed records *only* upon admission of the patient or a patient complaint. (ALJD 17:44-47).

³⁸ This time for review was sometimes delayed due to intervening weekends or backlog caused by weekend or holiday admissions. (Tr. 2487-89).

whom there had been a complaint about care or if some other issue led her to the MARs or TARs. (Tr. 2016, 2030).

The clinical management team also spent more time on the floor and auditing nursing activities and patient care issues during this time period. Konjoh reviewed the patient records in more depth than she normally would have because she was new to the Center and unfamiliar with the Center's practices and because the State survey was pending.³⁹ (Tr. 2031). At that time, she discovered errors and omissions that led to employee discipline. (Tr. 2031). When she found a problem, Konjoh typically would start by verbally counseling the employee and, depending on the severity of the issue, progress from there.⁴⁰ (Tr. 2031-32).

From September 2010 to March 2011, 20 employees received discipline for patient care errors or omissions. Included in this group were Sheena Claudio (failing to complete critical documentation on three patients and failing to complete necessary treatment records for an entire shift), Jillian Jacques (failing to document on a patient, failing to complete incident reports, failing to correctly transcribe a medication order, and failing to complete a post-fall documentation on a patient), and Shannon Napolitano (negligently continuing to administer medication that had been discontinued by the doctor; failing to follow standard accepted nursing procedures to ensure the correct

³⁹ Claudio admitted in her testimony that when new DONs come to the Center, they have their own way of doing things. (Tr. 206).

⁴⁰ Regarding Somerset Valley's Progressive Discipline Policy, the Center generally utilizes a system of progressive discipline based on the severity of the offense. (Tr. 2035). The Center also uses two independent disciplinary tracks – one track for performance issues and one track for attendance-related issues. (Tr. 2085, 2741). Thus, an employee would not receive a first written warning for attendance and then receive a second written warning for a performance issue, such as a medication error. (Tr. 2085). Typical progressive discipline might include a documented verbal warning, a written warning, a suspension, or termination, again based on the severity of the offense. (Tr. 2035). When issued discipline, employees have an opportunity to respond to the disciplinary action verbally and in writing. (Tr. 2035-36).

patient ingested the correct medication; and negligently recording incorrect patient information on the patient's chart). All three employees received multiple disciplinary warnings for their infractions before ultimately being terminated.⁴¹

i. Sheena Claudio's Critical Patient Care Errors

On September 20, 2010, Claudio received a final written warning for administering aspirin to a patient two days in a row when the medication had been prescribed to the patient only every other day. (Tr. 137-39, 2187, 2189, 2610; GC-17). At the time that Claudio received this final written warning, she was told that future errors could result in her termination. (Tr. 2215). Claudio admitted that she made a mistake and misread the order, but disagreed with the discipline.⁴² (Tr. 139, 263-64). Although the doctor's order that the medication was to be given every other day was written on the left column of the MAR, Claudio complained that the nurse who transcribed the order onto the MAR also should have "blocked off" the days on the MAR when the patient was not to receive the medication. (Tr. 2189; GC-17). Blocking off days, however, is not a nursing requirement at Somerset Valley, nor is it a state or federal requirement. (Tr. 2189). Consequently, Claudio should have administered the medication every other day, as prescribed, notwithstanding that no dates were blocked

⁴¹ While Illis and Konjoh were aware that Napolitano and Jacques had served as Union observers at the election, they were unaware of any other Union activities by these employees. In addition, they did not know whether Claudio was a Union supporter. Moreover, no consideration of the Union ever entered into any decision to issue any of these disciplinary notices to Napolitano, Jacques, or Claudio, or to terminate them. (Tr. 2174, 2220, 2943, 2947-48, 2952).

⁴² Specifically, Claudio admitted that if a nurse gives a patient medication every day when it is only prescribed for every other day, that is a nursing error, and it would also constitute a deficiency if found by a State surveyor. (Tr. 245).

off on the MAR, and she was disciplined accordingly.⁴³ (Tr. 2189). LPN Doreen Dande made the same error with the same patient as Claudio and received the same warning for this error on October 10, 2010. (Tr. 2190-91, 2477-78, 2610-11; R-85).

Claudio received further discipline in October 2010 for documentation errors for failing to complete critical documentation on three patients.⁴⁴ (Tr. 149-50, 2192-2193, 2606; GC-19; R-6, R-86). These errors were discovered by Konjoh while she was auditing admission charts and paying particular attention to post-fall documentation. (Tr. 2196). The documentation errors Claudio made were as follows: (1) she failed to properly document a patient fall and subsequent neuro check; (2) she failed to document post-fall on a new admission,⁴⁵ and then failed to document on that same patient on the admission notes,⁴⁶ and (3) she provided treatment on a patient with a skin tear without a physician's order⁴⁷ and failed to write an order for the skin care treatment

⁴³ The ALJ's finding that the night shift nurse should have been disciplined for failing to conduct a 24-hour check of the medication administration and failure to discipline this nurse was motivated by discriminatory or retaliatory animus towards Claudio is misplaced as Konjoh's testimony that she was not aware of such a requirement is undisputed. (ALJD 46:40-45). Accordingly, Konjoh could not discipline another employee for conduct she was unaware merited discipline.

⁴⁴ Konjoh is not aware of any situation where a nurse made any type of documentation error and the nurse was not disciplined. (Tr. 2292).

⁴⁵ Claudio admitted to participating in numerous in-services during her employment at Somerset Valley, including a detailed in-service on admissions reporting, as well as in-services on medication administration, documentation of treatments, and med pass techniques. (Tr. 206, 215-27; R-1, R-2, R-3, R-4).

⁴⁶ When a new patient is admitted, checks must be performed and documented on the patient for a minimum of 72 hours per Medicare regulations and Center policy. (Tr. 1873-75, 2212-13; R-64). Thereafter, skilled nurses' notes must be completed daily in accordance with Center policy. (Tr. 1876; R-65). In a post-fall situation, checks and documentation must be performed on each shift for three days. (Tr. 2212-13). State regulators evaluate this documentation during their surveys. (Tr. 1875).

⁴⁷ Claudio permissibly performed treatment on the bleeding patient, but then was required to obtain an order from the physician and transcribe the order, which she failed to do. (Tr. 2201-02). All skin wounds, even minor wounds, require a physician's order for treatment. (Tr. 2562-63). The Center's policy on wound care addresses the procedure to follow for caring for

even though she documented the treatment on an incident report. (Tr. 2192-93, 2197-2202, 2259-60; GC-19; R-86). These documentation errors and provision of care without a doctor's order, for which Claudio received a final written warning and a two-day suspension, could have been detrimental to patient care. (Tr. 21922214-15; R-86). Claudio could have been terminated at this time because of her previous final written warning for the medication error and because Konjoh had addressed these types of documentation errors in a nurses' meeting, but Konjoh chose not to terminate Claudio's employment at that time. (Tr. 2215-16, 2607). Significantly, Claudio admitted to all of the errors, with the exception of the new admission documentation.⁴⁸ (Tr. 150-52, 2195-96; R-86). With regard to that alleged error, the patient's chart clearly lacked the admission note (which should have been the first entry on the chart). (Tr. 2195-96, 2214; R-86).

Finally, Claudio was disciplined and ultimately terminated for a bizarre incident in which she returned to the Center after her shift and attempted to sign for all of her treatments for the entire day.⁴⁹ (Tr. 2216-18, 2937-41; R-125). Illis discovered Claudio's attempt to cover up her errors and forced her to leave the Center. (Tr. 2937-38). It was entirely unacceptable and inappropriate for Claudio to return to the Center

wounds, including providing emergency treatment if necessary, but then following up with the physician to obtain an order from the physician for the wound care. (Tr. 1871-72; R-63). Wound care and documentation of wound care is an area that State surveyors evaluate. (Tr. 1872).

⁴⁸ Claudio admitted to failing to complete the necessary post-fall documentation and wrote in her statement that there was "no excuse" for this error. (Tr. 155; GC-20). Both Claudio and Jacques further testified that it is a nursing error if a nurse fails to document post-admission and post-fall status for the requisite number of days. (Tr. 265, 601).

⁴⁹ Claudio admitted that failing to complete her TARs was an error on her part, but failed to report it to supervision until she was later discovered. (Tr. 252). Claudio further acknowledged that if there is incomplete documentation, the nurse on the next shift does not know whether treatments have been performed. (Tr. 255-57).

approximately nine hours after the end of her shift and attempt to sign for treatments at that time.⁵⁰ (Tr. 2937-38).

The next day, Claudio called Konjoh to discuss the events of the previous night. (Tr. 2217). Konjoh told Claudio that the incident was being investigated and that she was going to review the TARs, discuss the incident with Illis, and discuss the incident with the night shift nursing supervisor. (Tr. 2217). Konjoh then followed through with this course of action: she reviewed the TARs; spoke with Illis in detail about the incident; and obtained statements from nursing supervisor Janet Mathias and Jacques who witnessed Claudio attempting to sign the TARs. (Tr. 2218, 2940-41; R-125). In reviewing the TARs, Konjoh learned that Claudio had failed to document approximately 20 patient treatments. (Tr. 2218; R-125). This was a violation of state and federal requirements and, if found by a State surveyor, would have resulted in a deficiency. (Tr. 2218).

⁵⁰ Claudio's testimony vacillated repeatedly regarding the number of treatments for which she neglected to sign and how she typically signed for her treatments. First, she testified that she realized after she left the Center that she "forgot to sign two of her treatments." (Tr. 168). Later, she testified that she told Konjoh the next day that she forgot to sign for "a few" treatments. (Tr. 172). She also explained that nurses have to complete each treatment as it is scheduled, but to the contrary that nurses have until the end of the shift to complete the TARs for their patients. (Tr. 163). She further testified that she would regularly do *all* her treatments and then sit down at night and sign that they were done. (Tr. 210). She then explained that she would do her notations *after five patients*, but then waffled again and said she would usually do it at the end of the day because they were very busy. (Tr. 211). Claudio went on to say that she mostly signed her TARs at the end of her shift, but she may have signed a few earlier in the shift. (Tr. 212-13). At this point, Claudio testified that at the end of her shift she might have 100 treatments to log in her book. (Tr. 214-15). This testimony is inconceivably at odds with her initial testimony that there were only a "couple" or "few" treatments for which she forgot to sign. (Tr. 168, 172). Finally, after continued cross examination, Claudio admitted that she may have had over 100 treatments that day, but only recalls filling in her TARs for one of her 22 patients' treatments. (Tr. 249-50). Even Jacques agreed that nurses are supposed to fill out their TARs and have them completed before they leave for the day. Otherwise there is no record of the treatments having been performed. (Tr. 640). The ALJ failed to reconcile or acknowledge the numerous inconsistencies in Claudio's testimony, yet, somehow, gave her testimony full weight and credit.

Konjoh and Illis made the decision to terminate Claudio after full investigation of this incident. (Tr. 2940-43; R-125). Neither Konjoh nor Illis are aware of any other nurses who failed to complete their TARs by the end of their shift and were not disciplined, and also were not aware of any other nurse who returned to the Center after her shift to complete the TARs.⁵¹ (Tr. 2218, 2220, 2292, 2940). Illis and Konjoh also were not aware of whether Claudio was a Union supporter and the decisions to discipline and terminate her employment were in no way related to any Union support or activity. (Tr. 2220, 2943).

ii. Jillian Jacques' Critical Patient Care Errors

LPN Jillian Jacques repeatedly was disciplined for work performance issues. (Tr. 2220; GC-43; R-87). First, Jacques received a final written warning in December 2009 for improper pain assessment,⁵² the same issue for which the Center received a G-level deficiency in its 2009 Survey. (Tr. 597-98, 1448-49; R-10). Thereafter, in September 2010, although Jacques could have been terminated based on her prior final warning, Jacques instead received a first written warning for failing to document a patient's status post-admission and post-fall, and failing to document a second patient's status post-

⁵¹ If a nurse realized before the end of her shift that she had neglected to sign for a treatment and advised Konjoh of the error and the treatment could be confirmed, Konjoh would allow the nurse to sign for the treatment in the TARs. (Tr. 2219, 2409-10, 2555-58). However, if the nurse left the Center and then realized the TARs had not been completed, the nurse would be disciplined for the error. (Tr. 2219). If the treatment could be proven the next day, the record of that treatment would not be made in the TARs, it would be made in the nurses' notes in the patient's chart. (Tr. 2555-56). Konjoh is not aware of any similar situation where a nurse left the building after her shift ended without having completed her TARs and was not disciplined. (Tr. 2292, 2940). Moreover, while nurses sometimes do regular charting, such as patient assessment and vital signs, at the end of the shift, MARs and TARs should be completed at the time the medication is administered or the treatment is given. (Tr. 1950-51).

⁵² Notably, this directly contradicts the ALJ's claim that discipline was not issued until after the September 2, 2010 election.

admission. (Tr. 2221; GC-43; R-87). These documentation issues had been covered in a staff meeting earlier in the month. (Tr. 2221).

After Konjoh issued Jacques the discipline on the various documentation errors, Jacques followed up on one issue and noted that there was a discrepancy with regard to one of the documentation issues occurring on September 25, 2010, and that the error actually was made by another LPN, Patricia Beck. (Tr. 2221-22, 2242, 2255, 2498). Konjoh examined the records again and agreed with Jacques that she did not make this particular error and then lined through that portion of the disciplinary write-up and the remaining discipline stayed in effect – justifying the issuance of the write-up. (Tr. 2222, 2224, 2254-56). Konjoh made the decision to issue Jacques disciplinary action and also determined the level of disciplinary action that Jacques should receive based on the severity of her infractions. (Tr. 2225; GC-87). Konjoh and Illis were aware that Jacques served as an observer for the Union during the election,⁵³ but did not base their disciplinary decisions on this fact. (Tr. 2225, 2444, 2951-52).

Jacques did not have any comment, excuse, or explanation for any of the other errors that were the subject of this disciplinary action, nor did she write any responsive comments to the discipline. (Tr. 2222-23, 2225). With the exception of the error that was removed from the disciplinary action, Jacques agreed that she had failed to complete all of the other documentation.⁵⁴ (Tr. 2225). The discipline was based on the severity of her infraction. (Tr. 2242).

⁵³ Jacques was a roving observer during the election and carried a sign that told employees that it was time to vote. (Tr. 2445).

⁵⁴ Other than this issue involving Beck, Konjoh is aware of no other situation where a nurse failed to properly document a patient admission or fall and was not disciplined. (Tr. 2292-93). Konjoh intended to discipline Beck for the remaining error, but instead disciplined Beck for a

In November 2010, Jacques was issued a final written warning for failing to complete multiple incident reports. (Tr. 2231-33; GC-46; R-88). Southgate originally approached Jacques about the incomplete incident reports for four patients. (Tr. 2231-33). At that time, Jacques told Southgate that she had called Konjoh about one of the incidents and left her a voicemail message stating that she could not complete a particular incident report for that incident because the CNA who witnessed the incident had already left for the day.⁵⁵ (Tr. 2233-35). Jacques, however, did not provide any explanation for any of the other incomplete incident reports and previously had been inserviced on how to properly complete incident reports, as well as other clinical education. (Tr. 662-66, 2234; R-11, R-14, R-15, R-16, R-17). As such, Konjoh instructed Southgate to proceed with issuing disciplinary action to Jacques.⁵⁶ (Tr. 2234-35; GC-43, GC-46; R-88).

Finally, in February 2011, Jacques was suspended by new DON Jackie Engram pending investigation for a medication transcription error after mistakenly transcribing regular aspirin rather than the prescribed enteric coated aspirin, on the Physician's

similar documentation error made on that same day. (Tr. 2242, 2255-57; R-90). Konjoh was not aware of whether Beck was a Union supporter. (Tr. 2244).

⁵⁵ Southgate issued a verbal warning to Jacques' immediate supervisor for failing to ensure Jacques properly completed incident reports. (Tr. 2473-74, 2603-04; GC-115).

⁵⁶ At no time did Konjoh ever tell Southgate to only issue discipline to employees that Konjoh or Southgate thought were Union supporters, nor did Konjoh ever tell Southgate to look for errors made by Union supporters so that Konjoh could issue discipline to those individuals. Further, Konjoh made no statements to Southgate that implied that Southgate should target Union supporters for disciplinary action, and she also did not focus her attention on anyone who she thought to be a Union supporter to target them for discipline or tell Southgate that she was going to scrutinize those individuals for discipline. (Tr. 2276-77).

Order Sheet (“POS”) and further neglecting to transcribe any aspirin onto the MAR.⁵⁷ (Tr. 1887-89; R-66). Jacques again admitted to her errors.⁵⁸ (Tr. 574-75, 1891-92; R-66). Thereafter, Jacques’ employment was terminated as a result of her repeated serious clinical errors.⁵⁹ (Tr. 1885, 1961, 1969-71, 2951; R-66). While Illis knew that Jacques had been an observer for the Union, she was not aware of any other Union activity that Jacques was engaged in and the fact that Jacques was a Union observer and may have been a Union supporter was not considered in any way in the decision to terminate her employment. (Tr. 2952). Moreover, as the new DON, Jackie Engram had no knowledge of Jacques engaging in any Union activities or supporting the Union at the time of Jacques’ termination – more than five months after the September 2, 2010 election. (Tr. 1894).

iii. Shannon Napolitano’s Critical Patient Care Errors

On September 16, 2010, Konjoh received a call from the social worker at the Center asking Konjoh to meet with a patient. (Tr. 2146). Konjoh proceeded to meet with the patient who complained to her that her nurse that day had not inserted her catheter and had not given her “her pink pill.” (Tr. 2146, 2563). The “pink pill” the patient was referring to was a zinc capsule which is often prescribed to aid in wound healing. (Tr. 2146). The patient further claimed that the only nurse who gave her the

⁵⁷ The ALJ erroneously found Jacques improperly *administered* aspirin; however, it is undisputed that Jacques erred in failing to properly transcribe the physician’s order and in failing to complete the order on the MAR.

⁵⁸ Jacques noted that the fax machine was not functioning on the evening that she made these errors. However, a fax machine was not needed for her to accurately transcribe an order on the MARs. (Tr. 1983-85; R-66).

⁵⁹ Jacques’ prior discipline for attendance issues was not considered when the decision was made to terminate her employment, as attendance discipline runs on a separate track from other performance discipline. (Tr. 2741-42).

“pink pill” was Shannon Napolitano. (Tr. 2146). Konjoh wrote up the patient’s complaint on a grievance form noting that the patient was confused about her medications and immediately looked into the complaint. (Tr. 2146, 2153; R-82).

Konjoh examined the patient’s MAR and learned that the patient was not currently prescribed any “pink pill” and there was no signature for a nurse having administered a “pink pill” to the patient. (Tr. 2147). Konjoh then followed up with the patient and told the patient that there was no record of any pink pill on the MAR and she was not supposed to be getting a pink pill. (Tr. 2147). Konjoh then told the patient that if a nurse tried to give her a pink pill, she should not take the pill and tell the nurse that she did not want it and was not supposed to take it.⁶⁰ (Tr. 2147, 2392).

The next morning, the patient called Konjoh into her room. (Tr. 2148). The patient showed Konjoh a cup with a pink capsule in it and told Konjoh, “I told you I was getting a pink pill.” (Tr. 2148). Konjoh apologized to the patient and told her that as far as Konjoh knew she was not supposed to be getting a pink pill. (Tr. 2148). Konjoh took the cup from the patient and told the patient she would look into the matter further. (Tr. 2148). When exiting the patient’s room with the cup, Konjoh saw Napolitano in the hallway. (Tr. 2148-49). Napolitano remarked to Konjoh that Konjoh was holding the patient’s zinc capsule. (Tr. 2149). Konjoh then asked whether the patient was supposed to be receiving zinc. (Tr. 2149). Napolitano replied, “Yes.” (Tr. 2149). Konjoh responded, “Okay. Let’s look through the MAR. Maybe I did not see it.” (Tr. 2149). The two then went together and looked at the MAR, but did not see any record

⁶⁰ The ALJ’s finding that Konjoh told the patient that if she was given the pill again, she should hold it and show it to Konjoh is directly contradicted by Konjoh’s clear, unrebutted testimony. (ALJD 19:39).

of the zinc capsule. (Tr. 2149). Napolitano informed Konjoh that the patient used to be on zinc. (Tr. 2149). Konjoh then speculated that there may have been a transcription error in omitting the medication from the prior month to the current month's MAR. (Tr. 2149). The two proceeded to look for the medication on the med cart. (Tr. 2149). There was a box on the med cart with a few zinc capsules in it. (Tr. 2149). Although medication normally is removed from the med cart when it is discontinued to keep the cart clean, removing a discontinued medication from the med cart is not a requirement and not something that would be considered to be a deficiency in a state survey. (Tr. 2165-66, 2392). Konjoh had not checked the cart the day before because she initially found no evidence of a pink pill on the MAR, thus giving her no indication that the patient was actually receiving "a pink pill."⁶¹ (Tr. 2167, 2390-91, 2566). She also had not asked Napolitano about it because Napolitano was not working the day the patient had brought the concern to her attention, and Konjoh had not yet seen Napolitano by the next morning when the patient brought the pill to Konjoh. (Tr. 2394, 2563-64).

Konjoh then went to the nurses' station to review the POS and the prior month's MAR to see if the patient was supposed to be taking the zinc capsule. (Tr. 2149, 2156-57; R-82). The current POS had no zinc prescribed for this patient. (Tr. 2149). However, the POS for August did have zinc on it. (Tr. 2149). The August MAR showed that the zinc should have been discontinued on August 23. (Tr. 2149; R-82). Konjoh then noticed several signatures apparently indicating that the zinc had been improperly

⁶¹ The ALJ erred in finding that Konjoh "improperly" took no steps to remove the medication from the cart. (ALJD 20:23-25). Further, Konjoh's testimony that she was not aware that the discontinued medication was on the cart until *after* the patient showed her the "pink pill" is unrebutted. It is axiomatic that Konjoh could not remove a medication from the cart before she became aware of its existence.

administered after August 23, even though the nurse who had transcribed the medication on the MAR had plotted out the days that the zinc was to be administered and drew a line on the MAR at the point in time at which the medication should have been discontinued. (Tr. 2149-50; R-82). Although the ALJ's findings imply that the medication was not properly transcribed and "boxed out" on the MAR, this reasoning is directly contradicted by the evidence, as set forth above. (ALJD 20:4-6). Further, this delineation was not a nursing requirement, but simply made it easier for the administering nurses to discern when the medication was to be discontinued. (Tr. 2157-58).

The correct process for administering medication to a patient includes: (1) reviewing the MAR to determine what medication is to be administered to the patient; (2) confirming the appropriate dosage; (3) retrieving the medication; (4) checking the medication against the order; (5) putting the medication in a cup; (6) administering the medication and ensuring it is ingested by the patient;⁶² and (7) documenting on the MAR that the medication has been administered. (Tr. 2150-51). This process was in effect at Somerset Valley and nurses are taught this proper procedure for administering medication in nursing school which includes "five rights in administering medication." (Tr. 1858-60, 2152; R-58). Additionally, nurses, including Napolitano, had received in-services at Somerset Valley on proper medication administration and proper medication pass process, including the importance of not leaving a medication at the patient's

⁶² There must be a physician's order to allow a patient to self-administer medication and there are restrictions and protocols to follow for self-administration of medications. (Tr. 1861-62; R-59). There was no evidence that Napolitano's patient was approved for self-administration of medication.

bedside, as well as training on other nursing protocols.⁶³ (Tr. 414-16, 1866-68, 2152; R-2, R-7, R-8, R-17, R-60).

Konjoh discovered that Napolitano repeatedly⁶⁴ had not followed the correct procedure for administering this medication. (Tr. 2151-52). She did not review the MAR before administering the medication;⁶⁵ she did not ensure the patient ingested the medication;⁶⁶ and she did not properly document administering the medication. (Tr. 2151-52; R-82). These are serious issues that would have resulted in deficiencies if found by the State during a survey. (Tr. 2182; R-82). Significantly, Napolitano admitted that she was giving the zinc capsule to the patient in error. (Tr. 2152; R-82). Additionally, she admitted that she left the medication on the table at the patient's bedside. (R-82). Although this patient was not harmed by receiving the additional zinc, taking too much zinc can impair kidney function and potentially result in death. (Tr. 2167).

⁶³ Claudio testified that in-services were conducted wherein it was conveyed to nurses that the patient must ingest any medication given to them. (Tr. 214-15; R-1). Claudio further testified that it is very important that a nurse watch a patient swallow the medication and that this is a fundamental element of being a good nurse. (Tr. 214-15).

⁶⁴ Napolitano identified her initials three times on the August MAR after the medication had been discontinued, and she also mistakenly gave the medication on the day it was discovered by Konjoh. Thus, Konjoh concluded that Napolitano had made the same error a total of four times. (Tr. 2375). According to the daily assignment sheets and daily schedules, Napolitano was not scheduled to work during the day on August 27 or 28, but was scheduled to work on August 26, August 30, and August 31. (Tr. 2376-77, 2596-97; GC-100, GC-101, GC-102, GC-103; R-101).

⁶⁵ Napolitano admitted that if a nurse continues to give a patient a discontinued medication, this is considered to be an error. (Tr. 433). Claudio similarly testified that if a State surveyor found that a nurse had given a patient the wrong medication, that would constitute a survey deficiency. (Tr. 245).

⁶⁶ Konjoh is not aware of any similar situation where a nurse gave a patient medication but did not watch the patient ingest the medication and the nurse was not disciplined. (Tr. 2292). Konjoh also is not aware of any similar situation where a nurse gave a patient medication after that medication was discontinued or made any other error in administering medication and the nurse was not disciplined. (Tr. 2292).

Konjoh completed a full write-up on the “facility follow-up” portion of the patient grievance form after learning that the patient had in fact received the medication in error numerous times. (Tr. 2154; R-82). Konjoh wrote in the report that the zinc was last ordered for a two-week duration on August 9 and should have been completed on August 23, but that the patient received the medication sporadically after that time. (Tr. 2154). Significantly, the patient was already receiving zinc in the form of a multi-vitamin at this same time. (Tr. 2159; R-82). The extra zinc had only been ordered for the two-week period on August 9 to promote wound healing because the patient had a Stage 4 wound at that time. (Tr. 2159). Konjoh further noted in the report that disciplinary action had been taken and that the family was made aware of the errors. (Tr. 2154; R-82). Konjoh had an initial disciplinary meeting with Napolitano to discuss these repeated medication errors on September 17, 2010.⁶⁷ (Tr. 2167-68). Napolitano did not object or state that she disagreed with the disciplinary issues raised by Konjoh at this time. (Tr. 2168).

While Konjoh initially concluded that there were multiple nurses’ initials on the MAR showing nurses who had mistakenly administered the zinc capsule to the patient, (Tr. 2154, 2158; R-82), Napolitano was the only nurse who admitted to administering the medication to the patient. (Tr. 2158, 2381-82). Notably, Claudio’s initials also appeared on the MAR; however, she had crossed through her initials. (Tr. 2158, 2162). Similarly, the two other nurses who worked these days also had a line drawn through their initials and they also claimed that they had not given the patient the medication.

⁶⁷ Napolitano previously had received a final written warning in January 2010 for improper pain assessment – the same issue identified as a G-level deficiency in the 2009 survey. (Tr. 1446-47; R-36). Again, this discipline was issued prior to the September 2, 2010 election, contrary to the ALJ’s claim that discipline was not issued prior to the election.

(Tr. 2381-82). All of the other relevant initials for the zinc administration, Napolitano identified as her own. (Tr. 2165). Contrary to the ALJ's erroneous finding that "other nurses also improperly gave the patient the zinc pill after it was discontinued" (ALJD 20:1-2), the unrefuted testimony is that when Claudio and the other two nurses were asked by Konjoh whether they had administered the zinc to the patient, they told Konjoh that they had not done so. (Tr. 2158, 2162, 2369-70, 2381-82, 2433-35; GC-106). This was consistent with the patient's statement that Napolitano was the *only nurse* who was giving her the pink pill. (Tr. 2396). Thus, Konjoh could not determine whether Claudio and the other two nurses had made the same error as Napolitano and, consequently, the other nurses were not disciplined.⁶⁸ (Tr. 2158, 2162, 2381-82; R-82).

At the same time that Konjoh discussed the repeated medication errors with Napolitano, she also discussed with Napolitano that she had erred in recording a patient's oxygen at zero percent on September 17, 2010.⁶⁹ (Tr. 2160, 2167-68; GC-34; R-82). This error was an obvious one⁷⁰ and one that was contrary to the Center's policy on assessing pulse oximetry. (Tr. 1868; R-61). This also is an issue that surveyors

⁶⁸ Interestingly, one of the nurses who initialed that she administered the zinc and then crossed off her initials and, therefore, was not disciplined, was Claudio. The decision not to discipline Claudio in this situation clearly indicates that there was no intent by Somerset Valley to retaliate against Claudio.

⁶⁹ During this disciplinary meeting, Konjoh and Napolitano also discussed the issue of proper patient pain assessments. Napolitano was *not* disciplined with regard to patient pain assessments; however, she wrote a response to this issue because she and Konjoh disagreed about the proper approach. (Tr. 380, 2169-72, 2367; GC-33). Napolitano told Konjoh that the State surveyor the year prior had told her that pain assessment should be initialed at the beginning of the shift. (Tr. 2411). This was the only issue raised during the disciplinary meeting with which Napolitano disagreed. (Tr. 2171-72).

⁷⁰ A zero percent oxygen level would have meant that the patient was dead. (Tr. 2160). The prior nurse recorded a 95 percent oxygen level for this same patient. (Tr. 2161; R-82). Significantly, because of the time delay from charting until discovery, if the patient actually had been dead, the chart would seem to indicate that the Center had a patient who had been dead for that period of time, yet nothing was done. (Tr. 2169).

examine in their annual surveys. (Tr. 1869). Like the zinc medication errors, Napolitano admitted to this error.⁷¹ (Tr. 2160, 2169).

As a result of Napolitano's series of admitted patient care errors, Somerset Valley terminated Napolitano's employment.⁷² The ALJ erroneously found that Napolitano had been "set up;" however, this finding was based solely on an unfounded, conclusory statement by disgruntled former employee Southgate and had absolutely no basis in record evidence. (ALJD 21:29). Moreover, there is no evidence that anyone suggested or encouraged Napolitano to continue giving the patient the discontinued medication. While Konjoh and Illis knew that Napolitano had been an observer for the Union in the election, they were not aware of any other Union activity that Napolitano was engaged in and the fact that Napolitano was a Union observer was not considered in any way in the decision to terminate her employment. (Tr. 2174, 2947-48).

iv. Other Discipline for Critical Patient Care Errors

Claudio, Jacques, and Napolitano were not the only employees disciplined for patient care errors, however. Like the alleged discriminatees, numerous other employees at Somerset Valley similarly were disciplined for patient care issues, including improper administration of medication and improper documentation. (Tr. 2175, 2183-84, 2239-40).

For example, on September 17, 2010, LPN Doreen Dande was given a written warning for administering aspirin to a patient on consecutive days rather than every

⁷¹ Konjoh is not aware of any similar situation where a nurse incorrectly recorded an oxygen reading or some other observation of a patient's medical condition and the nurse was not disciplined. (Tr. 2292).

⁷² Napolitano's prior discipline for attendance issues was not considered when the decision was made to terminate her employment, as attendance discipline runs on a separate track from other performance issues. (Tr. 2742, 2947).

other day as prescribed by the physician. (Tr. 2190-91, 2477-78, 2610-11; R-85). On November 30, 2010, LPN Doreen Dande was given a written warning for not giving a patient prescribed vitamin B12⁷³ nasal spray, after a patient reported to a physician that she had not received the medication. (Tr. 2175; R-83). Dande also was issued a written warning and later terminated for documentation and other patient care errors.⁷⁴ (Tr. 2259-60; R-93). Konjoh did not know whether Dande was a Union supporter, whether she engaged in the Union's organizing activity, or whether she testified at the Objections Hearing. (Tr. 2178, 2483).

LPN Maharanie "Shanny" Mangal also was issued a written warning for a medication error in 2010. (Tr. 2178, 2510; R-25). On December 14, 2010, Mangal was observed by a State surveyor failing to properly measure Miralax⁷⁵ to give to a patient.⁷⁶ (Tr. 2179). The error was observed prior to administration to the patient, thus the patient was not harmed. (Tr. 2179). Nevertheless, the Center received a survey deficiency based on this error and Mangal was disciplined based on the severity of her infraction. (Tr. 2179; R-25). Mangal also received discipline from the ADON for leaving Lactulose⁷⁷ at a patient's bedside, similar to Napolitano leaving the zinc capsule with the

⁷³ Vitamin B12 aids in the creation of blood cells. (Tr. 2175).

⁷⁴ Contrary to the ALJ's finding, Dande never improperly administered regular aspirin as opposed to enteric coated aspirin and, accordingly, was never disciplined for having done so. (ALJD 26:19-22).

⁷⁵ Miralax is a stool softener used to relieve constipation. (Tr. 2179).

⁷⁶ The Center did not perform well in the December 2010 survey, but there was an improvement over the prior year's survey. (Tr. 1480-84, 2960; R-37). Thus, while the Center received a large number of deficiencies at this time, there were no "G" level deficiencies. (Tr. 1480-84, 2960; R-37). Illis had to submit a Plan of Correction following the December 2010 survey, but no resurvey was required for recertification. (Tr. 1480-84, 2960; R-38).

⁷⁷ Lactulose allows a patient to move his/her bowels to lower potassium or decrease ammonia in the individual's blood system. (Tr. 1968).

patient. (Tr. 2182; R-24). Konjoh participated in the determination of the level of discipline to be issued to Mangal for this error, which was based on the severity of the infraction. (Tr. 2183-84).

LPN Michele Moore similarly received a written warning on December 23, 2010 for a medication error and other clinical mistakes.⁷⁸ (Tr. 2180, 2239; R-84). During the State survey, Moore was witnessed administering Reglan, an anti-nausea medication, to a patient during a meal instead of prior to the meal as prescribed. (Tr. 2180). The patient could have suffered harm from this error, but fortunately did not in this instance. (Tr. 2180). The Center, however, received a deficiency from the State for the error. (Tr. 2180). At the time Moore was disciplined for this medication error, Konjoh also disciplined Moore for failing to write out a discharge order for a patient, as well as failing to transcribe a prescription of Ativan onto the POS.⁷⁹ (Tr. 2180). Although the affected patients could have been harmed by these errors, fortunately they were not. (Tr. 2186). Moore was disciplined based on the severity of her infractions. (Tr. 2180-81). Konjoh did not know whether Moore was a Union supporter. (Tr. 2181). Moore later received a final written warning from Jackie Engram in February 2011 for failing to document and complete PICC line dressings for a patient on January 20 and January 27, 2011. (Tr.

⁷⁸ Moore had received a verbal warning in March 2010 for not reporting significant changes to a patient on the 24 hour report or to the physician. (Tr. 2506; GC-118). Moore also received discipline in June 2010 for failure to check the bed alarm for a patient and other care issues. (Tr. 2508; GC-119). Again, proof that discipline was issued to LPNs prior to the September 2, 2010 election. Konjoh, however, generally did not go back and consider employee discipline prior to the time she came to the Center when making decisions about issuing new discipline. (Tr. 2463-64, 2576-77, 2608). When she got to Somerset Valley, Konjoh decided to start the employees on a clean slate; otherwise, many employees would have been fired on their first offense under her management because they had already received prior discipline. (Tr. 2576).

⁷⁹ The order was on the MAR, thus there was no error in administering the medication. (Tr. 2185-86). However, by failing to put the order on the POS, the pharmacy does not send out the medication and the Center has to rely on having sufficient supply in stock, which it sometimes does not. (Tr. 2185-86).

1896-97; R-68). Like Konjoh, Engram did not know whether Moore supported the Union or engaged in Union activity, and whether she was a Union supporter did not affect the decision to discipline Moore for these errors. (Tr. 1901).

LPN Salaimatu Conteh similarly was issued a verbal warning for a documentation error. (Tr. 2240; R-89). A telephone order for a patient was received from the treating physician on November 26, 2010 and Conteh failed to transcribe the order to the POS or the MAR. (Tr. 2240). When asked about the error, the newly licensed nurse responded that she had not been educated as to how to do this correctly. (Tr. 2240). Konjoh was involved in determining the level of discipline, which was based on the severity of the infraction, as well as the fact that Conteh was a brand new nurse. (Tr. 2240-41). Because Conteh apparently had not been trained on this procedure during orientation, the ADON followed up by instructing Conteh on the proper procedure for transcribing the order, so that this error would not reoccur. (Tr. 2241; R-89). Conteh later was terminated for patient care issues. (Tr. 2955; R-131). Neither Konjoh nor Illis was aware of whether Conteh supported the Union or engaged in Union activity. (Tr. 2955). Moreover, whether Conteh was a Union supporter was not considered in the decision to discipline her or terminate her employment. (Tr. 2241, 2955).

LPN Jerry Santos also received a verbal warning from the ADON with regard to this same incident. (Tr. 2459-62; GC-111). Santos received disciplinary action for administering the medication from the telephone order that Conteh had taken but failed to transcribe. (Tr. 2459; GC-111). Knowing about the telephone order that Conteh had taken from the physician, Santos proceeded to administer the medication to the patient,

but should have confirmed that Conteh had written the order before he administered the medication. (Tr. 2462-63). Santos correctly followed the physician's order, but should have waited to administer it until it had been transcribed correctly. (Tr. 2461-62). Santos similarly was issued a verbal warning for a documentation error in November 2010 by Konjoh.⁸⁰ (Tr. 2244; R-91). A patient was admitted to the Center on November 26, 2010 and Santos failed to properly document the admission assessment. (Tr. 2244). Konjoh made the decision to discipline Santos and determined the level of the discipline based on the severity of the infraction. (Tr. 2244). Konjoh was not aware as to whether Santos was a Union supporter. (Tr. 2244).

LPN Sandy Mootosamy similarly was issued discipline for documentation errors in September 2010. (Tr. 2257-58; R-92). Mootosamy failed to document on a patient post-fall, failed to complete post-admission documentation, and failed to document a patient's vital signs. (Tr. 2257-58). All of these documentation errors could have been detrimental to the affected patient. (Tr. 2258). Konjoh made the decision to discipline Mootosamy and determined the level of the discipline to be issued. (Tr. 2258). The ALJ's finding that Claudio and Mootosamy were similarly situated is erroneous as this finding fails to acknowledge Somerset Valley's progressive discipline policy. (ALJD 46:51-47:4). Under this policy, Claudio and Mootosamy were not at comparable levels of discipline. Konjoh was not aware as to whether Mootosamy was a Union supporter and did not take this into consideration when deciding to issue her discipline. (Tr. 2258-59).

⁸⁰ Santos had received discipline in March 2010 (prior to the September 2, 2010 election) for failure to reorder medication in a timely manner, which resulted in a delay in the patient receiving the medication. (Tr. 2463; GC-112). Konjoh, however, was not aware of this past discipline. (Tr. 2463-64, 2576).

LPN Patricia Beck was issued a first written warning for documentation errors on September 14, 2010. (Tr. 2260; R-94). Beck documented in error that three Lidoderm patches had been removed from the patient, but the patient still had the patches on the next day. (Tr. 2261, 2571). Konjoh made the decision to discipline Beck for this error and determined the level of discipline to be issued. (Tr. 2261). Whether Beck was a Union supporter did not factor into the decision to discipline Beck. (Tr. 2261). Beck also received a final written warning from Engram in February 2011 for improperly changing a patient's wound dressing. (Tr. 1898; R-69). New ADON Francia Dominique signed this notice of disciplinary action because she had received the complaint about the issue from the patient. (Tr. 1899; R-69). Beck admitted to making this error. (Tr. 1899). Engram did not know whether Beck supported the Union and whether Beck was a Union supporter was not considered in the decision to issue her this discipline. (Tr. 1901).

LPN Mohammed Bockarie received a verbal warning in December 2010 for failing to document pain management for a patient.⁸¹ (Tr. 2453, 2956; GC-110, GC-131). Neither Illis nor Konjoh was involved in issuing this disciplinary action and Konjoh does not believe she was present at the Center at the time that it was issued. (Tr. 2456). The discipline was issued by Dominique.⁸² (Tr. 2454). Bockarie later was

⁸¹ Bockarie admitted that the level of patient care in the Center in the Fall of 2010 needed to improve. (Tr. 3173).

⁸² Illis did not believe that a verbal warning was a sufficient level of discipline in this instance and she told Dominique such when she learned of the discipline. Illis did not go back and change the discipline to make it more severe, as it has never been her practice to do so. She did, however, instruct Dominique that Dominique should inform her or the DON before issuing discipline to ensure that it was appropriate. (Tr. 3129-32).

suspended in May 2010 and then terminated for failing to adequately perform his job.⁸³ (Tr. 2956; R-132). Engram and Illis met with Bockarie on the day that he was suspended prior to his termination. (Tr. 3284-85). Bockarie was loud and rude during this meeting and repeatedly cut off Engram while she was speaking. (Tr. 3284-85). Thereafter, Bockarie wrote a statement related to his performance issues and came into the Center to give it to Illis but refused to sign it, and loudly told Illis that he was not signing anything and that she should go ahead and fire him.⁸⁴ (Tr. 2956). Illis received a signed statement from Bockarie about a week later and the decision was made to terminate his employment. (Tr. 3287). Bockarie was not employed at the Center during the Union's organizing campaign⁸⁵ and Illis does not know whether Bockarie was a Union supporter or engaged in any Union activity. (Tr. 2956). Whether Bockarie was a

⁸³ Bockarie's post-termination testimony that DON Jackie Engram and Unit Manager Michael Yannota made errors for which they were not disciplined is entirely unreliable. (Tr. 3177-82, 3214-16). Engram and Yannota credibly denied that the alleged errors were even made and Bockarie admitted that he had no knowledge of management discipline and did not sit in on any disciplinary meetings with employees or managers. (Tr. 3183-92, 3202, 3252-55).

⁸⁴ When Illis noticed that Bockarie's statement was not signed, she asked him to sign it. (Tr. 3285-87). Bockarie outrageously claimed that Illis sexually harassed him because she allegedly pulled on his shirt as he was leaving to get his attention to sign the statement when she noticed it was not signed. (Tr. 3202-04). Bockarie then, unconvincingly, claimed that he was "100 percent okay" with Illis suspending him prior to his termination, but also admits he is considering filing charges. (Tr. 3204-06). Notably, Bockarie previously stopped speaking to Illis around January 2011 after Illis had a conversation with Bockarie wherein she instructed him to focus on his job duties, stop using his cell phone at the nurses' station, and stop bossing people around, and had another conversation with him about talking to an RN before he spoke with a physician because the physician could not understand him. (Tr. 3279-82).

⁸⁵ Bockarie transferred from Holmdel to Somerset Valley in the latter part of October 2010. (Tr. 2976-78). He had been an LPN since July 2010. (Tr. 3159-60). Bockarie's transfer was approved by the Holmdel Administrator, Dimitri Ruchaevesky, who also determined the timing of the transfer. (Tr. 3263-66; R-141, R-142). Illis did not solicit Bockarie to transfer from Holmdel to Somerset Valley and did not ask that Bockarie solicit other employees to come to Somerset Valley. (Tr. 3261-62). Illis also did not ask Bockarie to be her eyes in the building, did not ask Bockarie to look for any employee errors, did not ask Bockarie to find out who was in favor of the Union, did not ask Bockarie how employees would vote if there was another election, did not ask Bockarie to attend a Union meeting, did not ask Bockarie who she should get rid of, and did not show Bockarie a list of employees she wanted to discipline. (Tr. 3272-74, 3279-81, 3284).

Union supporter did not enter into Illis' decision to terminate his employment. (Tr. 2956).

Moreover, Miguel Roque (Tr. 2261-63, 2574-75; R-95), Paulino Sagrario (Tr. 2287-88; R-98), Adeline Destin (Tr. 2287-88; R-98), Yendy Daustruche (Tr. 2287-89; R-98), Cheryl Dacres (Tr. 2287-89; R-98), Maria Granda (Tr. 2287-88, 2290; R-98), Adanmo Nwaro (Tr. 2952-54; R-129), Sheriff Osman (Tr. 2954-55; R-130), and Nicole Ibe (Tr. 1895-96, 1900, 2955; R-67), were also similarly disciplined for patient care errors and/or omissions. Somerset Valley did not know whether any of these employees supported the Union and did not consider whether they supported the Union in deciding to discipline them.

5. Other Administrative Changes Implemented at the Center

In addition to taking all of the foregoing steps toward changing Somerset Valley's culture and improving its operations, Illis and Konjoh also brought with them their own way of handling relatively minor administrative and technical issues. One such issue, made relevant by the Acting General Counsel's allegation that Somerset Valley unlawfully accelerated Lynette Tyler's ("Tyler") resignation, was how they dealt with departing employees. It had been Illis' practice in her previous position to immediately relieve employees who resigned their employment from their duties immediately and pay them for their notice period. (Tr. 2929; R-123, R-124).

Illis continued this practice upon her arrival at Somerset Valley. Specifically, when Tyler voluntarily resigned her employment with Somerset Valley by letter dated September 9, 2010, Illis accepted Tyler's resignation, told Tyler that she would not be required to return to work, and paid Tyler for her two week notice period. (Tr. 2927-

2929). Illis was not seeking to force Tyler out of her position early. In fact, Tyler resigned despite requests from Somerset Valley management that she continue her employment at the Center. (Tr. 2090). In the two weeks prior to her resignation, Tyler had several conversations with Konjoh regarding family-related issues which were affecting Tyler's work. (Tr. 2086). Chief among those issues were scheduling concerns related to her obligations as a single parent with two children, one of whom (her son) is disabled. (Tr. 2086-87, 2347). Specifically, Tyler was uncomfortable leaving her daughter at home with the male nurses who provided in-home care to her son on a daily basis. (Tr. 2087). Accordingly, Konjoh told Tyler that Somerset Valley would consider allowing Tyler to work a flexible schedule, permitting her to come in late and/or leave early on occasion. (Tr. 2087). Somerset Valley also allowed Tyler to bring her daughter to work on several occasions. (Tr. 2346-47).

On September 8, 2010, the day before Tyler resigned, Tyler told Konjoh that she was interested in going to nursing school because she would be eligible, as a licensed nurse, to receive government funding to stay home and care for her son. (Tr. 2089). In the same conversation, Tyler also told Konjoh that if she could not get appropriate care for her son, she would have to resign her employment. (Tr. 2090). Konjoh tried to talk Tyler out of resigning, but her efforts were unsuccessful.⁸⁶ (Tr. 2090). Tyler resigned the following morning. (Tr. 2090, 2927-28; GC-58).

C. The Union's Organizing Campaign at Somerset Valley

As sometimes happens in situations where businesses are having operational issues and morale is in decline, some of the efforts to improve Somerset Valley's

⁸⁶ The ALJ found, despite Illis' denials, that Illis interrogated Tyler about her Union sympathies and that Tyler's response was non-committal. (ALJD 49:32).

operations coincided with the development of union activity at the Center. In or around May or June 2010, the Union began a campaign to organize certain of Somerset Valley's full-time, part-time, and per diem non-professional employees. (Tr. 51, 288, 494). On July 22, 2010, an election petition was filed with the National Labor Relations Board ("NLRB").

D. Somerset Valley's Response to the Union's Campaign

Following the filing of the election petition, and continuing through August 2010, Somerset Valley held informational meetings with employees during which it lawfully responded to and opposed the Union's organizing activities. (Tr. 100).

The first round of meetings with employees about the Union's organizing campaign occurred at the end of July, following Somerset Valley's receipt of the petition.⁸⁷ (Tr. 333-34, 1459). Andrea Lee conducted these meetings to provide information to employees about the potential implications of signing a union authorization card and union organizing. (Tr. 101-02, 334, 409, 1010-11, 1459-60, 1640, 2647). Hutchens was in attendance but spoke only to introduce himself,⁸⁸ and no

⁸⁷ Although Napolitano alleged she was told about this meeting by Illis and that Hutchens introduced himself as "Doreen's boss" in this meeting, the meeting actually took place at the end of July – prior to Illis' arrival at the Center. (Tr. 334). Furthermore, Napolitano erroneously alleged that Hutchens told employees he heard their complaints and transferred Heedles to CareOne at Holmdel, a center of an affiliated company, and brought the Administrator from Holmdel, Illis, to their facility. (Tr. 337). Again, this meeting was prior to Illis joining Somerset Valley – as Napolitano admitted, Illis introduced herself to Napolitano in the hallway – around August 2010. (Tr. 339). Moreover, Napolitano later admitted she could not recall what Lee or Hutchens said in the meeting word for word. (Tr. 410).

⁸⁸ Dominique Joseph erroneously alleged that Hutchens did not identify himself in this meeting; however, this does not comport with the testimony of any other witness who testified about this meeting. (Tr. 770). Despite the conflict between Joseph's testimony and that of all other witnesses, the ALJ erred in summarily concluding that all Acting General Counsel's witnesses were credible.

employees spoke during the meetings.⁸⁹ (Tr. 102-03, 336, 1011, 1460, 1465, 2648-49). Hutchens' presence was to ensure that there was no dispute that no unlawful statements were made during the meetings. (Tr. 1646). During the meeting, Lee never asked employees why they wanted a union and employees were not asked to voice complaints or grievances about their jobs (Tr. 1460, 1463-64, 2647-48).

Somerset Valley continued to hold informational meetings and lawfully oppose the Union's organizing drive through August 2010. (Tr. 100). Ultimately, however, the Union won an election for representation on September 2, 2010 (GC-3, GC-4, GC-6), and the result of the election was certified by the Board on August 26, 2011.

III. QUESTIONS PRESENTED

1) Whether the Judge erred in finding that Respondent violated Section 8(a)(1) of the Act by interrogating its employees about their union membership, sympathies and/or activities?

2) Whether the judge erred in finding that Respondent violated Section 8(a)(1) of the Act by soliciting employee complaints and grievances and promising employees increased benefits and improved terms and conditions of employment if they refrained from union organizing?

3) Whether the judge erred in finding that Respondent violated Sections 8(a)(1) and 8(a)(3) of the Act by issuing a written warning to employee Shannon

⁸⁹ Although witnesses for both sides all testified consistently that no employees spoke in the meeting, the Acting General Counsel's witness, Dominique Joseph, testified that at the meeting where Lee showed the DVD, Joseph thought Lee was from the Union and she told Lee she thought the Union was a good thing. (Tr. 767-68). Joseph alleged this conversation occurred after the meeting had started and about five or seven other people were in the meeting at the time. (Tr. 768). Joseph testified that in response to her voluntary statement to Lee, Lee gave no response. (Tr. 768). No other employees testified about this statement Joseph purportedly made in Lee's presence.

Napolitano on or about September 13, 2010, and by terminating Napolitano on September 17, 2010?

4) Whether the judge erred in finding that Respondent violated Sections 8(a)(1) and 8(a)(3) of the Act by issuing two written warnings to employee Jillian Jacques on or about September 13, 2010, by issuing a written warning to Jacques on or about November 5, 2010, by suspending Jacques on or about February 9, 2011, and by discharging Jacques on or about February 10, 2011?

5) Whether the judge erred in finding that Respondent violated Sections 8(a)(1) and 8(a)(3) of the Act by issuing two written warnings to employee Sheena Claudio on or about September 20, 2010, and by issuing a written warning to Claudio on or about September 27, 2010, and by terminating Claudio on or about October 21, 2010?

6) Whether the judge erred in finding that Respondent violated Sections 8(a)(1) and 8(a)(3) of the Act by issuing a written warning to employee Valarie Wells on or about September 16, 2010, and by issuing a written warning to Wells on or about September 20, 2010, and by terminating Wells on or about September 9, 2010?

7) Whether the judge erred in finding that Respondent violated Sections 8(a)(1) and 8(a)(3) of the Act by accelerating the resignation date of its employee Lynette Tyler on or about September 9, 2010?

8) Whether the judge erred in finding that Respondent violated Sections 8(a)(1) and 8(a)(3) of the Act by reducing the hours of per diem employees Daysi Aguilar, Dominique Joseph, Rita Onyeike, Gertrudis Rodriguez-Arias, and Annie Stubbs?

9) Whether reinstatement is an appropriate remedy for employees who have admittedly committed serious patient care errors?

10) Whether Respondent's legal opposition to the Union constitutes evidence of anti-Union animus sufficient to sustain a violation of 8(a)(3) of the Act?

IV. STANDARD OF REVIEW

The Board reviews an administrative law judge's findings of fact *de novo*. *Standard Dry Wall Products, Inc.*, 91 N.L.R.B. 544, 544-45 (1950) ("in all cases which come before us for decision, we base our findings as to the facts upon a *de novo* review of the entire record"). While the Board generally affords some deference to ALJ credibility determinations which are based on the demeanor of the witnesses, even those determinations cannot be rubber-stamped by the Board. *Permaneer Corporation*, 214 N.L.R.B. 367, 369 (1974) ("an administrative law judge cannot simply ignore relevant evidence bearing on credibility and expect the Board to rubber stamp his resolutions by uttering the magic word 'demeanor'"). The Board must review the record in its entirety and determine whether the clear preponderance of all the relevant evidence supports the ALJ's credibility determinations. *Standard Dry Wall Products, Inc.*, 91 N.L.R.B. at 545. Where it does not, those findings should be reversed. *Id.*

V. SUMMARY OF EXCEPTIONS

The ALJ's findings of fact and conclusions of law are not only contrary to weight of the evidence in the record and established board law and policy; they are incomplete, inaccurate, and replete with inherent contradictions. The ALJ omitted a series of material facts from his analysis, made unreasoned findings indicative of arbitrary decision-making, and made misstatements of fact that reflect a troubling lack of

familiarity with the proof and the witnesses from whom the proof was elicited at the hearing. For example, the ALJ failed to acknowledge similarly-situated comparators to the alleged discriminatees (ALJD 24:8-10); failed to acknowledge Somerset Valley's use of progressive discipline and the disparate disciplinary histories of those he identified as similarly-situated comparators to the alleged discriminatees (ALJD 46:51-47:4; 47:44-45); and simply ignored, without attempting to reconcile, evidence tending to counter his credibility determinations, all of which were in favor of the Acting General Counsel's witnesses.

In fact, the ALJ was even openly receptive to contradictory proof relating to the Acting General Counsel's witnesses. For example, when faced with contradictory proof regarding whether Gertrudis Rodriguez-Arias signed a Union card in a patient's room or at a co-worker's house, the ALJ chose, arbitrarily and without questioning the veracity of either account, to credit the proof that the card was signed in a patient's room, noting only that Rodriguez-Arias' "pre-trial affidavit which states that she signed the card at a co-worker's house does not fatally harm her credibility." (ALJD 34:19-20; 34:50-51).

Furthermore, the ALJ's findings were themselves contradictory on a number of issues. By way of example, the ALJ initially acknowledged in his decision that Somerset Valley acted in response to its failure of the December 2009 state recertification survey by bringing in its Regional Clinical Nurse Specialist and Vice President of Clinical Operations to ensure the Center was compliant with state and federal regulations for the January 2010 resurvey. (ALJD 7:14-18). Notwithstanding that finding, the ALJ later reversed course, finding that "the Respondent took no affirmative steps relating to changes in its administration or increased oversight of the

employees' performance immediately following the results of the survey in December 2009." (ALJD 16:26-28).

As an example of the ALJ's apparent unfamiliarity with the facts and witnesses, it should be noted that the ALJ referred to Avian Jarbo as "he" throughout his decision.⁹⁰ (ALJD 10:18-24; 40:17-21). Jarbo, however, is a female, and she testified at the hearing. The ALJ, however, apparently could not recall her testimony, or her gender. Accordingly, his credibility determination regarding Jarbo—and his credibility determinations generally—can, at best, be considered inherently unreliable.

Finally, the ALJ blindly credited Onyeike's testimony despite the fact that her identification of Konjoh as an individual who allegedly took action against her for wearing a purple scrub is not even plausible. In testifying that Konjoh confronted her when she was out of uniform, introduced herself, and told her to "leave the facility or she would call the cops," Onyeike described Konjoh as a "short, light-skinned" individual. Konjoh, however, is neither short nor light-skinned, as the ALJ personally observed at hearing and her passport photo, in evidence, clearly shows. Accordingly, Onyeike's testimony in this regard was not credible and suggests that she simply invented it out of whole cloth. For this reason alone, all of her testimony should be discredited. Although the ALJ had full opportunity to observe Konjoh, who is tall and dark-skinned, over several days at the hearing and view her passport in evidence, he failed entirely to reconcile Onyeike's falsified testimony on this issue. (ALJD 35:50-36:11). In failing to do so, his finding of Onyeike's credibility is questionable at best.

⁹⁰ Inasmuch as the ALJ mischaracterized Jarbo in two separate sections of his decision, the error would not appear to be merely typographical.

Each of the foregoing examples is indicative of the Judge's failure to carefully review and analyze the proof before him. This case is not about the Union or the Union's organizing campaign at Somerset Valley. It is about an employer's legitimate efforts to revive a crippled business. Somerset Valley had been operating inefficiently and ineffectively, and its poor performance threatened to compromise the health and safety of its patients. In fact, the Center's prior management group had deteriorated the clinical environment at the Center so significantly that Somerset Valley feared that it may be in danger of losing its certification to receive new patients, Medicare payments, and/or its operating license. The business decisions underlying this case were made solely to remedy those issues, and the preponderance of the evidence introduced at the hearing before the ALJ supports that conclusion.

VI. LAW AND ARGUMENT

A. The Judge's Credibility Determinations Were Erroneous

The ALJ made numerous credibility determinations in favor of witnesses for the Acting General Counsel that are not supported by, and in some cases are in direct conflict with, the weight of evidence in this case. Notably, the Judge made the broad, conclusory statement that in all cases where the testimony of employees conflicted with that of Respondent's witnesses, he credited the employee's testimony. He purportedly based this determination on the fact that the employees testified in a "straightforward, confident, consistent manner with respect to conversations and events which must have made an indelible mark on their memories." The ALJ, however, failed to reconcile testimony which directly conflicts with his broad determination.

During her testimony Southgate stated numerous times that she “could not recall exactly” or that something was said “to the effect that.” Despite Southgate’s clear indications that she *could not* recall exactly, the ALJ incredibly *quoted* portions of Southgate’s testimony regarding things Konjoh allegedly said to her about the employees or the Union, affording Southgate’s testimony full weight. (ALJD 4-6, Tr. 1118). Notably, Southgate made sweeping allegations that she “thought” some managers said in a meeting that they had seen the Union YouTube video, but she did not recall anyone specifically saying this and her testimony lacked conviction and was not conclusive. Moreover, the ALJ erroneously credited broad conclusory statements by Southgate that clearly are her personal assumptions and have no basis in fact. In fact, on several occasions during her testimony, Southgate made broad allegations with no apparent assuredness of their truth and on cross-examination, either could not remember or could not provide facts to support these broad statements; admitted that she did not actually know and that these were merely her suppositions or personal conclusions; or retracted her statement altogether. Furthermore, inasmuch as she testified that she thought her termination was “unfair,” notwithstanding that she did not dispute Somerset Valley’s assessment of her poor performance, Southgate had motive to misrepresent the facts at the hearing to injure her former employer.

Further, as set forth above, the ALJ erred in crediting Onyeike’s testimony based on her misidentification of Konjoh. Onyeike’s identification of Konjoh as an individual who allegedly took action against her for wearing a purple scrub is not even plausible, yet the ALJ inexplicably gave the testimony full weight and credit. Accordingly, his finding of Onyeike’s credibility should be disregarded.

Additionally, the Judge's finding that Avian Jarbo testified credibly is not supported by the preponderance of the credible evidence in the record. Jarbo's testimony was grossly exaggerated. For example, Jarbo testified that Somerset Valley held a series of meetings with employees approximately 12 weeks prior to the September 2, 2010 election—around the beginning of June 2010. Such a statement grossly exaggerates the number of meetings held by the Employer. Significantly, the Employer was not aware of any organizing activity 12 weeks prior to the election and the unrefuted evidence shows that the Employer did not begin to hold informational meetings with employees about the Union until late July 2010. Moreover, inasmuch as the ALJ referred to Jarbo as "he" throughout his decision, his credibility determination regarding Jarbo is inherently unreliable. Jarbo is a female and she testified at trial. The ALJ's mischaracterization of her sex indicates that he cannot reliably identify her testimony. It is therefore axiomatic that he likewise cannot reliably credit her testimony. Accordingly, the ALJ's credibility determination with regard to Jarbo is unsupported by the weight of the record evidence, inherently unreliable, and should be dismissed.

As discussed previously, the ALJ also erroneously credited testimony by Rodriguez-Arias even though she clearly contradicted her hearing testimony in her sworn affidavit taken before the hearing. Moreover, Rodriguez-Arias could not supply, on cross-examination, facts to support the various conversations and other broadsweeping assertions she made during direct – a fact that went completely unacknowledged by the ALJ.

Finally, it is inconceivable that the ALJ credited the testimony of Bockarie when his exchange with Bockarie at hearing clearly indicates a lack of credibility. At hearing,

in response to a hypothetical question, Bockarie incredibly testified that it was *not even possible* that an event could have occurred and he not know about it:

JUDGE DAVIS: The objection is addressed to me. The question, first of all, is a speculative question. The question is Michael could have been disciplined by someone else. It's possible. Anything is possible. Can you agree with that, that Michael could have been –

THE WITNESS: I disagree.

JUDGE DAVIS: Excuse me?

THE WITNESS: I disagree.

JUDGE DAVIS: You disagree?

THE WITNESS: Yes.

(Tr. 3188-89). Despite the ALJ's obvious incredulity at Bockarie's response to the question, he credited Bockarie's testimony in its entirety.⁹¹ It is also worth noting that in crediting Bockarie over Illis (ALJD 19:21), the ALJ relied upon the fact that Illis and Bockarie frequently communicated by text message to support his conclusion that Illis trusted Bockarie and relied on him to identify Union supporters. (ALJD 27:34-49). In doing so, however, the ALJ failed to acknowledge the undisputed testimony that Illis texted with Bockarie frequently because Bockarie was difficult to understand verbally. (Tr. 3275-76). This fact was made abundantly clear at the hearing when Bockarie was testifying as the ALJ repeatedly asked Bockarie to repeat himself, stated that he did not understand what Bockarie had said, and repeated the testimony he thought he heard by

⁹¹ Bockarie's testimony on the whole was evasive, argumentative, contradictory, and sometimes unintelligible. In fact, Bockarie at one point outrageously testified that Illis sexually harassed him because she allegedly pulled on his shirt to get his attention as he walking away from her and that he was considering filing charges against Somerset Valley. Thus, to the extent Bockarie (and Southgate, who also had been terminated by Somerset Valley and had a motive to lie) testified that Illis targeted Union supporters for disciplinary action, and/or disciplined employees in a discriminatory manner, their testimony simply is not credible.

way of clarifying Bockarie's statements. (Tr. 3163, 3164, 3165, 3166, 3167, 3168, 3172, 3174, 3177, 3179, 3183, 3184, 3199, 3204, 3214).

In light of the foregoing, the ALJ's credibility determinations should not be "rubber stamped," and should instead be dismissed, as it is clear that these findings are not supported by the preponderance of the record evidence.

B. Somerset Valley Did Not Violate Section 8(a)(1) of the Act

The ALJ found that Somerset Valley violated Section 8(a)(1) of the National Labor Relations Act (the "Act") by interrogating employees and soliciting grievances and promising employees increased benefits and improved terms and conditions of employment if employees refrained from union organizing activity. For the reasons set forth below, the ALJ's findings are against the weight of all of the credible, relevant evidence in the record and established Board law and policy.

1. The ALJ Erred in Finding Somerset Valley Violated the Act by Unlawfully Interrogating Employees

The ALJ's finding that Somerset Valley unlawfully interrogated employees in violation of 8(a)(1) of the Act was based on his findings that Konjoh asked Claudio how she believed her co-workers intended to vote in the election; Konjoh asked Stubbs what she thought of the Union; Illis asked Tyler what she thought about management's informational meetings regarding the Union, how Tyler intended to vote in the election, and how she believed her co-workers intended to vote in the election; and Arroyo asked Jarbo how she intended to vote in the election. (ALJD 40:11-42). The ALJ's findings are contrary to the preponderance of the credible evidence and established Board law.

An employer violates Section 8(a)(1) of the Act if it engages "in conduct that reasonably tends to interfere with the free exercise of employees' Section 7 rights."

Curwood, Inc., a Div. of Bemis Co., 339 NLRB 1137, 1140 (2003). This standard is objective and does not take into account the subjective perceptions of individual employees. *Id.* Interrogation of employees is not *per se* unlawful. Instead, it becomes unlawful and a violation of Section 8(a)(1) only when, under the totality of the circumstances, the employer's inquiry tends to interfere with, restrain, or coerce employees in the exercise of their Section 7 rights. *Rossmore House*, 269 NLRB 1176 (1984), *aff'd*, *Hotel Employees and Restaurant Employees Union, Local 11 v. NLRB*, 760 F.2d 1006 (1985). The factors to be considered in determining coerciveness: (1) the background of the interrogation; (2) the nature of the information sought; (3) the identity of the questioner; and (4) the place and method of interrogation. *Id.* In this case, the evidence does not establish that Illis, Konjoh, or Arroyo made any inquiry that tended to interfere with, restrain, or coerce Somerset Valley employees so as to violate Section 8(a)(1) of the Act.

First, Illis did not unlawfully interrogate Tyler. During the weeks following her arrival at Somerset Valley in early August 2010, Illis made every effort to learn the Center's operations and to get to know its employees. To the extent that Illis made inquiries to employees, those inquiries were related to the operations of the Center, were not coercive, and did not tend to interfere with employees' exercise of their Section 7 rights. *See Wal-Mart Stores, Inc.*, 352 NLRB at 825 (asking questions of employees dealing with daily operations "was precisely what a manager should do.").

While Illis held group meetings with employees during the period preceding the election, she did not have any individual conversations with any employees wherein the Union or even the election was discussed. The ALJ's finding that Tyler testified credibly

regarding her conversations with Illis about the Union was erroneous. Moreover, even if made, there is no evidence that Illis' inquiries were made in a threatening or coercive manner or even that Konjoh displayed any hostility towards Claudio or the Union. Finally, even if Illis' inquiries were unlawful, they were unrelated to the 8(a)(3) allegations in this case, and were thus isolated and *de minimis*. See *Albertson's, Inc.*, 351 NLRB 254, 256 (2007).

Next, Konjoh did not unlawfully interrogate Claudio about how she thought people were going to vote in the election. Konjoh credibly denied doing so. Moreover, there is no evidence in the record that Konjoh's alleged inquiry was made in a threatening or coercive manner or even that Konjoh displayed any hostility towards Claudio or the Union.⁹² Rather, the inquiry was simply what Claudio thought the outcome of the election would be. Konjoh further allegedly shared with Claudio her prior experience with the Union and asked that Claudio give the Center's management team a chance. Importantly, Konjoh did not ask Claudio who was going to vote, how particular individuals were going to vote, or even whether Claudio was going to vote for the Union. Based on the totality of the circumstances, even if made, Konjoh's inquiry did not reasonably tend to interfere with, restrain or coerce Claudio in her choice of whether or not to engage in Union activity, and therefore was not a violation of Section (8)(a)(1).⁹³

⁹² While Claudio alleged that the conversation occurred in the medical supply room, she admitted that Konjoh did not summon her to the room. (Tr. 108-111). Rather, Claudio testified that she was already going to the supply room to "get something." (Tr. 108-111). It is undisputed that employees had access to and were able to go freely in and out of the medical supply room at any time. (Tr. 108-111). Further, Claudio did not testify that the supply room door was locked or even that she could not leave, if she chose to do so. (Tr. 108-111).

⁹³ Furthermore, there is no evidence that the alleged conduct was witnessed by anyone else. In fact, Claudio testified that no one else was present during her alleged conversation with

Likewise, Konjoh did not unlawfully interrogate Stubbs. Again, Konjoh denied asking Stubbs about the Union. Even assuming Konjoh asked Stubbs “what she thought of the Union,” Stubbs’ claimed that she replied that she did not know and there is no indication that Konjoh’s inquiry was threatening or coercive or that Konjoh displayed any hostility towards Stubbs. Based on the totality of the circumstances, even if true, Konjoh’s inquiry did not reasonably tend to interfere with, restrain, or coerce Stubbs in her choice of whether or not to engage in Union activity, and therefore was not a violation of Section (8)(a)(1).⁹⁴

Finally, Jessica Arroyo did not unlawfully interrogate Jarbo. The ALJ’s finding that Jarbo testified credibly as to her conversations with Arroyo is unreliable and must be dismissed.⁹⁵ Even assuming the ALJ properly found that Jarbo testified credibly, which Somerset Valley disputes, Arroyo’s inquiry was not related to any 8(a)(3) allegation in this case, and was therefore isolated and *de minimis*. See *Albertson’s, Inc.*, 351 NLRB at 256. There is no evidence that the conduct was witnessed by anyone else or that any other employee was affected by this alleged interrogation. In fact, Jarbo testified that no one else was present during their conversation and the door to the medical supply room was only cracked open.

Konjoh. (Tr. 108-111). There also is no evidence of dissemination or evidence that any other employee could have been affected by this alleged isolated violation.

⁹⁴ Again, there is no evidence that the alleged conduct was witnessed by anyone else. Like Claudio, Stubbs testified that no one else was present during her conversation with Konjoh. There is also no evidence of dissemination or that any other employee was affected other than Stubbs.

⁹⁵ As set forth above, the ALJ referred to Jarbo as “he” throughout his decision. Jarbo is female. Inasmuch as Jarbo testified at trial, the ALJ’s mischaracterization of her indicates that he cannot reliably identify her testimony. For this and all the reasons discussed above, the ALJ’s credibility determination with regard to Jarbo is inherently unreliable and should be dismissed.

In light of all the foregoing, the ALJ's finding that Somerset Valley unlawfully interrogated employees in violation of Section 8(a)(1) of the Act is against the weight of all of the credible, relevant evidence in the record and established Board law.

2. The ALJ Erred in Finding Somerset Valley Violated the Act by Unlawfully Soliciting and Promising to Remedy Employee Grievances

The ALJ's finding that Somerset Valley unlawfully solicited and promised to remedy employee grievances in violation of 8(a)(1) of the Act was based on his findings that Illis withdrew certain scheduling changes which previously had been proposed by Heedles; Hutchens and Illis told employees that they would try to "fix" things and that they clearly "fixed" the schedule changes proposed by Heedles; Illis removed the recording of patient weights from Tyler's responsibilities in response to Tyler's complaint that her job was overwhelming; and Hutchens directed that garbage bags be made available to employees at all times in response to a complaint from Stubbs. (ALJD 41:24-44). The ALJ's findings are contrary to the preponderance of the credible evidence and established Board law.

It is well-established that mere solicitation of grievances by an employer is not unlawful. It is the employer's explicit or implicit promise to remedy such grievances that violates Section 8(a)(1) of the Act. See *Uarco, Inc.*, 216 NLRB 1 (1974). An employer's solicitation of grievances raises an inference that there is an implied promise, but this inference may be rebutted by a showing that the employer did not promise to remedy the employee's grievance. *Id.*; see, e.g., *Kinder-Care Learning Centers*, 284 NLRB 509 (1987) (finding that the employer rebutted the inference of an implied promise to resolve employees' grievances by stating that it could not promise to remedy its employees'

grievances). Here, there is no credible testimony or other evidence to establish that Illis or Hutchens unlawfully solicited employees' grievances or promised to remedy such grievances. Indeed, it is undisputed that Hutchens told employees that he *could not* promise to remedy any issues the employees raised.

First, Illis did not unlawfully solicit or promise to remedy any employee grievances. With regard to the ALJ's finding that Illis altered Tyler's responsibilities after Tyler complained that her job was overwhelming, Illis credibly testified that she never asked Tyler about any problems she had with her job or transferred, changed, or removed any of Tyler's job duties or assignments in an effort to influence her vote or to get her to vote against the Union. Moreover, Tyler admitted that the change in her job duties occurred only after a new Dietary Manager began working at the Center. (Tr. 1008). Significantly, the new Dietary Manager communicated the change to Tyler and there is no evidence that Illis was involved in the decision. (Tr. 1008). Even if Illis did unlawfully solicit or remedy a grievance from Tyler, her actions were unrelated to the 8(a)(3) allegations in this case, and were thus isolated and *de minimis*. See *Albertson's, Inc.*, 351 NLRB at 256. Moreover, there is no evidence that her doing so reasonably tended to interfere with, restrain, or coerce Tyler in her choice of whether or not to engage in Union activity.

With regard to the ALJ's finding that Illis and/or Hutchens "fixed" employee grievances about the schedule changes Heedles proposed, there is no evidence in the record that Illis or Hutchens solicited employees' issues or concerns, asked employees how they could make things better, or stated that they would resolve any of their issues. The Acting General Counsel's witnesses all testified that both Hutchens and Illis only

asked “for a chance.” Such a request does not violate Section 8(a)(1) of the Act. See *Wal-Mart Stores, Inc.*, 352 NLRB 815, 825 (2008); *National Micronetics, Inc.*, 277 NLRB 933 (1985); *Flamingo Hilton-Laughlin*, 324 NLRB 72 (1997). Moreover, even assuming Illis unlawfully solicited or remedied grievances about the schedule changes, there is no evidence that her doing so reasonably tended to interfere with, restrain, or coerce those employees in their choice of whether or not to engage in Union activity.

Next, Hutchens did not unlawfully solicit or promise to remedy any employee grievances. While Stubbs testified that she expressed that she did not have access to sufficient trash bags to remove soiled diapers and bed linens at a meeting where Hutchens was present, and that shortly thereafter trash bags were made more accessible, there is no evidence in the record that Hutchens asked Stubbs about any of her concerns or otherwise solicited any grievance. In fact, Stubbs consistently testified that Hutchens *did not* ask employees to voice their concerns.

Moreover, the provision of trash bags to employees in a nursing home—a necessity—constituted neither a conferral of a benefit nor an attempt to interfere with or influence Stubbs’ vote in the election. See *Wal-Mart Stores, Inc.*, 352 NLRB at 831 (citing *United Airlines Servs. Corp.*, 290 NLRB 954 (1988)) (“The critical inquiry is whether the benefits were granted for the purpose of influencing the employees’ vote in the election and were of the type reasonably calculated to have that effect”); see also *Flamingo Hilton-Laughlin*, 324 NLRB at 115 (1997) (asking whether a “legitimate explanation founded in prudent and ordinary business judgment has been forthcoming,” and holding that installation of a better ventilation system to employees during the main phase of a union campaign was not a conferral of benefits because specific medical

limitations and “ordinary health considerations were present”). Trash bags were necessary for the employees to remove soiled diapers and linens from the Center. In fact, some employees were unable complete their jobs without the bags. Furthermore, proper removal of these soiled items minimizes the risk of infection of patients, which is paramount in a long-term care center. Thus, Hutchens’ conduct in ensuring that a sufficient number of trash bags were available was motivated by factors other than the election and consequently, did not violate Section 8(a)(1).⁹⁶

In light of all the foregoing, the ALJ’s finding that Somerset Valley unlawfully solicited and promised to remedy employee grievances in violation of Section 8(a)(1) of the Act is against the weight of all of the credible, relevant evidence in the record and established Board law.

C. Somerset Valley Did Not Violate Section 8(a)(3) of the Act

Alleged violations of Section 8(a)(3) involving questions of employer motivation must be analyzed under the burden-shifting doctrine articulated in *Wright Line*, 251 NLRB 1083, 1087 (1980). Under *Wright Line*, the Acting General Counsel bears the initial burden of proving by a preponderance of the evidence, for each alleged violation of Section 8(a)(3), that: (1) the employee as to whom the alleged violation was committed engaged in conduct protected by Section 7 of the Act; (2) the employer knew of the employee’s protected conduct; (3) the employer took an adverse employment action against the employee; and (4) the protected conduct was a motivating factor in the decision to take the adverse action. *Wright Line*, 251 NLRB at 1087.

⁹⁶ Even assuming Hutchens unlawfully solicited grievances or conferred any benefit in the form of supplying trash bags to employees, his conduct was not related to any of the 8(a)(3) allegations in this case and was, therefore, isolated and *de minimis*. See *Albertson’s, Inc.*, 351 NLRB at 256.

In the absence of direct evidence of discrimination, the Acting General Counsel must establish a causal link between the protected activity and the adverse employment action by circumstantial evidence—i.e., by showing that the employer's decision was inconsistent with its other actions, its treatment of similarly-situated employees, or its past practices, or by establishing some temporal proximity between the employment action and the protected activity. See *DTG Operations, Inc.*, 357 NLRB No. 6, 2011 NLRB LEXIS 357, *19 (July 20, 2011). If the Acting General Counsel's proof is insufficient to establish each of the foregoing elements, the inquiry is over. *Wright Line*, 251 NLRB at 1087. However, if the Acting General Counsel makes this threshold showing, the employer still may avoid liability by proving by a preponderance of the evidence that it would have taken the same action regardless of the employee's protected conduct. *Id.*

In evaluating the proof in this regard, the Board may not second guess an employer's business decisions. *Ryder Distribution Resources, Inc.*, 311 NLRB 814, 816 (1993) ("the Board does not substitute its own business judgment for that of the employer"). Thus, the question is not whether the Board would have made the same decision under similar circumstances. *Id.* Instead, the appropriate inquiry is whether the non-discriminatory reasons proffered by the employer would, more likely than not, have compelled the employer's decision even absent protected conduct. *DTG Operations, Inc.*, 2011 NLRB LEXIS at 19; *Ryder Distribution Resources, Inc.*, 311 NLRB at 816-17. Accordingly, the ALJ's heavy reliance on any difference between the Employer's pre-election and post-election disciplinary actions is misplaced. To the

contrary, the ALJ's analysis should have focused on the Employer's motivation and consistent discipline of all employees. See *Wright Line*, 251 NLRB 1083.

The employer's defense does not fail simply because it is not supported by all of the evidence, or even because it is refuted by some of the evidence. *DTG Operations, Inc.*, 2011 NLRB LEXIS at 20. Indeed, the employer needs only to prove its defense by a preponderance of the evidence. *Id.* Notwithstanding the employer's opportunity to establish its defense, the ultimate burden of proving discrimination remains with the Acting General Counsel at all times. *Wright Line*, 251 NLRB at 1088 n.11.

Here, despite the Acting General Counsel's failure to meet that ultimate burden, the ALJ erroneously found that the Employer acted unlawfully. As the facts set forth above bear out, this case is not about the Union or the Union's organizing campaign at Somerset Valley. It is about an employer's legitimate efforts to turn around a crippled business. Somerset Valley had been operating both inefficiently and ineffectively, and its poor performance threatened to compromise the health and safety of its patients. Rather than acknowledge the clear, unrefuted evidence of this poor performance, the ALJ improperly relied on the previous administration's inaction in finding that that the new management's efforts to improve patient care were somehow unlawful. In fact, mismanagement (primarily by the Center's prior management group) had deteriorated the clinical environment at the Center so significantly that Somerset Valley feared that it may be in danger of losing its certification to receive new patients, Medicare payments, and/or its operating license. The multiple G-level deficiencies issued by the New Jersey Department of Health and Senior Services in December 2009 were a wake-up call to upper management. As a result of this near disastrous recertification survey, the

Regional Director of Operations, Hutchens, increased his scrutiny of Somerset Valley's nursing department, seeking to hold Administrator, Elizabeth Heedles, and DON, Eileen Meyer, more accountable for the Center's performance.

Mere increased scrutiny, however, was insufficient to remedy Somerset Valley's operational problems. Contrary to the ALJ's erroneous finding that no action was taken until after there was union activity at Somerset Valley, it is undisputed that Meyer resigned in the spring of 2009 as a result of being held to higher standards of accountability and performance, and was replaced by Kamala Kovacs, who also struggled to improve the Center's performance. Following Meyer's resignation, Hutchens learned that systemic scheduling and staffing issues continued to plague the Center and that employee morale had begun to deteriorate. Thus, Hutchens decided that more radical changes were necessary. Accordingly, in early August 2010, Somerset Valley's Administrator, DON, and Unit Manager all were replaced in an effort to improve the performance of the Center's clinical areas.⁹⁷

While Somerset Valley opposed the Union's organizing efforts at the Center, as it is entitled to do under the Act, see 29 U.S.C. §§ 158(a)(3), 158(c); *Vanella Buick Opel, Inc.*, 191 NLRB 805, 813 (1971), there is no evidence in the record to establish that Somerset Valley acted unlawfully in doing so. Indeed, the record in this case, at best,

⁹⁷ Hutchens' decisions regarding Somerset Valley's management team (and the decisions of Somerset Valley's new managers following their arrival, as set forth below) must be considered in the context of Somerset Valley's continuing efforts to repair its business operations and to ensure the health and safety of its patients. Hutchens' focus, at its core, was on saving a business that was suffering so significantly that it was in danger of losing its license to operate. Inasmuch as Hutchens' changes in management personnel were made for legitimate business reasons, they did not violate the Act. See *The Inn at Fox Hollow*, 352 NLRB 1072, 1073 (2008) (citing *Stanadyne Automotive Corp.*, 345 NLRB 85, 91 (2005)) (discharge of management personnel, even unpopular management personnel, does not violate the Act when made for reasons other than the pending election).

establishes nothing more than that the Union activity coincided in time with some of Somerset Valley's necessary business decisions which were aimed at improving its business and improving patient care.⁹⁸ While such a coincidence might raise a suspicion regarding those decisions made in proximity to the Union activity, it "cannot substitute for proof of unlawful motivation." See *Frierson Building Supply Co.*, 328 NLRB 1023, 1024 (1999) (citing *Lasell Junior College*, 230 NLRB 1076 n.1 (1977)). Thus, timing alone is insufficient to sustain a charge of discrimination under Section 8(a)(3). *Id.* Moreover, Somerset Valley's lawful opposition to the Union cannot be considered evidence of unlawful motive in support of the alleged 8(a)(3) violations. *NLRB v. Rockwell Manuf. Co.*, 271 F.2d 109 (3rd Cir. 1959). Inasmuch as the Acting General Counsel offered nothing more, the ALJ should have found that the Section 8(a)(3) allegations failed.⁹⁹

Against this legal framework and the factual background set forth above, Somerset Valley will address each of the Section 8(a)(3) allegations for which the ALJ erroneously found merit:

⁹⁸ Moreover, all of the alleged Section 8(a)(3) violations occurred *after* the Union's organizing drive and the related election. Logic dictates that if Somerset Valley truly had been motivated by the Union's organizing drive rather than legitimate business concerns, it would have terminated the alleged discriminatees prior to the election in an effort to change the election outcome. It did not. Accordingly, the timing of the challenged decisions was simply a product of Somerset's Valley's continued efforts to improve its business and rectify patient care deficiencies, and there is no evidence of animus toward any of the alleged discriminatees.

⁹⁹ Even assuming the Acting General Counsel had established some violation of Section 8(a)(1), the alleged Section 8(a)(1) violations were isolated and wholly unrelated to the alleged Section 8(a)(3) violations. In fact, there is no evidence of any threat of reprisal directed toward any Union supporter. Accordingly, the Acting General Counsel's alleged Section 8(a)(1) violations, even if true, do not support the allegations that Somerset Valley disciplined and/or terminated any employee because of her support for the Union and the ALJ erred in so finding.

1. **The ALJ Erred in Finding Somerset Valley Violated the Act by Reducing the Work Hours of Per Diem Employees**

The ALJ found that beginning on or about September 18, 2010, Somerset Valley unlawfully reduced the work hours of per diem employees Daysi Aguilar, Annie Stubbs, Gertrudis Rodriguez-Arias, Dominique Joseph, and Rita Onyeike because of their support for the Union. However, the ALJ's finding erroneously relied on testimony that clearly was not credible and was against the weight of the record evidence. For example, clear evidence demonstrates that the schedules of these employees were altered, along with numerous other per diem employees, not because of their support for the Union but instead to improve the efficiency and effectiveness of Somerset Valley's operations, including its ability to provide critical continuity in patient care.

As a threshold matter, the Acting General Counsel failed to establish that Somerset Valley knew that Aguilar,¹⁰⁰ Stubbs, Rodriguez-Arias,¹⁰¹ or Joseph supported the Union and the ALJ failed to acknowledge that fact. Accordingly, the Acting General Counsel has failed to establish a prima facie Section 8(a)(3) claim with regard to those employees and the ALJ erred in finding a Section 8(a)(3) violation with respect to this issue. See *Wright Line*, 251 NLRB at 1087.

¹⁰⁰ Aguilar seemed particularly confused during her testimony by repeatedly looking at counsels for the Acting General Counsel and Union before answering and appeared to be concerned about whether she was testifying as the Acting General Counsel and Union wanted her to testify.

¹⁰¹ Any reliance by the ALJ on Rodriguez-Arias' (or any other employee's) appearance in the Union's flyer as indicative of her Union support is wholly misplaced. The photos for the flyer were taken over a month before the Union published the flyer. Significantly, the vast majority of employees at the Center appeared in one or more pieces of Union propaganda and a number of these employees even testified in the Objections Hearing for the Employer. Moreover, there is no evidence that those managers who viewed the Union's flyer considered the contents of those items to be conclusive of Union support.

Even assuming Somerset Valley had known Aguilar, Stubbs, Rodriguez-Arias, and/or Joseph were Union supporters or had engaged in protected activity, Somerset Valley would have made the same decisions regarding all per diem employees whether they supported the Union or not. As set forth above, Somerset Valley's new management sought to address a series of operational issues, a significant number of which were related to staffing. Perhaps the most significant staffing issue was improper scheduling, including the misuse of per diem employees by Somerset Valley's former Staffing Coordinator, Valarie Wells. Shortly after their arrival at the Center, Konjoh and Illis discovered that Wells had been utilizing per diem employees on fixed schedules each week – a fact the ALJ erroneously relied on in finding the per diems "scheduled hours" had been reduced. (ALJD 32:19-20). However, it is undisputed that Wells' practice was contrary to Somerset Valley's and the Company's policies of filling the weekly schedule with full-time and part-time employees and scheduling per diem employees only "as needed" to fill holes in the schedule. Moreover, Wells' practice was not only economically inefficient (per diem employees earn at least \$2.00 per hour more than similarly-situated part-time and full-time employees), it also compromised the continuity, and thus the quality, of patient care.

Given these economic and patient care concerns, in September 2010, Illis aligned Somerset Valley's practice with the Company's policy of using per diem employees only on an "as needed" basis while filling the regular schedule with full-time and part-time employees. As a result, Somerset Valley's needs for fill-in help changed. So, too, did the cost at which Somerset Valley could staff the Center. Likewise, the continuity of the care Somerset Valley provided to its patients improved. ✓

Contrary to the ALJ's findings, Illis was not precluded by the Act from adhering to Somerset Valley's policy for per diem scheduling simply because Wells had failed to do so. See *Precoat Metals*, 341 NLRB 1137, 1190 (2004) ("nothing in the Act prohibited [the new manager] from prohibiting practices and procedures that had previously been tolerated"); see also *Frierson Building Supply Co.*, 328 NLRB at 1024. Thus, Illis' actions were in no manner unlawful or discriminatory.

Somerset Valley's adjustment to its scheduling of per diem employees, and the resulting change in the use of per diem employees at the Center, resulted in several former per diem employees working their last shifts in and around September, October, and November of 2010. Those employees who were not scheduled to work following the change in Somerset Valley's scheduling practice, however, were not limited to the few alleged discriminatees hand-picked by the Acting General Counsel. To the contrary, in addition to Aguilar, Stubbs, Rodriguez-Arias, Joseph, and Onyeike, Lusette Ceus also worked her last per diem shift in September of 2010. The ALJ failed to acknowledge clear record evidence that former per diem employees Greg Calderon, Philomena Di Quollo, Narinder Singh-Kaur, Aminata Conteh, and Carol Forero all worked their last per diem shifts at Somerset Valley in October or November of 2010.¹⁰² Inasmuch as the per diem employees who had not been scheduled to work included not only the alleged discriminatees but also several other employees, it is clear that Somerset Valley took these employment actions for legitimate business reasons and not because of any alleged discriminatee's Union support and thus, would have made

¹⁰² There is absolutely no evidence in the record that any of these individuals supported the Union or were alleged to have supported the Union, or that the Employer had any knowledge whatsoever of any alleged Union support by these individuals. Again, this fact erroneously was ignored by the ALJ.

the same decisions absent any alleged protected conduct. The ALJ failed entirely to consider these other per diem employees. As such, his findings on this issue should be overturned.

Among the factors attributable to certain of the foregoing employees not being scheduled to work is that per diem employees, when used properly, are expected to be available to work at almost any time and often on very short notice. Thus, they must be able to maintain extremely flexible schedules (for which they are compensated at a premium) and to be willing and able to take shifts on both days of a single weekend and/or multiple days during the week, when necessary. When properly utilized, per diem employees do not have fixed work schedules, but instead are used on an on-call basis for short term coverage. As a result, those clinical employees who were unable or unwilling to provide Somerset Valley with the flexibility expected of a true per diem employee were ill-suited to continue filling shifts on a per diem basis. For example, Aguilar, Stubbs, and Joseph all indicated to management that they had specific limitations on the dates, shifts, or times for which they were available to work. None of these employees, therefore, were available to work on the days and shifts the Center needed filled. Furthermore, due to these limitations, they really were not well-positioned to serve Somerset Valley in a per diem role at all.

Moreover, because its decisions were motivated by financial and performance concerns, Somerset Valley did not seek to eliminate the hours of the alleged discriminatees at the expense of other per diem employees who did not support the Union. In fact, prior to the time she was removed from the system as a per diem CNA, Stubbs was offered a part-time position. She declined the offer. Likewise, at the

suggestion of Konjoh, Rodriguez-Arias was offered a full-time position, which she declined as well. While the ALJ acknowledged that Stubbs and Rodriguez-Arias were offered part and full-time positions, respectively, he nevertheless inexplicably concluded that Somerset Valley sought to reduce and/or eliminate their hours based on their support for the Union. However, inasmuch as alleged discriminatees Stubbs and Rodriguez-Arias were offered part-time or full-time positions with Somerset Valley before the time that they last appeared on the regular schedule, Somerset Valley clearly was not seeking to eliminate these employees from the schedule because of either employee's alleged support for the Union. To the contrary, Somerset Valley would have made the same decisions regarding per diem employees even absent any Union activity. Indeed, Illis credibly testified that all of her decisions with regard to per diem employees were made without regard for whether any employee supported the Union. Further, the ALJ's finding that the five alleged per diem discriminatees were replaced with other per diem workers who transferred from CareOne's Holmdel facility is not based on any record evidence as no evidence was introduced that the exact slots being filled by these individuals were filled by other per diem employees and no evidence was introduced of per diem employees from the Holmdel facility transferring to Somerset Valley. (ALJD 38:29-31).

2. **The ALJ Erred in Finding Somerset Valley Violated the Act by Disciplining Shannon Napolitano, Jillian Jacques, or Sheena Claudio for Poor Attendance and Tardiness**

The ALJ found that Somerset Valley unlawfully disciplined employees Shannon Napolitano, Jillian Jacques, and Sheena Claudio¹⁰³ on September 13, 14, and 16, 2010,

¹⁰³ The ALJ's reliance on Claudio's appearance in the Union's flyer or YouTube video as indicative of her Union support is misplaced. The photos were taken and releases obtained

respectively, because of their support for the Union. Somerset Valley, however, disciplined Napolitano, Jacques, and Claudio on those dates not because of any support for the Union, but instead for poor attendance and/or tardiness in accordance with its established attendance policy. Notably, the ALJ improperly failed to acknowledge that Konjoh and Illis represented a new management team in place at Somerset Valley, relying instead on lax practices by former management who undisputedly were doing a subpar job.¹⁰⁴ See *Precoat Metals*, 341 NLRB at 1190. As such, the ALJ erred in suggesting Konjoh should not have issued attendance-related discipline because it was previously “common practice” for employees to arrive late and that Konjoh should not have asked that attendance-related calls be directed to her.

In addition to the per diem scheduling issues, Konjoh and Illis determined that attendance and tardiness also were significantly affecting the quality and continuity of Somerset Valley’s patient care. Indeed, notwithstanding the existence of Somerset Valley’s policy prohibiting excessive absenteeism, tardiness, and/or a pattern of absenteeism, and the fact that employees are instructed regarding performance expectations during orientation, Konjoh learned that it was commonplace for employees to arrive at work up to an hour late. Accordingly, in September 2010, after their first few

over a month in advance of publication. Likewise, the videos were shot well in advance of publication. Significantly, the vast majority of employees at the Center appeared in one or more pieces of Union propaganda and those managers who viewed the Union’s flyer or YouTube video did not consider the contents of those items to be conclusive of Union support. Notably, neither Illis nor Konjoh viewed the YouTube video prior to Claudio’s termination. There was no evidence to the contrary.

¹⁰⁴ For example, the ALJ supported his findings by relying on testimony that prior to the election, employees who were late were simply told to come in “as soon as possible” and were not disciplined. The ALJ’s findings also failed to acknowledge that Jacques was counseled for her poor attendance by the prior administration. Moreover, the ALJ again failed to acknowledge that a new management team, which held higher expectations, was in place at the time. See *Precoat Metals*, 341 N.L.R.B. at 1190.

weeks on the job, Konjoh and Illis set out to address the pervasive attendance and tardiness issues which had been neglected by former management. Specifically, Illis asked managers and department heads to communicate to employees the expectation that employees arrive at work on time as scheduled. Illis and Konjoh also decided to audit the Center's attendance records, identify the worst offenders, and discipline employees who had demonstrated a history of absenteeism or tardiness in an effort to change employee behavior with regard to call-outs and tardiness to improve staffing and patient care.¹⁰⁵

Accordingly, Somerset Valley took disciplinary action against at least 11 of the worst offenders, including alleged discriminatees Napolitano, Claudio, and Jacques. Specifically, with regard to the alleged discriminatees, on September 13, 2010, Napolitano received a first written warning for arriving to work late a total of 93 times since January 2010, and nine times in the preceding 30 days.¹⁰⁶ Jacques was issued a first written warning on September 14, 2010, for being late 109 times since January 2010, and 11 times in the preceding 30 days, and a second written warning the same day for the separate offense of pattern absenteeism. Claudio was issued a first written

¹⁰⁵ The ALJ relied upon his finding that Illis became aware of excessive absenteeism among employees immediately upon her arrival to conclude that because "no action was taken against anyone for six weeks, not until shortly after the election" that Somerset Valley sought to retaliate for the Union's election victory. (ALJD 44:26-28). Not only did it take Illis some time in her new position to identify the severity of the attendance issues, the Center's clinical issues were the most urgent at the time of her arrival.

¹⁰⁶ While Napolitano offered the excuse that she habitually was late because she lived nearly an hour away from the Center, she offered no evidence to establish that she had permission from any manager to be tardy. Moreover, Napolitano lived only approximately 20-25 minutes from the Center until the second week of August 2010, while the late arrivals for which she was disciplined dated all the way back to January 2010. Notably, Napolitano did not move until *after* Illis' and Konjoh's arrivals at the Center and her tardiness clearly had not been excused in light of the disciplinary action taken. The fact that Napolitano purposely misrepresented the distance from her home to the Center during the first eight months of 2010 evidences her general lack of credibility. A fact the ALJ disregarded without explanation.

warning on September 16, 2010, for pattern absenteeism, and a second written warning on the same day for being late 64 times since January 2010, and 16 times in the preceding 30 days.

Notwithstanding the ALJ's finding that Napolitano, Claudio, and Jacques were targeted for the foregoing disciplinary action because of their support for the Union, Somerset Valley took *the same disciplinary action* against numerous other employees for substantially similar conduct, which the ALJ failed to acknowledge. By way of example, May Novelette was issued a first written warning on September 13, 2010, for being late 47 times since January 2010, and a second written warning on the same day for the separate offense of abuse of sick leave. Likewise, Lurette Ceus was issued a first written warning for tardiness on September 13, 2010, and a final written warning for absenteeism the same day. Somerset Valley also took similar disciplinary action against other employees during the same time period, including Beatrice Beauvoir, Soledad Guillaume, Dominique Joseph, Jennifer McAuley, Patsy Benimadho, and Cassandra Burke. Significantly, no evidence of the Company's knowledge of any Union support by any of these individuals was introduced.

All of the disciplinary action identified above was issued in furtherance of Somerset Valley's legitimate efforts to combat the serious attendance and tardiness issues hampering the Center's performance and not for discriminatory reasons. In fact, the record reflects not only that Somerset Valley engaged in concerted efforts to correct its attendance problems, but also that those efforts were successful. Attendance improved across the board at the Center following the round of disciplinary actions

issued in September 2010. Moreover, alleged discriminatees Jacques and Napolitano both demonstrated improvement in their attendance.¹⁰⁷

In light of the foregoing, the ALJ's finding that Somerset Valley disciplined Napolitano, Jacques, or Claudio because of their alleged support for the Union is erroneous and should be overturned.

3. **The ALJ Erred in Finding Somerset Valley Violated the Act by Accelerating the Resignation of Lynette Tyler**

The ALJ found that Somerset Valley accelerated Lynette Tyler's resignation because of her support for the Union. To the contrary, Tyler voluntarily resigned her employment with Somerset Valley by letter dated September 9, 2010, despite Somerset Valley's efforts to persuade her to stay, and her resignation was accepted immediately pursuant to the practice of the new Administrator, Doreen Illis. The ALJ erred in his failure to acknowledge un rebutted evidence that Illis accelerated resignations of other employees at her prior facility. Accordingly, he erroneously compared Tyler's resignation only to those of supervisors.

The ALJ's finding that Illis' immediate acceptance of Tyler's resignation was unlawful is not supported by the preponderance of the evidence. Illis' decision to immediately accept Tyler's resignation was not adverse to Tyler or the Union or in any manner discriminatory or unlawful.¹⁰⁸ In fact, Tyler was paid for an additional two weeks after her last day of work and received all of the benefits to which she would otherwise

¹⁰⁷ Notably, the ALJ failed to acknowledge Jacques' admission that when her attendance improved, Illis wrote her a thank you card and praised her.

¹⁰⁸ Moreover, during cross-examination, Tyler became visibly hostile and aggressive. She began leaning over the witness stand and raising her voice. At one point, she came out of her chair as if to confront counsel. Such behavior is consistent with Illis' testimony that, while Tyler did her job duties in an acceptable manner, Tyler exhibited a bad attitude and was rude and disrespectful when issues were brought to her attention.

have been entitled had she worked during those two weeks. Moreover, Tyler never requested to continue working during that two-week period, nor did she indicate to anyone that she was in any way unhappy with the paid time off. Further, Tyler never attempted to rescind her resignation. Additionally, because Tyler voluntarily resigned after the election, and there was no election pending, the Union similarly was not adversely affected by Somerset Valley's decision to accept Tyler's resignation on the day that it was given. Accordingly, neither Tyler nor the Union suffered any harm as a result of any action taken by Somerset Valley and the ALJ erred in his failure to acknowledge the same.¹⁰⁹

4. **The ALJ Erred in Finding Somerset Valley Violated the Act by Disciplining and Terminating Shannon Napolitano For Critical Patient Care Issues**

The ALJ found that Somerset Valley terminated Shannon Napolitano on September 17, 2010, because of Napolitano's support for the Union. However, Napolitano was not terminated because of any support for the Union but instead because of critical, repeated performance issues related to patient care.

As set forth above, after receiving a complaint from a patient claiming that her nurse had not given her "her pink pill," Konjoh learned that Napolitano had continued to administer medication to a patient after the treating physician had discontinued that medication for the patient.¹¹⁰ When confronted with the patient's MAR indicating that

¹⁰⁹ The case cited by the ALJ in support of his finding of illegal conduct by Somerset Valley is inapposite. In *Gelita USA Inc.*, 352 NLRB 406, 415 (2008), the employer accelerated an employee's departure date in advance of an election, thereby removing a potentially adverse employee from the voting pool. In contrast, in this case, with no rerun election in sight, Tyler's departure date had no significance to Somerset Valley or the Union – a fact which the ALJ improperly failed to acknowledge.

¹¹⁰ Following an investigation, Konjoh determined Napolitano had erroneously administered zinc to the patient on four separate occasions and Napolitano agreed with Konjoh's finding.

the medication had been discontinued, Napolitano admitted to Konjoh that she had repeatedly administered the medication to the patient in error and that she “was going by memory” of the patient’s prior receipt of the medication. Thus, Napolitano admitted that she failed to comply with the proper procedure for administering medication to a patient, which includes: (1) reviewing the patient’s MAR to determine what medication is administered to the patient; (2) confirming the appropriate dosage; (3) retrieving the medication; (4) checking the medication against the order; (5) putting the medication in a cup; (6) administering the medication and ensuring it is ingested by the patient; and (7) documenting on the MAR that the medication has been administered.¹¹¹

Specifically, Napolitano did not review the patient’s MAR, did not ensure the patient ingested the medication,¹¹² and did not properly document her administration of the medication. The ALJ’s rationale that Napolitano should not have been disciplined for failing to ensure the patient ingested the medication because the medication was not prescribed is nonsensical. (ALJD 21:24-26). Napolitano clearly did not know that the

This undisputed evidence directly contradicts the ALJ’s illogical finding that Somerset Valley only administered the discontinued pill on August 25th and 30th. (ALJD 19:51-20:1).

¹¹¹ Not only did Napolitano admit her errors, but her testimony was inconsistent regarding the specifics of her handling and administration of the zinc pill. Moreover, Napolitano’s testimony was fraught with factual inaccuracies as she also mistakenly testified that Valarie Wells was a supervisor at the facility (which she was not) and that Illis had informed her of a meeting regarding the Union’s organizing campaign in July, 2010, before Illis joined Somerset Valley. Finally, Napolitano’s testimony was not credible. On cross-examination, she often paused for long periods of time while looking eagerly at counsels for the Acting General Counsel and Charging Party, or stared out into space, before being prompted to answer questions. Throughout her testimony, Napolitano often giggled before, during, or after her answer as if the hearing were a game or the opportunity to execute her agenda of retribution against the Company. It is disconcerting that Napolitano was often glib or cavalier in addressing the serious patient care implications of her nursing errors and omissions.

¹¹² The ALJ’s finding that Napolitano waited until the patient swallowed all the medication she gave her is clearly contradicted by the evidence – particularly Napolitano’s admission on the disciplinary notice she signed *acknowledging* that she left the medication at the patient’s bedside. (ALJD 19:39-40).

medication was not prescribed and she was disciplined for failing to adhere to standard medication administration protocol. While the patient was not harmed in this instance, Napolitano's errors in administering additional medication could have resulted in serious physical injury or even death. Unfortunately, Napolitano's unacceptable patient care did not end there. Indeed, Konjoh also discovered (and Napolitano once again admitted) that Napolitano incorrectly charted a patient's oxygen saturation level as zero percent.¹¹³ In light of these serious patient care errors, Konjoh and Illis made the necessary decision to terminate Napolitano's employment. Napolitano's termination was solely motivated by legitimate patient safety concerns and the same employment action would have been taken even absent any Union activity or support.

Since the time of their arrival at Somerset Valley, Konjoh and Illis have taken all patient care issues very seriously, and have disciplined (in varying degrees) and/or terminated numerous other employees for related patient care errors. By way of example, Doreen Dande received a second written warning on November 30, 2010, for not giving a patient her prescribed vitamin B12 nasal spray, and Maharanie Mangal was issued a written warning on December 14, 2010, for failing to properly measure the amount of Miralax to be given to a patient.¹¹⁴ The ALJ failed to acknowledge these facts. (ALJD 24:8-10). Moreover, inasmuch as Dande's and Mangal's errors, while potentially harmful to their patients, did not carry with them the risk of serious injury like Napolitano's erroneous administration of zinc, they were considered less severe and the

¹¹³ Moreover, while not relied upon in the decision to terminate Napolitano's employment, it should be noted that Napolitano previously had received a final written warning in January 2010, for improper pain assessment – the same issue identified as a G-level deficiency in the 2009 survey.

¹¹⁴ Neither Dande nor Mangal were known by Somerset Valley to be Union supporters.

discipline issued was also less severe. Furthermore, Somerset Valley has disciplined a host of other employees who were not known Union supporters based on clinical and patient care issues in varying degrees.

Although Jillian Jacques alleged that Mohammed Bockarie failed to give a patient Coumadin for three days, that she recorded this error in Somerset Valley's 24 hour reports, and that she reported Bockarie's error to Konjoh the same day, Jacques' testimony on this issue was not credible. (Tr. 472-76). In fact, Konjoh had been out of the country at the time of the alleged error and at the time Jacques allegedly reported the error to her. (Tr. 472-74, 630, 649-52, 2279-83; R-97). Konjoh testified credibly that neither Jacques nor any other employee ever informed her of the alleged error.¹¹⁵ (Tr. 2278-79, 2286). Moreover, while all of the 24 hour reports for the relevant time period were produced by Somerset Valley, the Acting General Counsel never introduced into evidence any 24 hour report containing a record of the error Jacques alleged Bockarie committed.¹¹⁶ The ALJ, however, failed to acknowledge that the Acting General Counsel's failure to introduce the alleged "smoking gun" 24 hour report, an inference may appropriately be drawn that no such error occurred, and therefore that no such error was recorded or reported to Somerset Valley.

¹¹⁵ Jacques also alleged that Dande had committed an error related to the administration of Coumadin. She admitted, however, that she did not report that alleged error to any supervisor or manager at the Center.

¹¹⁶ While Bockarie testified that Jacques brought this alleged error to his attention and told Konjoh about it, his testimony also was not credible. As set forth above, Konjoh credibly testified that she was out of the country at the time of the alleged error, which is supported by the dates stamped on her passport (R-97), and was never informed of the error by Jacques or any other employee. Jacques' testimony on this issue was also inconsistent. She first testified that she reported the error to Konjoh the day it happened and later changed her story and said that she reported it to Konjoh the following day. Moreover, Bockarie had a motive to lie (given his recent termination from Somerset Valley and his blatant animosity toward Illis as demonstrated in the Center's reception area following a visit he made to the facility).

The Board has consistently recognized the fundamental import to healthcare institutions of ensuring patient safety and eliminating deficient patient care. See *Vencor Hospital-Los Angeles*, 324 NLRB 234, 251 (1997) (holding discharge for poor patient care did not violate Section 8(a)(3) based on credible testimony regarding the professional evaluation of patient care needs notwithstanding that the witnesses' testimony was deemed incredible on other issues); *Jupiter Medical Center Pavilion*, 346 NLRB 650, 651 (2006) (holding discipline issued for patient care deficiencies lawful under Section 8(a)(3)). Indeed, in light of the severity of Napolitano's errors in this case, and her corresponding admission to those errors, Somerset Valley's decision to terminate Napolitano's employment is nearly inviolate. Napolitano admitted to errors that could have seriously injured or killed a patient.

Notwithstanding any question regarding Somerset Valley's lawful opposition to the Union,¹¹⁷ Somerset Valley would have taken the same employment action under any circumstances, given the serious patient safety concerns and hazardous and neglectful conduct by Napolitano.

The Acting General Counsel, therefore, failed to establish that Somerset Valley violated Section 8(a)(3) when it terminated Napolitano's employment. Accordingly, the ALJ's finding of a violation of Section 8(a)(3) regarding Napolitano should be overturned.

¹¹⁷ As set forth above, mere opposition to union activity, in and of itself, is not unlawful. See *Vanella Buick Opel, Inc.*, 191 NLRB 805, 813 (1971).

5. **The ALJ Erred in Finding Somerset Valley Violated the Act by Disciplining and Terminating Sheena Claudio For Critical Patient Care Issues**

The ALJ found that Somerset Valley unlawfully disciplined Sheena Claudio in September and October 2010, and ultimately terminated her employment in October 2010, because she supported the Union. Contrary to this finding, however, Somerset Valley disciplined and ultimately terminated Claudio for a series of critical patient care related issues.¹¹⁸

As a threshold matter, the Acting General Counsel failed to establish that Illis or Konjoh knew that Claudio supported the Union. In fact, both Illis and Konjoh (the sole decision makers responsible for Claudio's disciplinary action and termination) credibly testified that they had no knowledge as to whether Claudio supported the Union and that their decisions to discipline and terminate her were in no way related to any Union activity or support. While the ALJ noted that Hutchens knew that Claudio had appeared in a Union YouTube video, there was no evidence in the record that Illis or Konjoh knew Claudio supported the Union. Accordingly, there was no basis for the ALJ's finding that the decisions to discipline and/or terminate Claudio (made by Illis and Konjoh) were motivated by that Union support. Thus, the Section 8(a)(3) allegations with regard to Claudio should have been dismissed.

Even assuming Illis or Konjoh had known Claudio was a Union supporter, however, Somerset Valley would have made the same decisions with regard to her employment regardless of any such Union support. This is particularly evident in light of Illis' and Konjoh's efforts to instill a heightened sense of accountability with regard to

¹¹⁸ As set forth above, Claudio's testimony was not credible. In addition to being a disgruntled former employee, she routinely became combative and hostile during cross-examination.

adherence to Somerset Valley's policies and procedures in the clinical environment to improve patient care and ready the Center of the pending State survey.

Here, Claudio received a written warning on September 20, 2010, for a medication error for administering aspirin two days in a row despite a prescription that provided the medication was only to be administered every other day. Claudio was not alone in receiving this disciplinary action. In fact, Dande also received a final written warning for making the same error with the same patient. Moreover, at the time Claudio received her final written warning, she was told that future errors could result in her termination.

Despite this admonition, Claudio received further discipline in October 2010 for failing to complete critical patient care documentation on three separate patients. Claudio's documentation errors were as follows: (1) she failed to properly document a patient fall and subsequent neuro check; (2) she failed to document post-fall on a new admission and then failed to document on that same patient on admission notes; and (3) she provided treatment on a patient with a skin tear without an order to do so, and failed to write an order for the skin care treatment despite documenting the treatment on an incident report. Claudio admitted to each of the errors for which she was disciplined with the sole exception of the new admission note, which she claimed she had written.¹¹⁹ Upon review of the file, however, Claudio acknowledged that the admission note was not present. In light of her prior written warning and previous instructions regarding the types of documentation Claudio had failed to complete, Somerset Valley

¹¹⁹ Despite clear, undisputed testimony that Claudio admitted to all but one of the errors for which she was disciplined, the ALJ erroneously failed entirely to acknowledge this record evidence. (ALJD 22:8-14).

could have terminated Claudio at this time. Nevertheless, Illis and Konjoh chose to give Claudio yet another chance and decided to suspend, rather than terminate, Claudio at that time.

Unfortunately, however, Claudio's second written warning did not have the intended effect on Claudio's hazardous patient care practices. Indeed, in a rather bizarre chain of events on or about October 7, 2010, Claudio returned to the Center at approximately 11:25 p.m., approximately nine hours after her shift had ended, to sign for treatments that she had provided to patients during earlier that day. She was observed by Illis and upon inquiry, told Illis that she was signing for treatments that she had forgotten to sign for previously. Illis informed Claudio that she could not sign off on any medical treatments as she had completed her shift and was no longer on the clock working. After initially disregarding Illis, nursing supervisor Janet Mathias physically took the book from Claudio, and Illis told Claudio she needed to leave the Center. Upon subsequent review, Konjoh learned that Claudio had failed to document approximately 20 patient treatments. Indeed, while her testimony was wildly inconsistent on this issue, Claudio ultimately admitted that she may have had over 100 treatments that day, but could only recall recording the treatments for one of her patients. Accordingly, and in light of Claudio's prior discipline which clearly had been ineffective in reforming Claudio's behavior, Konjoh and Illis made the decision to terminate Claudio's employment.

In light of the seriousness of Claudio's repeated patient care errors, Somerset Valley's decisions to discipline her and ultimately terminate her employment clearly were based on legitimate business considerations and were in no way related to any

Union support or activity.¹²⁰ Moreover, such disciplinary action was not unique to Claudio. First, as set forth above, Dande received disciplinary action identical to Claudio's first written warning for the same conduct. Next, Somerset Valley has disciplined several other employees, including but not limited to, Sandy Mootosamy (in September 2010), Patricia Beck (in September 2010), and Michele Moore (in February 2011) for similar documentation errors. Furthermore, to the extent that the ALJ found that Mohammed Bockarie received only a verbal warning for failing to document a patient pain assessment, Konjoh credibly testified that she was not involved in issuing this discipline to Bockarie and does not believe she was at the Center at the time it was issued.¹²¹ Moreover, it was undisputed that Illis also was not aware of this discipline until after it was administered, and she admonished the ADON that the discipline was not harsh enough. Finally, neither Konjoh nor Illis is aware of any other nurse who failed to complete treatment documentation by the end of a shift and was not disciplined, and neither is aware of any nurse attempting to return to the Center following the end of a shift to complete such documentation, nor is there record evidence of any such similar situations. Accordingly, the ALJ's reliance on Claudio's testimony regarding alleged practices by nurses failing to complete TAR entries, or not completing them in accordance with proper protocol, prior to Illis' and Konjoh's arrivals at the Center is misplaced as is his reliance on Southgate's testimony that she failed to

¹²⁰ The ALJ's finding that Claudio's termination letter did not state that she was being terminated for failing to perform the treatments is directly contradicted by Claudio's termination documentation. (ALJD 23:7-9, R-125). Accordingly, the ALJ's reliance on this incorrect finding to support his reasoning behind discrediting Konjoh and finding her testimony "exaggerated" is erroneous and not supported by evidence. (ALJD 39:31-34; 47:20-23).

¹²¹ In as much as the ALJ compared Bockarie to Claudio as an employee who was not treated similarly, the ALJ erroneously failed to consider the fact that Bockarie's disciplinary history was not at the same level.

properly complete her TARs without being disciplined as she admitted she did not know if management was aware of her improper practice. (ALJD 23:32-34; ALJD 47:15-18).

Inasmuch as Somerset Valley did not know Claudio supported the Union, and would have taken the same employment actions even if it had, the Acting finding that Somerset Violated Section 8(a)(3) by disciplining Claudio in September and October 2010 or by terminating Claudio's employment was erroneous and should be overturned.

6. The ALJ Erred in Finding Somerset Valley Violated the Act by Disciplining and Terminating Jillian Jacques For Critical Patient Care Issues

The ALJ erroneously found that Somerset Valley unlawfully disciplined Jillian Jacques in September and November 2010, and terminated her employment in February 2011, because of her support for the Union. Jacques, however, like Napolitano and Claudio, was disciplined and later terminated for a series of critical patient care issues.

The clear preponderance of the record evidence establishes, contrary to the ALJ's findings, that Jacques was disciplined and ultimately terminated solely based on legitimate patient care issues. She initially received a final written warning for issues in December 2009, well before any union activity at the Center. Notwithstanding that discipline being a final warning, she received multiple chances thereafter. This is entirely inconsistent with the notion that Jacques' discipline termination was discriminatory or motivated by anti-Union animus. On September 28, 2010, Jacques received a written warning for multiple failures to document the post-admission and post-fall status of patients. With the exception of one documentation error, which was identified as having been committed by another nurse, Jacques admitted to all of the

errors for which she was disciplined. Jacques received a final written warning on November 5, 2010, for failing to complete multiple incident reports. Again, Jacques disputed the warning as to a single incident report which she asserted she was unable to complete because the CNA that witnessed the incident had left for the day, but did not dispute or provide any explanation or excuse for the other incidents identified.

Finally, in February 2011, through a routine audit of its nursing records, Somerset Valley discovered that Jacques had mistakenly transcribed a physician order sheet as an order for regular aspirin while the physician had instead ordered enteric coated aspirin and had further neglected to transcribe the order onto the MAR. Upon investigating the medication-related error, Somerset Valley learned that Jacques also had failed to complete post-fall documentation on the same patient. Jacques admitted to all of these errors. Accordingly, and in light of Jacques' disciplinary history, Illis and DON Jackie Engram made the decision to terminate Jacques' employment.

Inasmuch as Jacques repeatedly committed serious clinical errors, Somerset Valley's decisions to discipline Jacques and ultimately terminate her employment clearly were based on legitimate business considerations and would have been made even absent any protected activity. In fact, as set forth above, Jacques, like Napolitano and Claudio, was but one of several Somerset Valley employees who were disciplined and/or terminated for patient care related performance issues. Somerset Valley disciplined several other employees, including but not limited to, Sandy Mootosamy (in September 2010), Patricia Beck (in September 2010), and Michele Moore (in February 2011) for documentation errors similar to those committed by Jacques.¹²² Furthermore,

¹²² The ALJ erroneously found that Jacques was disciplined more severely than Dande for improperly administering aspirin (instead of enteric coated aspirin); however, as set forth above,

as set forth above, Bockarie did not receive less severe discipline for similar documentation errors, Bockarie's discipline for those errors was issued by ADON Francia Dominique without support of, or knowledge by, Illis or Konjoh and, therefore, is not comparable.¹²³ Moreover, to the extent that Jacques' termination was based on her disciplinary history as a whole, it was consistent with Somerset Valley's past practice and treatment of similarly-situated employees.¹²⁴ Specifically, Bockarie, like Jacques, eventually was terminated for job performance issues. Similarly, Dande was terminated following a series of patient care errors.¹²⁵ Inasmuch as Somerset Valley consistently applied its policies and procedures in a necessary effort to reform its clinical operations, there is no evidence that it discriminated against any employee based on her support for the Union.

In light of the foregoing, the ALJ's finding that Somerset Valley violated Section 8(a)(3) by disciplining Jacques in September and November 2010 and by terminating Jacques' employment should be overturned.

neither Jacques nor Dande ever improperly administered regular aspirin instead of enteric coated aspirin. Accordingly, *neither* Jacques nor Dande was ever disciplined for improperly administering regular aspirin instead of enteric coated aspirin.

¹²³ The ALJ's reliance on Southgate's testimony that she "did not believe" Bockarie was disciplined for his mistake is misplaced as Southgate's "belief" is directly contradicted by the disciplinary notice itself. (ALJD 24:49-52).

¹²⁴ The ALJ erred in failing to acknowledge that Jacques' termination was based on her disciplinary history as a whole and Somerset Valley's adherence to a progressive discipline policy. (ALJD 26:18-27).

¹²⁵ The ALJ erred in failing to acknowledge that Dande resigned *in lieu of* termination and instead incorrectly implied that Dande only received a disciplinary warning rather than termination for her patient care errors. (ALJD 26:30).

7. **The ALJ Erred in Finding Somerset Valley Violated the Act by Disciplining and Terminating Valarie Wells for Critical Performance Issues**

The ALJ erroneously found that Somerset Valley unlawfully disciplined Valarie Wells in September 2010, and subsequently terminated Wells' employment because of her support for the Union. However, Wells was not disciplined or terminated because of her support for the Union, but instead because she was unable and/or unwilling to appropriately perform the basic functions of her job.

At the outset, it must be noted that the Acting General Counsel failed to establish that Somerset Valley knew whether Wells was a Union supporter. In fact, both Illis and Konjoh (the sole decision makers responsible for Wells' discipline and termination) credibly testified that they were not aware that Wells supported the Union¹²⁶ and that their decisions to discipline and terminate her were in no way related to any Union support.¹²⁷ Therefore, the Acting General Counsel failed to establish a prima facie Section 8(a)(3) claim based on any employment action taken against Wells. See *Wright Line*, 251 NLRB at 1087. Accordingly, the ALJ's finding that Somerset Valley violated Section 8(a)(3) with regard to Wells should be overturned.

Furthermore, even assuming Illis or Konjoh had known that Wells supported the Union, they would have made the same decisions regarding Wells' employment. As

¹²⁶ Finding Wells' appearance in the Union's flyer or YouTube video as indicative of her Union support is contrary to record evidence. As referenced previously, the photos were taken and releases obtained over a month in advance of publication. Likewise, the videos were shot well in advance of publication. Significantly, the vast majority of employees at the Center appeared in one or more pieces of Union propaganda and those managers who viewed the Union's flyer or YouTube video did not consider the contents of those items to be conclusive of Union support. Notably, neither Illis nor Konjoh, the decisionmakers responsible for Wells' termination, viewed the YouTube video prior to Wells' termination.

¹²⁷ Significantly, Wells' position was specifically excluded in the stipulated description of the bargaining unit. (GC-4).

fully set forth above, Somerset Valley's new management team, including Illis and Konjoh, sought to address a series of operational issues, the most significant of which were related to clinical staffing and scheduling, for which Wells was responsible. In light of these staffing and scheduling issues, Konjoh began having regular meetings with Wells in or around September 2010 shortly after Konjoh came on board to discuss the problems with the schedule and attempt to find resolutions to those problems. Despite these meetings, the scheduling problems continued. Accordingly, Konjoh and Illis prepared and provided Wells with specific written guidelines as a means of helping to improve Wells' ability to properly schedule and staff the Center.¹²⁸ The guidelines given to Wells did not change Wells' duties and performance expectations; they simply set forth existing duties and expectations in writing as a reference for Wells to use in performing her job. Despite repeated discussions and being given these written expectations, Wells continued to improperly staff the Center and failed to demonstrate any willingness to receive additional training or otherwise seek guidance as to how she might do a better job.

On September 15, 2010, following a meeting in which Wells acted as though she was not in any way concerned with ensuring the accuracy of the schedule moving forward despite Illis' and Konjoh's extreme efforts to help her, Illis issued Wells a first written warning in an effort to help Wells understand the seriousness of the scheduling

¹²⁸ The ALJ erred in finding that prior to the election, Wells received no discipline for her work performance. (ALJD 29:33-34). First, Illis and Konjoh were new to the Center and must not be held to poor standards set by prior management. See *Precoat Metals*, 341 NLRB at 1190. Second, Illis and Konjoh initially talked to Wells prior to the election without issuing discipline in an effort to coach and counsel her without penalty. Accordingly, they should not be penalized for attempting to correct Wells' poor performance without issuing discipline. Further, the ALJ's finding that prior to the election neither Illis nor Konjoh referred to any problems with Wells' performance is contrary to record evidence. (ALJD 29:35-36).

issues and her performance deficiencies. Problems continued, however, unabated. In fact, the following day, Wells failed to provide a copy of the daily schedule to Konjoh as specifically requested and discussed in the earlier meetings. Wells admitted her error, and was issued a second written warning.

On September 20, 2010, Wells received a third and final written warning for numerous scheduling errors, including but not limited to, her failure to reconcile the schedule for shift call-outs and cancellations, including an employee who appeared on the daily assignment sheet but not on the schedule, and erroneously cancelling an employee's shift resulting in short staffing. While Wells disputed certain of the errors identified on the third written warning (which ultimately were removed from the warning), she did not dispute that she had committed the remaining errors, nor did she offer any excuse as to why she had committed these errors. Significantly, the remaining errors sufficiently supported the discipline. Finally, when Wells was unable to avoid similar scheduling errors the following day, September 21, 2010, her employment was terminated.¹²⁹

¹²⁹ Additionally, following Wells' termination, Somerset Valley learned that Wells had violated the Company's Technology Policy while she was still employed by forwarding a series of emails containing confidential Company information from her work computer to her home email address without permission. Had Somerset Valley learned of this violation of policy while Wells was still employed, she would have been terminated for her actions. Thus, even assuming Illis or Konjoh had known that Wells supported the Union, Wells' employment would have been terminated for not one but two separate legitimate, non-discriminatory reasons. Moreover, because of this after-acquired evidence of wrong-doing by Wells, she has forfeited any right to reinstatement, and backpay, if any, shall be appropriately limited. *John Cuneo, Inc.*, 298 NLRB 856 (1990). Further, the ALJ's determination that this issue was not "fully litigated" is contrary to the evidence in this case. (ALJD 32:10-15, 32:50-51). The policy was entered into evidence and Wells' violation of the policy was unrefuted. The Acting General Counsel's failure to put on any contrary proof or otherwise refute this evidence does not equate to the issue not being "fully litigated."

While Wells was not a direct caregiver, her performance issues were at least as significant as those of any other employee at Somerset Valley. Indeed, Illis and Konjoh had identified staffing and scheduling as being at core of the clinical issues which threatened the health and safety of the Center's patients. Accordingly, the errors for which Wells was consistently disciplined and ultimately terminated were as egregious as those committed by any direct caregiver. Therefore, Wells was not treated any differently than any other employee to whom Illis and/or Konjoh had issued cumulative discipline in an effort to correct deficient performance.

In light of the foregoing, the Acting General Counsel failed to establish that Somerset Valley took any adverse employment action against Wells based on any alleged support for the Union rather than for legitimate business reasons. Accordingly, the ALJ's finding that Somerset Valley violated Section 8(a)(3) with regard to Wells should be overturned.

8. The ALJ Erred in Finding that Reinstatement is an Appropriate Remedy for Employees Who Have Admittedly Committed Serious Patient Care Errors

The ALJ ordered Somerset Valley to reinstate Napolitano, Claudio, Jacques, and Wells. None of these alleged discriminatees are entitled to reinstatement in light of their admitted serious patient care and performance errors and the significant risk they pose to the health and safety of Somerset Valley's patients.

The Act does not require reinstatement of individuals who are not competent to carry out the job from which they were discharged. See *NLRB v. Western Clinical Lab, Inc.*, 571 F.2d 457, 461 (9th Cir. 1971) (declining to enforce reinstatement of a lab worker without evidence of competence despite evidence that worker had been

terminated for union activity). As the court in *Western Clinical* noted, this is particularly true in the healthcare field:

In our view, promotion of the beneficial policies of the National Labor Relations Act attributable to the reinstatement of an illegally discharged employee cannot take precedence over the public interest in being free from incompetent workmanship by a hospital employee, whose work, if incompetently done, would jeopardize the health and lives of patients . . . [R]einstatement of incompetent employees in the health care field does not effectuate the policies of the Act.

Id. at 461.¹³⁰

The Supreme Court has stressed that the unique nature of health care facilities requires the Board to take into account patient well-being in enforcing the Act. See *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 498, 505 (1978). As the Court cautioned in *Beth Israel Hospital*, “[healthcare facilities] give rise to unique considerations that do not apply in the industrial settings with which the Board is more familiar. The Board should stand ready to revise its rulings if future experience demonstrates that the well-being of patients is in fact being jeopardized.” *Id.*

Moreover, the Supreme Court has made clear that, in deciding what remedies are available under the NLRA, it will not provide the remedy the Board requested where to do so would be inconsistent with other competing federal policies. *Hoffman Plastics v. NLRB*, 535 U.S. 137, 143-44 (2002). As the Supreme Court stated in *Hoffman Plastics*, “the Board has not been commissioned to effectuate the policies of the Labor Relations Act so single-mindedly that it may wholly ignore other and equally important

¹³⁰ See also *Family Nursing Home and Rehab Ctr.*, 295 NLRB 923, 923 (1989) (affirming order finding employer committed unfair labor practices yet refusing to reinstate discharged employees who engaged in misconduct when employer’s business was “care of the elderly and infirm” and employee’s conduct was “not compatible with that undertaking”); *NLRB v. Big Three Industrial Gas & Equip. Co.*, 405 F.2d 1140, 1142-43 (5th Cir. 1969) (declining to reinstate truck driver with safety record inconsistent with safety on public roads).

congressional objectives.” *Id.* at 143. Thus, the Court has “never deferred to the Board’s remedial preferences where such preferences potentially trench upon federal statutes and policies unrelated to the NLRA.” *Id.* at 144. Consequently, “where the Board’s chosen remedy trenches upon a federal statute or policy outside the Board’s competence to administer, the Board’s remedy may be required to yield.” *Id.* at 147 (internal citations omitted).

Here, Napolitano, Claudio, Jacques, and Wells each admitted to errors which compromised the health and safety of patients. Somerset Valley acknowledges the legal importance of the principles underlying the Act, but it would be reckless to reinstate these employees under the facts of this case. Even if, for example, the negligent and erroneous administration of medications (conceded to have been committed by Napolitano and Jacques, respectively, here) did not seriously harm a patient in this instance, the results of such errors can be disastrous. Inasmuch as these individuals have each admitted to significant errors both directly and indirectly related to patient care, their reinstatement would undermine the well-defined public policy of ensuring safe and competent nursing care and Somerset Valley’s ability to fulfill its obligations to its patients.

Accordingly, even assuming Somerset Valley did violate the Act with regard to Napolitano, Claudio, Jacques, or Wells (which the preponderance of the record evidence does not support), their reinstatement is wholly inappropriate in this case and the ALJ’s order to the contrary should be overturned.

VII. CONCLUSION

Based on the foregoing, the ALJ's findings of fact and conclusions of law are not supported by a preponderance of all of the relevant evidence in the record and/or are contrary to established Board law or policy. Accordingly, the ALJ's Decision and Order should be reversed, Judgment should be entered in favor of Somerset Valley on all counts, and the Complaint should be dismissed in its entirety.

Respectfully submitted,

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The undersigned certifies that on the 18th day of January, 2012, the foregoing pleading was filed via electronic filing with:

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