

**UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD**

1621 ROUTE WEST OPERATING COMPANY,
LLC D/B/A SOMERSET VALLEY
REHABILITATION AND NURSING CENTER,

and

Cases 22-CA-29599
22-CA-29628
22-CA-29868

1199 SEIU UNITED HEALTHCARE WORKERS
EAST, NEW JERSEY REGION.

**RESPONDENT'S REPLY TO COUNSEL FOR THE ACTING GENERAL COUNSEL'S AND
CHARGING PARTY'S ANSWERING BRIEFS TO RESPONDENT'S EXCEPTIONS TO THE
DECISION OF THE ADMINISTRATIVE LAW JUDGE**

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Respondent 1621 Route 22 West Operating Company, LLC d/b/a Somerset Valley Rehabilitation and Nursing Center (“Center” or “Respondent”) submits this Reply to the Answering Briefs of Counsel for the Acting General Counsel (“AGC”) and Charging Party.¹

I. The Issue of the Reinstatement of Wells Must be Remanded

The Administrative Law Judge (“ALJ”) stated that the issue of whether after-acquired evidence precludes reinstatement of Valerie Wells (“Wells”) was not “fully litigated” and “will be left to be decided in a Compliance proceeding.” (ALJD 32:10-15, 32:50-51). The AGC agrees that the ALJ did not rule on this issue. (AGC at 109, fn 87). Respondent put on proof that Wells had knowledge of its computer use and email policy, that Wells violated that policy, and that it would have terminated Wells for violation of this policy had it known about it during her employment. (See Tr. 1319, 2862-71, 1778-79). Proof that an employee would be discharged for unprotected conduct on the basis of after-acquired evidence “is material to the question of the appropriateness of the usual remedy of reinstatement with backpay.” *Bob’s Ambulance Service*, 183 NLRB 961, 961 (1970). The Board has specifically ruled that “the issue of employment misconduct which may warrant the forfeiture of reinstatement goes to the remedy and not to the issue of compliance with the remedy.” *Id.*² Remand, therefore, is required.

II. Respondent’s Treatment of Wells did not Violate the Act

The AGC states that neither Illis nor Konjoh spoke to Wells before the election about her performance. Yet at the same time, the AGC acknowledges the inconvenient fact that Illis testified that she did speak to Wells about her performance before the election. (AGC at 43). The AGC also claims that the asserted reason for disciplining Wells is a pretext and that Wells

¹ Cited as “AGC at ___” and “CP at ___,” respectively.

² The AGC states that Respondent did not prove that this violation “contributed to the discharge decision.” (AGC at 109, fn 87). The very nature of after-acquired evidence is that it was discovered after the fact. Respondent’s burden is to show that it would have discharged Wells on the basis of this unprotected conduct had it known of it at the time, not that it contributed to the decision made. See, e.g., *First Transit, Inc.*, 350 NLRB 825 (2007).

did not use the SmartLinx system for scheduling because no one told her to use SmartLinx. (AGC at 44). In almost the next breath, however, the AGC acknowledges that Wells testified that she monitored changes in the daily assignment sheets “that might need to be documented in SmartLinx” and generated a census report “out of SmartLinx.” (AGC at 45). This testimony belies the assertion that Wells did not use or was not told to use the SmartLinx system. The AGC also fails to establish pretext by claiming that Respondent did not discipline Director of Nursing (“DON”) Inez Konjoh (“Konjoh”) for making similar scheduling errors. Konjoh was a Supervisor. She temporarily assumed the scheduling duties after Wells was discharged until a new Scheduling Coordinator could be hired. The AGC acknowledges that Respondent removed Konjoh as the DON and removed her from the Center for performance reasons after only a few months. (*See, e.g.*, AGC at 8: “[Konjoh] was transferred from Somerset five months after she started there for substandard performance and since then has held two lower level positions at other Care One facilities – neither job being a DON”). Konjoh was “disciplined” for her performance and, therefore, Respondent’s treatment of Konjoh does not establish pretext.

III. Respondent’s Treatment of Tyler did not Violate the Act

Initially, the AGC incorrectly states that Lynette Tyler (“Tyler”) was “discharged.” (AGC at 1). It is undisputed that Tyler voluntarily submitted her resignation. (GC-58; Tr. at 1037-38, 2086, 2090). The AGC also asserts that the Center’s response to Tyler’s resignation deviated from its policies, practices and treatment of other employees. (AGC at 1-2, 15-16, 81, and fn 15). The record, however, does not support this assertion. The AGC cites to no evidence that Respondent permitted employees who voluntarily resigned to work out their notice periods. Indeed, the record shows that it was the practice of the Center’s Administrator Doreen Illis (“Illis”) to not require resigning employees to work out their notice period. (Ex. GC58; Tr. at

2928-29, 2934-35). Moreover, the handbook provision cited by the AGC does not require Respondent to let resigning employees work out their notice period. Finally, the AGC suggests that Illis's anti-union motivation was evidenced by her comment on Tyler's discharge document that Tyler had "a bad attitude toward the Company." (AGC at 16 and 82). The record, however, supports this factually accurate assessment by Illis. Tyler admitted that on at least three occasions during the nine months she worked at Somerset, she got mad and walked out during the middle of her shift. (Tr. at 1043-47). The record also shows that Illis previously discussed Tyler's attitude and behavior with her. (Tr. at 2926-27).³

IV. Respondent's Treatment of Napolitano did not Violate the Act

The AGC states that Konjoh fabricated her testimony as to why she thought Napolitano was the only nurse who gave the patient the "pink capsule." (AGC at 24, 85-86 and fn 26). Konjoh testified that she believed this because the patient said that "Shannon" was the "only" nurse giving her the pink capsule and also said that the other nurses did not give it to her. (See R-82, p.2: "Pt ... states that ... only nurse Shannon gives her the 'pink capsule' all other nurses including the one today 'CC' did not give her her pink capsule."). The accuracy of this report from the patient was never called into question or disputed at the hearing. There is nothing fabricated about Konjoh believing what the patient told her. The AGC further misleads the Board about the number of times Konjoh claimed Napolitano administered the discontinued medication. (AGC at 85, fn 73). Konjoh identified the four occasions (Tr. 2375):

I believe at the time that I -- we looked at the documentation, Ms. Napolitano herself identified her signatures for August for three of them. The fourth one was the actual day

³ The AGC claims that this testimony is false because Illis did not mention Tyler's performance or attitude in a Declaration that Illis gave in a related 10(j) case. (AGC at 82). Illis's 10(j) Declaration does not mention these facts because they were not part of Respondent's defense to the request for 10(j) relief. That Declaration was intended to address the issues in the 10(j) proceedings, not the issues in this case. The absence of this testimony from that Declaration, therefore, is neither relevant nor probative in this case nor does it constitute "evidence" in this case.

of the medication actually being administered to the patient. There is no signature for that except the evidence of the medication itself. And that's how I counted four.

In terms of the significance of the error, it matters not whether it was one time or four times. The AGC also claims that Konjoh embellished her testimony that Napolitano did not witness the patient take the medication as required, citing Napolitano's testimony that she observed the patient take her medication and waited five minutes to confirm that she did so. (AGC at 23). Konjoh's testimony was not embellished. The patient actually handed the medication to Konjoh (so she could not have taken it) and when Konjoh confronted Napolitano, Napolitano admitted that she, in fact, "did not witness the patient take medications" that day. (R-82, p. 1).

The AGC sites page 966 of the transcript to support the statement that after Konjoh terminated Napolitano, she "explained to Southgate how she had told resident 15W to hold the medication and that led her to discipline Napolitano for committing a medication error." (AGC at 26). This assertion misstates Southgate's testimony. As set forth below, at pages 965-66, Southgate testified only that Konjoh told her Napolitano was terminated for medication errors:

Q: You said you had a discussion with her after the discharge as well.

A: Right.

Q: And where was that discussion?

JUDGE DAVIS: A discussion with Inez, right?

THE WITNESS: Inez's office.

....

Q: Inez's office. How soon after the discharge was that discussion?

A: It was sometime after 3:00. It was after Shannon had been – had left the building.

....

Q: Okay. And how were you called into that meeting?

A: Inez called me in to talk to her about what had happened.

Q: Okay. What if anything did Inez say to you?

A: She told me that Shannon had multiple medication errors. She had a copy of the MAR.

JUDGE DAVIS: She what?

THE WITNESS: She had a copy of the MAR, the medication administration record. That's about what I recall. (Tr. at 965-66).

V. Respondent's Treatment of Claudio did not Violate the Act

Respondent disciplined Claudio for giving a patient the same medication every day, when the doctor prescribed it for every other day. The AGC incorrectly states that Respondent "did not discipline other responsible parties." (AGC at 91). Doreen Dande ("Dande") committed the same error with this patient on the same days. The record shows that on the day Respondent disciplined Claudio for her error, it issued the same level of discipline to Dande for her error. (Tr. 2190-91 and R-85). The record shows Respondent also disciplined Claudio for not obtaining a doctor's order in connection with her treatment of an elderly patient for a skin tear. (R-86). The AGC suggests that it makes little sense for nurses to obtain a doctor's order to treat what he deems a "scratch" and a "minor issue." (AGC at 29, fn 35, and 93-94). The AGC's lack of a medical license and his personal opinions notwithstanding, Claudio admitted that nurses need a doctors' order, before or after treatment, to treat cuts or bleeding. (Tr. 268). A Licensed Practical Nurse ("LPN") is not a doctor. Claudio also admitted that LPNs must follow doctors' orders and cannot change them. (Tr. 244-48). Scratches and skins tears in elderly patients can lead to or be the result of other medical issues. Therefore, as other witnesses confirmed, **all** treatments provided to a patient by an LPN, including for scratches, must be accompanied by a physician's order. (Tr. at 2201-02, 2562-63; *see also* Tr. 1871-72). Finally, the AGC asserts that Respondent's discipline of Claudio for attempting to document treatments eight hours after her shift ended was motivated by union animus because Respondent routinely allowed nurses to do it the next day without discipline. To support this claim, the AGC cites a conversation in which one LPN told another LPN that she failed to document a patient's treatment the day before and the second LPN then documented the activity. (AGC at 30). The fallacy with the AGC's conclusion is that all the people involved in this discussion were employees. No Supervisor was

aware of the error or that this nurse documented a treatment the next day. Respondent, therefore, did not “allow” a nurse to document treatments the next day without discipline.

VI. Respondent’s Treatment of Jacques did not Violate the Act

The AGC misleads the Board as to the content of the Center’s Accident/Incident policy and the application of that policy to the event for which Jacques was disciplined on November 1, 2010. The policy does not provide that nurses have 24 hours to complete Incident/Accident reports as the AGC states. (AGC at 34, fn 41 and 99-100). Rather, the policy expressly requires: “Regardless of how minor an accident or incident may be, it must be reported to the nursing supervisor, and appropriate documentation *completed on the shift* that the accident or incident occurred.” (R-62 §1.1) (emphasis added). Jacques was disciplined for *not completing the report on the shift during which the incident occurred*: “Incident reports not fully completed.” (R-88). Also, the discipline notice listed numerous incomplete aspects, such as “unclear statements” and “intervention missing” – items the AGC conveniently ignored when representing that a missing aide’s statement was the only problem with the report.

The AGC also misleads the Board about the evidence reflecting Respondent’s September 28, 2010, discipline of Jacques and suggests that Konjoh manufactured testimony on this issue. The notice of discipline given to Jacques listed multiple errors. Jacques showed Konjoh that she was not working when one of the listed errors happened. Konjoh then scratched that item off a copy of the form. The copy with the item marked through was received into evidence as R-87. (See also Tr. 2221-22, 2254-56). The AGC makes no mention of this exhibit. Most important, however, Jacques admitted that she saw Konjoh scratch that item “off her list.” (Tr. 644). Jacques further admitted that the “unlined” copy of the document introduced by the AGC (GC-43) was a copy of what Konjoh “had given” to her *prior to* scratching the item off. (Tr. 644).

That the copy attached to Respondent's Statement of Position is not the "lined through" copy does not contradict Konjoh's testimony or, more importantly, the admissions by Jacques. Counsel for Respondent simply attached a copy of the unmarked document at a time when the level of detail that would surface in this case was unknown and unforeseen.

Finally, the AGC describes the error for which Jacques was terminated as "minor." (AGC at 100). Jacques committed two medication errors for which she was terminated – she transcribed the medication order incorrectly (therefore an attending nurse would have given the patient the wrong medication) and she failed to write the medication down on the MAR (therefore, an attending nurse would not give any medication to the patient). Again, notwithstanding the AGC's lack of a medical license or his personal opinions, the fact that a nurse incorrectly transcribes prescribed medication and fails to list prescribed medication to be given are serious issues for which discipline is warranted -- well before an elderly patient is caused harm or actually dies. In connection with this discipline, Charging Party claims that Konjoh "should have known" about a Plan of Correction ("POC") put in place months before she arrived, under which other employees should have caught this error. (CP at 17, fn 26). Charging Party acknowledges that Konjoh denied having any knowledge of the POC, yet still claims that she "ignored" it. (CP at 31). "Ignore," however, involves knowledge. Likewise, the AGC asserts that Konjoh's failure to enforce this POC "evinces that her conduct was retaliatory." (AGC at 91). This assertion suffers from the same infirmity. Konjoh could not ignore or refuse/ fail to enforce a POC that she did not know about.

VII. Respondent had no Knowledge of Union Activity by Aguilar

The record contains no evidence that Respondent had knowledge of Daysi Aguilar's ("Aguilar") alleged union activity. The AGC's only "evidence" strains credulity. Allegedly, on

the day of the election, Konjoh saw Aguilar attempt to hug or greet Union Observer Jacques. (AGC at 60, 121). Konjoh denied witnessing this event. Even if Konjoh saw this action, the isolated fact that one co-worker attempted to hug or greet another co-worker did not give Konjoh or Respondent knowledge that Aguilar engaged in union activities or supported the Union.

VIII. Respondent's Quality of Care Concerns Were not a Pretext

The AGC attempts to minimize the significance of a G level deficiency by noting that it does not fall within the regulatory definition of "substandard care." (AGC at 38). As the AGC acknowledges, however, a G level deficiency indicates that "actual harm" was caused to the patient. Actual harm to patients is not something that Respondent believes meets the standard of care that it should provide to its patients and neither should the Board. The AGC then states that Hutchens did nothing to address the quality of care issues until "nine months" after the Center received the G-Level deficiencies. (AGC at 39). Similarly, Charging Party asserts that the ALJ correctly found that the "eight month" time period between the receipt of the 2009 survey results and its change of the Administrator and the DON makes Respondent's defense untenable. (CP at 1-3). These assertions ignore the undisputed evidence (and the ALJ's findings) of the interim measures Respondent implemented to turn operations around short of the drastic step of replacing an Administrator and a DON. Indeed, such a position penalizes Respondent for those efforts. Finally, the AGC states that Hutchens had real-time access to the Center's nursing department schedules in SmartLinx, but there is no evidence of him raising the issue of regularly scheduled per diem aides prior to the Union's election victory. (AGC at 52). This argument begs the question. Although Hutchens had "access" to that information, there is no evidence that

he actually exercised that access or reviewed the SmartLinx data before the time he testified that he actually became aware of the situation.⁴

IX. Respondent's Exercise of its Legal Rights is not Evidence of Unfair Labor Practices

Charging Party states that Respondent's "hostility to the Union," as evidenced by its lawful dissemination of information during the campaign, supports the ALJ's findings. (CP at 6-7, 31). The AGC makes similar claims. (AGC at 10, 84, 90, 97). Nothing in Respondent's campaign materials, however, was alleged to violate the Act. Moreover, there was no proof or finding that those materials violated the Act. Section 8(c) of the Act, 29 U.S.C. § 158(c), states, "[t]he expressing of any views, argument, or opinion, or the dissemination thereof, whether in written, printed, graphic, or visual form, *shall not constitute or be evidence of* an unfair labor practice ... if such expression contains no threat of reprisal or force or promise of benefit." (emphasis added). *See also NLRB v. Rockwell Manufacturing Co.*, 27 F.2d 109, 118-19 (3rd Cir. 1959) (Board cannot find animus to support violation based upon privileged speech); *National Association of Manufacturers v. NLRB*, 11-cv-01629 (ABJ), Memorandum Opinion [Doc. 59] at 30-31 (D.D.C. Mar. 2, 2012) (protected § 8(c) conduct does not "interfere with" § 8(a)(1) rights). Respondents' lawful campaign materials and communications, therefore, are not evidence of unfair labor practices and cannot support a finding of a violation of the Act.⁵

X. Reinstatement is not Appropriate for the Discharged LPNs

The AGC attempts to distinguish *NLRB v. Western Clinical Lab, Inc.*, 571 F.2d 457 (9th Cir. 1971) on the ground that the Ninth Circuit remanded that case to the Board for the resolution

⁴ Charging Party similarly claims that Hutchens exercised "strict oversight" of the Center and had full knowledge of the situation well before he took action: the Administrator reported to Hutchens, Hutchens visited the Center about once a week, and Hutchens had access to the Center's computer network. (CP at 5, 32). These meager facts hardly equate to "strict oversight." Moreover, there is no evidence that Hutchens actually reviewed the data to which he had access or when and how often he reviewed that data.

⁵ To the extent the Board decisions relied upon by the ALJ, the AGC, and the Charging Party hold otherwise, those decisions are in irreconcilable conflict with the plain language of the Act.

of credibility conflicts regarding the employee's competence. In that case competence was still at issue. In the present case, however, Napolitano, Claudio and Jacques each admitted to having committed the majority of errors, if not all the errors, for which they were disciplined. Thus, their competence to provide safe and effective patient care is not disputed. The fundamental premise for which *Western Clinical* stands is as follows: "reinstatement of incompetent employees in the health care field does not effectuate the policies of the Act." 571 F.2d at 461. Where, as here, the alleged discriminatees have admitted to significant errors related to patient care, they should not be reinstated. Furthermore, the AGC's assertion that reinstatement is appropriate because the patient care errors at issue did not result in actual patient harm is similarly misguided. The Board has consistently declined to require reinstatement, even in the absence of actual patient harm, where the employee's conduct is incompatible with the provision of competent patient care. See *Family Nursing Home and Rehab Ctr.*, 295 NLRB 923, 923, 931 (1989) (denying reinstatement in absence of actual harm to patients); see also *Western Clinical Lab, Inc.*, 571 F.2d at 461 ("both the Board and we must be very hesitant to compel reinstatement of an illegally discharged employee if the credited evidence leaves substantial doubt that the employee is competent to perform his job when his work directly affects the health and safety of the persons whom his employer serves"); Cf. *Sacred Heart Medical Center*, 347 NLRB 531, 533 (2006) (finding, in context of union solicitation rules, that healthcare employers "need not wait for the awful moment when patients or family are disturbed" before restricting employee action).⁶

XI. Conclusion

The ALJ's Decision and Order should be reversed, Judgment should be entered in favor of Respondent, and the Consolidated Complaint should be dismissed in its entirety.

⁶ For these reasons, the AGC's suggestion that discipline of these LPNs was not warranted because no patient was actually harmed is equally unavailing.

Respectfully submitted,



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The undersigned certifies that on the 14th day of March, 2012, the foregoing pleading was filed via electronic filing with:

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