

Nymed, Inc., d/b/a Ten Broeck Commons¹ and United Industry Workers Local 424, a Division of United Industry Workers District Council 424, Petitioner. Case 3-RC-10166

February 2, 1996

DECISION AND ORDER

BY CHAIRMAN GOULD AND MEMBERS BROWNING
AND COHEN

Upon a petition for election filed under Section 9(c) of the National Labor Relations Act, a hearing was held on July 22 and 25, 1994, before a duly designated hearing officer of the National Labor Relations Board. On August 5, 1994, pursuant to Section 102.67 of the Board's Rules and Regulations, the case was transferred to the Board for decision.

On October 28, 1994, the Board held oral argument in this case and *Providence Hospital*,² in which the Board directed the parties to address the impact of the Supreme Court's recent decision in *NLRB v. Health Care & Retirement Corp.*, 114 S.Ct. 1778 (1994), on the determination of supervisory status under Section 2(11) of the Act. All parties in both cases as well as numerous amici curiae³ presented oral arguments and/or filed preargument briefs.

Having carefully reviewed the entire record in this proceeding, including the posthearing briefs filed by both parties and the testimony at oral argument, the Board makes the following findings:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are affirmed.
2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction.
3. The labor organization involved claims to represent certain employees of the Employer.⁴

¹ The Employer's name has been amended in accordance with the stipulation of the parties at the hearing.

² *Providence* subsequently issued at 320 NLRB 717 (1996).

³ The Chamber of Commerce of the United States; New Jersey Hospital Association; American Federation of Labor and Congress of Industrial Organizations, et al.; Labor Policy Association; American Nurses Association; Council on Labor Law Equality; Service Employees International Union, AFL-CIO, CLC; American Health Care Association; Local 1199, National Health and Human Service Employees Union; American Hospital Association; the Union of American Physicians and Dentists; and the General Counsel of the National Labor Relations Board.

⁴ At the hearing, the Employer refused to stipulate that the Petitioner is a labor organization within the meaning of Sec. 2(5) of the Act. It is clear from the record evidence, however, that the Petitioner exists for the purpose of dealing with employers concerning employee wages, hours, and other conditions of employment and that employees participate by electing officers, shop stewards, negotiating committees, and ratifying collective-bargaining agreements.

The Employer does not contest these facts. Instead, it relies on a decision by the Public Employment Relations Board of the State of New York in Case Nos. C-4165, et cet., dated May 31, 1994, involving the labor organization status of United Public Service Em-

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. Nymed, Inc., d/b/a Ten Broeck Commons (the Employer) operates a state-licensed nursing-home facility in Lake Katrine, New York. The Petitioner seeks to represent a unit of approximately 45 licensed practical nurses (LPNs) employed at this facility.⁵ The Employer contends that the petitioned-for LPNs are supervisors within the meaning of Section 2(11) of the Act as they have the authority to assign and responsibly direct, discipline, evaluate, and transfer other employees, or effectively to recommend such action, and therefore the petition should be dismissed. Having considered the record facts as set forth below and the relevant legal precedent, including the Supreme Court's decision in *Health Care & Retirement*, we find that the LPNs are not statutory supervisors.

I. FACTS

The Employer's nursing home provides residential, nursing, housekeeping, and dietary services to approximately 240 residents. It is located in a single story building which is divided into six wings or units (three on each side) which are joined in the middle by various common areas such as the dining room, kitchen, and administrative offices. The 6 units—Ashroken, Brinck, Catskill, Dewitt, Esopus, and Foxhall—house 40 residents each.

The nursing services department is one of approximately eight departments under the Employer's administrator. The nursing department consists primarily of the director of nursing (DON), the assistant director of nursing (ADON), staff development, registered nurses (RNs), LPNs, and certified nursing assistants (CNAs).

employees Union Local 424, a Division of United Industry Workers District Council 424. In that case, the intervenors contended that Local 424 could not fulfill its obligations as a collective-bargaining representative because its constitution and that of District Council 424 gave District Council 424 control over contract negotiations, administration, and enforcement. Local 424 alleged that both constitutions had been amended and the case was remanded for further investigation.

That decision is not pertinent to the issue of the Petitioner's labor organization status here; the Petitioner was not a party in that case and thus its status was not litigated. In any event, although the Petitioner and United Public Service Employees Union Local 424 are both subdivisions of United Industry Workers District Council Local 424, the record evidence in this case shows that the Petitioner is governed by its own constitution and bylaws. In addition, there is no evidence in the record before us that District Council 424 controls the Petitioner's collective-bargaining activities. Accordingly, we find the Petitioner to be a labor organization under Sec. 2(5) of the Act.

⁵ Local 200-D, Service Employees International Union, AFL-CIO initially intervened in this proceeding on the basis of a showing of interest. At the close of the hearing, however, Local 200-D requested by letter of July 25, 1994, that it be permitted to withdraw from the proceeding. The request is granted.

The facility operates on a 24-hour, 7-day-a-week, three-shift basis. The day shift runs from 6:45 a.m. to 3:15 p.m.; the evening shift, 2:45 p.m. to 11:30 p.m.; and the night shift, 11:15 p.m. to 7:30 a.m. On the day shift, both the DON and the ADON are present in the facility as well as two RN nursing supervisors, who each have overall responsibility for three units. In addition, on each of the units there is one unit manager who is also an RN, two LPNs, and four to five CNAs. On the evening shift, although there are no unit managers on duty, there are again two RN nursing supervisors in the facility as well as one to two LPNs, and three to four CNAs on each unit. The night shift is similar. There are one to two RN nursing supervisors present in the facility along with one LPN per unit and two to three CNAs on each unit.

The RN unit manager is responsible for overseeing the entire unit and the staff assigned to that unit. In particular, the manager is responsible for the overall long-term care of the residents and for seeing that such care is properly performed and documented on all three shifts. After attending a morning report meeting in which the day's activities are discussed, the unit manager spends the rest of the day in the unit performing a variety of functions. Approximately one-half of each day is spent doing paperwork in the conference room located approximately 50 feet from the nursing station. The rest of the time, the unit manager is on the floor at the nursing station. At all times, the unit manager is available to all staff persons, including LPNs and CNAs, who have questions or need assistance. In addition, the unit manager spends about an hour a day checking on each individual patient by doing rounds—once in the morning and then again later in the day.

Although there are no unit managers at the facility on the evening and night shifts, there are normally two RN nursing supervisors on duty. These RNs make clinical rounds of the patients, check on those patients who are ill, and consult with the LPNs as to the condition of patients on their units. They also give medical advice to LPNs when needed and deal with medical emergencies including transferring patients to the hospital if necessary. In addition, their duties include checking to be sure there is adequate staff present, and if not, calling off duty personnel for volunteers or calling personnel assigned to the next shift to see if they can come in early.

Overall staffing is handled by the staff coordinator. If a CNA is unable to come to work as scheduled, the coordinator is responsible for finding a replacement. Similarly, requests by CNAs for vacations, time off, or overtime are also handled by the staff coordinator.

RNs earn approximately \$17 per hour; LPNs approximately \$11 with a 50-cent-per-hour differential

for evening and night shifts; and CNAs earn from \$6 to \$8 per hour. All three receive the same benefits.

An LPN may function as a charge nurse, treatment nurse, or a medication nurse. Typically, one LPN serves as a combination charge nurse and treatment nurse; the other as a medication nurse. LPNs take turns performing these functions, deciding among themselves which tasks each will perform that day or leaving it up to the unit manager to decide.

The duties of the LPN charge nurse include overseeing the CNAs, making rounds to be sure that the residents are being properly cared for, consulting with the physician, ordering medications from the pharmacy as instructed by the doctor, picking up orders, filling out charts, and updating patient information. As the charge nurse is also the treatment nurse, the LPN serving as charge nurse would also perform whatever medical treatments the residents need.

When serving as a medication nurse, the LPN generally performs that function for the entire 8-hour shift. This LPN is responsible for giving medication to all residents in the unit at whatever hours are specified for the resident to receive the medication. The medication nurse is also charged with the responsibility to properly administer and document each patient's medications.

When a resident is initially admitted, a long-term care plan is filled out by an RN, or by the LPN on duty who then must have the plan reviewed and approved by an RN. The plan details the resident's requirements in such areas as bathing supervision; the need for hearing aides, dentures, or eyeglasses; the proper bed positions and when the patient is to be turned; toileting requirements; and mobility level. The plan is subsequently changed as the needs of the resident change.

The residents in each unit are divided into three, four, or five established groups called "runs." The number of runs depends on the number of CNAs on duty. The unit manager determines which residents should be grouped together on the day shift; the LPNs determine the runs on the evening and night shifts. If there is a disagreement on the placement of a particular patient in a run, the nursing supervisor on the evening and night shifts will review the problem and decide the placement. The makeup of the run changes only when residents die or new residents are admitted.

CNAs are responsible for attending to the daily needs of the residents. Such duties include assisting residents in getting in and out of bed; properly positioning the residents in bed; placing residents in chairs; bathing, dressing, and feeding the residents, and taking care of the residents' toileting. When the day-shift CNAs arrive at work, typically they make rounds of the patients on their run, checking their condition and where they are in the morning routine, i.e., out of bed,

eating, or dressing. The CNA knows the precise needs of each resident by consulting the long-term care plan for each resident which is kept in a book referred to as the Aidex. The CNAs follow the plan throughout the day and initial each task they perform for the resident, such as toileting every 2 hours. When LPNs make their patient rounds, they check to see that the CNAs have carried out the duties described in each resident's long-term care plan.

When CNAs are first hired, they are given in-house orientation. Two days are spent in the classroom and the remaining three on the unit during the day shift to get a feel for the routine. CNAs must also complete an orientation skills checklist. Each CNA is required to satisfactorily demonstrate proper performance and understanding of each listed skill such as feeding, bathing, positioning, and transporting residents; disposing of trash and infectious waste; operating various mechanical devices such as lifting equipment, hydrotubs, and wheelchairs; and obtaining lab specimens. An RN or an LPN initials and dates each skill as it is performed. The checklist is kept on the unit until all skills have been checked off. The form, when completed, is signed by the staff development coordinator.

LPNs are also responsible for assigning each CNA to a run. Such assignments are made on a monthly basis to provide continuity. At the end of the month, the CNAs are switched so that each CNA rotates to a different run each month. In making such assignments, LPN Carol Farrell testified that she considers the personalities of the CNA and the resident and what skills each CNA is strongest in. When a regularly scheduled CNA is absent, another CNA from a different unit—a float CNA—is sometimes asked to fill in. In these cases, the LPN can make adjustments to the runs by splitting a run or assigning the less difficult residents to the float CNA. Usually, however, runs remain the same. Basically, all CNAs perform the same duties and consequently, every CNA can substitute for another. If a CNA unexpectedly does not show up for work and no substitute can be found, the established three- or four-run grouping is used rather than the four or five runs.

LPNs also fill out a daily assignment sheet by indicating which CNA will perform one or more of the "extra duties": cleaning either the dining room, the kitchen, the utility rooms, or the tub rooms; passing out nourishments to the patients, usually twice a day on the day shift; taking the patients' TPR (temperature, pulse, and respiration) and blood pressure; monitoring the Aidex (making sure the CNAs have initialed everything done for the patient that day); or filling water pitchers. Generally, the LPNs assign these duties on a rotational basis so that the CNAs are not performing the same job each day. LPNs also try to accommodate the personal preferences of the CNAs.

LPNs also indicate on the daily assignment sheet which CNAs get the first lunch and break periods and which go to the second lunch and breaks. The LPNs usually change these assignments every day so the CNAs do not have the same lunch or break periods day after day. LPNs also consider the expressed preferences of the CNAs for one or another particular breaktime; for example, CNAs who smoke often like to take their breaks together.

LPNs have the authority to give CNAs oral warnings for initial infractions. If the misconduct continues, the LPN can then write up the incident in a report which is then given to one of the RN supervisors. The report contains no recommendations but merely a narrative account of the incident involved. Sometimes, LPNs will make oral reports to the RN nursing supervisor, and the supervisor writes the narrative report. According to the incident reports submitted into evidence, employees have been warned for such conduct as leaving patients wet at the end of their shift, poor work attitude, excessive use of the telephone, failure to turn and position residents as documented in the Aidex, and taking too long for lunch.

The nursing supervisor reviews all reports turned in by LPNs and investigates those reports involving serious misconduct such as patient abuse. During this process, the nursing supervisor or even the ADON may discuss the matter with the LPN who wrote the report as well as the CNA. In one example, an LPN wrote up a CNA for not properly responding to a door alarm signaling that a resident had wandered out of the unit. The LPN gave the report to the nursing supervisor who in turn gave it to the ADON. The ADON then spoke with the LPN and together the ADON and LPN spoke to the CNA. The LPN made no recommendation with respect to discipline. The CNA was given in-service training.

The report also has a place for the CNA to write a statement about the incident. For example, one CNA, who was warned for not doing her extra assignment of TPRs, explained that TPR was not on the assignment sheet when she checked in.

In cases involving serious misconduct, the LPN notifies an RN, either a nursing supervisor or unit manager, immediately. The LPN and RN together then talk to the CNA about the problem.

The incident report is given by the RN nursing supervisor or the LPN to the CNA who signs it. The written reports are then sent to the DON for review. The DON checks to see if there are any additional reports in the CNA's file and then consults with the RN nursing supervisor and the LPN. The DON testified that she does not independently investigate the incident by talking with the CNA or the patient involved unless the incident concerns abuse. The DON and nursing supervisor then decide what, if any, discipline is to be

meted out based on the facts in the documents before them. The written report is then placed in the employee's file.

There is no progressive disciplinary system, hence there is no predetermined discipline based solely on the receipt of a certain, set number of warnings. Management does not consider all warnings to be equal but judges each incident on its own.

LPNs on the evening and night shifts also fill out a portion of the CNA's 6-month evaluation as well as the CNA's annual evaluation which occurs 12 months later, after 18 months of service. On the day shift, unit managers perform this function, not the LPNs. In filling out the appraisal form, the LPN gives point values from zero to three to various criteria such as knowledge, productivity, cooperation, and dependability and fills out section 2 describing the employee's accomplishments and strong points as well as the areas in which the employee needs to improve. The nursing supervisor reviews the values given by the LPN and changes those she disagrees with. The nursing supervisor then completes section 3 of the evaluation which sets out the objectives and projects assigned to the employee as well as a work plan to achieve the objectives. The LPN and nursing supervisor sign the evaluation and then discuss it with the employee who also signs it. The employee may write explanatory comments in section 4 of the appraisal. After the DON reviews and signs the appraisal, it is placed in the employee's file.

The 6-month appraisal takes place at the end of the employee's probation. If the employee is not performing well, that person may be terminated, or the probation period may be extended. If performance has been satisfactory, the employee receives a salary increase of 50 cents an hour. At the time of the hearing, there had been no annual performance appraisals because the Employer's facility, which opened in March 1993, had not been in operation for 18 months. Although there was testimony that the annual evaluations when given will lead to wage raises based on merit, the amounts of such awards had not been decided. Whether the employee has received warnings during the appraisal period will also be a factor in determining whether the employee is entitled to a merit increase.

According to the DON, both LPNs and RNs have recommended to the DON that CNAs be transferred to a different shift or unit because they were not performing well. One LPN testified that when she was the charge nurse on the night shift, she recommended to the RN supervisor that a CNA be transferred to the day shift because she felt her poor performance was due to tiredness caused by her pregnancy. The recommendation was presented to the DON and ultimately the CNA was transferred to the day shift. An-

other LPN testified, however, that she had never been involved in the transfer of an employee.

When a recommendation to transfer a CNA is made, the CNA is notified, and the DON looks into the situation. Transfers, however, are not automatic and may not even be feasible. Accordingly, when these situations arise, the DON also discusses with the in-service orientation director the possibility of sending the CNA back to orientation for a couple of weeks in order to get more training. Over the past year, about six CNAs have transferred to a different shift or unit.

II. SECTION 2(11) SUPERVISORY INDICIA

The term "supervisor" is defined in Section 2(11) of the Act as:

[A]ny individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

To meet this definition, a person needs to possess only one of the specific criteria listed, or the authority to effectively recommend, so long as the performance of that function is not routine but requires the use of independent judgment.

Of the supervisory indicia listed in Section 2(11), the Employer claims that its LPNs are statutory supervisors because they have the requisite authority with respect to assignment and direction of work, discipline, evaluation, and transfers. Each of these indicia is discussed below.

A. Assignment and Direction

The Board's analysis of assignment and direction following the Supreme Court's *Health Care & Retirement* decision is set forth in detail in *Providence Hospital*, 320 NLRB 717 (1996). Applying that analysis, we note initially that Congress, in enacting Section 2(11), emphasized its intention that only supervisory personnel vested with "genuine management prerogatives" should be considered supervisors, and not "straw bosses, leadmen, setup men and other minor supervisory employees." See Senate Rep. No. 105, 80th Cong., 1st Sess., 4 (1947), reprinted in 1 NLRB Legislative History of the Labor Management Relations Act, 1947 at 407, 410 (1985). Indeed, the Board has long recognized that "there are highly skilled employees whose primary function is physical participation in the production or operating processes of their employer's plants and who incidentally direct the movements and operations of less skilled subordinate

employees,” who nevertheless are not supervisors within the meaning of the Act because their authority is based on their working skills and experience. *Southern Bleachery & Print Works, Inc.*, 115 NLRB 787, 791 (1956), enf. 257 F.2d 235 (4th Cir. 1958), cert. denied 359 U.S. 911 (1959).

In *Northcrest Nursing Home*, 313 NLRB 491 (1993), the Board discussed at length the issue of whether LPN charge nurses responsibly direct aides within the meaning of the Act. In finding the nurses not to be statutory supervisors, the Board relied on a “patient care” analysis, i.e., a nurse’s direction of less skilled employees, in the exercise of professional judgment incidental to the treatment of patients, is not authority exercised “in the interest of the employer.” *Northcrest*, supra at 493–497. In doing so, however, the Board also acknowledged its “leadman” analysis, noting that leadpersons have traditionally been found to be lacking in supervisory authority even though they direct employees’ work, as such direction is based on their greater skill and experience. Id. at 494.

In *Health Care & Retirement*, the Supreme Court was presented with the narrow question whether the Board’s patient care analysis for determining the supervisory status of nurses, specifically its reliance on the phrase “in the interest of the employer,” is consistent with the definition in Section 2(11). In a five-to-four decision, the Court found the Board’s test to be inconsistent with the statute and the Court’s precedents. Succinctly put, the Court could find no basis for the Board’s assertion that supervisory authority exercised in connection with patient care is somehow not in the interest of the employer. “Patient care is the business of a nursing home and it follows that attending to the needs of the nursing home patients, who are the employer’s customers, is in the interest of the employer.” *Health Care & Retirement*, supra, 114 S.Ct. at 1782. The Court also admonished the Board for devising a test that was industry-specific. According to the Court, the Board erred in giving such statutory terms as “responsibly to direct” and “independent judgment” a different meaning in the health-care industry than it does in other industries.

Although the Court’s rejection of the Board’s patient care analysis resulted in a finding that the LPNs were statutory supervisors, the Court agreed with the Board’s argument that phrases such as “independent judgment” and “responsibly to direct” are ambiguous and thus the Board needs a wide latitude in its application of these indicia to various categories of employees. Id. at 1783. More importantly, the Court made clear that an examination of an employee’s duties to determine whether one or more of the Section 2(11) supervisory indicia is performed in such a way that the employee becomes a statutory supervisor “is, of course, part of the Board’s routine and proper adju-

dicative function. In cases involving nurses, that inquiry no doubt could lead the Board in some cases to conclude that supervisory status has not been demonstrated.” Id. at 1785. The Court noted that in other cases, the Board has found the disputed employees not to be supervisors based on the fact that the employee’s authority arose from professional knowledge and the employee’s exercise of 2(11) indicia was merely routine. Ibid. Indeed, even in *Northcrest*, the Board did not find that every assignment and direction given to aides by charge nurses required the use of independent judgment; it found only that they “may require the use of independent judgment.”⁶

Bearing these directives in mind, and as we more fully explained in *Providence Hospital*, we have decided to treat charge nurses the same as all other employee classifications and shall apply to them the same test we apply to all other employees. In determining whether their direction of work meets the definition of Section 2(11), we shall decide whether such direction requires the use of independent judgment or whether such directions are merely routine.⁷ This is the approach we have always used in leadperson cases, and in the past we have even applied it in some health care cases. See *Meharry Medical College*, 219 NLRB 488 (1975); *Beverly Manor Convalescent Centers*, 275 NLRB 943 (1985).

Applying the above analysis to the facts of this case, we find that the LPNs do not exercise independent judgment in making assignments or in directing the work of the CNAs.

The LPNs’ authority to assign CNAs to runs is limited by the fact that such assignments are made on a monthly basis, at the end of which CNAs are routinely rotated to another run. While there was testimony to the effect that the LPN considers the personality and capabilities of the CNA in making these assignments, these factors appear to have limited significance in view of the Employer’s established monthly rotation procedure. Moreover, the record evidence shows that all the CNAs have the same skills as they all must complete the same orientation check list.

While such assessments may also play a role on those occasions when a substitute CNA is filling in, reconfiguring runs is not normally done. It would thus appear that the substitute CNA usually takes the run

⁶ *Northcrest*, 313 NLRB at 504–505 (emphasis added).

⁷ In *Providence Hospital*, supra, we recognized that supervisory status based on the authority to direct also depends on whether the disputed individual possesses the authority to responsibly direct, and that in some cases an analysis of “responsibly” may be required. *Providence Hospital*, supra, 726–727. This case, however, like *Providence*, does not require such an analysis. A determination of whether the charge nurses’ directions render them statutory supervisors can be adequately analyzed under the Board’s traditional approach of deciding whether the directions given require independent judgment or whether such directions are merely routine.

normally assigned to the regular CNA who is absent. Moreover, although the record does not indicate how often a CNA is absent, it is clear that substitutes cannot always be located; indeed, management has already provided for that possibility by having the residents pregrouped into three to five runs so that if a lesser number of CNAs is present, a three- to four-run grouping is used rather than the optimum five.

The assignment of lunch and break times clearly requires no independent judgment. There are only two times available, early and late; the CNAs are regularly switched between the two so they do not go at the same time each day; and the choice between the two may also be determined by the preference of the CNA.

The LPNs' assignment of extra duties is equally routine. These duties are regularly rotated among the CNAs so they do not always have to perform the same job, or these duties may be assigned in accordance with which task the CNA prefers.⁸

The record also fails to show that LPNs use independent judgment in directing the work of the CNAs. The essential duty of the CNA is to take care of elderly people who are no longer able to care for themselves. For the most part, such duties require little skill, are repetitive, and at times even unpleasant.

Every day, CNAs must perform the same care, in the same manner, for the same people. To be sure this is done, the Employer requires that each patient's particular needs be kept in the Aidex. It is the responsibility of the CNA to consult and follow the Aidex with respect to each patient and perform all functions indicated for each resident.

One of the LPNs' responsibilities is to be sure that the CNAs are properly performing their jobs. Thus, LPNs make patient rounds and consult the Aidex. If an LPN sees a patient that needs attending to or a job that has not been properly done, the LPN will call it to the attention of the CNA. This type of direction does not require the independent judgment of Section 2(11). To some degree, the greater skill and experience of the LPN may be involved as the LPN may more quickly recognize a situation that needs immediate attention. In other situations, the problems are usually quite obvious (resident is wet or needs to be dressed, etc.). In any event, workday tasks are governed by the detailed instructions contained in the Aidex.⁹

⁸ Contrary to our dissenting colleague, merely having the authority to assign work does not establish statutory supervisory authority. Instead, the exercise of such authority must require the use of independent judgment. Here, as discussed above, the LPNs do not exercise independent judgment in assigning CNAs to runs or to extra duties. Rather, these assignments are determined primarily by the fact that CNAs are routinely assigned to a different run each month and extra duty assignments are regularly rotated among the CNAs.

⁹ As our dissenting colleague concedes, the resident's long-term care plan which is kept in the Aidex must be reviewed and approved by an RN. Thus, these daily work directions actually come from the RN, not the LPN. Moreover, devising a resident's long-term care

We agree with our dissenting colleague that the tasks contained in a resident's long-term care plan are of critical importance to the health and well being of the resident. However, we disagree with our colleague's conclusion that the monitoring and directing of such tasks cannot be routine. There is an important distinction between designing complex work tasks and directing employees in carrying out those tasks. If this distinction is blurred, it becomes easy to be misled into concluding that an individual exercises independent judgment based simply on the fact that the work tasks being designed by that individual are relatively "complex" or "important." Here, although the LPNs use their technical expertise and judgment to prepare a comprehensive health care plan for each resident, the directions they give to the CNAs in carrying out the plan do not require the use of Section 2(11) independent judgment but are merely routine.¹⁰

In the view of our dissenting colleague, although the distinction between designing important and complex tasks and directing employees in carrying out these tasks may be applicable to the engineering and construction industry, it cannot be applied to the health care field. We disagree. While, "a sick human being is not the same as a building," to use the words of our colleague, the work of professionals and technicals in both fields has a direct impact on human life. Thus, although the directions given to implement a detailed architectural blueprint may be routine, they must be executed with the same concern as a direction given with respect to the care of an aged or infirm nursing home resident. Failure to perform as directed in either case could result in physical injury or death. Accordingly, the fact that severe adverse consequences might flow from an employee's routine direction or monitoring of the work of others does not, without more, make the employee a supervisor. See our discussion in *Providence Hospital*, supra.

We also note that LPNs, by virtue of their specialized training, have many other responsibilities that do not involve CNAs, such as preparing and passing out medications, giving treatments, contacting doctors, and updating patients' charts. Thus, the LPNs' supervision of CNAs is narrowly circumscribed to giving rather

plan is more in the nature of planning the work that needs to be done, rather than directing a CNA to perform the work. Accordingly, unlike our dissenting colleague, we would not characterize the LPN's preparation of health care plans as "effectively recommend[ing] the daily work direction" of the CNAs.

¹⁰ Designing a plan of medical care is not in these circumstances an exercise of supervisory judgment within the meaning of Sec. 2(11) but is an exercise of the expert judgment of the nurses vis-a-vis their position as technical or professional employees. As our dissenting colleague has recently stated: "Thus, for example, the task of devising a patient treatment plan involves the use of *professional judgment*. The nurse who devises the plan is a *professional employee*." (Emphasis added.) See Member Cohen's dissent in *Providence Hospital*, supra, at 736-738.

general, routine directions to lesser skilled employees in order to maintain the quality of their work. This type of authority is typical of that of the industrial strawboss and leadman, skilled employees with only limited authority, who are routinely excluded from the definition of supervisor.¹¹

B. Discipline

Nor do we find that the LPNs' involvement in discipline renders them supervisors within the meaning of Section 2(11). The record evidence in this case clearly establishes that LPNs do not discipline CNAs nor do they effectively recommend disciplinary action. The role of the LPNs is merely to report incidents of unacceptable work performance or behavior. They make no recommendations with respect to discipline. Moreover, these reports do not automatically result in discipline nor is the discipline, when given, a product solely of the LPNs' reportorial account. Thus, the reports are reviewed by the nursing supervisor and, sometimes, the ADON, who discuss the matter with the LPN and the CNA. The CNA may even write a statement on the report to explain or justify the complained-of incident. Finally, it is reviewed by the DON who, on the basis of all the documentary evidence, decides in conjunction with the nursing supervisor what action, if any, should be taken.

¹¹ *Beverly Manor Convalescent Center*, 275 NLRB 943, 947 (1985), and cases cited there.

Contrary to our dissenting colleague, we believe the definition of leadperson in *Southern Bleachery* aptly describes the LPNs as they are "highly skilled employees whose primary function is physical participation in the . . . operati[on] . . . of their employer's [business] and who incidentally direct . . . less skilled subordinate employees." Thus, LPNs are charged with the primary responsibility of making sure that the residents are being properly cared for. In carrying out this function, LPNs perform a number of duties including giving, when necessary, directions to lesser skilled CNAs as they perform the tasks as detailed in the Aidex. Such directions are primarily determined by the contents of the long-term care plans. The LPNs only remind the CNAs when necessary that a task needs to be done or direct a CNA to perform a necessary duty. The directions so given are, at most, based on the LPNs' greater skill and experience in recognizing that certain tasks need to be done. In these circumstances, we find that such monitoring and directive functions are routine in that they do not utilize the independent judgment required in Sec. 2(11).

Our dissenting colleague's contrary view is based on Senator Flanders' use of the terms "personal experience, training, and ability" in describing the meaning of "responsibly to direct" as a Sec. 2(11) indicia. However, our colleague ignores the full context of Senator Flanders' comments which we set forth in *Providence Hospital*, supra at 725. Moreover, our dissenting colleague's claim based on a quote from Senator Flanders that "an individual who makes a 'personal judgment based on personal experience, training, and ability' is making an independent judgment" is contrary to well-established Board precedent. As set forth above and in greater detail in *Providence Hospital*, supra, employees who merely direct lesser skilled subordinate employees based on their greater knowledge or expertise are not considered statutory supervisors.

The authority to give employees oral warnings and also to write up warnings on forms retained in the employee's personnel file is typical in cases involving nursing-home charge nurses. Usually, the director of nursing or some other managerial/supervisory person investigates and decides what, if any, discipline is warranted. Where this has occurred, the Board has found that the charge nurses are not supervisors either because their warnings do not result in any personnel action, or, if they do, such action is not taken without independent investigation or review by others. See *Northcrest Nursing Home*, supra, 313 NLRB at 497 fn. 29.

Passavant Health Center, 284 NLRB 887 (1987), where we found charge nurses not to be supervisors, is quite similar to the instant case. There, as here, nurses had the authority to issue oral reprimands and written incident reports documenting unacceptable performance. The reports were sent to the nursing office and placed in the employee's file. The director of nursing decided what, if any, disciplinary action should be taken. No such action was taken without the nursing office interviewing the individuals involved or those who had information about the incident. In finding that the nurses had no disciplinary authority but instead performed only a reportorial function, we noted that the incident reports did not contain any recommendations for disciplinary action and that any action taken was determined after the nursing office had inquired into the matter. Id. at 889. Accordingly, because the written reports and warnings issued by the nurses had no independent effect and did not, by themselves, affect job tenure or status, the Board found the nurses not to be supervisors.

The same is true here. The incident reports prepared by LPNs contain no recommendations and are given to the nursing supervisor for review. That review, as clearly demonstrated by record testimony, has included discussing the incident with both the LPN and the CNA. The ADON has also been personally involved in incident reports. When the DON decides that disciplinary action must be taken, that decision is not based solely on the report as written by the LPN but is also based on discussions with the nursing supervisor who has already looked into the matter; together, they decide what discipline to impose.

The Employer, in arguing that LPNs have statutory authority to discipline, relies heavily on the fact that the DON testified that she does not "independently investigate" the incident reports unless patient abuse is involved. This reliance is misplaced. The record is clear, indeed the nursing supervisor testified, that the reports are reviewed by the RN supervisor who personally inquires into the situation by talking to the individuals involved. This, we find, constitutes independent investigation. Moreover, although the DON does

not personally investigate the incident before discipline is imposed, she discusses it with the nursing supervisor who has been personally involved.

C. Evaluation

The Board has consistently found that LPNs are supervisors when they independently perform evaluations of other employees which lead directly to personnel actions affecting those employees, such as merit raises. By contrast, the Board has consistently declined to find supervisory status when charge nurses perform evaluations that do not, by themselves, affect other employees' job status. See *Northcrest Nursing Home*, supra at 498 fns. 36 & 37 (1993); *Bayou Manor Health Center*, 311 NLRB 955 (1993).

Here, although the record shows that the 6-month evaluation leads directly to discharge, additional training, or a wage increase, no annual appraisals had been written as of the time of the hearing. Consequently, there is no showing that an annual performance appraisal determines wage increases. Although there was testimony that such appraisals, when given, would lead to merit increases, such testimony is merely speculative. Moreover, there is additional testimony that merit increases would also depend on whether the employee had received any warnings which, as we have found, also involve review by the nursing supervisor. It would appear, therefore, that merit increases will be determined by a combination of factors and not solely on the employee's performance appraisal.

In any event, the appraisals here are not the sole product of the LPN. In the first place, only evening and night-shift LPNs fill out appraisal forms; day-shift LPNs do not. Moreover, not only does the RN nursing supervisor fill out a portion of the evaluation, the supervisor reviews the numbers assigned by the LPN and changes those the RN thinks do not accurately reflect the work of the CNA. Nor is there any showing that it is the numerical portion of the evaluation that determines the outcome rather than an overall review of the entire appraisal. The LPN does not make any recommendations on the form.

Bayou Manor, relied on by the Employer, is distinguishable. There, as here, the LPN assigned numerical scores (in *Bayou*, the scores ranged from 1 to 10) to a number of items covering work performance and personal characteristics. Unlike here, however, in *Bayou* there was no review of the numerical scores awarded by the LPN and the scores so given directly determined the amount of the employee's merit increase and departmental bonus. Here, as noted above, the numbers assigned by the LPN are not only reviewed but are sometimes changed, and there is no direct cor-

relation between these numbers and any wage increase.¹²

D. Transfers

Although the record shows that the LPNs have recommended to the DON that CNAs be transferred, the record does not establish that these recommendations are effective. Recommendations to transfer a CNA to a different shift or unit are not automatically granted. There may even be circumstances present which make the transfer impossible or difficult to accommodate. In such situations, the DON may, instead, send the CNA back for additional training. Thus, although six CNAs transferred to a different unit or shift in the past year, the record does not establish that these transfers were based solely on the recommendations of LPNs. Instead, the record demonstrates that transfers are determined by the DON based on her assessment of the situation, including the possibility of giving the CNA additional training rather than a transfer.¹³

III. CONCLUSION

Based on the above, we find that the Employer's LPNs are not supervisors within the meaning of Section 2(11) of the Act.¹⁴ The Employer, however, also

¹² We agree with our dissenting colleague that the LPNs play an important role in preparing employee evaluations as they have first-hand knowledge of the CNAs' work performance. However, where, as here, that role is reviewed by higher authority, the LPNs' evaluations are at times changed by the reviewer, and there is no direct connection between the LPNs' input and a wage increase, the LPNs' role in evaluations does not constitute the exercise of statutory supervisory authority.

¹³ Although, as pointed out by our dissenting colleague, there is no evidence that an LPN's recommendation has not been followed, there is also no evidence that the six CNAs were transferred simply because an LPN recommended the transfer. Instead, as noted above, the DON and in-service orientation director both review the situation and make a decision based on all the factors involved.

¹⁴ At the hearing, the Petitioner stipulated that the infection control practitioner, an LPN, is a statutory supervisor and thus should not be included in the petitioned-for LPN unit. The Employer refused to take a position on the status of this individual. In its posthearing brief, however, the Employer takes the position that if the LPNs are found not to be supervisors, the infection control practitioner should also be found nonsupervisory.

The record shows that the infection control practitioner is responsible for seeing that the entire staff—RNs, LPNs, and CNAs—is following proper infection control procedures. When infections break out, the infection control nurse has to investigate the infection, report to the DON and ADON, and contact the local and state health departments. This LPN is also required to keep detailed records and perform quality assurance audits. If the infection control practitioner sees a staff member, including RNs, following improper procedures, she has the authority to correct the situation on the spot and to file a report if necessary. The infection control nurse also investigates complaints filed by any staff member regarding incorrect infection control procedures.

We find the infection control practitioner not to be a statutory supervisor. Although this LPN can correct any staff member who is not following proper procedures, including writing them up, there is

Continued

contends that even if the LPNs are not statutory supervisors, the instant petition should be dismissed because the LPNs do not constitute a separate appropriate unit. Instead, the Employer argued at the hearing that the LPNs should be included in the service and maintenance unit which at the time was the subject of another petition in Case 3-RC-10155 involving the same parties. Subsequently, on January 3, 1995, the Petitioner was certified as the collective-bargaining representative of the service and maintenance employees.¹⁵

Whether a separate technical unit of LPNs is appropriate in a nonacute care facility such as the nursing home involved here is an issue that is decided on the facts of each case. See *Park Manor Care Center*, 305 NLRB 872 (1991). Consequently, if the Petitioner wishes to represent the LPNs in a separate unit, the record will have to be reopened and the issue litigated. However, if the Petitioner only wishes to represent them as part of its service and maintenance unit, the Regional Director will direct an election in a voting group of LPNs. If a majority of ballots in the voting group are cast for the Petitioner, the employees will be included in the existing service and maintenance unit; if not, the employees will remain unrepresented. Accordingly, we shall remand the case to the Regional Director for further appropriate action.

ORDER

The petition in Case 3-RC-10166 is remanded to the Regional Director for further appropriate action.

no evidence that such reports are any different from incident reports written by all LPNs with respect to CNAs and, as such, they do not render this LPN a supervisor. Nor does the fact that she investigates complaints. There is no evidence that she has resolved any employee grievances or that any complaint so investigated has led to any personnel action.

¹⁵In Case 3-RC-10155, the Petitioner initially sought to represent an overall unit of the Employer's service and maintenance employees, including LPNs. However, when the Employer claimed the LPNs were statutory supervisors, the parties entered into a Stipulated Election Agreement on July 1, 1994, for a unit of service and maintenance employees, excluding LPNs. That same day, the Petitioner filed the instant petition seeking to represent the LPNs in a separate unit. The Employer then sought to withdraw from the Stipulated Election Agreement, but its request was refused by the Regional Director. The Employer's appeal of that decision was pending before the Board at the time of the hearing in the instant case. Subsequently, on August 5, 1994, the Board denied the Employer's request for review. Thereafter, the election in Case 3-RC-10155 was conducted, and, as noted above, the Petitioner was certified as collective-bargaining representative of the service and maintenance unit on January 3, 1995.

The fact that the Petitioner initially sought the LPNs in an overall unit and then agreed to their exclusion in a Stipulated Election Agreement is not a waiver by the Petitioner of its right to file a petition seeking to represent these employees. See *S. S. Joachim & Anne Residence*, 314 NLRB 1191, 1192 (1994). However, as discussed above, there remains the question whether the LPNs constitute an appropriate separate unit or whether the Petitioner must include them in the service and maintenance unit it already represents.

MEMBER COHEN, dissenting.

I do not agree that the LPNs are employees. Rather, I think it clear that they are supervisors. Accordingly, I dissent.¹

In *Healthcare & Retirement Corp. of America*, 114 S.Ct. 1778 (1994) (*HCR*), the Supreme Court held that the Board could not avoid a finding of supervisory status for nurses simply by asserting that the nurses acted in the interest of the patient rather than in the interest of the employer. As the Court pointed out, "patient care is the business of a nursing home and it follows that attending to the needs of the nursing home patients, who are the employer's customers, is in the interest of the employer." Thus, the Board is obligated to determine whether the nurses exercise, or have the authority to exercise, one of the powers listed under Section 2(11) of the Act. If they do, and use independent judgment in doing so, they are supervisors. The assertion that they act in the interest of the patient will not change the result.

With *HCR* on the books, my colleagues nonetheless seek to avoid a supervisory conclusion by stretching the language of Section 2(11) of the Act. As set forth below, that bit of stretching will not work. The LPNs in this case possess authority with respect to a number of functions listed in Section 2(11) of the Act.

I begin with the assignment of work. Residents in each unit are divided into three, four, or five groups called "runs": A CNA (certified nursing assistant) is then assigned to a run. The LPNs determine the runs on the evening and night shifts. In addition, the LPNs on all shifts have the authority to reconfigure the runs. Finally, the LPNs assign CNAs to their runs. In sum, the LPN effectively controls the number and identity of the residents that a given CNA will serve.

I recognize that CNAs are switched to different runs once a month. However, I know of no case, and none is cited, standing for the proposition that an assignment is not an assignment if it is for a short duration. Certainly, the language of the Act contains no such limitation. I also recognize that, if the CNAs and the runs stay the same, each CNA will eventually service every run. However, even if this turns out to be the case, the LPN nonetheless has the power to determine the sequence in which the assignments are made.

There is uncontradicted testimony that the LPNs make these assignments by considering the personality and capabilities of the CNA. Clearly, these are subjective judgments of the LPN, and they therefore reflect the LPN's independent judgment. Equally clearly, these judgments result in an assignment.

The LPNs also assign "extra duties" to CNAs. The LPN chooses which CNA will perform a particular extra duty and can even assign more than one extra

¹For additional analysis of my position on this issue, see my dissent in *Providence Hospital*, 320 NLRB 717 (1996).

duty to a CNA. Again, although these assignments are often changed, this does not mean that they are not assignments.

The LPN also responsibly directs the CNA. When a resident is admitted, either the RN or the LPN fills out a long-term care plan.² The plan deals with virtually every facet of care for that resident. The plans are compiled in a book called the Aidex. The LPN regularly checks to see that the Aidex functions are performed by the CNA. If they are not, the LPN will direct the CNA to perform them.³

My colleagues assert that the LPN, in performing these monitoring and directing functions, is simply acting on the basis of “greater skill and experience.” Interestingly, it is precisely those qualities which characterize the supervisory nature of the LPN’s function. In this regard, I note that Senator Flanders was the person who successfully proposed the “direction” portion of Section 2(11) of the Act. In doing so, he spoke specifically of persons who “exercise . . . personal judgment based on personal experience, training and ability.” Senator Flanders was essentially describing the qualities of the LPNs in this case and the charge nurses in *Providence Hospital*. Senator Flanders thereby effectively rejected the notion, espoused by my colleagues here and in *Providence Hospital*, that these qualities do not involve independent judgment. The essence of independent judgment is that the individual’s actions are based on the thought processes of that individual, rather than on some outside force or person. Certainly, an individual who makes a “personal judgment based on personal experience, training and ability” is making an independent judgment. Thus, Senator Flanders spoke directly to the issue of independent judgment, and he squarely rejected the argument made by my colleagues.⁴

My colleagues also argue that the foregoing LPN functions are those of “leadmen” and thus not supervisory. The phrase “leadman” appears in Senate Labor Committee Report No. 105. However, at the

²When the LPN fills out the plan, it must be approved by an RN. There is no evidence that long-term care plans prepared by the LPN are substantively changed by the RN. Thus, the LPN effectively recommends the daily work direction contained in the plans.

³My colleagues draw a distinction between “planning the work that needs to be done” and “directing a CNA to perform the work.” The distinction may be valid, but one must be careful in its application. If a patient treatment plan simply sets forth the treatment (e.g., bathe the wound three times a day), the devising of that plan is a professional task. See my dissent in *Providence Hospital*, supra. However, to the extent that the plan directs specific employees to perform the task, the direction is a supervisory function. In any event, even if the plan itself is silent as to such direction, the implementation of the plan is a supervisory function. That is, the actual direction and monitoring of the employees are supervisory responsibilities.

⁴My colleagues suggest that my analysis is contrary to Board precedent. Assuming arguendo that this is so, I prefer to be guided by the statute as illuminated by precise legislative history.

time of that report, the phrase “responsibly to direct” was not even in the proposed legislation. That phrase was added later by Senator Flanders. Thus, the relevant legislative history for that phrase is *not* Committee Report No. 105, but rather Senator Flanders’ remarks specifically describing his addition to the legislation.

Further, even assuming arguendo that the Committee Report is relevant in this respect, it is clear that the LPNs are not leadpersons. Leadpersons are “highly skilled employees whose primary function is physical participation in the production or operating processes of their employers’ plants and who incidentally direct the movements and operations of less skilled subordinate employees.” *Southern Bleachery & Print Works, Inc.*, 115 NLRB 787, 791 (1956). The instructions of such persons are “inherent in the craftsman-helper relationship.” *Ibid.* In the instant case, the LPNs do not “incidentally” monitor and direct the CNAs. Rather, such monitoring and direction is an important part of the LPN function. Further, as noted, that function is to ensure that there is adherence to the care plan for residents. Given the importance and complexity of the Aidex (the care plan for residents), it can hardly be said that the monitoring and directive function is a routine or clerical task.⁵

The LPNs also play an effective role in the disciplining of CNAs. They give oral warnings to CNAs, and they can write reports concerning CNA misconduct. These warnings and reports can lead to discipline. Although the DON ultimately decides on discipline, the DON does not ordinarily conduct an independent investigation. Rather, she relies, inter alia, on the LPN’s report and, on occasion, will speak to the LPN who prepared the report. Finally, irrespective of whether discipline is imposed, the written report is placed in the CNA’s file.

LPNs also evaluate CNAs. On the evening and night shifts, they perform an evaluation at the end of CNA’s 6-month probationary period. The appraisal has a point system for various criteria (e.g., knowledge, productivity) and a narrative portion. This evaluation can lead to retention and a salary increase or to discharge. The fact that the evaluation is reviewed by the LPN’s superiors does not detract from the importance of the LPN’s role. It is a system, not uncommon, in which the evaluation by the first-line supervisor is subject to review by higher levels of authority. In such systems,

⁵My colleagues suggest that a task can be important and complex while the monitoring and direction of that task is routine and clerical. This may be true in certain fields, but it is not true in the health care field. For example, an architectural blueprint may be extraordinarily precise and detailed, and thus the directions to implement the blueprint may be routine. However, a sick human being is not the same as a building. Of necessity, the plan for the care of the former must be carried out with discretion and judgment. There are subtle nuances in the care of a sick human being, such that a plan cannot be woodenly administered with the precision of a blueprint.

higher authority relies heavily on the first-hand knowledge of the first-line supervisor.

There is also an evaluation that occurs 12 months after the 6-month evaluation, and annually thereafter. Because the facility in this case was new at the time of the hearing, there were no such evaluations. However, there is uncontradicted testimony that LPNs perform these evaluations, and that the evaluations can lead to merit wage increases.⁶

⁶My colleagues respond that the LPN's evaluation of a CNA is reviewed by higher authority and is occasionally changed. I do not view this as inconsistent with an "effective recommendation." That is, the recommender is still a supervisor, even if an occasional recommendation is not followed.

Finally, LPNs make recommendations to transfer CNAs to a different shift or units because the CNAs are not performing well. Over the past year, about six CNAs have been transferred for this reason. There is no evidence that a LPN's recommendation has not been followed.⁷

Based on all of the above, I find that the LPNs perform a number of supervisory functions. Any one of them is sufficient, by itself, to confer supervisory status under Section 2(11) of the Act. I therefore conclude that they are supervisors.

⁷My colleagues assert that others make the decision based, *inter alia*, on the recommendation of the LPN. That is not inconsistent with an effective recommendation.