

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD  
DIVISION OF JUDGES

ORCHARD PARK HEALTH CARE CENTER, INC.  
d/b/a WATERS OF ORCHARD PARK

and

Case 3-CA-23704

CAROL A. GUNNERSEN, an Individual

*Nicole Roberts*, Esq., for the General Counsel.  
*Dennis M. Devaney*, Esq., of Detroit, MI, for the Respondent.

DECISION

Statement of the Case

MARION C. LADWIG, Administrative Law Judge. This case was tried in Buffalo, New York on November 12–13, 2002.<sup>1</sup> The charge against the Nursing Home was filed July 12 and the complaint was issued August 29.

This case involves the suspension of licensed practical nurse Carol Gunnensen (serving as a charge nurse) and the suspension and later discharge of certified nursing assistant (CNA) Kathleen Reed, for making a call on the confidential patient care hotline to the New York State Department of Health on July 4 to report the excessive heat in unit 2 of the Nursing Home.

Charge nurse Gunnensen, CNA Reed, and four other aides were taking care of 40 elderly, mostly frail, patients in the facility's 30-year-old original section (constructed in 1972), which is not air conditioned (Tr. 95, 140, 270).

Administrator Daniel Detor admitted at the trial (Tr. 167) that yes, the Nursing Home knew that the temperatures in unit 2 in the first week of July "placed patients at risk" (Tr. 161, 167).

New York State regulation § 483.15(h)(6)—which Detor also admitted (Tr. 138–139) is part of "the requirements that we have to meet to be licensed as a nursing home in New York State"—provides (R. Exh. 5):

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71–81° F; and  
. . . Although there are no explicit temperature standards for *facilities certified on or before October 1, 1990*, these facilities must maintain *safe and comfortable* temperature levels. [Emphasis added.]

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<sup>1</sup> All dates are in 2002 unless otherwise indicated.

Thus, the State of New York requires the Nursing Home to maintain, for the patients, “safe and comfortable” temperature levels for it to operate as a nursing home in the State. Admittedly the temperatures in unit 2 were unsafe, “placing patients at risk,” and of course the excessive heat was far from being comfortable.

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Gunnensen credibly gave undisputed testimony that the temperature in unit 2 during the last 2 weeks in June was in the high 80s and much hotter the first week of July (Tr. 66). The temperature was monitored by maintenance engineers, who did not testify (Tr. 75).

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On July 1, in an unsuccessful effort to cope with the high temperature in unit 2, the Nursing Home installed two free-standing used 10,000 BTU air conditioners from Spot Coolers. One was installed next to the nurses station and the other one was installed in the short hall leading from the nurses station—but none in the long hall leading from there to the double doors, separating the old section of the building from the new, air-conditioned part of the building (Tr. 37–40, 67, 156–157, 159; R. Exh. 10). Although the employees were instructed to keep the outside windows and the doors down the short hall closed, the air conditioners were insufficient to keep unit 2 from getting hotter that week (Tr. 12, 18, 47–48, 66, 225).

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On July 1, after patient Adeeb Hussain was sent to the hospital, as charge nurse Gunnensen credibly testified, the hospital nurse reported back to her that Hussain “was admitted for dehydration” (Tr. 91–96, 242–243, 249), although at the end of the shift, Nursing Supervisor Cynthia Fields (who did not testify) told her to write on the nurses notes, “admitted . . . for electrolyte imbalance” (Tr. 250–252; R. Exh. 17). (By Gunnensen’s demeanor on the stand, she impressed me most favorably as a candid, truthful witness, who has a good memory.)

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On July 3, patient Ann Ruhland was also sent to the hospital (Tr. 31–32; R. Exh. 13).

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Regarding any difference in the care that management required that first week in July, CNA Reed credibly testified that “We were all instructed to push extra fluids” to cope with the heat, testifying that both charge nurse Gunnensen and Supervisor Fields gave those instructions (Tr. 20–21).

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CNA Heather Fite credibly testified that in this first week of July, she talked to Supervisor Fields about it being “very hot,” that “the residents didn’t look good” and were dehydrated, and that Fields told her “to just keep pushing fluids on the residents” (Tr. 105).

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On July 4, it was “extremely hot” in unit 2 (Tr. 66, 268). When CNA Reed arrived at 2 p.m., two additional patients, Robert Magner and Pearl Peterson (R. Exh. 13), had been sent to the hospital. As Reed credibly testified, she observed that patients had a lack of appetite, were refusing to drink fluids, were slouched in their chairs, and for the first time were taking off their clothes, even in main corridors. “When asked to put their clothing back on, they told me it was too hot.” (Tr. 13.)

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When charge nurse Gunnensen arrived at 3 p.m. on July 4, as she credibly testified, “a lot of the residents were overheated and a lot of the windows were already beginning to be open” (Tr. 67). “Patients were lethargic. I can recall one specific time when I went to pass medication to a patient [who] was usually awake. She was slumped in her chair. It took about two or three times of prompting before I could even awake her, in order to give her medication.” Some of the patients were “ripping their clothing off.” (Tr. 69, 98–99.)

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Gunnensen further credibly testified that a few residents went out with family members and when they returned, for example one in a wheelchair, they would ask “Are you sure you’re

going to be okay?" Because when they got off the elevator, "the explosion of heat was there. And, it was a feeling like, I don't want to leave you. . . . It's really hot here. Are you sure you're going to be okay? And, the resident did tell the family member yes." (Tr. 70-71.)

5           Gunnensen asked Supervisor Fields if she knew that the elderly can dehydrate within 8 hours, and Fields said yes (Tr. 77).

10           Before installing the free-standing air conditioners on July 1, the Nursing Home had taken the unprecedented action of furnishing bottled spring water for the staff to carry around with them to avoid being dehydrated themselves, but the bottled water had run out and was no longer available on the afternoon of July 4 (Tr. 75-76, 85, 156, 194-196). The water was locked in Nursing Director Tracy Sullivan's office during her holiday absence that afternoon (Tr. 189, 223). The Nursing Home also supplied popsicles for the staff and purchased cooling headbands for all the staff members (Tr. 195). None of these measures was a direct benefit to the patients.

15           Meanwhile, as Gunnensen further testified, "a lot of the employees came to me [and] complained about the heat and . . . said they couldn't take" it, but "They are very dedicated employees and . . . everybody went back to work . . . for the patients" (Tr. 74).

20           Around 4:30 o'clock that afternoon, July 4, as Reed credibly testified, when she, Gunnensen, and Supervisor Fields went outside on break, Gunnensen told Fields to look "how sick I was" and that "I should be sent home." Fields refused, explaining that Sullivan had ordered that no one could leave. (Tr. 21-22, 79.)

25           As an important part of the employees' working conditions in caring for the patients, the State requires the posting of the patient care hotline notice. In unit 2, it is posted on the side of the elevator, directly across from the nurses station. It requires, for protection of the patients, that the employees report unsafe conditions, as follows (Tr. 42; R. Exh. 1):

30                               This notice must be posted in a location accessible to patients, visitors and employees.

## Important Notice

35           **Patients and Visitors**

. . . .

### Employees and Licensed Health Professionals

40           You are required by New York State Public Health Law, Section 2803-d, to report any instance of *patient physical abuse, mistreatment or neglect* to the New York State Department of Health. Call the Patient Care Hotline. A copy of the law and applicable regulations are available from this facility's administrator. [Emphasis added.]

45           **Patient Care Hotline**

The Patient Care Hotline may be used 24 hours a day, seven days a week, to report nursing home situations requiring immediate action.

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## 888-201-4563

Explaining her concern for the patients when she dialed the State hotline number for Reed to report the conditions in unit 2, Gunnensen credibly testified (Tr. 79-80):

5 A. Because we all felt like . . . the problem of over heatedness after four days was not being solved. And, nobody knew about it. And, when we started sending people to the hospital and people were dehydrating, we didn't know where we were going from there. There was really nobody around. It was the 4th of July. We were scared [and wanted to call the State] . . . Just because we cared about the residents.

10 CNA Reed credibly testified that she had been told in training that the CNAs were the eyes and ears of the elderly patients, that they are to report "any and all conditions that you feel may be hazardous," that calls on the State hotline are confidential, and that "you don't have to identify yourself." (Tr. 22, 28, 80, 235, 244, 270.)

15 As Reed credibly recalled at the trial, when she received the phone from Gunnensen, she told the State that she was a relative of a resident [because of fear of retaliation], that it was extremely hot in unit 2, there was no spring water available for staff members, that several residents were dehydrated, that several residents were taken out because of the extreme heat, "and I felt it was a concern and I wanted them to come and look into it" (Tr. 22-23, 268-269).

20 Gunnensen credibly testified that she was busy getting her medication cart ready and did not overhear what Reed told the State, except that when she returned to the nurses station at the end of the call, she heard Reed say "And I am in concern for the residents" (Tr. 80, 269). CNA Fite overheard Reed say only that she was a family member of a resident and was calling about the heat (Tr. 267). None of the other CNAs who were present were called to testify.

25 The next morning, on Friday, July 5, Administrator Daniel Detor received an urgent call on his cell phone from Assistant Administrator Peter Fadeley. Detor was on vacation that whole week and was then "up on Lake Ontario fishing" with his son. As Detor admitted, "all [Fadeley] said [in this first call] was that somebody had called the hotline." (Tr. 133-134.)

30 Fadeley and Detor later "had phone calls back and forth" (Tr. 131). Detor recalled that (in one of the calls), Fadeley said that CNA Judy Benzin (who did not testify) had tried to touch base with him that Friday (July 5) but couldn't and later called him, giving him the (hearsay) information that Reed made the State hotline call (Tr. 133).

35 Detor obviously feared that somebody had reported the heat in the Nursing Home's old section, which is not air conditioned, admittedly "plac[ing] patients at risk," adversely affecting the health of elderly and frail patients. This could be in violation of the State regulation requiring "safe and comfortable" temperature levels and could adversely affect the State license to operate the Nursing Home.

40 Knowing that "You can't really talk to the State [about who made the hotline call and what was reported] because that's *confidential* [emphasis added]," Detor "asked [Fadeley] to involve Tracy [Nursing Director Sullivan] and for them to investigate the accusations" Tr. 134). Because of the urgency, Fadeley immediately called Sullivan at home and had her come in early to begin the investigation (Tr. 197-198).

45 That Friday afternoon, July 5, Reed was called to Sullivan's office and questioned about the State hotline call. For fear of retaliation, Reed claimed she had no knowledge of the call. (Tr. 24.) Sullivan then phoned Gunnensen who, also for fear of retaliation, denied knowing anything about the hotline call (Tr. 81-82).

5 Later that Friday, Reed was called back to Sullivan's office to meet with her and Fadeley. Reed credibly expressed her feeling about the meeting, stating that it was "very fearful," that they were "raising their voices, telling me that through two reliable sources . . . I was the one that made the State phone call" and asking, "Is this true or is this not true?" She began crying and admitted, "Yes, it is." (Tr. 231.)

10 Sullivan told Reed "to write down everything that I told the State" (Tr. 25-26). Feeling that she could not refuse to give a statement, Reed volunteered to do so, "[u]nder pressure," feeling "the pressure to write it to . . . try to save my job" (Tr. 25-26, 237).

15 Reed credibly testified that in the meeting, Sullivan stated: "Do you know the seriousness of these allegations? I can take your CNA certification and Carol Gunnensen's license for doing this." (Tr. 27.) When Sullivan was asked on cross-examination about "Reed's testimony yesterday" and "Did you threaten her if she didn't provide a statement?" Sullivan answered no and testified that she asked Reed to voluntarily provide a statement (Tr. 202). Regarding Sullivan's credibility, I note that she later falsely denied that employees complained to her about temperatures in unit 2, but after being shown her pretrial affidavit, admitted that yes, staff members did complain to her about the heat in the unit (Tr. 221-223).

20 Reed began writing the statement (R. Exh. 12), stating nothing about what the Nursing Home was seeking, concerning what Reed reported to the State about the condition of the patients in unit 2 in the facility's old section, which is not air conditioned, or about patients being sent to the hospital. Reed credibly testified that she was trying to make light of the statement to "protect my job." (Tr. 234, 239-240.)

25 She wrote that there was "a lot of joking" about how hot unit 2 was (although clearly it was not a joking matter); that "we couldn't have any spring water" (which Sullivan already knew, because the bottled spring water for the staff had been locked in her office); that "Complaints were said about the cookout being just for [day-shift employees] and how mad everyone was with that"; that unit 2 was "super hot" and "I didn't feel good at the time"; and that Gunnensen said "we should call the State about the heat" and dialed the phone and threw it at her after deciding to use the company phone.

30 Reed showed what she had written in her statement to Sullivan, who threw the statement and the pen back toward her and stated: "Elaborate on your statement" and "What about the residents that went to the hospital with dehydration? . . . Write that on there" (Tr. 26).

35 Reed added the following to her statement (R. Exh. 12), making no mention of dehydration: "I stated that there was no water on unit [referring to no spring water for the staff, mentioned earlier in her statement], very hot and several residents were recently sent to hospital. I hung up and everyone was laughing." (Reed credibly testified that by stating the everyone was laughing, she meant that she heard her coworkers saying "Ah-hah, wow, you're in trouble for making that phone call" Tr. 234.)

40 This expanded statement—which included confidential information sought by the Nursing Home concerning what Reed reported to the State about how "very hot" it was (for the patients in the facility's old section) and residents being sent to the hospital—satisfied Sullivan and Fadeley (Tr. 26), both of whom signed the statement below Reed's signature (R. Exh. 12). Reed credibly testified that she signed the statement, thinking "if I signed it, possibly, I wouldn't be retaliated against."

45 Instead, Reed was suddenly suspended: "I was then asked to leave the premises,

pending further investigation of the State hotline phone call”—without “any other reason” being given for her suspension (Tr. 27). On July 11, after Administrator Detor returned from vacation, he discharged her (Tr. 150).

5           Meanwhile on Saturday, July 6, Sullivan called Gunnensen, said that Reed had admitted that she and Gunnensen had called the State, and “I was therefore suspended” (Tr. 82, 243–244). The Nursing Home has stated no reason for suddenly suspending her, other than her dialing the hotline number for Reed to report to the State.

10           The primary issues are whether the Nursing Home unlawfully suspended Reed and Gunnensen and discharged Reed for engaging in protected, concerted activity, to discourage employees from making hotline calls to the State to report unsafe conditions for patients in the facility’s old section, which is not air conditioned, violating Section 8(a)(1) of the Act.

15           On the entire record, including my observation of the demeanor of the witnesses, and after considering the briefs filed by the General Counsel and the Nursing Home, I make the following

## Findings of Fact

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### I. Jurisdiction

25           The Respondent, a corporation, operates its facility in Orchard Park, New York. It annually derives over \$100,000 in gross revenue and receives goods valued over \$5,000 directly from outside the State. It admits and I find that it is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

### II. Alleged Unfair Labor Practice

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#### A. Contentions of the Parties and Findings

##### 1. Concerted activity

35           The General Counsel contends (brief at 9) that “The record clearly establishes that Reed and Gunnensen were engaged in concerted activity when they contacted the State.”

40           The Nursing Home contends in its brief (at 18) that “Complainants’ [CNA Reed’s and charge nurse Gunnensen’s] Assertion of an Alleged Statutory Right” by making the hotline call to the State, was not concerted. It cites, as “binding precedent,” the Board’s decision in *Meyers Industries*, 281 NLRB 882 (1886), which held: “We merely find that invocation of employee contract rights is a continuation of an ongoing process of employee concerted activity, *whereas employee invocation of statutory rights is not* [emphasis added].” Even if otherwise applicable, that decision refers (281 NLRB at 887–888) to conduct of a single employee, not two or more employees, as here.

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I find that Reed’s and Gunnensen’s making the hotline call was concerted activity.

##### 2. Working Conditions

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          The Nursing Home contends in its brief (at 16–18), “Complainants Did Not Complain About Section 7 Matters—Working Conditions,” citing the employees’ nonlegal opinions of what constitutes “working conditions” (Tr. 44, 84).

As found, the posted patient care hotline notice—informing the employees that they are required by State law, for protection of the patients, to report an unsafe condition (“patient physical abuse, mistreatment or neglect”)—is an important part of the employees’ working conditions in caring for the patients.

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I find that the July 4 call to the State on the hotline, reporting the heat in the facility’s old section, which is not air conditioned, admittedly “plac[ing] patients at risk,” did involve a working condition.

### 3. Personal concern

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The Nursing Home contends in its brief (at 20–21) that Reed told Sullivan (Tr. 201) that she placed the hotline call to the State for a *purely personal* reason, “that she was upset about the cookout.” Contrary to Sullivan’s claim, Reed indicated in her written statement on July 5 (R. Exh. 12), that she told the State, as quoted above, “Complaints were said about the cookout being just for [day-shift employees] and how mad everyone was with that.” Reed therefore was clearly referring to a group complaint of the second-shift employees, not a personal complaint.

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In making this contention, the Nursing Home ignores Reed’s undisputed testimony (Tr. 236) that she attended the picnic that morning, in her off-duty hours. “I was there so I wouldn’t have been upset about a picnic.”

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Moreover, this and some of the other statements that Reed made on July 4 in her written statement were not relevant to the “report [of] patient abuse” which, as acknowledged in the Nursing Home’s brief (at 15), was “Complainants’ admitted purpose in calling” the State on the hotline. The State was concerned only about matters pertaining to patients’ unsafe conditions covered by State regulations.

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### 4. Protected activity

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The General Counsel contends (brief at 16) that the conduct of Reed and Gunnensen, for which they were suspended, was protected activity.

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The Nursing Home contends in its brief (at 22–31) that for many purported reasons, both that the General Counsel failed to prove that “The Complainants [Reed and Gunnensen] Engaged in Protected Activity” and that “The Complainants Lost Protection Under the Act,” as follows:

The Nursing Home contends in its brief (at 22–24) that

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(a) Both complainants made false representations to the State on the hotline (although Gunnensen merely dialed the hotline number and said nothing to the State).

(b) “Complainants lost their protection under the Act . . . when they lied to management in its internal investigation of the incident.”

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Both employees, however, did so in fear of retaliation when the Nursing Home was investigating the confidential report on July 4 to the State. An important part of their working conditions in caring for the patients, as found, was the *requirement* under State law—as stated in the posted patient care hotline notice—that employees report to the State any condition that is unsafe for the patients. Admittedly, the heat “placed patients at risk” in the facility’s old section, which is not air conditioned.

Moreover, even if their attempt to conceal their participation in making the confidential call was wrong, this was not given as a reason for their sudden suspension after the Nursing Home confirmed that both of them participated in the hotline call, in which Reed informed the State of the unsafe condition of patients in the facility's old section.

(c) The complainants lost protection under the Act because their conduct was insubordinate and unlawful (without explanation or applicable precedent).

The Nursing Home contends in its brief (at 24–26) that

(d) Both complainants, “through their own testimony, concede that they lied to the State” (although Gunnensen merely dialed the number and said nothing to the State).

(e) Reed told the State hotline operator that there was “no water” at the Nursing Home.

This contention misstates Reed’s second reference to water in her July 5 written statement, that there is “no water *on unit* [emphasis added]”—not no water in the facility.

This was the second reference to water in Reed’s written statement. As found, this reference to “no water” referred to what Reed wrote earlier in her statement, that “we” could not have any “spring water,” referring to the bottled spring water locked during the afternoon that July 4th holiday in Nursing Director Sullivan’s office.

Even if the call—on the Nursing Home’s *company* phone—were considered to be from a relative of a resident, rather than from a staff member, the statement that “we could not have any spring water” would not be construed as no spring water for visiting relatives and residents. Furnishing spring water even to staff members was unprecedented.

The Nursing Home admits in its brief (at 11) that “the bottled water was provided only for the employees.”

(f) Reed’s representation to the State that there was no water “was undisputedly” a “fraudulent misrepresentation” (although, to the contrary, her report of no spring water for the staff was true).

(g) Reed admittedly lied to the hotline operator about being a family member of one of the residents (although this was not given as a reason for her suspension).

The Nursing Home contends in its brief (at 26–28)

(h) That Reed’s and Gunnensen’s telling management that they had no knowledge of the State hotline call on July 4 was a serious offense in the employee handbook, subjecting an employee to immediate discharge (although not only did the Nursing Home not discharge Reed immediately, but this was not given as a reason for suspending either Reed or Gunnensen).

(i) That complainants “deliberately violated legitimate and important workplace rules regarding honesty in an investigation and in doing so, undermined the employer’s authority” (although not given as a reason for their suspension).

(j) That complainants' deceit to the State was "clearly insubordination" (although Gunnensen merely dialed the hotline number and said nothing to the State; there is no explanation how Reed's report to the State was insubordinate or any applicable precedent; and this was not given as a reason for suspending Reed and Gunnensen).

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(k) That complainants' "blatant and intentional" violation of the rule against providing false information in an investigation undermines the Nursing Home's authority (although not given as a reason for their suspension).

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The Nursing Home contends (at 28-29) that

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(l) The company hotline was the proper channel for employees to follow for complaints about working conditions—not calling the State hotline (although, as found, employees are "required" by State law to report such unsafe conditions for patients—making this requirement an important part of the employees' working conditions in caring for the patients).

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(m) The complainants' failure to follow the facility's established departmental procedures was a specific offense in the employee handbook and "unnecessarily wasted the State's and the company' time and money" (although not given as a reason for their suspension).

The Nursing Home contends in its brief (29-31)

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(n) That the complainants' motivation for placing the State hotline call was disloyal (without explanation or any applicable precedent).

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(o) That "the weight of the evidence . . . establishes that the State hotline call was made to retaliate against the Company for failing to provide a picnic to the second shift staff" (completely ignoring all the evidence about the excessive heat).

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(p) That the "Complainants' argument that they were concerned about the effects of the heat on the patients' health is simply incredible" (ignoring Administrator Detor's admission at the trial that the temperatures in unit 2 "placed patients at risk").

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(q) The fact that the building "was not equipped with air conditioning throughout did not cause the facility to violate any code or regulation," because the 30-year old section of the building was "grandfathered in under the applicable code" (ignoring § 483.15(h)(6) of the State regulation that facilities certified before October 1, 1990 "must maintain safe and comfortable temperature levels").

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(r) That the State visited the site and investigated the complaint (on July 8, 4 days after the "extreme" heat on July 4), finding (on August 14, R. Exh. 7) "no violations of State or Federal regulations," and that the Board "owes deference to the findings of the New York Department of Health."

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The Board, however, clearly has the sole responsibility to determine if the Nursing Home unlawfully suspended Reed and Gunnensen and discharged Reed to discourage employees from making hotline calls to the State to report unsafe conditions for patients in the facility's old section, which is not air conditioned, in violation violated Section 8(a)(1) of the Act.

(s) That complainants' testimony that their motivation for making the hotline call was their legitimate concern for the safety of the residents, is "simply incredible," because the patients had plenty of water (although the evidence is clear that neither complainant claimed that the patients did not have plenty of water, and the evidence abundantly shows that they called the State because of the heat, which admittedly "placed patients at risk".

In addition to these 19 purported reasons for contending that the conduct of Reed and Gunnensen was not protected activity, the Nursing Home emphasizes in its brief (at 10-12, 25-26, 30-31) a contention that Reed's hotline call was not a protected activity because she *lied* to the State that several residents were sent to the hospital for or due to dehydration.

To the contrary, Reed *did not* lie to the State that several residents were sent to the hospital because of dehydration.

The evidence shows that Reed carefully avoided telling the State that residents were sent to the hospital with a diagnosis of dehydration. Both she and Gunnensen, as the Nursing Home points out in its brief (at 12), "admitted that they were not qualified to diagnose dehydration"—certified nursing assistant Reed testifying, "I'm not a medical nurse," and licensed practical nurse testifying, "I'm not a doctor, so I can't diagnose it" (Tr. 30, 72).

Instead, as Reed credibly testified, she told the State on the hotline call that "several residents were taken out because of the extreme heat." (Tr. 22-23, 268-269.)

This was a truthful report of what she was observing. Both she and Gunnensen credibly testified about the "extreme" heat on July 4 (Tr. 66, 268). Administrator Detor admitted at the trial that the temperatures that week in unit 2 where they worked "placed patients at risk"—referring to the mostly frail patients with many ailments that could be aggravated by the heat. Detor was on vacation that first week of July, but the evidence is undisputed that maintenance engineers (who did not testify) monitored the temperature.

As found, one patient (Adeeb Hussain) was sent to the hospital that Monday, July 1, and another patient (Ann Ruhland) was sent that Wednesday, July 3 (R. Exh. 13). On July 4 when Reed arrived at 2 p.m., two additional patients, Robert Magner and Pearl Peterson (R. Exh. 13), had been sent to the hospital. Reed observed, as found, that patients had a lack of appetite, were refusing to drink fluids, were slouched in their chairs, and for the first time were taking off their clothes, even in main corridors. "When asked to put their clothing back on, they told me it was too hot." (Tr. 13.)

When Nursing Director Sullivan on July 5 returned to Reed her written statement about what she told the State in her July 4 hotline call and instructed her to elaborate on it, stating "What about the residents that went to the hospital with dehydration? . . . Write that on there," Reed wrote "very hot and several residents were recently sent to hospital"—not stating that they were sent because they were dehydrated (Tr. 26; R. Exh. 12).

In Reed's pretrial affidavit (Tr. 34-35), she stated that "patients were sent out for dehydration"—not that she told the State that. She explained that she "perceived it as dehydration" because "I do know some of the signs and symptoms of it" and because "I feel I was trained in my CNA Pathways Class that I took on how to define dehydration."

The Nursing Home did not call as a witness Nursing Secretary Fields or any of the other staff member who was present in unit 2 on July 4.

## B. Concluding Findings

5 The complaint alleges that the Nursing Home violated Section 8(a)(1) by suspending and/or terminating Kathleen Reed and suspending Carol Gunnensen “to discourage employees” from “contacting the New York State Department of Health” concerning “employees’ working conditions.”

10 As found, an important part of the employees’ working conditions—in caring for the 40 elderly, mostly frail, patients in unit 2 of the Nursing Home’s 30-year-old section, which is not air conditioned—is the predominately displayed State notice. It informs the employees that they are “required” by State law, for protection of the patients, to report any unsafe condition (“patient physical abuse, mistreatment or neglect”) to the New York State Department of Health by calling the Patient Care Hotline at 888-201-4563.

15 Administrator Detor admitted at the trial that the heat in the old section of the facility created an unsafe condition for the patients, by testifying that the temperatures in unit 2 “placed patients at risk.”

20 As found, the Nursing Home suddenly suspended Reed and Gunnensen upon confirming how “super hot” it was on July 4, when Gunnensen dialed the hotline number and Reed reported in the call to the State the excessive heat in the facility’s old section, creating an unsafe condition for the patients, several of whom were recently sent to the hospital. At the time, the Nursing Home gave no other reason for suspending them.

25 The evidence clearly shows that the Nursing Home suspended Reed and Gunnensen to discourage employees in unit 2 from reporting any unsafe condition for patients in the facility’s old section, which is not air conditioned.

30 As found, in the meeting when Reed was called to Nursing Director Sullivan’s office on July 5 and told that two reliable sources said she had made the State hotline call on July 4, Sullivan stated: “Do you know the seriousness of these allegations? I can take your CNA certification and Carol Gunnensen’s license for doing this.” Undoubtedly, this statement was intended to discourage employees from making hotline calls to the State.

35 The Nursing Home’s reaction when it first heard on July 5 that “somebody had called the hotline” on July 4, clearly reveals its concern about employees making hotline calls to the State.

40 Assistant Administrator Fadeley immediately made an urgent call, by cell phone, to Administrator Detor, who was on vacation, fishing at a lake with his son. Detor asked Fadeley to involve Sullivan and for them “to investigate the accusations.” Because of the urgency, Fadeley immediately called Sullivan at her home and had her come in early to begin the investigation. When they confirmed that Gunnensen and Reed had made the hotline call, the two employees were suddenly suspended.

45 The officials obviously feared that employees using the State hotline to report the excessive heat in unit 2, in violation of the State regulation requiring “save and comfortable” temperature levels, could adversely affect the State license to operate the Nursing Home.

50 In view of these findings, I find that the many contentions made by the Nursing Home in its brief are mere afterthoughts. The contentions ignore the controlling issue whether the Nursing Home suspended and discharged Reed and suspending Gunnensen “to discourage employees” from making hotline calls to the State about any unsafe condition for patients.

I therefore find that the Nursing Home suspended Reed and Gunnensen and discharged Reed for engaging in protected, concerted activity, to discourage employees from making hotline calls to the State to report any unsafe condition for patients in the facility's old section, which is not air conditioned, violating Section 8(a)(1) of the Act.

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#### Conclusions of Law

By suspending CNA Reed and charge nurse Gunnensen and discharging Reed for engaging in protected, concerted activity, to discourage employees from making patient care hotline calls to the New York State Department of Health to report unsafe conditions for patients in its facility's old section, which is not air conditioned, Respondent Nursing Home violated Section 8(a)(1) and Section 2(6) and (7) of the Act.

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#### Remedy

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Having found that the Respondent has engaged in certain unfair labor practices, I find that it must be ordered to cease and desist and to take certain affirmative action designed to effectuate the policies of the Act.

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The Respondent having discriminatorily suspended two employees and discharged one of them, it must offer reinstatement to the discharged employee and make both of the suspended employees whole for any loss of earnings and other benefits, computed on a quarterly basis from date of discharge to date of proper offer of reinstatement, less any net interim earnings, as prescribed in *F. W. Woolworth Co.*, 90 NLRB 289 (1950), plus interest as computed in *New Horizons for the Retarded*, 283 NLRB 1173 (1987).

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On these findings of fact and conclusions of law and on the entire record, I issue the following recommended<sup>2</sup>

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#### ORDER

The Respondent, Orchard Park Health Care Center, Inc. d/b/a Waters Of Orchard Park, Orchard Park, New York, its officers, agents, successors, and assigns, shall

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#### 1. Cease and desist from

(a) Suspending, discharging, or otherwise discriminating against any employee to discourage employees from making any patient care hotline call to the New York State Department of Health to report an unsafe condition for patients.

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(b) In any like or related manner interfering with, restraining, or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act.

#### 2. Take the following affirmative action necessary to effectuate the policies of the Act.

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(a) Within 14 days from the date of this Order, offer Kathleen Reed full reinstatement to

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<sup>2</sup> If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

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her former job or, if that job no longer exists, to a substantially equivalent position, without prejudice to her seniority or any other rights or privileges previously enjoyed.

5 (b) Make Kathleen Reed and Carol Gunnensen whole for any loss of earnings and other benefits suffered as a result of the discrimination against them, in the manner set forth in the remedy section of the decision.

10 (c) Within 14 days from the date of this Order, remove from its files any reference to the unlawful suspension of Reed and Gunnensen and discharge of Reed, and within 3 days thereafter notify the employees in writing that this has been done and that the discrimination will not be used against them in any way.

15 (d) Preserve and, within 14 days of a request, or such additional time as the Regional Director may allow for good cause shown, provide at a reasonable place designated by the Board or its agents, all payroll records, social security payment records, timecards, personnel records and reports, and all other records, including an electronic copy of such records if stored in electronic form, necessary to analyze the amount of backpay due under the terms of this Order.

20 (e) Within 14 days after service by the Region, post at its facility in Orchard City, New York copies of the attached notice marked "Appendix."<sup>3</sup> Copies of the notice, on forms provided by the Regional Director for Region 3, after being signed by the Respondent's authorized representative, shall be posted by the Respondent immediately upon receipt and maintained for 25 60 consecutive days in conspicuous places including all places where notices to employees are customarily posted. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. In the event that, during the pendency of these proceedings, the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent 30 at any time since July 5, 2002.

(f) Within 21 days after service by the Region, file with the Regional Director a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

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Dated, Washington, D.C. February 13, 2003

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Marion C. Ladwig  
Administrative Law Judge

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<sup>3</sup> If this Order is enforced by a judgment of the United States court of appeals, the words in the notice reading "POSTED BY ORDER OF THE NATIONAL LABOR RELATIONS BOARD" shall read "POSTED PURSUANT TO A JUDGMENT OF THE UNITED STATES COURT OF APPEALS ENFORCING AN ORDER OF THE NATIONAL LABOR RELATIONS BOARD."

## APPENDIX

### NOTICE TO EMPLOYEES

Posted by Order of the  
National Labor Relations Board  
An Agency of the United States Government

The National Labor Relations Board has found that we violated Federal labor law and has ordered us to post and obey this notice.

#### FEDERAL LAW GIVES YOU THE RIGHT TO

- Form, join, or assist a union
- Choose representatives to bargain with us on your behalf
- Act together with other employees for your benefit and protection
- Choose not to engage in any of these protected activities

WE WILL NOT suspend, discharge, or otherwise discriminate against any of you to discourage employees from making any patient care hotline call to the New York State Department of Health to report an unsafe condition for patients.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights guaranteed you by Section 7 of the Act.

WE WILL, within 14 days from the date of the Board's Order, offer Kathleen Reed full reinstatement to her former job or, if that job no longer exists, to a substantially equivalent position, without prejudice to her seniority or any other rights or privileges previously enjoyed.

WE WILL make Kathleen Reed and Carol Gunnensen whole for any loss of earnings and other benefits resulting from their suspension, less any net interim earnings, plus interest.

WE WILL, within 14 days from the date of the Board's Order, remove from our files any reference to the unlawful suspension of Kathleen Reed and Carol Gunnensen and discharge of Kathleen Reed, and WE WILL, within 3 days thereafter, notify them in writing that this has been done and that the suspension of Reed and Gunnensen and discharge of Reed will not be used against them in any way.

ORCHARD PARK HEALTH CARE CENTER, INC.  
d/b/a WATERS OF ORCHARD PARK

\_\_\_\_\_  
(Employer)

Dated \_\_\_\_\_ By \_\_\_\_\_  
(Representative) (Title)

The National Labor Relations Board is an independent Federal agency created in 1935 to enforce the National Labor Relations Act. It conducts secret-ballot elections to determine whether employees want union representation and it investigates and remedies unfair labor practices by employers and unions. To find out more about your rights under the Act and how to file a charge or election petition, you may speak confidentially to any agent with the Board's Regional Office set forth below. You may also obtain information from the Board's website: [www.nlr.gov](http://www.nlr.gov).

111 West Huron Street, Federal Building, Room 901, Buffalo, NY 14202-2387

(716) 551-4931, Hours: 8:30 a.m. to 5 p.m.

**THIS IS AN OFFICIAL NOTICE AND MUST NOT BE DEFACED BY ANYONE**

THIS NOTICE MUST REMAIN POSTED FOR 60 CONSECUTIVE DAYS FROM THE DATE OF POSTING AND MUST NOT BE ALTERED, DEFACED, OR COVERED BY ANY OTHER MATERIAL. ANY QUESTIONS CONCERNING THIS NOTICE OR COMPLIANCE WITH ITS PROVISIONS MAY BE DIRECTED TO THE ABOVE REGIONAL OFFICE'S COMPLIANCE OFFICER, (716) 551-4946.