

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD  
Eighteenth Region

Walker Methodist Health Center<sup>1</sup>

Employer

And

American Federation of State County and Municipal  
Employees, Council 14, AFL-CIO

Petitioner

Case 18-RC-17157

**DECISION AND DIRECTION OF ELECTION**

Petitioner seeks a unit of the Employer's licensed practical nurses (LPNs). The Employer contends, however, that its LPNs are supervisors within the meaning of Section 2(11) of the Act. The Employer also refused to stipulate that Petitioner is a labor organization within the meaning of Section 2(5) of the Act. Finally, the Employer contends that there is a bar to processing this petition because an election has been held in the last twelve months. After reviewing the record, it is clear that Petitioner is a labor organization that exists for the purpose of dealing with employers concerning employee terms and conditions of employment, and it is also clear that the Board's election year bar rule is inapplicable in this case. Finally, I conclude that the Employer has failed to meet its burden of proving that its LPNs are supervisors.

Under Section 3(b) of the Act, I have the authority to hear and decide this matter on behalf of the National Labor Relations Board. Upon the entire record in this proceeding, I find:

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<sup>1</sup> The Employer's name appears as amended at the hearing.

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby 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 herein.<sup>2</sup>

3. The labor organization involved claims to represent certain employees of the Employer.

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. The first section of this decision will summarize the record regarding Petitioner's status as a labor organization, and explain my conclusion that Petitioner meets the test set out in Section 2(5) of the Act. The second section of this decision will summarize the Employer's contention that further processing of this petition should be barred, summarize the evidence in support of the contention, and explain my conclusion that the election year bar rule is inapplicable in this case. The third section of this decision will summarize the record evidence on the issue of the supervisory status of the LPNs. Finally, I will summarize Board law on supervisory status and explain my conclusion that the Employer has failed to establish that its LPNs are supervisors.

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<sup>2</sup> The Employer, Walker Methodist Health Care, Inc., is a Minnesota corporation engaged in the operation of a nursing home at its facility in Minneapolis, Minnesota. During the past 12 months, a representative period, the Employer derived gross revenues in excess of \$100,000, and the Employer purchased and received at its Minneapolis, Minnesota facility goods and services valued in excess of \$50,000 from sources within the State of Minnesota which sources in turn purchased and received those good and services directly from points outside the State of Minnesota.

### **Petitioner's Status as a Labor Organization**

Uncontroverted testimony by Petitioner's Executive Director Roger Siegal is that Petitioner represents 15,000 employees in the negotiation of contracts and processing of grievances with various employers. These employers include cities, counties, hospitals, nursing homes, correctional facilities and private non-profits. Petitioner has 53 local unions. Clearly Petitioner exists for statutory purposes, and therefore, it is a labor organization. See Roytype, Division of Litton, 199 NLRB 354 (1972).

The Employer appears to be contending that Petitioner would not actually represent the LPNs, but would instead establish a new local. However, the mere fact that Petitioner might establish a local to represent the LPNs, if and when it is certified, is insufficient to establish that Petitioner is not a labor organization. Rather, such an event would involve questions of whether the identity of the bargaining representative has changed. See for example, H.B. Design & Mfg., Inc., 299 NLRB 73 (1990).

### **The Election Year Bar Issue**

There is no dispute regarding the facts that leads the Employer to contend that this petition should be barred. In Case 18-RC-17146, a petition filed on April 22, 2003, Petitioner sought a unit of the Employer's service and maintenance employees and LPNs. During discussions that eventually led to a Stipulated Election Agreement, the Employer maintained that a hearing was necessary because of its belief that the LPNs are supervisors. Petitioner dropped the LPNs from the unit, largely in order to avoid protracted litigation regarding the LPNs status. Thereafter, the Employer and Petitioner agreed on the terms of an election in 18-RC-17146, in an essentially service and maintenance unit. The election was held on May 30, 2003 and a majority

of votes were cast for representation by Petitioner. Thereafter, the Employer filed timely objections to the election.

It appears to be the Employer's position that by dropping the LPNs from the unit in Case 18-RC-17146, Petitioner is somehow estopped from thereafter filing a separate petition seeking to represent the LPNs for some period of time undefined by the Employer. In making this claim, the Employer uses the rubric of "election year bar." That rule is set forth in Section 9(b)(3) of the Act, and prohibits the holding of an election in any bargaining unit or subdivision in which a valid election has been held during the preceding 12-month period. However, the Board has rejected the Employer's position, and I decline to dismiss the petition on the basis of the fact an election was conducted in a service and maintenance unit on May 30, 2003. S.S. Joachim & Anne Residence, 314 NLRB 1191 (1994). In view of this conclusion, I also decline to dismiss the instant petition, as requested by the Employer in a pre-hearing Motion to Dismiss Petition dated June 3, 2003.

### **The Status of the LPNs**

The principal issue in this case is whether or not the LPNs are supervisors within the meaning of Section 2(11) of the Act. In considering this issue, I will first summarize the record regarding the Employer's overall operation and facility. I will then describe the operation of the patient care services (nursing) department, including the job duties, which the Employer contends establish the supervisory status of the LPNs. Finally, I will summarize Board law concerning supervisory status, and apply the law to the facts established by the record in this case.

### ***The Employer's Overall Operation and Facility***

The Employer operates a nonsectarian nonprofit licensed long-term care facility. Its facility consists of seven floors with 11 nursing units in two wings (named Gamble and Rains, after specific benefactors). There is also an assisted living unit called Walker Court, which houses 24 residents. In total, the facility has a 488-bed capacity, and employs approximately 570 employees. It is the second largest long-term care facility in the State of Minnesota.

### ***Operation of the Patient Care Services Department***

The hierarchy of the Patient Care Services (PCS) department was described by Administrative Director of Nursing Tina Hedalen. Three Assistant Directors of Nursing (ADONs) report directly to Hedalen. They are Ellen Siebenaler, Debra Johnson and Merri Sunday. These ADONs are responsible for the operation of assigned units of the facility. For example, the only ADON who testified, Ellen Siebenaler, is responsible for 2 and 3 Rains, Walker Court and 7 Gamble (the numbers refer to floors of the wings). Reporting to the ADONs are a clinical coordinator and three triage LPNs. Others directly reporting to Hedalen include a Clinical Director of Nursing, and five complex supervisors, all of whom are RNs.<sup>3</sup> There is little record testimony regarding the job duties of the triage LPNs, although the DON testified in a conclusory fashion that triage nurses could discipline. The clinical coordinator attends care conferences and prepares paperwork. The complex supervisors are the persons of highest authority, and are in charge of the building when the DON or ADONs (who generally work Monday through Friday) are absent. For example, the only complex supervisor who testified (Phyllis Palbicki) works from 10 p.m. to 8 a.m., Monday through Thursday. Complex supervisors coordinate staffing, answer questions regarding medical issues, and assist with

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<sup>3</sup> The parties are in agreement that none of these employees were appropriate for inclusion in the unit.

personnel issues involving employees. During that time, there are about 30 employees in the PCS Department. The DON is, however, on call 24 hours a day, seven days a week.

Below the ADONs on the organizational chart are the following listed categories of employees in descending order: Charge nurses, TMAs (trained medication aide), NARs (nursing assistant registered), and MTFs (meal time friend). Although Hedalen testified that the term “charge nurse” is commonly in use at the facility, along with the term “team lead,” LPNs who testified stated that they are not in fact referred to as charge nurses, but sometimes are called team leaders and, more often, floor nurses or just nurses. Documentary evidence appears to support the testimony of the LPNs who testified. That is, the job description for LPNs does not refer to the LPN as a charge nurse at any point. In addition, the LPNs are not held out to the public as charge nurses; that is, their nametags do not refer to them with that title (or, for that matter, as “supervisor”). Employees in the category of floor nurses are RNs (approximately 35) and LPNs (approximately 68). RNs and LPNs perform the same functions, except to the extent the RN license permits the RN to administer more complex treatment or medication. There are approximately 191 employees who occupy the lowest three classifications, with approximately 180 of those being NARs. The NARs and TMAs are included in the unit of service and maintenance employees in Case 18-RC-17146, described earlier herein.

The Employer’s facility operates seven days a week, 24 hours a day. LPNs work one of three shifts, the day shift (7:00 a.m. to 3:15 p.m.), the evening shift (3:00 p.m. to 11:15 p.m.) and the night shift (11:00 p.m. to 7:15 a.m.) NARs begin and end their shifts either at the same times as LPNs, or else an hour prior to LPNs. There was evidence that on weekends, some employees work 12-hour shifts. There was also evidence that while some staff is regularly scheduled, others work part-time, and others work on an “on-call” basis.

A central staffing office handles staffing. Staffing levels are generated by a fairly complicated formula of factors related to the residents' needs and status. Nursing staff gathers data on the units who assess the residents, and then the RAI (Resident Assessment Instrument) Coordinator, who fills out a Minimum Data Set (MDS), analyzes the data. This MDS is submitted to the State, and then a Resident Utilization Grouping (RUG) is generated, which determines the level of staffing which must be maintained by the Employer at any given time.

In general, within each unit there is some combination of nurses and NARs/TMAs on duty at any given time, referred to as a "team." In evidence is an exhibit showing staffing levels of nurses compared to NARs for each unit and shift. Levels range from four nurses and four NARs assigned to one unit to one nurse and one NAR (or even no NAR) for other units. Most units have two or three nurses and four or five NARS assigned to them. During the night, a typical combination will be one LPN and one NAR. It is the Employer's position that the LPNs operate as supervisors of the NARs/TMAs in each unit. It is undisputed that all classifications of employees on the floor are working together to provide care for the residents.

### ***Functioning of LPNs and NARs on the Floor***

LPNs' primary duties are to do treatments, pass medications, do assessments, fill out paperwork associated with residents' care, and generally to manage the workflow of the unit. They also communicate with residents' families and with doctors. NARs assist residents with grooming, dressing and toileting; get them in and out of beds and wheelchairs; bathe them; assist with feeding; and perform other general duties related to their well-being. NARs' duties are given to them by way of an assignment sheet prepared by an ADON.

A "group" of approximately eight or nine residents is assigned to each NAR, and NARS tend to work with the same residents every day. If an NAR is absent, the staffing office will

send a floater NAR to the floor, and he or she will be slotted in with whichever resident group was left open by the absence. If no floater is available, the unassigned group of residents will be split up among the remaining NARS. LPNs testified that usually, NARs are able to decide how to divide the group of unassigned residents without involvement by the nurse on duty, however, occasionally, the nurse will get involved to resolve the matter. On the other hand, ADON Siebenaler testified that the LPNs always decide how to divide up unassigned residents and that in doing so; the LPNs exercise independent judgment because of the complexity of the resident needs. Siebenaler did not explain the basis for her testimony that LPNs always decide how to divide residents who are unassigned, as she does not appear to be on the floors at shift changes. I also note that the NARs' responsibilities are limited to assisting residents with daily cares – there is no evidence that NARs give residents medication, assess residents' medical conditions, or are otherwise involved in health care issues. In any event, if the nurse is unable to resolve the question of reassigning residents due to the absence of an NAR, she will call the ADON or complex supervisor to come up to the floor and decide the matter. LPNs do not have the authority to transfer NARs on or off the floor. If an NAR does not show up for a scheduled shift, LPNs are limited to calling and reporting this fact to the staffing office.

For the most part, nurses and NARs work cooperatively. They will assist one another in various ways, including with residents' treatments and transfers, answering call buttons and generally making sure the residents' cares are performed.

### ***Functions of LPNs Related to Supervisory Status Issue***

#### ***1. Introduction/Employer Philosophy***

Administrative DON Hedalen testified that she has implemented some changes to the management philosophy and style at Walker in her three years there. She stated that the whole

concept is to push down supervision activity to the lowest level possible, thereby empowering lower level employees to manage the nursing units more effectively. She testified that she wants the nurses to take the opportunity to correct unacceptable behaviors on the spot and set out expectations for future conduct in that moment, rather than waiting until they can involve someone above them in the chain of command. Hedalen stated that she communicated these new management principles to her ADONs, who in turn communicated them to the LPNs. She has also spoken to some of the LPNs about these principles. She stated that she has stressed to both ADONs and nurses that they are accountable for the work performance of those below them in the chain of command. She stated that, as a result, some of the NARs had come to her to complain that the nurses don't have any right to be busybodies and tell them what to do, to which she has responded that indeed they do have that right and it is her expectation that they will be doing that.

Hedalen acknowledged that some LPNs are uncomfortable confronting NARs for fear of retribution or creating ill will among the team members. According to Hedalen, despite her guidance, these LPNs resist employing any type of disciplinary measures toward NARs such as a verbal or written warning or telling an employee to clock out and go home, which authority she claims LPNs have. As a result, the ADONs, complex supervisors, and even Hedalen herself get called in to some of the more difficult situations to manage conflicts between NARs that the LPNs are unable or unwilling to handle. Hedalen described a meeting that she called with three NARs who were resistant to having their assignments changed in any way by nurses. She testified that she spent over an hour with them to clarify what the expectations for their behavior at work were. She stated that she told them that any nurse on their unit should be considered their supervisor and had the authority to give them direction as well as discipline.

Hedalen stated that when she interviews individuals for LPN jobs, she goes over the LPN job description with them. This includes telling them that the job is a supervisory position and that they will be expected to provide direction to those below them.

*2. Indicia of Supervisory Status Listed in Section 2(11) Not Performed by LPNs*

As to the supervisory indicia listed in Section 2(11) of the Act, testimony of the LPNs established that they do not have the authority to hire, fire, lay off, recall, reward, grant time off,<sup>4</sup> transfer, assign overtime, or adjust grievances for NARs, or effectively recommend those actions.<sup>5</sup> Except for some general conclusionary disclaimers, Employer witnesses failed to refute this testimony, or agreed with it. For example, at the hearing Employer counsel suggested that LPNs recommend employees for hire because they can refer people for hire. However, Employer witnesses also acknowledged that NARs can refer individuals for hire, and that these referrals—whether by LPNs or NARs—are taken into consideration by the hiring official. Similarly, LPNs may recommend that a particular NAR be promoted to positions called “NAR Lead” (which pays 50 cents more per hour) or “NAR mentor” (which pays 75 cents more per hour), but the final decision on such promotions belongs to Hedalen. While she testified that she takes LPN recommendations into consideration, she offered no specifics. LPNs appear to have no opportunity to substitute for such management officials as ADONs or complex supervisors.

When NARs request to leave early, invariably, the LPNs will call the ADON or complex supervisor on duty, or have the NAR call her, to discuss whether that will be allowed. The

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<sup>4</sup> Documents were introduced showing that LPNs had signed off on time sheets for NARs who had forgotten to punch in, forgotten to bring their badge, etc., to show that they had been present and should be paid for the time indicated. The LPNs explained that they sign these forms as a witness to verify that the NAR was present during that time. LPN Melissa Martin testified, however, that she was told by complex supervisor Joan Wosley that she was not supposed to be signing time sheets, that it was only to be done by a supervisor.

<sup>5</sup> Hedalen testified that LPN Carolyn Tollefson recommended that NAR Tory Stone be terminated, and he was terminated. She did not testify that every recommendation of an LPN for termination of an NAR is necessarily followed, however.

staffing level is then reviewed, and the ADON or complex supervisor will decide whether the NAR's request can be granted or not. LPNs testified that they do not have authority on their own to allow NARs to leave early. ADON Siebenaler testified that LPNs do have such authority, however, she admitted that they do come and check with her to make sure it is acceptable.

LPNs do appear to play a role in the evaluations of NARs, TMAs and MTFs; however, their involvement in this process falls short of recommending that any raise be given or denied, or that adverse action result. It appears that, in the usual course of events, an acceptable evaluation results in an automatic raise in an amount that is pre-set on the Employer's wage scale. While DON Hedalen further testified that a poor evaluation may result in a delay in a raise while the individual is given an opportunity to improve, Hedalen failed to give any examples where this has occurred, and failed to explain what other factors are considered. I note, for example, that while the floor nurses initially fill out parts of the evaluations, they then turn them over to the ADONs, who must also sign off on them. There is also no evidence that an LPN (or RN, for that matter) has ever recommended that a raise be denied, and all of the LPNs testified that they have no idea what actions the Employer takes or doesn't take as a result of the evaluations. The Employer also presented evidence that LPNs fill out evaluations for probationary NARs and suggested that a poor evaluation of a probationary NAR might lead to termination. However, as testified to by one LPN, one of the evaluations she filled out on a probationary NAR (who continued to work beyond his probationary period) was completed months after the NAR's probationary period had expired. More importantly, ADON Siebenaler testified that not even she could discharge an employee—that all discharge decisions are ultimately made by the HR Department. No one from that department testified, so the impact of poor evaluations completed by LPNs on the job status of NARs is unknown. Finally, no

examples were given of instances where an LPN's evaluation of an NAR resulted in discipline or termination.

### *3. Indicia of Supervisory Status Listed in Section 2(11) That Are In Dispute*

There are three areas relating to LPNs' authority that are in dispute and that are enumerated in Section 2(11) of the Act. They are assignment of work, direction of work, and discipline of employees. Not coincidentally, these are also the only 2(11) indicia enumerated in the LPNs' job description. Item 8 of the job description states that LPNs are to manage/supervise NARs by providing mini in-service education as necessary, performing competency checks and appraisals (discussed above), and coaching, counseling and disciplining NARs consistent with the Employer's progressive discipline policy. Thus, I will analyze in detail the record evidence in each of these three areas:

**Assignment of work.** As noted, each NAR is assigned a specific group of residents to care for on each shift. The LPN on the shift before will receive a call from the staffing office telling him or her who will be working the next shift, and then the LPN will write their names down opposite the group to which each NAR will be assigned. If all the NARs coming on duty are regulars and they don't do group rotation, those groups are "pretty much permanently assigned," according to Hedalen. Changes to these group assignments are frequently made before the shift begins, and also during the shift. Break times are also preassigned by the ADON on some units. On other units, it appears that employees work together to decide break times.<sup>6</sup>

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<sup>6</sup> LPN Joan Kennedy testified that about six months earlier, a dispute arose in her unit where employees could not come to an agreement about when breaks should be taken. Kennedy attempted to resolve it, but was unable to. She called ADON Siebenaler, who came up, held a meeting with the affected employees, and rearranged the scheduled time for breaks.

NARs' duties are preassigned by the ADON for their unit. She includes on assignment sheets whatever cares NARs need to provide to specific residents during their shift, such as whether they will need feeding assistance, what type of lift they will need to transfer them from bed to wheelchair, for example, whether they have dentures, need a shower, etc. Ostensibly this information is drawn from a care plan that is created for each resident by a team that may include doctors, nurses, family members, and the resident, if he or she is able to participate. Everyone who works with the resident can review that care plan, however, only medical professionals are able to change it. It does not appear that LPNs have any involvement in the creation, change, or review of the NAR assignment sheets. In fact, LPN Tracy Plante testified that she changed a care plan on one occasion, and was told to never do it again.

There is also something called a "24-hour report board," which is a sheet that all three shifts of employees use that lists any changes to residents' conditions, transfers, deaths, discharges, etc. Nurses enter information on this board on a daily basis.

To the extent that LPNs need to "assign" work to NARs beyond what appears on the NARs assignment sheets, it would be to perform additional duties such as doing a "linen sweep" (collecting dirty linens from residents' rooms), or returning a piece of equipment to the central supply room. While the Employer's witnesses maintained that these assignments require independent judgment, most of the LPNs who testified emphasized that they made "requests" that NARs complete these jobs, much the same way an LPN would ask an NAR to do something he or she may have overlooked.

**Direction of Work.** DON Hedalen testified that part of what LPNs are responsible for is to perform "competency checks" meaning that they look at the rooms and the residents to assess if things are generally in good order. This would include looking at whether the bed is made,

things are put away, and whether the residents are clean shaven, teeth brushed, face clean, etc. Hedalen's expectation is that if the LPN notices something out of order, she will direct the responsible NAR back into that room to establish order. LPNs who testified generally agreed that part of their role is to assess the state of affairs in each resident's room with an eye toward whether each resident is well cared for. In part, they considered this to be part of the requirements of their license. Hedalen also expects LPNs to make sure that NARs complete and turn in their paperwork, although she did not specify what this entails.

It appears that NARs are trained to perform the cares that each resident requires<sup>7</sup> and that if they have any questions or need some instruction beyond what they have already learned, LPNs are available for that purpose, as are other NARs, plus NAR leads and NAR mentors.<sup>8</sup> It also appears that, in addition to answering questions, LPNs can and have instructed NARs to perform tasks on the assignment sheet that the NAR has failed to complete or has not completed in an acceptable fashion. Some LPNs who testified denied ever directing an NAR and, instead, stated they "asked" the NAR to perform a task because they view the NARs and themselves as a "team." However, other LPNs who testified acknowledged that they would tell an NAR to complete a task on the assignment sheet that had not been done.

**Authority to Discipline.** This subject generated the most conflict in testimony. DON Hedalen and ADON Siebenaler testified that LPNs have the authority to issue discipline to NARs and have, in fact, done so. They also testified that LPNs make recommendations regarding discipline, and that their recommendations are followed. Much of DON Hedalen's testimony was conclusionary, presumably in part because she emphasized that she does not deal directly

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<sup>7</sup> Any formal training is not provided by LPNs or RNs.

<sup>8</sup> There was some testimony that whenever more than one NAR is on duty on a unit, there is always an NAR lead or mentor on that care team.

with the LPNs or NARs, but relies on her ADONs to do so. On the other hand, of the numerous LPNs who testified, only one felt that she had the authority to discipline employees.

All witnesses for both the Employer and Petitioner agreed that one option available for LPNs when NARs fail to perform their jobs is to file an unusual incident report. In fact, virtually all of the LPNs who testified indicated that filling out and submitting an unusual incident report is the only way they would deal with problems with NARs. In the record are a number of unusual incident reports filled out by LPNs dealing with issues such as NARs avoiding picking up meal trays, not providing cares for a resident, and not completing a treatment. However, LPNs also testified without contradiction that anyone (family member of a resident, NAR, housekeeping employee) can fill out an unusual incident report; that some are filed where no employee malfeasance is involved; that they have no idea whether the reports result in discipline; and that no one from management gets back to them with regard to what happens as a result of the filing of these reports. A review of the unusual occurrence reports offered as exhibits also reveals that none recommend discipline.

With regard to the unusual incident reports, the testimony of Complex Supervisor Phyllis Palbicki suggests that, in her view, these reports are the method for LPNs to initiate discipline. She testified that part of the LPNs' job is to initiate the disciplinary process by writing an unusual occurrence report. In doing so, Palbicki testified it is imperative that the LPN describes the facts as she sees them and "not to put her own thoughts, just report what she saw." According to Palbicki, if the report suggests that there was an impact on a resident's well-being, she would then start an investigation.

In the record are written warnings or verbal written warnings that the Employer argues were either written by LPNs or the result of recommendations by LPNs. However, one of the

written warnings was issued by RN Stephen Weber on November 15, 2001—and not by an LPN. I recognize that the Employer claims that RNs and LPNs have the same authority. However, Employer witnesses also testified that RNs are above LPNs in its reporting hierarchy. Of the remaining warnings, almost all are signed by ADON Ellen Siebenaler or, in one case, by ADON Johnson. The warnings indicate that the NARs involved failed to follow directions of nurses or failed to perform their duties. For example, with regard to a January 23, 2003 written warning by Siebenaler, Siebenaler’s notes of her investigation are in the record, as well as an unusual occurrence report filed by LPN Carolyn Tollefson. Similarly, Johnson’s investigative notes of an NAR’s failure to perform assigned job duties are included with a written warning signed by Johnson on December 11, 2002. There is also a warning dated May 16, 2003, signed by both the LPN involved and Siebenaler. The warning itself makes clear that both Siebenaler and the LPN were involved in determining whether an NAR failed to toilet a resident, and, in fact, both assisted the resident when they figured out the NAR had not done so.

Two incidents involving an NAR in August 2002 warrant closer examination. In the first, on August 15, 2002, LPN Carolyn Tollefson wrote a verbal warning documentation criticizing an NAR for failing to shave a resident. However, Tollefson testified that before she wrote the warning, she went to Robyn Green (who also signed the warning in the blank for “manager signature”), who told Tollefson to write up the NAR (the record does not reflect Green’s position). Then, on August 21, 2002, Tollefson wrote up an unusual occurrence report on the same NAR for mistreating a resident. Among the statements in the report is that Tollefson told the NAR, “[Name of NAR] you know what are (sic) protocol is for toileting residents and if you have a problem with protocol you need to speak to Ellen our boss.” The report also states that Tollefson went to Siebenaler’s office seeking help, but that Siebenaler was not in her office.

There is also a great deal of testimony regarding a written warning issued by ADON Ellen Siebenaler on November 18, 2002. It criticizes an NAR for being argumentative with supervisors regarding staffing. DON Hedalen testified that she became involved in this matter because certain NARs questioned whether they had to follow the directions of nurses. At a meeting the DON told the NARs that often when licensed staff direct NARs to do something, it is “not open for dialogue but is something that needs to be done.” The DON’s notes also indicate, however, that the NARs suggested, “nurses need to address the issue they see at the time they see it and not always let it go to ADON. They [NARs] wish to be given the opportunity to correct before disciplinary action.” With regard to the incident that led to the discipline by DON Siebenaler, it appears that an LPN told an NAR that the NAR had to float to another unit, as a result of a call from staffing. Instead of floating, the NAR called staffing to argue, and all of the “staffing” on the floor spent time in a lengthy discussion, which Siebenaler viewed as inappropriate.

In addition to the above, DON Hedalen described an incident involving LPN Carolyn Tollefson to illustrate that LPNs have the authority to send NARs home. Tollefson called Hedalen to report that NAR Linda Kretzmann was crying and unable to perform her duties. Tollefson said she didn’t want Kretzmann up there any longer, and wanted Hedalen to come up right away and deal with it. Hedalen testified that she told Tollefson that if she felt Kretzmann couldn’t do the job and needed to go, she needed to send her off the unit, which apparently Tollefson did.

Finally, in the record is one verbal warning documentation dated May 9, 2003, signed by LPN Tollefson and ADON Siebenaler about an NAR failing to report to the nursing desk after the LPN asked two NARs involved in an argument to report to the desk. One NAR did go to the

desk, the other did not. Tollefson wrote up the one who did not without talking to Siebenaler before doing so. The warning does say that continued behavior of the sort covered by the warning could lead to termination.

One of the LPNs who testified, Anne Singh, suggested that she has verbally warned NARs. More specifically, Singh testified that she has given a couple of verbal warnings to NARs without first consulting with higher management. These had to do with correcting NARs in the use of equipment, and in completing assigned tasks before going home. On both occasions, Singh stated that she told the NARs that she would have to write them up the next time they did it incorrectly. There was no evidence that Singh did anything more than speak to the NARs, such as document the warnings for their personnel files. Another time, Singh noticed that an NAR was gone off the floor when he should have been working. She notified the clinical coordinator who met with the NAR and gave him a verbal warning. She has also reported to the clinical coordinator when NARs have not complied with her instruction to wear their transfer belts. She stated that she has never issued written discipline to anyone.

Singh further testified that she and the other nurse with whom she is working tell the NARs to be sure to let them know when they are going on break, and not to take breaks between noon and 12:30, because lunch trays are passed out to residents at that time. She also reminds NARs to sign in and out when taking breaks. She stated that normally the NARs with whom she works comply with what she asks them to do.

Not in the record is discipline involving the following incident. ADON Siebenaler testified that LPN Dorothy Russell was dealing with a situation where NARs in her unit were arguing, and she couldn't get them to stop. Siebenaler was paged, and she called the complex supervisor (stipulated by the parties to be a 2(11) supervisor) to go up to the unit and check it

out. She heard later that Russell and the complex supervisor asked both NARs to “swipe their badges” (punch out) and go home. The NARs were given verbal warnings, one by Russell and the other by the complex supervisor.

### **Board Law and Application of the Law to the Facts of this Case**

The party alleging that an individual is a supervisor has the burden of proof. NLRB v. Kentucky River Community Care, 532 U.S. 706 (2001). In order to prove supervisory status, the party alleging it must prove that the individual “possess(es) one or more of the indicia set forth in Section 2(11) of the Act and exercise(s) that authority in a manner which is not merely routine or clerical in nature.” Williamette Industries, Inc., 336 NLRB No. 59, slip op., p. 1. Any lack of evidence in the record is construed against the party asserting supervisory status. Elmhurst Extended Care Facilities, 329 NLRB 535, 536 fn. 8 (1999). Only individuals with “genuine management prerogatives” should be construed supervisors, as opposed to “straw bosses, leadmen . . . and other minor supervisory employees.” Chicago Metallic Corp., 273 NLRB 1677, 1688 (1985), enfd. in relevant part 794 F.2d 527 (9<sup>th</sup> Cir. 1986). Thus, an individual who exercises some “supervisory authority” only in routine, clerical or perfunctory manner will not be found to be a supervisor. Bowne of Houston, Inc., 280 NLRB 1222, 1223 (1986). “The Board must judge whether the record proves that an alleged supervisor’s role was other than routine communication of instructions between management and employees without the exercise of any significant discretion.” Quadrex Environmental Co., 308 NLRB 101, 102 (1992). See also Azusa Ranch Market, 321 NLRB 811 (1996).

Based on the record, I conclude that the Employer has failed to meet its burden of demonstrating that LPNs are supervisors within the meaning of Section 2(11) of the Act. In

reaching this conclusion, I note that the Employer does not contend, and the record does not establish, that LPNs have the authority to hire, lay off, recall, discharge, reward, grant time off, transfer, assign overtime, or adjust the grievances of employees. While the Employer contends otherwise, I also conclude that there is no evidence to establish that LPNs effectively recommend hiring. The Employer's evidence only establishes that LPNs refer individuals for employment. The LPNs are not involved in reviewing applications or in interviewing applicants. Moreover, the Employer's witnesses acknowledged that NARs (who it does not contend are supervisors) also refer individuals for employment. Moreover, whatever weight the Employer gives to referrals by LPNs, it also gives to referrals by NARs. While the Employer contends otherwise, there is also no evidence that LPNs effectively recommend the discharge of employees. Other than conclusionary testimony, there is no evidence that an LPN has recommended discharge and that that recommendation has been followed without further investigation. In fact, even ADON Siebenaler stated that she has no authority to discharge employees, and that all discharge decisions are made by the HR Department. Yet, no one employed in that department testified to explain what is and is not considered when deciding to discharge an employee. I also note that the LPN job description does not suggest that they are involved in hiring or firing NARs.

While there is documentary evidence that the Employer refers to LPNs as supervisors (for example, if they sign warnings, they do so on the line designated "supervisor") or references that part of the LPNs' jobs are to manage/supervise NARs (for example, the LPN job description), an individual is not found to be a supervisor merely because an employer holds out that individual as a supervisor. Polynesian Hospitality Tours, 297 NLRB 228 (1989). Such a conclusion is particularly appropriate in this case, where the LPNs are not held out to the Employer's customers as charge nurses or supervisors. Thus, pointing to a job description that

confers supervisory status is not enough if the individual does not exercise 2(11) authority.

Beverly Health & Rehabilitation Services, 335 NLRB No. 54, slip.op. at 36, and cases cited therein. Moreover, the fact that some (but not most) of the LPNs have signed warnings on the line designated for supervisor is not enough to establish 2(11) authority. Necedah Screw Machine Products, 323 NLRB 574, 577 (1997).

There is also no dispute that LPNs evaluate NARs, and there are numerous evaluations in the record that were partially completed by LPNs. It is also clear, however, according to DON Hedalen, that the evaluations do not affect raises. While Hedalen asserted that an unsatisfactory evaluation might result in a wage increase being delayed, there is no evidence that such an event has ever occurred. Also important is the fact that ADONs also review and fill out parts of the evaluations. Thus, the Employer failed to adequately explain the precise role the LPN evaluations play when the evaluation is unsatisfactory. I conclude, therefore, that the evidence is insufficient to establish that the evaluations completed by LPNs lead either to rewards or adverse action against NARs, and therefore, the fact that LPNs fill them out does not establish that the LPNs are supervisors. Williamette Industries, supra; Elmhurst Extended Care Facilities, 329 NLRB 535 (1999).

Of course, the key issues in this case are whether LPNs assign, responsibly direct, or discipline NARs in a way that suggests supervisory status. I conclude that the record does not support such a conclusion for the following reasons:

**Assignment of Work.** The staffing office schedules employees' hours of work and work locations, transfers employees among units, and determines whether and how to fill in for absent NARs. The schedule prepared by the staffing office even sets forth scheduled breaktimes for NARs. Assignment sheets and care plans dictate which NARs care for which residents, and

specify each resident's daily care needs. There is no evidence that LPNs schedule hours, assign breaktimes, determine which NARs work with which residents, or can deviate from established resident care protocols as set forth in doctors' orders, care plans, and daily assignment sheets. In fact, one LPN testified that she was directed not to alter a resident's care plan on her own, after making the mistake of doing so once. It appears that NAR breaktimes might be altered due to resident care needs, but neither the frequency nor independent judgment required to alter breaktimes is clear from the record. The only point of disagreement between Employer witnesses and Petitioner witnesses is the complexity involved when resident care duties have to be split among NARs in the absence of an NAR. I would emphasize, however, that the record fails to reveal how often units work short. It is clear, for example, that if the staffing office replaces the absent NAR with a floater, someone from another unit, or a temporary employee, that person is automatically assigned to the residents of the absent NAR. Moreover, virtually all of the LPNs who testified emphasized that the NARs work out these reassignments among themselves. I would also emphasize that in the event of a dispute involving these types of reassignments, the record makes clear that managers above the LPNs step in and assist in resolving disagreements. Therefore, I decline to find that the LPNs are supervisors because they adjust breaktimes or may be involved in deciding which residents are assigned to NARs in the event an NAR is absent and no replacement is provided for the absent NAR. Clark Machine Corp., 308 NLRB 555 (1992) (evidence fails to establish that assignments of work require independent judgment and are not routine); Anamag, 284 NLRB 621 (1987) (where assignments are determined by team as a group and no evidence team leaders exercise independent judgment when they move employees from one machine to another, team leaders are not supervisors).

**Direction of Work.** There is no question that LPNs are expected to direct and monitor the care provided by the NARs. It appears that some LPNs take the approach that they “ask” NARs to perform certain functions and immediately call their supervisor if the NARs refuse. It also appears that other (albeit fewer of those who testified) LPNs correct NARs in the performance of their tasks, and verbally admonish NARs when they fail to perform their jobs adequately. However, I am satisfied that the Employer has established that they expect the LPNs to monitor the performance of the NARs, to direct NARs who fail to perform their duties, and to take the first step of correcting NARs when they don’t perform their jobs properly.

However, unlike the Employer, I do not believe that these conclusions are sufficient to establish supervisory status. Rather, the key issue is whether the exercise of this authority is routine or clerical in nature, or whether it requires the use of independent judgment, and the degree of discretion used. NLRB v. Kentucky River Community Care, Inc., supra, at 713. In determining whether judgment is either “routine and clerical” or “independent” the Supreme Court approved the view that judgment is routine where an individual’s decision-making is limited and constrained by the directions of higher officials who have not delegated the power to make independent judgments. *Id.* at 714, citing Chevron Shipping Co., 317 NLRB 379, 381 (1995). In Chevron Shipping the Board concluded that the judgment of the employees in dispute was circumscribed by standing orders and operating regulations. In this matter, it is clear that the discretion of LPNs is circumscribed by doctors’ orders, by decisions made in the staffing office, by assignment sheets and by care plans. I find particularly relevant an Employer exhibit of minutes of a meeting between the DON and three NARs on November 18, 2002. The Employer offered the exhibit because it argues that it shows that NARs are expected to follow the directions of LPNs (the incident concerned a refusal by an NAR to transfer to a different unit as

told to do by an LPN). However, I believe that the minutes demonstrate the lack of discretion of the LPN involved, when DON Hedalen tells the NARs:

It was described about a situation that occurred where one person was being pulled to another unit ... The nurse did not give an explanation and nar (NAR) then called staffing ... First, staff needs to float when asked, it is part of the hire agreement. Second, staff are pulled based on productive nursing hours, census and emergent needs in the house. Staffer *and even charge nurse may not know rationale...*(emphasis added)

What this suggests of course, is the LPN was passing on a direction by the staffing office, and can hardly be said to be exercising discretion when she may not even know the rationale behind the decision to transfer. The same minutes also emphasize the need of the NARs to follow “job descriptions, facility policy, and unit routines,” as well as licensed direction. Thus, I would emphasize that the record contains little evidence that in directing, monitoring or correcting NARs, that LPNs exercise discretion. Beverly Health & Rehabilitation Services, supra, at 1, fn. 3 (LPNs not supervisors where their direction of employees is routine); Dynamic Science, 334 NLRB 391 (2001) (test leaders’ role in directing employees “extremely limited and circumscribed by detailed orders and regulations issued by the employer and other standard operating procedures,” and therefore, the degree of independent judgment exercised by test leaders “fell below the threshold required to establish statutory supervisory authority”).

**Authority to Discipline.** There is very little documentation that supports conclusionary testimony by DON Hedalen and ADON Siebenaler that LPNs have the authority to issue verbal and written warnings. Except for one documented verbal warning issued by an LPN in May, 2003, all other warnings entered as exhibits in the record reflect involvement by management above the LPN level. For example, any disciplines issued as a result of unusual occurrence reports were issued by the ADONs, and the unusual occurrence reports merely reported what

occurred with no recommendation for discipline. Other disciplines in the record are indeed signed by LPNs, but issued only after the LPNs checked with their ADONS, who either then told the LPN to write the discipline, or assisted the LPN in investigating NAR conduct. There is not one example in the record where an LPN either sent an employee home or issued a written warning without contacting either her complex supervisor or ADON for assistance. The Board has consistently held that in order to establish supervisory status, an employer must demonstrate that an individual's participation in the disciplinary process leads to a personnel action without an independent review or investigation by other management personnel. Franklin Home Health Agency, 337 NLRB No. 132, slip. op. at p. 3 (2002); Williamette Industries, supra at p. 2; Beverly Health & Rehabilitation Services, Inc., supra at p. 35; Waverly-Cedar Falls Health Care, 297 NLRB 390, 392 (1989), enfd. 933 F.2d 626 (8<sup>th</sup> Cir. 1991);

I find particularly compelling the testimony of Complex Supervisor Phyliss Palbicki and LPN Anne Singh. Palbicki testified that LPNs are to initiate the disciplinary process by writing unusual occurrence reports, and in doing so are to report only what they have seen, and not express their opinions. After reviewing the unusual occurrence reports in the record, that appears to be precisely what has occurred. LPN Anne Singh is the only LPN who testified that she could warn NARs without going to her ADON. While Singh testified that she has admonished NARs and threatened to write them up, on the one occasion when Singh could not find an NAR when and where the NAR should have been working, Singh notified the clinical coordinator. It was the clinical coordinator, and not Singh, who gave the NAR a documented verbal warning.

There is also insufficient evidence that to the extent LPNs issue warnings, that the warnings affect job status or tenure. I recognize that the Employer's employee handbook has a progressive discipline system in it. However, with regard to two incidents in August, 2002

involving LPN Carolyn Tollefson and the same NAR, it does not appear that the progressive discipline system was followed. On August 15, Tollefson signed a verbal documented warning that she stated issued at the suggestion of Robyn Greene. Then, on August 21, 2002, Tollefson wrote an unusual occurrence report because she witnessed the same NAR involved in inappropriate conduct with a resident. Yet the record does not reflect that the NAR was disciplined as a result of the August 21 unusual occurrence report. Thus, the Employer failed to make clear whether the warnings allegedly issued by LPNs are part of its progressive disciplinary policy set out in the employee handbook, and what little record evidence exists on this subject, suggests the LPNs' input is not part of that progressive discipline policy. The Board has held that where discipline issued by an individual does not affect job status or tenure, or is not part of a progressive discipline policy that could ultimately result in termination, supervisory status is not established. Ohio Masonic Home, 295 NLRB 390 (1989), and cases cited therein.

For all the reasons set forth above, I conclude that the Employer has not met its burden of establishing the supervisory status of the LPNs, and I find that they are not supervisors as that term is defined in Section 2(11) of the Act.

6. The following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

All full-time and regular part-time licensed practical nurses employed by the Employer at its Minneapolis, Minnesota facility; excluding registered nurses, clinical coordinators, guards and supervisors as defined in the Act, and all other employees.

## DIRECTION OF ELECTION<sup>9</sup>

An election by secret ballot will be conducted by the undersigned among the employees in the unit found appropriate at the time and place set forth in the Notice of Election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those in the unit who were employed during the payroll period ending immediately preceding the date below, including employees who did not work during that period because they were ill, on vacation or temporarily laid off. Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike which commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are persons who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike

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<sup>9</sup> Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 - 14th Street, N.W., Washington, D.C. 20570. This request must be received by the Board in Washington by **July 14, 2003**.

which commenced more than 12 months before the election date and who have been permanently replaced.<sup>10</sup>

Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by **American Federation of State County and Municipal Employees, Council 14, AFL-CIO.**

Signed at Minneapolis, Minnesota, this 30th day of June, 2003.

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Ronald M. Sharp, Regional Director  
Eighteenth Region  
National Labor Relations Board  
Suite 790, 330 Second Avenue South  
Minneapolis, MN 55401-2221

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177-8520-4700  
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177-8580-8050  
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<sup>10</sup> To ensure that all eligible voters have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses that may be used to communicate with them. Excelsior Underwear Inc., 156 NLRB 1236 (1966); NLRB v. Wyman-Gordon Co., 394 U.S. 759 (1969). Accordingly, it is directed that two copies of an election eligibility list containing the full names and addresses of all the eligible voters must be filed by the Employer with the Regional Director within seven (7) days of the date of this Decision and Direction of Election. North Macon Health Care Facility, 315 NLRB 359 (1994). The Regional Director shall make the list available to all parties to the election. In order to be timely filed, this list must be received in the Minneapolis Regional Office, Suite 790, 330 Second Avenue South, Minneapolis, MN 55401-2221, on or before close of business (4:30 p.m.) **July 7, 2003**. No extension of time to file this list may be granted by the Regional Director except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the filing of such list. Failure to comply with this requirement shall be grounds for setting aside the election whenever proper objections are filed.