

Orchard Park Health Care Center, Inc. d/b/a Waters of Orchard Park and Carol A. Gunnersen. Case 3-CA-23704

April 30, 2004

DECISION AND ORDER

BY CHAIRMAN BATTISTA AND MEMBERS LIEBMAN, SCHAUMBER, WALSH, AND MEISBURG

The issue presented in this case is whether two nursing home employees were engaged in protected concerted activity under the National Labor Relations Act (the Act) when they called the New York State Department of Health Patient Care Hotline to report excessive heat in the Respondent's nursing home. The administrative law judge found that the employees were so engaged and, thus, that the Respondent, Waters of Orchard Park, violated Section 8(a)(1) of the Act when it suspended and discharged one of the employees and suspended the second.¹ We agree with the judge that the employees were engaged in concerted activity. However, contrary to the judge and for the reasons discussed below, we find that the employees' activity was not protected under the Act because it did not relate to a term or condition of their employment. Accordingly, we shall dismiss the complaint.

I. THE FACTS

The Respondent operates a nursing home in the Buffalo, New York area. It was very hot at the end of June 2002² and even hotter during the first week of July. The older portions of the nursing home did not have central air-conditioning. To deal with the heat, the Respondent began furnishing bottled spring water for the staff, and, on July 1, the Respondent installed two freestanding air-conditioners in the unit of the nursing home involved in this case.

On July 1 and 3, two patients were sent to the hospital. Both showed symptoms of dehydration. When Kathleen

Reed, a certified nursing assistant (CNA), arrived at work at 2 p.m. on July 4, two more patients had been sent to the hospital. Reed observed that the patients were refusing to eat and drink, were unresponsive, and were taking off their clothes. When Carol Gunnersen, a licensed practical nurse acting as charge nurse, arrived at 3:30 p.m., she noticed that patients were lethargic and were taking their clothes off. There was no bottled water available for the staff on that day, since it was locked in Nursing Director Tracey Sullivan's office during her holiday absence.

Reed went on break around 4:30 p.m. with Gunnersen and Cynthia Fields, the nursing supervisor. Reed was not feeling well and asked if she could go home. Fields told Reed that Sullivan had said that no one could leave. Later that afternoon, Gunnersen dialed the phone number for the New York State Department of Health Patient Care Hotline and tossed the phone to Reed. Reed stated that there was no water for staff members, that several residents were dehydrated, and that she was very hot and wanted them to come look into the conditions. Reed did not identify herself truthfully, but said that she was a relative of a resident.

The next morning, the Respondent's assistant administrator, Peter Fadeley, learned from another CNA that someone had called the hotline. Fadeley contacted the facility's administrator, who was on vacation, and then called Sullivan at home to come in early to investigate. Reed was called into Sullivan's office and questioned about the call to the hotline. Initially, Reed claimed that she had no knowledge of the call. Reed was later called back to meet with Sullivan and Fadeley, and they told her that they had learned from reliable sources that she had made the call. Reed then admitted that she had made the call and began to cry. Reed was asked to write a statement. At first, she wrote that there was "a lot of joking" about how hot the unit was and that there was no spring water for the staff. Sullivan then told Reed to elaborate and said, "What about the residents that went to the hospital with dehydration? . . . Write that on there." Reed added to her statement, "I stated that there was no water on unit, very hot and several residents were recently sent to hospital. I hung up and everyone was laughing." Reed explained in her testimony that she meant that she heard her coworkers say, "[Y]ou're in trouble for making that phone call." Reed was suspended pending further investigation and was asked to leave the premises. Gunnersen was suspended on July 6. She never returned to work. On July 11, the Respondent discharged Reed.

¹ On February 13, 2003, Administrative Law Judge Marion C. Ladwig issued the attached decision. The Respondent filed exceptions, a supporting brief, and a reply brief. The General Counsel filed an answering brief.

The Board has considered the decision and the record in light of the exceptions and briefs and has decided to affirm the judge's rulings, findings, and conclusions only to the extent consistent with this Decision and Order.

The Respondent has excepted to some of the judge's credibility findings. The Board's established policy is not to overrule an administrative law judge's credibility resolutions unless the clear preponderance of all the relevant evidence convinces us that they are incorrect. *Standard Dry Wall Products*, 91 NLRB 544 (1950), enf'd, 188 F.2d 362 (3d Cir. 1951). We have carefully examined the record and find no basis for reversing the findings.

² All dates hereafter are in 2002.

The New York State Department of Health sent an inspector to the nursing home on July 8. No violations of State or Federal regulations were found.

II. THE JUDGE'S DECISION

The judge found that Reed and Gunnensen's conduct in calling the hotline was concerted activity. We agree.

The judge also found that the call involved a working condition. He reasoned that a posted patient care hotline notice—informing employees that they are “required” by New York State Public Health Law to report physical abuse, mistreatment, or neglect—is an important part of the employees' working conditions in caring for the patients. The judge concluded that the Respondent unlawfully suspended Reed and Gunnensen to discourage employees in their unit from reporting any unsafe conditions for patients in the facility's old section and that the Respondent feared that employees' using the hotline to report the excessive heat in violation of a State regulation requiring “safe and comfortable temperature levels” could adversely affect the State license to operate the nursing home.

III. THE PARTIES' CONTENTIONS

The Respondent claims that the employees' conduct in calling the State hotline was not protected activity because reporting concerns about the patients did not involve a complaint about working conditions and because an employee's personal concern is not protected. Even if their conduct was protected, the Respondent continues, Reed and Gunnensen lost such protection because they lied to the State about who they were and the reason for their call, they lied to management during the investigation, they violated work rules by lying and by failing to follow proper channels for complaints, and their motivation was improper and disloyal under *NLRB v. Electrical Workers Local 1229 (Jefferson Standard)*, 346 U.S. 464 (1953). The Respondent asserts that it acted against Reed and Gunnensen because they made false and fraudulent statements in the hotline call and because they provided false information about the call in the subsequent internal investigation.

The General Counsel contends that Reed and Gunnensen called the State hotline because patient safety was at risk due to the excessive heat. The issue, according to the General Counsel, is not simply whether general patient concerns are working conditions, but whether the State's legal mandate for employees to report unsafe conditions is a working condition, and therefore, protected under the Act. The General Counsel argues that the judge properly concluded that “an important part of the employees' working conditions” is the State requirement to report any “unsafe condition.”

The General Counsel also argues that Gunnensen and Reed did nothing to lose the protection of the Act. The General Counsel claims that the report was not rendered fraudulent by Reed's statement that there was “no water” as opposed to no bottled or spring water or by any distinctions between Reed's observing that the residents exhibited symptoms of dehydration and an actual diagnosis of dehydration. Further, the General Counsel asserts, Reed and Gunnensen, did not act with malicious intent.

IV. ANALYSIS

Section 7 of the Act provides employees with the right to engage in concerted activities for the purpose of collective bargaining or “other mutual aid or protection.” The judge correctly found that Reed and Gunnensen were engaged in concerted activity because they acted together in making the phone call. *Meyers Industries*, 281 NLRB 882 (1986), *affd.* sub nom. *Prill v. NLRB*, 835 F.2d 1481 (D.C. Cir. 1987), cert. denied 487 U.S. 1205 (1988). However, the key issue is whether Reed and Gunnensen's conduct in calling the hotline was *protected* concerted activity.

It is well established that Section 7 extends to employee efforts “to improve terms and conditions of employment or otherwise improve their lot as employees through channels outside the immediate employee-employer relationship.” *Eastex, Inc. v. NLRB*, 437 U.S. 556, 565 (1978). However, “some concerted activity bears a less immediate relationship to employees' interests as employees than other such activity,” and “at some point the relationship becomes so attenuated that an activity cannot fairly be deemed to come within the ‘mutual aid or protection’ clause.” *Id.* at 567–568. Here, Reed and Gunnensen's call to the State health department hotline did not involve a term or condition of their employment and was not otherwise an effort to “improve their lot as employees.” *Id.* at 565. Reed and Gunnensen explicitly disclaimed an interest in their own working conditions when they called the hotline. Reed called the hotline to express their concern about patients, as distinguished from an effort to improve their lot as employees. Indeed, Reed went out of her way, to the point of lying, to tell the authorities that she was a relative of a resident. If Reed wanted to complain about employee conditions, she need only to have truthfully identified herself as an employee. In addition, it is significant that the hotline that she called was the “Patient Care Hotline.”

The Board has held repeatedly that employee concerns for the “quality of care” and the “welfare” of their patients are not interests “encompassed by the ‘mutual aid or protection’ clause.” *Lutheran Social Service of Minnesota*, 250 NLRB 35, 42 (1980) (concerted activity of

employees of a home for troubled youth who complained about planned policy changes found unprotected, where the employees were found to be disturbed by decisions by management and a “perceived lack of competency of management which, in their view, threatened the ‘quality of care,’ ‘the quality of the program,’ and the ‘welfare of the children’”) See also *Good Samaritan Hospital & Health Center*, 265 NLRB 618, 626 (1982) (concerted activity of hospital’s occupational therapists who complained about the management of the hospital’s developmental learning program found unprotected, where the therapists were concerned with the “quality of the care offered by the program and the welfare of the children”) Complaints motivated by concerns for “residents’ living conditions” have also been found to be “not directly related to the employees’ working conditions.” *Damon House*, 270 NLRB 143, 143 (1984) (concerted activity of counselors at a drug treatment center found unprotected, where counselors sent a letter attacking the center’s executive director and his impact on the adolescent residents).

The fact that Reed and Gunnensen were reporting to State authorities does not make the activity protected. In *Autumn Manor*, 268 NLRB 239 (1983), nursing home employees testified at the nursing home’s relicensing hearing before the Kansas Department of Health and Environment about alleged patient abuse. The Board found that the employees’ testimony about management’s treatment of patients “had no direct relationship to the working conditions of employees.” *Id.* As with the employees’ testimony in *Autumn Manor*, the hotline call to the New York State Department of Health has no direct relationship to the working conditions of employees.

Like the employees in *Lutheran Social Service*, *Good Samaritan Hospital*, *Damon House*, and *Autumn Manor*, Reed and Gunnensen were concerned about the quality of the care and welfare of the residents, not their own working conditions. Indeed, as noted above, they conceded at the hearing in this matter that they did not call the hotline to address their own working conditions. Gunnensen testified, “[W]hen we used the line that day, it wasn’t for working conditions. It wasn’t meant for the staff members. It was about what was going on with the residents.” When Reed was asked what was the focus of the state requirements, she responded: “[a]ny and all concerns with regards to the patients.” Our dissenting colleagues would have us ignore Reed and Gunnensen’s testimony about their motive for calling the hotline because employees’ subjective characterizations of their conduct are not determinative of the conduct’s protected status. We agree that if, on the objective facts, the phone

call had been to protect employee working conditions, Reed and Gunnensen’s testimony to the contrary would not necessarily remove the conduct from the protection of the Act. However, as discussed, the objective facts are the other way, and the Reed and Gunnensen testimony supports the objective facts.

The cases relied on by our dissenting colleagues are distinguishable. In *Misericordia Hospital Medical Center*, 246 NLRB 351 (1979), *enfd.* 623 F.2d 808 (2d Cir. 1980), the nurses’ concerns—staffing levels and the number of patients to be cared for—were directly related to the nurses’ working conditions. That is, the nurses were complaining about their own staffing levels and the impact on patients. By analogy if, in the instant case, the employees were complaining that their own thirst was making them unable to care for patients, that could be protected activity. Similarly, in *Parr Lance Ambulance Service*, 262 NLRB 1284 (1982), *enfd.* 723 F.2d 575 (7th Cir. 1983), the employees’ concern—inadequate equipment—was directly related to the performance of their work. In addition, those employees faced the possibility of license revocation or a lawsuit if they failed to provide adequate emergency medical care because they lacked the State-required equipment to do so. Here, Reed and Gunnensen did not call the hotline because of a perception that their ability to deliver patient care was impaired or imperiled. Further, there is no showing that using or failing to use the hotline to complain about the heat would have any real or potential impact on Reed and Gunnensen’s employment.

The dissent, however, goes beyond precedent to find that, in the health care field, patient care should not be separated from working conditions. By that reasoning, any concerted conduct directed toward care would be protected. We do not think that Section 7 should be expanded to cover every situation where patient care is involved. We adhere to the Supreme Court’s teaching in *Eastex, Inc. v. NLRB*, 437 U.S. 556, 567–568 (1978), that “at some point the relationship [between concerted activity and employees’ interests as employees] becomes so attenuated that an activity cannot fairly be deemed to come within the ‘mutual aid or protection’ clause.” We find that the relationship between Reed and Gunnensen’s hotline call and their interests as employees was—as they themselves implicitly admit—so attenuated that it does not properly fall within the scope of Section 7.

Dreis & Krump Mfg. Co. v. NLRB, 544 F.2d 320 (7th Cir. 1976), cited by our dissenting colleagues, is inapposite. In that case, the employee alerted his fellow employees to supervisory deficiencies “which potentially affect on-the-job safety and performance.”

Our dissenting colleagues argue that the fact of discipline (discharge of Reed and suspension of Gunnensen) shows that their complaint was related to employment. Our colleagues have confused conduct with penalty. In employment cases, the discipline virtually always affects employment. However, under the NLRA, if the conduct is unprotected, the discipline therefore is lawful, irrespective of whether the discipline affects employment.

Finally, we note that Reed and Gunnensen were acting in the interests of the nursing home residents, and we commend them for their conduct. However, as discussed, that conduct is not protected by Section 7 of the Act.³ The Act protects employees' interests as employees. The interests of the nursing home residents are not protected by the Act. Reed and Gunnensen may be entitled to relief under a State whistleblower statute or under the public-policy exception to the employment-at-will doctrine.⁴ We find, however, that they are not entitled to relief under the Act, and accordingly, we dismiss the complaint.

ORDER

The complaint is dismissed.

MEMBER MEISBURG, concurring.

In response to unhealthy conditions at the Respondent's nursing home, employees Kathleen Reed and Carol Gunnensen telephoned New York State's Patient Care Hotline, as State law required them to do. When the Respondent learned who had placed the call, it discharged Reed and suspended Gunnensen. Gunnensen then filed an unfair labor practice charge with the Board.

I have no doubt that the employees did the "right" thing, however that term be defined. As both employees testified, they acted in the interest of their patients. Nevertheless, I concur in today's decision that their discipline did not violate the Act.

The National Labor Relations Act was enacted to vindicate the right of workers to join together (or not) to improve their working conditions. It protects both union-related activity and "other concerted activities for the purpose of . . . other mutual aid or protection." Over the years, the Board and the courts have given meaning to that statutory language. For example, in *Washington Aluminum*, the Supreme Court affirmed the Board's view that "mutual aid or protection" protects the right of unorganized employees to walk off the job to protest working conditions.¹ In *Eastex*, the Court affirmed the Board's

view that it protected employee leafleting on the employer's property urging fellow employees, among other things, to oppose a State right-to-work provision and to register to vote in order to "defeat our enemies and elect our friends."²

But the statutory language is not infinitely malleable. It was not intended to protect every kind of concerted activity, no matter how salutary. To hold otherwise would be one more example of a "hard case making bad law."

It is undoubtedly a good thing that the employees in this case complied with the State law requiring them to report the conditions they found. It is even more of a good thing when the State law at issue protects an interest as important as patient care. But the National Labor Relations Act is not a general whistleblowers' statute. Absent an intent to improve wages, hours, or working conditions, concerted action of the type in this case cannot be deemed "mutual aid or protection." Because the employees here testified that their *sole* motive was to act in the interest of their patients, we cannot find that their conduct was protected by the Act.

The dissent contends that the requisite link to "mutual aid or protection" is present both because the employees had a legal obligation to report patient abuse and because patient care is inextricably bound up with the working conditions of health care workers. I join the majority in rejecting both of those arguments. As stated above, both employees testified that their motive in calling the hotline was to protect their patients. Neither employee, when questioned at the hearing, mentioned either employee working conditions or State law even as a motive. Therefore, on this record I do not believe we can find, consistent with the statutory purpose, that the bare existence of the State law is sufficient to bring the employees' conduct within the ambit of "mutual aid or protection."³

I am also unwilling to find that the patients' well-being was itself a working condition. Patient well-being is, for all intents and purposes, the "product" of a health care facility. Although employee interest in that product is desirable, it is not thereby converted into a working condition. Factory workers, too, may manifest a strong interest in the goods they produce, but the nature of those goods is not a condition of employment, and certainly not a bargainable subject.

² *Eastex, Inc. v. NLRB*, 437 U.S. 556, 559–560 (1978).

³ Since we find Reed and Gunnensen's conduct unprotected, we need not address the Respondent's arguments that they lost any such protection.

⁴ See Davis, *Defining the Employment Rights of Medical Personnel Within the Parameters of Personal Conscience*, 1986 Det. C.L. Rev. 847, 856–857 (1986).

¹ *NLRB v. Washington Aluminum*, 370 U.S. 9 (1962).

³ Unlike my dissenting colleagues, I see no problem in letting this case turn on the employees' own testimony concerning their motive in placing the call to the hotline. Motive is often an issue in Board cases, especially those where discrimination is alleged. It is settled that motive is a question of fact. See, e.g., *NLRB v. McClain of Georgia, Inc.*, 138 F.3d 1418, 1424 (11th Cir. 1998).

Finally, I note that the State law which in this case obligates health care employees to report patient abuse also prohibits employer retaliation against whistleblowers.⁴ Although not strictly relevant to our inquiry, the availability of a remedy in some other forum helps bolster my view that we may not expand the coverage of the Act by decisional fiat just so we might reach a desirable result.

In short, the “mutual aid or protection” clause of Section 7 is not a whistleblowers’ protection act, even when the whistleblowing is both concerted and undertaken with the best of intentions. Accordingly, I agree with the majority’s disposition of this case.

MEMBERS LIEBMAN and WALSH, dissenting.

Contrary to our colleagues, we would find that Kathleen Reed and Carol Gunnersen were engaged in protected activity when they called the New York State Department of Health Patient Care Hotline to report excessive heat in the Respondent’s nursing home. As explained below, we believe that Reed and Gunnersen’s concerns over patient care necessarily involved their working conditions and that Board law supports this conclusion. We further find that Reed and Gunnersen did nothing to lose the protection of the Act.

Facts

The relevant facts are not in dispute. At the beginning of July 2002, Reed, a certified nursing assistant (CNA), Gunnersen, a licensed practical nurse acting as charge nurse, and other employees at the nursing home were concerned about the heat in the Respondent’s nursing home and its effects on the nursing home residents. Several of the employees had talked to the supervisors about the high temperatures and the fact that the residents did not look well. The employees had been told to “push extra fluids” on the residents. The Respondent had started providing bottled spring water, popsicles, and cooling headbands for the staff, and it had installed two freestanding air-conditioners in the unit of the facility that was not centrally air-conditioned.

On July 4, it was extremely hot in the unit, and the residents were lethargic, slumped over, and taking off their clothing. Reed herself was feeling sick. She testified that her ears were ringing, that she was feeling faint, and that she was sweating profusely. She was denied

permission to go home. Later that day, Gunnersen dialed the phone number for the State health department hotline and tossed the phone onto the desk next to Reed. Reed picked up the phone, identified herself as a family member of one of the residents, stated that there was no water for staff members, that several residents were dehydrated, and that she was very hot and wanted them to come and look into the conditions. The next day, after initially denying that she had been the one to call the hotline, she admitted that she had made the call, and she gave a statement to that effect. Nursing Director Tracey Sullivan told Reed that she could lose her CNA certification and that Gunnersen could lose her license for calling the hotline. Reed was suspended that day and discharged on July 11. Gunnersen was suspended on July 6 and did not return to work.

Analysis

A. Reed and Gunnersen’s Conduct was Protected

As the judge found, the Respondent posted a notice issued by the New York State Department of Health. That notice required employees and licensed health professionals, pursuant to the New York State Public Health Law, “to report any instance of patient physical abuse, mistreatment or neglect” to the New York State Department of Health. The notice stated that “the Patient Care Hotline may be used 24 hours a day, seven days a week, to report nursing home situations requiring immediate action.”

This notice was posted in several conspicuous places in the nursing home—in the employee dining room and on the side of the elevator, directly across from the nurses’ station. We agree with the judge that the requirement to protect patients by reporting an unsafe condition, set forth in the prominently displayed State notice, was an important part of the employees’ working conditions in caring for the patients.¹ There is no question that the Respondent’s suspension and discharge of Reed and its suspension of Gunnersen for calling the hotline to report the dangerously hot conditions in the nursing home directly interfered with their fulfillment of this important job duty.

Furthermore, there can be no question that the severity of the heat directly affected the manner in which the

⁴ See *NY Pub Health Law*, § 2803-d. New York State law has long provided statutory protection for whistleblowers. See *NY Lab Law* § 740. In 2002, before the events in this case, the State enacted special whistleblower protection for health care workers, including nursing home employees. *NY Lab Law* § 741. Under that statute health care workers may bring a civil action against their employer for suspending, discharging, or otherwise retaliating against them for reporting what they, in good faith, believe to constitute improper quality of patient care.

¹ Our concurring colleague asserts that we have found that this requirement was an important part of the employees’ working conditions because the employees had a legal obligation to report patient abuse. It appears that our colleague has misinterpreted our position. The requirement to report patient abuse was an important part of the employees’ work conditions—not because it was their legal duty—but because the Respondent, their employer, incorporated the State-law obligation into their working duties by conspicuously posting the State health department notice throughout the nursing home.

nursing home employees carried out their resident-care duties. Resident care, after all, is the responsibility of the nurses and nursing assistants, and the conditions that affect the residents surely have a profound effect on how the nurses and nursing assistants carry out that duty. This is illustrated by the fact that the nurses and nursing assistants were told to “push extra fluids” on the residents because of the heat. The severity of the heat was directly related to how much they would have to “push fluids” or take other extraordinary measures to care for the residents. Accordingly, Reed and Gunnensen’s call to the State hotline was directly related to conditions that affected their job duties and thus their terms and conditions of employment.

The finding that Reed and Gunnensen’s conduct was protected is supported by Board law. In *Misericordia Hospital Medical Center*, 246 NLRB 351 (1979), enf. 623 F.2d 808 (2d Cir. 1980), a head nurse was found to be engaged in protected activity when she participated in preparing an ad hoc committee’s report to the Joint Commission on Accreditation of Hospitals. The nurse was required by the Code of Nurses of the American Nurses Association to improve the standards of nursing care and to join with others to meet the public’s health needs. Compliance with that code was a condition of the nurse’s employment, and her cooperation with the ad hoc committee was a step toward meeting that professional obligation. Here, compliance with the posted health department notice was a condition of the employees’ employment, and Reed and Gunnensen’s call to the hotline was a step toward meeting that obligation.

Parr Lance Ambulance Service, 262 NLRB 1284 (1982), enf. 723 F.2d 575 (7th Cir. 1983), is similarly supportive. There, an ambulance driver and an emergency medical technician (EMT) were found to be engaged in protected concerted activity when they refused to operate an inadequately equipped ambulance. The Board noted that under State regulations, an EMT’s certification could be revoked for failing to perform an indicated procedure for which training has been received and that the employees could be sued if they failed to provide adequate care because they lacked State-required equipment. Here, Reed and Gunnensen maintain the necessary certification and licensing for their respective positions that require a mandated level of patient care, which is a condition of their employment with the Respondent or any other long-term care provider. The Respondent is aware of the importance of employee certification and licensing as demonstrated by Sullivan’s statement that Reed and Gunnensen could lose their certification and license, respectively, for calling the hotline. In enforcing the Board’s order in *Parr Lance*, the Seventh Circuit

stated, “To the extent that an employee’s duties relate to providing patient care . . . a lack of necessary medical equipment affects both the patient’s welfare *and* the working conditions of the health care provider.” 723 F.2d at 578. In this case, the high temperatures in the nursing home, similar to the lack of necessary equipment in *Parr Lance*, affected both the residents’ welfare and the working conditions of the nursing home employees.

Lutheran Social Service of Minnesota, 250 NLRB 35 (1980); *Good Samaritan Hospital & Health Center*, 265 NLRB 618 (1982); and *Damon House*, 270 NLRB 143 (1984), relied on by the majority, are distinguishable. Those cases all involved employee complaints directed to the management of the facility or the philosophy of the employer’s programs, rather than actual employee concerns about the patients and their care. *Autumn Manor*, 268 NLRB 239 (1983), is also distinguishable inasmuch as the employees in that case testified at a relicensing hearing about alleged patient abuse and did not give any specific testimony regarding the patients to whom they provided care.

As the majority and concurring opinions point out, Reed and Gunnensen admitted that they called the hotline out of concern for the residents. However, it is well established that:

The motive of the actor in a labor dispute must be distinguished from the purpose for his activity. The motives of the participants are irrelevant in terms of determining the scope of Section 7 protections; what is crucial is that the purpose of the conduct relate to collective bargaining, working conditions and hours, or other matters of “mutual aid or protection” of employees. [Citation omitted.]

Dreis & Krump Mfg. Co. v. NLRB, 544 F.2d 320, 328 fn. 10 (7th Cir. 1976). Indeed, in *NLRB v. Parr Lance Ambulance Service*, the Seventh Circuit reiterated this principle when it found that the ambulance driver’s concern over the adequacy of medical equipment qualified as a working condition. The court stated: “Even if a health care employee phrases a complaint about a situation solely in terms of its effect on patient welfare, the employee is protected if the situation relates to a working condition.” 723 F.2d at 578. Applying this principle here, “what is crucial” is that “the purpose of the conduct,” seeking relief from the dangerously high temperatures in the nursing home, “relate[d] to . . . working conditions.” *Dreis & Krump*, supra at 328 fn. 10.

Further, in the health care field, it is illogical to separate patient care from working conditions. “In the health care field patient welfare and working conditions are often ‘inextricably intertwined.’” *NLRB v. Parr Lance Ambulance Service*, 723 F.2d 575, 577 (7th Cir. 1983),

quoting *Misericordia Hospital Medical Center v. NLRB*, 623 F.2d 808, 813 (2d Cir. 1980).² “To a health care professional, such as a registered nurse, the handling of patient care is a condition of employment.” *Holy Rosary Hospital*, 264 NLRB 1205, 1210 (1982). In this case, the care of the residents was an explicit condition of the job the employees were expected and required to perform. When Reed and Gunnensen called the hotline, they were caring for the residents and acting in accordance with that explicit job condition.³

Contrary to the majority, we do not believe that the intertwining of patient care with the working conditions of those in the health care field impermissibly expands the scope of Section 7. Taking care of the patients here is the work of Reed and Gunnensen. If they cannot protect their patients from the effects of excessive heat, they cannot fully perform their work. The link between their call to the hotline and their interests as employees is, therefore, direct and in no way attenuated.

B. Reed and Gunnensen Did Not Lose the Act’s Protection

We reject the Respondent’s contention that Reed and Gunnensen lost the Act’s protection. Although Reed did not give her identity when she called the hotline and although she initially denied that she had called the hotline,

² In claiming that patients’ well being is not a working condition, the concurrence draws an analogy between health care workers and factory workers. Similar analogies have been rejected by the courts. *Parr Lance Ambulance Service*, supra at 578 (ambulance driver providing patient care not analogous to car mechanic servicing an ambulance); see *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 508 (1978) (health care cases “give rise to unique considerations that do not apply in the industrial settings with which the Board is more familiar”).

³ Indeed, one could argue, as does Professor Cynthia Estlund, that the “open-textured language of section 7, read in light of the overwhelming evidence of the meaning of work for employees, should lead to the protection of employees’ right to express their own concerns about the quality of the product or service they produce.” She notes while considerations of economic security and personal satisfaction inhibit employees’ willingness to “go public” with criticism of their employer, those same considerations might push employees to the conclusion that “informing the public of problems and pressuring the employer to institute changes” serves the long-run interests of the enterprise and its employees. She also points out that “many professional employees are bound by professional ethics to act in the interest of their patients or clients and to adhere to standards of professional integrity that transcend whatever obligations of loyalty they may have to their employer” and that nonprofessional employees, such as nursing aides and child care workers, “who tend to be relatively low-paid, may have chosen these less lucrative jobs because of the satisfaction they gain from serving people and doing good.” Estlund concludes that “[e]mployees who join together and express their shared concerns about how their work and their enterprise affect the world are indeed engaged in ‘concerted activity for mutual or protection.’” Estlund, *What Do Workers Want? Employee Interest, Public Interests, and Freedom of Expression Under the National Labor Relations Act*, 140 U. Pa. L. Rev. 921 (1992).

she acted solely out of fear of retaliation. Further, the fact that Reed referred to “no water,” rather than to no bottled or spring water, and to observed dehydration symptoms, rather than a diagnosis of dehydration, did not render her report fraudulent. “[I]t is well settled that the truth or falsity of a communication is immaterial and is not the test of its protected character.” *Delta Health Center, Inc.*, 310 NLRB 26, 36 (1993), enfd. mem. 5 F.3d 1494 (5th Cir. 1993), citing *Professional Porter & Window Cleaning Co.*, 263 NLRB 136, 139 fn. 12 (1982), enfd. mem. 742 F.2d 1438 (2d Cir. 1983). Protection under the Act is “not denied to an employee regardless of the inaccuracy or lack of merit of the employee’s statements absent deliberate falsity or maliciousness.” *CKS Tool & Engineering, Inc. of Bad Axe*, 332 NLRB 1578, 1586 (2000). Here, Reed and Gunnensen did not act with deliberate falsity or maliciousness, but out of concern for the residents and out of fear of retaliation.

We also reject the Respondent’s argument that Reed and Gunnensen’s conduct was disloyal under *NLRB v. Electrical Workers Local 1229 (Jefferson Standard)*, 346 U.S. 464 (1953). Reed’s statements to the hotline were “true, and unlike the statements found unprotected in *Electrical Workers*, supra, they were directly related to protected concerted activities then in progress.” *Community Hospital of Roanoke Valley, Inc. v. NLRB*, 538 F.2d 607, 610 (4th Cir. 1976). In any event, there was no attempt in the instant case, as in *Jefferson Standard*, to disparage the Respondent’s reputation in a public forum.

C. Conclusion

In sum, we agree with our colleagues that Reed and Gunnensen acted concertedly out of concern for the nursing home residents. However, we disagree that this precludes a finding that they also acted out of concern for their own working conditions. In this case, patient welfare and working conditions are inextricably intertwined, and the effort by Reed and Gunnensen to improve the conditions of the residents was necessarily an effort to improve their lot as employees. Accordingly, we would find that Reed and Gunnensen were engaged in protected concerted activity under Section 7 of the Act and that the Respondent violated Section 8(a)(1) when it suspended and discharged Reed and when it suspended Gunnensen for calling the hotline about the excessive heat in the nursing home.

Nicole Roberts, Esq., for the General Counsel.

Dennis M. Devaney, Esq., of Detroit, Michigan, 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, 2002.¹ 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 Gunnersen (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 Gunnersen, 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 "[y]es, 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.]

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.

Gunnersen 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).

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).

On July 1, after patient Adeeb Hussain was sent to the hospital, as Charge Nurse Gunnersen 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 Gunnersen's demeanor on the stand, she impressed me most favorably as a candid, truthful witness, who has a good memory.)

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

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 Gunnersen and Supervisor Fields gave those instructions (Tr. 20–21).

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).

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.)

When Charge Nurse Gunnersen 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.)

Gunnersen 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.)

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

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

¹ All dates are in 2002 unless otherwise indicated.

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.

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 “[t]hey are very dedicated employees and . . . everybody went back to work . . . for the patients” (Tr. 74).

Around 4:30 p.m., 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.)

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):

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

Important Notice

Patients and Visitors

....

Employees and Licensed Health Professionals

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.]

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.

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):

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.

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.)

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).

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.

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.)

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).

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.

Knowing that “[y]ou 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).

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).

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.)

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,” feel-

ing “the pressure to write it to . . . try to save my job” (Tr. 25–26, 237).

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).

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.)

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 “[c]omplaints 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 “[W]e should call the State about the heat” and dialed the phone and threw it at her after deciding to use the company phone.

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).

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).

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, “[I]f I signed it, possibly, I wouldn’t be retaliated against.”

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).

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.

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.

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

I. JURISDICTION

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 \$5000 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

A. Contentions of the Parties and Findings

1. Concerted activity

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

The nursing home contends in its brief (at 18) that “[c]omplainants’ [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 (1986), 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 (Id. at 887–888) to conduct of a single employee, not two or more employees, as here.

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

2. Working conditions

The nursing home contends in its brief (at 16–18), “[c]omplainants 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.

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

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.

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."

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.

4. Protected activity

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

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

The nursing home contends in its brief (at 22–24) that

(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."

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).

(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).

The nursing home contends (at 28–29) that

(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).

(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's time and money" (although not given as a reason for their suspension).

The nursing home contends in its brief (29–31)

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

(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).

(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").

(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").

(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."

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 of 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, and 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

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.”

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.

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.”

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.

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.

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.

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.

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.

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.

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.

CONCLUSION 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.

REMEDY

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.

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).

[Recommended Order omitted from publication.]