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

CLARA MAASS MEDICAL CENTER

and Cases 22-CA-317355

1199 SEIU UNITED HEALTHCARE WORKERS EAST

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DECISION

STATEMENT OF THE CASE

MICHAEL A. ROSAS, Administrative Law Judge. This case was tried in Newark, New Jersey from February 24 to 27, 2025. Based on timely filed charges by 1199 SEIU United Healthcare Workers East (Union), Counsel for the Acting General Counsel (General Counsel) issued the above-captioned complaint and notice of hearing (the complaint) on November 8, 2024 in Cases 22-CA-317355, 22-CA-327662, and 22-CA-339228. At the hearing, the General amended the complaint by withdrawing Cases 22-CA-327662 and 22-CA-339228, the related allegations at complaint paragraphs 10 and 11, and all references to RWJ Barnabas Health.

The complaint, as amended, alleges that the Clara Maass Medical Center (Respondent or CMMC) violated Section 8(a)(1) and Section 8(a)(3) and (1) of the National Labor Relations Act (the Act)[1] by: (1) placing employees Glenda Eng, Tanya Howard, John Galiger, Olivia Fernandez-Brown, Lia Devers, Francesca Lopes, and Luisa Lopez on administrative leave on May 2, 2023,[2] issuing them written warnings on May 11, and discharging Eng on May 15, because they delivered petitions on April 26 to supervisor Bianca Michel signed by the Respondent's employees protesting its suspension of Glenda Eng and its failure to provide Eng with a peer review; and (2) placing the Respondent's employees Bianca Soto[3] and Malisa Vibulbhan on administrative leave because the Respondent mistakenly believed they were involved in delivering the petition to Bianca Michel.

[1] 29 U.S.C. Sec. 151-169.
[2] All dates refer to 2023 unless stated otherwise.
[3] Bianca Soto's correct name is Alanna Soto. (Tr. 8.)

The Respondent denies the material allegations and asserts that the seven disciplined employees were not engaged in protected concerted activity at the time of the April 26 incident, their misconduct caused them to lose the protection of the Act, their misconduct was not provoked by the Respondent's unfair labor practice, they were paid while on administrative leave pending the investigation, and the discipline imposed was reasonable.

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

FINDINGS OF FACT

I. JURISDICTION

The Respondent, a New Jersey corporation, is an acute care hospital with offices and principal place of business in Belleville, New Jersey. In conducting its operations at the facility, the Respondent annually derives gross revenues in excess of $500,000, and purchases and receives goods valued in excess of $5,000 directly from points outside the State of New Jersey. The Respondent 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 and that the Union is a labor organization within the meaning of Section 2(5) of the Act.

II. ALLEGED UNFAIR LABOR PRACTICES

A. The Respondent's Operations

The Respondent is part of the RWJ Barnabas Health network, which operates medical institutions throughout the State of New Jersey. During the relevant period, the Respondent's managers included: Alfred Torres—Vice President of Human Resources; Chinwendu Emenyeonu—Assistant Vice President of Patient Care Services; Tersea DiElmo—Chief Nursing Officer and Vice President for Patient Care; Gregory Rivera—Director of Human Resources; and Bianca Michel—Director of Critical Care.

The Respondent employs approximately 550-600 nurses. The following Department of Critical Care registered nurses were supervised by Michel: Gloria Eng, Tanya Howard, John Galiger, Olivia Fernandez-Brown, and Luisa Lopez. Lia Devers was a registered nurse in the Women's Health Center. Francesca Lopes was a registered nurse in the Emergency Department.

Throughout the hospital, daily huddles were conducted in every department at the beginning of each shift The Intensive Care and Critical Care Units (collectively, the ICU) were part of the Critical Care Department. During the daily ICU huddles, which were attended by Bianca Michel, night and day staff report to each other regarding unit operations, staffing, and patient care issues. Approximately 20 to 28 nurses attended the daily huddles. The night shift was staffed by approximately 12 nurses.

B. The Relevant Written Policies and Procedures

1. Workplace Violence

The Respondent's Employee Handbook(employee handbook) sets forth its policy on Workplace Violence:[4]

> Preventing workplace violence in healthcare settings is essential for creating a safe and therapeutic environment for patients. their families. and our staff. Violence is defined as any physical assault. or any physical or verbal threat of assault or harm against anyone on any of the RWJBH properties. For more information, please refer to your local policy.
>
> Any events witnessed by an employee should be reported to your Supervisor or the Human Resources Department and an event report should be completed in the Verge system. No retaliatory action will be taken against an employee for reporting violent incidents.

2. Fair and Just Accountability Policy

The Respondent's Fair and Accountability Policy states, in relevant part, that "Employees should strive to . . . "[a]void causing unjustified risk or harm to patients, visitors or colleagues.

3. Restraints

The restraints policy applicable to CMMC and the Respondent's other hospitals, effective May 2022, sets forth the following policy statement:[5]

> Recognizing that all patients have the right to freedom from restraint of any form and that use of restraint can only be utilized to ensure the immediate physical safety of the patient, the staff or others it is the philosophy of RWJBH that use of restraint will:
>
> a. Only be utilized when they are clinically appropriate and adequately justified to protect the patient, staff or others.
> b. Utilize the least restrictive and most effective method of restraint
> c. Be discontinued as soon as the risk and/or demonstrated behaviors are no longer present and the threat of harm is removed.
> d. Never used as a means of coercion, discipline, convenience or retaliation.
> e. Not considered to be a routine part of a falls prevention program.
> f. Consider the underlying causes for the exhibited behaviors requiring restraint.
>
> Alternatives to restraints and less restrictive measures will be evaluated and implemented prior to initiation of restraints unless the situation poses the risk of immediate harm to the patient, staff or others. (See appendices for suggested alternatives)
>
> Exceptions to restraints:

[4] GC Exh. 14.
[5] CP Exh. 1.

A. A restraint does not include such as orthopedic devices, surgical dressings, protective helmets, adaptive supports such as braces and age appropriate safety devices such as cribs, stroller, high chair belts, IV arm boards, or a medically necessary securing device used to temporarily immobilize a patient during a procedure. Full side rails during when used for patients on seizure precautions are also exempt. Also excluded are other methods of physically holding for the purpose of conducting routine examinations or testing.

B. Recovery from anesthesia that occurs in a critical care or post anesthesia area is considered part of the surgical procedure and therefore medical necessary restraint use in this setting would not be considered a restraint.

C. Physical Escort: An escort that provides a "light" grasp (patient is able to remove or escape the grasp) to escort the patient to a desired location is not considered a restraint.

D. Transportation: if a patient is on a stretcher the risk of injury from a fall is significant; therefore raised side rails are not a restraint; likewise the use of a seatbelt on a wheelchair when transporting a patient is not a restraint.

E. The use of handcuffs, manacles or shackles or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention and public safety reasons are not governed by 482.13(e). The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application and monitoring of these restrictive devices. The hospital is still responsible for appropriate patient assessment and provision of safe, appropriate care to its patient (law enforcement prisoner)

Additionally, the Respondent's policy applicable to restraints for "Violent and Non-Violent Non-Self Destructive" defines a restraint as follows:[6]

> Restraint: Any manual method or physical/mechanical device, material or equipment that immobilizes or reduces the ability of a patient to freely move his/her arms/legs/body or head. A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Restraint types include those used for Violent Self Destructive behaviors or Non Violent Self Destructive behaviors.

That policy also states that "[i]n an emergency situation the RN may need to restrain a patient to protect themselves or others." In such cases, a physician's "order must be obtained either during the emergency application of immediately (within a few minutes) after the application." It is further noted that, "[i]n some situations the need for restraint may occur so quickly that an order cannot be obtained prior to the application of restraint."[7]

B. The Collective-Bargaining Relationship

The Union is a national healthcare union that represents full-time, regular part-time, and per diem registered nurses. Spurred by working conditions during the COVID-19 pandemic, the Respondent's employees voted to join the Union. On August 18, 2022, the Union was certified as

[6] R. Exh. 3 at 1.
[7] Id. at 2-3.

the nurses' labor relations representative and entered into a collective bargaining agreement with the Respondent in February 2025.[8] Andy Cassagnol is the Union's contract administrator.

C. The March 1 Incident

Gloria Eng has 30 years of experience as a registered nurse and holds four certifications: basic life support, advanced cardiac life support, vascular support, and critical care. A certification in vascular support trains nurse on the various methods for the intravenous insertion of tubes or needles in order to administer medical therapies, blood transfusions, and emergency medications.

Eng began her employment with the Respondent in 2003. From 2018 until her employment ended in May 2023, Eng was assigned to the Rapid Response Team (RRT) and worked a 7:00 p.m. to 7:00 a.m. shift. Prior to March 2023, Eng had never been disciplined by the Respondent. The RRT was responsible for responding to medical emergencies, medical code alerts, or whenever a nurse determined that a change in a patient's condition required a physician's attention. In that capacity, Eng and other RRT nurses were required to assist physicians by assessing, identifying, and treating patients. Since the Respondent did not have staff specifically responsible to administer IVs, it tasked RRT nurses to do that whenever they were not dealing with an emergency.[9]

Under certain circumstances, Eng was permitted or required to restrain patients while applying an IV line. The Respondent provided Eng with a training course in the use of patient restraints. On September 2, 2021, Eng received a top score of 100 in that course, which is listed in her "Learning Transcript" as "CLM 2021 – RN Competency – Restraints." The course materials provided a "Restraint Ordering Application Policy/Procedure" listing the conditions for the application of restraints, including emergency situations, a physician's order to restrain the patient, and follow-up assessments within one hour by a physician.[10] The training was consistent with the RWJ Barnabas Health system's "Procedure: Restraints – Violent and Non-Violent Non Self Destructive" effective May 2022, which applied to all of its facilities, including the Respondent.[11]

On March 1, Eng responded to a physician's request to insert an intravenous catheter into a patient. At the time, the patient was under observation through a video monitor by a non-nurse telesitter located at Newark Beth Israel Medical Center, another RWJ Barnabas Health facility. The patient had not received her prescribed antibiotics in over 24 hours, her medical record stated that "Patient is Danger to Self or Others," and Eng considered her at risk for sepsis. However, there was no order in the patient's chart for the use of restraints. Although not documented in the patient's medical record, Eng considered it an emergency and determined that it was necessary to restrain the patient in order to insert the catheter. She then wrapped surgical tape over a surgical pad on the patient's wrist and tied it to the bed rail. At some point during the encounter, the telesitter called the nurses station and reported that the patient's left wrist was taped to the bed rail. The attending nurse then entered the patient's room and the telesitter communicated with Eng. Eng

[8] GC Exh. 2.

[9] Michel's testimony regarding her responsibilities was uncontroverted. (Tr. 124-131, 182-183.)

[10] Eng conceded that the Respondent arranged for her to receive training on the use of restraints as part of her responsibilities. (Tr. 182-184, 189-191; R. Exhs. 1-2.)

[11] R. Exh. 3.

completed the IV procedure within a few minutes and removed the restraint. The telesitter followed up by filling out a "Verge" form, the Respondent's version of an incident report.[12]

The Verge report was sent to DiElmo, who forwarded it to Emenyeonu and Michel for review. On March 10, Union representative Andy Cassagnol inquired with Torres and Rivera in Human Resources about the status of "Eng's suspension pending investigation."[13]

On March 8, Eng met with Rivera regarding her suspension. On March 13, she followed-up in an email to Michel and Rivera:[14]

> I am following up regarding our meeting last Wednesday, March 8th. I feel I am entitled to a timely resolution to the [grievance] brought forth by a telesitter at NBI. I strongly maintain that I was wrongly accused of using restraints on a patient (V.V.) while performing a procedure with UIS guided IV insertion.
>
> As discussed in our meeting, I as the professional nurse providing the procedure, deemed it medically necessary to use a temporary immobilizing device to prevent harm to the patient; as well as to myself. Once the procedure was done, the primary nurse (Melonissa Beadle RN-SN) assisted me in removing the surgical tape used to stabilize the patients arm.
>
> I am attaching our restraint policy for the hospital which governs our actions as registered nurses. I am scheduled to work Tues, Wed & Thurs this week and I expect to be advised to the resolution regarding this matter. Thank you!

On March 17, Eng was issued a final written warning and three-day suspension.[15] On the same day, Cassagnol emailed Rivera initiating the grievance process and requesting information relating to the Respondent's investigation and all complaints issued against Michel by bargaining unit employees. On March 28, Cassagnol emailed Rivera again requesting the disciplinary information. On March 29, Torres responded by providing Cassagnol with copies of the Verge report and the Respondent's restraint policies. He also mentioned that Eng was asked if she wanted a peer review, a process by which management appoints three non-supervisory peers to a committee to review disciplinary actions. Cassagnol replied that a request for a peer review had been emailed to Rivera and asked Torres to "accept this as formal notice." He also reminded Torres about the Union's request for copies of all complaints made by nurses about Michel.[16]

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[12] Eng's testimony regarding the use of restraints was inconsistent and not entirely credible. Initially, Eng denied that she tied the patient's arm to the bed rail. (Tr. 180-181.) On further cross-examination, however, Eng conceded that she tied the patient's arm or wrist "[t]o the side of the bed rail, yes." (Tr. 193.) Nevertheless, although the patient's chart is devoid of any reference to sepsis, the need for restraints, or the existence of an emergency, the Respondent's witnesses did not dispute Eng's assessment of the patient's medical condition. Nor did the Respondent produce the telesitter, the other nurse, or other reliable evidence to refute Eng's testimony as to what she did or did not hear the telesitter say. (Tr. 193-199; R. Exhs. 5-7.)

[13] It is unclear whether Eng was already suspended when the she was issued a final warning. No records documenting her March discipline were offered in evidence. (GC Exh. 5(c).)

[14] CP Exh. 3.

[15] R. Exh. 13 at 1.

[16] GC Exh. 5(b).

On March 31, Allison Hogan, an HR employee, was notified to schedule Eng's peer review. On April 3, Hogan called and left a message requesting Eng's "timeline availability."[17]

On April 3, Rivera informed Cassagnol that he was in the process of scheduling a peer review, did not have any records of complaints against Michel, and the Verge report and policy on restraints were "all the documents" related to the investigation. Cassagnol found that concerning because the Verge report was submitted by the telesitter and the restraint policy was preexisting. He asked, "[w]here is HR's investigation Gregory? What did you collect that justifies the disciplinary action against our member?" A few minutes later, the Union submitted another information request for "[a]ll notes, witness statements, reports, correspondence (including email) and any other documents and materials relied upon by the facility in its decision to discipline" and "relevant written policies, procedures and protocols the member is alleged to have violated."[18]

On April 4, Eng emailed DiElmo, Torres, Rivera, and Michel the "RRT [Rapid Response Team] Job Description," insisting that "the recent actions and position you have taken against me, it impacts all of us in the Rapid Response Team moving forward." The email further stated, in relevant part:[19]

> We have reviewed our job deception/functions as a Rapid Response Nurse and it does not include functioning as an IV team. We have repeatedly expressed to upper management that we have identified that the lack of an IV team greatly handicaps our ability to promote our mission statement promising to provide high quality delivery of healthcare. However, we as a team continue to provide assistance to our fellow co-workers to give them support and to promote best positive outcomes for our patients.

On April 9, Rivera responded to Cassagnol by providing "the relevant policies, [V]erge report and summary of the [V]erge . . . which are the entirety of the documents collected in our investigation of this matter."[20]

Hogan and Eng had difficulty connecting but eventually scheduled a peer review for April 17. That meeting was cancelled, however, because Torres was scheduled to meet with the Respondent's labor relations counsel. Hogan called Eng with available times on April 25 and 26. On April 21, Eng left Hogan a message that she was unavailable on those dates because she had to attend a relative's funeral. On April 25, Hogan tried to contact Eng but no one answered and voicemail was unavailable.[21]

D. Presentation of the Petition on April 26

By April 20, Eng had grown impatient with the delay in scheduling her peer review. With the assistance of several coworkers, Eng prepared a petition addressing her concerns regarding her actions on March 1 and the grievance process. Between April 20 and 26, Eng, Galiger, and others

[17] GC Exh. 12 at 1.
[18] GC 5(a) at 2-3.
[19] CP Exh. 4.
[20] GC Exh. 5(a) at 1-2.
[21] It is undisputed that a peer review was the appropriate avenue for appeal of Eng's final written warning and was to be arranged through Human Resources. (GC Exh. 12; Tr. 203-205, 378-379.)

obtained the signatures of 139 CMMC nurses, including a medical doctor and medical officer, supporting the petition:

> By signing below, we are in agreement that the actions of Glenda Eng during the insertion of an IV/Midline are consistent with the RWJ/Barnabas Health Policy of Restraints that was made effective on 5/2022 and approved by the Professional Nursing Practice Committee. Based on the policy, Glenda's actions fall under the "Exceptions to Restraints." We also strongly believe that a proper Grievance Process must be put in place to properly come to a fair and impartial resolution.[22]

Attached to the petition was a letter signed by 16 nurses, most of whom signed the petition and were trained to perform ultrasound-guided IV access, and midline and PICC insertions:

> [I]n light of the recent actions and position the faculty has taken regarding a member of our team, we collectively have decided that we will no longer insert [ultrasound] guided IV/Midline insertions to those patient populations we deem as unable to be directed or are unable to follow direction due to their existing physical or medical condition.[23]
>
> We stand united as one voice. If we as practitioners are not covered by the policy set forth by this facility, then we will no longer provide the U/S ultrasound guided IV/midline insertion to those patient populations who we deem unable to be directed or who post a potential harm to ourselves and others.

On April 26, Eng and several coworkers planned to give the petition to Michel, their supervisor and Director of Critical Care, at the ICU daily huddle. The purpose of the huddle was for night shift staff to update day shift staff about patient-related issues which arose during the night shift. Huddles are usually attended by approximately 20 nurses and take place in the hallway near the ICU front desk between 7:00 a.m. and 7:30 a.m.—the overlap between the overnight and day shifts. Eng, John Galiger, her day shift nurse, and Tanya Howard, a day shift nurse and Union officer, were also present. Before Eng had the chance to give Michel the petition, an emergency patient code cut the huddle short. Several nurses, including Eng and Galiger, went to deal with the emergency, which lasted about 15-20 minutes. Howard remained at the nursing station waiting for an update from the nurse she was relieving, who also went to deal with the emergency.[24]

The group also planned for Jake Ephros, a Union representative, to be present when Eng presented the petition to Michel.[25] While some nurses were dealing with the emergency code, another nurse informed Howard that Ephros had arrived and was waiting in the lobby downstairs. She left the nursing station and met Ephros at the main desk. After showing his identification to

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[22] GC Exh. 3 at 1-5.

[23] Id. at 6-7.

[24] It is clear from the consistent and detailed testimony of Galiger, Eng, and Howard that the huddle was cut short due to a code. (Tr. 32-34, 130, 144-147, 150, 156, 204, 206, 228, 238, 243; GC Exh. 4; R. Exh. 18.) Michel denied that the huddle was cut short that morning but lacked recollection of an important detail—whether Eng was present in the huddle. (Tr. 499.)

[25] It was anticipated that Ephros would arrive in the ICU between 7:00 a.m. and 8:00 a.m., which was during non-visiting hours. (Tr. 66, 70-72, 207-208.)

the security guard, Ephros was given a visitor's pass but was told not to go into the ICU or patient care area. Howard then escorted Ephros to the ICU. Howard returned to the nursing station while Ephros went to the visitors' lounge, where several nurses had already congregated.[26]

After the patient was stabilized—around 7:35 a.m. to 7:40 a.m.—Eng and Galiger reconvened in the hallway space next to the nurses station. While they spoke, Howard was being updated by the night shift nurse. Around the same time, nurses Olivia Fernandez-Brown, Lia Devers, Luisa Lopez, and Francesca Lopes, all signatories to the petition, congregated in the area by Eng and Galiger for the purpose of supporting Eng when she spoke to Michel. All of the nurses worked in the ICU except for Lopes and Devers. Lopes was assigned to the Emergency Department; Devers worked in the Mother-Baby Unit.[27]

While the group discussed possible next steps, Michel, standing about 20 feet away, called out, "John, what's going on?" Michel walked towards the group, stopping a few feet from them in front of the doorway to Room 1301. Again, she asked, "John, what are you doing?" Believing this was an opportune moment to hand the petition to Michel, Eng told Michel that she was putting her on the spot and, emphatically waving and pointing her finger at the petition and Michel, standing about three feet away, insisted she needed Michel explain why she was suspended and received a final warning. Michel told Eng not to point a finger in her face.[28]

As they spoke, the other nurses remained gathered around, except Howard, who was sitting. At some point, Ephros left the visitors lounge and stood with the group. Eng asked Michel if they could talk in her office or the visitors' lounge. Michel refused to engage and stated that if Eng wanted to speak with her, she needed to schedule an appointment. However, Eng persisted, explaining she collected the signatures of 160 hospital employees in support of her grievance. Michel replied it was neither the time nor place to discuss those issues, referencing their location on the ICU and in front of Room 1301, which was occupied by a patient. In an attempt to conclude the discussion, Michel told everyone to go back to their work areas. She also observed one of the nurses holding her phone and told her to put it away. However, no one moved, and Eng once again asked Michel to take the petition, holding it out to her. Addressing the group, Michel stated this was the last time she was going to ask everyone to go back to their stations, at which point the nurses began to disperse.[29]

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[26] I credited Howard's undisputed testimony that (1) it was not unusual for ICU nurses to leave the floor to get a cup of coffee while they waited to receive their shift report, and (2) there was no policy prohibiting visitors who are not family members from going to the ICU. (Tr. 238-242, 261-262, 272-274.)

[27] The security department's notes and reports of interviews with the nurses that did not testify—Lopes, Fernandez-Brown, Lopez, Soto, and Vibulbhan (GC Exh. 11 at 4, 7-15.)—corroborated the testimony of Eng, Galiger, and Howard regarding the concerted purpose of the petition. (Tr. 37-39, 150; R. Exh. 13 at 4, 7-8.) Michel identified nurses Alana Soto and Malisa Vibulbhan as being in the group but it was subsequently determined that they were not. Soto was in a room caring for a patient at the time and Vibulbhan went to the nursing station to have someone contact a physician to get an order for a patient's sugar levels. (GC Exh. 11 at 11, 14-15; R. Exh. 13 at 4, 7-8.)

[28] I credited Michel's testimony that Eng pointed and waved a finger at her during their conversation. (Tr. 482, 488.) Eng conceded that she used her finger for emphasis and Michel told her not to do that. (Tr. 148-152, 209-210.) Howard heard Michel tell Eng not to point the finger in her face. (Tr. 278.)

[29] I based these findings primarily on Michel's detailed and consistent testimony. However, I do not credit her speculative testimony that the patient could see and hear everything that transpired outside his

Seeing that Eng was upset, Howard stood up and put her arms around Eng to calm her down as the conversation ended and Michel left the area.[30] Throughout the discussion between Eng and Michel, which lasted between one and four minutes, their voices were not raised.[31]

E. Michel's Supervisor and Eng Separately Contact Human Resources

Immediately after the incident, Michel contacted her supervisor, Chinwendu Emenyeonu, Assistant Vice President of Patient Care Services, to report what had happened. Shortly thereafter, Michel met with Teresa DiElmo, the Chief Nursing Officer. Michel was visibly upset when she met with Emenyeonu and DiElmo. She did not mention anything about Eng trying to hand her a petition. DiElmo then contacted Alfred Torres, the Vice President of Human Resources, who asked her to have the nurse involved in the incident report to him.[32]

Around the same time, Eng and Ephros left the ICU and went to the Human Resources office, where they met Torres. Torres notified DiElmo of Eng's arrival and invited her to join them in the office. As he waited for DiElmo, Eng explained her frustration with the delay in getting a peer review and gave Torres the petition. Torres apologized and agreed to schedule it for the next day. When DiElmo entered the office, Eng attempted to show her the petition that she tried to give to Michel who refused to accept it. However, DiElmo cut Eng off and stated that the matter involved an ongoing grievance and she could not be involved. DiElmo then accused Eng of intimidating Michel by surrounding her with a mob. Torres followed up, stating that Michel should have submitted the petition to the peer review committee, not Michel, and needed to let that process takes its course. He told Eng that she made her situation worse and the matter would be investigated. Torres also admonished Ephros for being in a patient care area.[33]

After his meeting with Eng, DiElmo, and Ephros, Torres informed Mary Cline, the Respondent's Chief Executive Officer, and Mary Deno, the Senior Vice President of Human Resources, about the incident. and the fact that it related to Eng's complaint about the delay in

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room since the nurses had congregated in front of the nurses station, which is to the left of the Room 1301. (Tr. 481-489, 490-492.) Eng and Howard, on the other hand, were evasive, non-responsive, or hedged when cross-examined regarding this incident. (Tr. 150-154, 209-210, 219-220, 247-249, 251-252, 275-277.). Galiger was also less than convincing, often hesitating and displaying a selective recollection of the facts. (Tr. 37-43, 45-46.) Finally, I did not give any weight to the notes compiled by the Respondent's security department and Emenyeonu during their interrogations of the nurses who did not testify—Lopes, Fernandez-Brown, and Lopez (GC Exhs. 4 and 11 at 9-15; R. Exhs. 13, 18-19.)

[30] Michel testified that Howard "stood up, to put her arms across Glenda to restrain her." (Tr. 486-487.) However, there is no evidence that Eng did more than wave and point her finger at Michel. Eng conceded that she was "frustrated," while Howard "could hear emotion in Glenda's voice." (Tr. 45-46, 249.)

[31] It is undisputed that neither Eng nor Michel raised their voice during this conversation. (Tr. 45, 219-220, 248-249.) Eng testified it "felt like a long time, but maybe less than five minutes, if that much." (Tr. 154.) Galiger testified that "if it lasted all of a minute." (Tr. 44.)

[32] While Emenyeonu and DiElmo credibly testified regarding Michel's emotional appearance and the steps they took following the incident, it is also evident that Michel did not tell them about the petition. (Tr. 332-334, 343, 382-383, 483-484, 492, 582-585.)

[33] Neither DiElmo nor Torres denied Eng's testimony about the comments they made to her during the meeting. (Tr. 155-158, 160-162, 335-336, 383-384.)

receiving a peer review. At 11:58 a.m., Torres emailed Cline, DiElmo, and Deno with his notes of that meeting.[34]

At 1:55 p.m., Torres followed-up in another email conceding his department's failure to schedule Eng's peer review within a reasonable time:

> As a follow-up from our earlier discussion, please see the timeline of scheduling the Peer Review from Allison.
>
> I have stressed with Greg [Rivera] and Allison [Hogan] the need to tighten the process. In hindsight, this probably should have taken preceden[ce] over Bob Clarke meeting.[35]

On April 27, Eng attended the peer review with Cassagnol, at which time she presented her case to the peer review panel. Torres was also present. Michel and Emenyeonu met with the panel before Eng entered. Eng or Cassagnol asked for the names of the panel members and their departments. Torres denied the request. The session lasted about 30 minutes. On May 2, Eng was informed that her appeal of the three-day suspension and final written warning was denied.[36]

Around the same time, Torres convened a meeting with approximately 40 nurse managers who expressed concerns about the April 26 incident.[37]

Following the April 26 incident, Michel expressed concerns to management about continuing to work in the ICU. CMMC arranged for a coworker to escort Michel to her car and offered to relocate her office out of the ICU. There were also check-ins from administration executives and security officers and she saw a therapist following the incident. Michel left work early one day because she was not feeling well and never returned to CMMC. Over the next nine to ten months, Michel was on paid administrative leave by the Respondent. She then returned to work at the Respondent's Robert Wood Johnson Hospital in Somerset as ICU Director, where her commute is about 45 minutes longer.[38]

F. The Investigation

1. The April 26 Report

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[34] Asked why he wrote that in his notes that the incident was intended to "intimidate" Michel, Torres conceded that it was based on his assessment. (GC Exhs. 11 at 32-34, and 12 at 2-3; Tr. 424.)

[35] Bob Clarke, incorrectly listed in the transcript as "Bob Clark," is the Respondent's labor relations counsel. (GC Exh. 12 at 1; Tr. 450-451, 463.)

[36] There is no indication whether any of the peer review panel members were medical professionals. Torres only described the panel as "mixed" personnel from different departments. (Tr. 166-167, 379-382.)

[37] While it is undisputed that Torres met with the nurse managers regarding their concerns over the April 26 incident, there is no evidence that this development had any bearing on the Respondent's decision to suspend and discharge Eng. (Tr. 417-419.)

[38] Michel's testimony regarding her employment status and the security measures taken following the April 26 incident was inconsistent, vague, and evasive. (Tr. 334, 527, 493-494, 525-526, 531-532, 548.) Regarding the panic button that Michel said she was given, she could not describe it or recall how long she wore it, where she kept it, and what happened to it. (Tr. 516-517.) Moreover, her manager Emenyeonu was unaware that Michel wore a panic button. (Tr. 592-593.)

On April 26, immediately after meeting with Eng, DiElmo and Ephros, Torres instructed Gregory Rivera, the Director of Human Resources at CMMC to investigate the April 26 incident as a workplace violence incident under the New Jersey Health Care Act. He also asked Rivera to ascertain the identity of the other nurses present that day and interview them.[39]

Later that day, Eli Cruz, Director of Security, issued an investigation report entitled, "WPV [Workplace Violence] Incident targeting Bianca [Michel]," and described the incident as follows:

> Work Place Violence incident initiated by a group of employees and a union representative against another employee (member of management) by placing Bianca [Michel] in a position with the intent to humiliate, offend, and cause distress to [Michel] by their collective actions including videotaping [Michel].

The report was based on information provided to Cruz by Torres, DiElmo, Michel, and the security officer who gave Ephros a visitor's pass, and security video shown to Michel for the purpose of identifying the individuals involved. Torres and DiElmo provided him with the following details of their meeting with Eng and Ephros:

> [Eng] said [the ICU interaction] had not been "staged" however [DiElmo] and [Torres] pushed back – "if it wasn't staged, why were the union organizer and RNs from other units there at the time." The incident was premeditated and scheduled as a way to intimidate the director in question . . .
>
> [Torres] put [Ephros]on notice that the union was not allowed on the units. It was something they had agreed to.
>
> Jake was very quiet during the meeting. He did not argue or misbehave.
>
> Glenda was also not argumentative and handled the conversation with Terri and Al professional even though they had different perspectives.

Cruz reported that Michel identified Ephros and nine nurses: Eng, Galiger, Devers, Howard, Lopes, Lopez, Fernandez-Brown, Malisa Vibulbhan, and Alana Soto.[40] He also included a list of pending tasks that needed to be addressed, including the following:

> We still need to obtain a copy of the petition with the alleged 160+ signatures.
>
> The petition signers should be identified and interviewed and the decision for them to sign the petition should be reviewed. If they signed the petition and were knowledgeable to the facts of the incident, and still agree with signing the petition, they should be addressed, since taping a patient to an arm rail has never been nor will it ever be appropriate patient care in the identified circumstance.

[39] Torres testified that "it was a very intentional situation that occurred. I consider it a workplace violence. I consider that it was intended to intimidate and bully a coworker." (Tr. 384-385, 392, 438-439.)

[40] GC Exh. 11.

Cruz concluded that "[t]he actions that took place in the ICU that were directed toward Bianca [Michel] can be considered a gang mentality in the workplace, harassment and bullying which are all forms of work place violence."[41]

While the investigation remained underway, all nine employees identified by Michel as present during the April 26 incident were placed on paid "administrative leave pending further investigation."[42] Between April 27 and May 2, Cruz, Rivera, and Emenyeonu interviewed all of the nurses, except for Eng. On May 2 and 3, Cruz issued reports of those interviews. He stated that the nurses were uncooperative and provided minimal detail during questioning. The nurses were asked if they were present during the April 26 incident and, if so, why they were there. Cruz also asked if they signed the petition, why they signed it, and if they agreed with it. The reports and notes of those interviews also reflect reticence on the part of the nurses, with several protesting that they were being subjected to harsh interrogation.[43]

On May 2, Torres notified senior management that all nine nurses who were present during the April 26 incident were suspending pending further investigation. Cassagnol was informed and provided with the names of the nine employees.[44]

On May 3, Nadine Williamson, the Union's Executive President, emailed Torres expressing her disappointment about the nine suspensions and asking, "is there any interest in resolving this differently? If so – let's chat. (Strongly recommended)." Torres forwarded that email to senior management, including Deno, the Senior Vice President of Human Resources. Deno replied a short while later:

> Will rely on Bob's good counsel here on next appropriate steps in positioning with Nadine, but these employees knowingly and willingly disrupted patient care in violation policy, and contrary to our mission and core values. Besides, 1199 does not get to come in a be there hero here for these employees.
>
> + Carol Haynes on this email.
>
> Al - do you think you and Greg will have a summary of the interviews with a recommendation for overall outcome? No doubt, any discipline up to and including separation will lead to peer review and I know we are the heals of another set negotiation day tomorrow. Want to make sure we dot our l's and cross out T's but also show a strong front as an organization.
>
> Bob - thoughts?

[41] Id. at 6-7.

[42] GC Exh. 13.

[43] Galiger and Howard were neither cooperative nor forthcoming during their interviews. However, their testimony that Cruz was aggressive and intimidating during the interviews is undisputed. (GC Exh. 10; R. Exh.12; Tr. 50-52, 257-258, 384-385, 556-559.)

[44] GC Exh. 13 at 1-2.

Shortly thereafter, Torres forwarded Rivera's draft of the April 26 incident, including the employee interviews, adding that the report would be completed after Rivera's final employee interview later that morning.[45]

G. The Respondent Disciplines Seven Employees

On May 11, the Respondent issued discipline to seven of the nine employees; Soto and Vibulbhan were not disciplined because the Respondent determined that they had not participated in the conversation.[46] The disciplinary notices listed the following categories: verbal warning, written warning, suspension, final warning, discharge, and resignation in lieu of discharge. They were signed by Emenyeonu and cited violations of the Respondent's "Standards of Workplace Behavior, Code of Conduct" (Code of Conduct) as the basis for the discipline.[47]

1. Gloria Eng

Eng was suspended for one day. Since she had already been issued a final warning for the March 1 incident, she was discharged, effective May 15.[48] The disciplinary notice listed the details:

> On April 26, 2023, you led an incident, while working, involving several employees. When the leader approached the group, you confronted her regarding a disciplinary action you received the month before. It was reported that you "waved your finger" at the leader and questioned her in front of the group. This occurred within view and hearing of at least one patient and was intimidating and threatening to the leader and was in violation of CMMC Standards of Workplace Behavior and Code of Conduct.

In addition, on May 19, Emenyeonu reported the March 1 incident to the New Jersey Division of Consumer Affairs' Board of Nursing and attributed Eng's discipline to "professional misconduct which relates adversely to patient care or safety."[49]

2. Tanya Howard

Howard was suspended for one day and also issued a final warning based on the following details:

> On April 26, 2023 you escorted a non-employee to the ICU and participated in an incident during which several employees congregated outside of the family waiting room and a

[45] Id. at 3-4.

[46] Although they were not further disciplined, Soto and Vibulbhan had been kept off the schedule since May 2. In Vibulbhan's case, she had also been suspended until Human Resources met with her.

[47] The Respondent's "Standards of Workplace Behavior, Code of Conduct" were not offered in evidence. Torres testified that he made the final disciplinary decisions after consulting with Mary Deno, Respondent's Senior Vice President of Human Resources and Carol Haynes, Respondent's Vice President of Employee Relations. (Jt. Exh. 2; Tr. 388-393, 447-448.)

[48] Torres testified that Eng was terminated because she "was already in a final written warning" and it was "the next step of discipline determination." Asked whether that would have occurred "regardless of what the next action was," Torres answered, "[t]hat's correct." (Tr. 392.)

[49] CP Exh. 2.

patient room to address the nurse leader regarding a disciplinary action against another nurse. You were on shift when you escorted the non-employee up to and into the ICU and not on authorized break.

This incident occurred within view of at least one patient and was intimidating and threating to the leader and was in violation of Standards of Workplace Behavior, Code of Conduct.

3. Galiger, Fernandez-Brown, and Lopez

Galiger, Fernandez-Brown, and Lopez were issued written warnings, with their notices listing identical details as the basis for their discipline:

On April 26, 2023, you participated in an incident during which several employees congregated outside of the family waiting room and a patient room to address the nurse leader regarding a disciplinary action against another nurse.

This incident occurred within view of at least one patient and was intimidating and threating to the leader and was in violation of the Standards of Workplace Behavior, Code of Conduct.

Devers, the nurse assigned to the Woman's Health Department, was issued a written warning based on the following details:

On April 26, 2023, you participated in an incident during which several employees congregated outside of the family waiting room and a patient room to address the nurse leader regarding a disciplinary action against another nurse. You were not scheduled to work or assigned to that unit; you had no business reason to be on the unit. You were also observed recording the incident on your phone.[50]

This incident occurred within view of at least one patient and was intimidating and threating to the leader and was in violation of the Standards of Workplace Behavior, Code of Conduct and Personal Use of Cellular & Electronics Devices Policy.[51]

Lopes, a nurse assigned to the Emergency Department, was issued a written warning based on the following details:

On April 26, 2023, you participated in an incident during which several employees congregated outside of the family waiting room and a patient room to address the nurse leader regarding a disciplinary action against another nurse. You were not scheduled to work or assigned to that unit; you had no business reason to be on the unit.

[50] Devers denied recording the incident and maintained she was text messaging her children. (Tr. 419-421, 620; GC Exh. 11 at 27.)

[51] The Respondent's Personal Use of Cellular & Electronics Devices Policy was not offered in evidence. However, Rivera testified that the policy prohibits employees from using their personal cell phones during working hours. (Tr. 568-569.)

H. The Respondent's Discipline of Comparable Violations

There is no evidence in the record of discipline for violations of the Respondent's policies comparable to the discipline of the seven nurses on May 11 and Eng's discharge on May 15. At the hearing, the General Counsel moved pursuant to *Bannon Mills, Inc.*, 146 NLRB 611, 613, fn. 4, 633-634 (1964), for an adverse inference regarding the Respondent's contention that it disciplined the seven nurses for specific violations of workplace rules or in accordance with its disciplinary practices. Specifically, the General Counsel seeks a ruling precluding the Respondent from arguing that the nurses violated established rules or that the Respondent acted in accordance with its disciplinary practice when it disciplined them. The General Counsel's motion asserts that the Respondent failed to comply with the request at Paragraph 21 of Subpoena Duces Tecum B-1-1NHF8UR (the subpoena), dated January 16 for production of the following:[52]

> 21. (a) Documents that reflect disciplines or discharges issued to Respondent CMMC to non-supervisory employees who were disciplined or discharged for the same or similar reasons as the employees named above in paragraph 11.
>
> (b) For each of the employees who were issued disciplines or discharges provided in response to the request in subparagraph (a), documents that reflect the following:
>
> i. Hire date and separation date, if applicable;
> ii. Job title(s) during the period of this subpoena;
> iii. Disciplines, including but not limited to verbal counselings and warnings, issued to the named individual over the course of their employment.

The Respondent did not file a petition to revoke pursuant to Board Rule 102.31(b) objecting to that or any other part of the subpoena. In response to Paragraph 21, the Respondent stated prior to and during the hearing that a search was conducted for instances of discipline based on the "same or similar conduct," as instructed in the subpoena.[53] In support of that assertion, the Respondent relied on Torres's testimony that "there has never been a similar incident in the past; that is, where employees assembled to intimidate/accost a co-worker or supervisor."[54]

The Respondent contends that its search was adequate because it was based on a reasonable interpretation as to what constituted the "same" or "similar" conduct. I disagree. The disciplinary notices all referred to conduct by the seven disciplined employees that was "intimidating and threatening" to their manager "in violation of the CMMC Standards of Workplace Behavior and Code of Conduct." Rivera conceded that the Human Resources Department "define['s]workplace violence very broadly," including "instances where it could just be a verbal conversation, where maybe the tone got a little high . . . it really varies." Such violations also result from arguments or

[52] The subpoena covered the period from August 10, 2022 to the present. (GC Exh. 16.)

[53] R. Brief at 44; Tr. 471-478.

[54] Torres testified that his department limited the search to incidents within the hospital where "employees assembled to intimidate a co-worker like it transpired on the 26th." (Tr. 425-427.) Asked for more specificity about the search undertaken, Torres confirmed that it was limited to instances involving "a whole bunch of employees accosting a supervisor." (Tr. 428-429.)

disagreements between employees. They are common and the CMMC Human Resources Department is involved in several cases every month.[55] Violations of the electronic devices policy also occur often. Violations for employees taking unauthorized breaks occur a few times per year.[56]

During argument, the Respondent was given the opportunity to maintain its position or request additional time to comply with the subpoena. It chose to stand by its production. By doing so, the Respondent relied on an extremely narrow interpretation of what constituted "similar" documents. The disciplinary notices assert that the seven disciplined nurses congregated in the ICU to "address," i.e., converse with the manager and were "intimidating" and "threatening." Those were search terms that one would reasonably expect to have identified numerous Code of Conduct violations at CMMC since August 2022 resulting from disagreements or arguments between employees."

The General Counsel's motion is granted in part. When a party fails to comply with a subpoena duces tecum served on it by an opposing party, the Board may impose a variety of sanctions. These sanctions include drawing adverse inferences against the noncomplying party. *McAllister Towing & Transportation Co., Inc.*, 341 NLRB 394, 396-397 (2004), enfd. 156 Fed. Appx. 386 (2d Cir. 2005); *International Metal Co.*, 286 NLRB 1106, 1112 fn. 11 (1986); *Bannon Mills,* supra. Here, the Respondent's failure to perform a reasonable search prevented the General Counsel from reviewing potentially relevant information relating to the Respondent's past discipline of employees for engaging in verbal altercations, taking unauthorized breaks, letting non-employees into patient areas, and violating the cell phone use policy.

Accordingly, the Respondent is precluded from asserting that it acted in accordance with its disciplinary practices when it disciplined Eng, Howard, Devers, Galiger, Lopes. Lopez, and Fernandez-Brown for their conduct on April 26.

LEGAL ANALYSIS

A. Applicable Law

The Board has traditionally applied the framework in *NLRB v. Burnup & Sims, Inc.*, 379 U.S. 21, 23 (1964) in cases like this one where the conduct for which an employee is disciplined is intertwined with the employee's otherwise protected activity, and the employer's motivation is not an issue. Under *Burnup & Sims,* the General Counsel has the initial burden to establish that the employee was disciplined or discharged for conduct occurring during the course of protected activity, the employer knew it was such, and the basis of the discipline was an alleged act of misconduct during that activity. *Detroit Newspapers,* 342 NLRB 223, 228 (2004). The burden then shifts to the employer to show "that it held an honest belief that the [disciplined] employee engaged

[55] Rivera testified that the most common Code of Conduct violations are "verbal between two employees." He estimated that were three to four such cases that his department was involved in during the last month. (Tr. 566-567.)

[56] Torres' testimony that the Respondent searched for records of warnings relating to the personal use of cellular and electronic devices was not credible. Rivera testified that violations of the cell phone use policy occur about one to two times per month. While Torres testified that the Respondent did not search for instances in which an employee let a non-employee into a patient area, Rivera conceded unauthorized break violations by employees occurred "a few times a year." (Tr. 429-430, 565-571.)

in misconduct. If it meets its burden, the burden shifts to the General Counsel to show that the employee did not, in fact, engage in the asserted misconduct." *Roadway Express*, 355 NLRB 197, 204 (2010), enfd. 427 F. App'x 838 (11th Cir. 2011).

B. The Employees Were Disciplined for Engaging in Protected Concerted Activity

The General met the initial burden of establishing that the seven nurses were disciplined for conduct occurring in the course of protected activity. On and before April 26, they engaged in protected concerted conduct by signing, along with 132 other nurses and one doctor, a petition agreeing with Eng's position regarding the appropriate use of patient restraints and demanding that "a proper Grievance Process must be put in place to properly come to a fair and impartial resolution" regarding Eng's discipline for her conduct on March 1. As a result of the Respondent's discipline of Eng on March 1, the nurses also stated they would "no longer provide the U/S ultrasound guided IV/midline insertion to those patient populations who we deem unable to be directed or who post a potential harm to ourselves and others." Cassagnol, their Union representative, was also involved in trying to advance the grievance process and the planning to present the petition to Michel, Eng's supervisor. See *Sheraton Anchorage*, 359 NLRB 803, 851-852 (2013) (employees engaged in protected concerted activity by presenting petition for boycott of the hotel to the general manager); *Superior Travel Serv., Inc*., 342 NLRB 570, 574 (2004) (employees engaged in protected concerted activity by preparing, circulating, signing, and presenting a petition as a group, as "these types of group approaches to an employer are concerted and protected by the Act").

In response to the employees' protected concerted activity on April 26, the Respondent disciplined the employees for violating the Code of Conduct by placing the nine nurses on administrative leave on May 2, and issuing discipline on May 11 to the seven nurses. Eng, charged with having "led an incident" and "waved her finger at the leader and questioned her in front of the group," was suspended and discharged because she was already under a final warning; Howard was issued a final warning and suspended for one day for escorting a non-employee into the ICU during an unauthorized break; and Devers, Galiger, Lopes, Lopez, and Fernandez-Brown were issued written warnings.

C. The Employees Did Not Engage in Egregious Misconduct

As the Board held in *Consumers Power Co.*, 282 NLRB 130, 132 (1986), "when an employee is discharged for conduct that is part of the res gestae of protected concerted activities, the relevant question is whether the conduct is so egregious as to take it outside the protection of the Act, or of such a character as to render the employee unfit for further service." (footnotes omitted). The subjective state of coworkers has no bearing on whether an employee engaged in serious misconduct, even if management has a legitimate concern to prevent harassment. *Consolidated Diesel Co.,* 332 NLRB 1019, 1020 (2000).

It is evident from the undisputed hearing testimony and the disciplinary notices that it was Michel who "approached the group" and not the other way around. Michel saw the employees assembled by the ICU's nursing station and asked Galiger what was going on. He did not answer so Michel walked right towards the group. Standing a few feet away, Eng told Michel she was putting her on the spot for the complaints contained in the petition, and attempted to hand it to her.

Michel refused to accept it, insisted it was the first time she heard about Eng's efforts to receive a peer review of her discipline for her conduct on March 1, and told her to make an appointment. Eng, who previously emailed Michel on March 13 requesting a "timely resolution" to her grievance, was not deterred. She continued insisting Michel accept the petition, waving her hand and pointing at the petition and Michel. Michel told Eng not to point a finer at her and instructed the nurses twice to get back to work. The nurses did not respond and Michel stated it was the last time she would tell them to get back to work. At that point, the on-duty nurses returned to their stations.

Eng's conduct, which occurred while she was off-duty, did not amount to egregious misconduct. She was clearly upset, continued to press her case, and Howard stood up and hugged Eng in order to calm her down. However, Eng's voice was not raised and there is no testimony indicating that she was about to attack Michel or acted in a threatening manner. Moreover, Michel was not encircled by the nurses; she walked into the group. See *Consumers Power Co.*, supra (conduct of employee raising fists reflexively in response to supervisor's gesturing or shaking a finger at him was not "so inherently egregious as to lose the protection of the Act"); cf. *Piper Realty Co.*, 313 NLRB 1289, 1290 (1994) ("although employees are permitted some leeway for impulsive behavior when engaging in concerted activity," the discharged employee "clearly went too far" by his insubordinate and profane conduct in the course of repeatedly resisting a work assignment); *BHC Northwest Psychiatric Hospital, LLC, 365 NLRB 739, 746* (2017) (employee's outburst was not protected by Act in part, because "the place of the discussion was in a hospital setting, very near, on one occasion, to a patient care area.").

Although Michel was also upset after the incident and eventually transferred to another hospital, she was hardly intimidated when she approached the group of employees, six of whom stood around listening while Eng pleaded her case. Nevertheless, "[t]he Board has long held that legitimate managerial concerns to prevent harassment do not justify policies that discourage the free exercise of Section 7 rights by subjecting employees to investigation and possible discipline on the basis of the subjective reactions of others to their protected activity." *Consolidated Diesel Co.*, 332 NLRB 1019, 1020 (2000).

Moreover, although the disciplinary notices charged that the seven nurses violated the Respondent's Code of Conduct, a copy of such a policy was not offered in evidence. In fact, the only written policy in the record workplace behavior is the employee handbook's section on Workplace Violence. That policy defines workplace violence as "any physical assault, or any physical or verbal threat of assault or harm against anyone on any of the RWJBH properties"—none of which apply to the April 26 incident.

Nor did Galiger, Devers, Lopez, Fernandez-Brown and Lopez engage in egregious misconduct by remaining in front of the nursing station in support of Eng as she attempted to hand Michel the petition. They were already there when she got there, asking, "John, what's going on?" The nurses listened to the conversation and left after Michel told them several times to return to their stations.

Devers and Lopes were also charged with being in a unit to which they were not assigned, and Devers was charged with recording Michel on her cell phone. While the subpoena required production of all policies the seven nurses were accused of having violated, the Respondent

produced no policy prohibiting employees from going to a unit to which they were not assigned. Nor did the Respondent produce evidence of a policy prohibiting employees from using cell phones or electronic devices while working.

Howard was disciplined for taking an unauthorized break by leaving the nurses station while on duty in order to escort Ephros to the ICU. Although it was not unusual for nurses to take unauthorized breaks while they waited to receive their shift report, Howard misrepresented the purpose of Ephros' visit by telling the security guard that he was there on Union business. She then, in direct contravention of the security guard's instruction that Ephros not to go into the ICU or patient care areas, took him directly there. Although he initially went to the visitors lounge, the record established that he was in the patient care area when Eng tendered the petition to Michel. See *KHRG Employer, LLC*, 366 NLRB No. 22, slip op. at 2 (2018) (discharged employee lost the protection of the Act by misrepresenting to the security guard that the delegation consisted only of employees, and then providing the non-employees with unauthorized access to the secure by using his passcode). Once again, however, the Respondent failed to produce any policy prohibiting visitors who are not family members of patients from going to the ICU.

D. The Respondent Did Not Have A Good Faith Belief That the Employees Engaged in Misconduct

The General Counsel having established that the seven nurses were disciplined as the result of their protected concerted activity on April 26, the burden shifted to the Respondent to show that it had a good faith belief that they engaged in misconduct. Failed to meet its burden.

From Eng's first meeting with Torres and DiElmo on April 26, it was evident that management had already concluded that she engaged in misconduct. When Eng attempted to show DiElmo the petition that she tried to give to Michel, DiElmo cut off Eng and proceeded to accuse her of intimidating Michel by surrounding her with a mob. Torres, having just learned of the incident, concluded that Eng should have submitted the petition to the peer review committee, not Michel, and needed to let that process take its course. He told Eng that she made her situation worse and the matter would be investigated.

In a report later that day, and prior to interviewing the nurses involved, Cruz, CMMC's Director of Security, issued a report titled, "WPV Incident targeting Bianca [Michel] Director RN," and defining the incident as follows:

> Work Place Violence incident initiated by a group of employees and a union representative against another employee (member of management) by placing Bianca [Michel] in a position with the intent to humiliate, offend, and cause distress to [Michel] by their collective actions including videotaping [Michel].

Within days, Cruz, Rivera, and Emenyeonu interviewed eight of the nurses identified by Michel as being present on April 26—everyone except for Eng. Nowhere in those notes is it indicated that Eng or anyone else raised their voices, used profanity, threatened or intimidated Michel, or disrupted ICU operations in any way. The Respondent then placed the nurses on administrative leave between May 2 and May 11 in order to further investigate. However, the record reflects that there was no further investigation, only discussions between hospital

administrators about the nurses and the Union. That was evident from the disciplinary notices, which contained no details other than the Respondent's conclusions that the employees intimidated and threatened Michel by congregating by the family waiting room in order to "address" her "regarding a disciplinary action against another nurse."

Moreover, based on the preclusion ruling above, there is no evidence that the Respondent acted in accordance with its disciplinary practices when it disciplined Eng, Howard, Devers, Galiger, Lopes. Lopez, and Fernandez-Brown for their conduct on April 26.

E. Application of the Wright-Line Framework

As requested by the Respondent, the facts will also be analyzed under the *Wright-Line* framework. In proving that an employer unlawfully discriminated against an employee to hinder Section 7 activity under *Wright-Line*, the General Counsel must make a prima facie case that the employee's protected activity was a motivating factor in the adverse employment action. That burden is satisfied with proof that the employee engaged in protected concerted activity, the employer knew of that activity, and the employer bore animus towards that activity. 251 NLRB 1083 (1980), enfd. 662 F.2d 889 (1st Cir. 1981), cert. denied 455 U.S. 989 (1982), approved in *NLRB v. Transportation Management Corp.*, 462 U.S. 393, 399–403 (1983); *American Gardens Management Co*., 338 NLRB 644 (2002). If the General Counsel makes that showing, the burden shifts to the employer to demonstrate that the same action would have taken place even in the absence of the protected conduct. *Intertape Polymer Corp.*, 372 NLRB No. 133, slip op. at 6 (2023), enfd. 2024 WL 276 (6th Cir. 2024).

The causal link may be established by direct evidence or "inferred from circumstantial evidence based on the record as a whole." *DHL Express (USA), Inc.*, 360 NLRB 730, 730 fn. 1 (2014) (inferring animus where employer discharged employee one day after employee engaged in union activity); *Embassy Vacation Resorts*, 340 NLRB 846, 848 (2003) (employers' actions were motivated by union animus where union supporters were suspended less than two weeks after a second election was ordered and discharged a few weeks after union was certified).

If the evidence as a whole "establishes that the reasons given for the [employer's] action are pretextual—that is, either false or not relied upon—the [employer] fails by definition to show that it would have taken the same action for those reasons, absent protected conduct, and thus there is no need to perform the second part of the *Wright Line* analysis." *Donaldson Bros. Ready Mix, Inc.*, 341 NLRB 958, 961 (2004), citing *Wright Line*, supra at 1089. See also *Cintas Corporation*, 372 NLRB No. 34, slip op at 5 (2022), citing *Metropolitan Transportation Services*, 351 NLRB 657, 659 (2007) (employer's burden not met by merely showing a legitimate reason).

Here, the first two *Wright-Line* factors have already been met. The seven nurses engaged in protected concerted activity when they signed Eng's petition and stayed to support her while she addressed Michael about her discipline. The Respondent knew about that activity almost immediately after it happened, placed them on administrative leave, and disciplined them.

The remaining factor, the Respondent's unlawful motivation and antiunion animus was evident by the Respondent's failure to conduct a meaningful, good-faith investigation as noted

above. The animus was further demonstrated by the Respondent's failure to recognize Cassagnol as Eng's union representative. Torres ignored Cassagnol's requests that the Respondent communicate with him regarding the peer review process, insisting that Eng needed to request and schedule the peer review herself. The Respondent's animus is further evident in Deno's May 3 email stating that she would not let the Union "come in here" and be a "hero . . . for these employees." Perhaps the most glaring disregard for the nurses protected activities was evident from Cruz's recommendation that all of the employees who signed the petition "be addressed."

In conclusion, using either the *Burnup & Sims* or *Wright-Line* framework, the facts demonstrate that the Respondent violated Section 8(a)(1) and Section 8(a)(3) and (1), respectively, by disciplining Glenda Eng, Tanya Howard, John Galiger, Lia Devers, Olivia Fernandez-Brown, Francesca Lopes, and Luisa Lopez because they engaged in protected concerted and union activities, and by placing Bianca Soto and Malisa Vibulbhan on administrative leave because the Respondent mistakenly believed they were involved in delivering the petition to Bianca Michel.

CONCLUSIONS

1. The Respondent, Clara Maass Medical Center (Respondent), is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

2. 1199 SEIU United Healthcare Workers East (Union) is a labor organization within the meaning of Section 2(5) of the Act.

3. The Respondent violated Section 8(a)(1) and 8(a)(3) and (1) of the Act by:

(a) Placing nurses Lia Devers, Glenda Eng, Olivia Fernandez-Brown, John Galiger, Tanya Howard, Francesca Lopes, Luisa Lopez, Alana Soto, and Malisa Vibulbhan on administrative leave on May 2, 2023.

(b) Issuing formal discipline to Lia Devers, Glenda Eng, Olivia Fernandez-Brown, John Galiger, Tanya Howard, Francesca Lopes, and Luisa Lopez on May 11, 2023.

(c) Discharging Glenda Eng on May 15, 2023.

4. The above unfair labor practices affected commerce within the meaning of Section 2(6) and (7) of the Act.

REMEDY

Having found that the Respondent engaged in certain unfair labor practices, I shall order it to cease and desist therefrom and to take certain affirmative actions designed to effectuate the polices of the Act.

The Respondent, having discriminatorily placed Alana Soto and Malisa Vibulbhan on administrative leave on May 2, and placed Lia Devers, Olivia Fernandez-Brown, John Galiger, Tanya Howard, Francesca Lopes, and Luisa Lopez on administrative leave on May 2, 2023 and issued them written warnings on May 11 because they engaged in or were believed to have engaged

in protected concerted activities, shall make them whole for any loss of earnings and other benefits. The Respondent, having suspended Glenda Eng on May 2 and discharged her Eng on May 15, 2023 because she engaged in protected concerted conduct, must offer her reinstatement and make her whole for any loss of earnings and other benefits. Backpay shall be computed in accordance with *F. W. Woolworth Co.*, 90 NLRB 289 (1950), with interest at the rate prescribed in *New Horizons*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical Center*, 356 NLRB No. 8 (2010).

The Respondent shall reimburse Eng in amounts equal to the difference in taxes owed upon receipt of a lump-sum backpay award and taxes that would have been owed had there been no discrimination. The Respondent shall also take whatever steps are necessary to ensure that the Social Security Administration credits her backpay to the proper quarters on her Social Security earnings record. To this end, the Respondent shall file with the Regional Director for Region 22, within 21 days of the date the amount of backpay is fixed, either by agreement or Board order, a report allocating the backpay award to the appropriate calendar years.

The Respondent shall remove from its files any references to the discipline of the nine employees, including the suspension issued to Tanya Howard and the discharge issued to Glenda Eng. The employees shall be and notified in writing that this has been done, and that the discipline, suspension of Howard, and discharge of Eng will be used against them in any way. The Respondent shall also be ordered to post copies of the attached notice in places at CMMC where notices to employees are customarily posted and on the Respondent's GroupMe messaging platform.

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended[57]

ORDER

The Respondent, Clara Maass Medical Center, their officers, agents, successors, and assigns, shall

1. Cease and desist from:

(a) Disciplining and discharging employees because they engage in protected concerted conduct. from discussing working conditions and legal options

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

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

(a) Within 14 days of the Board's Order, offer Glenda Eng reinstatement to her position

[57] If no exceptions are filed as provided by Section 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Section 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

as a registered nurse in the CMMC intensive care unit. or, if that position no longer exist, to a substantially equivalent position, without prejudice to her seniority or any other rights or privileges to which she would have been entitled.

(b) Within 14 days of the Board's Order, reimburse Glenda Eng for any wages and benefits lost because the Respondent discriminatorily discharged her on May 15, 2023, less any interim earnings, plus interest.

(c) Within 14 days of the Board's Order, reimburse Lia Devers, Olivia Fernandez-Brown, John Galiger, Tanya Howard, Francesca Lopes, Luisa Lopez, Alana Soto, and Malisa Vibulbhan for any wages and benefits lost because the Respondent discriminatorily placed them on administrative leave on May 2, 2023, less any interim earnings, plus interest.

(d) Within 14 days after service by the Region, post copies of the attached notice marked "Appendix" at the Respondent's facility. Copies of the notice, on forms provided by the Regional Director for Region 22, after being signed by the Respondent's authorized representative, shall be posted by the Respondent and maintained for 60 consecutive days in conspicuous places, including all places where notices to employees are customarily posted. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other materials. In addition to physical posting of paper notices, the notices shall be distributed electronically, such as by email, posting on an intranet or internet site, by text message and/or other electronic means, if the Respondent customarily communicates with their employees by such means.

(e) Remove from the Respondent's files all references to the discharge of Glenda Eng, the suspension of Tanya Howard, and discipline of Lia Devers, Olivia Fernandez-Brown, John Galiger, Francesca Lopes, Luisa Lopez, Alana Soto, and Malisa Vibulbhan

(f) Notify the nine employees in writing that this has been done and that the discipline, suspension, and discharge will not be used against them in any way.

(g) Within 21 days after service by the Region, file with the Regional Director for Region 2 a sworn certificate of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

Dated: Washington D.C. May 30, 2025

Michael A. Rosas
Administrative Law Judge

APPENDIX

NOTICE TO EMPLOYEES

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

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

FEDERAL LAW GIVES YOU THE RIGHT TO

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

WE WILL NOT discipline, suspend, or discharge you because you engage in protected concerted activity.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of your above stated rights guaranteed under Section 7 of the National Labor Relations Act.

___Clara Maass Medical Center___

(Employer)

Dated: _____By: _____
(Representative) (Title)

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

20 Washington Place, 5th Floor, Newark, NJ 07102-3110
(973) 645-2100, Hours: 8:30 a.m. to 5 p.m.

The Administrative Law Judge's decision can be found at www.nlrb.gov/case/22-CA-317355 or by using the QR code below. Alternatively, you can obtain a copy of the decision from the Executive Secretary, National Labor Relations Board, 1015 Half Street, S.E., Washington, D.C. 20570, or by calling (202) 273-1940.

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

THIS NOTICE MUST REMAIN POSTED FOR 60 CONSECUTIVE DAYS FROM THE DATE OF POSTING AND MUST NOT BE ALTERED, DEFACED, OR COVERED BY ANY OTHER MATERIAL. ANY QUESTIONS CONCERNING THIS NOTICE OR COMPLIANCE WITH ITS PROVISIONS MAY BE DIRECTED TO THE ABOVE REGIONAL OFFICE'S COMPLIANCE OFFICER (862) 229-7055.