

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

HURON VALLEY SINAI HOSPITAL

Cases 7-CA-50192
7-RC-23071

and

MICHIGAN COUNCIL 25, AMERICAN FEDERATION
OF STATE, COUNTY AND MUNICIPAL EMPLOYEES
(AFSCME), AFL-CIO

Robert Drzyzga, Esq., for the General Counsel.
Daryl Adams and Shaun Ayer, Esqs. (Floyd E. Allen and Associates),
of Detroit, Michigan, for the Respondent.
Eric I. Frankie, Esq., (Miller Cohen, P.L.C.), of Detroit, Michigan, for the Charging Party.

DECISION

Statement of the Case

ARTHUR J. AMCHAN, Administrative Law Judge. This case was tried in Detroit, Michigan, on July 23-26, and August 20-23, and August 29, 2007.¹ The Union, Michigan Council 25 (AFSCME), filed its original charge on March 2, 2007. On March 23, 2007, the Union filed timely objections to an election conducted on March 16, 2007. In that election 211 employees voted against representation by the Union and 46 voted in favor of such representation. The General Counsel issued his Complaint, Report on Objections and Notice of Consolidation on May 31, 2007.

Respondent, Huron Valley Sinai Hospital (HVSH), is a wholly owned subsidiary of the Detroit Medical Center (DMC). The General Counsel alleges that Respondent HVSH, by Clinical Manager Jacqueline Dye, violated Section 8(a) (1) of the Act in coercively interrogating employee Robin Taylor about his union sympathies and activities in mid-to-late January 2007. He also alleges that Respondent violated Sections 8(a)(3), 8(a)(4) and 8(a)(1) by taking a number of adverse personnel actions against Robin Taylor. These include verbal counselings and two written warnings that Respondent presented to Taylor on February 2, 2007, its suspension of Taylor on March 2, and its termination of Taylor on March 13, 3 days before Respondent's employees participated in the NLRB representation hearing.

Further, the General Counsel alleges that Respondent violated Section 8(a)(1) of the Act by promulgating and maintaining the following policies: 1) a rule prohibiting employees from being on its property during non-working hours except under clearly reasonable circumstances; 2) a rule forbidding any solicitation and distribution on its premises without management approval; and 3) a rule permitting off-duty employees on DMC property for lawful purposes only to the extent the general public is generally permitted on its property. Respondent prohibits

¹ The August 29, 2007 hearing session was conducted via videoconference.

greater access to its property unless it has granted the off-duty employee specific authorization to enter areas from which the general public is barred.

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

Findings of Fact

10 I. Jurisdiction

Respondent, a wholly owned subsidiary of the Detroit Medical Center (DMC), is a hospital in Commerce, Michigan. 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. I also find that the Union is a labor organization within the meaning of Section 2(5) of the Act.

II. Alleged Unfair Labor Practices

Allegations relating to Robin Taylor

20 *Robin Taylor's work record at HVSH*

Robin Taylor has worked at Respondent's hospital since 1993 or 1994. For approximately the past 8 years he has been a patient care associate (PCA). In that capacity, he performs such tasks preparing IVs for the nurses, drawing blood, shaving male patients, accompanying patients to the toilet, administering physical therapy, inserting and removing catheters, bathing bedridden patients, transporting patients from one area of the hospital to another and stocking supplies. He has also on many occasions worked as a sitter. In that capacity, his job has been to keep patients who are deemed to pose a danger to themselves or others under continual observation.

As a patient care associate, Taylor worked in the pre-op department. For the first 3-4 years that Taylor worked in that department, the Clinical Manager was June Jones. Three to four years before his termination, Jones relinquished that position and became the charge nurse. Jones was replaced as Clinical Manager by Jacqueline Dye. Taylor's relationship with Dye was never very good and much worse than his relationship with Jones. His performance ratings from Dye were appreciably less complimentary than those he received from Jones.

40 While Jones was clinical manager, Taylor on at least some occasions came to work earlier than his shift started and left earlier than it ended. On at least one occasion in March 2004, she counseled him about this. Jones offered the following assessment of Taylor:

... sometimes, he was a good worker, and sometimes, he did his own thing, and it's difficult to make him change.

45 Tr. 1023.

In response to my observation that the ratings she gave to Robin Taylor appeared very favorable, Jones responded:

50 Well, he—like I said, he can be—he can treat people with kindness. When he brings them back, he can. And at times, he's very, very good at what he does. But I liken

Robin to the—there's a little kid poem. The little girl with the little curl on the forehead.
When he's good, he's very good, and when he's bad, he's not.

Tr. 1029-30.

5

Dye was much harsher in her assessment of Robin Taylor, testifying that incidents of misconduct were continuous from the day she became his manager, Tr. 668.² However, Dye could point to only a few occasions on which she counseled Taylor before he assisted the Union at the January 2007 representation hearing. In June 2005, Respondent prepared a discipline report form for Taylor purporting to issue him a written warning for berating a patient for crying. It has not been established, however, that Respondent ever presented the form to Taylor.³ Taylor testified he never saw it and Dye couldn't recall whether or not she gave it to him. I find that Respondent never gave Taylor a written warning prior to February 2, 2007.

15

Respondent contends that it placed Taylor on two performance improvement plans (PIP) that are in the record as R Exhibits 12 and 13.⁴ Like the written warning, I find that it has not been established that either PIP was ever presented to Taylor. The first from January 2005 to January 2006 concerned time and attendance issues and failure to do his stocking of supplies adequately. The second from July 2005 to 2006 involved wearing his ID badge and identifying himself to patients and their families, his stocking responsibilities, some unspecified concern about bringing patients and visitors to the department and failure to adhere to DMC customer service policies. The allegation regarding customer service refers to the incident of June 28, 2005, in which Taylor is accused of berating a patient for crying.

25

However, Taylor begrudgingly concedes that his supervisor, Jacqueline Dye, put him on a 30-day PIP in about November 2006. This was administered for poor stocking of supplies next to the patient's beds and poor customer relations. The latter deficiency concerned Dye's assessment of Taylor's relations with co-workers, as opposed to patients.

30

Dye testified that she warned Taylor at least twice in 2004 about taking young girls to the bathroom and closing the door. However, at hearing, Dye testified that, "I'm not accusing him of attacking these young girls in the bathroom; I'm thinking it really looks bad... So when I caution that I'm not saying Mr. Taylor you're monkeying around with those little girls. I didn't say that. I said you don't go in a room and close the door with you and a young girl in there; do not do that."

35

Tr. 816.

40

In the performance appraisal Dye signed for Taylor on July 10, 2006, she commented:

² However, Dye agreed with Jones that "at times" Taylor did his job well.

45

³ The form, R. Exh. 16 is not signed by Taylor and he denies having seen it prior to the hearing in this matter. The form states that if an employee declines to comment on the discipline, "your Supervisor will make a notation to that effect." Since there is no such notation, I conclude that the warning was never presented to Taylor.

50

⁴ Taylor denies receiving either performance improvement plan (PIP). He signed neither document. After testifying on direct examination that Taylor's signature was not required on a PIP, Jackie Dye conceded on cross examination that DMC policy required both the manager and the recipient to sign a PIP.

Robin does take pride in his department and believes he is professional and courteous with customers. Customers do not always respond well, and at times Robin is inappropriate with touching and with comments. Robin does not always seem to understand why some of these issues presented problems.

5

R. Exh. 15, GC Exh. 85.⁵

Robin Taylor's Union and other protected activity

10 Taylor signed a union authorization card in October 2006. In December 2006, he attended a meeting with other employees, in which he complained, in the presence of Human Resources Director Paul Sturgis, about Respondent's discontinuance of a short-term disability program and the loss of other benefits and bonuses. Taylor stated in Sturgis' presence that the hospital was better off in the old days and that "it was all the fault" of DMC's chief executive officer, Mike Dugan.

15

The Union filed a representation petition on December 4, 2006, withdrew it and then filed a second petition on January 4, 2007. Between Monday, January 22, 2007 and Thursday, January 25, the Board conducted a hearing at the Detroit Regional Office pertaining to the Union's second petition to represent a unit of Respondent's employees. One of, if not the principal issue at the representation hearing was whether patient care associates should be included in the bargaining unit.

20

The Union subpoenaed several employees to assist it in this hearing, including Patient Care Associates Robin Taylor, Lisa Blumerich and Nancy Birrell. Taylor attended all four days of the hearing, as did Respondent's human resources director, Paul Sturgis.

25

Disciplinary actions taken against Robin Taylor after Respondent was aware of his union and other protected activity

30

February 2, 2007 Written Warnings

On February 2, 2007, Respondent summoned Robin Taylor to a meeting with Human Resources Director Paul Sturgis, Jacqueline Dye, the Clinical Manager for the hospital's Recovery Room and Pre-Admission testing, and Karen Moore, the Director of Surgical Services. Ms. Dye was Taylor's manager and she reports to Ms. Moore. At this meeting Respondent presented Taylor with a first written warning for leaving work early on January 10, 11, 17 and 19, 2007 (GC Exh. 18). This warning stated that Taylor had been counseled about clocking out early on July 17, 2006 and that his early departures constituted a violation of DMC Attendance Policy 1 HR 503.

35

40

The Attendance Policy in effect on February 2, 2007 became effective on January 1, 2007, GC Exh. 4. This policy provides in paragraph 3.e. that:

45 Failure to complete scheduled shift (e.g. going home sick) will count as one unscheduled absence if employee leaves one hour or more before the end of a scheduled shift. Two such absences of less than one hour will count as one unscheduled absence.

50

⁵ Taylor was off of work for surgery from July 18 to September 2006. Although his performance appraisal was signed by Dye on July 10, Taylor received it on or about September 25, 2006.

Paragraph 5, entitled, "Unacceptable levels of unscheduled absence," provides:

a. Full-time employees: Four (4) unscheduled absences in a quarter will result in disciplinary action.

5

Robin Taylor's duty hours are 5:00 a.m. to 1:30 p.m. Taylor clocked out at 12:52 p.m. on January 10; 12:35 on January 11; 1:06 on January 17 and 12:16 on January 19. Respondent alleges that on these four occasions, Taylor did not have permission to leave work early. Taylor submits that the charge nurse on duty (not necessarily June Jones) approved his early departure. In any event, pursuant to the Respondent's attendance policy at the time of the alleged infraction, Taylor clearly had less than four unscheduled absences for the dates in question and was not subject to disciplinary action for leaving early on those occasions. This is so because on only one of the four afternoons did he leave more than one hour before the end of his shift.

15

Respondent's Human Resources Director, Paul Sturgis, contended that this warning was consistent with the existent attendance policy because Taylor absences were "patterned." Paragraph 6 of that policy defines "Patterned Absences."

20

Employees will also be subject to disciplinary action for patterned absences in accordance to (sic) provisions of DMC Progressive Discipline Policy 1 HR 506. Example: Unscheduled absences that are consistently in conjunction with scheduled days off, holidays, weekends, paydays, and so forth.

25

There is nothing in the record that supports Sturgis' contention that Taylor's early departures on January 10, 11, 17 and 19, 2007 can be deemed to be "patterned absences." The warning document does not indicate that Taylor violated Respondent's attendance policy by means of "patterned absences." The policy on its face does not appear to be directed to conduct similar to Taylor's and there is no indication that any other employee has been disciplined for "patterned absences" in similar circumstances. Sturgis' testimony regarding "patterned absences" is a post-hoc rationalization of a disciplinary action that is inconsistent with the plain meaning of Respondent's attendance policy.

30

On February 2, Respondent also presented Taylor with a second written warning (GC Exh. 26), which states:

35

On the mornings of January 24 and January 25th 2007 Mr. Taylor was confirmed to be present in immediate patient care areas (2-East). On both dates, Mr. Taylor had indicated that he would be unavailable to work. Mr. Taylor's presence in the hospital in patient care areas was not work-related, related to visiting an admitted patient, or authorized by his supervisor. Violation-On DMC property during non-working hours.

40

This warning was issued alleging a violation of the following "minor infraction" set forth in paragraph 12 "o" of its Policy No. 1 HR 506, entitled Progressive Discipline:

45

Being on DMC property during non-working hours except under clearly reasonable circumstances.

50

On the morning of Wednesday, January 24, and again on the morning of Thursday, January 25, Taylor came to floor 2-East to meet patient care assistants Nancy Birrell and Lisa

Blumerich.⁶ Taylor then drove them in his vehicle to the NLRB Regional Office to participate in the NLRB Representation Hearing.

5 Robin Taylor is the only employee ever to be disciplined by Respondent for a violation of this rule. However, it is uncontroverted that on numerous prior occasions several of Respondent's employees came onto HVSH property and into patient care areas during non-work hours.

10 Taylor himself had, over the course of six years, come to the units to pick up employees who were riding with him to DMC-sponsored diversity meetings. He gone to the unit to check his schedule when off-duty. While being treated at the hospital and not on duty, Taylor had gone to the unit when Jacqueline Dye was present.

15 An employee named Eric Altis brought his new child to the unit when off-duty. Dye, Karen Moore and June Jones played with the baby on this occasion. In December 2006 or January 2007, Nurse Barbara Hunter, dressed in civilian clothes, brought her son and grandchildren to the nurse's station in the pre-op unit on one occasion and her daughter on another. On the occasion when Hunter brought her grandchildren, Dye and Jones played with the children. Nurse Ellen Brashear also brought her children and grandchildren to the nurse's station in 2006 or 2007. On this occasion, as well, Dye and Jones played with the children.

February 2, 2007 counselings

25 On February 2, 2007, in addition to giving Taylor the two written warnings Respondent presented him with a verbal counseling memo from Jacqueline Dye, R. Exh. 5. Dye counseled Taylor for:

30 Whiting out his time sheet entries for January 23 and 24, which showed that his absences for those dates were unexcused;
 Calling in less than two hours before the start of his shift on January 25 and 26, to inform Respondent that he would not be at work;
 Coming to work more than 15 minutes prior to the start of his shift;
 Making clinical assignments, such as room assignments.

35 The most controversial portion of this counseling is the portion that pertains to calling in less than two hours before the start of Taylor's shift. First of all, Respondent's existing attendance policy defines a "late call" as failure to report an absence less than 1 hour **after** shift start time. Secondly, with regard to January 25, the counseling is factually inaccurate. Taylor called the hospital at about 3:43 a.m., more than two hours prior to the start of his shift, to inform his supervisor that he was not coming to work that day in order to attend the representation hearing (Tr. 182, 192, GC Exh. 17). Moreover, prior to January 24, Taylor had told his supervisors, Charge Nurse June Jones and Clinical Manager Jacqueline Dye, that he would not be available to work on January 24 and 25, Tr. 354, also see Tr. 451.⁷ Finally, Human Resources Director Sturgis was aware, on Monday, January 22, that Taylor would not be at work for the duration of the hearing (Tr. 176).

50 ⁶ On at least one of these occasions, Taylor went first to the employee break room. Then, not finding his riders in the breakroom, he went to the nurse's station to look for them.

⁷ Taylor was not only in compliance with Respondent's attendance policy with regard to notifying Respondent of his absence on January 25, but its scheduling policy, R. Exh. 6, as well.

On Friday, January 26, 2007, Taylor became ill on his way into work and went directly to the emergency room at Respondent's hospital. The Emergency Department registered him at 4:25 a.m. with complaints of abdominal pain and vomiting. While in the emergency room, Taylor vomited again and was admitted to the hospital. An emergency room employee called Taylor's unit at 4:45 a.m. to inform unit personnel that he would not be reporting for work that day. By having someone call into his unit within an hour after the start of his shift, Taylor was not in violation of Respondent's attendance policy. Clinical Manager Dye and her supervisor, Karen Moore, visited Taylor in the hospital on January 26.⁸ Taylor informed Dye and Moore that he had called the house supervisor. Moore told him not to worry, everything is being taken care of and that she did not want him to come to work sick. Taylor was discharged from the hospital on Saturday, January 27.

Taylor protested the counseling for whiting out his supervisor's timesheet entry for January 23 and 24. The entries indicated that his absence that day was unexcused. Taylor, Nurses Lisa Blumerich and Nancy Burrell were initially told that their absences from work to attend the representation hearing, pursuant to the Union's subpoena, would be unexcused. On January 25, the final day of the hearing, H.R. Director Sturgis had assured the three employees that their absences from work would be excused. On February 2, management informed Taylor that he was prohibited from altering his timesheet regardless.

20

The events of February 23-26, 2007, that led Respondent to terminate Robin Taylor⁹

⁸ Dye did not specifically contradict Taylor's testimony on this point. She testified that she doesn't believe that on the morning of January 26, that she knew Taylor was in the emergency department. She testified that she found out later from other employees. Moore testified that she did not remember whether on February 2, she was aware that Taylor was in the emergency room on January 26. I credit Taylor's testimony that Dye and Moore visited him in the emergency room on the afternoon of the 26th.

⁹ With regard to what transpired in Room 334 on February 25, I credit Robin Taylor's testimony unless it is contradicted by nonhearsay evidence. Respondent relies completely on the hearsay testimony of Dorothy Kempf, its Administrative Co-coordinator for Customer Service, and Billie Jo Anderson, the third sitter for patient 334. Neither was present on February 25 and Respondent has offered no satisfactory reason for failing to call patient 334 to testify to those matters where its hearsay evidence differs from Taylor's first-hand account.

I would note that Respondent had information in its records prior to Mr. Taylor's discharge that would raise concerns regarding the patient's reliability. In a discharge summary for a hospitalization at HVSH for lower back pain, Dr. Jeet N. Pillay observed in November 2006:

There were numerous issues with pain control with the patient. She seemed to have an exaggerated pain complaint during her admission. Numerous times, she was noted to appear comfortable, ambulating, sitting up talking in her bed with her roommate on the phone. However, upon seeing medical staff, the patient would immediately begin to grimace, lay back and writhe in pain and say the pain control was not working, GC Exh. 79, p. 2, also see unnumbered progress note dated November 2, 2006.

45

Additionally, the patient was hospitalized on March 25, 2007 and again on May 7, 2007, for overdosing with prescription drugs. The March hospitalization was diagnosed as a suicide attempt, indicating that patient does in fact experience some manner of mood swings. Although these events occurred after Taylor's termination, his appeal of the termination was ongoing and Respondent did not review the records of any hospitalizations, other than that of February 23-26, in denying his appeal.

50

Continued

5 On Friday, February 23, 2007, a 33-year old Caucasian female, hereinafter referred to as "the patient" or "patient 334," was admitted to HVSH after ingesting an overdose of Xanax (60 pills) and Vicodin (47 pills). The patient had used cocaine at some time in the past and apparently had attempted suicide in high school. She also suffered from Multiple Sclerosis and depression. She apparently also overdosed two weeks previously.

10 After being treated in the HVSH emergency department, patient 334 was sent to the intensive care unit where she remained until Sunday, February 25.¹⁰ On that day, Robin Taylor was contacted and asked to work overtime as sitter for this patient, who was deemed a potential danger to herself, pending a psychiatric evaluation. As a sitter, Taylor was obligated not to let the patient out of his sight—unless some other staff member was observing her in his absence.

15 Taylor began his shift while the patient was still in the intensive care unit (ICU). He removed the patient's catheter, had a female PCA removed the leads for the heart monitor from the patient's breast and transported her in a wheelchair to room 334 on HVSH's 3 East unit. 3 East is not the unit where Taylor usually works.

20 A student nurse, Jen McRitchie, who is also a PCA, joined Taylor and the patient in room 334 for a short while. The patient asked if she could take a shower. Taylor asked the nurse in charge of patient 334 if she could shower and got an affirmative answer. He had McRitchie sit in the room while he went to get fresh towels, washcloths, tape and scissors. When Taylor returned he put two towels on the floor and told McRitchie to sit and watch the patient shower with the bathroom door cracked open. While the patient showered, Taylor went to obtain fresh hospital garments for her. Taylor returned after 15-20 minutes and handed the garments to McRitchie. He then went to the nurse's station to eat a snack.¹¹

30 I do not deem Taylor to be a completely credible witness. At times, he resisted conceding matters for which there is convincing documentary evidence. Examples of this are Taylor's unwillingness to admit that he discussed being abused with the patient and that he was put on a 30-day PIP in November 2006. However, when making a determination as to whether to believe Taylor's uncontradicted testimony, subject to cross-examination, versus Respondent's total reliance on hearsay, I credit Taylor in every instance.

35 Many of Respondent's witnesses are also not completely credible. At various points their testimony was either contradictory, internally inconsistent or inconsistent with that of other of Respondent's witnesses, or simply extremely implausible.

40 ¹⁰ Up until the sixth day of hearing, everyone associated with this case assumed that Robin Taylor sat for patient 334 on Saturday, February 24. Bette Fitz, who reviewed the patient's medical records, testified on August 21, that this is incorrect, that the relevant dates regarding Mr. Taylor's conduct are Sunday, February 25 and Monday, February 26, 2007. The patient's medical records corroborate Ms. Fitz's testimony in this regard, Tr. 1082-83, R. Exh. 33, pp. 21 and 34.

45 ¹¹ Jen McRitchie did not testify at the hearing in this case. That she is the student nurse in question is established by R. Exh. 33, pg. 53. She was not interviewed by Respondent before it terminated Mr. Taylor but was apparently interviewed by Bette Fitz three weeks after Taylor was fired, R. Exh. 32. To the extent, the hearsay account of this interview conflicts with Taylor's account, I credit Taylor. In large part, however, Fitz's notes are consistent with Taylor's testimony. Although Fitz records that McRitchie told her that the patient was already in the shower when she entered the room, she confirms that Taylor asked her to watch the patient

Continued

Afterwards, the patient told Taylor she was hungry and he showed her how to order food. In the course of conversation, the patient said she worked at an eating establishment. Taylor mentioned that he had a catering business. Then the patient asked Taylor if he had a card. He said that on his lunch break, he would get one from his locker. On his lunch break,
 5 Taylor obtained a card and gave it to the patient. On the back of the card Taylor wrote the telephone number for the pre-op department where he usually works. The phone rings at the desk of the unit clerk.¹²

10 At 3:00 p.m. Nancy Leach relieved Taylor as the patient's sitter. Leach did not testify at this proceeding and therefore there is no reliable evidence as to what transpired while Leach sat for the patient or what the patient said to Leach.

15 Respondent did not interview Leach prior to terminating Taylor. However, almost a month after HVSH terminated Robin Taylor, Bette Fitz, Respondent's Vice-President for Patient Care Services, interviewed Leach either in person or by telephone. The sum total of what Leach apparently related to Fitz is as follows:¹³

20 She was the sitter for the patient right after Robin was assigned to her. Nancy recalled the patient and stated that she had an OK shift. The patient was in a very good mood but did comment to her that Robin had given her his phone number and she was uncomfortable with this. The sitter encouraged her to talk to her nurse about it. She did not witness the patient talking to her nurse during that shift. Stated the patient was very talkative and alert and oriented.

25 R. Exh. 32(a).

What is very striking is the fact that, other than giving the patient the telephone number at which he could be reached at the hospital, Leach related none of the accusations of inappropriate conduct on the part of Taylor that were the basis for his termination.

30

Monday, February 26, 2007

At 7:00 a.m. on Monday, February 26, 2007, Billie Jo Anderson took over as the sitter for the patient in room 334. It is not entirely clear whether Leach sat until Anderson took over, or

35

through a crack in the door while he left the room. Had she been subjected to cross-examination, it is quite possible that McRitchie's account would be even more supportive of Taylor's testimony.

40 Even the patient's hearsay account (as told to Dorothy Kempf) contains no allegation that Taylor observed her in the shower until she was fully dressed, R. Exh. 3, CP Exh. 4. Moreover, the fact that patient did not mention the fact that a female employee (McRitchie) was stationed outside the door for part of the time that she showered, but only recalled Taylor talking to her through the door, raises questions as to the reliability of her account of what transpired.

45 ¹² Although Taylor's testimony regarding the circumstances under which he gave the patient a card for his catering business is self-serving, I credit it because there is no evidence, even hearsay evidence, to the contrary. I would note that Dorothy Kempf's recollection of her conversation with the patient lends some support to Taylor's version. Kempf believes that the patient told her on February 26, that the patient worked in a restaurant.

50 ¹³ I say "apparently related" in that the only evidence of what Leach told Fitz are Fitz's brief notes of the conversation.