

**Park Manor Care Center, Inc.¹ and Local 1199,
Drug, Hospital and Health Care Employees
Union, AFL-CIO, Petitioner Local 431.** Case
18-RC-14810

December 18, 1991

DECISION ON REVIEW AND ORDER
REMANDING

BY CHAIRMAN STEPHENS AND MEMBERS
DEVANEY, OVIATT, AND RAUDABAUGH

The issue presented in this case² is the standard by which the Board will determine appropriate bargaining units in nonacute health care facilities. The Board recently adopted a rule for determining appropriate bargaining units for acute care hospitals. 29 CFR § 103.30. That rule was approved by the Supreme Court in *American Hospital Assn. v. NLRB*, 111 S.Ct. 1539 (1991). The Board, however, explicitly excluded from the definition of an acute care hospital “facilities that are primarily nursing homes.” 29 CFR § 103.30(f)(2). For those facilities as well as all other nonacute health care facilities, as defined in Section 2(14) of the National Labor Relations Act, the Board stated that it would determine appropriate units “by adjudication.” 29 CFR § 103.30(g). As the Employer here operates a nursing home, an excluded facility, at which the Petitioner seeks to represent a service and maintenance unit excluding technicals, the Board must now decide whether, and by what standard, the petitioned-for unit is appropriate.

On review, after carefully considering the issue presented and the entire record, the Board has decided to remand the case to the Regional Director for further consideration in light of the principles set out below, and to permit the parties to present further evidence and arguments with respect thereto.

I. THE FACTS

The Employer operates an intermediate care³ nursing home in Fort Dodge, Iowa. Its employees are cur-

rently unrepresented.⁴ The Petitioner seeks a service and maintenance unit, excluding office clericals and technicals; the Employer’s sole technical employees are four licensed practical nurses (LPNs). The parties agree on the scope of the unit,⁵ except that the Employer would include the LPNs, and the Petitioner would exclude them.⁶

The Employer has a staff of 67, including supervisors and employees. It is run by an administrator, assisted by several department heads. The department of nursing is headed by the director of nursing, and under her are 5 registered nurses (RNs, excluded as professionals), the 4 LPNs in issue, 5 certified medication aides (CMAs), and 23 certified nursing aides (CNAs).

The Employer operates three shifts: 6 a.m. to 2 p.m., 2 to 10 p.m., and 10 p.m. to 6 a.m. The director of nursing is generally on duty from 8:30 a.m. to 5 or 6 p.m. Although there are several references in the record to “shift (or charge) nurses,” it is clear that either the director or the assistant director of nursing, an RN, is always on call, and none of the individuals in other classifications, including charge nurse, is alleged to possess supervisory responsibilities.

All employees in the nursing department are involved in direct patient care, with the director of nursing making all assignments. The Employer has no formal job descriptions for RNs, LPNs, CMAs, or CNAs. Although, as indicated, the RNs are professionals whose status and exclusion from the unit are not in dispute, the record indicates that their duties are similar to those of the other department employees, except that only RNs are permitted to make periodic “restraint assessments,”⁷ only RNs administer certain drugs and initiate intravenous therapy, and only RNs can orient new aides.

The LPNs at Park Manor are primarily responsible for passing out medications, providing treatments, and taking routine care of patients. They are not permitted

⁴There have been two prior bargaining units at this facility. In 1976, in Case 18-RC-11024, a union was certified for all full- and regular part-time employees of the Employer (then known as Villa Park Care Center, Inc.), excluding cooks, RNs, LPNs, office clerical employees, guards, and supervisors. The union disclaimed interest in approximately 1987. In 1978, in Case 18-RC-12003, a union was certified for a unit of all technicals, including LPNs; that certification was revoked on November 22, 1983, as a result of the union’s disclaimer following the filing of a decertification petition.

⁵The unit found appropriate by the Regional Director was: All full-time and regular part-time kitchen employees, including dietary aides and med aides, CNAs and CMAs, laundry employees, housekeepers, activities assistants, and maintenance employees employed by the Employer at its Fort Dodge, Iowa nursing home facility; excluding technical employees, licensed practical nurses, housekeeping supervisors, administrative assistants, activities director, director of social services, registered nurses, office clerical employees, guards and supervisors as defined in the Act.

⁶At the hearing, the Petitioner contended additionally that the LPNs were statutory supervisors. The Regional Director found otherwise, and the Petitioner did not request review.

⁷This term is not defined in the record.

¹The Employer’s name appears as amended at the hearing.

²On June 12, 1990, the Regional Director issued a Decision and Direction of Election in which he acceded to the Petitioner’s request to exclude the Employer’s licensed practical nurses (LPNs) from what was otherwise an all-inclusive service and maintenance unit, excluding office clerical employees, on grounds the LPNs were technicals. Thereafter, in accord with Sec. 102.67 of the Board’s Rules and Regulations, the Employer filed a timely request for review, which the Board granted on July 10, 1990. No briefs on review have been submitted.

³At the time of the hearing and the Regional Director’s decision, the Employer was seeking a license to operate 44 of its 100 beds as a skilled care facility. On May 16, 1990, the Iowa State Health Facilities Council granted the Employer a 1-year extension from that date to accomplish the conversion. According to the Employer, conversion to skilled care will lead to an increased role for RNs, with LPNs dealing with a smaller total number of beds.

to initiate or control intravenous therapy, though they may monitor it. They do not possess supervisory authority.⁸ Like other employees in the department, they report to the director of nursing, are hourly paid with extra compensation for overtime, and are required to wear a white uniform for which they are reimbursed by the Employer at the rate of 8 cents an hour. They share the same holidays, sick leave, and additional benefits, such as health insurance, as other employees, and utilize the same promotion and grievance procedures. LPNs have considerable patient contact, and work most closely with CNAs. All employees at the facility, including RNs, LPNs, CMAs, and CNAs, are considered “mandatory reporters” under the state system, in that they are required to report to their supervisor and the State any instances of patient abuse or neglect. The record contains no evidence as to the educational or training requirements for the LPNs.

The other employees in the nursing department are CMAs and CNAs; there are no uncertified aides. As indicated, all employees in the department have substantial patient contact. The CMAs and CNAs possess similar training, skills, and job requirements, and are “on a very similar wage and payment scale,” to LPNs. CNAs receive 20 hours of orientation, plus 75 hours in a classroom, to obtain certification from the State of Iowa. To obtain the higher level CMA certificate, CNAs must take an additional 40-hour course through the community college system. CNAs bathe, clothe, feed, and assist residents in their daily living activities; like LPNs, certified CMAs can also administer medications, assign employees to patients from lists, “chart” the course of patients’ treatment, and serve as charge nurse.

Supervisory meetings are attended only by department heads, but approximately once a month the Employer also holds a professional meeting, attended by RNs, LPNs, and CMAs, at which such subjects as medication administration are discussed. All employees do self-evaluations on Employer-provided forms, but either RNs, LPNs, or CMAs receive another part of each employee’s form for evaluation purposes. LPNs may be evaluated by RNs or CMAs, and vice versa. Neither RNs nor LPNs discipline other employees, but merely gather and report data when appropriate.⁹ LPNs do not keep time records for employees; rather, each employee has her own timecard.

⁸There is some indication in the record that LPNs make assignments to CMAs and CNAs, but these appear to be largely routine dividing of patients among the aides, who then perform duties as previously assigned by the director of nursing.

⁹In fact, all employees fill out generic “write up” forms, reporting information on incidents to the director of nursing, who decides, with the administrator, whether disciplinary action is needed.

II. THE REGIONAL DIRECTOR’S DECISION

Finding that the Employer’s LPNs are technical employees, the Regional Director excluded them from the service and maintenance unit found appropriate, in conformity with the Petitioner’s request and with several cases cited by him.¹⁰ For the most part, the cited cases apply the community-of-interests standard, and hold that technical employees enjoy a separate community of interests.¹¹

The Employer in its request for review argues that, rather than community of interests, the proper test is disparity of interests, which has been characterized by several courts of appeals as being most consistent with the “Congressional directive to ‘prevent undue proliferation of bargaining units in the health care field.’”¹² The disparity-of-interests test requires sharper than usual differences in wages, hours, and working conditions before the requested unit will be granted. The Employer’s position is that such sharper than usual differences do not exist here, especially between the LPNs and the larger group of CNAs and CMAs who are concededly part of the service and maintenance unit. The Employer also points out that there are only four LPNs in the nursing home, and no other technicals.

¹⁰*A.W. Schlesinger*, 260 NLRB 452 (1982); *Highview, Inc.*, 223 NLRB 646 (1976); *Pine Manor Nursing Home*, 238 NLRB 1654 (1978); *Madeira Nursing Center*, 203 NLRB 323 (1973). The Regional Director’s reasoning was: “The Board has held that licensed practical nurses are technical employees who, because of their distinct functions, training, skills and education, do not share a sufficient community of interest with other nontechnical employees to warrant their inclusion in the same bargaining unit.” The Regional Director did not discuss these individual factors as they related to the facts of this case.

¹¹In *Pine Manor*, the Board gave the LPNs a self-determination election, to determine whether they wished to return to the service and maintenance unit (as urged by the intervenor) where they once were, or constitute a separate unit of all technicals (as advocated by the petitioner.) In *Madeira*, the Board discussed historical representation patterns for LPNs, especially in Ohio, and noted its experience that “the duties and responsibilities given to LPN’s vary considerably from one nursing home to another.” Though stating that LPNs could be included in overall units in many situations, the Board found that they could also be excluded, based on their “substantial community of interest among themselves which is separate and distinct from the broader interests they share with the other nursing home employees.” 238 NLRB at 325.

¹²Among the cases cited by the Employer are *Presbyterian/St. Luke’s Medical Center v. NLRB*, 653 F.2d 450, 455 (10th Cir. 1981), and *St. Anthony Hospital v. NLRB*, 884 F.2d 518 (10th Cir. 1989). In its recent decision upholding the Board’s Rule for bargaining units in acute care hospitals, however, the Supreme Court stated the admonition was “best understood as [merely] a form of notice to the Board that if it did not give appropriate consideration to the problem of proliferation in this industry, Congress might respond with a legislative remedy.” *American Hospital Assn. v. NLRB*, 111 S.Ct. at 1545. In any event, the Court held that the Board’s Rule, finding appropriate 8 units in acute care hospitals, did not contravene the admonition; application of the disparity test was not required. *Id.* at 1544–1546.

III. DISCUSSION

For the reasons set out below, we are remanding the case for further consideration that takes account of (1) what was learned about nursing homes, LPNs, and technicals generally in the rulemaking proceeding that led to the Board's Rule governing units in acute care hospitals, and (2) Board cases involving nursing home units issued prior to the rulemaking. As also explained, we believe that the development of a fuller factual record may be necessary to determining whether the LPNs in this case have a community of interests that warrants keeping them separate from a unit that includes the CNAs and CMAs.

A. *The Rulemaking Proceeding*

In its original form, the Board's Rule for bargaining units in acute care hospitals also encompassed nursing homes. 52 Fed.Reg. 25142, 284 NLRB 1516 (1987). The earliest proposed rule contained the same units for small hospitals and nursing homes as for large hospitals, except that instead of providing for separate units of MDs and RNs, it provided for an all-professional unit. The Board decided tentatively to eliminate the narrower units in favor of broader ones (in small hospitals and nursing homes) because it believed that in smaller facilities there would be less division of labor and specialization and thus more functional integration of employees' services than normally is the case in large hospitals. The Board also noted that it expected that there were far fewer professionals other than physicians and nurses in the smaller facilities (especially in nursing homes), and therefore that separate units of "other professionals" were less likely to be appropriate. 53 Fed.Reg. 25148, 284 NLRB at 1524.

Subsequent to hearings conducted at various locations throughout the United States, however, the Board concluded from the evidence presented that a rule concerning appropriate units in nursing homes was neither feasible nor necessary. Thus, the evidence submitted at the hearings revealed that to a larger extent than acute care hospitals, nursing homes varied both in size and type of service rendered. The Board noted that, generally speaking, there are three basic types of nursing home facilities: skilled nursing, intermediate care, and residential care. Skilled nursing homes provide 24-hour inpatient nursing care to chronically ill or stable convalescent patients, are state licensed, and are eligible for both Medicare and Medicaid. Intermediate care facilities also provide 24-hour inpatient care, but care is less intensive and more oriented to daily living. These homes are also state licensed or certified but are eligible only for Medicaid. Residential care facilities meet only social needs, not medical, and are not licensed. The facilities range in size from 10–500 patients. One-third have a capacity for fewer than 50 residents, one-

third for 50–99, and one-third for over 100. See 53 Fed.Reg. 33927–33928, 284 NLRB at 1567.

The evidence also indicated that, unlike hospitals, nursing homes are populated primarily by the elderly and provide long-term care rather than medical treatment of a specific illness. Nursing home staff members are concerned with their residents' physical well-being as well as their social and psychological needs. Thus, there is less diversity in nursing homes among professional, technical, and service employees, and the staff is more functionally integrated. Generally, nurses provide a less intensive, lower level of care to patients in skilled and extended care facilities than that provided in acute care hospitals, and thus receive lower salaries. The evidence further indicated that there is for the most part little difference between the duties of LPNs and those of nurses aides. Both are primarily responsible for providing nursing care to patients. The Board observed, "there appears to be a greater overlap of functions as well as greater work contact between the various nursing home non-professionals." 53 Fed.Reg. 33928, 284 NLRB at 1567.

In commenting on the differences between nursing homes, the Board noted that they have resulted in greater differences in organization, regulations, and staffing patterns. For example, duties of staff may vary with the size of the institution. Also,

[i]n a small, 10-resident facility, the staff will have overlapping responsibilities, and thus an overall unit would be appropriate. In a large, skilled care facility with specialized units (see *infra*), more than one unit might be appropriate. In an intermediate care facility which also cares for the mentally disabled as a result of trauma, there may be a separate group of employees, such as psychiatrists, who have distinct supervision and little contact with other professionals.

53 Fed.Reg. 33928, 284 NLRB at 1567–1568.

The Board also received evidence that regulations with respect to staffing patterns and employee qualifications vary widely from State to State. For example, Connecticut requires more skilled nursing care than Iowa, where the instant case arises, and in some States, skilled nursing facilities must have 24-hour RN coverage. A majority of States have no specific training requirements. In Massachusetts, for example, nursing homes must be staffed by LPNs or RNs, and they are required to provide substantial direct patient care. In contrast, in Indiana, with lesser staffing requirements, nurses aides provide direct patient care, and LPNs perform RN-type duties such as distributing medication and assisting doctors.

Moreover, the nursing home industry is also in a period of rapid transition. Growth is now rapid owing to the increased population of older persons, as family re-

sponsibility for older parents lessens. In addition, many longterm facilities will increasingly offer nontraditional specialized services, i.e., head and spinal cord injury units, Alzheimers, respiratory therapy, hospice care, AIDS, and home health care. These services require different staffing needs. The staff in a specialized service area such as a coma unit may also be far more integrated than nurses and aides who work in the nursing area.

Finally, the Board noted that there has been no prolonged litigation and no party has expressed any problem in the area. The Board thus concluded that it was best to continue a case-by-case approach with respect to nursing homes.

Having decided to make unit determinations in nursing homes by adjudication, the Board now faces the question of the proper method of analysis in reaching such determinations. The Board has traditionally determined appropriate units based on the community-of-interests standard and, for a short period, a disparity-of-interests standard. Under those standards, the Board evaluates various factors, including similarity of wages and hours, extent of common supervision, frequency of contact with other employees, and area practice and patterns of bargaining. However, such conceptual formulations as “community of interests” and “disparity of interests” were abandoned by the Board in the course of promulgating its rule respecting appropriate bargaining units in acute care hospitals, although it recognized that the factors it was considering were similar to those under the prior tests.¹³ Indeed, the Board noted that it had earlier minimized the theoretical difference between the two tests, and that perhaps the differences were largely semantic.¹⁴ In any event, the Board stated that its decision to determine units by rulemaking reflected a desire to replace earlier doctrinal applications with formulation of units based on the realities of the workplace, as learned from evidence presented during the rulemaking proceedings.¹⁵

Although the Board’s decision to adopt a rule with respect to acute care hospitals was unanimously upheld by the Court, we do not have a sufficient body of empirical data as to nursing homes to make a uniform rule as to them at this time, and perhaps never will because we are not sure that all are sufficiently uniform to warrant finding the same units appropriate for all.

¹³ Such factors included:

uniqueness of function; training, education and licensing; wages, hours and working conditions; supervision; employee interaction; and factors relating to collective bargaining, such as bargaining history, matters of special concern, etc. Location and scope of job market may be relevant: i.e., whether the classification is part of a job market external to the facility or even to health care, or rather shares a job market with others in the facility or, perhaps, in the areawide health care community

53 Fed.Reg. 33905-33906, 284 NLRB at 1536.

¹⁴ See, e.g., *St. Vincent Hospital*, 285 NLRB 365, 367-368 (1987).

¹⁵ 53 Fed.Reg. 33905, 284 NLRB 1535.

Moreover, we do not choose at this time to substitute for either “disparity of interests” or “community of interests” yet another short-hand phrase by which units in all nursing homes or other nonacute care facilities will be measured. Instead, we prefer to take a broader approach utilizing not only “community of interests” factors but also background information gathered during rulemaking and prior precedent. Thus, as more fully set forth below, our consideration will include those factors considered relevant by the Board in its rulemaking proceedings, the evidence presented during rulemaking with respect to units in acute care hospitals, as well as prior cases involving either the type of unit sought or the particular type of health care facility in dispute.¹⁶ We hope, however, that after various units have been litigated in a number of individual facilities, and “after records have been developed and a number of cases decided from these records, certain recurring factual patterns will emerge and illustrate which units are typically appropriate.”¹⁷

Although nursing homes were excluded from the Board’s rulemaking, the Board nonetheless believes that comparing and contrasting individual nursing home work forces with those in acute care hospitals would aid in determining appropriate units. As the instant case involves the appropriateness of a technical unit,¹⁸ we note that the evidence with respect to technicals found by the Board in its rulemaking proceeding to be a separate appropriate unit in acute care hospitals indicates that they occupy various classifications such as medical laboratory, respiratory therapy, radiography, emergency medicine, and licensed practical nurse. The record showed they perform jobs involving the use of independent judgment and specialized training, whereas service and maintenance employees generally perform unskilled tasks and need at most a high school education. Most hospital technicals are either certified, licensed, or state-registered. Although “de-skilling” is occurring in some specialties, the Board found that the gap was tending to widen be-

¹⁶ For those most comfortable with verbal formulas, perhaps this might be referred to as the “pragmatic or empirical community of interests” approach. Compare the “expanded community of interests” test concerning the inclusion of relatives of owners as set forth in *Futuramik Industries*, 279 NLRB 185 (1986), and approved by the Supreme Court in *NLRB v. Action Automotive*, 469 U.S. 490 (1985).

¹⁷ *St. Francis Hospital*, 271 NLRB 948, 953 fn. 39 (1984), an approach cited with apparent approval in the Supreme Court’s opinion. *American Hospital Assn. v. NLRB*, 111 S.Ct. at 1546.

¹⁸ Though this issue arises in this case as the requested exclusion of technical employees from a service and maintenance unit, the prospective appropriateness of technical employees as a separate unit is obviously the controlling consideration. If the technical employees could not themselves constitute a separate appropriate unit, perforce they must be included in the service and maintenance unit here sought.

tween technicals and other employees, with higher levels of skill being generally required for the technicals.

The Board further observed, based on evidence in the rulemaking proceeding, that technicals in acute care hospitals earn approximately \$2000 per year more than service employees. Their wages are tied to the earnings of the more highly skilled technologists with whom they work, whereas the wages of unskilled service employees are tied to the unskilled labor market. The Board noted that technicals tend to work in laboratories rather than patient care areas, and that cross-training of technicals was shown to occur almost exclusively with other technicals, thus maintaining the integrity of the technical classification.

Whether some or all of these factors are present here should be considered in determining whether technicals in nursing home facilities constitute a separate appropriate unit or, conversely, must be included in a requested service and maintenance unit.

In addition, the Board in its rulemaking for acute care hospitals set forth a number of other considerations by which it would be guided:

[I]n exercising its discretion to determine appropriate units, the Board must steer a careful course between two undesirable extremes: If the unit is too large, it may be difficult to organize, and, when organized, will contain too diversified a constituency which may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent; on the other hand, if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage whip-sawing, and may even be deleterious for the union by too severely limiting its constituency and hence its bargaining strength. [Footnote omitted.] The Board's goal is to find a middle-ground position, to allocate power between labor and management by "striking the balance" in the appropriate place, with units that are neither too large nor too small. [Footnote omitted; 53 Fed.Reg. 33904, 284 NLRB 1534.]

These general principles are equally applicable to unit determinations in nonacute care facilities.

We also note that some of the earlier described matters as to which evidence concerning nursing homes was taken in the rulemaking proceeding should also be considered even though the Rule itself excludes nursing homes. For example, the Board observed, *inter alia*, from the limited evidence it received, that:

[T]here is less diversity in nursing homes among professional, technical and service employees, and the staff is more functionally integrated [cites to testimony omitted]. Generally, nurses provide a

less intensive, lower level of care to patients in skilled and extended care facilities, and thus receive lower salaries than that paid in acute care hospitals [cites to testimony omitted]. . . . [T]here is for the most part little difference in the duties of LPNs and nurses' aides [cites to testimony omitted]. Both are primarily responsible for providing nursing care to patients. [53 Fed.Reg. 33928, 284 NLRB 1567.]

We must examine the record here to determine to what extent the facts at this nursing home accord with the generally observations made in the course of the rulemaking proceeding.

B. Prerulemaking Unit Cases Concerning LPNs at Nursing Homes

A number of cases prior to issuance of the Rule, involving units at nursing homes, should also be considered. Noting in one pre-1974 case that "the duties and responsibilities given to LPN's vary considerably from one nursing home to another," the Board nonetheless made reference to "the educational requirements generally prevailing for the practice of licensed practical nursing,"¹⁹ and found that the LPNs in that case enjoyed a "substantial community of interest among themselves which is separate and distinct from the broader interests they share with other nursing home employees,"²⁰ thus warranting their exclusion from the requested unit. Moreover, in a lead case shortly after passage of the 1974 health care amendments, the Board found LPNs to be technical employees, and included them with all other technicals.²¹ Since that time, LPNs have almost always been found to be technicals in adjudicated cases.²²

Nonetheless, even in nonhealth care facilities, while technicals are frequently excluded from broader units, they are not *automatically* excluded. In *Sheffield Corp.*, 134 NLRB 1101 (1961), the Board announced that, thenceforth, it would "make a pragmatic judgment in each case [involving placement of technicals], based upon an analysis of the following factors, among others: desires of the parties, history of bargaining, similarity of skills and job functions, common supervision, contact and/or interchange with other employees, similarity of working conditions, type of industry, organization of plant, whether the technical employees work

¹⁹ *Madeira Nursing Center*, 203 NLRB 323, 325 (1973).

²⁰ *Ibid.*

²¹ *Barnert Memorial Hospital Center*, 217 NLRB 775, 780-781 (1975). See also *Newington Children's Hospital*, 217 NLRB 793 (1975).

²² *Pine Manor Nursing Home; Trinity Memorial Hospital of Cudahy*, 219 NLRB 215, 216 (1975); *Alexian Bros. of Elizabeth*, 219 NLRB 1122 (1972); *St. Catherine's Hospital of Dominican Sisters*, 217 NLRB 787 (1975). See also *Southern Maryland Hospital Center*, 274 NLRB 1470, fn. 1 (1985). But see *Children's Hospital of Pittsburgh*, 222 NLRB 588 (1976).

in separately situated and separately controlled areas, and whether any union seeks to represent technical employees separately.” *Supra* at 1103–1104 (footnote omitted). Many of these factors are relevant in nonacute health care cases.

C. Conclusion

Though the instant case was heard and decided after the Board had promulgated the final rule, the Regional Director applied the traditional, community-of-interests standard,²³ concluding that the LPNs, as technicals, should be excluded because of their “distinct functions, training, skills and education.”

Obviously, the Regional Director did not analyze this case under the approach discussed above. In addition, the parties have never had an opportunity to address the issue in this case from this perspective.

Moreover, the present record fails to answer some of the questions we have posed. There is no evidence as to the education and training required of the Employer’s LPNs; nor is there evidence as to their pay as compared to that of other nonprofessionals. The record

²³In *St. Vincent Hospital*, 285 NLRB 365 (1987), decided while the rulemaking proceeding was pending, the Board stated that the disparity-of-interests test would be applied until the final rule was issued.

reveals that there are only a few functions performed by LPNs that are not performed by CMAs and CNAs and that the LPNs’ greatest contact is with CMAs and CNAs. All employees in the nursing department have considerable patient contact. Finally, there are only four LPNs, a number too few to lead automatically to a separate technical unit even if this were an acute care hospital subject to the Rule.²⁴

Accordingly, we have decided to remand the case to the Regional Director to consider and address all the factors set forth above. On remand, the Regional Director may reopen the hearing, should any party request it, to adduce additional evidence. Lastly, we have noted the Employer’s plans to convert a number of beds to skilled care leading, allegedly, to a further demarcation between the skill levels of RNs and those of other employees. We invite the parties to argue all pros and cons of the inclusion or exclusion of the LPNs from the unit in the circumstances that now exist at the Employer’s nursing home.

ORDER

This case is remanded to the Regional Director for further processing in conformity with this opinion.

²⁴Units of five or fewer are, under the Rule, an “extraordinary circumstance.” 54 Fed.Reg. 16341–16342, 284 NLRB 1588.