)

Secretary of Labor,	*	
Complainant,	*	
	*	
v.	*	OSHRC Docket No. **97-0023**
	*	
Thoroughgood, Inc., d/b/a Azalea Court,	*	
Respondent.	*	

)

APPEARANCES

Theresa C. Timlin, Esq.
Office of the Solicitor
U. S. Department of Labor
Philadelphia, Pennsylvania
For Complainant

Kenneth L. Oliver, Jr., Esq.
Obermayer, Rebmann, Maxwell & Hippel, LLP
Philadelphia, Pennsylvania
For Respondent

Before: Administrative Law Judge Nancy J. Spies

DECISION AND ORDER

Thoroughgood, Inc., d/b/a Azalea Court (Azalea), contests the November 25, 1996, serious citation issued to it as a result of the Occupational Safety and Health Administration's (OSHA) inspection of its personal care facility on September 19, 1996. The citation alleges that Azalea violated § 1910.141(a)(5) (item 1) by failing to prevent the entrance or harborage of rodents and insects. The citation also alleges ten separate violations of the bloodborne pathogens standard, § 1910.1030, *et seq*. The alleged violations of this standard are: §§1910.1030(c)(1)(i) (item 2) failing to establish a written exposure control plan; 1910.1030(d)(1) (item 3a) failing to practice universal precautions; 1910.1030(d)(2)(i) (item 3b) failing to use work practice and engineering controls; 1910.1030(d)(3)(i) (item 3c) failing to provide appropriate personal protective equipment (PPE) for personal care attendants (PCAs); 1910.1030(d)(4)(iii)(B)(1)(iii) (item 3d) failing to place regulated waste in appropriate containers; 1910.1030(d)(4)(iv)(A)(2) (item 3e) failing to place contaminated laundry in appropriate containers; 1910.1030(d)(4)(iv)(B) (item 3f) failing to provide

appropriate PPE to laundry personnel; 1910.1030(d)(4)(iv)(C) (item 3g) failing to place laundry shipped to an outside facility in appropriate containers; 1910.1030(f)(2)(i) (item 4) failing to make hepatitis B vaccinations available to employees; and 1910.1030(g)(2)(i) (item 5) failing to provide a training program for employees exposed to bloodborne pathogens.

Azalea argues that its extermination program complied with the standard and that the bloodborne pathogen standard was inapplicable to Azalea's facility. Alternatively, Azalea argues that the cited sections of the bloodborne pathogen standard were not violated. A hearing was conducted in this case in Philadelphia, Pennsylvania. For the reasons stated below, the Secretary prevails on certain of the issues, and Azalea prevails on others.

Facts

Azalea is a residential care home located in downtown Philadelphia, Pennsylvania. Azalea, a facility called Ivy Ridge, and other personal care homes are owned by one individual, Rosalind Lavin (Tr. 150-53). Azalea housed approximately 70 or 80 men and women. The majority of the residents required only "non-personal" care, meaning they could care for most of their own needs, while 10 or 15 residents needed assistance caring for themselves (Tr. 60, 83, 521). Some residents had physical or mental disabilities, Alzheimer's disease, or slight dementia (Tr. 508). One resident suffered from full-blown AIDS (Tr. 538).

The inspection arose from a "non-formal" complaint filed with the OSHA Philadelphia Area Office.[1] Following Azalea's "unsatisfactory" response, OSHA assigned industrial hygienist Judith Posusney to inspect the facility (Tr. 118-19).

The Azalea staff included personal care assistants (PCAs); housekeepers, who were responsible for the cleanliness of the facility and for changing bed sheets; cooks; dishwashers; and a laundry worker.

[1] A nonformal complaint is an "[o]ral or unsigned complaint[], or [a] complaint[] by former employees or non-employees." OSHA Field Inspection Reference Manual (FIRM) I-(C)(2)(d). Donna Baker, an employee of an outside program housed at Azalea's facility, testified that she filed the written complaint with OSHA (Tr. 50). The FIRM specifies that "[i]f no action has been taken [on the part of the employer], the nonformal complaint shall normally be activated for inspection." FIRM, I-(C)(7)(d)(1).

Discussion

In order to establish a violation of an occupational safety or health standard, the Secretary must prove:

> (a) the applicability of the cited standard, (b) the employer's noncompliance with the standard's terms, (c) employee access to the violative conditions, and (d) the employer's actual or constructive knowledge of the violation (*i.e.*, the employer either knew, or with the exercise of reasonable diligence could have known, of the violative conditions).

Atlantic Battery Co., 16 BNA OSHC 2131, 2138 (No. 90-1747, 1994).

Hearsay Testimony

During the course of the hearing, the Secretary attempted to introduce several out-of-court statements through Posusney. Certain statements attributed to individuals, offered as party-opponent non-hearsay, were deemed inadmissable under the Federal Rules of Evidence (FRE) and were excluded. For these and for other excluded statements, the Secretary argues that the Commission is subject to the Administrative Procedures Act, 5 U.S.C. § 551, *et seq.*, (APA) and that hearsay evidence should be generally admissible in administrative proceedings. In hearings before the Commission, however, the Federal Rules of Evidence have been made explicitly applicable. 29 C.F.R. § 2200.71. Hearsay statements are not generally admissible, but can be admitted if they fall within the oft-invoked provisions of FRE Rule 801(d)(2)(D) or other applicable Federal Rules of Evidence. *See Regina Construction Company*, 15 BNA OSHC 1044, 1047-48 (No. 87-1309, 1991). The Secretary's proffered statements did not qualify for admission under the FRE.

Citation 1

Item 1: § 1910.141(a)(5)

The Secretary alleges that Azalea did not prevent the entrance or harborage of rodents and insects in its facility. The standard provides:

> Every enclosed workplace shall be so constructed, equipped, and maintained, so far as reasonably practicable, as to prevent the entrance or harborage of rodents, insects, and other vermin. A continuing and effective extermination program shall be instituted where their presence is detected.

Since the 1960s, Azalea's residential care facility has operated in an older three-story structure located in the inner city of Philadelphia (Tr. 543). Mice and insects were observed in the Azalea facility by the employee witnesses, as well as by the contract employee Donna Baker. Mice were sighted in the back of the facility near the dispensary, in a dining room, and in the hallway. Roaches were seen in the dining room. The facility was not air-conditioned, and residents frequently propped open a rear-door near the facility's dumpster (Tr. 18-19, 42-44, 51, 61). The regular presence of flies was reported.

Azalea contends that the standard does not require a workplace to be "free of rodents," but only that there be a "continuing and effective program of extermination" (Azalea brief, pp. 6-7). The standard requires that the workplace be maintained vermin free "as far as reasonably practicable." As Azalea suggests, it may not always be reasonable for such an older facility to be completely vermin free where food is prepared and where numbers of people live in close quarters.

As required for personal care facilities, Azalea had a regularly-scheduled vermin control program. The contract exterminator, SAB Environmental Services, submitted reports of its bi-monthly inspections to Azalea. Relying on SAB's reports for an approximate nine-month period (Exh. C-8), the Secretary argues that Azalea's vermin control program was ineffective. The reports repeatedly indicated the presence of "harborage areas," "openings," and "rodent dropping[s]." SAB's technicians reiterated that Azalea should repair a hole in a "pot sink" and that "openings and cracks" should be sealed "throughout."[2] Even assuming that some of the comments refer to different areas of deficiency in the facility (with the exception of the "pot sink" and sealing cracks "throughout"), the reports document the existence of vermin control problems which remained uncorrected for long periods, including the period at issue here.

It was reasonably practicable for Azalea to follow SAB's recommendations on how to lessen its vermin infestation. Because Azalea repeatedly ignored the recommendations of its own vermin control contractor, and because vermin were continually observed during the period at issue, it is

[2]The direction to seal the hole under the "pot sink" is found in the sanitation reports dated February 9 and 23, May 10, June 28, September 13, and October 11 and 21, 1996, and to "seal all cracks and holes throughout" appears in the February 23, March 8, April 26, May 24, June 28, August 23, September 13, and October 25 reports.

concluded that Azalea neither prevented the harborage of vermin nor instituted an effective vermin control program. Azalea violated the terms of the standard.

Vermin and insects were in areas accessed by employees. Even if the vermin sightings were not reported to management, Azalea had constructive knowledge of the deficiencies in its vermin control efforts through SAB's reports. Also, it could have observed the vermin had it inspected its premises (Tr. 356).

Dr. Angela Presson, a medical officer with the Office of Occupational Medicine, Department of Labor, provided compelling expert testimony on the health hazards vermin present to humans. Rodents, insects, and their excreta carry disease and infectious parasites, such as tapeworms and echinococcus, salmonella, and shingles, although the potential illnesses depend upon factors specific to the site. Mice seen out in the open and near food sources are usually unafraid of humans. These are typically the most dominant and aggressive of the species and can be expected to bite or scratch humans (Tr. 399, 421-23, 426-427, 473-75).

A violation is serious if there is a substantial probability that death or serious physical harm could result. It is not necessary that there is a substantial probability that the employees would become infected after coming into direct contact with the vermin or their excreta. It is only necessary to prove that the contact is possible and that death or serious physical harm could result. The likelihood of infection is an important factor in assessing the gravity of the violation for penalty purposes, rather than for determining whether the violation is serious. *See, e.g., Bethlehem Steel Corp. v. OSHRC,* 607 F.2d 1069 (3rd Cir. 1979). Death is not probable, but serious illnesses from exposure to vermin-carried viruses and bacteria can occur (Tr. 421-427). The violation is affirmed as a low-gravity serious violation.

The Commission must give "due consideration" to the size of the employer's business, the gravity of the violation, the employer's good faith, and history of past violations in determining an appropriate penalty. *J.A. Jones Constr. Co.,* 15 BNA OSHC 2201, 2213-14 (No. 87-2059, 1993). These factors are not accorded equal weight. The gravity of the violation is the primary element in the penalty assessment. *Trinity Indus.,* 15 BNA OSHC 1481, 1483 (No. 88-691, 1992). The Secretary properly allowed a 40 percent credit because of the small size of the facility and a 10 percent credit because Azalea had no past history of OSHA violations (Tr. 148, 212, 214-15).

Since Azalea made little or no effort to correct its harborage problems, no credit is afforded for good faith. Twenty-seven employees were potentially exposed (Tr. 156). Considering these factors and the low gravity of the violation, a penalty of $800 is assessed.

Bloodborne Pathogen Standard Is Applicable

Items 2a through 4 relate to specific provisions of the bloodborne pathogen standard, 29 C.F.R. § 1910.1030, *et seq*. Azalea argues that the standard is inapplicable.

The bloodborne pathogen standard "applies to all occupational exposure to blood or other potentially infectious materials" under § 1910.1030(b). "Occupational exposure" is "reasonably anticipated skin, eye, mucous membrane, or parenteral[3] contact with blood or other potentially infectious materials that may result from the performance of an employee's duties." "Blood" is defined as "human blood, human blood components, and products made from human blood," while "other potentially infectious materials" are defined as:

> (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids . . . .

Azalea argues that the standard is meant to apply only to "healthcare workers, undertakers, healthcare laboratories, or other places where there is regular exposure to liquid blood," not to Azalea's personal care facility (Azalea brief, p. 4). Azalea mistakenly focuses on particular industries where exposures are expected. The standard, in contrast, is concerned with the specific tasks which result in exposures, regardless of the industry. *American Dental Ass'n v. Martin*, 984 F.2d 823 (7th Cir. 1993). The standard applies to an employer where employees are exposed to blood or other potentially infectious bodily materials, and the exposures are reasonably anticipated."[4]

---

[3]Parenteral is defined as "piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions" § 1910.1030(b).

[4] Even assuming *arguendo* that it is necessary to show that the potentially infectious contact caused exposure to skin, eye, mucous membrane, or parenteral contact, Azalea's workers contacting, for example, blood soaked incontinence pads or used insulin needles, were physically exposed in a manner which satisfies this requirement. The condition of the employees' dermis is not controlling. Azalea argues that "contact" (referenced in a non-existent section of the standard) cannot be considered contact with "intact skin." Possibly Azalea refers to

(continued...)

As the Secretary contends, three categories of Azalea's employees perform tasks where exposures are reasonably anticipated: the PCAs, the housekeepers, and the laundry worker (and those who fill in for these positions).

(1) PCAs: Azalea's PCAs bathe, shave, and dress residents. They change soiled bed linens when housekeeping is not on duty (Tr. 55, 164). Since at least two residents were pre-menopausal and required assistance during their menstrual cycle, PCAs changed incontinence pads soaked with blood, as well as blood-soaked sheets (Tr. 84-86, 96).[5] Employees were exposed to blood while shaving male residents. Because of mental or physical disabilities, some residents were difficult to shave; and cuts did occur (Tr. 71-72). Despite contrary assertions by Azalea Resident Services Coordinator Lilian Black, PCAs changed residents' bandages and bandaged cuts (Tr. 71, 95). One resident received care for a gangrenous leg and his open sore which oozed blood and bodily fluids (Tr. 183). Employees also described caring for a resident who frequently fell and cut himself, causing a significant amount of bleeding. Although the time in which this particular resident lived at Azalea was questioned, employees did regularly attend to bleeding wounds that were not considered severe enough to merit the care of a doctor or registered nurse (Tr. 61, 65, 92). Three residents at the facility required insulin injections, and at least one resident was not always able to self-inject insulin (Tr. 516-17). Azalea's PCAs dispensed syringes for self-injection, then disposed of the contaminated needles, or injected residents who were unable to do this for themselves (Tr. 522).

Azalea counters that first aid duties were not assigned to its employees. Resident Services Coordinator Black testified that Azalea does not have a registered nurse on staff, and that if a wound required bandaging, the resident would be sent to the hospital or a doctor would be called (Tr. 509-10). The record does not bear this out. Further, Azalea required PCAs to be trained in first aid,

---

[4](...continued)
the definition of an "exposure incident," which is irrelevant to a determination of occupational exposure.

[5] The Secretary argued that the PCAs were also exposed when changing incontinence pads soiled with feces and blood. Under OSHA's policy, feces and urine are considered potentially infectious only when they are visibly contaminated with blood. § 1910.1030(b). The Secretary did not prove that the employees had contact with feces visibly contaminated with blood.

cardiopulmonary resuscitation, and the Heimlich Maneuver. According to Black, this training was provided solely because the state required it (Tr. 528). *See* Pennsylvania Code Title 55, Section 2620.73(d). Azalea's suggestion that its employees waited by an injured resident for the arrival of an ambulance or doctor was unconvincing in light of other testimony. The failure to act would seemingly defeat the spirit of the Pennsylvania law.

(2) Housekeepers: Azalea's housekeepers cleaned rooms, disposed of waste, and removed and bagged soiled bed linen. The housekeepers were exposed to bloodborne pathogens when the linen was soiled with the residents' menstrual and other blood and bodily fluids from sores or wounds (Tr. 510-511).

(3) Laundry worker: Azalea sent its soiled bed linen to a commercial laundry, but the laundry worker washed towels and personal items, such as nightclothes, onsite. The laundry worker sorted soiled garments before washing them.[6] On rare occasions, the laundry worker was asked to wash bloody bandages (Tr. 169, 171-172, 262, 328).

Exposure was "reasonably anticipated" and predictable as each of the three classifications of employees performed their required duties. PCA Felicia Ennis estimated that during her employment at Azalea, on average, her uniform came in contact with blood or other bodily fluids three time a week (Tr. 70-71). The bloodborne pathogen standard is applicable to Azalea's facility.

Item 2: § 1910.1030(c)(1)(i)

The Secretary alleges that Azalea did not establish a written exposure control plan in violation of § 1910.1030(c)(1)(i). The standard provides:

> Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

The purpose of the standard is to eliminate or reduce occupational exposure to bloodborne pathogens. As discussed, exposure at Azalea was "reasonably anticipated" for its PCAs, housekeepers, and laundry personnel. Azalea should have examined its procedures to determine

[6] The Secretary believed that the laundry worker also shook out and counted the bed linen before it was sent to the commercial laundry. The exposure to blood arguably may have been greater if this occurred. However, the record does not support that bags of soiled bed linen were opened before being sent to the outside laundry.

where, how, and to whom exposures could occur. This is the important first step of exposure control, and its assessment should have been reduced to writing. Having been asked for Azalea's exposure control plan, Administrator Peg Bucci gave Posusney a document entitled "Instructions to All Employees Re: AIDS" (Exh. C-6; Tr. 154, 176-77). The document sets out in its "Ivy Ridge Personal Care Policy" that HIV and AIDS residents have the same rights as other residents and that their records were to remain confidential. The document in no way constitutes a plan "designed to eliminate or minimize employee exposure" to bloodborne pathogens. Azalea offered no other bloodborne pathogen-related document. The violation is affirmed. Failure to devise methods and procedures to control exposures limits the employees' ability to protect themselves from contagion with HIV or HBV, both grave diseases (Tr. 404 - 406). The violation is affirmed as serious.

The gravity of the violation is high. Twenty employees would have been covered by the plan had Azalea complied with the standard. Contrary to the FIRM IV- (C)(2)(i)(2), Posusney did not recommend a 40 percent penalty credit in recognition of Azalea's small size (Tr. 224). She mistakenly believed that no credit for size was appropriate for a high gravity violation. Considering this and other penalty factors discussed for item 1, a penalty of $3,500 is assessed.

Item 3a: § 1910.1030(d)(1)

The Secretary alleges that Azalea failed to observe universal precautions in violation of § 1910.1030(d)(1). The standard provides:

> Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

Section 1910.1030(b) defines "universal precautions" as "an approach to the control of infection . . . [where potentially infections substances] are treated as if known to be infectious." Because blood from "source individuals" cannot reliably be identified or segregated, precautions are taken with all blood and infectious fluids. Azalea contends that the Secretary provided no real proof that it failed to follow universal precautions. Azalea notes that its employees were afforded latex gloves and sharps containers. Although gloves and sharps containers are components of the practice of universal precautions, it is not all the standard requires. This section of the bloodborne pathogens

standard requires an "approach" or "a standard of care" to possible contagion (Tr. 434). The specifics of what the "approach" requires are set out in subsequent sections of the standard. However, having this standard of care is a separate requirement for employers with exposure to bloodborne pathogens.

The Secretary primarily relies on Bucci's admission to Posusney that the facility had not enacted universal precautions (Tr. 180-81). In addition, the Secretary points out that Azalea's employees did not have PPE consistently available, were not provided with hepatitis B vaccinations, were not trained in avoiding exposure, and were not even familiar with the term bloodborne pathogens (Tr. 487). It is determined that Azalea did not observe universal precautions and that Bucci and others in management were aware of that fact. Failure to practice universal precautions lessens the chance of avoiding contagion with a grave, infectious disease. The violation is affirmed as serious.

Item 3b: § 1910.1030(d)(2)(i)

The Secretary alleges that Azalea did not employ engineering or work practice controls to minimize occupational exposure to bloodborne pathogens in violation of § 1910.1030(d)(2)(i). The standard provides:

> Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

"Engineering controls" are defined as "controls (*e.g.*, sharps disposal containers, self-sheathing needles) that isolate or remove the bloodborne pathogens hazard from the workplace," while "work practice controls" are defined as "controls that reduce the likelihood of exposure by altering the manner in which a task is performed (*e.g.*, prohibiting recapping of needles by a two-handed technique)." Section 1910.1030(b). When an employer has occupational exposure to bloodborne pathogens, it must first attempt to eliminate or lessen the exposure through engineering and work practice controls before relying on PPE. Azalea had some engineering and work practice controls in place, such as sharps disposal containers and latex gloves, although the parties dispute whether gloves were always available.

According to Posusney, Azalea did not institute the engineering control of using red bio-hazard bags for regulated waste and did not use the work practice controls of requiring employees to wear impervious gowns to change bandages. Nor, allegedly, did employees always wash their hands after removing their gloves or when contacting other blood or bodily fluids (Tr. 237, 240-41). However, there is no proof that employees failed to wash their hands when necessary. For the rest, these are the same asserted facts, requiring the same abatement, which the Secretary relies on to support violations of other sections, discussed below, which more specifically apply to the alleged conditions. *See Flint Engineering & Constr. Co.*, 15 BNA OSHC 2052, 2056-57 (No. 90-2873, 1992). The facts asserted do not sufficiently support the alleged violation. Item 3b is vacated.

Item 3c: § 1910.1030(d)(3)(i)

The Secretary alleges that Azalea did not provide employees with personal protective equipment impervious to contaminants in violation of § 1910.1030(d)(3)(i). The standard provides:

> When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

If engineering and work practice controls do not eliminate exposure, employees must utilize PPE. Azalea's employees generally wore gloves while caring for the personal needs of residents. However, PCA Ennis, among others, testified that Azalea ran out of gloves "a lot," usually on a monthly basis. Even without gloves, she continued to perform her duties, including shaving residents and changing incontinence pads soiled with menstrual blood. She simply "tried her best" not to get anything on her hands (Tr. 97-98). Former employee Droxine Sample, employed at the facility during the time of the inspection, also testified that the facility would run out of gloves (Tr. 122-23, 131-32, 145-46). As discussed, Azalea could reasonably anticipate that its PCAs would be exposed to blood and other bodily fluids on a regular and recurring basis.

It knew that PPE was required but that gloves were not always available. Its management was attempting to control what it considered the employees' overuse of gloves. Also, when gloves were not available, Ennis noted the fact in the log book (Tr. 98, 131-32).

The types of PPE needed for specific tasks should be determined by the employer, after it realistically assessed the facts (Tr. 247). The standard does not require that all the types of PPE included in the standard be provided to employees. The record establishes that, at a minimum, Azalea was required to provide protective gloves. Since Azalea did not consistently provide PPE in the form of gloves to its employees during the applicable period, the violation is affirmed. Exposure to blood can result in contracting grave diseases of HIV or HBV. The violation is affirmed as serious.

Item 3d: § 1910.1030(d)(4)(iii)(B)(1)(iii)

The Secretary alleges that regulated waste (other than sharps) was not placed in appropriate containers in violation of § 1910.1030(d)(4)(iii)(B)(1)(iii). The standard provides:

> Regulated waste shall be placed in containers which are: . . . labeled or color-coded in accordance with paragraph (g)(1)(i) this standard.

Regulated waste is defined as:

> liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling . . . .

Incontinence pads from menstruating residents, bandages, and dressing from the residents' sores or wounds, which the PCAs treated at the facility, constituted regulated waste. The PCAs explained that all waste, including regulated waste, was disposed of by placing it in unmarked, green plastic bags (Tr. 129, 524). Many employers comply with the requirement for disposal of regulated waste by using readily-available red bio-hazard plastic bags. During her inspection, Posusney did not observe these or any other identifiable containers for regulated waste. Bucci told her that after a recent contact with a state agency Azalea had the red bags. Resident Services Coordinator Black explained that red bags were available at the time of the inspection, but they were kept in a drawer in her office, in case they were needed. In Black's opinion, the red bags were needed if someone whose medical history was unknown to her was badly hurt and bleeding (Tr. 154, 253, 557-58). Even if Azalea had the red bags at the facility, employees were not aware

that they should use them to dispose of the regulated waste which it routinely generated. In fact, Angela Bridges, who held the same position as Black, did not know that Azalea had the red bags at the facility (Tr. 590). Bio-hazard containers or red bags should have been used for all regulated waste, not only those which prompted Black's concern. Failure to properly identify regulated waste may lead to contagion through contact with blood or infectious bodily fluids. The violation is affirmed as serious.

Item 3e: § 1910.1030(d)(4)(iv)(A)(2)

The Secretary alleges that contaminated laundry was not placed or transported in appropriate containers in violation of § 1910.1030(d)(4)(iv)(A)(2). The standard provides:

> Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded . . . . When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with Universal Precautions.

As with regulated waste, contaminated laundry must be identifiable so that employees know it requires special handling. Azalea laundered towels and the residents' personal clothing at the facility, but sent its soiled bed linen to a commercial laundry (Tr. 255, 262). At times, the bed linen and the personal clothing were contaminated with blood and bodily fluids (Tr. 92-97). Laundry contaminated with blood and bodily fluids should have been placed in bags or identified containers.

Resident Services Coordinator Black testified to Azalea's procedure for handling laundry. Neither her description nor that of the interviewed or testifying employees included any special handling for contaminated laundry. The housekeepers (and the PCAs if the housekeepers were not available) gathered the soiled items off the beds and from the rooms and placed them in the same type of unmarked green bags used for all waste (Tr. 534-525). Failure to place items contaminated with blood into recognizable containers or bags violated the standard. Because bloodborne pathogens can be passed to employees either in the liquid, semi-liquid, or dried blood states, as would commonly be found in laundry, the violation is affirmed as serious.

Item 3f: § 1910.1030(d)(4)(iv)(B)

The Secretary alleges that employees who had contact with contaminated laundry were not provided with appropriate personal protective equipment in violation of § 1910.1030(d)(4)(iv)(B). The standard provides:

> The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

Contaminated laundry is defined as "laundry which has been soiled with blood or other potentially infectious materials or may contain sharps." 1910.1030(b).

Resident Services Coordinator Black testified that as the linens were removed from the beds, the soiled laundry was counted and placed into bags. A piece of paper with the count was placed on the bag, and the laundry was taken to the basement. There were separate bins for bed linens, which would be sent to the outside laundry, and for the residents' personal clothing and towels. The latter were laundered on the premises (Tr. 524-25). Laundry employee Rona Holmes explained to Posusney that she always used impervious gloves when sorting or touching the laundry. Unlike the PCAs and housekeepers, Holmes did not describe running out of gloves. In Posusney's opinion, Holmes should have worn impervious protective clothing on her arms and over her lap, in addition to her gloves (Tr. 250-51). Posusney's concern that Holmes shook out bed linens was not substantiated. The Secretary did not establish the type of gross contamination which required additional protective clothing, beyond what was afforded by gloves. Item 3f is vacated.

Item 3g: § 1910.1030(d)(iv)(C)

The Secretary alleges that contaminated laundry, which was not in appropriate containers, was shipped to a facility that did not utilize universal precautions in violation of § 1910.1030(d)(iv)(C). The standard provides:

> When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with paragraph (g)(1)(i).

Azalea shipped a portion of its laundry to an outside, "second" laundry. Some of the laundry was contaminated with blood or bodily fluids. At the hearing, Azalea argued, and the undersigned agreed, that the Secretary must show that the second facility did not utilize universal precautions in order to sustain a violation (Tr. 499-501). Upon the Secretary's failure to present

admissible evidence on the issue, Azalea's motion to dismiss this item was granted (Tr. 505). Reconsideration of the action does not yield a different disposition. For the reasons previously stated, Item 3g is vacated.

Penalty for Items 3a, 3c, 3d, and 3e

The gravity of the violation is high, even for the laundry worker, who may not have had contact with the blood or infectious fluids for many hours after initially deposited. As Dr. Presson responded when asked if sheets or towels soiled with blood could cause contagion (Tr. 412):

> A. Hepatitis B has been shown to survive and still be active after at least 7 days on a dry surface, and it is believed to live much longer than that in moist environments. Also, HIV has been found up to 18 hours and later in a person after that person has died. So, yes.

The Secretary grouped items 3a through 3g for penalty purposes, noting that all were directed at specific methods of compliance with the standard (Tr. 244). Four of the seven grouped items have been affirmed. The same penalty factors previously discussed apply here. The bloodborne pathogens can cause serious, life-threatening diseases. A penalty of $5, 000 is assessed.

Item 4: § 1910.1030(f)(2)(i)

The Secretary alleges that hepatitis B vaccinations were not made available to employees as required by § 1910.1030(f)(2)(i). The standard provides:

> Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 working days of initial assignment to all employees who have occupational exposure . . . .

Hepatitis B vaccinations are "made available" when an employer informs employees where they can receive the vaccination free of charge. *Dione Williams, M.D.*, 17 BNA OSHC 1815, 1816 (No. 95-1007, 1996) (ALJ). PCA supervisor Andrew Coach told Posusney that he had not received a hepatitis B vaccine, and Bucci told Posusney that the vaccinations were not offered to employees (Tr. 163-64, 173-74, 274). It is concluded that Azalea did not make the vaccinations available. Hepatitis B infection through exposure to bloodborne pathogens is not uncommon. Exposed persons may become carriers of the diseases or the disease may become acute, with death being the likely result (Tr. 404). The violation is affirmed as serious. Considering the

factors previously discussed, and the fact that as many as 20 PCAs, housekeepers, and laundry employees should have been offered the vaccine's protection, a penalty of $3,500 is assessed.

Item 5: § 1910.1030(g)(2)(i)

The Secretary alleges that Azalea did not ensure that employees exposed to bloodborne pathogens participated in a related training program in violation of § 1910.1030(g)(2)(i). The standard provides:

> Employers shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours.

Azalea required its employees to participate in CPR, first aid, and Heimlich Maneuver training. It somewhat weakly claims that it had scheduled bloodborne pathogen training for the month after Posusney began the inspection (Exh. C-10; Tr. 276). Resident Services Coordinator Black asserted that such training was provided, and that she recalls attending this training in 1995 and 1996. Angela Bridges, formerly the resident services coordinator and supervisor, believed off-site training in bloodborne pathogens was provided to supervisors like herself. She was not aware whether any others were trained (Tr. 595-596). The supposition that other employees did not receive the same training is borne out by employee testimony and admissions. PCA Ennis testified that Azalea had not provided her with training on how to protect herself from bloodborne infections (Tr. 80-81). During the inspection, Coach and Holmes stated that they had not been trained in the hazards of exposure to bloodborne pathogens. Both had been longer-term employees who should have received training at the time of their initial employment. § 1910.1030(g)(2)(ii). Peg Bucci admitted to Posusney that Azalea did not offer a training program in bloodborne pathogens (Tr. 163, 169, 173).

The penalty factors discussed, as well as the high gravity of failing to train 20 employees on how to minimize the risks of occupational exposure to bloodborne pathogens, have been considered. Also considered was the fact that at least supervisors were trained. A penalty of $3,000 is assessed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The foregoing decision constitutes the findings of fact and conclusions of law in accordance with Rule 52(a), Fed.R.Civ.P.

ORDER

Based on the foregoing decision, it is ORDERED:

Item	**Standard**	**Disposition**	**Penalty**
1	§ 1910.141(a)(5)	Affirmed	$800
2	§ 1910.1030(c)(1)(i)	Affirmed	$3,500
3a	§ 1910.1030(d)(1)	Affirmed	$5,000 (grouped 3a,3c,3d,3e)
3b	§ 1910.1030(d)(2)(i)	Vacated	--
3c	§ 1910.1030(d)(3)(i)	Affirmed	--
3d	§ 1910.1030(d)(4)(iii)(B)(1)(iii)	Affirmed	--
3e	§ 1910.1030(d)(4)(iv)(A)(2)	Affirmed	--
3f	§ 1910.1030(d)(4)(iv)(B)	Vacated	--
3g	§ 1910.1030(d)(iv)(C)	Vacated	--
4	§ 1910.1030(f)(2)(i)	Affirmed	$3,500
5	§ 1910.1030(g)(2)(i)	Affirmed	$3,000

NANCY J. SPIES
Judge

Date: February 11, 1999