SECRETARY OF LABOR,

Complainant,

v.

GENESIS HEALTHCARE, CORP., d/b/a COOPER RIVER EAST CENTER

Respondent.

DISTRICT 1199C, NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, AFSCME, AFL-CIO,

Authorized Employee Representative.

DOCKET NO. 03-0300

APPEARANCES:

For the Complainant:
Marc G. Sheris, Esq., Office of the Solicitor, U.S. Department of Labor, New York, New York

For the Respondent:
John R. Merinar, Jr., Esq., David E. Dick, Esq., Steptoe & Johnson, Morgantown, West Virginia

For the Authorized Employee Representative:
Jennifer McQuaid, Cherry Hill, New Jersey

Before: Administrative Law Judge: Michael H. Schoenfeld

DECISION AND ORDER

Background

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. §§ 651-678) (the Act).

On July 29, 2002, an employee at the Cooper River East worksite sustained a needle stick. Following the incident, a complaint was filed with the Occupational Safety and Health Administration (OSHA), which initiated an inspection. As a result of that inspection, Genesis was issued citations alleging violations of the Act. By filing a timely notice of contest Genesis brought

this proceeding before the Occupational Safety and Health Review Commission (Commission). A hearing in this matter was held in Philadelphia, Pennsylvania at which all parties were represented and had the opportunity to present evidence and argument. The Secretary and Respondent have submitted briefs on the items remaining at issue and this matter is ready for disposition.

Jurisdiction

Respondent, Genesis HealthCare Corp (Genesis), at all times relevant to this action maintained a place of business at 5101 North Park Drive, Pennsauken, New Jersey, where it operated a nursing home, Cooper River East. Genesis does not deny that it uses tools, equipment and supplies which have moved in interstate commerce and concedes that it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

I find that Respondent is engaged in a business affecting interstate commerce.

Based on the above finding, I conclude that Respondent is an employer within the meaning of section 3(5) of the Act.[1] Accordingly, the Commission has jurisdiction over the subject matter and the parties.

ALLEGED VIOLATION OF §1910.1030(d)(4)(iii)(A)(1)

Serious Citation 1, Item 2, as amended, alleges:

> 29 CFR 1910.1030(d)(4)(iii)(A)(1): Contaminated sharps were not discarded immediately or as soon as feasible in containers that were:
> (i) Closable;
> (ii) Puncture resistant;
> (iii) Leakproof on sides and bottom; and
> (iv) Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.
>
> (a) Workplace: Sharps containers were not used immediately or as soon as possible to dispose of contaminated needles, on or about 7/31/02.

FACTS

This matter arises out of an incident which took place on July 29, 2002. On that date, Melody Moton, an LPN at the Cooper River East facility (Tr. 12), sustained a needle stick (Tr. 18).

[1] *Title 29 U.S.C. § 652(5).*

While Moton was on the north wing of the facility, speaking with another nurse and gesturing, she brought her hand down, and was punctured by the needle of an unsheathed syringe held by Rose Mustapha, a med nurse on that wing (Tr. 18-20, 26, 168-71).

Normally, the medication nurse fills a syringe with a built in sheath while standing at the meds cart; she then pulls the attached plastic sheath over the sharp before going into a resident's room to administer the injection (Tr. 28). After giving the injection, the sheath is pulled up and locked, the syringe is then placed in the sharps container on the meds cart (Tr. 28). On this date, however, Mustapha had just given an injection of Copaxone, which comes in a prefilled syringe, and has no built in engineering control, i.e. needle guard (Tr. 23-24, 174-75). Mustapha came out of the patient's room, but did not immediately dispose of the sharp; she stood in the hall talking with another nurse with the syringe held in her hand by her side (Tr. 23-24, 178). It was then that Moton was stuck by the needle (Exh. S-3, p. 2 of 2).

After Moton stuck herself on the unprotected sharp, Moton asked Mustapha where her sharps container was (Tr. 30-33), Mustapha replied that the mailbox type sharps container that had previously been on her cart was missing, and pointed to the area where it had been located (Tr. 22, 34; Exh. S-15, p. 4 of 4). Mustapha stated that she was not familiar with the newer carts, and did not know they had a cylindrical built-in sharps container (Tr. 177, 267, 271; Exh. S-14). At the hearing, Mustapha stated that although she did not know about the built-in sharps containers, her cart had a built-in container on it at the time of the needle stick incident (Tr. 185, 192, 194). Moton, however, stated that she looked for the cylindrical sharps container, and saw only an empty hole (Tr. 34, 361; Exh. S-15, p. 3 of 4).

Dorothy Schroeder, who was in charge of staff development and employee health, and who investigated the incident, noted on the accident report form that no sharps container was on the med cart, by which she meant there was no mailbox type container. Schroeder did not look for the cylindrical type container (Tr. 244, 274, 336-37; Exh. S-2).

Gladys Christopher, the administrator for Cooper River East, testified that she checked each and every one of the med carts, including Mustapha's, two hours after the needle stick incident (Tr. 163- 66). According to Christopher all the sharps containers were in place, as they had been on the previous days (Tr. 163, 166). Christopher stated that she made daily rounds two to three times every

day (Tr. 163-64). She checked the med carts on a daily basis to ensure that everything on the carts was where it needed to be, locked up and stored appropriately (Tr. 164).

Juliana Bonds, an LPN at Cooper River East during the relevant periods (Tr. 105-07), testified that the older med carts at the facility were equipped with clear mailbox type sharps containers, located on the side of the cart (Tr. 112; Exh. S-15, p. 4 of 4). In the summer of 2002, the facility switched to new carts with built in sharps containers (Tr. 114; Exh. S-15, p. 3 of 4). The built in containers were smaller, red, and cylindrically shaped (Tr. 114; Exh. S-15, p. 3 of 4). Bonds stated that there was always some kind of sharps container on the carts (Tr. 115, 121).

Debbie Corda, the assistant director of nursing and unit manager for the Cooper River East facility (Tr. 418-20), testified that the new carts came with the cylindrical sharps containers installed, and that extras were always available in the supply closets and in central supply (Tr. 421-22, 430). Corda confirmed that the nurses wanted the bigger boxes, and did not like the small sharps container (Tr. 422). Corda testified that nurses were trained to immediately dispose of sharps in sharps containers, and was not aware of any cases where nurses were not using the containers provided (Tr. 334, 423).

Maria De Marco, director of nursing at Cooper River East (Tr. 130-32), testified similarly (Tr. 136-37). According to De Marco, upon using the newer carts, some of the nurses expressed a preference for the larger, mailbox type containers (Tr. 137; *see also* testimony of CO Spina, Tr. 274-276). Len Allecknavage, Genesis' director of maintenance, testified that as the change to the new carts was made, he was asked to mount the old mailbox-type containers on the sides of some of the new carts. (Tr. 434-35). Hardware was ordered to outfit the remaining carts (Tr. 137, 435-36). DeMarco stated that no one ever complained to her about a shortage of the cylindrical sharps containers during the change over; to De Marco's knowledge, cylindrical containers were always available for use in space designed for them in the new carts (Tr. 137-38, 149-50, *see also* testimony of Gladys Christopher 154-55; CO Spina, Tr. 272-76). DeMarco testified that nurses are trained to dispose of needles properly, and that no one reported to her that sharps containers were not being used (Tr. 138).

Laura Spina, a Compliance Officer (CO) with OSHA, testified that she interviewed staffers at Cooper River East when she conducted her inspection of the facility after a complaint was filed

relating to the needle stick (Tr. 226-232). According to Spina, Mustapha told her that after giving a Copaxone injection she would walk the needle to her medication cart and put the needle into a Styrofoam drinking cup on the cart until she could get down to the medication room to dispose of the needle (Tr. 266; *see also* testimony of Melody Moton, p. 360). Spina stated that Pamela Walker told her that she used freestanding sharps containers in the medication room to dispose of her needles because she did not have a sharps container on her cart (Tr. 265, 271). Spina also testified that Julianna Bonds told her she had no sharps container on her cart. According to Spina, Bonds placed used needles in an empty drawer on her cart(Tr. 265, 271-72). Bonds told CO Spina that when she complained that she had no sharps containers, she was given a mailbox type container (Tr. 273). She did not like carrying it loose on her med cart, however, and so continued to use the sharps container in the medication room (Tr. 281).

At the hearing Walker stated that the new carts did not have a bracket to hold a mailbox type container, and that there was no cylindrical container in the space provided for the built-in (Tr. 67-68, 84). Walker knew that she was to immediately dispose of sharps after use, and so, for some period of time, she carried the sharps to the medication room to dispose of them (Tr. 71-72, 77-78; Exh. S-6). Walker told CO Spina that she asked the maintenance manager, Alecknavage, to install a bracket on the new cart to hold a mailbox type sharps container (Tr. 74-75, 273). Walker did not remember making any effort to obtain a container to fit the space provided for the built-in from medical supplies (Tr. 76, 80, 83-84). According to CO Spina, Genesis' medical supply clerk, Keith Stewart, told her that they never ran out of sharps containers (Tr. 337-39).

Juliana Bonds knew that sharps should always be properly disposed of (Tr. 112). At the hearing Bonds testified that, once, when the smaller sharps container on her new cart was full, she placed a sharp in the drawer of her med cart until she could get to the med room to properly dispose of the needle in a sharps container (Tr. 116, 122, 265; Exh. S-6, p. 2 of 2).

According to Mustapha, she had been trained to immediately dispose of sharps (Tr. 201). She testified that she did not remember using a Styrofoam drinking cup to dispose of used syringes (Tr. 176-77, 200). Mustapha stated that in the days immediately preceding the needlestick incident, she walked used Copaxone sharps from room 65, where she gave the injection, into the med room

next door, where she disposed of it in a sharps container stored there (Tr. 176, 200-02; S-6, p. 2 of 2).

Maggie Gizzi, a charge nurse at the Cooper River East facility (Tr. 375-76), testified that at the time of the OSHA inspection there were sharps containers, both the cylindrical and the mailbox type, available on the east wing, and that there was never a time when either type was unavailable (Tr. 378-79). Gizzi stated that she was trained to place all used syringes into a sharps container, whether or not they have engineering controls (Tr. 390, 404-06). After an August, 2001 incident in which Gizzi sustained a needle stick from a used sharp, which she had sheathed and placed in her pocket, Gizzi was retrained by Genesis' staff development personnel in the proper use of sharps containers (Tr. 388-90, 394, 397; Exh. S-12).

Patricia DeGannes the charge nurse on Cooper River East's west wing, testified that there were always sharps containers available for the medication carts on the west wing (Tr. 412).

DISCUSSION

29 CFR 1910.1030(d)(4)(iii)(A)(1) provides:

> Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:
> (A) Puncture resistant;
> (B) Labeled or color coded in accordance with this standard;
> (C) Leakproof on the sides and bottom. . .

In order to prove a violation of section 5(a)(2) of the Act, the Secretary must show by a preponderance of the evidence that (1) the cited standard applies, (2) there was a failure to comply with the cited standard, (3) employees had access to the violative condition and (4) the cited employer either knew or could have known of the condition with the exercise of reasonable diligence. *See, e.g., Walker Towing Corp.*, 14 BNA OSHC 2072, 2074, (No. 87-1359, 1991). It is clear that on July 29, 2002, Rose Mustapha failed to immediately dispose of a contaminated sharps in a labeled, puncture and leak resistant container. Testimony from Julianna Bonds establishes that, on at least one occasion, she placed a used syringe in the drawer of her med cart rather than in a sharps container. Finally, Pamela Walker testified that for some period of time during the summer

of 2002, she walked syringes down to the medication room instead of using a sharps container. Genesis maintains that these violations of the OSHA standard were violations of its established safety policies, that it was without knowledge of the violations, and that the violations were the result of unpreventable employee misconduct.

Knowledge. Under Commission precedent, the Secretary may satisfy her burden of proof as to knowledge by showing that a supervisor with the authority to direct that protective measures be taken was aware of the violation. In the Third Circuit, where this case arose, the Secretary must also show that the violation was foreseeable. *See, Interstate Brands Corp.,* 20 BNA OSHC 1102 (No. 00-1077, 2003). In that case, the Commission held that the Secretary may prove foreseeability by demonstrating the inadequacy of the employer's safety program, training or supervision. No such showing has been made in this case.

Every employee testifying was familiar with the proper disposal of used needles and knew that used sharps were to be placed immediately into a sharps container. The Secretary "theorizes," that Genesis ran out of sharps containers during the transition to new medication charts, forcing nurses, all of whom knew better, to find other ways of disposing of used syringes. *See* the Secretary's post-hearing memorandum, p. 22. The record, however, does not support the Secretary's theory.

The witnesses responsible for ensuring that supplies were on hand, Corda, De Marco and Christopher, all testified that sharps containers were available at the Cooper River East facility at all times. The charge nurses from the other wings testified that they could always obtain sharps containers. The administrator, Christopher, testified that she always found the containers in place on the carts during her daily walkthroughs. Though Mustapha claimed to have been unaware that her medication cart had a built-in sharps container, she testified at the hearing that she later learned there had been one available for her use. Walker knew there was a space on her medication cart for a built in sharps container, but never tried to locate one. When Bonds asked for a sharps container, she was given one, but opted not to use it.

The Secretary points out that all three nurses asked to have a bracket for the mailbox type containers added to their carts. The record, however, indicates that this request was common among the nurses, who preferred the larger containers. It does not follow that Genesis' supervisory

personnel must necessarily have deduced that, because the nurses asked for a mailbox type sharps container, they would not use the smaller built-in containers, but would instead carry their sharps to the med room. The director and assistant director of nursing both testified that they had no idea that sharps containers were not being used. The nurses' requests to install the mailbox type sharps containers does not demonstrates that they would be more prone towards hamartithia regarding disposal of sharps with the new carts.

On this record, I cannot find that Genesis failed to provide sharps containers for its employees' use, or that it knew, or could have foreseen that employees would not use the built-in sharps containers provided for them. Because the Secretary failed to establish its *prima facie* case, this item is VACATED.

ALLEGED VIOLATION of §1910.1030(d)(2)(i)

Serious Citation 1, Item 1 alleges:

> 29 CFR 1910.1030(d)(2)(i): Engineering and/or work practice controls were not used to eliminate or minimize employees occupational exposure:
>
> (a) Workplace: Employees used pre-filled syringes without sharps injury protection, such as an add-on device, on or about 7/31/02.

FACTS

Genesis had an exposure control plan for bloodborne pathogens for the Cooper River East facility (Tr. 259; Exh. S-10). Engineering controls are required for syringes; since June 2000, the plan has specifically required add-on devices for pre-filled syringes (Tr. 260, 455; Exh. S-10, p. 7 of 49). UltraSafe needle guards require that pre-filled syringe be placed into a needle guard before the injection is administered; afterwards, the guard slides up and over the sharp and is locked into place (Tr. 235, Exh. S-16, S-17). Both Bond and DeMarco testified that Dot Schroder demonstrated the use of the devices during in-service training sessions, which took place prior to the OSHA inspection (Tr. 120-21, 127-28, 133-135; Exh. S-4, p. 2 of 2, Exh. S-11). Charge nurse Gizzi and the assistant director of nursing, Corda, recalled having more than one training session covering add-ons (Tr. 379-81, 384-87, 398-400, 424). Charge nurse DeGannes also testified to having been

trained in the use of add-on devices with pre-filled syringes (Tr. 413). Gizzi and DeGannes' signatures appears on the log for a June 19, 2001 in-service covering exposure control and safety devices (Tr. 399-400; Exh. S-11, p. 5 of 7).

Schroeder and Corda told Spina that the add-on devices were distributed to the medication carts approximately one year prior to the needle stick incident (Tr. 241, 330). Gizzi and Corda confirmed that the devices were kept in the med carts (Tr. 382-83, 425-27). According to Bond, De Marco and Corda, the devices were available at the facility (Tr. 124, 136, 142, 427). However, Spina stated, Dot Schroeder told her she had to order more add-on devices after the needle stick incident (Tr. 241-42, 255). It is uncontroverted that add-on devices were in stock on the day of the inspection (Tr. 255-56, 300, 320, 427).

Despite the availability of add-on devices at Cooper River East, Spina testified, LPNs Rose Mustapha and Janet Weisman both gave injections with prefilled syringes without using an add-on safety device during the period immediately prior to the needlestick incident (Tr. 237, 250; Exh. S-4, p. 2 of 2).

Weisman testified that she administered one injection a day using a prefilled syringe without an add on device for approximately three weekends(Tr. 93-95, 237). Weisman testified that at the time of the OSHA investigation of Melody Moton's needle stick, she was not aware that add-on engineering controls needed to be used with prefilled syringes (Tr. 93). According to Weisman, she had never seen an add-on device or been trained in the use of the engineering controls (Tr. 95, 99-100). Add-on devices were provided to her during the ongoing OSHA inspection (Tr. 96). According to Weisman, there were only sporadic in-service training sessions available on the weekends, which was the only time she worked (Tr. 103). Weisman's name does not appear on any of the training logs for add-on devices (Tr. Exh. S-11)

Spina stated that Mustapha told her she was administering Copaxone for three weeks to a month without the use of an add-on device (Tr. 238). At the hearing Mustapha stated that she had received training in bloodborne pathogens, including the use of add-on devices for pre-filled syringes (Tr. 204-06; Exh. R-25, p. 12); however, it just did not occur to her at the time to use an add-on device to cover the needle (Tr. 29-30, 175). Approximately a year had gone by since the in-service, and she had not used any pre-filled syringes in the interim (Tr. 183, 194-95). When Mustapha began

using prefilled Copaxone syringes a week or two before the needle stick incident, it simply did not occur to her to use an add-on (Tr. 195, 197-98). She never looked in the cart for an add-on device (Tr. 199). Mustapha's name does not appear on the logs for the in-services dealing with add-on safety devices (Exh. S-11). According to Mustapha, her union told her that she did not have to sign some documents, and that as a result she frequently did not sign attendance logs at in-services she attended (Tr. 186).

During the inspection, Dot Schroeder provided CO Spina with all her training records pertaining to the use of add-on devices for the preceding year (Tr. 288, 347-48). According to Schroeder, that training had been provided in June 2001, and not since then (Tr. 289, 291-92; Exh. S-11, S-16). Schroeder could not find training records for Rose Mustapha and did not know whether she had received the training (Tr. 289). Maria DeMarco was aware that there were "episodes" when employees "would not feel comfortable signing a sign-in sheet that they had attended in-services or training" (Tr. 140). Schroeder told CO Spina that she did not keep track of which employees received training, but did not sign the log (Tr. 293-94). There would, therefore, be no record of some individuals receiving training though they had been in attendance (Tr. 140-41).

At the hearing Genesis introduced a sign up sheet for an October 25, 2001 in-service covering IV pumps (Exh. R-25). Moton's name appears on the log (Tr. 38, 47; Exh. R-25). Gizzi, who remembered Moton attending the IV training with her, recalled going through 14 pages of attachments during the October in-service, including pages addressing UltraSafe needle guards (Tr. 386-87).

Melody Moton, however, testified that she did not receive any bloodborne pathogen training in the year preceding the needlestick incident (Tr. 36-37). Moton specifically denied receiving training in the use of add-on engineering controls for pre-filled syringes (Tr. 37). Moton testified that the in-service covered only the means of inserting the tubing into the IV pump and did not include any discussion of add-on devices for pre-filled syringes (Tr. 39-41, 359). No handouts addressing UltraSafe Needle guards were provided to her (Tr. 48; Exh. C-25, p. 12-13 of 16). Schroeder did not provide Spina with copies of the sign in sheets for the October 2001 IV training, or tell Spina that she provided training on add-on devices during that in-service (Tr. 292).

DISCUSSION

29 CFR §1910.1030(d)(2)(i) 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.

The evidence conclusively establishes that employees Mustapha and Wiseman did not use add-on engineering controls to protect the needles of pre-filled syringes they administered to residents of the Cooper River East facility. Respondent argues, however, that the cited standard is inapplicable in this case and is unconstitutionally vague. Genesis further maintains that the violative conduct resulted from unpreventable employee misconduct, and that the Secretary failed to prove that it could have foreseen.

Applicability. 29 CFR §1910.130(b) *Definitions* states that:

> *Engineering controls* means controls (e.g., sharps disposal containers, self sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.

Add-on needle guards are controls that isolate the bloodborne pathogen hazard created by using a pre-filled syringe without a built in guard. Add-on needle guards thus clearly fall under the definition of engineering controls. That the devices are not specifically listed in the list of examples provided is irrelevant. Preceded by *e.g.*, literally "for the sake of an example," the list provided in the definition section is merely illustrative, not exclusive.

Vagueness. A standard is not impermissibly vague simply because it is broad in nature. The application of external objective criteria, including the knowledge and perceptions of a reasonable person may be used to give meaning to a broadly worded standard. *J.A. Jones Constr. Co.*, 15 BNA OSHC 2201 (No. 86-2059, 1993). In this case, not only do the subject add-on devices fall squarely within the plain meaning of the standard, add-on devices for prefilled syringes were specifically identified by Genesis' director of safety and loss control, Mark Santoleri, as engineering controls in a Safety Alert issued by his office prior to April 18, 2001 (Tr. 479; Exh. S-17). Respondent's contention is without merit.

Knowledge. As noted above, the Secretary may prove foreseeability by demonstrating the inadequacy of the employer's safety program, training or supervision. On this topic Genesis'

training program is clearly inadequate. No training on add-on safety devices had been provided in the preceding year. Nurses Weisman and Moton testified that they received no training addressing the add-on needle guards. Though Mustapha claimed to have received training, she was not at all familiar with add-on engineering controls, and did not know that their use was required with pre-filled syringes. Genesis was unable to supply records showing that any of the three nurses had received training, or to demonstrate that they had procedures in place which would ensure that nurses would receive training.

The bloodborne pathogen standard at §1910.1030 includes training requirements at paragraph (g) *Communication of hazards to employees.* Subparagraph (2) *Information and training* requires that:

> (i) 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.
> (ii) Training shall be provided as follows:
> (A) At the time of initial assignment to tasks where occupational exposure may take place;
> (B) Within 90 days after the effective date of the standard; and
> (C) At least annually thereafter.
>
> * * *
>
> (vii) The training program shall contain at a minimum the following elements:
> (F) An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment.

Section 1910.1030(g)(2) requires that employees exposed to bloodborne pathogens receive, at a minimum, annual training including the use of engineering controls designed to reduce their exposure. Genesis last provided training in add-on devices to its nurses in June, 2001, more than a year prior to the needle stick incident. Genesis' contention that it provided additional training addressing add-on devices during the October 2001 IV in-service is specifically rejected. Dot Schroeder, the employee allegedly supplying the training (Tr. 118-20, 386), failed to testify at the hearing, and her name does not appear on the in-service log as a trainer. Moreover, Schroeder did not identify that in-service as dealing with add-on devices when she was asked to provide OSHA with all records pertaining to the add-on devices. Finally, both Moton and the assistant director of nursing testified that only needleless syringes are used in conjunction with IV pumps (Tr. 53-54,

431-32). Any discussion of add-on devices would have been irrelevant to the identified topic of the in-service.

The nurse involved in the needlestick incident, Rose Mustapha, testified that the training had been so long before that it never occurred to her to look for or to use the add-on devices. Assuming, arguendo that Mustapha was trained in June, 2001, she would have been due for retraining approximately a month prior to the needlestick incident pursuant to subparagraph (g)(2)(ii)(C). Had Mustapha been retrained as required, she would have been aware of the need to use an add-on device with a pre-filled syringe, and the needlestick could have been prevented.

Section 1910.1043(h) *Recordkeeping* requires that the employer keep records of, *inter alia*, (2)(i)(D) "[t]he names and job titles of all persons attending the training sessions. At the hearing Genesis' supervisory personnel testified that they knew employees attended training sessions without signing the attendance logs. Genesis, therefore, had no means of knowing which employees had received the required training. Nothing in the record suggests that Genesis made any effort to ensure that all its employees had the training required under the bloodborne pathogens standard, however; without adequate recordkeeping, it had no way of knowing which employees had been trained. As noted above, Genesis could have ensured that each of its employees received the required training had they put in place an system for maintaining and reviewing training records, as required by the bloodborne pathogen standard.

Genesis argues that the Secretary failed to prove that its supervisory personnel knew that Mustapha and Wiseman did not use add-on engineering controls with pre-filled syringes. However, the fact that the Genesis may not have known of the specific instance of violative conduct at the time it occurred does not mean that the conduct was unpreventable. *Ormet Corp.*, 14 BNA OSHC 2134, 2138-39 (No. 85-531, 1991). Reasonable diligence includes adequate supervision of employees and the formulation and implementation of training programs and work rules designed to ensure that employees perform their work safely. *See; Mosser Construction Co.*, 15 BNA OSHC 1408 (No. 89-1027, 1991); *Gary Concrete Prod., Inc.*, 15 BNA OSHC 1051 (No. 86-1087, 1991). Genesis' training and supervision of its employees was inadequate in that it did not meet the minimum requirements set out in the standard. The failure of its nursing staff to follow procedures or to use

required engineering controls in the absence of adequate training was foreseeable. Genesis' knowledge of the cited violation is established.

Unpreventable Employee Misconduct. Genesis' employee misconduct defense must also fail, as it relies on the same evidence discussed under the knowledge section, above. Where, as here, the Secretary has shown that the employer did not adequately train its employees to follow safety procedures required under the Act, the affirmative defense of employee misconduct cannot stand.

PENALTY

The Commission has often held that in determining appropriate penalties for violations, including those classified as willful, "due consideration" must be given to the four criteria under section 17(j) of the Act, 29 U.S.C. 666(j). Those factors include; the size of the employer's business, gravity of the violation, good faith and prior history. While the Commission has noted that the gravity of the violation is generally "the primary element in the penalty assessment," it also recognizes that the factors "are not necessarily accorded equal weight. *J.A. Jones Construction Co., supra.,* 15 BNA OSHC at 2214.

A penalty of $5,000.00 was proposed for this item. CO Spina testified that the failure to use add-on engineering controls with pre-filled syringes was serious, in that employees were likely to sustain needlesticks from the unguarded syringes (Tr. 247, 260-61). A needlestick can transmit HIV, hepatitis or other bloodborne diseases (Tr. 261). While the violation has been established on the basis of two employees using the unguarded syringes for approximately three weeks (Tr. 254, 261, 283), the consequences of an inadvertent needle puncture are severe. Accordingly, I find that the penalty as proposed is appropriate.

ALLEGED VIOLATION OF §1910.1030(g)(2)(v)

Other than serious Citation 2, Item 2 alleges:

> 29 CFR 1910.1030(g)(2)(v): Employees were not provided additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affected the employee's occupational exposure:
>
> (a) Workplace: Employees were not provided with training on the use of add-on devices for pre-filled syringes, on or about 7/31/02.

The cited standard provides:

> Employers shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

According to the testimony of Mark Santoleri, Genesis instituted new procedures in June 2000 when it began mandating the use of add-on devices with pre-filled syringes (Tr. 455). At that time Genesis was required to provide training for employees affected by the change. As discussed in citation 1, item 1, above, Genesis had no system of ensuring that all nursing personnel received that training. As a result, nurses required to use add-on devices, specifically Janet Weisman were not trained. The cited violation has been established.

FINDINGS OF FACT

All findings of fact necessary for a determination of all relevant issues have been made above. Fed. R. Civ. P. 52(a). All proposed findings of fact and conclusions of law inconsistent with this decision are hereby denied.

CONCLUSIONS OF LAW

1. Respondent was, at all times pertinent hereto, an employer within the meaning of section 3(5) of the Occupational Safety and Health Act of 1970, 29 U. S. C. § § 651 - 678 (1970).

2. The Occupational Safety and Health Review Commission has jurisdiction over the parties and the subject matter.

3. Respondent was in violation of section 5(a)(2) of the Act in that it failed to comply with the standard at 29 C.F.R. §1910.1030(d)(2)(i) as alleged in Citation 1, Item 1. A penalty of $ 5,000 is appropriate.

4. Respondent was not in violation of section 5(a)(2) of the Act in that it failed to comply with the standard at 29 C.F.R. §1910.1030(d)(4)(iii)(A)(1), as alleged in Citation 1, Item 2.

5. Respondent was in violation of section 5(a)(2) of the Act in that it failed to comply with the standard at 29 C.F.R. §1910.1030(g)(2) as alleged in Citation 2, Item 2. The assessment of no penalty is appropriate.

ORDER

1. Serious citation 1, item 1, alleging violation of §1910.1030(d)(2)(i) is AFFIRMED, and a penalty of $ 5, 000. 00 is ASSESSED.

2. Citation 1, item 2, alleging violation of §1910.1030(d)(4)(iii)(A)(1) is VACATED.

3. Other than serious citation 2, item 2, alleging violation of §1910.1030(g)(2)(v) is AFFIRMED without penalty.

4. Having withdrawn its notice of contest as to Citation 2, item 1, (Tr. 7-8) that item is AFFIRMED. Respondent was in violation of section 5(a)(2) of the Act in that it failed to comply with the standard at 29 C.F.R. § 1910.1030(f)(5) as alleged in Citation 2, item 1. The violation was other than serious for which no civil penalty is appropriate.

/s/
Michael H. Schoenfeld
Judge, OSHRC

Dated: August 23, 2004
Washington, D.C.