NEVADA OCCUPATIONAL SAFETY AND HEALTH

REVIEW BOARD

CHIEF ADMINISTRATIVE OFFICER OF THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, DIVISION OF INDUSTRIAL RELATIONS OF THE DEPARTMENT OF BUSINESS AND INDUSTRY, STATE OF NEVADA

Complainant,

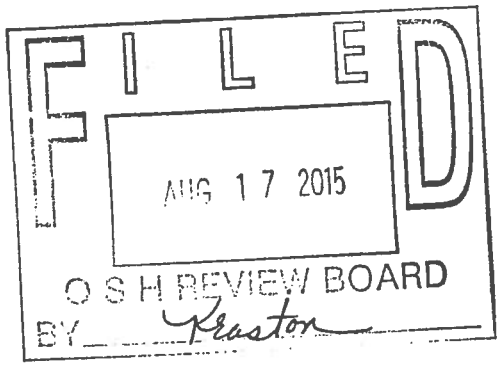
vs.

SUMMERLIN HOSPITAL MEDICAL CENTER,

Respondent.

_____/

Docket No. LV 14-1731



DECISION

This matter having come before the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** at a hearing commenced on the 10th and 11th day of June, 2015, in furtherance of notice duly provided according to law, MS. SALLI ORTIZ, ESQ., counsel appearing on behalf of the Complainant, **Chief Administrative Officer of the Occupational Safety and Health Administration, Division of Industrial Relations** (OSHA); and MS. CARLA GUINNAN, ESQ. appearing on behalf of Respondent, Summerlin Hospital Medical Center, the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** finds as follows:

Jurisdiction in this matter has been conferred in accordance with Chapter 618 of Nevada Revised Statutes.

The complaint filed by OSHA sets forth allegations of violation of Nevada Revised Statutes as referenced in Exhibit A, attached thereto.

Citation 1, Item 1 charged a "Serious" violation of Nevada Revised

Statute 618.375(1).

> **Citation 1, Item 1, Nevada Revised Statute 618.375(1):** Duties of employers. Every employer shall furnish employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his or her employees.

The violation was classified as "Serious." The proposed penalty for the alleged violation is in the amount of SIX THOUSAND THREE HUNDRED DOLLARS ($6,300.00).

1) Prior to this inspection, Summerlin Hospital Medical Center's most recent Tuberculosis (TB) **Risk Assessment did not include statistical data related to a 2013 significant workplace exposure** to Mycobacterium tuberculosis. At least two patients with **unrecognized** tuberculosis (TB) disease were admitted into the hospital and cared for by staff, exposing employees to Mycobacterium tuberculosis and subsequently causing 20 employees to contract tuberculosis and exhibit either active or latent forms of the infection. A **TB Risk Assessment that included this data is necessary so the quality of the hospital's TB infection control can be properly evaluated**, and needed improvements in infection control measures can be identified.

2) Since the recent workplace exposure to Mycobacterium tuberculosis, Summerlin Hospital Medical Center has **not followed its own TB Exposure Control Plan that states a "Risk Evaluation" will be conducted in the event of an exposure.** Prior to this inspection, Summerlin Hospital Medical Center did not conduct a Tuberculosis (TB) Risk Assessment that included statistical data related to a 2013 significant workplace exposure to Mycobacterium tuberculosis.

A feasible and accepted abatement method for reducing these hazards is to follow Summerlin Hospital Medical Center's TB Exposure Control

Plan which requires a Risk Assessment to be conducted in the event of an exposure. The Assessment should include data regarding the specific exposure. Furthermore, conducting TB Risk Assessment on an ongoing basis would reduce this hazard, as recommended by the Center for Disease Control and Prevention (CDC) in the 2005 "Guidelines for the Transmission of Mycobacterium tuberculosis in Health Care Facilities." The Assessment should be completed following the requirements of the TB Risk Assessment section.

Citation 1, Item 2 charged a "Serious" violation of Nevada Revised Statute 618.375(1).

> **Citation 1, Item 2, Nevada Revised Statute 618.375(1):** Duties of employers. Every employer shall furnish employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his or her employees.

The violation was classified as "Serious." The proposed penalty for the alleged violation is in the amount of SIX THOUSAND THREE HUNDRED DOLLARS ($6,300.00).

1) Prior to this inspection, Summerlin Hospital Medical Center's Tuberculosis (TB) Exposure Control **Plan has not been reevaluated since the occurrence of a significant workplace exposure to** Mycobacterium tuberculosis. In 2013, at least two patients with **unrecognized** tuberculosis (TB) disease were admitted into the hospital and cared for by staff, exposing employees to Mycobacterium tuberculosis and subsequently causing 20 employees to contract tuberculosis and exhibit either active or latent forms of the infection. A reevaluation is needed to identify and correct possible problems in TB infection control.

2) Prior to this inspection, there **was no requirement in Summerlin**

Hospital Medical Center's Tuberculosis (TB) Exposure Control Plan for annual reevaluations, and the program was not reevaluated on an annual basis. A yearly reevaluation is needed to identify and correct possible problems in TB infection control.

A feasible and accepted abatement method for reducing these hazards, as recommended by the center for Disease Control and Prevention (CDC), is to follow their 2005 "Guidelines for the Transmission of Mycobacterium tuberculosis in Health Care Facilities" and review the TB infection control plan according to the Guideline's Evaluation of TB Infection Control Procedures and Identification of Problems section. The facility's TB Exposure Control Plan should be revised to reflect the implementation of this.

Citation 1, Item 3 charged a "Serious" violation of Nevada Revised Statute 618.375(1).

> **Citation 1, Item 3, Nevada Revised Statute 618.375(1):** Duties of employers. Every employer shall furnish employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his or her employees.

The violation was classified as "Serious." The proposed penalty for the alleged violation is in the amount of SIX THOUSAND THREE HUNDRED DOLLARS ($6,300.00).

Prior to this inspection, Summerlin Hospital Medical Center **did not have procedures in place to ensure** that employees who have been directly exposed to patients with tuberculosis (TB) disease **are screened for the infection as soon as possible after exposure** to Mycobacterium tuberculosis, or are provided follow up screenings if needed. In 2013, at least two patients with unrecognized tuberculosis disease were admitted into the hospital and cared for by staff, exposing employees

to Mycobacterium tuberculosis and subsequently causing 20 employees to contract tuberculosis and exhibit either active or latent forms of the infection. At least one hospital employee who had direct contact with at least one of the infected patients was not given an initial TB screening until 8 weeks after the exposure.

A feasible and accepted abatement method for reducing this hazard, as recommended by the center for Disease Control and Prevention (CDC), is to follow their 2005 "Guidelines for the Transmission of Mycobacterium tuberculosis in Health Care Facilities" and institute proper procedures according to the Guideline's Problem Evaluation and Contact Investigation sections. The facility's TB Exposure Control Plan should be revised to reflect the implementation of this.

Citation 1, Item 4 charged a "Serious" violation of Nevada Revised Statute 618.375(1).

> **Citation 1, Item 4, Nevada Revised Statute 618.375(1):** Duties of employers. Every employer shall furnish employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his or her employees.

The violation was classified as "Serious." The proposed penalty for the alleged violation is in the amount of SIX THOUSAND THREE HUNDRED DOLLARS ($6,300.00).

Prior to this inspection, Summerlin Hospital Medical Center's Tuberculosis (TB) Control **Plan did not require prompt evaluations for all employees whose TB screening tests converted from negative to positive after exposure to M. Tuberculosis.** In 2013, at least two patients with unrecognized tuberculosis disease were admitted into the hospital and cared for by staff, exposing employees to Mycobacterium tuberculosis and subsequently causing 20 employees to contract

tuberculosis and exhibit either active or latent forms of the infection. At least eight hospital employees who had converted as a result of this workplace exposure had to wait seven days or longer to receive a chest x-ray to rule out active tuberculosis.

A feasible and accepted abatement method for reducing this hazard, as recommended by the Center for Disease Control and Prevention (CDC), is to follow their 2005 "Guidelines for the Transmission of Mycobacterium tuberculosis in Health Care Facilities" and promptly evaluate employees who converted to a positive tuberculosis screening test result with a chest radiograph. The facility's TB Exposure Control Plan should be revised to reflect the implementation of this.

Citation 1, Item 5 charged a "Serious" violation of Nevada Revised Statute 618.375(1).

> **Citation 1, Item 5, Nevada Revised Statute 618.375(1):** Duties of employers. Every employer shall furnish employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his or her employees.

The violation was classified as "Serious." The proposed penalty for the alleged violation is in the amount of SIX THOUSAND THREE HUNDRED DOLLARS ($6,300.00).

1) Summerlin Hospital Medical Center does **not conduct proper diagnosis measures for patients who display signs of tuberculosis** (TB). In 2013, at least two patients with unrecognized TB disease were admitted into the hospital and cared for by hospital staff, one of whom displayed signs of tuberculosis, presenting with miliary TB with pulmonary involvement, but a sputum examination was never conducted. Employees were exposed to Mycobacterium tuberculosis, subsequently causing 20 employees to contract tuberculosis and exhibit either active

or latent forms fo the infection.

2) Prior to this inspection, Summerlin Hospital Medical Center's TB Exposure Control Plan did not include all the significant symptoms that are indicative of a tuberculosis diagnosis, nor did it require the administration of subsequent diagnostic measures, such as a sputum culture, in the presence of these symptoms.

A feasible and accepted abatement method for reducing these hazards, as recommended by the Center for Disease Control and Prevention (CDC), is to follow their 2005 "Guidelines for the Transmission of Mycobacterium tuberculosis in Health Care Facilities" and conduct proper diagnostic measures for patients with signs of lung infection and chest radiograph findings suggestive of TB disease. The facility's TB Exposure Control Plan should be revised to reflect the implementation of this.

Citation 1, Item 6 charged a "Serious" violation of Nevada Revised Statute 618.375(1).

> **Citation 1, Item 6, Nevada Revised Statute 618.375(1):** Duties of employers. Every employer shall furnish employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his or her employees.

The violation was classified as "Serious." The proposed penalty for the alleged violation is in the amount of SIX THOUSAND THREE HUNDRED DOLLARS ($6,300.00).

1) Summerlin Hospital Medical Center **does not initiate precautions for patients who display signs of tuberculosis** (TB). In 2013, at least two patients with **unrecognized** TB disease were admitted into the hospital and cared for by hospital staff, one of whom displayed signs of tuberculosis, presenting with miliary TB with pulmonary involvement,

airborne precautions were never initiated. Employees were exposed to Mycobacterium tuberculosis, subsequently causing 20 employees to contract tuberculosis and exhibit either active or latent forms of the infection.

2) Prior to this inspection, Summerlin Hospital Medical Center's TB Exposure Control **Plan did not require initiation of airborne precautions for all inpatients who exhibit signs or symptoms of tuberculosis (TB) disease**. The Plan only addressed the institution fo airborne precautions for patients that are known or suspected in the Emergency Room and Admitting Area. The TB Exposure Control Plan also did not specify persons authorized to initiate and discontinue airborne precautions.

A feasible and accepted abatement method for reducing these hazards, as recommended by the Center for Dïsease Control and Prevention (CDC), is to follow their 2005 "Guidelines for the Transmission of Mycobacterium tuberculosis in Health Care Facilities" and initiate airborne precautions for patients exhibiting signs or symptoms indicative of TB disease. The facility's TB Exposure Control Plan should be revised to reflect the implementation of this.

Citation 2, Item 1 charged an "Other" violation of 29 CFR 1904.11(a).

> **Citation 2, Item 1, 29 CFR 1904.11(a):** Basic requirement. If any of your employees has been occupationally exposed to anyone with a known case of active tuberculosis (TB), and that employee subsequently develops a tuberculosis infection, as evidenced by a positive skin test or diagnosis by a physician or other licensed health care professional, you must record the case on the OSHA 300 Log by checking the "respiratory condition" column.

The violation was classified as "Other than Serious." The proposed

penalty for the alleged violation is in the amount of NINE HUNDRED DOLLARS ($900.00).

In 2013, 20 employees of Summerlin Hospital Medical Center converted to positive tuberculin skin tests (TST) and developed either active or latent forms of a tuberculosis (TB) infection after at least two patients with unrecognized TB disease were admitted into the hospital. The employer did not record these 20 cases of occupational exposure to TB on its 2013 OSHA 300 logs, which were certified by the employer as true, accurate and complete on January 8, 2014.

Citation 2, Item 2 charged an "Other" violation of 29 CFR 1904.29(b)(7)(iv).

> **Citation 2, Item 2, 29 CFR 1904.29(b)(7)(iv):** How do I determine if an injury or illness is a privacy concern case? You must consider the following injuries or illnesses to be privacy concern cases; HIV infection, hepatitis, or tuberculosis.

The violation was classified as "Other than Serious," with no proposed penalty.

Summerlin Hospital Medical Center did not ensure that an employee who was potentially exposed to tuberculosis was entered on the OSHA 300 logs as a "privacy concern case." Employee privacy was not protected and the employee's full name was listed for Case #7161 on the 2013 OSHA 300 logs, which were certified by the employer as true, accurate and complete on January 8, 2014.

Counsel for complainant and respondent presented brief opening statements. Complainant stated the following:

> "This case deals with the hospital's response to an infectious disease patient that was admitted into their hospital. Unfortunately, despite the admission and the various symptoms, the tuberculosis in this case remained unrecognized until the patient, the Patient 0, was actually transferred to a different facility in another

state. Unfortunately, she passed away there, and it was at the autopsy that they were finally able to diagnose the TB diagnosis there. They informed Summerlin.

As a result of this, Nevada OSHA received a referral. We went in to inspect and found that while there were some aspects of the infection control that were included in Summerlin's control plan, there were deficiencies in the plans and there were also instances that even issues that were included in the plans were not actually followed. So those policies, even though they were in place, were not implemented properly because of a misunderstanding regarding the continued contagion capability of the baby that remained at the hospital at the time.

We will be able to show through the documentation and through the testimony that these processes are well recognized according to CDC Guidelines as far as what symptoms should have triggered the alert to test for TB and what precautions should have been taken and once those precautions were implemented, what should have happened as part of those precautions that needed to be followed. They were not - they were not discretionary steps that needed to be taken.

At the conclusion of that, they ended up doing an inspection and evaluation with all of their employees and, in fact, 20 employees did end up converting from negative tests to positive tests as a result of this exposure. You will also see in the evidence packet, I believe it's Exhibit C, that will show that the Health Department also concluded that the CDC in their Epi-Aid report concluded that more steps needed to be done; corrections needed to be made to the program that Summerlin has regarding infection control, specifically TB. And for all those reasons we're going to ask that the Board affirm the citations as written. (Tr. 13-14)"

Respondent counsel stated:

". . . there were six serious citations issued. The citations all are basically in two categories. They are items that relate to the TB Exposure Control Plan itself. You will hear that there was a TB Exposure Control Plan in effect at Summerlin Hospital in 2013. Summerlin, upon notice that the patient who deceased had TB, did implement their TB Exposure Control Plan. They implemented what's known as airborne precautions, which required that anyone going into the baby's room had to wear

appropriate PPE. You will hear our witnesses testify to the implementation of those protocols. You will also hear from our witnesses that this does follow the CDC guidance on tuberculosis.

And with regard to the CDC and what the CDC did, CDC actually came in after it was known that tuberculosis had occurred at Summerlin Hospital, and they took over all of the testing protocols that were required to be done after a known exposure to TB had occurred. So it was actually the CDC, in conjunction with the Southern Nevada Health District, that outlined all of the specific protocols with regard to testing of the employees.

You will also hear from our witness, Dr. Joseph, about the issue of whether or not Summerlin Hospital could have done any more than what they did with regard to the patient who was admitted on two separate occasions into the hospital. . .

Upon each of these admissions there were screenings that were done for tuberculosis, which is standard protocol for a hospital. And all of the screenings that were conducted - there were screenings conducted upon admittance into the hospital as well as when the patient arrived in the emergency room. So there were separate screenings done. All of the screenings that were taken pursuant to CDC protocol indicated that there was no indication of tuberculosis.

There were a number of doctors involved in this case treating the patient, none of whom diagnosed the patient for tuberculosis. It should also be known that the doctors who are - who go to Summerlin Hospital are not employees of the hospital . . .

Based upon the doctors' information, the patient was being treated with various antibiotics and no protocols were implemented until after the patient left Summerlin Hospital, was transported to UCLA, subsequently died, and then on July 8th, it was discovered through autopsy that she had tuberculosis.

Upon that discovery, the autopsy examiner notified - did the correct notifications through the chain of command and notified the Southern Nevada Health District. The Health District actually notified Summerlin that there had been a case of tuberculosis. . .

. . . Summerlin had the CDC as well as the Southern

Nevada Health District in place looking at the issue of TB. Because the issue of the TB not only affected potentially the employees of the hospital, but it also affected anybody who might have come into the hospital. So the Health District and CDC worked together to tell Summerlin what they needed to do with regard to testing of not only employees but anyone else who had had any type of contact. So this is something that the CDC took over. And the hospital had no choice but to follow the CDC guidance and requirements with regard to the tuberculosis.

Ultimately, everyone was tested. The CDC wrote a report . . . (See Respondent Exhibit C.)

We dispute that the CDC findings were not complimentary. Actually, the CDC said that the Health District had responded appropriately and immediately upon notification of the TB outbreak and incident at Summerlin . . .

. . . Nevada OSHA came on the site in October and began an inspection. Their inspection commenced in April when they issued citations in this case . . .

. . . federal law and the Nevada law both have a statute of limitations time period in that law, which requires that after an exposure the citation must be issued within six months. Federal OSHA has looked at the issue of tuberculosis, has issued enforcement guidance on the issue. They have issued an interpretation letter on the issue. And you will also hear that Nevada OSHA has not followed Federal OSHA's guidance, although Federal OSHA had mandated in their guidance document that the states were to follow the guidance document that they put out . . .

. . . in this matter the six months statute of limitations definitely applies . . .

. . . the Joint Commission (hospital accrediting agency) was at Summerlin Hospital . . . reviewed specifically the Infection Control Plan and the TB Exposure Control Plan in July of 2013, the same plan that has been cited by Nevada OSHA as being deficient. And the Joint Commission did not find any deficiencies in either plan . . .

. . . the CDC and the Health District having looked at the issue intently, we would ask that the Board consider that agencies with more experience with regard to tuberculosis opine . . ." (Tr. 15-21)

FACTS

This case arose after a tuberculosis (TB) exposure event at the Summerlin Hospital Medical Center (SH) in Las Vegas, Nevada. A maternity patient entered the SH on May 9, 2013 and delivered premature twin babies on May 11, 2013. The mother was discharged on May 16, 2013. The premature babies remained in NICU. One baby died on June 1, 2013. The mother returned to SH as a patient on June 19, 2013, with undiagnosed illness. She was transferred to the UCLA Hospital on June 30, 2013 for further medical treatment. The mother subsequently expired on or about July 1, 2013. SH received notification from the Southern Nevada Health District (SNHD) on or about July 8, 2013 that the patient mother had tuberculosis, meningitis. Upon notification by SNHD of potential TB exposures, SH immediately implemented its TB Exposure Control Plan (Plan). The second baby died in the SH NICU on August 1, 2013.

Summerlin Hospital (SH) was inspected by Nevada OSHA (NVOSHA) on or about October 11, 2013. Commencement of the formal inspection process was delayed to obtain enforcement guidance from federal OSHA, and because of concerns over the potential for an appearance of conflict due to a familial relationship with the decedents and an employee of NVOSHA.

NVOSHA determined that based upon Federal and Nevada OSHA enforcement guidelines, including the time limitations on enforcement action for the **TB exposure events** under the recognized **statutes of limitations**, delays in the inspection proceedings restricted enforcement action to **ONLY** violations for **deficiencies in the SH written tuberculosis Exposure Control Plan** (Plan). Inspection information and reporting references to the actual TB exposure events, encompassing

allegations of SH inaction or failures from May through August 2013 were to be considered only as ". . . examples to highlight the cited Plan deficiencies . . .."

NVOSHA cited six (6) separate "Serious" items under Citation 1, alleging violations of NRS 618.375(1), commonly referred to as the **"general duty clause."** The provision is incorporated in Nevada Revised Statutes from the Code of Federal Regulations (CFR) and Federal Occupational Safety and Health Act (OSHA). When no **specific standards** under the CFR are **applicable** to employee workplace safety conditions, the **general duty clause** is relied upon.

NVOSHA charged SH failed to include and/or implement required safety protocols for the **recognized** hazards of TB exposure in their written TB control Plan. The mandatory safety measures required by NVOSHA for inclusion in the SH Plan were those referenced in the Center for Disease Control (CDC) 2005 Guidelines for controlling TB exposures in healthcare settings. Each of the six (6) items cited as violations alleged deficiencies within the Plan, although specifying different but related aspects.

SH denied any deficiencies in its Plan and asserted SH and the Plan were compliant as the CDC Guidelines were incorporated into and implemented under the Plan.

The parties stipulated to the admission in evidence of complainants Exhibits 1 through 3 and respondents Exhibits A through H.

The parties also stipulated that the penalty calculations proposed were as directed in the NVOSHES operations manual.

Complainant presented witness testimony from three individuals, Ms. Amber Rose, a Federal OSHA Inspector, Dr. Michael Hodgson, Director of Medicine and Nursing at Federal OSHA and Ms. Kerry Sanchez, the NVOSHA

Industrial Hygienist (IH) and Compliance Safety and Health Officer (CSHO) who conducted the investigation.

Respondent presented witness testimony from three individuals, namely RN Ms. Linda LaPointe, NICU Manager, RN Ms. Louise Hesse, Infection Prevention Manager, and Dr. William Patrick Joseph, a practicing physician in the San Francisco area and board certified in internal medicine, infectious disease epidemiology and quality assurance.

The transcript of proceedings comprised one and one-half days of hearings, complied in 417 pages. Both legal counsel submitted written closing arguments including legal points and authorities.

ISSUE

The sole issue for decision before this Review Board is whether the Summerlin Hospital (SH) written TB Exposure Control Plan (Plan) was deficient as alleged by NVOSHA to establish violations of NRS 618.375, the Nevada General Duty Clause, by a preponderance of evidence.

WITNESS TESTIMONY

Industrial Hygienist (IH)/Compliance Safety and Health Officer **(CSHO) Kerry Sanchez** testified as to her background and experience including having conducted 100-200 inspections for the Nevada Division of Occupational Safety and Health (NVOSHA). Ms. Sanchez identified the complainant exhibits stipulated in evidence, specifically Exhibits 1 through 3 and testified from the documents. She referenced the inspection report and safety narrative at Exhibit 1. Ms. Sanchez explained her investigation findings and conclusions which provided the basis for recommending issuance of the Serious violations at Citation 1, Items 1 through 6 and the "Other than Serious" record keeping violations at Citation 2, Items 1 and 2. She testified the NVOSHA

position is that the respondent (Summerlin Hospital) (SH) TB Exposure Control Plan (Plan) was deficient and referenced the specific citation charging allegations of violations.

NVOSHA cited six separate violative conditions under the general duty clause of the Nevada Occupational Safety and Health Act. Each of the items referenced at Citation 1, Items 1 through 6 alleged different aspects of deficiencies within the Plan which were classified as "Serious" and included total proposed penalties of $37,800.00. Ms. Sanchez testified she personally reviewed the Plan and made the determinations of deficiencies after consultation with federal OSHA personnel and her supervisors. She referenced the allegations in the citations and testified the respondent failed to specify required safety protective measures in the Plan, and comply with the Centers for Disease Control (CDC) 2005 guidelines for controlling TB exposures in healthcare settings. CSHO Sanchez testified the **CDC 2005 Guidelines are the NVOSHA accepted feasible means for abating the alleged hazardous conditions.**

Ms. Sanchez provided extensive testimony regarding facts she found and conclusions reached during her inspection. She referenced her interviews with respondent employees, document reviews and the NVOSHA interpretation of respondent's Plan, to support her allegations of failures in the SH Plan and compliance with the CDC Guidelines.

At Citation 1, Item 1, Ms. Sanchez alleged there was a "**lack of proper procedures and controls** in the SH neonatal intensive care unit (NICU) where employees had been exposed to and diagnosed with tuberculosis." She testified the hospital, as a medical facility, must expect to encounter patients with suspected tuberculosis (TB), however patients with unrecognized active TB were admitted to the hospital for treatment and cared for by the employee staff without proper procedures

and controls.

Ms. Sanchez testified the SH Plan she reviewed at the time of inspection did **not include the statistical data** nor a **TB risk assessment** she determined required. She cited the two instances of violation in the Plan because it did not include appropriate statistical data nor did SH follow its own Plan requirements for risk evaluation procedures after the event of TB exposure. Ms. Sanchez testified that **feasible and acceptable abatement compliance** for reducing the referenced hazard exposure would have been **to include the statistical data and follow the Plan which requires a risk management assessment be conducted in the event of an exposure.** She testified the CDC requires risk assessments be conducted on an ongoing basis in accordance with its 2005 Guidelines.

Ms. Sanchez described her determination for the violation classification of "Serious" and the potential resultant hazards recognized by the healthcare industry to be expected from Plan failure to include and enforce tuberculosis control protections.

At Citation 1, Item 2, Ms. Sanchez referenced the exhibits and citation issued to the respondent. She described the cited deficiency of the Plan for a **failure to include reevaluation of the Plan after a TB exposure and on an annual basis.** Ms. Sanchez testified the Plan incorporated the CDC Guidelines which outlined a protocol that included it be "updated annually. (Tr. 253)" She testified the Plan needed to be, in the first instance, reevaluated **after the occurrence of a significant (TB) exposure,** and in the second instance, **annually.** She testified the Plan was only being evaluated every three years, which is not in accordance with the Plan or CDC Guidelines.

At Citation 1, Item 3, Ms. Sanchez again referenced her citation for a general duty clause violation as a deficiency in the Plan. She

alleged there were **no procedures in place for screening as soon as possible after an exposure to TB.** She testified the abatement compliance to address the recognized hazard would be to follow the CDC 2005 Guidelines. (Tr. 259) She alleged that at least one employee was not given a TB screening until 8 weeks after her exposure. Ms. Sanchez testified there is "**nothing in their TB control program that has anything to do with employee testing following an exposure.** The only thing **they cover is their yearly (annual) testing.** (Tr. 257)" Ms. Sanchez identified the SH employee in a position to be aware of the exposure and lack of screening as Ms. Louise Hesse. She testified that Ms. Hesse informed her SH had "no control" because it was all within the CDC and Sierra Nevada Health Department (SNHD) responsibility.

On direct examination, in response to a question that SNHD was directing the testing, the witness responded "they shouldn't have needed to be there." Counsel asked if that absolved Summerlin; Ms. Sanchez responded it did not even though the exposure issue was being addressed by SNHD it did not absolve the respondent "Not in Nevada OSHA's eyes. It is the employer's responsibility . . . to ensure their employees are getting tested when they need to be tested . . .. (Tr. 260)"

Ms. Sanchez further testified ". . . they (SH) are required to comply with the CDC Guidelines . . . they **stated repeatedly in their control Plan they are basing . . . all their control Plan content off of CDC . . . and they're not because they are missing key elements** . . .. (Tr. 259-260)"

At Citation 1, Item 4, IH Sanchez referred to her narrative report, the exhibits, and the citation charging allegations. She testified the cited deficiency in the Plan is that it did **not require "prompt evaluations for employees who had converted from negative to positive**

after an exposure." She testified that because the Plan did not require these evaluations, employees failed to receive chest x-rays **promptly,** given time frames of 7-21 days.

The "actual violation was that their Plan did not include the CDC requirement for **prompt evaluation** upon conversion." In questioning Ms. Sanchez on employer (SH) **knowledge** for this requirement to be in the Plan, she responded "I would assume they knew because they wrote the Plan . . . SH had no control over anything that was going on with the rounds of testing or x-rays because it was in the hands of the CDC and SNHD . . .." She testified the matter was being handled by CDC and SNHD but that did that not absolve SH from responsibility and responded, ". . . I don't recall them saying anything particular about . . . their Plan, . . . about acknowledging that they were aware or unaware . . .. (Tr. 263)"

Ms. Sanchez testified that it was the deficiency in the Plan which was subject of the citation and not the exposure itself.

At Citation 1, Item 5, CSHO Sanchez referenced her narrative report, Exhibit 1, and the citation issued confirming the allegations she made to support the citation. She testified SH did not **conduct proper diagnostic measures** for patients who displayed signs of tuberculosis and that the **Plan did not have proper requirements the CDC includes for diagnostic testing.** Ms. Sanchez again confirmed she did not cite the respondent for any failure to conduct the testing, but rather for a deficiency for same in their program Plan. She described the deficiencies including, under instance 2, lack of cultures required under the CDC Guidelines for undertaking proper diagnostic measures. On question from counsel noting the citation was not issued because there were no sputum cultures performed, Ms. Sanchez testified no one

at SH advised why they were not performing the cultures described. She testified there were no assurances in place for the procedures.

At Citation 1, Item 6, CSHO Sanchez testified on the **failure of the Plan to require initiation of airborne precautions.** (Tr. 266) Ms. Sanchez described the instances of failures she found and alleged on the part of the staff at SH to **implement** precautions, and her conclusion there was a **lack of control in the Plan relating to the airborne exposures.**

Respondent counsel conducted **cross-examination of IH/CSHO Sanchez.** Counsel inquired as to background, training and experience, including tuberculosis Plan inspections. Ms. Sanchez testified her previous experience with inspections ". . . did not include any tuberculosis focused investigations." She did not cite for failures to perform testing, x-rays, or TB work, but rather for deficiencies in the TB Exposure Control Plan (Plan).

At **Citation 1, Item 1**, Ms. Sanchez testified the "**recognized hazard**" was that a hazard assessment was **not** done for 2012 or 2013. She revised her answer to testify that the actual hazard itself would be tuberculosis and that the failure to do a risk assessment could result in the potential exposure to tuberculosis. In questioning on the risk classification examples Ms. Sanchez referred to the CDC Guidelines at Exhibit H. She **admitted** on questioning that the **CDC Guidelines would not require annual risk assessments**, but the Summerlin **Plan** program reflected they would perform same **annually dependent upon the risk level.** Ms. Sanchez admitted the Summerlin Hospital (SH) **was categorized as a "low risk."**

In continued questions, Ms. Sanchez **admitted the SH control Plan incorporated Exhibit H, the CDC Guidelines.** She **testified the**

recommended "feasible abatement" method in this case was to comply with the CDC Guidelines. Counsel questioned how Ms. Sanchez could cite for Plan deficiency despite the Plan incorporating the CDC Guidelines and her admission that compliance with the CDC Guidelines would be the feasible abatement of the recognized hazard. When challenged on her position in the citation against her answers, Ms. Sanchez could not explain her distinction between charging violative conditions for TB exposure events rather than actual Plan deficiencies as cited. (Tr. 322)

"But you've already testified that this is not about SH noncompliance. This is about there being a plan deficiency. You've testified multiple times that your citations have nothing to do with failures to do something under the plan. That it is actually a failure of the plan to account for something to be done?" She responded "Right. I'm sorry. I'm just not understanding what you're getting at. I agree with you . . .. (Tr.322)"

Counsel further questioned the witness with regard to **Citation 1, Item 2**, charging a **Plan** deficiency for **failure to require reevaluation of the Plan** since the 2013 occurrence and **"failure to evaluate annually."** Counsel referenced the CDC requirements incorporated into the SH Plan. Ms. Sanchez **testified ". . . CDC requires annual if possible . . . and Summerlin has it in their Plan for an annual . . ..** (Tr. 318-319)"

Counsel referenced Exhibit B and Ms. Sanchez confirmed SH did perform an evaluation of their TB Exposure Control Plan (Plan) in April 2013. Ms. Sanchez **admitted SH would not have been required to do an annual reevaluation until April 2014.** Ms. Sanchez admitted **SH did perform a review and revised the Plan in January 2014.** (Tr. 316-324.)

CSHO Sanchez further testified other than an SH Plan annual review,

there is **no added requirement under the CDC Guidelines to do another review of the Plan.**

At Citation 1, Item 3, referencing the citation for failure of a **lack of screening procedures in the Plan** as basis for the citation for Plan deficiency, counsel directed the witness to page 21 of the Plan. Counsel questioned Ms. Sanchez based upon her previous testimony that the Plan reference to the incorporated CDC Guidelines would constitute feasible abatement. **"Don't the CDC Guidelines instruct a hospital to work in collaboration with the local state or health department?" Ms. Sanchez responded affirmatively.** (Tr. 324-330)

Counsel challenged the witness and asked whether Summerlin did have procedures in place to perform TB screenings as required by the Plan and incorporated CDC Guidelines at Exhibit H and Exhibit D, which do **not** require the specificity you testified as renders the Plan deficient? Ms. Sanchez responded "It does say that what - what I was referring to is under these it talks about problem evaluations and contact investigations and so forth. (Tr. 328-329)"

At Citation 1, Item 4, the citation charged the Plan to be deficient for failure to require **"prompt evaluation"** when employees screening tests converted from negative to positive after exposure to tuberculosis. Cross-examination was focused on IH Sanchez finding the Plan faulty due to the failure to use the word "prompt" and the meaning of same. Ms. Sanchez testified she relied upon the Webster Dictionary for interpretation of the word "prompt." She **admitted the Plan did incorporate the CDC Guidelines for evaluations.** Counsel challenged the witness asking if she cited a deficiency of the Plan simply because SH failed to use the word "prompt;" to which the witness testified: "right."

At Citation 1, Item 5, Ms. Sanchez referenced the citation and responded on her basis for finding a violation in the Plan. She alleged SH does not conduct **proper diagnostic measures** for patients who display signs of tuberculosis and testified in support of the charges by referencing a lack of a sputum examination having never been conducted at instance 1. At instance 2 she alleged the Plan did not include significant symptoms that are indicative of a tuberculosis diagnosis nor require the administration of subsequent diagnostic measures. Ms. Sanchez admitted again that her citation was **not based upon SH failing to conduct proper diagnostic measures but rather the failure of the Plan** to "talk about diagnostic measures for patients." CSHO Sanchez explained her reasoning for the citation and Plan failure as based upon there being no SH **oversight** in the Plan. On further questioning, Ms. Sanchez **admitted the Plan at page 4 does account for screening patients for early detection of TB.** (Tr. 332-333) She further **admitted the screening process in the Plan is what is suggested by the CDC Guidelines.** (Tr. 333) On further cross-examination, Ms. Sanchez testified she was not citing the respondent for there being no oversight from the hospital to ensure what needs to be done. Counsel again challenged the answers of Ms. Sanchez now **admitting there are diagnostic measures in the Plan, which includes any information required in the CDC Guidelines**, yet asserting failure to provide "oversight." Counsel challenged the response and asked Ms. Sanchez to confirm the CDC Guidelines didn't address oversight and she responded "**correct.**"

At Citation 1, Item 6, the witness was directed to the citation alleging SH did not "**initiate** airborne precautions . . ." at instance 1; and at instance 2 **the Plan** did not "**require initiation**" of airborne precautions for all patients. When challenged on the relationship of

her allegation of **"initiation" as an event exposure charge and the citation based upon a "deficient Plan", the witness admitted that page 5 of the Plan, Exhibit D, described how the isolation precautions would be "initiated."**

The witness acknowledged the exhibit terms and confirmed on questioning ". . . that would be "airborne precautions by respondent", answering "right on the issue of patient isolation in the Plan . . .." When questioned as to **whether that would constitute airborne precautions in the Plan, Ms. Sanchez answered "right."**

In response to the question of **"the Plan does reference the CDC Guidelines and utilizes all of the guidelines suggested by the CDC . . ., Ms. Sanchez answered "correct."** Counsel again challenged the witness, referring to the **Plan inclusion** of these precautions from the CDC Guidelines which had been incorporated into the SH Plan. **CSHO Sanchez admitted the airborne precautions were accounted for as well as initiation in the Plan.** (Tr. 337-338)

In concluding cross-examination, counsel inquired of CSHO Sanchez inspection experience at the beginning of October 2013 including any specific courses related to tuberculosis. Ms. Sanchez testified it consisted of a biohazards class at the OSHA Training Institute (OTI) which included tuberculosis. She admitted there was no stand-alone classes specific to tuberculosis. The OTI biohazard class lasted two weeks, but Ms. Sanchez could not respond to how many hours were spent on the subject of tuberculosis. CSHO Sanchez admitted she had "no specialized training" prior to October 2013 regarding how to write a TB Exposure Control Plan. (Tr. 339)

Complainant counsel presented witness **testimony from Ms. Amber Rose.** She identified herself as the Federal OSHA inspector who assisted

Ms. Sanchez in the investigation. Ms. Rose described her experience, education and background as a Federal CSHO/Industrial Hygienist. She assisted Ms. Sanchez during the interview process by taking notes of the verbal inquiries and actually writing the responses as a "scribe." She further testified that the Plan provides the hospital ". . . will do annual risk assessments . . . but they were not done so she did not believe . . . they were following their own Plan."

Ms. Rose testified primarily as to employee TB **exposure event** issues and lack of employer compliance rather than **Plan deficiencies**. She helped CSHO Sanchez with review of some of the Plan and testified ". . . yes we found concerning things . . . they said they were following CDC . . . and we just found discrepancies there . . .."

On cross-examination Ms. Rose explained the Exhibit B, federal OSHA Interpretation Letter, providing guidance for citing general duty clause violations. **She admitted the Summerlin Hospital Plan did include the CDC protocols**, and responded affirmatively that the SH Plan had a program for testing. Ms. Rose testified SH maintains an education and training program for TB.

Ms. Rose reviewed the Exhibit B five steps and testified how any one of those would be a basis for Federal OSHA citation. She explained her purpose for being involved in the SH investigation as due to a familial relationship between a Nevada CSHO and an infected person so NVOSHA wanted to avoid any appearance of conflict or impropriety. On questions with regard to the specific requirements of Nevada OSHA Ms. Rose testified ". . . Federal OSHA and state OSHA have different sets of standards . . so I wouldn't be able to offer any assistance . . . I don't know what their standards are." (Tr. 75)

Ms. Rose testified there was no OSHA requirement for an annual Plan

review so federal OSHA does not cite for that; but explained there could be a citation if the employer Plan was violated.

Complainant counsel presented witness testimony from **Dr. Michael Hodgson**, the Federal OSHA Director of Medicine and Nursing. He testified that he did not inspect the Summerlin Hospital site but merely read the Plan on the website and consulted with the CSHO on how to conduct an investigation from a medical standpoint. He testified on a wide range of medical issues, controls and healthcare practices in TB exposure cases.

On cross-examination Dr. Hodgson admitted that **Summerlin Hospital does have a TB control program "Plan."** He never reviewed the systems at the hospital, the controls nor the program other than reading about it on the web. (Tr. 171) Dr. Hodgson could not answer questions of what may be required under the general duty clause for Summerlin Hospital to assure compliance with the Plan. He testified that symptoms alone would not signal the existence of tuberculosis. He further testified that **Summerlin Hospital did follow the federal OSHA Interpretation Letter and criteria** (Exhibit B); however it did not "implement" the **Plan** procedures.

At Citation 1, Item 1, Dr. Hodgson testified, he had **no opinion** with regard to the charges on **Plan statistical data and risk assessment** for tuberculosis.

At Citation 1, Item 2 on question of requirements for **reevaluation** of the Plan and whether he had any evidence or an opinion if done or needed; he answered **"no."**

At Citation 1, Item 3 charging there were **no Plan procedures** in place and question of did he know whether employees were screened, he testified that **"yes, I know some were."**

At Citation 1, Item 4, he testified that he **had no evidence** as he was not required to participate in the issue.

At Citation 1, Item 5, on charges that SH did not conduct proper diagnostic measures and whether he had any evidence in that regard, Dr. **Hodgson testified "no."** On continued cross examination, Dr. Hodgson admitted he had already testified that SH **did have diagnostic procedures in their Plan** and reiterated he **answered "yes."**

At Citation 1, Item 6 charging the hospital did not initiate **airborne precautions**, Dr. Hodgson answered ". . . I **cannot answer that** . . .."

Complainant rested the NVOSHA case.

Respondent presented witness testimony from three individuals, namely SH RN NICU Manager Linda LaPointe, SH Infection Prevention Manager RN Louise Hesse, and Dr. William Patrick Joseph.

Ms. LaPointe testified as to her education and experience, noting her position as manager of the SH NICU which she described as the higher level of care for newborns. She described and explained the **airborne precautions** in the Summerlin Hospital Plan during the time of exposures as maintained at the ". . . highest level of isolation in which a patient can be placed . . .." She testified those airborne precautions were in place at the Summerlin Hospital during the time periods relating to the TB exposure event subject of the hearing. On questioning as to how soon those airborne precautions were in place, she answered ". . . **within minutes of finding out the mom was diagnosed with tuberculosis** . . .. (Tr. 361)" On questions as to whether she or any of the nurses were not using appropriate PPE when they went into the NICU, she responded "no." She confirmed her familiarity with the Summerlin Hospital Tuberculosis Exposure Control Plan and testified "**we have the**

annual mandatories every year . . . as part of our computerized education . . .." (Tr. 362) As to a question of whether there is annual training on tuberculosis, Ms. LaPointe testified "yes."

On cross-examination Ms. LaPointe denied ever discussing any "air exchanges" with OSHA inspectors. She further denied telling the inspectors that she worked after a positive skin test, responding to the question with "no." She testified there were never any employee discussions about working before she had an x-ray. On questioning as to any discussions involving a respiratory therapist named Rita Scales having a positive skin test before an x-ray she responded "we didn't discuss any of the (test) results of any employees." Ms. LaPointe denied having made any references of "grill cleaning" to the inspectors. (Tr. 362-364)

Respondent presented testimony from **RN Ms. Louise Hesse** who identified herself as the Summerlin Hospital Infection Prevention Manager for 2-1/2 years. Ms. Hesse identified the SH computer data technology as the "Cerner System." She explained use of the system **to assess patients, if criteria met through the hospital for positive culture results, to determine risk and need for isolation.** (Tr. 365-366) When she accepted her position at SH, there was an infection control Plan in place at SH. She further testified to a question as to "was there a **TB Exposure Control Plan at SH?" Ms. Hesse responded "yes."** The witness testified how infection control assessment works in conjunction with TB risk assessment Plan. She described the information that goes into the infection control plan and how it is utilized for various types of monitoring. (Tr. 366, line 22 - 367, line 7) She described the TB risk assessments under the SH Plan and coordination with the State Health Department (SNHD). Ms. Hesse testified on

performances of **risk assessment at the hospital prior to the October 2013 exposure**; answering "I was involved in the **active, ongoing process when we had the TB exposure.**"

Ms. Hesse identified Exhibit H as the CDC Guidelines in evidence. She explained the classification of the hospital as a "medium risk" testifying that means they will test again, "**and we do test yearly anyway**. (Tr. 370-371)"

Ms. Hesse identified the SH Tuberculosis Exposure Control Plan (Plan) at Exhibit D and confirmed she was involved in **reevaluation of the document in April 2013.** She further testified as to a 2013 Plan review and identified Exhibit E as the **reevaluated 2014 version of the Plan.** (Tr. 373) Ms. Hesse testified on her involvement in the review conducted of the Plan in January of 2014. She also testified there was an independent outside **review of the SH Plan during July of 2013** after the exposure incident referenced in this case, by the "**Joint Commission for Hospital Accreditation . . . it's our regulatory body** . . . they came in and reviewed the Plan as well . . . they reviewed specifically the TB Exposure Control Plan and the Infection Control Plan . . . **they found "no deficiencies whatsoever** . . ., in fact I got no deficiencies for the whole infection control program. (Tr. 374-375)"

On questions of speaking with the CDC about protocols for testing of employees after the tuberculosis exposure incident was known in July 2013, Ms. Hesse testified she spoke with the epidemic intelligence officer at the CDC Southern Nevada Health District (SNHD) Ms. Kaci Hickox. After being notified of TB exposure by the SNHD "we immediately placed the baby into airborne isolation and put up the airborne isolation sign . . . we made sure that everyone knew about the airborne isolation and needed to wear an N95 mask. (Tr. 376)" She testified the

SNHD and Ms. Hickox ". . .outlined the protocols for testing during the time period and managed the process through until its completion. (Tr. 377) The CDC Guidelines require SH to work with the health district and the CDC on exposures. SH was following the CDC Guidelines by working in conjunction with the SNHD and CDC . . .. (Tr. 377)"

Ms. Hesse denied ever telling any employees they didn't have to wear personal protective equipment in NICU because of comments from the SNHD. In response to a question as to whether the SNHD indicated the baby did not need to be placed in isolation, she responded even though the health district stated by telephone they did not need to do so, "we followed our policy and procedure for suspected or confirmed TB cases and the baby was placed in airborne isolation. (Tr. 379)"

On question whether there is any training conducted on the Plan, she testified "yes it's through RHR . . . and the training program is a component of the CDC Guidelines. (Tr. 379)" She further testified the Plan training takes place "annually."

Ms. Hesse testified that ". . . during her role as Infection Control Manager, no one within the hospital or any entity that reviewed the Plan ever indicated the (control) Plans are deficient or confusing."

On cross-examination, Ms. Hesse testified the **Plan does address the screening issues and referenced Exhibits D and E.** In response to a question whether the screening required if there is ". . . only one positive answer for it to be a positive result?" She responded "it does not" (Tr. 381-384). She further testified that nurses are trained in risk assessment . . . there is no direct oversight on the accuracy of screening testing. Ms. Hesse denied ever telling any employee that according to the SNHD the baby was not contagious (Tr. 385). She further denied she told any employees that isolation was only for

comfort or that respiratory use in the isolation room was not necessary, testifying "no, I would never say that either . . .." She further denied ever telling an employee the TB contact at SH came from a grocery store.

On question as to whether any signed employee statements attributing the foregoing to her in discussions would be lies, Ms. Hesse answered she would never have said those things and denied the various forms of a series of similar questions. Counsel questioned "they are saying that you told them the respiratory protection was unnecessary because the SNHD told you the babies were not contagious . . .?" Ms. Hesse responded "I did not ever say that." As to a question "is it your opinion if a Summerlin employee has a suspicion of TB they are authorized to initiate isolation and procedures." Ms. Hesse answered "correct."

On final questioning counsel asked "In terms of documentation you were asked about screenings, whether those were accurate and whether you had oversight, is there any kind of protocol with the hospital for review of medical documentation?" The witness responded, after clarification, "accuracy of medical records," "yes they are reviewed . . . I don't have responsibility for reviewing medical records . . . not part of your job . . . yes."

Respondent presented testimony from **Dr. William Patrick Joseph.** He identified himself as a practicing physician in the San Francisco area and board certified in internal medicine, infectious disease epidemiology and quality assurance. He testified as to his education, background, and position of chief of medical staff and described his associated duties. Dr. Joseph testified as to his medical experience treating tuberculosis, as well as his background in writing and training

for TB Exposure Control Plans. He **reviewed the Summerlin Hospital TB Exposure Control Plan dated April 2013.** On direct question **"did you determine there were any Plan deficiencies in the Plan," he responded "no, I thought it was very typical of a TB Exposure Control Plan . . .** it's only one of many exposure control plans in a hospital . . . there are exposure control plans for many infectious diseases . . . each one of them is written based on the likelihood of that type of exposure occurring in a hospital . . . the **TB Exposure Control Plan that I read from Summerlin is boiler plate, bullet proof, contains all the necessary components** therefore a good Plan . . .." (Tr. 398)

On question are you familiar with the CDC Guidelines, Dr. Joseph responded "very much so." Are you familiar with the term risk assessment? The witness answered "certainly" and explained what it means and the terms of the classification SH had in place in 2013. He testified ". . . **there was nothing confusing about the Summerlin TB Exposure Control Plan** . . .." He testified the "SH **TB Exposure Control Plan would have provided the hospital staff with the necessary means to make judgments to appropriately handle TB exposure control.** (Tr. 401)" He testified it was no surprise in the subject case that SNHD was very integral as well as the CDC in the TB exposure incident.

On cross-examination, Dr. Joseph explained his description of the SH Plan as "boiler plate." He testified that "boiler plate means there is a template used for multiple hospitals, it's a template that's reviewed by legal counsel . . . by a group of physicians, a group of nurses . . . and then if changes are necessary for an individual hospital then it's made to the template . . .." On question as to whether there should be "something more than boiler plate . . ." Dr. Joseph answered "not in the Plan." He explained the risk assessment

analyses associated with developing control plans.

On redirect and re-cross examination Dr. Joseph explained the medical processes on TB exposure, testing, time periods, and the reasonableness of the Plan provisions in the SH workplace. He testified there is no medical definition for "prompt response." He responded to a question as to a time line as "usually they refer to the CDC Guidelines . . .."

At the conclusion of presentation of evidence and testimony complainant and respondent submitted written closing arguments.

The Board in reviewing the facts, documentation, testimony and other evidence must measure same against the established applicable law developed under the Occupational Safety & Health Act.

APPLICABLE LAW

A serious violation can be established under Nevada occupational safety and health law in accordance with Nevada Revised Statutes (NRS).

NRS 618.625(2) provides:

> ...a **serious** violation exists in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which exists or from one or more practices, means, methods, operations or processes which have been adopted or are in use at the place of employment **unless the employer did not and could not, with the exercise of reasonable diligence, know of the presence of the violation.** (emphasis added)

N.A.C. 618.788(1) provides:

> In all proceedings commenced by the filing of a notice of contest, the **burden of proof rests with the Administrator.**

NRS 618.375(1) commonly known as the **"General Duty Clause"** provides in pertinent part:

> ". . . Every employer shall:

> 1. Furnish employment and a place of employment which are **free from recognized hazards** that are **causing or are likely to cause death or serious physical harm** to his employees . . .” (emphasis added)

NRS 233B(2) provides:

> **"Preponderance of evidence"** means evidence that enables a trier of fact to determine that the **existence of the contested fact is more probable than the nonexistence of the contested fact.** (emphasis added)

To establish a violation of the Nevada **general duty clause,** Nevada OSHA is required to prove by a **preponderance of the evidence** the employer failed to render its workplace "free" of a hazard:

> (1) The hazard was recognized;
> (2) The recognized hazard is causing or likely to cause death or serious physical harm;
> (3) There was a **feasible and useful method to correct the hazard which the employer had not undertaken;** and
> (4) The **employer knew or could have known with due diligence of the circumstances in violation** of the OSHA.
>
> When the Secretary has introduced evidence showing the existence of a hazard in the workplace, the **employer may, of course, defend by showing that it has taken all necessary precautions to prevent the occurrence of the violation.** *Western Mass. Elec. Co.*, 9 OSH Cases 1940, 1945 (Rev. Comm'n 1981). (emphasis added)
>
> In citing an employer under the general duty clause, it is specifically necessary to demonstrate the existence of a recognized hazard as mandated by the statute; whereas citing an employer under a specific standard does not carry such a requirement because Congress has, in codification, adopted the recognition of (certain) hazards for the particular industry. **To establish a violation of the general duty clause, the complainant must do more than show the mere presence of a hazard.** The general duty clause, ". . . obligates employers to rid their workplaces of **recognized hazards** . . .” *Whitney Aircraft v. Secretary of Labor*, 649 F.2d 96, 100 (2nd Cir. 1981). (emphasis added)
>
> "The elements of a **general duty clause** violation identified by the first court of appeals to

interpret Section 5(a)(1) have been adopted by both the Federal Review Commission and the Courts. In *National Realty and Construction Co., Inc. v. OSHRC*, 489 F.2d 1257 (D.C. Cir. 1973), the court listed three elements that OSHA must prove to establish a general duty violation; the Review Commission extrapolated a fourth element from the court's reasoning: (1) a **condition** or activity in **the workplace presents a hazard to an employee**; (2) the **condition** or activity is **recognized as a hazard**; (3) the hazard is causing or is likely to cause death or serious physical harm; and (4) a **feasible means exists to eliminate or materially reduce the hazard (which the employer failed to undertake)**. The four-part test continues to be followed by the courts and the Review Commission. E.g., *Wiley Organics Inc. v. OSHRC*, 124 F.3d 201, 17 OSH Cases 2125 (6th Cir. 1997); *Beverly Enters., Inc.*, 19 OSH Cases 1161, 1168 (Rev. Comm'n 2000); *Kokosing Constr. Co.*, 17 OSH Cases 1869, 1872 (Rev. Comm'n 1996). The *National Realty*, decision itself continues to be routinely cited as a landmark decision. *See, e.g., Kelly Springfield Tire Co. v. Donovan*, 729 F.2d 317, 321, 11 OSH Cases 1889 (5th Cir. 1984); *Ensign-Bickford Co. v. OSHRC*, 717 F.2d 1419, 11 OSH Cases 1657 (D.C. Cir. 1983); *St. Joe Minerals Corp. v. OSHRC*, 647 F.2d 840, 845 n.8, 9 OSH Cases 1946 (8th Cir. 1981); *Pratt & Whitney Aircraft Div. v. Secretary of Labor*, 649 F.2d 96, 9 OSH Cases 1554 (2d Cir. 1981); *R.L. Sanders Roofing Co. v. OSHRC*, 620 F.2d 97, 8 OSH Cases 1559 (5th Cir. 1980); *Magma Copper Co. V. Marshall*, 608 F.2d 373, 7 OSH Cases 1893 (9th Cir. 1979); *Bethlehem Steel Corp. v. OSHRC*, 607 F.2d 871, 7 OSH Cases 1802 (3d Cir. 1979). Rabinowitz Occupational Safety and Health Law, 2008, 2nd Ed., page 91. (emphasis added)

OSHA must also prove that the employer actually knew, or could have known with the exercise of reasonable diligence, of the physical circumstances that violate the Act. This element must also be proved in general duty clause cases. The element requires OSHA to establish the **employer's actual or constructive knowledge of the physical circumstances that comprise the violation.** OSHA is not required to show that an employer knew the conditions violated the Act or posed hazard to employees. *E.g., New York State Elec. & Gas Corp. v. Secretary of Labor*, 88 F.2d 98, 105, 17 OSH Cases 1650 (2d Cir. 1996); Pennsylvania Power & Light Co. v. OSHRC, 737 F.2d 350, 11 OSH Cases 1985 (3d Cir. 1984); *Ragnar Benson Inc.*, 18 OSH Cases 1937, 1939 (Rev. Comm'n 1999); *Continental Elec.*, 13 OSH Cases 2153, 2154 (Rev. Comm'n 1989)

(knowledge is a required element even for nonserious violations). *See, United States Steel Corp.*, 12 OSH Cases 1692, 1699 (Rev. Comm'n 1986). *East Tex. Motor Freight v. OSHRC*, 671 F.2d 845, 849, 10 OSH Cases 1457 (5th Cir. 1982); *Omaha Paper Stock Co. v. Secretary of Labor*, 19 OSH Cases 1584 (Rev. Comm'n 2001), *aff'd*, 304 F.3d 779, 19 OSH Cases 2039 (8th Cir. 2002); *Ormet Corp., 14 OSH* Cases 2134, 2138 (Rev. Comm'n 1991); *Southwestern Acoustics & Specialty Inc.*, 5 OSH Cases 1091 (Rev. Comm'n 1977) (employer need be shown only to have had knowledge of "physical conditions which constitute a violation," F.2d 1265, 1272, 15 OSH Cases 1238 (11th Cir. 1991) (employers are charged with knowledge of matters duly published in Federal Register). Occupational Safety and Health Law, Bloomberg BNA 2013, 3rd Ed., page 90. (emphasis added)

The legal duty of respondent is not to protect against **unknown**, unforseen or extreme events, but rather **recognized hazards** as defined by or developed under applicable occupational safety and health law.

"A condition may be recognized as a [recognized hazard] only when the evidence shows that it is commonly known by the public in general or in the cited employer's industry as a hazard of such type." *Consolidated Engineering Co., Inc.*, 2 OSHC 1253, 1974-1975 OSHD ¶ 18,832, at page 22,670 (1974). Also see *National Realty and Construction Company, Inc. v. OSAHRC*, 489 F.2d 1257, 1265 n. 32 (D.C. Cir. 1973); *Atlantic Sugar Association*, 4 OSHC 1355, 1976-1977 OSHD ¶ 20,821 (1976). (emphasis added)

". . . The Secretary's obligation to demonstrate the alleged violation by **a preponderance of the reliable evidence of record requires more than estimates, assumptions and inferences** . . .[t]he Secretary's reliance **on mere conjecture is insufficient to prove a violation** . . . [findings must be based on] 'the kind of evidence on which responsible persons are accustomed to rely in serious affairs.'" William B. Hopke Co., Inc., 1982 OSAHRC LEXIS 302 *15, 10 BNA OSHC 1479 (No. 81-206, 1982) (ALJ) (citations omitted). (emphasis added)

"The Secretary (administrator) may also prove industry knowledge through publications and other materials that reflect industry knowledge or practice. As the commission has stated '[b]oth the Commission and appellate courts have consistently

> held that voluntary industry codes and **guidelines are evidence of industry recognition.'** Thus, in *Kokosing Construction Co.* The Commission found a standard published by the American National Standards Institute (ANSI) and a guideline published by the Scaffold, Shoring and Forming Institute to be compelling evidence of industry recognition. Similarly, in *Reich v. Arcadian Corp.*, the Secretary pointed to industry-specific information to establish that the alleged hazard involved pressure vessels was recognized. . . ." 17 OSH Cases 1869, 1873 (Rev. Comm'n 1996), 110 F.3d 1192, 17 OSH Cases 1929 (5th Cir. 1997). Occupational Safety and Health Law, Bloomberg BNA 2013, 3rd Ed., page 106.

DISCUSSION

The Board finds **no preponderant evidence** to satisfy the complainant's **burden of proof** to establish violations of NRS 618.375, the general duty clause, at **Citation 1, Items 1 through 6.**

While the inspection of Summerlin Hospital (SH) by NVOSHA in this case raised questions of potential hazardous conditions emanating from **tuberculosis (TB) exposure events**, the **citations** were based **solely** upon allegations charging **deficiencies in the Summerlin Hospital (SH) tuberculosis Exposure Control Plan (Plan).** Allegations, testimony and/or evidence as to **events of exposure** were **not subject of the citations nor before this Board for decision.**

The facts in evidence portray an unusual, and ultimately impeded enforcement process resultant in part from the NVOSHA determination the governing statute of limitations prohibited citations for tuberculosis exposure **events.** This enforcement position limited the citations issued to **only** alleged deficiencies in the SH **Plan.** However, the testimony and documentary evidence offered at hearing and the citations actually issued clearly remained centered on alleged **events of tuberculosis exposure** and **failures or inaction on the part of SH**, medical staff, employees, and/or supervisory personnel to protect employees from

contamination in the SH workplace. The facts, testimony, and documentary evidence demonstrate NVOSHA inferences to extrapolate violations from the respondent tuberculosis control **Plan** to salvage the enforcement position lost through expiration of the statute of limitations for **exposure events.**

Complainant counsel and the principal witness, CSHO Ms. Kerry Sanchez, often repeated at hearing that the subject citations are ". . . **ONLY for the Plan, NOT for the exposure events** . . .," asserting the ". . . **events of exposure only** serve to . . . highlight the inadequate SH Exposure Control **Plan** . . .," (emphasis added). However, the testimony and evidence demonstrate the enforcement action brought before this Board was mired in **alleged violative conduct for exposure events** although brought in the form of **Plan deficiencies.** The evidentiary problems of proof resulted in a confusing portrayal of alleged but unsupported **Plan** shortcomings or deficiencies, making it impossible for this Review Board to find reliable factual support and legally competent proof for citations charging general duty clause violations. To do otherwise would require **extrapolations, estimates, assumptions, inferences, and/or conjecture** drawn from allegations of **event exposures** rather than reliable evidence of **Plan deficiencies.** The governing occupational safety and health law does not permit this Board to find violations for other than the **cited** infractions and then by **preponderance of the reliable evidence of record.**

The preponderant evidence confirmed SH did in fact have a **compliant TB Control Plan in place which incorporated the recognized CDC 2005 Guidelines.** The Plan was reviewed by the "Joint Committee," an independent health facility oversight authority, and found compliant. The **feasible abatement method to address the recognized hazards**

associated with tuberculosis exposures and prevention control throughout the healthcare industry are the protocols in the 2005 Center for Disease Control Guidelines (CDC).

The transcript testimony demonstrates the complainant case relied almost exclusively upon the observations, findings and conclusions of IH CSHO Sanchez. However her testimony was equivocal, often contradictory, and substantially rebutted by her own cross examination answers and/or correcting testimony, as well as the opposing credible respondent witness testimony and documentary evidence.

CSHO Sanchez had no experience in writing or implementing a TB Exposure Control Plan. (Tr. 298) She never previously investigated a TB exposure event or plan (Tr. 299) She did not provide clear, convincing nor preponderant testimonial or documentary evidence to support the citation charges of **Plan deficiencies.** There was no support in the form of legally competent proof to corroborate the CSHO allegations, nor produced by documents or reliable testimony to satisfy the burden of proof to confirm violations of NRS 618.375 under governing occupational safety and health law. The burden of proof is upon the complainant.

Ms. Sanchez admitted the Summerlin TB control Plan incorporated the **same** CDC Guidelines for **abatement** that she identified would **eliminate or materially reduce the recognized hazards.** The incorporated CDC Guidelines in the SH Plan are the established healthcare industry, NVOSHA and Federal OSHA feasible means to abate the recognized hazards the TB control Plan was designed to address.

Further, there was **no evidence** to satisfy the required proof element that SH had **knowledge** or notice, directly or constructively of any recognized hazard control failures or deficiencies in **the Plan itself.** NVOSHA was required to **prove SH had "knowledge"** of the actual

Plan deficiencies to establish the citations for **serious** hazard violations in the TB Exposure Control **Plan.** This necessitated preponderant proof under the NVOSHA burden that SH **knew, directly or constructively,** there were deficiencies in the **Plan.** While recognition of a hazard "may be shown by proof that 'a hazard . . . is recognized as such by . . . general understanding in the [employer's] industry,'" there was no competent evidence or proof Summerlin recognized and/or had knowledge, directly or constructively, there were hazards relating to deficiencies existent in their **TB Exposure Control Plan itself.**

NRS 618.625(2) provides:

> ...a **serious** violation exists in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which exists or from one or more practices, means, methods, operations or processes which have been adopted or are in use at the place of employment **unless the employer did not and could not, with the exercise of reasonable diligence, know of the presence of the violation.** (emphasis added)
>
> Also see "The elements of a **general duty clause** violation identified by the first court of appeals to interpret Section 5(a)(1) have been adopted by both the Federal Review Commission and the Courts. In *National Realty and Construction Co., Inc. v. OSHRC*, 489 F.2d 1257 (D.C. Cir. 1973), the court listed three elements that OSHA must prove to establish a general duty violation; the Review Commission extrapolated a fourth element from the court's reasoning: (1) a condition or activity in the workplace presents a hazard to an employee; (2) the condition or activity is recognized as a hazard; (3) the hazard is causing or is likely to cause death or serious physical harm; and (4) a **feasible means exists to eliminate or materially reduce the hazard, which the employer failed to undertake.** Ibid at page 34.

There was no legally competent evidence to support or establish **knowledge** of any **Plan** deficiencies. *Otis Elevator Co.,* 21 BNA OSHC 2204, 2207, 2004-2009 CCH OSHD ¶ 32,920, p. 53,546 (No. 03-1344, 2007)

(quoting *Kokosing*, 17 BNA OSHC at 1873, 1995-1997 CCH OSHD at p.43,725).

The preponderant evidence established the Plan incorporated the CDC Guidelines which are **the** healthcare industry wide protocols for TB control Plans to address the **recognized hazards** associated with tuberculosis exposures. The Plan and Guidelines together comprised the SH Plan for recognized hazard abatement. Without proof of the required element of "knowledge," direct or constructive, by SH that the Plan was indeed deficient, erroneous or incomplete as alleged, even if true, defeats the complainant's burden of proof. **Failure of the knowledge element** satisfies the well established OSHA defense to avoid a general duty clause violation.

The **plain meaning** of the terms used in the Summerlin Control **Plan** including incorporated CDC Guidelines for healthcare settings is persuasive and preponderant evidence of a compliant Plan. The Plan terms and unrebutted testimony of qualified expert epidemiologist Dr. William Patrick Joseph on the accepted standards of the medical industry to address TB exposure abatement through control plans was additional preponderant evidence of an SH OSHA compliant Plan.

The respondent witnesses testifying - RN Ms. LaPointe, RN Ms. Hesse, and Dr. Joseph, provided competent credible testimony. Dr. Joseph testified the **Summerlin Plan complied with the CDC Guidelines and was not deficient.** (Tr. 397-298) **It was "boiler plate . . . typical of what should be in there . . . and similar to the medical industry . . . I am a board certified epidemiologist . . .."**

The proof of a compliant Plan was corroborated by unrebutted evidence of the **"Joint Committee for Hospital Accreditation"** review and findings.

The testimony of respondent witnesses was neither impeached,

rebutted nor undermined by any contrary legally competent documentary evidence or testimony.

Testimony offered by complainant's witnesses, Dr. Hodgson and Ms. Rose, did not establish any specific plan deficiencies to constitute violations. The testimony provided no clear, persuasive, reliable nor preponderant evidence of **deficiencies in the Plan.**

Conflicting testimony, standing alone, requires finding a lack of preponderant testimonial evidence and defeats the complainant's burden of proof.

> Conflicting testimony also may arise between a witness for OSHA and a witness for the employer (or conflicting real evidence). **If conflicting testimony of equal weight concerns an element OSHA must prove by a preponderance, OSHA must go forward with additional evidence to avoid dismissal of the citation.** An example of this is where an administrative law judge vacated a citation for a serious violation after the parties gave conflicting evidence. Because neither side's evidence was "more persuasive or believable" than the other's, the **Secretary had failed to provide the requisite showing of a preponderance.** *Flaherty Sand Co.*, 3 O.S.H.C. 1030 (Administrative Law Judge, 1975). *See also, Secretary of Labor v. Metro Steel Construction Co.*, 18 O.S.H.C. 1705, 1706 (1999) (testimony of OSHA compliance officer, who observed site from only one location in parking lot, was open to contradiction by more specific testimony of employer's two witnesses). (emphasis added)

At **Citation 1, Item 1** there was no preponderant evidence to establish a violation of NRS 618.375 in the SH Plan. The preponderant evidence demonstrated the SH **TB Control Plan**, which incorporated the CDC Guidelines was managed in conjunction with the SH overall **Infection Control Plan** through computer support technology identified as the "Cerner System." The Plan provided for risk assessment reevaluation.

At **Citation 1, Item 2** there was no preponderant evidence to establish a violation of NRS 618.375 in the SH Plan. The preponderant

evidence of record demonstrated the SH Plan provided for reevaluation. The SH Plan incorporated the CDC Guidelines which provided for annual reevaluations as appropriate.

At **Citation 1, Item 3** there was no preponderant evidence to establish a plan violation of NRS 618.375. The preponderant evidence demonstrated the SH Plan incorporated the CDC Guidelines for screenings as required by the CDC.

At **Citation 1, Item 4** there was no preponderant evidence to establish a plan violation of NRS 618.375. The preponderant evidence demonstrated the SH Plan, by incorporating the CDC Guidelines, meaningfully addressed timely evaluation for TB screenings converted from negative to positive after exposures.

At **Citation 1, Item 5** there was no preponderant evidence to establish a plan violation of NRS 618.375. The preponderant evidence demonstrated the SH Plan was compliant through adoption of the CDC Guidelines to address the diagnostic measures required.

At **Citation 1, Item 6** there was no preponderant evidence to establish a plan violation of NRS 618.375. The preponderant evidence demonstrated the SH Plan compliant through incorporation of the CDC Guidelines which did address and account for the initiation of airborne precautions.

The burden of proof is upon the complainant to establish violations by a preponderance of evidence.

Nevada OSHA was required to **do more than merely show that a hazard may have been present.** *Southern Ohio Building Systems v. OSHRC*, 649 F.2d 556, 558 (6th Cir. 1981).

> ". . . The Secretary's obligation to demonstrate the alleged violation by a **preponderance of the reliable evidence** of record **requires more than**

> **estimates, assumptions and inferences** . . .[t]he Secretary's **reliance on mere conjecture is insufficient to prove** a violation . . . [findings must be based on] 'the kind of evidence on which responsible persons are accustomed to rely in serious affairs.'" *William B. Hopke Co., Inc.*, 1982 OSAHRC LEXIS 302 *15, 10 BNA OSHC 1479 (No. 81-206, 1982) (ALJ) (citations omitted). (emphasis added)

The Occupational Safety and Health Act does not require employers to provide **"certainty"** or **to eliminate all "inherent" risks**, but only to take **"reasonable precautionary steps" against "foreseeable" hazards.** *Brennan v. OSHRC,* 494 F.2d 460, 463 (8th Cir. 1974). (emphasis added) The United States Supreme Court explained; "the statute (OSHA) was not designed to require employers to provide **absolutely risk-free workplaces whenever it is technologically feasible," but rather to reduce "significant risks of harm".** *Indus. Union Dep., AFL-CIO v. Am. Petroleum Ins.,* 448 U.S. 607, 642 (1980); *see also Nat'l Realty & Constr. Co. v. OSHRC,* 489 F.2d 1257 (D.C. Cir. 1973) (emphasis added) ("Congress **quite clearly did not intend the general duty clause to impose strict liability.**"); *Pelron Corp.,* 12 BNA OSHC 1833. (emphasis added)

The Nevada Occupational Safety and Health Review Board has no jurisdictional authority to expand the citations or charging allegations. The general duty clause is broad, but does not permit imposition of violations or penalties upon an employer without notice of the charges and an ability to defend. Here the respondent was placed on notice to defend only citations for **Plan deficiencies.**

The prohibition against vague standards applies with particular force in the context of the general duty clause, which provides only that employers "shall furnish . . . a place of employment . . . free from recognized hazards that are causing or are likely to cause death

or serious physical harm to his employees." 29 U.S.C. § 654(a)(1). "[A]ny statute . . . imposing general obligations," such as the general duty clause, "raises certain problems of fair notice." *Nat'l Realty,* 489 F.2d at 1268 n. 41. "[T]hese problems dissipate," the Ninth Circuit explained, only "when we read the clause as applying when a reasonably prudent employer in the industry would have **known** that **the proposed method of abatement was required under the job conditions where the citation was issued.**" *Donovan v. Royal Logging Co.,* 645 F.2d 822, 831 (9th Cir. 1981)); *see also, e.g. Davey Tree Expert Co.,* 11 BNA OSHC 1898 (finding that the "broad, generic definition" of a hazard did not "apprise [the employer] of its obligations and identify conditions or practices over which [it could] reasonably be expected to exercise control.") (emphasis added)

NVOSHA failed to satisfy the statutory burden of proof by a preponderance of evidence to confirm violations of NRS 618.375 for citations alleging a deficient tuberculosis control **Plan**. Even if complainant, arguendo, met the burden to establish a **prima facie** case for violation, which it did not, the respondent provided preponderant evidence that a **feasible method of abating the industry recognized hazard** of tuberculosis control existed in the Summerlin **Plan** which incorporated the CDC Guidelines in conformance with the healthcare industry practice.

It is well recognized in the field of occupational safety and health law that violations charged under the general duty clause are the most difficult to establish.

> **The breadth of the general duty clause has made it one of the most frequently litigated provisions of the Act.** *E.g., Reich v. Arcadian Corp.,* 110 F.2d 1192, 1196, 17 OSH Cases 1929 (5th Cir. 1997). *Anoplate Corp.,* 12 OSH Cases 1678, 1687 (emphasis added)

The findings, conclusions and decision in this matter are limited to a failure to prove violations of the general duty clause based solely upon the allegations in citations for a deficient Tuberculosis Exposure Control **Plan**. Any issues with regard to hospital practices, procedures, training, supervision or other matters were not cited nor brought within the jurisdictional purview of the Nevada Occupational Safety and Health Review Board.

The jurisdictional mandate of this Board is limited to a review and findings for only violations cited and proven in accordance with established occupational safety and health law. The burden of proof must be met by a preponderance of evidence.

The Nevada Occupational Safety and Health Review Board finds no preponderance of evidence under the facts and evidence at the worksite to conclude the employer committed "**Serious**" violations at Citation 1, Items 1 through 6, as particularly charged for a ". . . failure to furnish employment and a place of employment . . . free from the recognized hazard . . .."

NVOSHA also issued two (2) "**Other than Serious**" citations for record keeping violations at 29 CFR 1904.11(a) and 29 CFR 1904.29(b)(7)(iv), Citation 2, Items 1 and 2. Complainant presented evidence and testimony in support of the Citation 2, Items 1 and 2, "Other than Serious" record keeping violations. Respondent offered no evidence or testimony in rebuttal at Citation 2; and in closing argument "takes no position" regarding those items. Accordingly the two record keeping violations cited at Citation 2, Item 1 and 2 are confirmed.

Based upon the evidence of record, it is the decision of the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** there were no violations at Citation 1, Items 1 through 6, of Nevada Revised Statute 618.375(1) and

the proposed penalties are denied.

The violation at Citation 2, Item 1, 29 CFR 1904.11(a), classification of the violation as "Other than Serious" and the proposed penalty in the amount of Nine Hundred Dollars ($900.00) is confirmed.

The violation at Citation 2, Item 2, 29 CFR 1904.29(b)(7)(iv), classification of "Other than Serious," and zero proposed penalty is confirmed.

The Board directs **Respondent, Summerlin Hospital Medical Center,** to submit proposed Findings of Fact and Conclusions of Law to the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** and serve copies on opposing counsel within twenty (20) days from date of decision. After five (5) days time for filing any objection, the final Findings of Fact and Conclusions of Law shall be submitted to the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** by ordered counsel. Service of the Findings of Fact and Conclusions of Law signed by the Chairman of the **NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD** shall constitute the Final Order of the **BOARD.**

DATED: This 17th day of August, 2015.

NEVADA OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD

By /s/
JOE ADAMS, Chairman