Covid-19---Insp #1549571 Morrison Management, Specialists Inc.

A **53 year old male** employee contracted COVID-19 while preparing food and washing dishes in the kitchen area of a restaurant at a nursing home facility. The restaurant is a cafeteria style dining experience with large grills and buffets.

The victim worked in the onsite kitchen cooking food for residents. The employer operates a morning to afternoon shift and an evening shift. Typically, each shift in the kitchen is staffed by three to four employees: a cook and food service employees. Employees do not normally have contact with the residents, and only minimal contact with the nursing staff. Food trays are prepped and loaded into carts, which are delivered to the nursing staff who distribute the meals to the residents of the facility.

When employees arrive at the facility, they are to perform a self-screen which includes a temperature check and questionnaire signoff at a check-in station. Normally, the check-in station was staffed. The employer stated because there were no active cases and it was the weekend, the station was unmanned. On August 03, an unvaccinated vector employee self-reported, to the employer, that a relative where he lived was COVID-19 positive. The vector employee was tested that day and was found to be COVID-19 negative and allowed to continue working for three more shifts in the food service position around other employees including the victim. During this time the vector employee was reported to have continued interactions with his sick relative.

On August 08, after a week of going between work and interacting with sick relatives, the vector employee began to feel symptomatic for COVID-19. The now symptomatic vector employee reported to the site and entered the building. This employee stated he proceeded to the kitchen to get direction on what he should do by talking with the victim and another unvaccinated coworker in the kitchen's small office. The vector employee located a nurse and was tested for COVID-19 using the rapid BinaxNow test. With COIVD-19 positive test results, the employee returned to the kitchen to let his coworkers know and call the supervisor, who was not on site. The supervisor instructed the vector employee to leave the facility and quarantine, per the employer's COVID-19 policy. According to time sheets provided by the employer, the vector employee was on site for 54 minutes.

On the following Monday, August 16, the victim and two co-workers who had previous worked shifts with the employee, reported to work not feeling well. They proceeded with the screening process, tested and were all found to be COVID-19 negative. The victim and an unvaccinated employee proceeded to the Emergency Room of the community hospital where they were retested and found to be positive for COVID-19. The third employee, who was fully vaccinated, did not follow up with a secondary test and did not quarantine. On the fifth day, the employer called to check on the employees in quarantine but was unable to reach the victim. The victim died on or about 8/24/21.

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A review of the screening practices, employer policies, and employee interviews found that the employer had not followed the relevant CDC guidelines for quarantine, isolation, screening controls to reduce exposure to SARSCoV- 2 or COVID-19 positive co-workers.

## Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

**Citation 1 Item 1** **Type of Violation: Serious** **$4500**

**TCA 50-3-105(1):** The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees where employees were exposed to SARS-CoV-2 (the virus that causes COVID-19) from asymptomatic and pre- symptomatic employees.

The employer did not implement and administer effective work practice controls to ensure that employees were protected from potentially infectious co-workers.

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