

A **55 year old female** employee contracted **COVID-19** while working in a hospital as a nurse designated to caring for patients in the COVID ward (5th floor).

Based on employee interviews from the 5th floor, employees were required to have on all required PPE when entering the patient's room also known as the "hot zone". Interviews indicated that signage was posted on the doors of patients' rooms and a PPE cart was often located outside of the patients' door. PPE was also available prior to entering the COVID Unit also known as the "warm zone". Interviews indicated that employees would don N95 filtering facepiece respirators, and face shields prior to enter the COVID unit. Most employees also used surgical masks over their N95 respirators.

On or about 08/07/2021, the victim was working with a patient on the 3rd floor that tested positive for COVID-19. Interviews with the family indicated that the victim began feeling ill after she received a call from the hospital informing her that she had been exposed to a patient she cared for on the 3rd floor that tested positive. It was learned that the victim was not required to wear all the PPE worn on the COVID unit while working on the 3rd floor.

The victim's last date of work was 08/08/2021. She tested positive on or about 08/11/2021 and was hospitalized on or about 08/18/2021 then passed away on 08/29/2021. According to the employer, the victim was diagnosed with COVID Pneumonia.

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.

<u>Citation 1 Item 1a</u>	Type of Violation:	Serious	\$6000
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29 CFR 1910.134(g)(1)(iii): Employee(s) did not perform a user seal check each time they put on a tight-fitting respirator using the procedure in Appendix B-1 of 29 CFR 1910.134 or procedures recommended by the respirator manufacturer that the employer demonstrated were as effective as those in Appendix B-1:

User seal checks were not performed with each donning of particulate filtering facepieces required to be worn by employees while providing care to suspected and confirmed COVID-19 positive patients.

<u>Citation 1 Item 1b</u>	Type of Violation:	Serious	\$0
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29 CFR 1910.134(h)(2)(i): Respirators were not stored to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging

chemicals or were not packed or stored to prevent deformation of the facepiece and exhalation valve:

Respiratory protection used for providing care to suspected and confirmed COVID-19 patients was stored in a bag after doffing then reused resulting in potential contamination.

<u>Citation 1 Item 1c</u>	Type of Violation:	Serious	\$0
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29 CFR 1910.134(k)(1)(iv): The employer did not ensure that each user could demonstrate knowledge of how to inspect, put on, remove, use, and check the seals of the respirator:

Each employee was not aware of the requirement to perform a user seal check or how to perform a user seal check with each donning of their N95 particulate filtering facepiece respirators. The respirators were required to be worn by employees while providing care to suspected and confirmed COVID-19 positive patients.

<u>Citation 1 Item 1d</u>	Type of Violation:	Serious	\$0
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29 CFR 1910.134(k)(1)(v): The employer did not ensure that each user could demonstrate knowledge of the procedures for respirator maintenance and storage:

Employees required to wear particulate filtering facepiece respirators while caring for suspected and confirmed COVID-19 positive patients were not provided effective respiratory protection training on how to correctly store respiratory protection (i.e. N95s) during meal breaks or when respirators are not in use.

<u>Citation 1 Item 2a</u>	Type of Violation:	Serious	\$3200
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29 CFR 1910.1030(h)(1)(ii)(B): The employer did not establish and maintain an accurate record for each employee with occupational exposure which includes a copy of the employee's hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by paragraph (f)(2) of the OSHA Bloodborne Pathogens Standard.

The employer failed to maintain a Hepatitis B Vaccination record for each employee that includes the accurate dates in which all the Hepatitis B vaccinations were given. An employee's record showed the 3rd vaccination dose was received on "01/01/0101"

<u>Citation 1 Item 2b</u>	Type of Violation:	Serious	\$0
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29 CFR 1910.1030(h)(5)(i): The employer did not establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps:

The employer failed to maintain a 2021 Sharps Injury Log that documented the evaluation of circumstances surrounding an exposure incident dated 08/07/2021 which would have also included the type and brand of device used at the time of the exposure incident.

<u>Citation 2 Item 1</u>	Type of Violation:	Other-than-Serious	\$600
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29 CFR 1910.1200(h)(1): Employees were not provided effective information and training on hazardous chemicals in their work area at the time of their initial assignment and whenever a new hazard that the employees had not been previously trained about was introduced into their work area:

The employer did not provide employees with effective training on hazardous chemicals used in the workplace, such Clorox Healthcare Bleach Germicidal Wipes and Clorox Healthcare Hydrogen Peroxide Wipes.

Citation 2 Item 2a **Type of Violation:** **Other-than-Serious** **\$800**

TDLWD Rule 0800-01-03-.03(27)(b)3: Each recordable injury or illness was not entered on the OSHA 300 Log and/or an incident report (OSHA Form 301 or equivalent) within seven (7) calendar days of receiving information that a recordable injury or illness has occurred:

The employer failed to record a work related needlestick injury sustained on 08/07/2021 within 7 days on the 2021 OSHA 300 Log.

Citation 2 Item 2b **Type of Violation:** **Other-than-Serious** **\$0**

TDLWD Rule 0800-01-03-.05(2)(a): Copies of records kept under 0800-1-3 requested by an authorized government representative were not provided within four (4) business hours:

Recordkeeping documents for employee injuries/illnesses sustained at 3960 New Covington Pike were requested during the inspection on 08/31/2021 but were not provided until 09/01/2021.



Covid-19---Insp #1550282 Methodist Healthcare-Memphis Hospitals

