A **60 year old male** employee died after a positive diagnosis of COVID-19. The victim was hospitalized with a confirmed case of COVID-19 and subsequently died during his hospitalization. The TOSHA inspection found that he was 1 of 49 employees of the facility who tested positive for COVID-19 between April 17, 2020 and August 5, 2020.

The victim worked as a CNA in one of the red zones at the rehab center in May 2020. Red zones are areas where residents with confirmed positive cases of COVID-19 were housed in an attempt to prevent spread between the residents. He had scheduled vacation time for June so his last day working at the facility was May 29. During a conversation with his daughter, she informed the CSHO that the victim came home from work feeling ill on May 29 but that neither he nor his family believed the illness to be COVID-19. During his vacation time, his symptoms progressively worsened and on June 8 his wife took him to be tested. By June 10, he had not received his results back, so he went to American Family Care to take a rapid test.

The rapid test results indicated he was positive for COVID-19. When the family received the initial results from June 8, they also indicated he was positive.

On June 11, he was admitted into Southern Hills Hospital. According to his family, on June 23, Southern Hills had him transferred to Centennial Hospital where he passed on July 7.

During the course of the inspection, contact was made with several members of TN Department of Health and Metro Nashville Public Health Department who worked in and with the facility in relation to the facility's response to the COVID-19 pandemic. During conference calls with the both departments, it was stated that they had performed a review of the facility's response to COVID-19 as well as performed contact tracing. According to an epidemiologist with the Metro Nashville Public Health Department, the contact tracing records indicated that several employees who tested positive for COVID-19 believed their diagnosis to be work-related. This was also determined during our discussions with positive employees.

In addition, the TN Department of Health indicated that the facility did not appear to respond to the COVID-19 pandemic with appropriate cleaning and disinfecting procedures, adequate training on the use of personal protective equipment, or adequate training on hand hygiene. The Department of Health indicated that many similar facilities were not equipped to handle the COVID-19 pandemic.

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.

17 COVID--Inspection #1482454 Bethany Center for Rehab & Healing

Citation 1 Item 1 **Type of Violation: Serious** **$1250**

29 CFR 1910.141(a)(3)(i): Places of employment were not kept clean to the extent that the nature of the work allowed:

On 07/08/2020, the employer did not ensure that the facility was kept clean to the extent the nature of the work allowed. Employees required to clean the facility were not aware of the appropriate contact times for disinfectants.

Citation 1 Item 2a **Type of Violation: Serious** **$2000**

29 CFR 1910.134(c)(1): A written respiratory protection program that included the provisions in 29 CFR 1910.134(c)(1)(i) - (ix) with worksite specific procedures was not established and implemented for required respirator use:

On 07/08/2020, the employer had not established and implemented a written respiratory protection program with worksite specific procedures when respirators were required to be worn in the workplace.

An adequate written program would include, at minimum, the following provisions:

a) Procedures for selecting respirators for use in the workplace;
b) Medical evaluations of employees required to use respirators;
c) Fit testing procedures for tight-fitting respirators;
d) Procedures for proper use of respirators in routine and reasonably foreseeable emergency situations;
e) Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators;
f) Procedures to ensure adequate air quality, quantity, and flow of breathing air for atmosphere-supplying respirators;
g) Training of employees in the respiratory hazards to which they are potentially exposed during routine and emergency situations;
h) Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance; and
i.) Procedures for regularly evaluating the effectiveness of the program.

Citation 1 Item 2b **Type of Violation: Serious** **Grouped**

29 CFR 1910.134(e)(2)(ii): The medical evaluation did not obtain the information requested by the questionnaire in Sections 1 and 2, Part A of Appendix C of 29 CFR 1910.134:

On 07/08/2020, the medical evaluation questionnaire provided by the employer did not obtain information including, but not limited to; the employees' tobacco use, history of asbestosis or silicosis, chest injuries or surgeries, and shortness of breath when performing certain tasks.

Citation 1 Item 2c **Type of Violation: Serious** **Grouped**

29 CFR 1910.134(e)(6)(i)(C): The employer did not obtain a statement that the physician or other licensed health care professional (PLHCP) had provided the employee with a copy of the PLHCP's written recommendation:

On 07/08/2020, the employer had not obtained a statement that the PLHCP had provided the employees with a copy of the PLHCP's written recommendation regarding respirator use.

Citation 1 Item 2d **Type of Violation: Serious** **Grouped**

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:

On 07/08/2020, the employer did not ensure that employees who wore N95 Respirators performed a user seal check each time they put on the tight fitting respirator.

Citation 1 Item 2e **Type of Violation: Serious** **Grouped**

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:

On 07/08/2020, the employer did not ensure that each employee who was required to wear a N95 respirator could demonstrate knowledge of how to put on and check the seals of the respirator.

Citation 1 Item 2f **Type of Violation: Serious** **Grouped**

29 CFR 1910.134(m)(2)(i)(B): The employer did not establish a record of the qualitative and quantitative fit tests administered to an employee which included the type of fit test performed:

On 07/08/2020, the employer did not maintain records of fit testing which included the type of fit test performed for each employee who was required to wear an N95 Respirator.

Citation 1 Item 2g **Type of Violation: Serious** **Grouped**

29 CFR 1910.134(m)(2)(i)(C): The employer did not establish a record of the qualitative and quantitative fit tests administered to an employee which included the specific make, model, style and size of respirator tested:

On 07/08/2020, the employer did not maintain records of fit testing which included the specific make, model, style and size of respirator tested for each employee who was required to wear an N95 Respirator.

Citation 1 Item 2h **Type of Violation: Serious** **Grouped**

29 CFR 1910.134(m)(2)(i)(E): The employer did not establish a record of the qualitative and quantitative fit tests administered to an employee which included the pass/fail results for qualitative fit tests of the fit factor and strip chart recording or other recording of the test results for quantitative fit tests:

On 07/08/2020, the employer did not maintain records of fit testing which included the pass/fail results for each employee who was required to wear an N95 Respirator.

Citation 2 Item1 **Type of Violation: Other-than-Serious** **Grouped**

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 301or equivalent) within seven (7) calendar days of receiving information that a recordable injury or illness has occurred:

In that, each recordable case of COVID-19 was not entered in the OSHA 300 Log within 7 calendar days of the employer receiving information that the recordable illnesses had occurred.