31 Covid—Insp# 1492086 TN State Veterans Home

A **56 year old female** employee died due to exposure to the COVID-19 virus as a result of working as a certified nurse assistant (CNA) in a nursing home for veterans.

The facility has three zones set up for COVID-19. There is a Red Zone for COVID-19 positive residents and residents exhibiting symptoms of COVID-19, a Yellow Zone (Observation Hall) for residents that have to leave the facility for some reason such as a doctor's appointment and then come back to the facility. The residents are placed in the Yellow Zone for an observation period of 14 days when they return because they left the facility and could have been exposed to COVID-19 while outside the facility. There is a Green Zone for those residents that are not exhibiting symptoms of COVID-19 and have not tested positive for COVID-19.

Investigation revealed that the employees and facility are following the CDC guidelines. They do have direct patient contact and it appears that the employees wear masks or N95 respirators along with other types of PPE such as gloves, gowns, face shields, shoe coverings, and hair coverings when providing patient care and are following social distancing recommendations when possible. The employer is providing weekly and bi- weekly COVID-19 testing for all employees at the facility. This weekly testing began on July 6, 2020. The employees also have their temperatures taken every day before they begin their shifts.

Hand sanitizers, sinks, and cleaning materials are all provided by the employer. It was determined that the facility is sanitizing properly, the employees are wearing and provided the correct PPE, the employer is encouraging social distancing when possible, the employer is staggering breaks for employees, and that the employer is quarantining employees that test positive. The employer conducts contact tracing through the TN Department of Health. It was found that the employer is following CDC guidelines and all of the employees interviewed felt like they had been adequately trained on the guidelines.

According to information gathered, the facility had 39 positive cases of COVID-19 recorded on the OSHA 300 Log since 7-6-2020. According to the employer, the victim was tested at work for COVID-19 on 7-22-20 as part of the facility's weekly testing protocols. The test results came back negative. The victim went to the hospital on 7-26-20 because she was not feeling well. She tested positive for COVID-19 while at the hospital and was admitted to the hospital. She was in the hospital from 7-26-20 until 9-5-20 when she passed away. The employer was informed of the fatality on 9-6-20 and did not report it to TOSHA until 9-9-20.

It was found that there was reason to believe that this COVID fatality should be considered worked related.

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.

Violation 1 Item 1 **Type of Violation: Serious** **$0**

29 CFR 1910.1030(c)(1)(ii)(A): The employer's Exposure Control Plan did not include the exposure determination required by 29 CFR 1910.1030(c)(2):

On 10/19/20, it was determined that the employer had not completed an exposure determination for those job titles that have occupational exposure and documented them in the Exposure Control Plan.

Violation 1 Item 2 **Type of Violation: Serious** **$0**

29 CFR 1910.1030(c)(1)(iv)(B): The review and update of the exposure control plan did not document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure:

On 10/19/20, it was determined that the employer failed to document in the Exposure Control Plan the type of safer medical devices used by employees. The employer had not documented the annual evaluations of safer sharp devices, the devices that were in-use, and the devices that were evaluated and not put into use during the annual review of the Exposure Control Plan. Employees use devices such as Monoject 1mL Tuberculin Safety Syringe with Needle, Medline Safety Syringe 22G x 1.5", Magellan Hypodermic Safety Needle, Smith's Medical Hypodermic Needle-Pro Edge Safety Device 25G x 1", Medline Sure Site IV Slide Safety IV Catheter 20G x 1", Medline Safety Syringe 23G x 1", and Smith's Medical Hypodermic Needle-Pro Syringe and Needle with Needle Protection Device 3mL 25G x 5/8".

Violation 2 Item 1 **Type of Violation: Other-than-Serious** **$0**

TDLWD Rule 0800-01-03-.05(1)(a)1: Within eight (8) hours after the death of any employee as a result of a work-related incident, the employer did not report the fatality to TOSHA:

On 9/10/20, it was determined that the employer had not reported the death of an employee within eight hours. The employee passed away on 9/5/20 from complications due to COVID-19 and the employer was notified on 9/6/20 of the fatality. The employer did not report the fatality to TOSHA until 9/9/20.

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