

A **25 year old male** employee contracted **COVID-19** while working as an RN Team Lead over the night shift in the Pods ICU at the hospital. The Pods ICU consisted of three different units, one of which was designated the COVID-19 overflow unit. The COVID-19 overflow unit was located on its own hallway isolated from other areas by at least 2 doors. Each room on the COVID-19 overflow unit was equipped with negative pressure and was cleaned on a daily basis by housekeeping. The victim did not provide direct patient care; however, he did interact with employees that provided care on the COVID-19 overflow unit.

The victim tested positive for COVID-19 on October 28, 2020 and was subsequently hospitalized due to the infection on November 4, 2020 at Saint Thomas West Hospital. It was determined that he began experiencing symptoms including cough on October 26, 2020. He passed on November 28, 2020 during his hospitalization.

During the employer's own investigation, it was found that on October 22, 2020, the victim spent time in the office of a physician at the facility. The physician was a friend of the victim's and was diagnosed with COVID-19 in the days following their conversation. Initially this interaction was believed to have occurred outside of working hours; however, further evaluation indicated it was likely that this conversation occurred during the regular course of their work. The employer determined that the victim likely contracted the virus in the course of normal work activity, and therefore is a recordable work-related fatality in accordance with TDLWD Rule 0800-01-03.

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: Other-than-Serious

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29 CFR 1910.1200(h)(2)(iii): Employees were not informed of the location and availability of the written hazard communication program and safety data sheets required by 29 CFR 1910.1200:

On 12/04/2020, employees could not recall the location of safety data sheets in the facility.

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