A **40 year old female** employee was exposed to COVID-19 while working as an LPN caring for COVID-19 patients on the COVID-19 Unit at Methodist North Hospital. The victim's last day of work was 09/09/2020. Prior to her last days of work, she was caring for a patient who had removed their mask due to frequent vomiting. The victim began having symptoms on 09-10-2020 and was tested on 09/14/2020.

Employees have a 24-hour call center to contact if they are experiencing any COVID-19 symptoms. On 09-15- 2020, it was revealed that the victim called in and informed the intake Nurse that she was not feeling well and had been tested for COVID-19. The victim revealed that the test was positive. On 09/21/2020 the victim was seen at Methodist Germantown Hospital's ER and sent home. On 09/24/2020, the victim sought help at Saint Francis Hospital - Bartlett and was admitted. While at hospital, the victim's condition worsened and she was transferred to the Critical Care Unit at Saint Francis Hospital - Memphis on 09/27/2020. She passed away on 10/31/2020 while at Saint Francis Hospital - Memphis.

The victim had medical history of Diabetes Type 2 and was considered obese.

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 1a **Type of Violation: Serious** **$6,000**

29 CFR 1910.134(c)(1)(v): The written program did not contain procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators:

The employer failed to update the written Respiratory Protection Program and policies with worksite-specific procedures necessary to reflect the changes in the workplace. The program did not include the following:

a) Procedures limiting the number of N95 donnings before employees should reprocess or dispose of N95s worn while caring for COVID-19 patients; and
b) Procedures to inform employees when and/or how often brown paper bag used for storing the N95s should be replaced.

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

29 CFR 1910.134(e)(6)(i): The employer did not obtain from the physician or other licensed health care professional (PLHCP) a written recommendation regarding the employee's ability to use the respirator:

The employer failed to obtain a written recommendation regarding the employee's ability to use N95 filtering facepiece respirators while providing care to suspected and confirmed COVID-19 positive patients.

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

29 CFR 1910.134(f)(2): Employee(s) using a tight-fitting facepiece respirator were not annually fit tested:

The employer failed to provide annual fit tests to employees required to wear available N95 particulate filtering facepiece respirators while providing care to suspected and confirmed COVID-19 positive patients.

Citation 1 Item 1d **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:

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.

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

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 the same brown paper bags after each doffing for several days resulting in potential contamination.

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

29 CFR 1910.134(k)(1): The employer did not provide effective training to ensure that each employee could demonstrate knowledge of 1910.134(k)(1)(i) - (vii):

The employer did not provide effective training on respiratory protection for employees required to wear particulate filtering facepiece respirators while providing care to suspected and confirmed COVID-19 positive patients.

Citation 1 Item 1g **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:

An employee's fit test record indicated that an employee failed all three sizes of respiratory protection, yet passed the fit test. The fit test record, however, did not include type and model respirator the employee was fit for.

Citation 1 Item 2a **Type of Violation: Serious** **$3,200**

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 sharps injury log did not contain, at a minimum the requirements of 29 CFR 1910.1030(h)(5)(i)(A) through 29 CFR 1910.1030(h)(5)(i)(C):

The employer failed to record needlestick injuries on the Sharps Injury Log. The employer also failed to include information related to the type and brand of the sharp involved in the incidents as well as an explanation of how the incidents occurred.

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

TDLWD Rule 0800-01-10-.04(2): Engineered sharps injury protection devices evaluated and currently used were not documented in the Exposure Control Plan.

The following safer medical devices commonly used were not listed in the company's Bloodborne Pathogen's Exposure Control Plan (ECP):

a) Magellan Hypodermic Safety Needle 18G 1.5";
b) Magellan Hypodermic Safety Needle 23G 1"; and
c) Magellan Hypodermic Safety Needle 25G 5/8".

Citation 1 Item 3 **Type of Violation: Serious** **$2,800**

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:

Effective training in Hazard Communication was not provided to each employee using disinfectants to clean highly touched surfaces, workstations and equipment.

Citation 2 Item 1a **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 301or equivalent) within seven (7) calendar days of receiving information that a recordable injury or illness has occurred:

The employer failed to record workplace related injuries and illnesses within 7 days on the 2020 OSHA 300 Logs.

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

TDLWD Rule 0800-01-03-.04(1)(b)4: An injury or illness occurred at one of the employer's establishments, but the employer did not record the injury or illness on the OSHA 300 Log of the establishment at which the injury or illness occurred.

An injury or illness occurred at one of the employer's establishments on 07/15/2020, but the employer did not record the injury or illness on the OSHA 300 Log of the establishment at which the injury or illness occurred. The injury was entered on the OSHA 300 log for the employer's establishment located at 3960 New Covington Pike.