Covid-19---Insp #1508853 Life Care Center of Cleveland

A **69 year old** female employee contracted COVID-19 while working as a receptionist at a skilled nursing facility. Beginning in March of 2020, she was tasked with administering a COVID-19 questionnaire and taking the temperatures of all employees and personnel entering and exiting the facility through the front entrance.

It was determined that the victim's infection and death were part of a larger outbreak of COVID-19 among the staff. Between 11/11/2020 and 12/31/2020, 58 employees tested positive for the virus. According to the facility's executive director, the virus was first discovered in the facility on 7/9/2020 when a resident tested positive. The resident was quarantined, and no other patients or employees tested positive. The virus emerged again on 11/10/2020 when a resident on the skilled nursing unit tested positive. The resident was placed on isolation. As other residents began to test positive, they were placed on the same wing as the first positive patient in order to sequester all positive patients away from healthy ones, as is recommended by the CDC.

Although the victim did not have direct patient contact, she was exposed to employees daily.All employees and personnel entering the facility were required to don a mask and a face shield prior to entering the facility. If the facility had a COVID positive resident, they were required to wear an N95. Once employees entered, the victim would use an infrared thermometer to scan the employee's forehead. Employees interviewed reported that the kept their masks on for screening but had to lower or remove their face shields in order to be scanned. The victim would stand behind her reception desk and reach around the Plexi glass barrier on the desk. She was required to wear a mask and face shield at all times while in the facility.

The employee tested positive for COVID-19 on 12/4/2020 during routine testing at the workplace. On 12/11/2020 the employee was admitted to the hospital, where she passed away on 1/4/2021 from COVID-19.

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** **$5400**

29 CFR 1910.132(f)(l)(iii): Employee(s) required to use PPE by this section were not trained to know how to don, doff, adjust, and wear PPE.

The employer did not ensure that employees involved in administering COVID-19 rapid tests to other employees sanitized their hands after doffing a pair of gloves.

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

29 CFR 1910.134(g)(l)(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.

The employer did not ensure that employees performed a user seal check each time they donned a tight-fitting respirator.

Citation 1 Item 2 **Type of Violation:** **Serious** **$5400**

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

The employer did not ensure that surfaces within 6 feet of the specimen collection and handling area were disinfected between each specimen collection or hourly during COVID-19 testing.

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