Company Name: Hayward Sisters Hospital
Establishment DBA: St. Rose Hospital and its successors
Inspection Site: 27200 Calaroga Avenue
Hayward, CA 94545

Citation 1 Item 1 Type of Violation: General

Title 8 section 5162(c) Emergency Eyewash and Shower Equipment
(c) Location. Emergency eyewash facilities and deluge showers shall be in accessible locations that require no more than 10 seconds for the injured person to reach. If both an eyewash and shower are needed, they shall be located so that both can be used at the same time by one person. The area of the eyewash and shower equipment shall be maintained free of items which obstruct their use.

Prior to and during the course of the inspection including but not limited to on June 19, 2020, the employer failed to ensure that an eyewash located on the fourth and fifth floors, remained free of items which would obstruct its use, when employees are exposed to corrosive substances including, but not limited to Virex disinfectant cleaner.

Date By Which Violation Must be Abated: Corrected During Inspection
Proposed Penalty: $560.00

State of California
Department of Industrial Relations
Division of Occupational Safety and Health
Oakland District Office
1515 Clay Street, Suite 1303
Oakland, CA 94612
Phone: (510) 622-2916 Fax: (510) 622-2908
Citation and Notification of Penalty

Company Name: Hayward Sisters Hospital
Establishment DBA: St. Rose Hospital and its successors
Inspection Site: 27200 Calaroga Avenue Hayward, CA 94545

Citation 1 Item 2 Type of Violation: General

Title 8 section 5199(d) (2)(G) Aerosol Transmissible Diseases. Aerosol Transmissible Diseases Exposure Control Plan.
(d) Aerosol Transmissible Diseases Exposure Control Plan.
(2) The Plan shall contain all of the following elements:
(G) The procedures the employer will use to identify, temporarily isolate, and refer or transfer AirID cases or suspected cases to All rooms, areas or facilities. These procedures shall include the methods the employer will use to limit employee exposure to these persons during periods when they are not in airborne infection isolation rooms or areas. These procedures shall also include the methods the employer will use to document medical decisions not to transfer patients in need of All in accordance with subsection (e)(5)(B).

Prior to and during the course of the inspection including, but not limited to June 19, 2020, the employer’s written procedures for the identification, temporary isolation, referral and transfer of airborne infection disease (AirID) cases or suspected cases were ineffective in the following instances:

1. The Plan did not contain procedures for the transfer of suspect or confirmed AirID cases to airborne infection isolation rooms within the required timeframe and, when necessary, to other facilities. [REF: 5199(d)(2) (G)]

2. The Plan did not contain procedures for documenting medical decisions not to transfer patients in need of All in accordance with subsection (e)(5)(B). [REF: 5199(d)(2)(G)]

3. The Plan did not contain effective measures for cohorting of patients infected with novel pathogens, who could not be transferred to other facilities, that maximized the use of airborne infection isolation rooms in designated units. At the time of the inspection patients cohorted on the 4th and 5th floors due to infection with SARS-CoV-2 were placed in rooms that did not provide airborne infection isolation, while AIRs in that unit were vacant.
Date By Which Violation Must be Abated: January 2, 2020
Proposed Penalty: $750.00

Wendy Hogle-Lui
Compliance Officer / District Manager