State of California
Department of Industrial Relations
Division of Occupational Safety and Health
Oakland District Office
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Oakland, CA 94612
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Inspection #: 1478320
Inspection Dates: 06/09/2020 - 02/04/2021
Issuance Date: 02/05/2021
CSHO ID: U1591
Optional Report #: 028-20

Citation and Notification of Penalty

Company Name: Sutter Bay Hospitals
Establishment DBA: Alta Bates Summit Medical Center
and its successors
Inspection Site: 350 Hawthorne Avenue
Oakland, CA 94609

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

California Code of Regulations, Title 8, §5199(h)(6)(C). Aerosol Transmissible Diseases.

(h) Medical Services.

(6) Exposure Incidents.

(C) Each employer who becomes aware that his or her employees may have been exposed to an RATD case or suspected case, or to an exposure incident involving an ATP-L shall do all of the following:

1. Within a timeframe that is reasonable for the specific disease, as described in subsection (h)(6)(B), but in no case later than 72 hours following, as applicable, the employer's report to the local health officer or the receipt of notification from another employer or the local health officer, conduct an analysis of the exposure scenario to determine which employees had significant exposures. This analysis shall be conducted by an individual knowledgeable in the mechanisms of exposure to ATPs or ATPs-L, and shall record the names and any other employee identifier used in the workplace of persons who were included in the analysis. The analysis shall also record the basis for any determination that an employee need not be included in post-exposure follow-up because the employee did not have a significant exposure or because a PLHCP determined that the employee is immune to the infection in accordance with applicable public health guidelines. The exposure analysis shall be made available to the local health officer upon request. The name of the person making the determination, and the identity of any PLHCP or local health officer consulted in making the determination shall be recorded.

2. Within a timeframe that is reasonable for the specific disease, as described in subsection (h)(6)(B), but in no case later than 96 hours of becoming aware of the potential exposure, notify employees who had significant exposures of the date, time, and nature of the exposure.

3. As soon as feasible, provide post-exposure medical evaluation to all employees who had a

significant exposure. The evaluation shall be conducted by a PLHCP knowledgeable about the specific disease, including appropriate vaccination, prophylaxis and treatment. For M. tuberculosis, and for other pathogens where recommended by applicable public health guidelines, this shall include testing of the isolate from the source individual or material for drug susceptibility, unless the PLHCP determines that it is not feasible.

4. Obtain from the PLHCP a recommendation regarding precautionary removal in accordance with subsection (h)(8), and a written opinion in accordance with subsection (h)(9).

5. Determine, to the extent that the information is available in the employer's records, whether employees of any other employers may have been exposed to the case or material. The employer shall notify these other employers within a time frame that is reasonable for the specific disease, as described in subsection (h)(6)(B), but in no case later than 72 hours of becoming aware of the exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the diagnosing PLHCP. The notifying employer shall not provide the identity of the source patient to other employers.

Violation

Prior to and during the course of the inspection, including, but not limited to May 20, 2020, the employer failed to investigate an exposure incident with an employee, a Plant Operations Stationary Engineer who was a confirmed COVID-19 case, in the following instances:

Instance 1) The employer failed to conduct an exposure analysis to determine whether any employees had significant exposure to the employee. [5199(h)(6)(C)(1).]

Instance 2) The employer did not notify employees who had a significant exposure to the employee, within 96 hours of becoming aware of the potential exposure. [5199(h)(6)(C)(2).]

Instance 3) The employer failed to provide post-exposure medical evaluations as soon as feasible to all employees who had significant exposure to the employee. [5199(h)(6)(C)(3).]

Instance 4) The employer did not obtain from a PLHCP a recommendation regarding precautionary removal of the employee and employees who had a significant exposure to the employee in accordance with subsection (h)(8), or a written opinion in accordance with subsection (h)(9). [5199(h)(6)(C)(4).]

Instance 5) The employer failed to generate the documentation required by subsection (j)(3)(B) as part of this investigation required by subsection (h)(6)(C).

Date By Which Violation Must be Abated:	**February 17, 2021**
Proposed Penalty:	**$10125.00**

Wendy Hogle-Lui
Compliance Officer / District Manager