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

Inspection #: 1510380
Inspection Dates: 01/16/2021 - 05/27/2021
Issuance Date: 05/27/2021
CSHO ID: U7118
Optional Report #: 022-21

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 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 January 16, 2021, the employer failed to effectively investigate an exposure incident with an employee, a Registered Respiratory Therapist, who was a confirmed COVID-19 case, in the following instances:

Instance 1: The employer failed to conduct an effective exposure analysis to determine whether any employees had significant exposure to the employee. [Ref. T8 CCR §5199(h)(6)(C)1.]

Instance 2: The employer failed to notify employees who had a significant exposure to the employee, within 96 hours of becoming aware of the potential exposure. [Ref. T8 CCR §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. [Ref. T8 CCR §5199(h)(6)(C)3.]

Instance 4: The employer failed to 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). [Ref. T8 CCR §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:	**June 09, 2021**
Proposed Penalty:	**$19125.00**

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

California Code of Regulations, Title 8, §5199(g)(3)(B). Aerosol Transmissible Diseases.
(g) Respiratory Protection.
(3) Respirator selection.
(B) Effective September 1, 2010, the employer shall provide a powered air purifying respirator (PAPR) with a High Efficiency Particulate Air (HEPA) filter(s), or a respirator providing equivalent or greater protection, to employees who perform high hazard procedures on AirID cases or suspected cases and to employees who perform high hazard procedures on cadavers potentially infected with ATPs, unless the employer determines that this use would interfere with the successful performance of the required task or tasks. This determination shall be documented in accordance with the ATD Plan and shall be reviewed by the employer and employees at least annually in accordance with subsection (d)(3).

Violation

Prior to and during the course of the Division's investigation, the employer failed to ensure that at least one employee who performs high hazard procedures, including but not limited to intubating, nebulizing treatments, High-Flow Nasal Cannula treatments, and BiPAP treatments on suspected or confirmed COVID-19 cases during the month of December 2020, wore a powered air purifying respirator (PAPR) with a High Efficiency Particulate Air (HEPA) filter(s), or a respirator providing equivalent or greater protection.

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Citation 3 Item 1 Type of Violation: **Serious**

California Code of Regulations, Title 8, §5199(i)(4). Aerosol Transmissible Diseases.
(i) Training.
(4) The training program shall contain at a minimum the following elements:
(A) An accessible copy of the regulatory text of this standard and an explanation of its contents.
(B) A general explanation of ATDs including the signs and symptoms of ATDs that require further medical evaluation.
(D) An explanation of the employer's ATD Exposure Control Plan and/or Biosafety Plan, and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.
(E) An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to ATPs or ATPs-L.
(F) An explanation of the use and limitations of methods that will prevent or reduce exposure to ATPs or ATPs-L including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
(G) An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment employees will use.

Violation

Prior to and during the course of the inspection, including, but not limited to January 16, 2021, the employer failed to provide the required training in accordance with this subsection to one or more employees with occupational exposure to aerosol transmissible pathogens (ATPs), specifically the novel pathogen SARS-CoV-2, the virus that causes COVID-19, in the following instances:

Instance 1: The employer failed to train one or more employees by providing an accessible copy of

the regulatory text of the T8 CCR Section 5199 standard and an explanation of its contents. [Ref. T8 CCR Section 5199(i)(4)(A)]

Instance 2: The employer failed to train one or more employees by giving a general explanation of ATDs including the signs and symptoms of ATDs that require further medical evaluation. [Ref. T8 CCR Section 5199(i)(4)(B)]

Instance 3: The employer failed to train one or more employees by explaining the employer's ATD Exposure Control Plan, the means by which employees can obtain a copy of the written plan, and how employees can provide input as to the program's effectiveness. [Ref. T8 CCR Section 5199(i)(4)(D)]

Instance 4: The employer failed to train one or more employees of an effective method for recognizing the airborne hazards from specific tasks and other activities which generate exposure by inhalation of aerosols containing SARS-CoV-2. [Ref. T8 CCR Section 5199(i)(4)(E)]

Instance 5: The employer failed to train one or more employees on the limitations of N95 respirators and that they would not protect them against inhalation of infectious aerosols during high-hazard procedures performed on suspected and confirmed COVID-19 patients, and that NIOSH certified powered air purifying respirators (PAPRs) were necessary to protect against these exposures. [Ref. T8 CCR Section 5199(i)(4)(F)&(G)]

Date By Which Violation Must be Abated:	**June 09, 2021**
Proposed Penalty:	**$19125.00**

Spencer Wojcik / Wendy Hogle-Lui
Compliance Officer / District Manager