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April 17, 2020

**VIA EMAIL**

Kelly Tatum, District Manager
Cal/OSHA - Fremont District Office
39141 Civic Center Dr., Ste. 310
Fremont, CA 94538
Email: DOSHFremont@dir.ca.gov

**Re: Imminent Hazard Complaint – Multiple Skilled Nursing Facilities within Santa Clara County**

Dear District Manager Tatum,

Our firm represents Service Employees International Union, Local 521 ("SEIU Local 521" or "Union"), a labor union that, in turn, represents hundreds of healthcare workers employed by the County of Santa Clara ("County") across a diverse spectrum of specialties and job classifications.

Many of these professionals have responded to the ongoing coronavirus pandemic by moving from familiar healthcare assignments to new frontline positions that carry substantially higher risks of infection, serious health complications, and death. Unfortunately, the County's neglectful and opaque handling of these assignments has unnecessarily exacerbated these risks, contributing to the establishment and perpetuation of unlawful, life-threatening conditions within at least two skilled nursing facilities in San Jose, Calif. that are currently under County co-control. The hazards created by the practices in question are likely to cause death or serious physical harm absent immediate Cal/OSHA investigation and aggressive enforcement of workplace safety laws. Having exhausted informal efforts to address and resolve the deeply concerning underlying issues over the past weeks, SEIU Local 521 now finds it necessary to file the instant imminent hazard complaint in order to protect the health and safety of these frontline workers going forward.

Note that at present, there are approximately 110 total skilled nursing facilities and long-term care facilities within Santa Clara County. This complaint addresses conditions in only two of them.

## I. Legal Standard

Cal/OSHA maintains regulations intended to protect workers from being exposed to airborne infectious diseases such as COVID-19. Within these protections are heightened standards for those working in high-risk positions and locations. Workers at skilled nursing facilities are among these classes afforded more stringent protections and

safety standards. Specifically, California Code of Regulations title 8, section 5199 establishes the Aerosol Transmissible Diseases standard ("ATD standard"). The ATD standard, which applies to skilled nursing facilities such as those in question, sets forth requirements designed to protect employees from airborne infectious diseases such as COVID-19. Relevantly, this requires that employers take the following steps, among others, to protect their workers from the very real and life-threatening risks carried by potential exposure to airborne infectious diseases:

- Use feasible engineering and work practice controls to minimize employee exposures to such airborne infectious diseases. Where "engineering and work practice controls do not provide sufficient protection (e.g., when an employee enters an [airborne isolation infection ("AII")] room or area) the employer shall provide, and ensure that employees use, personal protective equipment, and shall provide respiratory protection";

- Implement work practices intended to prevent or minimize employee exposures to airborne, droplet, and contact transmission of aerosol transmissible diseases and pathogens; such workplace practices "may include, but are not limited to; handwashing and gloving procedures; the use of anterooms; and cleaning and disinfecting contaminated surfaces, articles and linens";

- Develop and implement effective written decontamination procedures, including appropriate engineering controls, for the cleaning and decontamination of work areas, vehicles, personal protective equipment ("PPE"), and other equipment;

- Provide to suspected or confirmed patients "disposable tissues and hand hygiene materials" as well as masks, and place these patients "in an AII room or area or [arrange their transfer] to a facility with AII rooms or areas…in a timely manner."; *and*

- Transfer any confirmed or suspected patient to AII rooms or areas within the facility within five hours of identification of the patient's suspected or confirmed positive status, or transfer the individual to another suitable facility if no AII room or area is available onsite within this timeframe.

Additionally, California Code of Regulations title 8, section 3380 requires that an employer assess whether COVID-19 is a workplace hazard at a given worksite, and then select and provide at-risk employees with personal protective equipment that will effectively protect them from contracting COVID-19. (*See* Cal/OSHA Interim Guidelines for General Industry on 2019 Novel Coronavirus Disease (COVID-19) (updated March 16, 2020).) Specifically, among other requirements, employers must:

- Ensure that affected employees are instructed on the use of protective equipment (e.g., equipment to protect the eyes, face, head, hands, feet and limbs and extremities (limbs), including protective clothing, respiratory protection, and protective shields and barriers) in accordance with the manufacturer's instructions;

- Provide training to affected employees to ensure that these employees know, at a minimum:

    - When PPE is necessary;

  - What PPE is necessary;
  - How to properly don, doff, adjust, and wear PPE; *an*d
  - The proper care, maintenance, useful life and disposal of the PPE.

- Conclude that each affected employee has demonstrated that they understand the aforementioned PPE training protocols and are able to use PPE properly before being allowed to perform the hazardous work in question;
- Ensure that affected employee actually use the aforementioned types of personal protective equipment intended to protect them from the hazards in question; *and*
- Retrain any employee who has already been trained but who the employer has reason to believe does not have the understanding and skill to safely perform the work in question. Situations that trigger this retraining requirement include when an employee's on-the-job use of PPE (or lack thereof) suggests that they have not retained the requisite understanding or skill concerning the use of PPE to safely perform their high-risk work duties without retraining.

Finally, Cal/OSHA's Interim Guidance for Protecting Workers at Skilled Nursing and Long-term Care Facilities from Exposure to Coronavirus Disease (COVID-19) (updated April 5, 2020) ("Interim Guidance for Protecting Workers at Skilled Nursing and Long-Term Care Facilities") analyzes and interprets the ATD Standard as applied to the ongoing pandemic, clarifying that workplace standards are even higher for skilled nursing and long-term case facilities that do not refer or transfer suspected and confirmed COVID-19 patients for more intensive medical treatment, but rather keep the patient within the facility. Among other obligations, such "non-referring facilities" must:

- Move any suspected or confirmed COVID-19 patient "in a timely manner to an airborne infection isolation room (AIIR) if the facility has one available" or, "[i]f no AIIR is available, the facility should consult with the California Department of Public Health and provide the maximum level of separation available and appropriate. This may include a private room with the door normally kept closed with portable systems to create negative pressure"; *and*
- Provide any medical screening or surveillance recommended by the California Department of Public Health or the Local Health Department to employees to support the early detection of COVID-19 infection.

## II. <u>Conditions and Practices at Two San Jose, Calif. Skilled Nursing Facilities Present Hazards that Could Cause Death or Serious Harm Immediately.</u>

In mid-to-late March 2020, as the coronavirus pandemic swept the globe and established an early epicenter within the United States in Santa Clara County, the County informed its healthcare employees that it anticipated a surge in COVID-19 patients locally, and that privately owned skilled

nursing and long-term facilities would likely experience a particular concentration of COVID-19 infections due to the fact that their residents are generally immunocompromised and/or elderly—i.e., at high risk for COVID-19 transmission for one if not multiple reasons. Compounding the dire forecast for these facilities was the reality that the facilities were reportedly experiencing high rates of staff turnover as their employees either contracted COVID-19 or resigned due to the risk of infection or any number of other reasons.

The County therefore requested on or around March 23, 2020 that many of its healthcare professionals commit to being reassigned to skilled nursing facilities for the sole purpose of helping combat the spread of COVID-19. Dozens of SEIU Local 521-represented employees responded to this call by offering their services to these private facilities on behalf of the County, knowing full well the risk this would present to them and to their loved ones with whom they lived. (Many of these employees decided to spend thousands of dollars on short-term housing rentals for the duration of their assignments to these private facilities rather than risk bringing COVID-19 infections home to their families.)

These workers were assured by the County that they would receive adequate training to allow them to perform their duties and protect their own health at their new assignments, and that they would be assigned only to work with residents who were not infected or suspected of being infected with COVID-19 (with existing facility staff being responsible for caring for residents who were either suspected or confirmed as having contracted COVID-19). These County employees were further assured that all applicable laws and safety standards, including straightforward decontamination, isolation, and PPE norms and protocols, would be followed during their assignments—i.e., that the impressive risks inherent to entering such hotbeds of COVID-19 transmission would be minimized to the greatest extent possible.

What these workers encountered when they arrived at the facilities in question in early April 2020 was something far different.

### a. Cross-Contamination and Missing PPE: Conditions at Canyon Springs Post-Acute Care Skilled Nursing and Rehabilitation Center

Following the call for commitments, the County provided its healthcare employees assigned to the two facilities in question with approximately 13 hours of passive and interactive training prior to these workers beginning their first shifts at these facilities. This training, completed on April 2, 3, and 7, 2020, consisted of basic instructions on such topics as using intravenous pumps, operating feeding tubes, taking vital signs, and donning and doffing PPE. A significant portion of the training consisted of watching video tutorials.

On April 7, 2020, several County healthcare employees completed approximately 60 to 90 minutes of training before receiving text messages assigning them to report to Canyon Springs at 2:30pm. These workers promptly traveled to Canyon Springs, where they met with remaining facility staff and became acquainted with basic processes. At the time of their assignment, these County employees remained under the impression that they would be working only with COVID-19-negative residents at Canyon Springs, providing services in isolation from the unknown number of Canyon Springs residents with confirmed or suspected COVID-19 infections.

The following day, without receiving additional hands-on training, these employees began shadowing facility staff delivering patient care. On information and belief, the facility staff were entirely unprepared to train the County employees on hands-on practices and procedures at Canyon Springs. On April 9, 2020, the County employees continued to take on increasing levels of responsibility and hands-on patient care duties as they continued to work in tandem with facility staff.

The County employees assigned to Canyon Springs quickly observed several worrisome conditions and practices at the facility that appeared to give rise to workplace violations and, most importantly, presented significant health risks to residents and staff alike. These included:

- Facility staff generally wore only surgical masks rather than respirators of N95 quality or better; it was unclear whether the facility had tried and failed to obtain such minimally protective masks;

- Staff also appeared to lack other basic medical and protective gear. (E.g., one facility employee was observed by County employees wearing a rain jacket and fishing boots in lieu of a gown and other appropriate PPE.);

- Insufficient isolation practices between the section of Canyon Springs designated to house and treat COVID-19-positive and suspected positive residents and the section without such residents. (E.g., the zipper entrance in the plastic barrier erected to separate the two sections generally remained open rather than being closed after every use, allowing air to pass freely between the two sections. Additionally, staff were not consistently changing or sufficiently sanitizing gowns and other protective equipment when crossing from one section to another, including most relevantly when crossing from the COVD-19 section to the ostensibly non-COVID-19 section.)

- Substandard practices to prevent cross-contamination between patients within each of these two sections. (E.g., it was not common practice to change gowns between seeing different patients, or even to sanitize gowns between seeing different patients. In some instances, staff were expected to hang up one common gown outside of each resident's room, with each employee donning and then doffing the common gown before and after treating the patient in question, even though these workers typically interacted with dozens of residents each day. These gowns were frequently not sanitized between uses.)

This absence of sufficient training and adherence to basic safety protocols produced, and absent intervention will likely continue to produce, real harm: On April 9, 2020, at least two County employees and two facility staff appear to have been exposed to a potential undiagnosed COVID-19 patient during a tragic and deeply disturbing incident. One of the County employees, a licensed vocational nurse, was shadowing a nurse employed by the facility that day. As they were distributing medication to various residents in the designated COVID-19-negative section of Canyon Springs, a certified nursing assistant informed the two nurses that a patient in a nearby room appeared to be dead. After Canyon Springs staff entered the resident's room and yelled "code blue," the County employee responded to the call and walked into the room, where she observed that the patient appeared to have died. The County employee reacted to the situation using her preexisting training

that predated the current pandemic, reaching to touch the patient's forearm to gauge her temperature and confirming that she was cold to the touch while observing that her lips were dark blue in color.

Working with facility staff in the room, the County employee was tasked with applying the "ambu bag" to the patient's mouth and nose. However, the County employee found that she could not easily reposition the resident's head in order to allow her to affix the ambu bag because the resident's body had already stiffened. After finally managing to affix the ambu bag, the County employee, working with at least one other County healthcare employee and two existing facility staff, helped administer CPR to the resident for approximately five to ten minutes until paramedics arrived. The resident was thereafter pronounced dead.

Based on the observations detailed above, it appears that this resident had died some unknown yet apparently substantial length of time before staff responded—a reality that suggests that the staff at Canyon Springs were completely overwhelmed and underprepared to effectively manage the outbreak of COVID-19 at the facility.

Moreover, a shortage of PPE at Canyon Springs has created conditions in which employees are experiencing heightened exposure to COVID-19: For example, during the aforementioned April 9, 2020 incident, the four employees administering CPR were necessarily required to make prolonged contact with the resident's body, including with her head and face. Neither the County employee nor the facility staff workers on the scene were wearing gloves during this incident, apparently because there was and continues to be a shortage of gloves at Canyon Springs, and employees did not want to use gloves in caring for a patient who had been labeled as COVID-19-negative. At least one of the employees administering CPR (the staff member of Canyon Springs who had been paired all day to work with one of the County employees) has reportedly since tested positive for COVID-19.

These safety shortcomings are unfortunately not isolated incidents, based on reports from employees assigned to Canyon Springs. For example, one of the workers who had co-administered CPR to the resident on April 9, 2020 reportedly was assigned to provide patient care to residents in the non-COVID-19 section of Canyon Springs on April 13, 2020. During this shift, she was forced to make physical contact with three of these residents while providing care without wearing gloves for the reason cited above: Canyon Springs is experiencing an ongoing dearth of PPE, and these residents had been classified as COVID-19-negative (though it does not appear that any had actually been tested at that point). All three have since tested positive and been moved to the COVID-19 section of Canyon Springs. The County employee who was exposed to all three residents has not been tested and continues to be assigned to work in the ostensibly COVID-19-negative section of Canyon Springs.

According to the best information currently available, approximately 26 Canyon Springs employees had tested positive for COVID-19 as of April 15, 2020. Moreover, approximately 54 of the facility's 144 total residents had tested positive, and another 22 test results for both staff and residents remained pending as of April 15, 2020.

Canyon Springs claims on its website (https://canyonspringspostacute.com/coronavirus-covid-19-faq/) that it has implemented and is enforcing robust safety procedures to comply with COVID-19 workplace safety standards, assuring visitors that "[s]taff hand hygiene compliance is monitored daily," and that "[e]ssential personnel are monitored for compliance with our enhanced visitor

precautions." Yet the aforementioned realities, as observed by multiple County employees, tell a different story. SEIU Local 521 and the workers it represents have raised this multiple times with the County, yet the County continues to assign employees to Canyon Springs without taking adequate measures to ensure that workplace violations cease at the facility prior to allowing County employees to continue working there at great risk to themselves and, potentially, their loved ones. In fact, the County informed the Union earlier this week that it plans to assign an additional 12 employees to Canyon Springs (as well as 15 other employees to a third skilled nursing facility, Valley House Rehabilitation Center in Santa Clara, Calif.[1]).

The foregoing conditions and practices at Canyon Springs continue to cause hazards that can and likely will cause additional serious physical harm and/or death before the hazard can be eliminated through regular Cal/OSHA enforcement procedures. An immediate investigation and appropriate enforcement action(s) are therefore warranted.

**b. <u>An Entire Facility Presumptively Positive: The Ridge Post-Acute Care Skilled Nursing Facility</u>**

After receiving training as detailed above on April 2 and 3, 2020, at least one healthcare employee,[2] a licensed vocational nurse, was assigned by the County on April 7, 2020 to work at The Ridge Post-Acute Care Skilled Nursing Facility (formerly known as Mount Pleasant Nursing Center) ("The Ridge"). The County assigned this employee to The Ridge after the worker and other employees ultimately assigned to Canyon Springs responded to the County's March 23, 2020 call for commitments by agreeing to provide their services during this time of need. The County initially indicated that the workers would have control over which facilities they might be assigned to, but ultimately it controlled this selection process.

As with the County employees assigned to Canyon Springs, this professional was informed that she would be working exclusively with residents at The Ridge who were presumptively not infected with COVID-19. Moreover, the County worker here was assured that she would be working as part of a team of County healthcare employees assigned to the facility.

Again, the reality on the ground was completely different than what had been promised: On arriving to The Ridge, the employee learned that she was the only County worker assigned to the facility, which seemed to be operating with very sparse staffing. Moreover, she discovered that nearly every resident and staff member had either tested positive for COVID-19 or was presumptively infected. The outbreak had escalated, in fact, to the point where she was advised on her arrival to assume that anyone she came into contact with within the facility was COVID-19-positive. To this end, while when she arrived the facility did maintain a plastic separation barrier between sections in

[1] While workplace conditions at Valley House Rehabilitation Center are beyond the scope of this complaint at this time, SEIU Local 521 has obtained information supporting that as of April 15, 2020, 44 of the facility's 98 residents and 17 staff members had tested positive for COVID-19, with test results pending for a total of 52 other residents and employees.

[2] On information and belief, the County has assigned additional employees not represented by SEIU Local 521 to one or both of the facilities named in this complaint. However, SEIU Local 521 does not have sufficient knowledge of the existence of or workplace conditions experienced by any other County employees placed at these facilities who are not represented by the Union.

The Ridge, the County employee in question was informed that this sheeting would soon be removed, as it had lost its relevance: The entire facility was presumed to have become infected.

This impression is supported by statistics obtained by SEIU Local 521: As of April 15, 2020, all but one of The Ridge's 41 residents had tested positive for COVID-19, and 14 employees had likewise tested positive.

As opposed to the situation at Canyon Springs, the County in this case pulled its employee off her assignment to The Ridge before she returned for a second day. However, the County thereafter failed entirely to properly test the exposed employee for COVID-19, and to this day continues to refuse to provide her with appropriate post-exposure treatment (see below).

The foregoing conditions and practices at The Ridge are, on information and belief, continuing to cause hazards that can and likely will cause additional serious physical harm and/or death before the hazard can be eliminated through regular Cal/OSHA enforcement procedures. An immediate investigation and appropriate enforcement action(s) are therefore warranted.

### c. Inadequate Testing of Exposed Employees

The ATD Standard, as noted by Cal/OSHA in the Interim Guidance for Protecting Workers at Skilled Nursing and Long-Term Care Facilities, mandates that an employer "[i]nvestigate and take preventative measures when an exposure incident occurs" by doing the following:

- Report any suspected or confirmed COVID-19 case to the local health officer;
- Notify any other employer of employees that may have had contact with a suspected or confirmed COVID-19 case, such as paramedics, emergency medical technicians, emergency responders or health care facilities or agencies receiving referred patients;
- Investigate and determine which employees had significant exposures to COVID-19 and conduct an exposure analysis. Make the exposure analysis available to the local health officer;
- Notify employees who had significant exposures of the date, time, and nature of the exposure;
- Have a licensed health care provider provide medical evaluations to all employees who had a significant exposure, which includes any appropriate vaccination, prophylaxis and treatment; *and*
- Remove employees from their regular assignment when necessary to prevent spread of COVID-19 if recommended by the licensed health care professional or local health officer.

As detailed above, County employees were unexpectedly placed in positions at both Canyon Springs and The Ridge where they endured much higher exposure risks than had been anticipated based on the information the County had provided prior to their respective assignments. The County has been made aware of the likely exposures at both facilities, yet it is not clear whether it has complied with its ATD Standard post-exposure duties as set forth above.

For example, in response to the employee exposure at The Ridge, the County did arrange for COVID-19 testing of the worker in question, yet the test was administered only approximately 10 hours after the employee completed her exposure period (as she concluded her one shift at The Ridge at approximately 12:30am on April 8, 2020, and received the test at approximately 10:30am that same day). SEIU Local 521 and the affected healthcare professional are concerned that such a short interval between exposure and testing jeopardized the accuracy of the test results, calling into question whether the County has ensured that the worker receive appropriate post-exposure treatment, among other obligations this exposure triggered in the County (as described above).

## III. Additional Cal/OSHA-Required Information

**a) Name, address, and telephone number of the worksites:**

The Ridge
1355 Clayton Rd.
San Jose, CA 95127
p: 408.251.3070

Canyon Springs Post-Acute Care
180 N. Jackson Ave.
San Jose, CA 95116
p: 408.259.8700

**b) Type of business:**

Skilled nursing facilities

**c) Name and job title of the manager at the worksites:**

Unknown

**d) Your name, address, telephone number, and email address:**

Ben Fuchs
Weinberg, Roger & Rosenfeld, APC
1001 Marina Village Pkwy., Ste. 200
Alameda, CA 94501
p: 510.775.5261
e: bfuchs@unioncounsel.net

**e) Detailed description of the hazard:**

Please see above

**f) If worksite is large, the specific location of the hazard:**

Throughout both worksites

**g) Operations, equipment, machinery, and chemicals used at the worksite:**

Various standard medical equipment typical of skilled nursing facilities

**h) Work tasks performed near the hazard:**

Various standard nursing/medical assistant patient-facing duties, including standard patient care and specialized care for suspected and confirmed COVID-19 patients

**i) How often the work tasks are performed and for how long at any one time:**

Daily; durations vary

**j) Number of work shifts, the time that each shift begins, and the shift when the hazard occurs:**

Canyon Springs: On information and belief, the facility is staffed on a 24/7 basis, broken into three shifts per 24-hour period.

The Ridge: On information and belief, the facility is staffed on a 24/7 basis, broken into three shifts per 24-hour period.

**k) Number of employees at the worksite, number of employees who may be exposed to the hazard, and how close the employees are to the hazard:**

Canyon Springs: Approximately 20 to 35 total employees (reflecting all facility and County employees, with the estimate range consistent with significant turnover at the facility); all are anticipated to be exposed to the hazards in question, and all are close to said hazards.

The Ridge: Approximately 15 total employees; all are anticipated to be exposed to the hazards in question, and all are close to said hazards.

**l) Employees injured or having symptoms caused by the hazard and whether the employees have received medical treatment for their injuries or symptoms:**

Unknown at this time

**m) How long the hazard has existed, whether the employer knows about the hazard, and whether the employer has tried to correct the hazard:**

The hazards have existed since, on information and belief, approximately mid-March 2020 (though as to members of SEIU Local 521, since only on or around April 7, 2020). The County has known about

the hazards at The Ridge since, on information and belief, no later than April 7, 2020, and at Canyon Springs since, also on information and belief, no later than April 8, 2020. The County does not appear to have engaged in sufficient efforts to correct the hazards at either facility or to reduce the exposure of its employees to such hazards at Canyon Springs (as it has apparently withdrawn all SEIU Local 521-represented County employees from The Ridge as of the time of this filing, though other workers reportedly remain working at that location).

**n) How long you expect the hazard will continue to exist at the worksite:**

Undetermined, as the duration of these hazards may depend on the actions of Cal/OSHA in response to the instant complaint, among other factors

**o) If there is an employee bargaining unit representative for the worksite, the person's name and contact information**

Mr. Cesar Serrano
Executive Representative to the Chief Elected Officer
SEIU Local 521
2302 Zanker Rd.
San Jose, CA 95131
p: 408.460.8686
e: Cesar.Serrano@seiu521.org

## IV. Conclusion

For the foregoing reasons, SEIU Local 521 respectfully requests that Cal/OSHA respond to the instant complaint by immediately investigating and bringing one or more enforcement actions against the County of Santa Clara and any other parties found to be responsible for creating or otherwise contributing to the calamitous and unlawful conditions at Canyon Springs and The Ridge skilled nursing facilities. The health and safety of the workers assigned to these facilities as well as that of the residents for whom they care requires nothing less.

Thank you for your prompt attention to this matter. Please do not hesitate to contact Cesar Serrano or myself with any questions or concerns.

Sincerely,

Benjamin J. Fuchs

cc: Mr. Cesar Serrano