NUHW NATIONAL UNION OF HEALTHCARE WORKERS
866-968-NUHW • nuhw.org • info@nuhw.org

July 1, 2020

Hang Nguyen
District Manager
Orange County District Office
681 S. Parker Street, Suite 200
Orange, CA 92868

RE: Complaint regarding Fountain Valley Regional Hospital and Medical Center

Dear Ms. Nguyen,

This letter represents a formal complaint and request for an investigation of conditions at Fountain Valley Regional Hospital and Medical Center (the Hospital), a 293-bed general acute care hospital located at 17100 Euclid St., Fountain Valley, California, 92708 (License Number: 060000109). We request that the California Department of Public Health investigate conditions that have contributed to the exposure of at least seven staff members and an unknown number of patients to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes Coronavirus disease 2019 (COVID-19), during two separate incidents on June 16 and June 25. A third outbreak incident has also emerged over the past week resulting in at least three employee infections. We also request that the CDPH investigate the Hospital's current infection control practices and conditions that fail to adequately prevent the widespread exposure of patients, staff and community members to a highly infectious disease.

Background: The National Union of Healthcare Workers (NUHW) represents 734 caregivers at the Hospital, including Certified Nursing Assistants, Phlebotomists, Radiology Technologists and Imaging Aides, Respiratory Therapists, Monitor Technicians, Unit Secretaries, Licensed Vocational Nurses, Environmental Services Representatives, Patient Ambassadors, Operating Room Technologists, Anesthesia Technologists, Surgical Procedure Technologists, Laboratory Technologists and Aides, Pharmacy Technologists, and Dietary Service Employees.

June 16 Incident:

On June 16, a Radiology Aide notified hospital management that family members in his home had tested positive for COVID-19.The Hospital did not provide the employee with a test for COVID-19, nor direct him to quarantine at home. Despite the employee's significant risk of exposure, and the known risk of asymptomatic transmission, the Hospital directed the employee to report to work, with temperature monitoring and the use of a standard surgical mask. The employee followed management's instructions.

On June 25, the employee became symptomatic during his work shift and went to the Hospital's Emergency Department, where he tested positive for COVID-19 and was subsequently admitted to the Hospital due to his condition.

This employee's duties include transporting patients for radiology services between multiple areas of the hospital. He is in frequent contact with multiple co-workers. These co-workers are generally only wearing surgical/procedural masks which is not sufficient Personal Protective Equipment (PPE) to protect against exposure to an individual infected with COVID-19, per Cal/OSHA's Aerosol Transmissible Diseases

(ATD) Standard, which states that the minimum level of respiratory protection "for suspect and confirmed COVID-19 patients is a NIOSH-approved respirator that removes at least 95 percent of airborne particles (N95) or more."

As a result of the Hospital's failure to test the employee once a likely exposure was identified, and the Hospital's failure to exclude the employee from work pending test results, the employee potentially exposed an unknown number of patients and staff members to the virus between June 16 and June 25. None of these patients or employees were wearing protective equipment that would have sufficiently protected them from exposure to an individual with COVID-19. Indeed, at least five other Radiology employees who worked in close proximity to the infected employee have now been sent home to self-quarantine. At least one of these employees is exhibiting symptoms of COVID-19.

To date, the Hospital has failed to do thorough contact tracing to identify all employees exposed to the infected employee and has refused to provide in-house testing for all employees. The Hospital has refused to disclose the extent to which they have conducted contact tracing and testing of exposed patients. The Hospital's actions pose a serious threat to patient and worker safety by 1) Failing to test and exclude from work the Radiology Aide once he disclosed an exposure to infected family members; 2) Subsequent failures to conduct thorough employee contact tracing and testing; and, 3) Potentially failing to conduct thorough contact tracing and testing of patients.

June 25 Incident:

On June 23 and June 24, a Certified Nursing Assistant (CNA) on the Telemetry unit, Room 224, worked two twelve-hour night shifts in a row as a patient sitter for the same patient. At the conclusion of the second 12-hour shift on the morning of June 25, the CNA was informed by the charge nurse on duty that the patient was infected with COVID-19. Prior to receiving this information, the CNA had not been informed that the patient was a PUI or had been tested, with results pending, nor was the CNA directed to deliver care in accordance with precautions for PUIs. By both CDC and Cal/OSHA standards, the CNA endured a high-risk exposure over the course of the two twelve-hour shifts, during which she sat in close proximity to the patient without wearing respiratory protection in the form of an N95 respirator as required by Cal/OSHA's ATD Standard, nor eye protection (she was only wearing a surgical mask). Due to the hospital's failure to properly identify the patient as a PUI, the patient was not in an airborne infection isolation room as is required under Cal/OSHA's ATD Standard for the safe care of suspected and confirmed COVID-19 patients.

Despite this significant exposure to a confirmed COVID-19 patient, the CNA was not placed on home quarantine nor offered testing by the Hospital. Instead the CNA returned to work the night shift on June 27 and June 28, each with a new patient assignment. On June 28, the CNA developed symptoms of COVID-19 and is now on home quarantine. The employer has not offered to test her. As far as NUHW is aware, hospital management has not conducted contact tracing of employees or patients who may have come into contact with the employee.

This incident reflects a serious lapse in the Hospital's infection control program. Once management became aware that the CNA had cared for a confirmed COVID-19 patient for two consecutive 12-hour shifts, without the appropriate PPE or infection control protocols, the Hospital failed to take numerous steps to protect patient and employee safety, including 1) excluding the exposed CNA from further shifts, 2) providing immediate testing for the CNA, 3) tracing, contacting and testing all employees with whom

the CNA had contact, and 4) promptly testing all potentially exposed patients. Instead, the CNA was kept on the schedule for two more shifts, potentially exposing an unknown number of patients and coworkers to COVID-19. The Hospital has refused to disclose to NUHW whether these potentially exposed patients have been tested.

July 1: NUHW has learned of an exposure incident among RNs and CNAs over the last week on M4, a medical unit. Two RNs are sick with COVID-19 symptoms and one CNA is sick and has tested positive (although testing was not done by the Hospital as management has not provided any employees with testing). NUHW is not aware of management's plan to do contact tracing and test all exposed patients and staff so we are concerned about the possibility of widespread infection of patients and staff on this unit.

Hospital-wide Issues:

The above incidents are only the most recent examples of the Hospital's inadequate infection control program and the resulting systemic threat in patient safety. The Hospital has failed to adopt multiple policies to protect patients and employees. The hospital has failed to do the following:

1. Test all newly admitted patients.

2. Treat all patients as PUIs until proven otherwise by test results.

3. Inform all employees of infection control protocols. (For example, the Hospital failed to inform all of its employees of its eye protection protocol, which requires employees to wear goggles for PUI or confirmed COVID-19 patient care.)

4. Cohort uninfected patients, PUIs, and COVID-19 positive patients in separate areas with assigned teams of caregivers who do not move between uninfected, PUI, and confirmed COVID-19 patient care. (For example, this month, the Hospital opened the M3 East Tower to COVID-19 patients but has failed to cohort PUIs, confirmed COVID-19 patients, and uninfected patients in three separate areas. CNAs working on M3 East Tower are being required to care for a mix of positive COVID-19 patients, PUIs, and uninfected patients.)

5. Test workers who are exposed to the SARS-CoV-2 virus during their work duties.

6. Place exposed employees on paid, precautionary leave pending testing.

7. Mask all patients medically able to wear a mask for source control.

8. Provide appropriate PPE to employees caring for all PUI and confirmed COVID-19 patients.

9. Establish adequate staffing to meet the increased demands of PUI and COVID-19 patient care. (For example, rather than adequately staff the hospital, management has forced CNAs to care for up to eight COVID-positive patients at a time, which is double the assignment given to registered nurses.)

Request: We have a number of concerns about apparent violations of state law and regulations that include, but are not limited to, the following:

Failure to protect patients through an infection control program:
Title 22 CCR §70739 requires hospitals to develop an infection control program, including the following:

1. Practices to reduce the risk of transmission of airborne infectious diseases;
2. Methods to handle patients to reduce the risk of transmission of potentially infectious etiologic agents from patient to patient and between patient and healthcare worker;
3. Procedures for managing outbreaks; and
4. Procedures for educating and training employees on infection control practices.

We believe that this complaint justifies immediate investigation by the CDPH, as it reflects a failure of the Hospital to comply with the following requirements that remain enforced during the state of emergency declared by Governor Newsom, as stated in the CDPH All Facilities Letter 20-26:

- Hospitals shall continue to provide necessary care in accordance with patient needs and make all reasonable efforts to act in the best interest of patients.
- Hospitals shall follow their disaster response plan.
- Hospitals shall follow infection control guidelines from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) related to COVID-19.
- CDPH will continue to investigate and conduct enforcement activities for allegations of the most serious violations impacting health and safety, pursuant to Executive Order N-27-20 (PDF).

As described in this complaint, the Hospital has failed to develop and implement effective infection control procedures and practices in order to reduce the risk of transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes the Coronavirus disease 2019 (COVID-19). This failure, NUHW alleges, places the Hospital in violation of California's Code of Regulations (CCR) Title 22 Section 70739.

Facilities such as the Hospital have shown to be acutely susceptible to the rapid spreading of SARS-CoV-2, making proper and timely intervention essential. Many of the Hospital's patients are elderly or suffer from comorbid illnesses, including diabetes, hypertension, and/or cardiovascular or pulmonary disease, which put them at higher risk for severe and life-threatening COVID-19 infections. As such, NUHW requests your immediate attention to the matters raised in this complaint and urges an immediate investigation of the Hospital.

Thank you for your attention to this urgent matter. Please contact Barbara Lewis at 1-310-736-5544 with any questions.

Sincerely,

Barbara Lewis, Southern California Hospital Division Director
National Union of Healthcare Workers
225 West Broadway, Suite 400
Glendale, CA 91204