FVRMC CITED FOR MULTIPLE HEALTH AND SAFETY VIOLATIONS

CA DEPARTMENT OF PUBLIC HEALTH FINDS VIOLATIONS

The 33-page report stated that the **"hospital failed to ensure an effective, active hospital-wide infection control program for the prevention, control, and investigation of infections and communicable diseases, including COVID-19,"** *and that* **"the cumulative effects of these systemic problems resulted in the hospital's inability to provide an effective hospital wide infection control program and increased the risk of cross-contamination and the spread of infection in the facility."**

Background: Throughout the spring of 2020, NUHW shop stewards held regular meetings with FVRMC management to raise concerns about the hospital's lack of health and safety protocols during the COVID-19 pandemic. We even reached out directly to hospital CEO Ken McFarland. Time and again, management refused to address our concerns.

On July 1, our Union, the National Union of Healthcare Workers (NUHW), filed a complaint with the California Department of Public Health (CDPH) citing health and safety violations at FVRMC.

The following day, NUHW members held a press conference outside FVRMC to annouce the filing of the complaint and share specific examples of the Hospital's failure to keep workers and patients safe.

That same day, CDPH entered FVRMC to begin their investigation. They found so many failures in infection control that a more expansive investigation was launched by the Federal government's Center for Medicare and Medicaid Services (CMMS).

After weeks of investigation, including interviewing NUHW members, **the CDPH issued a 33-page report on September 14, citing the hospital's massive violations in health and safety protections.**

SEE THE BACK

of this page for a summary of hospital violations.

You can also view the full 33-page report at:
NUHW.org/FVRMC-DPH

VIOLATIONS AT FVRMC

FAILURE OF THE HOSPITAL BOARD OF DIRECTORS/GOVERNING BODY TO:

"Ensure an effective, active hospital-wide infection control program for the prevention, control, and investigation of infections and communicable diseases, including COVID-19."

The report concluded that "**the cumulative effect of these systemic practices resulted in the failure of the hospital's Governing Board to ensure the provision of quality healthcare in a safe manner.**"

FAILURE OF HOSPITAL MANAGEMENT TO PROTECT PATIENTS AND STAFF:

- These failures placed **patients at risk for "cross contamination"** and **"for the non-COVID patients to be exposed to the COVID-19 positive patients. "**

- **Multiple failures in infection control** standards, on the **Pulmonary and Telemetry** units as well as the **Definitive Observation Unit** (DOU), **Pediatric unit, Pediatric Intensive Care Unit** (PICU), and **Medical Intensive Care Unit** (MICU).

- "The hospital failed to provide the dedicated nursing staff to the COVID-19 positive patients that required isolation for a highly infectious disease. **This failure had the potential to spread this infectious disease to other patients and staff.**"

- **Failed to assign dedicated care teams** to provide care to suspected and COVID-19 positive patients.

- Both patients under investigation (PUIs) and COVID-19 positive patients were placed on these units in a way that **put non-infected patients at risk for infection.**

- A COVID-19 patient was placed on the OB/GYN unit where pregnant women receive care.

- A PUI patient on the Oncology unit **where immunocompromised patients undergo chemotherapy.**

- Staff had to care for both COVID-19 and non-COVID-19 patients simultaneously.

- **Inconsistent and incomplete use of Patient Room log forms** to record which employees enter COVID-19 patient rooms

- Failure to ensure infection control surveillance tools were used to collect accurate data.

- Failure to provide separate break rooms and restrooms to staff assigned to COVID patients

- **Failure to ensure hand hygiene** was practiced **by physicians after caring for patients**.

READ THE FULL REPORT AT NUHW.ORG/FVRMC-DPH