BEFORE THE
STATE OF CALIFORNIA
OCCUPATIONAL SAFETY AND HEALTH
APPEALS BOARD

In the Matter of the Appeal of:	Inspection Number
Sutter Bay Medical Foundation **dba Sutter East Bay Medical Foundation** **139 Kifer Court** **Sunnyvale, CA 94086** **Employer**	**1475491** **DECISION AFTER RECONSIDERATION**

The Occupational Safety and Health Appeals Board (Board), acting pursuant to authority vested in it by the California Labor Code and having taken this matter under reconsideration on its own motion, renders the following decision after reconsideration.

JURISDICTION

Sutter Bay Medical Foundation, doing business as Sutter East Bay Medical Foundation (Employer), is a health care provider. On May 18, 2020, the Division of Occupational Safety and Health (Division) commenced an inspection of Employer's work site located at 2500 Milvia Street, in Berkeley, California. On August 31, 2020, the Division cited Employer for failure to ensure that medical assistants working at 2500 Milvia Street, the work site, used a respirator while in proximity to patients within the facility who were suspected of having COVID-19 (COVID).[1] Employer timely appealed and administrative proceedings were held before an Administrative Law Judge (ALJ) of the Board. Those proceedings included nine days of contested evidentiary hearings over a period starting on April 19, 2022, and ending on March 17, 2023, among other pre- and post-hearing proceedings.

On October 9, 2023, the ALJ issued a decision (Decision) upholding the citation.

On November 3, 2023, the Board issued an Order of Reconsideration (Order) on its own motion. Both parties filed briefs regarding the Order.

Employer was cited for allegedly violating one of the requirements of section 5199, a safety order requiring employers to provide respiratory protection to employees exposed or potentially exposed to airborne pathogens. As we shall explain below, the applicable provision required Employer to have its employees use respirators when in proximity to patients having or suspected of having COVID, and Employer did not do so. Under the circumstances during the

[1] "COVID-19" or "COVID" is used here to refer to the SARS-CoV-2 virus, the pathogen which caused a worldwide pandemic starting in early 2020. SARS-CoV-2 is a "coronavirus."

time at issue and the concurrently evolving knowledge about COVID, however, we find that Employer charted a reasonable and responsible path balancing the relative risks. Thus, for reasons detailed below, we affirm the Decision's holding that Employer was in violation of the safety order as cited, and we reclassify the violation from Serious to General, adjusting the penalty accordingly.

ISSUES

1. Was the ALJ correct in granting the Division's motion to amend the citation?
2. Did the Division meet its burden to prove the alleged violation?
3. Was the ALJ correct in upholding the Serious classification of the violation?

FINDINGS OF FACT

1. The COVID virus can cause death or serious physical harm in humans.
2. China reported an outbreak of pneumonia of unknown etiology to the World Health Organization on December 31, 2019.
3. The cause was shortly thereafter identified as a "novel corona virus."
4. The first U.S. case was announced by the Centers for Disease Control and Prevention (CDC) on January 21, 2020.
5. The virus which causes COVID was unknown before early 2020.
6. When COVID was first recognized its means of transmission between individuals was not well understood.
7. Preliminary indications and the early medical/scientific reports were that COVID was transmitted through droplets and by contact with contaminated surfaces.
8. Between February and May 2020 information from the CDC and California Department of Public Health (CDPH) stated that the primary means of transmission for COVID was droplets and/or contaminated surfaces.
9. Later data established that the COVID virus is transmitted through droplets and smaller aerosols.
10. Employer's health care facility on Milvia Street included a unit devoted to providing pediatric services to patients. The pediatric unit is the unit at issue.
11. The pediatric unit is on the second floor of the Milvia facility.
12. The employees at issue were medical assistants (MAs) working in the pediatric unit.
13. Starting on or about February 24, 2020, patients[2] were screened over the phone for COVID. On or about March 10, 2020, patients were screened before entering the Milvia facility and instructed to use an exterior stairway to access the pediatric unit.
14. A medical assistant would meet the patient on the exterior stairway and direct them to one of two treatment rooms. The medical assistants maintained physical separation from the patients while doing so.

[2] As noted, Employer's facility's pediatric unit is at issue. Because of their age pediatric patients were accompanied by parent(s) or guardian(s) for their visits to the facility. For brevity's sake, our use of "patients" includes the accompanying adults.

15. Opening the stairway door on the second floor, directing the patients to the treatment rooms, telling the patients the doctor would see them shortly, and closing the treatment room door were the only occasions in which medical assistants approached patients having or suspected of having COVID.
16. Prior to June 2020 MAs wore surgical masks when greeting and escorting patients to the treatment rooms.
17. Starting in April 2020 MAs wore N95 respirators if conducting procedures other than escorting patients. Starting in June 2020 MAs also wore N95 respirators[3] when escorting patients.
18. Patients aged two years and older wore masks unless doing so was medically contraindicated.
19. The time involved in meeting patients and directing them to one of the two treatment rooms was brief, approximately one to three minutes. MAs stayed at least six feet from patients, but on occasion would very briefly come closer.
20. In February 2020 one MA contracted COVID.
21. In April 2020 a second MA contracted COVID.
22. Neither of those two COVID cases was shown to have resulted from workplace exposure.
23. Employer "prioritize[ed]" the use of certain PPE (including N95 respirators) for those healthcare workers, including MAs, who were directly involved in the diagnosis and treatment of "high-risk patients (suspected/COVID-19+)" as of April 2020. (Ex. 24.)
24. Employer took steps to conserve its supply of N95 respirators and did not exhaust its supply of them during the time at issue.
25. CDC and CDPH recommendations to healthcare providers evolved during early stages of the pandemic.
26. Employer's Milvia facility did not have an "airborne infection isolation room" (AIIR).
27. The time at issue is January through June 2020.

REASONS FOR DECISION AFTER RECONSIDERATION

1. Was the ALJ correct in granting the Division's motion to amend the citation?

The Division made multiple motions to amend the original citation during the proceedings before the ALJ. In the Decision the ALJ noted that only the Division's last motion to amend, made after the hearing concluded, was granted. (Decision, pp. 3-7 (full discussion), p. 7 (grant of post-hearing motion).) The post-hearing motion had requested, should the ALJ not find a violation of section 5199, subdivision (g)(4)(H), that the citation be amended to allege in the alternative, violations of section 5199, subdivisions (g)(4)(B), (g)(4)(G), or (g)(4)(H),[4] based on the original Alleged Violation Descriptions (AVD).

[3] N95 respirators are also sometimes referred to as N95 masks.

[4] Unless otherwise noted all references are to title 8, California Code of Regulations.

Board regulation section 371.2, subdivision (a), provides in part that "A request for amendment that does not cause prejudice to the opposing party" may be made "at any time." If the request causes prejudice it shall be granted if the amended citation arises from the same general facts such that the amendment relates back to the original citation; there is a showing of good cause for the request; and any prejudice can be remedied. (§ 371.2, subd. (a)(2)(B).) Similarly, Board regulation section 386, subdivision (a), provides that the Board may amend the Division's action after a proceeding has been submitted for decision, and further that if such amendment would prejudice a party, the proceeding is to be continued to permit additional evidence to be introduced. (§ 386, subd. (b).) Here the ALJ granted the Division's post-submission motion to amend the citation.

Board precedent holds that requests to amend a pleading will be evaluated on whether there is prejudice to the nonmoving party. If the adverse party suffers no prejudice, the request will be granted. (*Sierra Forest Products*, Cal/OSHA App. 09-3979, Decision After Reconsideration (Apr. 8, 2016), quoting *Conolley v. Bull* (1968) 258 Cal.App.2d 183, 193 [if case tried on a theory later added by amendment to pleadings, no adverse party prejudiced].) A genuine showing of prejudice is required to defeat the request. (*Walmart Associates, Inc., dba Walmart Fulfillment Center #8103*, Cal/OSHA App. 1461476, Decision After Reconsideration (July 22, 2022).)

The ALJ permitted the Division to amend the citation to plead violations of three other safety orders in the alternative, and ultimately affirmed the violation based on one of those alternative theories, section 5199, subdivision (g)(4)(B). This alternative legal theory raised in the amendment, and ultimately affirmed by the ALJ, rested on the same factual basis alleged in the initial citation; therefore, there was no prejudice to Employer. (*L&S Framing, Inc. v. Occupational Safety & Health Appeals Bd*. (2023) 93 Cal.App.5th 995, 1012 ["'[i]f the same set of facts supports merely a different theory . . . no prejudice can result.' [Citation omitted.]"].) Accordingly, we affirm the Decision on this issue.

2. Did the Division meet its burden to prove the alleged violation?

The Division has the burden of proving a violation, including the applicability of the safety order, by a preponderance of the evidence. (*Howard J. White, Inc*., Cal OSHA App. 78-741, Decision After Reconsideration (June 16, 1983).) The Division also has the burden to prove employee exposure to the alleged violative condition. (*Benicia Foundry & Iron Works, Inc*., Cal OSHA App. 00-2976, Decision After Reconsideration (Apr. 24, 2003).)

Following the amendment, Employer was cited for, among other things, an alleged violation of section 5199, subdivision (g)(4)(B). Section 5199, subdivision (a)(1)(A), provides that the safety order applies to "[c]linics, medical offices, and other outpatient medical facilities[.]" It is not disputed that section 5199 applied to the Milvia facility. Thus, the issue is whether Employer violated section 5199, subdivision (g)(4)(B). The cited regulation states:

> (g) Respiratory Protection.
>
> (4) The employer shall provide, and ensure that employees use, a respirator selected in accordance with subsection (g)(3) and Section 5144 when the employee:
> […]
> (B) Is present during the performance of procedures or services for an AirID case or suspected case[.]

The term "case" as used in the safety order is defined as follows:

> Case. Either of the following:
> (1) A person who has been diagnosed by a health care provider who is lawfully authorized to diagnose, using clinical judgment or laboratory evidence, to have a particular disease or condition.
> (2) A person who is considered a case of a disease or condition that satisfies the most recent communicable disease surveillance case definitions established by the CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements.

(§ 5199, subd. (b).) Section 5199, subdivision (b) also includes an analogous definition of "suspected case." It defines a "suspected case" as:

> Suspected case. Either of the following:
> (1) A person whom a health care provider believes, after weighing signs, symptoms, and/or laboratory evidence, to probably have a particular disease or condition listed in Appendix A.
>
> (2) A person who is considered a probable case, or an epidemiologically-linked case, or who has supportive laboratory findings under the most recent communicable disease surveillance case definition established by CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements as applied to a particular disease or condition listed in Appendix A.

In lay terms, the safety order uses "case" in the sense of "a person being treated or helped, as by a doctor" or "an instance of a disease or problem." (Webster's New World Dict. (3d college ed. 1991, p. 216; Google's English dictionary by Oxford Languages (http://languages.oup.com/google-dictionary-en/), respectively.)

The Division alleged, "Prior to and during the course of the inspection, including but not limited to, on May 1, 2020, [Employer] failed to ensure that employees used a respirator when the employees transported patients with cases or suspected cases of airborne transmissible diseases such as COVID-19, within the facility when the patients were not masked."

Under section 5199, subdivision (g)(4)(B), four elements must be shown to exist for a violation to be found. First, COVID must fall within the definition of an airborne infectious disease (AirID). Second, there must be a patient present who is an AirID case or suspected case. Third, one or more employees must be "present during the performance of procedures or services" for that patient. Finally, the employee must not be wearing a respirator selected in accordance with subdivision (g)(3).

We start first with whether COVID falls within the scope of definition of an AirID in the safety order.

Section 5199, subdivision (b), provides two alternative definitions for an AirID, depending on what is known about the disease agent.

> Airborne infectious disease (AirID). Either: (1) an aerosol transmissible disease transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which AII is recommended by the CDC or CDPH, as listed in Appendix A, or (2) the disease process caused by a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

Based on the definition of AirID quoted above, there are basically two questions that must be asked to determine whether someone presents as an AirID case: (1) is the disease or pathogen listed on Appendix A; or (2) is it a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei. COVID is not specifically mentioned in Appendix A, but at the time in question, it was a novel or unknown pathogen and therefore it falls within the parameters of alternative (2). In addition, Appendix A itself applies to "Novel or unknown pathogens" or "Any other disease for which public health guidelines recommend airborne infection isolation." Thus, COVID qualifies as an AirID as defined in section 5199, subdivision (b).

We next turn to the second and third questions: whether there was a patient present who was an AirID case or suspected case, and whether one or more employees was "present during the performance of procedures or services" for them.

The evidence establishes that patients having or suspected of having COVID were greeted and directed to treatment rooms at the Milvia facility by MAs during the January – May of 2020 period. The issue is whether the MA meeting the patients and directing them to a treatment room was a "service."

It is not disputed that the MAs did not perform procedures on the patients and that the MAs were only with the patient for a brief time during the process of meeting and directing patients to one of two treatment rooms. It is also not disputed that the MAs were using surgical masks when meeting patients and directing them to the treatment rooms until June 2020, when they were given N95 respirators.

The dispute is whether it was a "service," as the term is used in section 5199, subdivision (g)(4)(B), for an MA to meet patients on the outside stairway or stairway door at the second floor and direct them to one of the two treatment rooms. We apply the ordinary meaning of an undefined term. (*Heritage Residential Care, Inc.,* v. *Division of Labor Standards Enforcement* (2011) 192 Cal. App. 4th 75, 81-83.) "Service" in this context is defined to mean "work done or duty performed for another" or "an act giving assistance or advantage to another." (Webster's New World Dict. (3d college ed. 1991, p. 1226).) Applying that definition, the MAs were providing a service to the patients since greeting and directing them was performing an assigned "duty" for Employer and was "giving assistance" to the patients. (*Id*.) We hold, therefore, the MAs performed a service when meeting patients at the stairway and directing them to a treatment room.

The sole remaining question is whether the MAs were wearing appropriate respirators. The record shows that MAs at the Milvia facility were not wearing N95 masks (or other appropriate respirator) when they performed the "service" of greeting and escorting for patients having or suspected of having COVID at the time in question. Thus, there was a showing that there was exposure to COVID as well as noncompliance with section 5199, subdivision (g)(4)(B). We conclude, then, that Employer violated section 5199, subdivision (g)(4)(B).

Section 5199, subdivision(b) includes a definition of "occupational exposure" which the Division's evidence must demonstrate. It states in part:

> Occupational exposure. Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATP [aerosol transmissible pathogens] or ATPs-L, if protective measures are not in place. In this context, "elevated" means higher that what is considered ordinary for employees having direct contact with the general public outside of the facility[y]. . . and operations listed in subsection (a)(1) of this standard. Occupational exposure is presumed to exist to some extent in [Employer's facility]. Whether a particular employee has occupational exposure depends on the tasks, activities, and environment of the employee, and therefore, some employees of a covered employer may have no occupational exposure. . .. Employee activities that involve having contact with, or being within exposure range of cases or suspected cases of ATD [aerosol transmissible disease], are always considered to cause occupational exposure.

The evidence shows that Employer's MAs were within exposure range of cases or suspected cases, albeit only briefly, when meeting and directing patients to one of the two treatment rooms.

The record establishes that COVID, by virtue of being a novel pathogen for which there was no clear evidence to rule out the possibility that it was spread by airborne droplets in early 2020, was covered by section 5199, subdivision (b). The Division may establish employee exposure to the violative condition by showing employee access to the zone of danger while performing assigned work duties. *(Benicia Foundry & Iron Works, Inc*., Cal OSHA App 00-2976, Decision After Reconsideration (Apr. 24, 2003).) The record shows that Employer's MAs at the Milvia facility were not wearing N95 respirators when they performed services at the time in question by greeting and directing patients having or suspected of having COVID to treatment rooms, thus showing both that there was exposure to COVID and noncompliance with section 5199, subdivision (g)(4)(B). We conclude, therefore, that Employer violated section 5199, subdivision (g)(4)(B).

3. Was the ALJ correct in upholding the Serious classification of the violation?

We now consider the classification of the violation. When determining whether a violation is properly classified as Serious, the relevant statute requires application of a burden shifting analysis. The Division initially bears the burden to establish "a realistic possibility that death or serious physical harm could result from the actual hazard created by the violation." (Lab. Code § 6432, subd. (a).) Labor Code section 6432, subdivision (a) provides:

> There shall be a rebuttable presumption that a "serious violation" exists in a place of employment if the division demonstrates that there is a realistic possibility that death or serious physical harm could result from the actual hazard created by the violation. The demonstration of a violation by the division is not sufficient by itself to establish that the violation is serious. The actual hazard may consist of, among other things: [¶] (1) A serious exposure exceeding an established permissible exposure limit. [¶] (2) The existence in the place of employment of one or more unsafe or unhealthful practices, means, methods, operations, or processes that have been adopted or are in use.

The Division met its initial burden here. The evidence developed at the hearing established that exposure to COVID created a realistic possibility of causing death or serious physical harm.

Labor Code section 6432, subdivision (c), provides a mechanism for Employer to rebut the presumption of a Serious violation. It provides:

> If the division establishes a presumption pursuant to subdivision (a) that a violation is serious, the employer may rebut the presumption [of a serious violation] . . . by demonstrating that the

> employer did not know and could not, with the exercise of reasonable diligence, have known of the presence of the violation. The employer may accomplish this by demonstrating both of the following:
> (1) The employer took all reasonable steps a reasonable and responsible employer in like circumstances should be expected to take, before the violation occurred, to anticipate and prevent the violation, taking into consideration the severity of the harm that could be expected to occur and the likelihood of the harm occurring in connection with the work activity during which the violation occurred. Factors relevant to this determination include, but are not limited to, those listed in subdivision (b).
> (2) The employer took effective action to eliminate employee exposure to the hazard created by the violation as soon as the violation was discovered.

To rebut the presumption that a violation is properly classified as Serious, Employer must show, among other things, that it took all the steps (1) "a reasonable employer should be expected to take before the violation occurred, to anticipate and prevent the violation[,]" and (2) "took effective action to eliminate employee exposure to the hazard created by the violation as soon as the violation was discovered." (Lab. Code § 6432, subd. (c).) When evaluating Employer's actions and whether it rebutted the presumption, we must consider Employer's actions in the context of the then-current state of knowledge regarding COVID's transmissibility and means of transmission, and we must also consider the availability of resources in the first half of 2020 to determine if Employer acted reasonably, effectively, and promptly. To that end, we summarize multiple relevant documents in the record showing the state of knowledge and relevant public health recommendations issued during the first half of 2020.

The record contains an All Facilities Letter (AFL) issued by the California Department of Public Health (CDPH) on January 23, 2020. (Exhibit 31.) It stated that China reported the outbreak to the World Health Organization (WHO) on December 31, 2019, and that the CDC announced the first U.S. case on January 21, 2020. The AFL stated that healthcare personnel entering the room in which a patient is being evaluated for COVID should wear an N95 or more protective respirator, among other PPE. It further noted that under section 5199, "employers must provide a powered air purifying respirator (PAPR) . . . or a respirator providing equivalent protection to employees who perform high hazard procedures on" patients suspected to have or having COVID. (Ex. 31, p.4.) The AFL defined "close contact" as "(a) being within approximately 6 feet (2 meters), or within the room or care area, of a novel coronavirus case for a prolonged period of time while not wearing recommended personal protective equipment or PPE[.] [C]lose contact can include caring for, living with, visiting or sharing a health care waiting area or room with a novel coronavirus case.—*or*—(b) having direct contact with infectious secretions or a novel coronavirus case (e.g., being coughed on) while not wearing recommended personal protective equipment." (*Id*., fn. 2. [Italics in original].) Employer, in separate internal publications, defined "prolonged" as 10 minutes or more. (Exs. 24, 131, C.) We find this significant since the MA exposures which form the basis of the citation were of brief duration and only occasionally involved distances of less than six feet from the patient.

Section 5199, subdivision (b) defines "high hazard procedures" (as pertinent here) as: "Procedures performed on a person who is a case or a suspected case of an aerosol transmissible disease . . . in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of [. . .] medications and pulmonary function testings." We hold that meeting patients and directing them to a treatment room is not a high hazard procedure as that term is defined in section 5199.

During the January through June 2020 period, CDPH, Cal OSHA and CDC published a series of updated guidance documents which are in the record of this proceeding. The content and timing of that guidance informs the analysis and findings in this Decision After Reconsideration. We have included excerpts from several of them in the Appendix attached to and incorporated into this Decision After Reconsideration.

We have considered all the evidence, including the several items of guidance from health authorities summarized above and those not specifically mentioned, in the context of Labor Code section 6432, subdivision (c). From all the evidence regarding how to protect against COVID exposure and the evolution of the scientific knowledge concerning it, we find that during the first several months of the COVID pandemic, during and after the time at issue, scientific understanding of the way COVID was transmitted among persons and the means of protecting persons from infection was evolving and remained uncertain. Those facts and the shortages of PPE, particularly N95 masks or "respirators" during the first half of 2020, lead us to conclude that Employer acted reasonably, rationally, and promptly, as PPE supplies allowed, to reduce the risk of exposure to the greatest extent possible under the circumstances. In view of the developing science and the N95 respirator shortage, we hold that Employer acted with reasonable diligence in allocating its supply of N95 respirators to the healthcare providers who examined and treated patients while taking the steps outlined above (phone screening, having patients wait in cars, outside stairway to access the facility, MAs and most patients wearing surgical masks, limited time and exposure to patients, etc.) to minimize MAs' exposure to COVID. And, when N95 respirators became more available in spring 2020, Employer issued them to all MAs, including those greeting and directing patients.

We acknowledge that the Division's expert, Lisa Brosseau, PhD., formed a different opinion. Dr. Brosseau pointed out (see Exhibits 118, 119) that the CDC and CDPH guidance regarding use of PPE called for use of N95 masks or equivalents, although she acknowledged that such guidance became more flexible as PPE shortages arose. We have considered all the conflicting evidence. On balance we find that the evidence shows there was scientific uncertainty over COVID's transmissibility during the first half of 2020 and that varying guidance was issued by the CDC, CDPH, and other authorities. This landscape of uncertainty and inconsistent guidance occurred alongside looming shortages of PPE, particularly N95 respirators. We find that Employer acted reasonably amidst the extraordinary emergent circumstances of the first half of 2020. During the early stages of a burgeoning pandemic and facing surging increases in COVID cases statewide, indeed worldwide, amid growing supply shortages, Employer's decision to limit the use of N95 respirators to HCP who were directly caring for and treating patients was reasonable. Employer's development of procedures and its allocation of PPE

resources reflects the application of triage[5] in a time of emergency. Employer took steps to minimize MAs' exposure to COVID by limiting their exposure to patients, such that their wearing surgical masks was reasonable. That action by Employer preserved its supplies of N95 masks for HCPs who examined and treated the patients, and who thus were necessarily in closer and more prolonged contact with the patients. In view of the health authorities recommending "social distancing" and limited contact with others at the times at issue, Employer's strategy was reasonable and rational. Similarly, Employer's decision to ration its supply of N95 respirators to those HCPs coming into close and direct contact with patients was an effective action, again in the unique circumstances present here, to eliminate employee exposure. Given that the shortage of N95 respirators made it impossible to eliminate all exposure for all employees, the decision to prioritize allocating the supply of N95 respirators to those HCPs having the riskiest contacts with patients was both rational and the best Employer could do until supplies of N95 respirators became more readily available.

In summary, while the alleged violation section 5199, subdivision (g)(4)(B) occurred, we hold that the violation, in the specific circumstances of this matter, should be classified as general, not serious, under the provisions of Labor Code section 6432, subdivision (c). The penalty is recalculated accordingly below.

As the Decision noted, penalties calculated in accordance with the requirements of sections 333 through 336 are presumptively reasonable. (Decision, p. 23.) The Division established that the "Extent" of the violation was low, and therefore the base penalty is to be decreased by 25 percent. (See Ex. 2.) Also, the penalty as adjusted for extent was reduced by an additional 50 percent for abatement.

The base penalty for a general violation is determined by evaluating the severity of the violation, which was shown to be high. (Ex. 2; § 336, subd. (b).) The base penalty is therefore $2,000. (§ 336, subd. (b).) As noted, the base penalty is decreased by 25 percent for low extent, for an adjusted penalty of $1,500. That amount is further reduced by 50 percent as credit for abatement, leaving a final penalty of $750.00. (§ 336, subd. (b).)

DECISION AFTER RECONSIDERATION

The alleged violation is affirmed and reclassified as a General violation.

[5] "1. A system of assigning priorities of medical treatment based on urgency, chance of survival, etc. and used on battlefields and hospital emergency wards. 2. Any system of establishing the order in which acts of assistance are to be carried out in an emergency." (Webster's New World Dict. (3d college ed. 1991) p.1426.)

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD

/s/ Ed Lowry, Chair
/s/ Judith S. Freyman, Board Member
/s/ Marvin Kropke, Board Member

FILED ON: 01/09/2025

APPENDIX

Timeline and Excerpts of Guidance Documents Issued by CDPH, Cal/OSHA and CDC

On February 10, 2020, the CDPH issued an All Facilities Letter (AFL) referring to CDC interim guidance issued February 8, 2020 and stating the following: "The HCP exposure risk factors described in the CDC interim guidance include, but are not limited to, the following: [¶] The duration of exposure (e.g., longer exposure time likely increase exposure risk) [¶] Whether the patient was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment [¶] Whether an aerosol generating procedure was performed [¶] The types of [PPE] used by HCP[.]" Employer's MAs were exposed for limited times, as noted, while they and patients (with few exceptions) were wearing surgical masks. (Ex. 33.)

On February 12, 2020, the CDC issued COVID-related guidance entitled "Interim Prevention and Control Recommendations for Patients with Confirmed 2019 Novel Coronavirus (2019-nCoV) or Persons Under Investigation for [COVID] in Healthcare Settings." (Ex. 112.) The guidance "is based on the currently limited information available on 2019-nCoV related to disease severity, transmission efficiency and shedding duration." The CDC stated, "For the purpose of this guidance, HCP refers to all persons, paid and unpaid, working in healthcare settings engaged in patient care activities, including: patient assessment for triage, entering examination rooms or patient rooms to provide care, . . . obtaining clinical specimens[.]" (Ex. 112, p. 1.) The guidance recommended separating infected persons by six feet from others. It also calls for HCP to use N95 masks or equivalents when entering the room where a patient is to be examined or treated. (Ex. 112, p. 3.)

On February 28, 2020, the CDPH issued "Outpatient Healthcare Facility Infection Control Recommendations for Suspect COVID-19 Patients." (Ex. 35.) It recommended that outpatient facilities be prepared to evaluate COVID patients by, among other items, "Ensuring that N95 respirators . . . are available." It further recommended that "Prior to interacting with patient inside or outside the facility, staff should don PPE [personal protective equipment]" including N95 masks. The document's recommendations for facilities without an airborne infection isolation room, such as the Milvia facility, included asking the patient to call after arrival but before entering the facility, having the patient wear a surgical mask or using other practical means of source control such as a blanket placed loosely over a child's head, bypassing waiting areas, immediately placing the patient in a private room, and allowing only essential staff to be in the room. (Ex. 35, pp. 1, 2.) Employer established those procedures except for having MAs wear N95 masks while meeting and escorting patients to the treatment rooms.

On March 3, 2020, the CDPH published AFL 20-17, "Guidance for Healthcare Facilities on Preparing for Corona Disease (COVID-19)," which provided "new and updated" guidance. (Ex. 32.) Apparently in recognition and response to N95 respirator shortages, this AFL noted that the CDC advised that certain N95 respirators past manufacturer-designated shelf life can be considered when responding to COVID. And it refers to Cal/OSHA's own "interim guidance" regarding use of respirator supplies "to ensure compliance with [section 5199]."

On March 28, 2020, Cal/OSHA published a document entitled "Interim Guidance for Health Care Facilities: Severe Respirator Supply Shortages," which states:

> In non-emergency conditions, covered employers must provide and ensure use of [N95 respirators] to all employees occupationally exposed to novel pathogens such as COVID. [¶] However, for the current COVID-19 crisis, covered employers must provide surgical masks when the respirator supply is insufficient for anticipated surges or when efforts to optimize the efficient use of respirators does not resolve the respirator shortage. Surgical masks can only be used for lower hazard tasks involving patient contact.

Note: This guidance was issued 24 days after Governor Newsom declared a state of emergency in California due to the COVID pandemic. Even as late as June 2020, Cal/OSHA published guidance allowing use of surgical masks when other respiratory protection options were exhausted. (Ex. 39, Cal/OSHA guidance 6/12/2020.)

On March 10, 2020, the CDC updated COVID guidance. (Ex. 111.) The guidance stated, "[F]acemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest risk to HCP." (Ex. 111, p. 1.) Further, the guidance states: "Early reports suggest person-to-person transmission most commonly happens during close exposure to the person infected with [COVID], primarily via respiratory droplets[. . .] The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely. . . [¶s] In times of shortages, alternatives to N95s should be considered[.] Special care should be taken to ensure that respirators are reserved for situations where respiratory protection is most important[.]" (Ex. 111, p.2.) The guidance also stated, "N95 [or equivalent or more protective] respirators should be used when performing or present for an aerosol generating procedure." (Ex. 111, p.5.)

On March 2020, the CDPH published "COVID-19 Health Care System Mitigation Playbook." (Ex. 45.) Regarding "Mode of Transmission" it states, "Evidence is building. Systems should ensure appropriate PPE is available for the most critical patients where procedures occur frequently. Reports from around the world indicate most infections have occurred when a contagious person has close contact with family, colleagues, or healthcare workers due to droplets which can spread up to 6 feet. [. . .] Similarly, there are some concerns about airborne transmission, but more data is needed on this." (p. 3.) The Playbook recommends re-use of N95 respirators and surgical masks to "conserve PPE supplies[.]" (p. 14.) And "Those escorting patients with respiratory symptoms or suspected to have COVID-19 do not need to wear a mask, if the patient is masked. If the patient is unable to wear a mask, staff must put on a mask while escorting. Staff must wear full PPE if in direct contact (touching or providing care) with patients during transport." (p. 15.) "Staff need not wear mask or other PPE if patient is wearing mask during transport." (p. 16.)

On April 1, 2020, the CDC issued guidance that included among its "key concepts" the need for "prioritiz[ing] respirators . . . for aerosol-generating procedures [and] implement[ing] PPE optimization strategies to extend supplies." (Ex. 106, p. 1.) It further stated: "This interim guidance has been updated based on currently available information on [COVID], and the current situation in the United States which includes cases of reports of community transmission . . . and shortages of facemasks [and] N95 [respirators][.]" (Id.) Its "mode of transmission" section restates the information in the March 10, 2020, guidance quoted above. (Ex. 106, pp. 1, 2.) This CDC guidance also says, "Special care should be taken to ensure that respirators are reserved for situations where respiratory protection is most important, such as performance of aerosol-generating procedures on suspected or confirmed COVID-19 patients or provision of care to patients with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis, measles, varicella)." It also includes, on page 5, two illustrations of PPE for HCP, which notes that "facemasks are an acceptable alternative" to N95 respirators. (Ex. 106, p. 2.)

On May 18, 2020, the CDC again updated its guidance. (Ex. 113.) In that update it repeated the information regarding the mode of transmission quoted from March 10, 2020, above. It also repeated that N95 respirators should be reserved for close contact with patients and for use by HCP conducting procedures which are likely to generate respiratory aerosols. It further republished the illustration used in the April 1, 2020, guidance stating that "facemasks are an acceptable alternative to" N95 respirators. The same illustration is published in the CDC's updated guidance dated June 19, 2020.

On October 5, 2020, the CDC published a report titled "How COVID-19 Spreads." It stated, "COVID-19 is thought to spread mainly through close contact from person-to-person, including between people who are physically near each other (within about 6 feet) . . . We are still learning about how the virus spreads[.]" Notably, this guidance was issued approximately five months after the violations at issue. It further stated, COVID "can sometimes spread by airborne transmission." This was approximately five months after the occurrence of the violations at issue and indicates continuing the medical/scientific uncertainty regarding how COVID is spread.