North Carolina Department of Labor
Occupational Safety and Health Division

Raleigh, North Carolina

Field Information System Operational Procedure Notice 132H

Subject: Special Emphasis Program for Long Term Care Facilities.

A. **Purpose and Scope.**

This Operational Procedure Notice (OPN) describes the North Carolina Department of Labor (NCDOL) Occupational Safety and Health (OSH) Division – Special Emphasis Program (SEP) for all inspections of Long Term Care (LTC) Facilities in North American Industry Classification System (NAICS) subsector 623 (NAICS 623110 – Nursing Care Facilities; 623210 – Residential Intellectual and Developmental Disability Facilities; 623220 – Residential Mental Health and Substance Abuse Facilities; 623311 – Continuing Care Retirement Communities; 623312 – Assisted Living Facilities for the Elderly; and 623990 – Other Residential Care Facilities).

The SEP has a primary focus on the major hazards prevalent in LTC facilities, specifically, ergonomic stressors relating to resident handling; exposure to blood and other potentially infectious materials (OPIM); exposure to tuberculosis; slips, trips, and falls; and workplace violence. However, as detailed in the Field Operations Manual (FOM), when the Compliance Safety and Health Officer (CSHO) becomes aware of additional hazards, the scope of the inspection may be expanded to include those hazards. Note that this OPN addresses only enforcement-related procedures.

B. **Special Emphasis Program History.**

In August 1996, the US Department of Labor – Occupational Safety and Health Administration (OSHA) implemented a seven-state nursing home initiative to address hazards in the LTC industry. This federal initiative was terminated on February 10, 1998. All enforcement policies for the initiative were replaced by a National Emphasis Program (NEP) on nursing and personal care facilities and were addressed by compliance directive (CPL 02) 02-03 – OSHA's National Emphasis Program – Nursing and Personal Care Facilities SIC 8051, 8052, 8059, which ended on September 30, 2003. A new NEP (CPL 03-00-016) was created on April 4, 2012 and expired April 5, 2015.

NCDOL had similar strategic plan goals from 1999 to 2003 and an SEP focused on LTC facilities. The inspection procedures contained in the federal directives were implemented with state-specific changes. The OSH Division included the SEP for LTC facilities in the Strategic Management Plans for October 1, 2004 - September 30, 2013 and continued it for the October 1, 2013 - September 30, 2018 Strategic Management Plan.

C. **Background.**

LTC facilities had one of the highest injury and illness rates among industries for which nationwide lost workday injury and illness (LWDII) rates were calculated for calendar year 2000 (CY 2000). According to data from the Bureau of Labor Statistics (BLS), the national average LWDII rate for private industry for CY 2000 was 3.0. LTC facilities experienced an average LWDII rate of 7.9, despite the availability of feasible controls that had been identified to address hazards within this industry. CY 2000 data from

BLS indicated that overexertion and injuries from slips, trips, and falls accounted for a high percentage of total nonfatal occupational injury and illness cases with days away from work in LTC facilities. Taken together, these accounted for 72% of all cases involving days away from work (53.4% from overexertion and 18.6% from slips, trips, and falls). In addition, LTC workers had the potential for exposure to bloodborne pathogens and tuberculosis.

In spite of significant reductions in the number of injuries that occurred between 1998 and 2008, the case rate for the LTC industry in North Carolina rose and remained above the national rate in 2009 and 2010. In 2011, the LTC case rate dropped below the national rate and continued to drop in 2012. However, the industry's rates are still well above the average North Carolina employer statewide. Therefore, LTC remains an SEP in the Strategic Management Plan.

D. **Program Procedures.**

LTC assignments will be generated through accidents, complaints, referrals and general schedule criteria. The assignments will have priority based upon instructions in the Field Operations Manual (FOM).

E. **Compliance Inspection Procedures.**

1. General.

   a. Compliance activities conducted under this SEP will normally be limited to programmed inspections (the general industry schedule assigned from the OSH Division Targeting System and/or any specific programmed random scheduled list including NAICS subsectors covered by this OPN).

   b. If a complaint, referral, or accident inspection is conducted in an establishment covered by this OPN, CSHOs will follow guidance listed below and in FOM Chapter IX – Complaints, Referrals and Accidents.

   c. If a fatality or catastrophe investigation is conducted in an establishment covered by this OPN, CSHOs will follow guidance listed below and in FOM Chapter VIII – Fatality and Catastrophe Investigations.

2. Pre-Inspection Preparation.

   a. CSHOs assigned to conduct unprogrammed, partial scope inspections (fatalities, catastrophes, accidents, complaints, referrals, etc.) must review the site listing on the OSH Division Targeting System to determine if an exemption has been issued for the employer/site by the Consultative Services Bureau (CSB) or the Education, Training and Technical Assistance (ETTA) Bureau (Carolina Star). If the site has an exemption, the CSHO will refer to FOM Chapter III – Inspection Procedures, paragraph D.3.h. – Exemptions from Compliance Inspections for guidance regarding exemptions to be applied to the current inspection.

3. Inspection Process.

a. CSHOs will evaluate the major hazards of this SEP found in paragraph b. below, during all programmed compliance inspections. Unless the site is exempt per E.2.a, any unprogrammed partial-scope inspections conducted at NAICS 623 sites under this SEP may be expanded to cover the following SEP hazards, provided all procedures outlined in the appropriate FOM chapter are followed (see paragraph E.1. for references).

b. SEP Hazards.

i. Ergonomic Risk Factors Relating to Resident Handling.

Ergonomic evaluations, as they relate to risk factors associated with resident handling, shall be conducted in accordance with the FOM instructions in Chapter XVII – Ergonomics Inspection Procedures. Using those procedures helps to identify case outcomes as early as possible in the inspection process in order to conserve department resources.

Evaluations will begin with a determination of the extent of resident handling, its hazards, and the manner in which the hazards are addressed. Then the CSHO will assess the establishment incidence and severity rates, determine whether the rates are increasing or decreasing over a period of at least three years, and evaluate whether the establishment has implemented a process to address these conditions in a manner that can be expected to have a useful effect. When assessing an employer's efforts to address these conditions, the CSHO should evaluate program elements, such as the following:

A. Program Management.

1. Whether there is a system for hazard identification and analysis.

2. With whom the responsibility and authority for compliance with this system resides.

3. Whether the employees have input in the development of the establishment's lifting procedures.

4. Whether there is a system for monitoring compliance with the establishment's policies and procedures and following up on deficiencies.

5. If there have been recent changes in policies/procedures and what effect they have had (positive or negative) on injuries and illnesses.

B. Program Implementation.

1. How resident mobility is determined.

2. What decisions are made for using lift assist devices, and under what circumstances manual lifts occur.

3. With whom does the decision on how to lift patients reside.

4. Whether there is an adequate quantity and variety of appropriate lift assist devices available and operational. Note that no single lift assist device is appropriate in all circumstances.

5. Whether there are an adequate number of slings for lift assist devices, double handled gait belts, or other transfer assist devices (such as, but not limited to: slip sheets, pivot transfer devices) available and maintained in a sanitary condition.

6. Whether the policies and procedures are appropriate to reduce exposure to the lifting hazards at the establishment.

C. Employee Training.

1. Whether employees have been trained in the recognition of hazards associated with resident handling.

2. Whether management has an effective process for abating those hazards.

3. Whether there is early reporting of injuries.

D. Occupational Health Management.

1. Whether processes are established to ensure that ergonomic disorders are identified and treated early to prevent the occurrence of more serious problems.

2. Whether this process includes restricted or accommodated work assignments.

Citation Guidance. As outlined in FOM Chapter XVII – Ergonomics Inspection Procedures, CSHOs will evaluate the facility's incidence and severity rates and the extent of the employer's program. Following this analysis, a decision will be made as to the need to continue the ergonomic portion of the inspection. CSHOs will follow procedures in the FOM regarding the issuance of ergonomic hazard alert letters or

pursuing citations. Voluntary guidelines published by OSHA will not be used as a basis for citations issued under this SEP.

ii. Slips, Trips, and Falls.

A. Evaluate the general work environments (i.e., kitchen, hallways, laundry, bathing areas, and egress) and document hazards likely to cause slips, trips, and falls such as but not limited to:

1. Slippery or wet floors; uneven floor surfaces; cluttered or obstructed work areas/passageways; poorly maintained walkways; broken equipment; or inadequate lighting (especially for night shift).

2. Unguarded floor openings and holes.

3. Damaged or inadequate stairs and/or stairways.

4. Elevated work surfaces that do not have standard guardrails.

5. Inadequate aisles for moving residents.

6. Improper use of ladders and stepstools.

B. Note any policies, procedures and/or engineering controls used to deal with wet surfaces. These would include but are not limited to ensuring spills are reported and immediately cleaned up, posting signs/barriers alerting employees to wet floors, passageways/aisles kept clear of clutter, and using appropriate footgear. Where appropriate, evaluate the use of no-skid waxes or other types of coated surfaces designed to enhance surface friction.

Citation Guidance. Where hazards are noted, the CSHO should cite the applicable standard (29 CFR 1910 Subpart D – Walking-Working Surfaces and Subpart J – General Environmental Controls). If employees are exposed to falling hazards while performing various tasks including maintenance from elevated surfaces, then CSHOs will determine the applicability of 29 CFR 1910.140 – Personal Fall Protection Systems.

iii. Bloodborne Pathogens (BBP).

In order to conduct inspections and prepare citations for occupational exposure to blood and other potentially infectious materials (OPIM), CSHOs should refer to OSHA Instruction CPL 02-02-069 (CPL 2-2.69) - Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens. In addition, outreach and educational materials for employers are available at www.nclabor.com and www.osha.gov.

In accordance with CPL 02-02-069, the CSHO should ensure that the following items are addressed during this portion of the LTC inspection:

A. Evaluate the employer's written Exposure Control Plan (ECP) to determine if it contains all the elements required by the standard.

B. Assess the implementation of appropriate engineering and work practice controls.

1. Determine which procedures require the use of a sharp medical device (e.g., syringe administration of insulin) and determine whether the employer has evaluated, selected and is using sharps with engineered sharps injury protection (SESIPs) or needleless systems.

2. Confirm that all tasks involving sharps have been evaluated for the implementation of safer devices. For example, does the employer require safety-engineered needles for pre-filled syringes and single-use blood tube holders?

3. Determine whether the employer solicited feedback from non-managerial employees responsible for direct resident care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation and selection of effective engineering and work practice controls and whether the employer documented solicitation in the ECP.

C. Ensure that proper work practices and personal protective equipment (PPE) are in place.

D. Assess whether containment of regulated waste is performed properly.

E. Evaluate and document the availability of handwashing facilities. If immediate access to handwashing facilities is not feasible, ascertain whether skin cleansers are used (e.g., alcohol gels).

F. Assess the use and availability of appropriate PPE in appropriate sizes.

G. Ensure that a program is in place for the immediate and proper clean-up of spills and disposal of contaminated materials, specifically for spills of blood or other body fluids.

H. Determine that the facility has chosen an appropriate Environmental Protection Agency (EPA)-approved

disinfectant to clean contaminated work surfaces and that the product is being used in accordance with the manufacturer's recommendations.

I. Determine that all employees with occupational exposure to blood and OPIM have been offered the hepatitis B virus (HBV) vaccine series within ten (10) days of initial assignment at no cost. For employees who declined the vaccine series, determine that declinations have been properly documented.

J. Ensure that healthcare workers who have contact with residents or blood and are at ongoing risk for percutaneous injuries have been offered an antibody test for the HBV surface antigen in accordance with United States Public Health Service guidelines.

K. Evaluate the ECP for procedures for post-exposure evaluation and follow-up and that the procedures have been implemented.

1. Determine that establishment-specific post-exposure protocols specify where and when to report exposure incidents.

2. Determine whether medical attention is immediately available, including administration of a rapid HIV test, in accordance with United States Public Health Service guidelines.

L. Determine whether employees have received training in accordance with the BBP standard, 1910.1030.

M. Evaluate the employer's sharps injury log. Ensure that injuries recorded on the sharps injury log have also been recorded on the OSHA 300 log and that they have been recorded as privacy concern cases. Verify that post-exposure evaluation and follow-up was provided for each entry on the sharps injury log. In addition, determine whether the employer evaluated safer alternatives for the medical device(s) involved in the sharps injury.

iv. <u>Tuberculosis (TB) Inspection and Citation Guidance.</u>

Determine whether the establishment has had a suspected or confirmed TB case within the previous six (6) months prior to the date of the opening conference. If not, do not proceed with this section of the inspection. If a case has been documented or suspected, proceed with inspection according to the guidance document, CPL 02-02-078 - Inspection Procedures and Scheduling for Occupational Exposure to Tuberculosis.

v. Workplace Violence Inspection and Citation Guidance.

A. Through employee interviews and a review of OSHA 300 logs, CSHOs conducting inspections in LTC care facilities should identify any instances that were the result of workplace violence to employees in these facilities. In accordance with the OSH Workplace Violence Memo dated 5/1/2017 (WPV 3), OSHA directive CPL 02-01-058 – Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence will be used as guidance for determining the applicability of citing the General Duty Clause (GDC) and any associated OSH standards for failure to establish a workplace violence prevention program. The memo, with attached CPL, can be found under Memos on the Field Information System (FIS).

c. Additional Concerns.

Additional hazards frequently exist at LTC facilities including, but not limited to the following: unprotected occupational exposure to Methicillin-resistant Staphylococcus aureus (MRSA) and other multi-drug resistant organisms (MDROs), and exposure to hazardous chemicals. The following items should be addressed when the CSHO is made aware of their existence. When determining whether to expand the scope of partial-scope inspections, CSHOs will follow procedures outlined in the appropriate FOM chapter (see paragraph E.1. for references).

i. Methicillin-resistant Staphylococcus Aureus and other multi-drug resistant organisms.

Nursing and residential care facilities are among the settings at increased risk of potential transmission of MRSA and other MDROs. Recommendations for standard precautions and contact precautions to reduce or eliminate exposure to MRSA and other MDROs are outlined in CDC guidelines, including *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007.* Appendix C provides an example of language that may be used in an Alleged Violation Description (AVD) for unprotected occupational exposure to MRSA specific to nursing and residential care facilities.

Note: Violations of applicable OSH Division standards (e.g., PPE standards) must be documented in accordance with the FOM. In GDC citations, the recognized hazard must be described in terms of the danger to which employees are exposed (e.g., the danger of being infected by MRSA, not the lack of a particular abatement method). Feasible abatement methods that are available and likely to correct the hazard must be identified.

ii. Hazard Communication.

Employee exposures to hazardous chemicals, such as sanitizers, disinfectants and hazardous drugs, may be encountered in nursing and residential facilities. Employers are required to implement a written program that meets the requirements of the Hazard Communication Standard (HCS) to provide worker training, warning labels and access to Safety Data Sheets (SDSs).

Note: Refer to OSHA Instruction CPL 02-02-079 – Inspection Procedures for Hazard Communication (2012), for inspection and citation guidance.

iii. Recordkeeping.

Recordkeeping issues must be handled in accordance with 29 CFR 1904, CPL 02-00-135 – Recordkeeping Policies and Procedures Manual, CPL 02-02-069 (CPL 2-2.69) – Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, FOM Chapter XVII – Ergonomics Inspection Procedures (which requires review of at least the past three years of injury/illness data), and other relevant field guidance.

iv. Privacy.

A. Resident Privacy and Medical Records.

1. Respect for resident privacy must be a priority during each inspection. Under no circumstances may a CSHO enter resident rooms or other areas where resident privacy could be compromised without the consent of the resident or their next-of-kin guardian.

2. In evaluating resident handling or other hazards, do **not** review any resident records that include personally identifiable health information, including diagnoses, laboratory test results, etc., provided by the employer without the consent of the resident or their next-of-kin.

3. Evaluations of workplace health and safety issues in this SEP may involve assessment of resident handling. Resident handling activities may take place in resident rooms, restrooms, shower and bathing areas or other areas where the privacy of residents could be compromised. Documenting resident handling activities by videotaping or photography requires the resident's informed, written consent. Family members or guardians may give consent for those residents who are incapable of giving

informed consent (see Appendix A – Resident Consent and Release).

v. Employee Medical Records.

A. If employee medical records are needed that are not specifically required by an OSHA standard (e.g., the results of medical examinations, laboratory tests, medical opinions, diagnoses, first aid records, reports from physicians or other health care providers), they must be obtained and kept in accordance with FOM Chapters III – Inspection Procedures, XIII – Fatality and Catastrophe Investigations, and XVI – Administrative File Activities.

B. Health and Human Services' Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164.512 (b)(1)(v), state that an employer (or its health care provider) can disclose and use confidential employee health information when conducting or evaluating workplace medical surveillance; or to evaluate whether an employee has a work-related illness or injury; or to comply with OSHA requirements under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose.

F. **Outreach.**

The outreach efforts of ETTA and CSB will be in accordance with the goals set forth in the OSH Division's Strategic Management Plan. Training marketing mailings will be sent when directed by the LTC SEP to all known employers in NAICS subsector 623 in order to provide outreach materials to all applicable employers.

G. **Recording and Tracking.**

1. For all unprogrammed inspections conducted in conjunction with a LTC SEP inspection, the OSHA-1 forms must be marked as "unprogrammed" in "Inspection Type" with the appropriate unprogrammed activity identified (e.g., accident, complaint, referral).

2. For programmed inspections, the OSHA-1 forms must be marked as "programmed planned" in "Inspection Type" with the appropriate activity identified (e.g., Health General Schedule (GS) list, Safety GS list).

3. Other Applicable Codes for the OSHA-1.

a. Select 'Strategic Plan Activity' and enter the value "LONG TERM CARE FACILITIES".

b. OSHA-1 Optional Information, Item 42 codes, as follows:

Code	Information
S-16	General Duty Ergonomic Citation Issued
S-17	Ergonomic Hazard Related Inspection
N-02-BLOOD	Bloodborne Pathogen Related Inspection
N-02-TB	TB Related Enforcement Inspection

c. Optional codes for workplace violence and slips, trips and falls are not necessary and have not been developed.

H. **Program Evaluation.**

BLS data will be reviewed to determine the effectiveness of the program. Reference Appendix B for additional resources such as compliance directives, publications and web links.

I. **Effective Date.**

OPN 132G is canceled. This OPN is effective on the date of signature. It will remain in effect until revised or canceled by the director.

Signed on Original
Jacopo Wiggins
SEP Team Leader

Signed on Original
Kevin Beauregard
Director

5/31/2017
Date of Signature

Appendix A - Resident Consent and Release.

I hereby consent and release to the North Carolina Department of Labor (NCDOL), Occupational Safety and Health (OSH) Division, the right to use my picture and sound being videotaped or photographed during an OSH inspection of _____ (name of facility) commenced on _____(date). I understand that this videotape or photograph will be used solely to document employee safety and health conditions at the facility, and may be used as evidence in legal proceedings related to those conditions.

_____ _____

Signature of Resident Date of Signature

In the event that there has been a medical or legal determination that a resident cannot give informed consent to be videotaped or photographed, the following shall be used:

On behalf of _____ (name of resident), I hereby grant to the OSH Division, the right stated above.

_____

Printed name of person authorized to give informed consent on resident's behalf

_____ _____

Signature of Authorized Person Date of Signature

_____ _____

Signature of Witness Date of Signature

Appendix B - Resources.

Title 29 Code of Federal Regulations Part 1904.

Title 29 Code of Federal Regulations Part 1910.

North Carolina Field Operations Manual.

Occupational Injuries and Illnesses; Recording and Reporting Requirements, published in the Federal Register on January 19, 2001 (66 FR 5915) and subsequent amendments.

OSHA Instruction CPL 02-00-135, Recordkeeping Policies and Procedures Manual (RKM), December 30, 2005 (or most current revision).

OSHA Instruction CPL 02-00-051, Enforcement and Limitations under the Appropriations Act, December 12, 2009.

Bureau of Labor Statistics (BLS), Table 1. Incidence Rates of Nonfatal Occupational Injuries and Illnesses by Industry and Selected Case Types, 2000, and following years.

OSHA Instruction CPL 02-02-069, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens Standard, 29 CFR 1910.1030, includes revisions mandated by the Needlestick Safety and Prevention Act (November 27, 2001).

OSHA Instruction CPL 02-02-078 – Inspection Procedures and Scheduling for Occupational Exposure to Tuberculosis, June, 30, 2015.

OSHA Instruction CPL 02-02-079, Inspection Procedures for the Hazard Communication Standard (HCS 2012), July 9, 2015.

OSH FIS Memorandum WPV 1, October 24, 2011 with attached CPL 02-01-052. Subject: Workplace Violence Inspections.

45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy, Subpart E - Privacy of Individually Identifiable Health Information, Section 164.512.

13 NCAC 7A.0900, Access to Employee Medical Records, March 1, 2010.

Publications:

NIOSH, Musculoskeletal Disorders and Workplace Factors, 2nd printing, US DHHS, CDC, NIOSH Pub No. 97-141.

Back Injury Prevention Guide in the Health Care Industry for Health Care Providers, Cal OSHA (11/97).

NIOSH, Elements of Ergonomic Programs: A Primer based on Workplace Evaluations of Musculoskeletal Disorders, DHHS/NIOSH Pub. No. 97-117.

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA publication # 3148.

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Web Links:

NIOSH Home Page
http://www.cdc.gov/niosh/homepage.html

OSHA Nursing Home E-Tool
http://www.osha.gov/SLTC/etools/nursinghome/index.html

OSHA Safety and Health Topics: Bloodborne Pathogens and Needlestick Prevention
http://www.osha.gov/SLTC/bloodbornepathogens/index.html

OSHA Safety and Health Topics: Nursing Homes and Personal Care Facilities
http://www.osha.gov/SLTC/nursinghome/index.html

OSHA Safety and Health Topics: Tuberculosis
http://www.osha.gov/SLTC/tuberculosis/index.html

OSHA Safety and Health Topics: Workplace Violence
http://www.osha.gov/SLTC/workplaceviolence/index.html

Ergonomic Web Links:

NIOSH Publication No. 2006-117: Safe Lifting and Movement of Nursing Home Residents
http://www.cdc.gov/niosh/docs/2006-117/

Best Practices for Nursing Homes
http://osha.oregon.gov/OSHAPubs/ergo/nursingbp.pdf

A Back Injury Prevention Guide for Health Care Providers
http://www.dir.ca.gov/dosh/dosh_publications/backinj.pdf

Safe Patient Handling in Washington State
http://www.washingtonsafepatienthandling.org/

Beyond Getting Started: A Resource Guide for Implementing a Safe Patient Handling Program in the Acute Care Setting
https://aohp.org/aohp/Portals/0/Documents/AboutAOHP/BGS_Summer2011.pdf

OSHA Safety and Health Topics: Ergonomics
http://www.osha.gov/SLTC/ergonomics/index.html

Guidelines for Nursing Homes, Ergonomics for the Prevention of Musculoskeletal Disorders
http://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html

NIOSH Ergonomics & Musculoskeletal Disorders Page
http://www.cdc.gov/niosh/topics/ergonomics/

Appendix C - Sample N.C. General Statute 95-129(1) AVD for MRSA Exposure.

Refer to the FOM and other OSH reference documents prior to proceeding with citation issuance. The following is provide ONLY as an example of the language that may be used in an AVD for unprotected occupational exposure to MRSA.

General Duty Clause, N.C. General Statute 95-129(1) – refer to the CDC guidelines: *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007,* which recommends standard precautions and contact precautions to reduce or eliminate exposure to MRSA. Abatement would include handwashing, cohorting of patients/residents, and device and laundry handling.

The General Duty Clause.

N.C. General Statute 95-129(1) of the Occupational Safety and Health Act of North Carolina: The employer did not furnish each of his employees conditions of employment and a place of employment free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to communicable diseases:

(a) Location – Address:
On or about *Date* employees were exposed to drug-resistant infections while providing care to residents with infections such as, but not limited to, Methicillin-Resistant Staphylococcus aureus (MRSA).

Abatement.

Feasible means of abatement include, but are not limited to: a) providing training on all routes of transmission of infections, the proper personal protective equipment to be used, and infection control practices to be utilized; b) notifying employees about the status of any resident with infection prior to beginning care assignments for every shift; c) cohorting patients/residents; and d) using administrative controls, such as limiting access to patients/residents with MRSA infections by non-essential personnel.

Appendix D – Sample Opening Conference Questionnaire.

NOTE*: This is not a required Questionnaire Form to be inserted into the case file and is not comprehensive of all information that may be required to obtain during an inspection. It is strictly intended as an investigatory aid for the CSHO.*

**An electronic version of this Questionnaire Form is available under Forms on the FIS.*

Ergonomics:

1. What is the system for ergonomic hazard identification and analysis?
2. What are the establishment's policies/procedures to reduce ergonomic risk factors associated with resident handling?
3. Who determines lifting policies/procedures?
4. How is resident mobility determined?
5. How are decisions made when to use lift assists and under what conditions are manual lifts performed?
6. Do employees have input in the development of the establishment's lifting procedures?
7. How are employees trained to lift patients?
8. What type of lift assists are available?
    - ☐ Slings
    - ☐ Double handled gait belts
    - ☐ Slip sheets/draw sheets
    - ☐ Pivot transfer devices
    - ☐ Hoyer lifts
    - ☐ Sit-stand lifts
9. Are they maintained in a sanitary condition? How often are they cleaned?
10. What is the system to determine that employees comply with the establishment's policies/procedures? Who is responsible for compliance with the system?
11. Have there been recent changes in policies/procedures? What effect have they had (positive or negative) on injuries and illnesses?
12. How and when would employees report injuries?
13. What are the processes to ensure that disorders are identified and treated early to prevent the occurrence of more serious problems?
14. Does the process include restricted or accommodated work assignments?

Slips, Trips, and Falls:

1. What are the policies/procedures to ensure that passageways/aisles are kept free of clutter?
2. What are the policies/procedures used to deal with wet surfaces?
3. What type of signs/barriers are used to alert employees to wet floors?
4. What requirements does the establishment have in terms of footgear?
5. What type of coated surfaces or no-skid waxes are used to enhance surface friction?

Bloodborne Pathogens:

1. Which tasks performed by the employees involve occupational exposure to blood and OPIM? How many hours per week are they performing these tasks?
2. Which procedures require the use of a sharp medical device?
3. Have there been any recent needlestick incidents?
4. Is the establishment using sharps with engineered sharps injury protection and needleless systems?
5. Are there any tasks where regular sharps are still being used? Would a safer device compromise patient safety or the outcome of a medical procedure?
6. Do your employees have input in the selection of safer devices?

7. What type of PPE do your employees wear? In what ways does it differ across tasks?
8. Do your employees ever express a concern for PPE availability?
9. Describe regulated waste disposal policies/procedures/devices.
10. Describe the policies and procedures for handling residents' laundry.
11. Describe availability of hand washing facilities/ skin cleansers (i.e., alcohol gels).
12. What is the policy for reporting/cleaning spills or contaminated materials, specifically for spills of blood or other body fluids?
13. What type of disinfectant is used to clean contaminated work surfaces?
14. Is the Hepatitis B vaccination series made available to employees within 10 days of their initial assignment?
15. If employees decline the vaccination, do you ask for vaccination records to confirm their vaccination status?
16. Are employees offered an anti-body test?
17. What are the procedures for reporting an exposure incident?
18. What post-exposure services are provided?
19. Describe the bloodborne pathogens training given to employees.
20. Do you use a computer program for bloodborne pathogens training? If so, how long have you been using this program?

Tuberculosis:

1. Has the establishment had a suspected or confirmed TB case? If so, when did the most recent suspected or confirmed case occur?
2. What procedures are in place to isolate and manage the care of a resident with suspected or confirmed TB?
3. Does the establishment offer tuberculin skin tests for employees responsible for resident care?

Workplace Violence:

1. Has there been any trouble with residents assaulting caretakers or other employees?
2. Have any procedures, controls or environmental design features been initiated to minimize workplace violence?
3. Do you have a workplace violence program?
4. Do you provide training to the employees on workplace violence prevention (i.e.; risk factors, diffusing a situation, procedures to follow)?

The following questions should only be considered during comprehensive inspections or those inspections where they could be included as plain sight hazards or otherwise allowed per guidance in the FOM regarding partial scope inspections (FOM Chapters 8 and 9).

MRSA:

1. Has the establishment had a suspected or confirmed MRSA case? If so, when did the most recent suspected or confirmed case occur?
2. What procedures are in place to isolate and manage the care of a resident with suspected or confirmed MRSA?

Hazard Communication:

1. Do you provide hazard communication training to your employees?
2. Where are the Material Safety Data Sheets (MSDS) or Safety Data Sheets (SDS) kept?
3. Do you have a hazard communication program and if so, where is it located?
4. How many hours per week are your employees performing tasks involving chemicals (not counting medications)?

Appendix E – Sample Employee Interview Questionnaire.

NOTE*: This is not a required Questionnaire Form to be inserted into the case file and is not comprehensive of all situations that may be encountered during an inspection. It is strictly intended as an investigatory aid for the CSHO.*

**An electronic version of this Questionnaire Form is available under Forms on the FIS.*

Employee name: Job title:

Address: Years of service: Years in industry:

Phone number:

Ergonomics:

1. What training on ergonomics or resident handling/lifting have you received?
2. What are the dangers of resident handling/lifting?
3. What types of employee injuries can occur?
4. What is the system for identifying and analyzing ergonomic hazards?
5. What are the establishment's policies/procedures to reduce ergonomic risk factors associated with resident handling?
6. Who determines methods that are used to lift residents?
7. How is resident mobility determined?
8. How are decisions made when to use lift assists and under what conditions are manual lifts performed?
9. Do you have input in the development of the establishments lifting procedures?
10. What type of lift assists are available?
    - ☐ Slings
    - ☐ Double handled gait belts
    - ☐ Slip sheets/draw sheets
    - ☐ Pivot transfer devices
    - ☐ Hoyer lifts
    - ☐ Sit-stand lifts
11. Are they maintained in a sanitary condition? How often are they cleaned?
12. Is there a sufficient quantity and variety of lift assist devices available? Are there enough slings for the lift assist devices?
13. What is the system to determine that you and other employees comply with the establishment's policies/procedures? Who is responsible for compliance with the system?
14. Have there been recent changes in policies/procedures? What effect have they had (positive or negative) on injuries and illnesses?
15. Do you believe the current policies/procedures for lifting are appropriate/effective for reducing injuries?
16. How and when would you report an injury?

Slips, Trips, and Falls:

1. What are the policies/procedures to ensure that passageways/aisles are kept free of clutter?
2. What are the policies/procedures that are used to deal with wet surfaces?
3. What types of signs/barriers are used to alert you and other employees to wet floors?
4. What requirements does the establishment have in terms of footgear?
5. What types of coated surfaces or no-skid waxes are used to enhance surface friction?

Bloodborne Pathogens:

1. Which tasks do you perform that involve occupational exposure to blood and other OPIM? How many hours per week are you performing these tasks (shaving residents with a razor would be included)?
2. Which procedures require the use of a sharp medical device?
3. Have there been any recent needlestick incidents?
4. Is the establishment using sharps with engineered sharps injury protection and needleless systems?
5. Are there any tasks where regular sharps are still being used? Would a safer device compromise patient safety or the outcome of a medical procedure?
6. Did you or other employees have input in the selection of safer devices?
7. What types of PPE do you wear? In what ways does it differ across tasks?
8. Do you have problems with PPE availability?
9. Describe regulated waste disposal policies/procedures/devices.
10. Do you wash residents' laundry? If so, describe the policies and procedures for handling and cleaning residents' laundry.
11. Describe availability of hand washing facilities/skin cleansers (i.e., alcohol gels).
12. What is the policy for reporting/cleaning spills or contaminated materials, specifically for blood spills or other body fluids?
13. What type of disinfectant is used to clean contaminated work surfaces?
14. Was the Hepatitis B vaccination series made available to you within 10 days of your initial assignment? If so, did you accept or decline the vaccination? If you declined, were your shot records requested?
15. Have you had the complete vaccination series?
16. Did you pay for the vaccination?
17. Were you required to obtain the vaccination on your own time or company time?
18. Are employees offered an anti-body test?
19. What are the procedures for reporting an exposure incident? (You may propose the scenario where an employee experiences a needlestick incident or blood being splashed into the mouth/nose/eyes)
20. What post-exposure medical services does your employer make available to you?
21. What are some examples of bloodborne pathogens?
22. What bodily fluids can be potentially infectious?
23. What are the routes of exposure for employees?
24. Are you familiar with the bloodborne pathogens standard, 29 CFR 1910.1030, and were you given access to a copy of the standard?
25. What is an Exposure Control Plan?
26. Where is the establishment's copy kept?
27. How would you obtain a copy of it if you wanted one?
28. Describe the hepatitis vaccine and its efficacy, safety, method of administration, and benefits of being vaccinated.
29. When was your last training session? Was there an opportunity for interactive questions and answers with the person conducting the training?

Tuberculosis

1. Has the establishment had a suspected or confirmed TB case? If so, when did the most recent suspected or confirmed case occur?
2. What procedures are in place to isolate and manage the care of a resident with suspected or confirmed TB?
3. Does the establishment offer tuberculin skin tests for employees responsible for resident care?

Workplace Violence

1. Has there been any trouble with residents assaulting caretakers or other employees?
2. Have any procedures, controls or environmental design features been initiated to minimize workplace violence?
3. Does your employer have a workplace violence program?
4. Have you been provided training on workplace violence prevention (i.e.; risk factors, diffusing a situation, procedures to follow)?

The following questions should only be considered during comprehensive inspections or those inspections where they could be included as plain sight hazards or otherwise allowed per guidance in the FOM regarding partial scope inspections (FOM Chapters 8 and 9).

MRSA:

1. Has the establishment had a suspected or confirmed MRSA case? If so, when did the most recent suspected or confirmed case occur?
2. What procedures are in place to isolate and manage the care of a resident with suspected or confirmed MRSA?

Hazard Communication

1. What chemicals do you used as part of your daily job tasks?
2. How many hours per week are you performing tasks involving chemicals (not counting medications)?
3. Have you had any hazard communication training?
4. Do you know what a MSDS or a SDS is and where they are kept?
5. Do you know where the hazard communication program is located?