

HIOSH DIRECTION

DIRECTIVE NO.: DIR 2021-02 (CPL02)	EFFECTIVE DATE: July 25, 2021 Revised: October 1, 2021
SUBJECT: Inspection Procedures for the COVID-19 Emergency Temporary Standard	

This CPL is adopted in its entirety on July 25, 2021. This CPL was revised due to HIOSH's adopting of DIR 2021-03 – Revised National Emphasis Program – Coronavirus Disease 2019 (COVID-19).

Clarifications: For the purposes of this OSHA Program Directive adopted by HIOSH, the following terms are defined:

Where the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) refers to the following terms, positions, or locations; for HIOSH, their equivalent will be:

11(c) of the OSHA Act: Section 8(e) of the Hawaii Revised Statutes (HRS).

1904: As incorporated and amended in section §12-52.1, Hawaii Administrative Rules (HAR)

1910: As incorporated and amended in section §12-60, Hawaii Administrative Rules (HAR)

Area Director: HIOSH Administrator or designated representative

Compliance Safety and Health Officer(s) (CSHO/CSHOs): Environmental Health Specialist(s) (EHS/EHS') and Occupational Safety & Health Compliance Officer(s) (OSHCO/OSHCOs)

Emergency Temporary Standard (ETS): HIOSH Emergency Temporary Standard (ETS) section §12-60-51, Hawaii Administrative Rules (HAR) adopted July 25, 2021.

Federal Register, 86 FR 32376, 29 CFR § 1910, Emergency Temporary Standard for COVID-19; Final Rule, June 21, 2021./29 C.F.R. Subpart U/§1910.502, 1910.504, 1910.505, or 1910.509: As adopted under the HIOSH Emergency Temporary Standard (ETS) section §12-60-51, Hawaii Administrative Rules (HAR) issued July 25, 2021.

Medical Access Order (MAO) Request Application/Office of Occupational Medicine and Nursing (OOMN: HIOSH procedures for Medical Access Orders (MAO) managed by the Occupational Health Branch Manager.

OSHA (Including Regional and Area Offices): Hawaii Occupational Safety & Health (HIOSH) Enforcement/Compliance and Consultation & Training sections, located at 830 Punchbowl Street, Room 425, Honolulu, Hawaii 96813

OSHA Instruction, CPL 02-00-158, Inspection Procedures for the Respiratory Protection Standard, June 26, 2014: HIOSH CPL 02-00-158, Inspection Procedures for the Respiratory Protection Standard, May 1, 2016.

OSHA Instruction, CPL 02-00-164, Field Operations Manual (FOM), April 14, 2020: HIOSH CPL 02-00-159, Field Operations Manual (FOM), April 15, 2016 (or successor directive)

Occupational Safety and Health Act of 1970 (Act): Chapter 396, Hawaii Revised Statutes, Occupational Safety and Health Law.

Supervisor(s): HIOSH Occupational Safety and/or Health and/or Consultation and Training Branch Manager and/or the Safety Supervisor

References: Directive references adopted by HIOSH can be found at <http://labor.hawaii.gov/hiosh/guidelines/directives/>.

Contact: Nicole Bennett, Program Specialist, HIOSH Administration & Technical Support Branch. 830 Punchbowl St, Rm 425, Honolulu, HI 96813.

By and Under the Authority of

**Norman Ahu
HIOSH Administrator**



OSHA DIRECTION

U.S. DEPARTMENT OF LABOR

Occupational Safety and Health Administration

DIRECTIVE NUMBER: DIR 2021-02 (CPL 02) | **EFFECTIVE DATE:** June 28, 2021

SUBJECT: Inspection Procedures for the COVID-19 Emergency Temporary Standard

ABSTRACT

Purpose: This Direction establishes inspection procedures and enforcement policies for the COVID-19 Emergency Temporary Standard, 29 CFR § 1910.502, and 29 CFR § 1910.504.

Scope: This Direction applies OSHA-wide.

References: [Presidential Executive Order on Protecting Worker Health and Safety](#), January 21, 2021.

Federal Register, 86 FR 32376, 29 CFR § 1910, *Emergency Temporary Standard for COVID-19; Final Rule*, June 21, 2021.

OSHA Instruction, [CPL 02-00-164](#), *Field Operations Manual (FOM)*, April 14, 2020.

OSHA Instruction, [CPL 02-00-158](#), *Inspection Procedures for the Respiratory Protection Standard*, June 26, 2014.

OSHA Direction, [DIR 2021-01 \(CPL-03\)](#), *National Emphasis Program – Coronavirus Disease 2019 (COVID-19)*, March 12, 2021 (or successor directive).

(See Section III for additional references.)

Cancellations: None.

State Impact: Notice of intent required. States are expected to have accessible enforcement policies and procedures in place which are at least as effective as those in this Direction.

Action Offices: OSHA National, Regional and Area Offices, and On-Site Consultation Programs.

Originating Office: Directorate of Enforcement Programs

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By and Under the Authority of

James S. Frederick
Acting Assistant Secretary

Executive Summary

In response to the [Presidential Executive Order on Protecting Worker Health and Safety, January 21, 2021](#), the Occupational Safety and Health Administration (OSHA) considered and determined that additional measures could be taken to prevent occupational exposures to SARS-CoV-2 and the spread of the resulting disease, COVID-19, that results in illnesses and death. OSHA examined, among other things, COVID-19 inspection and violation history, worker complaints and Hazard Alert Letters (HALs) issued, and petitions from stakeholders requesting that OSHA issue an ETS, and determined that specific requirements aimed at controlling COVID-19 hazards in the healthcare industry, *i.e.*, beyond the general duty clause, would improve worker protections.

Thus, OSHA issued an emergency temporary standard (ETS) to protect healthcare workers from occupational exposure to COVID-19. The ETS was published in the Federal Register on June 21, 2021, and became effective the same day. The ETS has multiple sections – healthcare (29 CFR § 1910.502), mini respiratory protection program (29 CFR § 1910.504), severability (29 CFR § 1910.505), and incorporation by reference (29 CFR § 1910.509).

During the period of the ETS, covered healthcare employers must develop and implement a COVID-19 plan to identify and control COVID-19 hazards in the workplace. As part of their COVID-19 plan, these employers must address and implement various requirements to reduce transmission of COVID-19 in their workplaces, including patient and non-employee screening and management requirements, standard and transmission-based precautions, controls for aerosol-generating procedures, physical distancing, physical barriers, personal protective equipment (PPE), cleaning and disinfection, ventilation, employee health screening and medical management, vaccination, training, anti-retaliation, recordkeeping, and reporting.

This new Directive establishes OSHA’s field inspection and enforcement procedures designed to ensure uniformity in enforcing the ETS when addressing workplace exposures to SARS-CoV-2, the virus that causes COVID-19 disease.

Significant Changes

Not applicable. This is a new enforcement program.

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[Appendix C: Additional Guidance for Determining Medical Removal Benefits](#)

I. Purpose.

The purpose of this Direction is to provide guidelines and establish uniform inspection and enforcement procedures for the (COVID-19 emergency temporary standard, hereafter referred to as the ETS. The two main sections of the ETS, 29 CFR § 1910.502 and 29 CFR § 1910.504, published in the *Federal Register*, became effective on June 21, 2021. Compliance with most provisions is required by July 6, 2021, and with training, ventilation, and barrier provisions by July 21, 2021.

II. Scope.

This Direction applies OSHA-wide.

III. References.

- A. Presidential Executive Order on Protecting Worker Health and Safety, January 21, 2021, www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-protecting-worker-health-and-safety.
- B. Federal Register, 86 FR at 32376, 29 CFR § 1910, *Emergency Temporary Standard for COVID-19; Final Rule*, June 21, 2021, <https://www.govinfo.gov/content/pkg/FR-2021-06-21/pdf/2021-12428.pdf>
- C. OSHA Instruction, CPL 02-00-164, *Field Operations Manual (FOM)*, April 14, 2020, www.osha.gov/enforcement/directives/cpl-02-00-164.
- D. OSHA Instruction, CPL 02-00-158, *Inspection Procedures for the Respiratory Protection Standard*, June 26, 2014, www.osha.gov/enforcement/directives/cpl-02-00-158.
- E. OSHA Instruction, CPL 02-02-078, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis*, June 30, 2015, www.osha.gov/enforcement/directives/cpl-02-02-078.
- F. OSHA Direction, DIR 2021-01 (CPL-03), *National Emphasis Program – Coronavirus Disease 2019 (COVID-19)*, March 12, 2021 (or successor directive), www.osha.gov/enforcement/directives/dir-2021-01cpl-03.
- G. OSHA Instruction, CPL 02-02-072, *Rules of agency practice and procedure concerning OSHA access to employee medical records*, August 22, 2007, www.osha.gov/enforcement/directives/cpl-02-02-072.
- H. OSHA Instruction, ADM 04-00-003, *Safety and Health Management System*, May 6, 2020, www.osha.gov/enforcement/directives/adm-04-00-003.
- I. CDC, *Hospital Preparedness Checklist*, www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.

- J. CDC, *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*, www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.
- K. CDC, *How to Wash Masks*, www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-wash-cloth-face-coverings.
- L. CDC, *Cleaning and Disinfecting Your Facility*, www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.
- M. CDC, *Symptoms of COVID-19*, www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.
- N. CDC, *Healthcare Facilities: Managing Operations During the COVID-19 Pandemic*, www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.
- O. CDC, *Burn Rate Calculator*, www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.
- P. Food and Drug Administration (FDA), *Emergency Use Authorization (EUA) for Respiratory Protection Equipment*, www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas#respirators.
- Q. FDA, *Umbrella EUA for Surgical Masks*, www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas#appendixasurgicalmasks.
- R. FDA, *Face Masks, Including Surgical Masks, and Respirators for COVID-19*, www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/face-masks-including-surgical-masks-and-respirators-covid-19.
- S. FDA, *Authorized Surgical Masks and Surgical Masks Removed from Appendix A*, www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas#appendixaremoved.
- T. CDC, *NIOSH-Approved Particulate Filtering Facepiece Respirators*, www.cdc.gov/niosh/npptl/topics/respirators/disp_part.
- U. CDC, *Counterfeit Respirators / Misrepresentation of NIOSH-Approval*, www.cdc.gov/niosh/npptl/usernotices/counterfeitResp.
- V. See 29 CFR § 1910.509 for additional guidelines and standards incorporated by reference. These guidelines and standards are also listed on the following webpage: www.osha.gov/coronavirus/ets/ibr.

IV. Cancellations.

None.

V. Action Offices.

A. Responsible Office.

Directorate of Enforcement Programs (DEP), Office of Health Enforcement (OHE).

B. Action Offices.

National, Regional and Area Offices, State Plan and OSHA On-Site Consultation programs.

C. Information Offices.

OSHA National Office.

VI. Federal Program Change.

Notice of Intent and Equivalency Required. This Direction describes a federal program change that updates OSHA's field inspection and enforcement procedures designed to ensure uniformity in enforcing the ETS when addressing workplace exposure to SARS-CoV-2, the virus that causes COVID-19 disease. State Plans have the option of adopting identically or of adopting different, but at least as effective, enforcement policies as those contained in this Direction. State Plans must provide for their own comparable internal administrative procedures and processes.

Within 15 days of the effective date of this Direction, a State Plan must submit a notice of intent indicating whether the State Plan will adopt or already has in place policies and procedures that are identical to or different from the federal program. State adoption, either identical or different, should be accomplished within 30 days. Under OSHA's regulation for Federal Program changes at 29 CFR 1953.4(b)(5), the date for adopting Federal Program changes is generally six months from the date of notification, but the Assistant Secretary may determine that the nature or scope of the change requires a different time frame. OSHA's Assistant Secretary has determined that the nature of OSHA's ETS requires that State Plans adopt this Direction within 30 days.

If adopting identically, the State Plan must provide the date of adoption to OSHA within 60 days of adoption. If the State Plan adopts or maintains policies that differ from those in this Direction, the policies must be available for review. Within 60 days of adoption, the State Plan must provide OSHA with an electronic copy of the policies or a link to where their policies are posted on the State Plan's website. The State Plan must also provide the date of adoption and identify differences, if any, between their policies and OSHA's. OSHA will provide summary information on the State Plan responses to this Direction on its website at: www.osha.gov/dcsp/osp.

VII. Expiration.

This Direction is effective for no more than 12 months from the effective date of the *Emergency Temporary Standard for COVID-19; Final Rule*, June 21, 2021, unless canceled or extended by a superseding directive.

VIII. Significant Changes.

N/A.

VIII. Background.

The World Health Organization declared the COVID-19 pandemic on March 11, 2020. COVID-19 has killed over 600,000 people in the United States in barely over a year, and infected millions more, and the impact of this new illness has been borne disproportionately by the healthcare and healthcare support workers tasked with caring for those infected by this disease. Nearly 500,000 healthcare workers have contracted COVID-19, and more than 1,600 of those workers have died.

Exposures may depend on a variety of factors including the physical environment of the workplace, the type of work activity, the health and vaccination status of the worker, the ability of workers to wear facemasks and abide by current CDC guidelines, and the need for close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with any person, including those known to have or suspected of having COVID-19, and those who may be infected with—and able to spread—SARS-CoV-2 without knowing it. Workers face a particularly elevated risk of exposure to SARS-CoV-2 in settings where patients with suspected or confirmed COVID-19 receive treatment or where patients with undiagnosed illnesses come for treatment (*e.g.*, emergency rooms, urgent care centers), especially when providing care or services directly to those patients. Other factors, such as conditions in communities where employees live and work, their activities outside of work, and individual health conditions, may also affect workers' risk of getting COVID-19 and/or developing complications from the illness.

OSHA and several public health agencies have developed recommendations to assist employers in preparing their workplaces to minimize transmission of the virus. On April 13, 2020, OSHA issued an [Interim Enforcement Response Plan for COVID-19](#) as a first step at establishing an emphasis on very high- and high-risk workplaces. Subsequently, on [May 19, 2020](#), and [March 12, 2021](#), Updated Interim Enforcement Response Plans for COVID-19 were issued. Soon after the issuance of this ETS CPL, OSHA expects to issue a further update to its interim enforcement response plan, pursuant to the ETS.

In addition, per the [Presidential Executive Order on Protecting Worker Health and Safety, January 21, 2021](#), OSHA developed and implemented a National Emphasis Program (NEP) for COVID-19, [DIR 2021-01 \(CPL-03\)](#), that became effective March 12, 2021. Soon after the issuance of this ETS CPL, OSHA expects to issue a revised NEP, pursuant to the ETS, and which will remain in effect for one year unless canceled or extended by a superseding directive. Under the NEP, OSHA is prioritizing COVID-19-related inspections involving deaths or multiple hospitalizations due to occupational exposures to

COVID-19. This NEP includes the added focus of ensuring that workers are protected from retaliation.

The Presidential Order also directed OSHA to consider issuing an ETS for COVID-19. OSHA considered and determined that healthcare workers face a grave danger from COVID-19 and the requirements of the ETS were necessary to protect these workers. The ETS was issued on [June 21, 2021](#). This directive provides instructions and guidance to Area Offices and compliance safety and health officers (CSHOs) for enforcing the COVID-19 ETS.

IX. Inspection Procedures.

A. Scope and Application.

The ETS establishes new requirements to protect healthcare and healthcare support workers across the nation from COVID-19.

With some exceptions, the Healthcare COVID-19 ETS, 29 CFR § 1910.502, applies to all settings where any employee provides healthcare services or healthcare support services.

29 CFR § 1910.502 does not apply to the following tasks and locations:

1. the provision of first aid by an employee who is not a licensed healthcare provider;
2. the dispensing of prescriptions by pharmacists in retail settings;
3. non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;
4. well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;
5. home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present;
6. healthcare support services not performed in a healthcare setting where direct patient care occurs (*e.g.*, off-site laundry, off-site medical billing);
or
7. telehealth services performed outside of a setting where direct patient care occurs.

The applicability of 29 CFR § 1910.502 is also limited in the following situations:

1. Where a healthcare setting is embedded within a non-healthcare setting (*e.g.*, medical clinic in a manufacturing facility, walk-in clinic in a retail setting), this section applies only to the embedded healthcare setting and not to the remainder of the physical location.

2. Where emergency responders or other licensed health care providers enter a non-healthcare setting to provide health care services, this section applies only to the provision of the healthcare services by those emergency responders or other health care providers. For example, if an unvaccinated nurse provides in-home healthcare while an electrician happens to be working separately in the house, the ETS applies to the nurse's activities but not those of the electrician.
3. In well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present, paragraphs (f), (h), and (i) of this section do not apply to employees who are fully vaccinated.

Notes to paragraphs (a)(2)(iv) and (a)(2)(v):

1. OSHA does not intend to preclude employers of employees who are unable to be vaccinated from falling within the scope exemption in paragraphs (a)(2)(iv) and (a)(2)(v). Under anti-discrimination laws, workers who cannot be vaccinated because of medical conditions, such as allergies to vaccine ingredients, or certain religious beliefs, may ask for a reasonable accommodation from their employer. Accordingly, where an employer reasonably accommodates an employee who is unable to be vaccinated in a manner that does not expose the employee to COVID-19 hazards (*e.g.*, telework, working in isolation), that employer may be within the scope exemption in paragraphs (a)(2)(iv) and (a)(2)(v).
2. Nothing in these sections is intended to limit state or local government mandates or guidance (*e.g.*, executive order, health department order) that go beyond the requirements of and are not inconsistent with these sections.
3. Employers exempted under paragraph (a) of the ETS are encouraged to follow public health guidance from the Centers for Disease Control and Prevention (CDC) even when not required by this section.
4. 29 CFR § 1910.502(l)(5)(iii) – (l)(5)(iv) and (q)(2)-(q)(3) do not apply where the employer has 10 or fewer employees on the effective date of the ETS. Although the number of employees may change after the effective date of the ETS, the number of employees on the effective date determines the employer's compliance obligations for the duration of the ETS.

The size of the employer is based on the total number of employees for the company nationwide and not per establishment. All individuals who are "employees" under the OSH Act are counted in the total; the count includes all full-time, part-time, temporary, and seasonal employees. For businesses that are sole proprietorships or partnerships, the owners and partners would not be considered employees and would not be counted. Other individuals who are not considered to be employees under the OSH Act are uncompensated volunteers, except for those working in a federal agency (*see* [29 CFR 1975.4\(b\)\(2\)](#), and [66 Fed. Reg. 5916, 6038](#)).

5. The Mini Respiratory Protection Program, 29 CFR § 1910.504, applies

only to respirator use in accordance with § 1910.502(f)(4)(i) and (ii). See corresponding sections in this Direction.

6. The ETS includes provisions to ensure employees are aware of their rights under the standard, and that they are protected from retaliation for exercising those rights.

B. Definitions.

Some terms used in the preamble and regulatory text of the respective standard are presented below.

1. Aerosol-generating procedure means a medical procedure that generates aerosols that can be infectious and are of respirable size. For the purposes of this section, only the following medical procedures are considered aerosol-generating procedures: open suctioning of airways; sputum induction; cardiopulmonary resuscitation; endotracheal intubation and extubation; non-invasive ventilation (e.g., BiPAP, CPAP); bronchoscopy; manual ventilation; and medical/surgical/postmortem procedures using oscillating bone saws; and dental procedures involving: ultrasonic scalers; high-speed dental hand-pieces; air/water syringes; air polishing; and air abrasion.
2. Airborne infection isolation room (AIIR) means a dedicated negative pressure patient-care room, with special air handling capability, which is used to isolate persons with a suspected or confirmed airborne-transmissible infectious disease. AIIRs include both permanent rooms and temporary structures (e.g., a booth, tent or other enclosure designed to operate under negative pressure).
3. Ambulatory care means healthcare services performed on an outpatient basis, without admission to a hospital or other facility. These services are provided in settings such as: offices of physicians and other health care professionals; hospital outpatient departments; ambulatory surgical centers; specialty clinics or centers (e.g., dialysis, infusion, medical imaging); and urgent care clinics. Ambulatory care does not include home healthcare settings for the purposes of this section.
4. Clean/cleaning means the removal of dirt and impurities, including germs, from surfaces using soap and water or other cleaning agents. Cleaning reduces germs on surfaces by removing contaminants and may also weaken or damage some of the virus particles, which decreases risk of infection from surfaces.
5. Close contact means being within 6 feet of any other person for a cumulative total of 15 minutes or more over a 24-hour period during that person's potential period of transmission. The potential transmission period starts 2 days before the person feels sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated.

6. Common areas means indoor or outdoor locations under the control of the employer that more than one person may use or where people congregate (e.g., building lobbies, reception areas, waiting rooms, restrooms, break rooms, eating areas, conference rooms).
7. COVID-19 (Coronavirus Disease 2019) means the respiratory disease caused by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). For clarity and ease of reference, this section refers to “COVID-19” when describing exposures or potential exposures to SARS-CoV-2.
8. COVID-19 positive and confirmed COVID-19 refer to a person who has a confirmed positive test for, or who has been diagnosed by a licensed healthcare provider with, COVID-19.
9. COVID-19 symptoms mean the following: fever or chills; cough; shortness of breath or difficulty breathing; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.
10. COVID-19 test means a test for SARS-CoV-2 that is cleared or approved by the U.S. Food and Drug Administration (FDA) or is authorized by Emergency Use Authorization (EUA) or Notification from the FDA to diagnose current infection with the SARS-CoV-2 virus; and administered in accordance with the FDA clearance or approval or the FDA EUA as applicable.
11. Direct patient care means hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring.
12. Disinfect/disinfection means using an EPA-registered disinfectant on EPA’s “List N,” (incorporated by reference, 29 CFR § 1910.509), in accordance with manufacturers’ instructions to kill germs on surfaces.
13. Facemask means a surgical, medical procedure, dental, or isolation mask that is FDA cleared, authorized by an FDA Emergency Use Authorization (EUA), or otherwise offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as “medical procedure masks.”
14. Fully vaccinated means 2 weeks or more following the final dose of a COVID-19 vaccine.
15. Hand hygiene means the cleaning and/or disinfecting of one’s hands by using standard handwashing methods with soap and running water or an alcohol-based hand rub that is at least 60% alcohol.
16. Healthcare services mean services that are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency medical personnel, oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health. Healthcare services are delivered through various means including: hospitalization, long-term care, ambulatory care (e.g., treatment in physicians’ offices, dentists’

offices, medical clinics), home health and hospice care, emergency medical response, and patient transport. For the purposes of this section, healthcare services include autopsies.

17. Healthcare support services mean services that facilitate the provision of healthcare services. Healthcare support services include patient intake/admittance, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/reprocessing services.
18. High-touch surfaces and equipment means any surface or piece of equipment that is repeatedly touched by more than one person (e.g., doorknobs, light switches, countertops, handles, desks, tables, phones, keyboards, tools, toilets, faucets, sinks, credit card terminals, touch-screen enabled devices).
19. Physical location means a site (including outdoor and indoor areas, a structure, or a group of structures) or an area within a site where work or any work-related activity (e.g., taking breaks, going to the restroom, eating, entering, or exiting work) occurs. A physical location includes the entirety of any space associated with the site (e.g., workstations, hallways, stairwells, breakrooms, bathrooms, elevators) and any other space that an employee might occupy in arriving, working, or leaving.
20. Respirator means a type of personal protective equipment that is certified by the National Institute for Occupational Safety and Health (NIOSH) under 42 CFR part 84 or is authorized under an Emergency Use Authorization (EUA) by the FDA. Respirators protect against airborne hazards by removing specific air contaminants from the ambient (surrounding) air or by supplying breathable air from a safe source. Common types of respirators include filtering facepiece respirators, elastomeric respirators, and powered air-purifying respirators (PAPRs). Face coverings, facemasks, and face shields are not respirators.
21. Screen means asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19.
22. Surgical mask means a mask that covers the user's nose and mouth and provides a physical barrier to fluids and particulate materials. The mask meets certain fluid barrier protection standards and Class I or Class II flammability tests. Surgical masks are generally regulated by FDA as Class II devices under 21 CFR § 878.4040 – Surgical apparel.
23. Vaccine means a biological product authorized or licensed by the FDA to prevent or provide protection against COVID-19, whether the substance is administered through a single dose, or a series of doses.

C. General Inspection Procedures.

1. Inspection procedures in [FOM Chapter 3](#) shall be followed, except as modified in this Direction. CSHOs should also consult other OSHA

directives, *e.g.*, [National Emphasis Program – Coronavirus Disease 2019 \(COVID-19\)](#) (or successor directive); [OSHA Field Safety and Health Manual, ADM 04-00-003](#); and other interim guidance, unless superseded, such as the [Updated Interim Enforcement Response Plan for COVID-19](#), and references cited in this Direction for further guidance. Inspections shall be conducted using either on-site or a combination of on-site and remote methods, except under circumstances where an on-site inspection cannot be conducted safely. In such cases, Area Offices will document the unsafe condition(s) preventing an on-site inspection and with Area Director (AD) approval, an alternate inspection process may be used so that the inspection can be done safely within the context of the situation.

2. Inspection Scheduling. In most cases, in accordance with the FOM, the highest inspection priority should be given to fatality inspections, and then to other unprogrammed inspections (*i.e.*, complaints and referrals) alleging employee exposure to COVID-19 related hazards. Programmed inspections are to be conducted as described in the COVID-19 NEP. Area Offices may schedule follow-up inspections related to COVID-19 hazards that contribute to meeting the goals of the NEP.
 - a. Expansion of inspections to areas involving occupational exposures to SARS-CoV-2 should be performed when information/evidence gathered or plain-view observations indicate deficiencies complying with OSHA requirements set forth in 29 CFR § 1910.502 and 29 CFR § 1910.504.
3. Opening Conference. CSHOs shall request to speak to the employer's representative or safety director, COVID-19 safety coordinator(s), infection control director, and other persons responsible for implementing COVID-19 protections or occupational health hazard control. Other individuals responsible for providing records pertinent to the inspection should also be included in the opening conference or interviewed early in the inspection (*e.g.*, facility administrator, training director, facilities engineer, director of nursing, human resources). Also, designated employee representatives and union officials, may participate in the opening conference and may accompany CSHOs during the inspection (*see also*, [FOM, Chapter 3](#), describing CSHO authority to ensure fair and orderly inspections).
4. CSHO Safety. Inspections shall be conducted in a manner that ensures the CSHO's safety, especially CSHOs not protected by vaccination, and that of all personnel with whom they come in close contact. This includes instituting all appropriate precautions for physical distancing, PPE use, and hygiene. When on site, CSHOs must take other necessary precautions, such as requesting to conduct opening conferences in a designated, uncontaminated administrative area or outdoors, while always wearing at least a N95 Filtering Facepiece Respirator, in accordance with

the most recent [Updated Interim Enforcement Response Plan for COVID-19](#) (and any Regional policies) and other necessary PPE (*e.g.*, gloves, eye protection). Note that OSHA's internal policies relative to CSHO protections during inspections may be updated based on current CDC guidance and COVID-19 vaccination status. See also, [Section XIV](#), Protection of OSHA Personnel of this Direction, for more information.

5. If an inspection is conducted under the COVID-19 NEP, the CSHO shall initially verify the correct North American Industrial Classification System (NAICS) code for the establishment with the employer and determine whether work practices conducted at the facility or worksite are exempted under the standard.

Verifying exemptions under 29 CFR § 1910.502(a):

- a. Determine if any of the exemptions outlined in sections 29 CFR § 1910.502(a) apply to the whole facility or to well-defined portions thereof. A well-defined portion of the facility could be an entire department (*e.g.*, radiology unit) or a section of a building (*e.g.*, room, floor, wing). An employer whose workforce is fully vaccinated with no reasonable expectation that any person with suspected or confirmed COVID-19 will be permitted entry does not have to comply with paragraphs (f), (h) and (i) of 29 CFR § 1910.502. CSHOs may verify the employer's assertions by interviewing employee(s) at the site regarding their vaccination status. If available, CSHOs may also request documentation that further supports the employees' vaccination status. A previously exempt area should be re-evaluated upon hiring of any new, unvaccinated employees.

NOTE: Where the only employees who are not vaccinated cannot be vaccinated because of medical conditions or certain religious beliefs, the employer may still be (partially) exempt from the requirements of the standard if they provide reasonable accommodations. The reasonable accommodation must be accomplished in such a manner that does not expose unvaccinated employees to COVID-19 hazards: *e.g.*, through telework, solitary work, or implementation of controls only in an area exclusively dedicated to unvaccinated employees.

- b. CSHOs should request the establishment's Injury and Illness Logs (OSHA 300, 301 and OSHA 300A) for calendar years 2020 and 2021 to identify work-related cases of COVID-19. Document whether any such cases were entered on the log. CSHOs should also request the COVID-19 log and inquire whether employees are aware of any recent COVID-19 cases among fellow employees.
- c. In cases involving programmed COVID-19 NEP inspections, and CSHOs verify that the employer is exempt from the standard based on any of the provisions in section 29 CFR § 1910.502(a)(2); (a)(3)

and (a)(4), **and** where there is an absence of recent or active work-related COVID-19 infections, CSHOs should document such findings, discontinue the inspection and exit the facility. The inspection shall be marked NO INSPECTION. However, pursuant to the COVID-19 NEP, if the inspection was initiated by an unprogrammed or follow-up activity, or the establishment is targeted under another NEP, or the Site-Specific Targeting (SST) Program, and/or a local or regional emphasis program, then the CSHO should proceed with the inspection in order to address any additional hazards alleged or those covered by another emphasis program.

NOTE: The exemptions and limited exceptions outlined in the ETS section (a), Scope and Application, do not apply if the establishment is not fully compliant with the terms of the particular exemption or exception (e.g., a non-hospital ambulatory care setting that screens but permits entry to suspected or confirmed COVID-19 visitors, patients, or residents is covered by the ETS.) In such cases, an employer may be cited for any deficiencies under this standard.

6. Program and Document Review. All COVID-19-related inspections should include a review of the employer's COVID-19 plan and related documents, and interviews with employers and employees. CSHOs should make the following assessments:
 - a. Determine whether the employer has a written COVID-19 plan (or elements thereof) which may be part of a safety and health plan that includes contingency planning for emergencies and natural disasters. For example, in healthcare, the employer should already have a pandemic plan, as recommended by the CDC.¹ If the COVID-19 plan is a part of another emergency preparedness plan, conduct a limited review of sections related to SARS-CoV-2 exposure(s).
 - b. Review evidence or documentation that a hazard assessment was conducted.
 - c. Determine whether the employer has established administrative and engineering control measures to facilitate physical distancing (e.g., barriers or administrative measures to encourage 6-foot distancing).
 - d. Review information such as medical records related to worker exposure incident(s), OSHA-required recordkeeping, and any other pertinent information or documentation deemed appropriate by the

¹ For hospitals, see www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.

CSHO. This includes gathering documentation on COVID-19-related fatalities, employees who have contracted COVID-19, have been hospitalized, or have been placed on precautionary removal/isolation as a result of work-related exposure to SARS-CoV-2.

- e. For assistance with accessing medical records, CSHOs are encouraged to use the online Medical Access Order (MAO) Request Application or contact the Office of Occupational Medicine and Nursing (OOMN) in the National Office. Area and Regional Offices in need of an OOMN consultation are encouraged to use the online OOMN consultation request form. Consider issuing a subpoena duces tecum for medical records to compel production of the records by employers, as necessary.
- f. Review the respiratory protection program and any modified respirator policies related to COVID-19 (*e.g.*, policies modified to accommodate use of respirators authorized by an EUA from the FDA for healthcare employers) and assess compliance with 29 CFR § 1910.504 and 29 CFR § 1910.134 where applicable.
- g. Review employee training records, including any records or instructional materials related to SARS-CoV-2 exposure prevention or in preparation for a pandemic, if available.
- h. Review any documented efforts made by the employer to obtain and provide appropriate and adequate supplies of PPE.
- i. Review documentation of maintenance and use of engineering controls such as HVAC systems and AIIRs according to manufacturers' instructions, where appropriate.
- j. Where appropriate, determine if the facility has airborne infection isolation rooms/areas (AIIRs), and gather information about the employer's use of air pressure monitoring systems and any periodic testing procedures.
- k. Review any procedures for assigning patients to AIIRs and procedures used to limit AIIR access to employees who are trained and adequately outfitted with PPE. See also [Section IX.L](#) on ventilation requirements.
- l. Review procedures for accepting COVID-19 patients transferring from other facilities.
- m. Establish the numbers and placements, *i.e.*, room assignments or designated area (cohorting) assignments, of confirmed and suspected COVID-19 patients under isolation at the time of inspection.

- n. Establish the pattern or practice of placements for confirmed and suspected COVID-19 patients.

7. Walkaround.

- a. CSHOs, in consultation with supervisors or ADs where needed, should determine which areas of a facility will be inspected (*e.g.*, emergency rooms, hospital morgue, respiratory therapy areas, bronchoscopy suites, locker rooms, break rooms, time clocks).
- b. CSHOs should not enter occupied patient rooms or treatment areas during high-hazard procedures. CSHOs, ADs and AADs should evaluate and determine the need to enter an occupied patient room. Photographs or videotaping where practical should be used for case documentation, such as recording smoke-tube testing of air flows inside or outside AIIR. However, *under no circumstances shall CSHOs photograph or take video of patients*, and CSHOs must take all necessary precautions to assure and protect patient confidentiality. Throughout their inspection of facilities treating COVID-19 patients, CSHOs should avoid interfering with the any ongoing medical services.

D. COVID-19 Plan.

29 CFR § 1910.502(c) establishes the requirements for a COVID-19 plan. Where there are more than 10 employees on the effective date of the ETS, the plan must be in writing. These requirements are applicable to all covered entities.

1. Inspection Guidance.

- a. Written COVID-19 Plan: CSHOs must request and review the employer's written COVID-19 plan to determine that it includes each of the required elements in paragraphs (c) 1-7. If the employer has multiple facilities with substantially similar operations, its COVID-19 plan may be developed by facility type rather than by individual workplace so long as all required site-specific information is included in the plan. Employers may also develop a single comprehensive plan in instances where employees are performing the same task(s) at different facilities as long as any required site-specific information is included.
- b. In order for an employer to be exempt from providing controls (*e.g.*, facemasks, physical distancing, physical barriers) in a well-defined area of the workplace on the basis that employees are fully vaccinated, the employer must have policies and procedures in its COVID-19 plan to determine employees' vaccination status. These policies and procedures may exist independently of any formal written COVID-19 response; may be part of an HR (Human Resources) portfolio; and may be accomplished in multiple ways, including, but not limited to, a verbal instruction to employees; a staff meeting discussing vaccination; a written staff memo or a

formal change to conditions of employment. CSHOs should verify the existence and effectiveness of these procedures for determining vaccination status by reviewing relevant proof or records, if available, or through interviews of employer and employees representatives.

- c. If it is not possible to physically define or delineate a dedicated area where all employees are vaccinated, then the employer is required to implement all elements of the COVID-19 plan. See [Section IX.C.6, Verifying exemptions under 29 CFR § 1910.502\(a\)](#), for further information on verification of exemptions.
- d. Employers have latitude in how they determine vaccination status. They may choose to verbally ask the employee and document the status, may keep photocopies of the vaccination card or may request that the employee provide other evidence of vaccination such as a letter from a physician or vaccination provider (e.g., retail pharmacy). Depending on the nature of the evidence maintained by the employer (e.g., photocopies of vaccination cards), CSHOs may need a Medical Access Order (MAO) to verify vaccination status.
- e. CSHOs should interview a sufficient number of affected employees on multiple shifts (where applicable) as part of the overall assessment of the employer's COVID-19 plan and, in cases where an employer makes an exemption claim, to verify that the employer assessed the vaccination status of the affected workforce. As defined in the standard, "*Fully vaccinated*" means 2 weeks or more following the final dose of a COVID-19 vaccine. CSHOs should inquire about each element of the program and document the employee's answers to determine whether the employer's COVID-19 plan follows the prescribed guidelines.
- f. COVID-19 Safety Coordinator(s): CSHOs should inquire if employers designated one or more COVID-19 safety coordinators to implement, monitor, and report on the COVID-19 plan developed under this section. CSHOs should review the written COVID-19 plan (where required) to ensure that the safety coordinator(s) is identified in writing and has the authority to ensure compliance with all aspects of the COVID-19 plan including to implement and update the plan as needed. The CSHO should interview the COVID-19 safety coordinator(s) regarding their professional knowledge and background in infection control principles and practices applied to the workplace and employee job operations. This facilitates in determining if they are qualified through training, education, work experience or a combination thereof. Management of the COVID-19 plan may be performed by a team of infection control personnel.

- g. Employee input: CSHOs should determine through private interviews if non-managerial employees and their representatives if any, had input into the hazard assessment and plan's development, whether the plan was provided to employees for input and whether a mechanism for feedback and continuous improvement exists.
- h. CSHOs must make a determination whether the COVID-19 plan contains adequate workplace-specific policies and procedures to address potential workplace hazards related to COVID-19 at the worksite being inspected.
- i. Monitoring and updating: CSHOs should establish, through employee interviews, the means by which the employer ensures the continued effectiveness of its plan, and how quickly corrective actions are taken if/when necessary. The standard does not define the frequency with which to update the COVID-19 plan. However, the workplace must be monitored and, as needed, updates must be made to ensure continued effectiveness of the COVID-19 plan. At a minimum, updates may be necessary when changes in tasks or processes create new or previously unidentified exposures or the vaccination status (including any possible booster shots recommended by the CDC) of the affected workforce changes. Through interviews, document review, and walkaround observations, CSHOs should determine whether there are any unaddressed hazards not covered in the COVID-19 plan. CSHOs should discuss observed deficiencies in the plan with the employer's designated COVID-19 safety coordinator(s) to determine what previous efforts, if any, may have been made to evaluate the plan and update it.
- j. Workplace Specific Hazard Assessment: A workplace-specific hazard assessment must be conducted. This requirement extends to the employer's own employees and to employees of other employers when multiple employers share the same physical location. Employers should follow basic and well-known hazard assessment techniques including:
- Identify potential risks and sources of exposure: Identify worker categories or job tasks with exposure, and classify the risk of worker exposure.
 - CSHOs should determine whether all reasonably anticipated workplace hazards related to COVID-19 have been identified. Exposure risk depends in part on the physical environment of the workplace, the type of work activity, the health status of the worker, the ability of workers to wear facemasks and abide by CDC guidelines, and the need for close contact (within 6 feet for a total of 15 minutes or more over a 24-hour period) with other people, including those known to have or suspected of having

COVID-19, and those who may be infected with—and able to spread—SARS-CoV-2 without knowing it.

- The hazard assessment and classification of risk should include all of the employees' duties in the workplace, such as: patient-facing tasks; the need to share tools or medical equipment (*e.g.*, radios or computer terminal); and sharing common areas. In healthcare, risks are typically associated with direct patient care including but not limited to patient screening (*e.g.*, at the hospital or clinic entrance); patient medical care (*e.g.*, in the dedicated COVID-19 ward); the type of care (*e.g.*, assistance with feeding or bathing) or the type of medical procedures to be performed (*e.g.*, intubation, bronchoscopy); etc. See also www.osha.gov/coronavirus/hazards.
- k. Minimizing Risks: 29 CFR § 1910.502 requires employers to establish policies and procedures to minimize the risk of transmission of COVID-19 for each employee through a multi-layered approach of engineering and administrative controls as discussed in paragraphs (d) through (n) of the 29 CFR § 1910.502 standard, except where this section does not apply under paragraphs (a)(2)-(a)(4) of the standard. The plan does not need to address each employee individually; it may address employees generally.
- CSHOs should determine whether employers rely on use of face masks by affected employees as the only protective measure or if employees are protected from exposure to COVID-19 through additional engineering control measures including physical distancing and physical barriers.
- l. Communication with other employers: CSHOs should determine whether the COVID-19 plan includes policies and procedures on how to effectively communicate and coordinate with other on-site employers or contractors. This requirement may be accomplished through a combination of formal or informal procedures. For example, employers may use pre-planned meetings with document exchanges; a joint agreement to a common set of rules and work practices; contractual obligations; coordination of schedules / tasks to minimize personnel overlap and maximize physical distancing; erecting permanent or temporary barriers to restrict access, etc. The plan must also include a mechanism for notifications between employers on multi-employer sites whenever any employees of any employer are exposed to conditions that do not meet the requirements of the standard. (See also Section XI. of the [Bloodborne Pathogens Directive](#) for more information on multiple employer scenarios in healthcare).
- CSHOs should determine whether the COVID-19 plan addresses the protection of non-vaccinated employees who, in the course of

their employment (*e.g.*, home health), enter into private residences or other physical locations controlled by a person not covered by the OSH Act (*e.g.*, homeowners, sole proprietors). CSHOs should assess whether such employees have been trained to recognize hazards and possible mitigation solutions (*e.g.*, requesting the homeowner to maintain a 6-foot distance; re-positioning a chair to create additional distance; requesting that doors be left open to minimize touching knobs; request opening of windows to increase ventilation). CSHOs should also determine if employees have been encouraged to discuss deficiencies with their supervisors and seek mitigating solutions. In circumstances where COVID-19 protections are insufficient or lacking, the affected employee(s) must be given the opportunity to withdraw from that location, without fear of retaliation.

2. Citation Guidance.

- a. If the employer has not developed and/or implemented a COVID-19 plan for each worksite in its jurisdiction, the Area Office should issue citations for 29 CFR § 1910.502(c)(1). If a facility is lacking a COVID-19 plan and other requirements of the standard have not been implemented, those paragraphs should be cited as separate violations in addition to paragraph (c).
- b. If the employer has failed to make the COVID-19 plan either site-specific (or task-specific), the Area Office may issue a citation for 29 CFR § 1910.502(c)(1).
- c. Where the employer has more than 10 employees on the effective date of the ETS, 29 CFR § 1910.502(c)(1), for lack of a COVID-19 plan, may be grouped with 29 CFR § 1910.502(c)(2), for lack of a written plan. These violations should normally be classified as serious.
- d. If the employer has more than 10 employees on the effective date of the ETS, and if no written COVID-19 plan exists, but all other provisions of the standard have been met, and it is unlikely that the deficiency would result in a serious hazard, the Area Office may consider the lack of the written program to be other-than-serious. Also, see the general citation guidance.
- e. If the employer developed and implemented a site-specific (or task-specific) COVID-19 plan but the written plan failed to address one or more of the elements under 29 CFR § 1910.502(c)(3) - (c)(7), respectively, the Area Office may issue citations for the specific provisions as appropriate.

Violations for deficiencies or omissions of one or more elements of the COVID-19 plan should normally be grouped, where appropriate.

For example, in circumstances such as multi-employer worksites, violations of 29 CFR § 1910.502(c)(4), for failure to identify all COVID-19-related exposure hazards in the workplace, would normally be grouped with violations for failure to communicate and coordinate with other employers, *i.e.*, 29 CFR § 1910.502(c)(7)(ii).

- f. If the employer has not designated a COVID-19 safety coordinator in its plan, the Area Office may consider a citation for 29 CFR § 1910.502(c)(3). If deficiencies in the COVID-19 safety coordinator(s)' knowledge and expertise in infection control practices and principles are established, but all other provisions of the standard have been met, and it is unlikely that this deficiency would result in a failure to follow proper practices, the Area Office should generally not issue any citations for these deficiencies.
- g. Violations for deficiencies or omissions in the workplace-specific hazard assessment which fail to identify workplace hazards, exposures, job tasks or worker categories may be cited under 29 CFR § 1910.502(c)(4)(i). For failure to include policies and procedures to determine employee vaccination status in the COVID-19 plan, the Area Office may issue a citation for 29 CFR § 1910.502(c)(4)(ii).
- h. If an employer claims an exemption from the standard based on workforce vaccination status and if during the course of the inspection CSHOs document the presence of unvaccinated employees, the Area Office may issue citations for all deficiencies found, including the COVID-19 plan and applicable (feasible) controls.
- i. If policies and procedures are included in the written plan but not implemented, then the specific requirement that has not been implemented should be cited, per 29 CFR § 1910.502(d)-(n).

E. Patient / Non-employee Screening and Management.

29 CFR § 1910.502(d) requires patient screening and management where direct patient care (as defined in the standard) is provided. Employers must limit the number of entrances to the facility, screen patients, residents and non-employees for symptoms of COVID-19, and follow CDC's COVID-19 Infection Prevention and Control Recommendations. These screening and management procedures must be included in the COVID-19 plan.

1. Inspection Guidance.

- a. This paragraph is in addition to health screening for employees required under paragraph 29 CFR § 1910.502(1)(1). Note: 29 CFR § 1910.502(d) does not apply to licensed health care providers and emergency responders entering a non-healthcare setting or private residence to provide healthcare services. This paragraph applies to

home healthcare unless they meet the exemption in § 29 CFR 1910.502(a)(2)(v).

- b. CSHOs should review a copy of the facility's COVID-19 plan to ensure screening and management procedures are included.
- c. CSHO should document procedures used to limit and monitor major points of entry (*e.g.*, the main entrance(s) to the building, the emergency department, the entrance to receptionist, appointment desk, registration, or check-in, connecting entrances from the parking garage, receiving areas, and other entrances where non-employees enter the facility). CSHOs should interview employees from various entry points (*i.e.*, either in-person or through remote means) to verify adherence to the procedures.
 - Methods to limit entrance to the facility are flexible but may include posting signs at the door instructing patients with fever, respiratory symptoms or other symptoms of COVID-19 to return to their vehicle (or remain outside if they are pedestrians) and call the telephone number for the healthcare center so that triage can be performed prior entering.
- d. CSHOs should determine how patients, residents or non-employee visitors are screened and document the findings. CSHOs should interview management (*e.g.*, the person in charge of infection control) when making this determination.
- e. Review documents used as guidance for determining the screening procedures implemented. CSHOs should obtain a copy of any checklist or protocol being used to screen non-employees coming into the facility.
- f. CSHOs should investigate to determine if any group of non-employees may be excluded from the employer's screening program and document that screening is done on all shifts.
 - All individuals entering the facility must be screened for COVID-19 symptoms including clients, patients, residents, delivery people, and other visitors, and other non-employees.
 - Screening methods may be flexible and may include in person or self-monitoring temperature or health surveys, upon arrival. Screening policies could include requiring hand hygiene at screening stations and mandatory use of source control (such as face coverings) in accordance with CDC's Infection Prevention and Control Recommendations (See also bullet h, below) if in-person screening is performed. Screening may also include an electronic monitoring system that require non-employees self-report symptoms or exposures (*e.g.*, absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been

exposed to others with SARS-CoV-2 infection during the prior 14 days), prior to arrival at the facility.

- g. In addition to screening, paragraph 29 CFR § 1910.502(d)(2) requires triage of any individual who may be experiencing COVID-19 symptoms. CSHOs should inquire about any existing triage protocols and decision-making following triage.
- Triage enables the facility to make decisions about access restriction, isolation, and/or referral of symptomatic persons for further medical evaluations, testing or treatment. Triage also assures more effective implementation of the appropriate level of personal protective equipment and other protections for employees. Patient segregation in healthcare settings also reduces nosocomial (healthcare-acquired) infections for employees.
- h. CSHOs should document patient management strategies including those listed below. Patient management strategies must be in accordance with the CDC's COVID-19 Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated February 23, 2021, at https://www.osha.gov/sites/default/files/CDC's_COVID-19_Infection_Prevention_and_Control_Recommendations.pdf, which has been incorporated by reference in 29 CFR § 1910.509, and may include:
- Advising patients that they should put on their own well-fitting form of source control before entering the facility and taking steps to ensure that everyone adheres to source control measures (*see* www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#source-control) and hand hygiene practices while in a healthcare facility.
 - Screening and then isolating patients showing symptoms of COVID-19 in an examination room with the door closed to prevent close contact with healthcare workers who are not providing direct care to that patient; designating a well-ventilated space as a waiting area to allow waiting patients and waiting room employees to separate by 6 or more feet, with easy access to respiratory hygiene supplies (*e.g.*, tissues and trash cans);
 - For inpatient or residential care of a COVID-19 positive or suspected COVID-19 patients, placing the patient in a single-patient room, if available, or, where single-patient rooms are not available, cohort patients with COVID-19 to prevent close contact with healthcare workers who are not providing direct patient care to those COVID-19 patients.

NOTE: The standard encourages employers to use telehealth as a means to limit the number of people in the facility. Telemedicine or Telehealth is the use of electronic information and telecommunication technology to get the health care needed while practicing physical distancing. This often involves a phone or a device with internet capabilities. While telehealth minimizes the risk of transmission for healthcare personnel and patients, it also can reduce the strain on personal protective equipment supplies. If the employer needs assistance with telehealth, CSHOs should direct them to the CDC website: www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.

2. Citation Guidance.

- a. If CSHOs find deficiencies in any portion of paragraph 29 CFR § 1910.502(d) (except for telehealth), cite the applicable provision in paragraph 29 CFR § 1910.502(d).

NOTE: The telehealth recommendation is an optional portion of the standard and thus cannot be cited. However, it may be a form of abatement for a citation of 29 CFR § 1910.502(d)(2) if the employer is not adequately managing patients to minimize risk of transmission to employees.

- b. If the employer did not include patient screening and management in the written COVID-19 plan, the Area Office may cite for that deficiency and group this citation with specific deficiencies of this paragraph if patient screening and/or management was not provided.
- c. If employees with direct patient care responsibilities are not trained on patient screening and management, 29 CFR § 1910.502(n)(1)(ii) should be cited.

F. Standard and Transmission-Based Precautions.

29 CFR § 1910.502(e) establishes the requirements for employers to develop and implement policies and procedures for Standard and Transmission-Based Precautions.

1. Inspection Guidance.

- a. In accordance with 29 CFR § 1910.502(e)(1), employers in settings where healthcare services or healthcare support services are provided, must develop and implement policies and procedures to adhere to Standard and Transmission-Based Precautions in accordance with “[CDC's Guidelines for Isolation Precautions](#),” dated 2007, which is incorporated by reference as specified in 29 CFR § 1910.509.
- Each Area Office should ensure that CSHOs are familiar with the above referenced guidelines prior to conducting inspections.

- b. CSHOs should request the transmission-based policies and procedures and conduct interviews with the designated employer representative(s). Conduct employee interviews to determine whether the employer has developed and implemented these policies and procedures. Document whether or not the employer has developed and implemented the policies and procedures.

2. Citation Guidance.

If CSHOs determine that the policies and procedures required by 29 CFR § 1910.502(e) have not been developed or implemented, the Area Office may consider issuing a citation for 29 CFR § 1910.502(e).

- G. Personal Protective Equipment.

29 CFR § 1910.502(f) establishes the requirements for healthcare employers to provide and ensure the use of PPE, such as facemasks, goggles, gowns in accordance with Subpart I. This section also covers respiratory protection requirements and the applicability of 29 CFR § 1910.134.

29 CFR § 1910.502(f)(1) requires a sufficient number of facemasks meeting the standard's definitions to be provided and worn by each employee over the nose and mouth when indoors, and when riding in a vehicle with another person for work purposes. Employers may permit employees to wear their own facemasks as long as they meet the same specifications.

The employer may provide or allow employees to provide their own respirators in lieu of using facemasks. Where respirators are used in lieu of required facemasks, 29 CFR § 1910.504 will apply.

1. Inspection Guidance.

- a. CSHOs should determine whether the use of facemasks is required under the standard, *i.e.*, where healthcare employees work indoors around other individuals, or ride in a vehicle with another person for work purposes. This does not include commuting.

NOTE: Paragraph 29 CFR § 1910.502(f)(3)(1)(iii) allows exceptions to the required use of facemasks in the following circumstances: (A) where a worker is alone in a room; (B) where employees are eating and are separated at least 6 feet apart or with barriers; (C) where workers wear respirators; (D) when masks impede communication (*e.g.*, communication with deaf or hearing impaired persons); (E) when employees have medical contraindications; or (F) when the mask creates a greater hazard. Where feasible, alternative measures such as use of a clear face shield must be used where these exceptions exist. However, for the exceptions D-F, if other infection control concerns exist that limit an employer's ability to implement use of a clear face shield as an alternative to facemasks, other alternative options such as PAPRs should be considered and provided.

- b. CSHOs should consider requesting the employer to provide a sample facemask for examination. CSHOs should refer to product labeling for evidence of the type(s) of facemasks in use at the facility along with the brand, model number(s), size, and any notable approval language. Purchase invoices or unopened inventory (boxes) of the product may also satisfy this requirement.
- c. Where employers are allowing employees to use their own facemasks, CSHOs should ensure that they meet the required specifications. Note that employers are not required to reimburse for employee-provided facemasks. However, CSHOs should determine if and how the employer ensured that employee-provided facemasks are compliant with the requirements.
- d. CSHOs should observe facemask positioning during the walk around portion of the inspection noting any instances of improperly positioned facemasks.
- e. Where facemasks are provided/used, CSHOs should determine if the employer is ensuring that employees change facemasks at least daily and whether the employer replaces them if soiled or damaged. In workplaces where facemasks may become wet, soiled or damaged and require replacement more frequently, employers may provide face shields to be worn over facemasks to reduce the frequency of changes throughout the workday.
- f. Where the employer requires the use of face shields, CSHOs should determine if face shields are cleaned at least daily and are not damaged, with cracks or voids.
- g. CSHOs should evaluate the use of respirators to assure they are used in accordance with 29 CFR § 1910.134 and other PPE (*e.g.*, gloves, isolation gowns or protective clothing, eye protection), to assure it is used in accordance with Subpart I, when employees are exposed to a suspected or known COVID-19 positive person as required by 29 CFR § 1910.502(f)(2).
 - If document(s) and/or interview(s) provide evidence that employees are not protected in accordance with the standard while exposed to suspected or known COVID-19 positive individuals, CSHOs should note the finding(s) and gather evidence regarding specific task description(s), frequency, and duration.
- h. CSHOs should evaluate whether the protective equipment required by 29 CFR § 1910.502(f)(3) (respirator, gloves, isolation gown or protective clothing, and eye protection) are provided and used for aerosol-generating procedures.
 - When aerosol-generating procedures are performed on a patient who is suspected or confirmed to be COVID-19 positive, the employer must provide respiratory protective equipment in

accordance with 29 CFR § 1910.134.

NOTE: Refer to 29 CFR § 1910.502(g) for additional requirements during aerosol-generating procedures.

- i. 29 CFR § 1910.502(f)(4) allows the employer to provide a respirator (or permit the employee to provide his/her own) instead of a facemask for conditions covered under in 29 CFR § 1910.502(f)(1)(i) or 29 CFR § 1910.502(f)(1)(ii). However, the employer must follow requirements for a Mini-Respiratory Protection Program found in 29 CFR § 1910.504.
- j. 29 CFR § 1910.502(f)(5) requires that employers provide respirators and PPE for Standard and Transmission-Based Precautions in accordance with CDC’s guidelines for Isolation Precautions and Subpart I.

NOTE 1: Facemask, as defined in paragraph (b) of the standard, is a term used by OSHA and is not synonymous with the same term when used by the FDA. It is important to note the differences when verifying the supplied facemask is cleared or authorized by an FDA EUA for use in accordance with paragraph (b) of this section. OSHA refers to these cleared or authorized surgical masks as facemasks. See also www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/face-masks-including-surgical-masks-and-respirators-covid-19.

NOTE 2: The term “suspected,” for purposes of this standard, follows CDC’s Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic: www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.

2. Citation Guidance.

- a. A serious violation may be considered when evidence supports deficiencies associated with any 29 CFR § 1910.502(f)(1) subparagraphs and may be grouped. For example:
 - When facemasks are required, if employer-provided facemasks (or ones permitted employees to optionally provide their own) do not meet the required specifications, a citation for 29 CFR § 1910.502(f)(1) should be issued.
 - Where reusable facemasks are provided by the employer, if CSHOs determine that employees are unable to obtain clean units at least daily, and replacements if their current units get soiled or damaged, and replacements at the frequency specified by the manufacturer, the Area Office may issue a citation for 29 CFR § 1910.502(f)(1)(ii).
- b. The Area Office may cite 29 CFR § 1910.502(f)(2)(i) when respirator(s) are not provided when employees are exposed to suspected or confirmed COVID-19 people. In situations where respirators are not used in accordance with 29 CFR § 1910.134, the

Area Office may group 29 CFR § 1910.502(f)(2)(i) with the applicable 29 CFR § 1910.134 paragraph(s).

- c. When employee exposures to suspected or confirmed COVID-19 individuals are documented and the employer fails to provide PPE such as gloves, isolation gowns or protective clothing and/or eye protection the Area Offices may cite 29 CFR § 1910.502(f)(2)(ii). If employees are provided personal protective equipment, but the personal protective equipment is not used or maintained in accordance with 29 CFR § 1910 Subpart I, the Area Office may cite 29 CFR § 1910.502(f)(2)(ii) and group the respective Subpart I paragraph.
- d. In accordance with 29 CFR § 1910.502(f)(4), where respirators are not required but the employer provides or allows employees to provide their own respirators instead of required facemasks, the employer must comply with 29 CFR § 1910.504. In most situations where an employer does not permit an employee to use their own respirators in lieu of facemasks, violations of 29 CFR § 1910.502(f)(4)(ii) would result in an other-than-serious violation (*i.e.*, where employees are provided with and use facemasks.) The respective 29 CFR § 1910.504 standards may be cited and grouped accordingly. Note: While 29 CFR § 1910.504 does not require a separate written respirator program, optional use of respirators, instead of required facemasks must be addressed in the COVID-19 plan.
- e. Where respirators and/or other PPE are required by this standard, the employer's failure to provide or ensure their use should normally be classified as serious.

H. Aerosol-Generating Procedures.

29 CFR § 1910.502(g) describes the requirements for limiting personnel, use of AIIRs, and cleaning/disinfection for aerosol-generating procedures on a person with suspected or confirmed COVID-19. Aerosol-generating procedures present a very high-risk for exposure to respiratory infections. Workers in a wide range of settings, such as emergency responders, healthcare providers, lab technicians, and mortuary workers, are at risk during aerosol-generating procedures. Aerosol-generating procedures covered by the scope of the standard, are described 29 CFR § 1910.502(b) *Definitions*.

1. Inspection Guidance.

- a. 29 CFR § 1910.502(g)(1): CSHOs should determine whether the number of personnel present during aerosol-generating procedures on suspected or confirmed COVID-19 patients is limited such that only employees essential to patient care and procedure are present.
- b. 29 CFR § 1910.502(g)(2): CSHOs should document the availability of an AIIR during an aerosol-generating procedure.

The employer must offer justification if an available AIIR is not used during an aerosol-generating procedure on a suspected or confirmed COVID-19 patient.

- The Area Office, in coordination with the Regional Office, should consult the Office of Occupational Medicine and Nursing (OOMN), as necessary to make determinations about limitations in medical personnel during aerosol-generating procedures or appropriate use of AIIRs.
 - See additional AIIR guidance found in sections [IX.C.7](#), General Inspection Procedures, and [IX.L](#), Ventilation, of this Direction.
- c. CSHOs should verify cleaning and disinfection procedures are performed in the room or area following aerosol-generating procedures on COVID-19 patients. Such cleaning and disinfection should be in accordance with 29 CFR § 1910.502(j)(1).

2. Citation Guidance.

- a. If CSHOs determine that the number of personnel present during aerosol generating procedures on suspected or confirmed COVID-19 patients is not limited, then a citation of paragraph 29 CFR § 1910.502(g)(1) may be issued.
- b. If CSHOs determine that aerosol generating procedures on suspected or confirmed COVID-19 patients are not done in available AIIRs, then a citation of paragraph 29 CFR § 1910.502(g)(2) may be issued.
- c. With the exception of 29 CFR § 1910.502(g)(3), generally violations issued for these subparagraphs will result in single, non-grouped violation. Violations issued for 29 CFR § 1910.502(g)(3) may be grouped with the appropriate subparagraph in 29 CFR § 1910.502(j).

I. Physical Distancing.

1. Inspection Guidance.

- a. 29 CFR § 1910.502(h) requires employers to create physical distancing between employees. CSHOs shall establish, through employer and employee interviews, the means by which the employer ensures that physical distancing is maintained between employees, and how quickly corrective actions are taken if/when necessary. This provision does not apply to momentary exposure while people are in movement (*e.g.*, passing in hallways or aisles) or for brief interactions dictated by operational necessities (*e.g.*, checking patient vitals or monitoring equipment). The employer must ensure that each employee is separated from all other people by at least 6 feet unless the employer can demonstrate that such physical distancing is not feasible for a specific activity (*e.g.*,

direct patient care).

Physical distancing can include methods such as: telework or other remote work arrangements; reducing the number of people, including visitors, in an area at one time; visual cues such as signs and floor markings to indicate where employees and others should be located or their direction and path of travel; staggered arrival, departure, work, and break times; and adjusted work processes or procedures, to allow greater distance between employees.

- b. CSHOs should determine whether the employer has designated eating and drinking areas with sufficient space to accommodate physical distancing or install appropriate physical barriers.
- c. For activities other than direct patient care, if an employer claims it is infeasible to separate employees, the CSHOs should interview the employer to determine why physical distancing is not feasible and what alternative measures were implemented. The CSHOs should request any relevant documentation, which supports the employer's position regarding infeasibility and document this in the casefile.
- d. When the employer establishes it is not feasible for an employee to maintain a distance of at least 6 feet from all other people, the employer must ensure that the employee is as far apart as feasible and implement the remaining layers of overlapping controls, including physical barriers, source control, hand hygiene, and ventilation, required by the standard to reduce the risk of COVID-19 transmission.

CSHOs should obtain photos and measurements during the walkaround of the affected area as necessary to document the workspace layout, and the physical distance between people. CSHOs must ensure that the privacy of residents/patients is taken into account prior to taking any photos during the walk-around.

- e. Where the AD has authorized a remote only inspection, CSHOs should request from the employer the relevant measurements and photographs of work areas along with the workspace layout (*e.g.*, from an emergency escape plan diagram or a floor plan), CSHOs should follow up with employee interviews to verify implementation of physical distancing measures.

2. Citation Guidance.

- a. If the employer has not instituted any feasible physical distance measures, or if the measures taken are inadequate, consider issuing a citation for 29 CFR § 1910.502(h)(1).
- b. If, during the course of the inspection, the CSHO determines that employees were not physically distanced and the employer was not complying with other sections of the standard, such as wearing

facemask or respiratory protection, then the Area Office should issue a citation for 29 CFR § 1910.502(h) and may consider grouping it with the other section(s) of the standard that was/were not implemented if abatement is the same. Note: Source controls (such as facemasks and face coverings) are not a substitute for physical distancing. Both practices should be used together, where feasible, with other protective measures as part of a multi-layered infection prevention strategy.

J. Physical Barriers.

29 CFR § 1910.502(i) establishes the requirements for creating physical barriers between employees at fixed workstations to block face-to-face pathways between individuals based on where each person would normally stand or sit. Physical barriers are not required in direct patient care areas or resident rooms.

1. Inspection Guidance.

- a. At each fixed work location in outside of direct patient care areas where each employee is not separated from all other people by at least 6 feet of distance, the employer must install cleanable solid barriers, except where the employer can demonstrate it is not feasible at the worksite.

CSHOs shall establish, through employee interviews and observations, that barriers are present where appropriate. CSHOs should assess whether barriers are at an appropriate height and positioned to block anticipated face-to-face pathways between individuals.

- b. Barriers may not create another hazard such as hindering employee egress from an area during an emergency. See part 29 CFR §1910 Subpart E – Exit Routes and Emergency Planning - for additional considerations.
- c. Where the Area Director has authorized remote-only inspections, CSHOs should request the relevant measurements and photographs of the area and follow up with employee interviews to verify and document implementation of barriers.
- d. If an employer is claiming it is not feasible to separate employees with barriers in fixed locations where employees are not separated by physical distancing, CSHOs should determine what alternative measures were implemented, and document that in the casefile. CSHOs should request any relevant documentation that supports the employer's position regarding infeasibility.

2. Citation Guidance.

- a. Where physical distancing is not feasible, and if an employer has not installed feasible barriers, the Area Office may cite 29 CFR § 1910.502(i).

- b. In rare situations where both physical distancing and physical barriers are not feasible, employers can still implement the remaining layers of overlapping controls, including facemasks or respirators, hand hygiene, and ventilation, required by the standard to reduce the risk of COVID-19 transmission.
- c. If the CSHO determines that physical barriers were not installed where feasible and the employer was not complying with other sections of the standard, such as wearing facemasks or respiratory protection, then the Area Office may issue a citation for 29 CFR § 1910.502(i). In some cases, the Area Office may group it with the other appropriate section(s) of the standard.

K. Cleaning and Disinfecting.

29 CFR § 1910.502(j) establishes the requirements for cleaning and disinfecting. Cleaning and disinfecting are not the same. See the definitions section. High touch surfaces and equipment are required to be cleaned at least once a day following manufacturers' instructions for application of cleaners. In addition, when a COVID-19 positive person has been in the workplace within the last 24 hours, the employer must clean and disinfect. The employer must also provide alcohol-based hand rub that is at least 60% alcohol or provide readily accessible hand washing facilities.

1. Inspection Guidance.

- a. CSHOs should determine whether the employer is cleaning high-touch areas and equipment at least once per day, and must determine if cleaning is in accordance with CDC guidance and with the manufacturers' instructions for the cleaners used. Some examples of high touch surfaces include but are not limited to tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks, and touch screens.
- b. CSHOs should determine whether cleaning and disinfecting are performed when a COVID-19 positive person has been in the workplace within the last 24 hours, and must determine whether this is done in accordance with CDC's "[Cleaning and Disinfecting Guidance](#)" (incorporated by reference, 29 CFR § 1910.509(b)(1)). CSHOs should request documentation such as the employer's COVID-19 log or verify through interviews when determining whether COVID-19 positive persons have been in the workplace.
- c. CSHOs should interview a sufficient number of affected employees on multiple shifts (where applicable) as part of the overall assessment of the employer's efforts to ensure cleaning and disinfecting (where appropriate) are taking place.
- d. In a healthcare setting, cleaning and disinfecting may be needed on a frequent basis throughout the day. This section requires that in patient care areas, resident rooms, and for medical devices and

equipment, the employer must follow standard practices for cleaning and disinfecting surfaces and equipment in accordance with CDC’s “[COVID-19 Infection Prevention and Control Recommendations](#)” and CDC’s “[Guidelines for Environmental Infection Control](#),” pp. 86–103, 147-149 (both incorporated by reference, 29 CFR § 1910.509(b)(4)). CSHOs should determine whether employers follow manufacturers’ instructions for application of cleaners and disinfectants.

- e. CSHOs should determine if hand washing facilities are readily available at the worksite or that alcohol-based hand rubs that contain at least 60% alcohol are provided.

2. Citation Guidance.

- a. If CSHOs document that the employer took no steps to clean and disinfect the facility in accordance with the standard, the Area Office should issue a citation for 29 CFR § 1910.502(j)(1) and (j)(2), as appropriate.
- b. If the employer was aware of a COVID-19 positive person in the work area within the last 24 hours and did not conduct cleaning and disinfecting in accordance with CDC guidelines, a citation for 29 CFR § 1910.502 (j)(2)(ii) may be issued. In accordance with the CDC guidance, if more than three (3) days have passed since the person who was sick or diagnosed has been in the workplace, then the cleaning and disinfection would not be necessary. A violation would not exist if the employer isolated the affected work area and restricted access to that area for at least three days following the presence of a COVID-19 positive person.
- c. Where disinfection is required, if CSHOs document that the employer did not use an EPA “List N” disinfectant for Coronavirus or a bleach solution, the Area Office should issue a citation for 29 CFR § 1910.502(j)(1) and/or (j)(2)(ii).
- d. If CSHOs determine that the employer did not follow standard practices and CDC’s COVID-19 Infection Prevention and Control Recommendations and Guidelines for Environmental Infection Control when cleaning and disinfecting surfaces and equipment in patient care areas, resident rooms, and medical devices, the Area Office should cite 29 CFR § 1910.502(j)(1).
- e. If CSHOs determine that cleaning and disinfecting was inadequate, *i.e.*, did not follow the cleaning/disinfecting chemical manufacturers’ instructions for lapse time on surfaces, the Area Office should cite 29 CFR § 1910.502(j)(2)(i).
- f. If CSHOs document that the employer did not provide appropriate hand washing facilities or alcohol-based hand rubs that contained at least 60% alcohol, the Area Office should cite 29 CFR §

1910.502(j)(3).

L. Ventilation.

29 CFR § 1910.502(k) establishes requirements for ventilation systems and apply to employers who own or control buildings or structures with an existing heating, ventilation, and air conditioning (HVAC) system(s). This section does not require installation of new HVAC systems or AIIRs for healthcare to replace or augment functioning systems. See [Section H](#) on Aerosol Generating procedures and [Appendix A](#) for additional information on AIIRs.

1. Inspection Guidance.

- a. Where employers own or control buildings or structures with an existing heating, ventilation, and air conditioning (HVAC) system(s), and AIIRs, CSHOs should evaluate if employers have implemented and maintained the ventilation controls in order to meet the requirements of this section. Facility industrial hygienists, building maintenance and facility engineering personnel, should be interviewed to determine if these systems are being operated and maintained in accordance with the manufacturers' instructions and design specifications.
- b. In healthcare, facility engineering personnel may be certified by the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) as a certified health care facility design manager, and/or certified healthcare physical environment worker, and should be interviewed. CSHOs should review documents to verify maintenance and testing of AIIRs in healthcare when necessary.
- c. Employers must ensure that existing HVAC systems including in exam rooms and AIIRs are used in accordance with the HVAC manufacturers' instructions and specifications. Employers must maximize outside air, use air filters rated MERV 13 or higher where required and compatible with HVAC systems, maintain and replace filters, and ensure that intake ports are clear of debris. CSHOs should request and examine documentation, such as HVAC system maintenance and filter change schedules and records, to ensure systems are properly maintained and air filters are replaced as necessary. CSHOs should also request and review purchase orders, which may indicate the compatible types of filters and filter efficiency ratings.
- d. CSHOs should visually inspect air intake ports for cleanliness and debris and CSHOs should consult the Salt Lake Technical Center (SLTC) for assistance in evaluating the adequacy of ventilation systems, as necessary. CSHOs may also consult ASHRAE guidance on the topic available at <https://www.ashrae.org/technical-resources/filtration-disinfection#replacement>.

NOTE: In addition to the requirements for existing HVAC systems, all employers should also consider other measures to improve ventilation in accordance with “CDC’s Ventilation Guidance,” www.cdc.gov/coronavirus/2019-ncov/community/ventilation. This could include maximizing ventilation in buildings without HVAC systems or in vehicles.

2. Citation Guidance.

- a. If CSHOs determine that the employer is not adequately implementing and/or maintaining its ventilation system and filters, violations for the specific paragraph of this section should be cited. This includes observations of HVAC systems that are not maintained according to manufacturer’s instructions, use of inadequate filtration, and/or intakes that are blocked with debris.
- b. Violations may be grouped if more than one deficiency in the HVAC system or AIIRs were identified. Citations for this paragraph should normally be classified as serious where employees have tested positive for COVID-19. See also sections on [Patient Management](#), on [Aerosol Generating Procedures](#), and [Appendix A](#) - Additional Specifications for AIIRs.

M. Employee Health Screening and Medical Management.

1. Inspection Guidance for Screening and Notification of symptoms:

- a. *Screening:* In accordance with 29 CFR § 1910.502(l)(1)(i)-(ii), employers must screen each employee before each workday and each shift. Through interviews and records review, CSHOs should determine if COVID-19 symptom screenings are being conducted before each workday and each shift.
 - Each workday refers to an 8-hour day or shift. For example if an employee enters the facility in the morning, works for 8 hours then leaves, but returns at a later time during the same 24 hour period to work a night shift, then two screenings are required, one for each time the employee begins a new workday or shift.
 - Screening methods can be flexible. Employers may screen employees in-person or ask employees to self-monitor before reporting to work. Some acceptable methods of COVID-19 screening and self-monitoring include temperature checks, employee questionnaires, and electronic screening apps.
 - Health screening personnel may need to be in close physical proximity to employees during in person screening. To ensure screeners and employees waiting to be screened are protected, an employer must continue to maintain compliance with all requirements of this standard for physical distancing, physical barriers, and facemask or other source control use. Screening

personnel may use touchless digital thermometers. Note that during the course of their work shift, employees have to wear at a minimum facemasks in accordance with 29 CFR § 1910.502(f)(1)(i), or respiratory protection as dictated by the type of patient care they are engaged in.

- If the employer requires a COVID-19 test, it must be provided at no cost to the employee. In such cases, CSHOs should verify that the employer does not require employees to pay for screening tests.
- Records of test results are medical records and must be handled in accordance with 29 CFR § 1910.1020. Screening records, such as temperature readings or responses to symptom screening questions, that are made or maintained by a physician, nurse, other healthcare personnel, or a technician are also considered to be employee medical records, as defined 29 CFR § 1910.1020. CSHOs should verify that such records are being retained in accordance with 29 CFR § 1910.1020(d)(1)(i) (*i.e.*, records must generally be preserved and maintained for at least the duration of the workers' employment, plus 30 years).

b. *Notification of symptoms:* In accordance with 29 CFR § 1910.502(l)(2)(i)-(iv), the employer must require employees to promptly notify the employer of a confirmed positive COVID-19 test, a diagnosis or reported suspicion of COVID-19 infection by a licensed healthcare provider, or serious symptoms such as loss of taste, loss of smell, or when experiencing high fever ($\geq 100.4^{\circ}$ F) combined with an unexplained cough. Prompt notification to the employer means as soon as possible after the employee became aware that they were experiencing one or more of the reportable conditions.

In accordance with 29 CFR § 1910.502(l)(3)(i)(A)-(C), the employer must notify all employees within 24 hours of becoming aware of COVID-19 exposures in the workplace. Employers must notify affected employers and employees who were not wearing a respirator of their close contacts with a COVID-19 positive person and must include the date(s) that the contact occurred and location where the infected person was in the workplace. The notifications are not required by the presence of a COVID-19 positive patient where services are normally provided to suspected or confirmed COVID-19 patients.

- The employer has flexibility in the methods employees use to notify them and mechanisms and procedures they implement to notify employees. As long as the requisite notifications are made, the employer has satisfied the requirement. Some suggested acceptable forms of notification of symptoms to the employer include verbal, e-mail/text, voice mail, written letter from the

employee, a family member, and/or physician or other licensed health care provider.

CSHOs should determine through management and employee interviews whether the employers have implemented procedures that required and encouraged employees to notify them of COVID-19 diagnoses, suspected infections or symptoms.

- CSHOs should determine through a combination of interviews and document reviews whether employees were notified of workplace exposures to COVID-19 positive individuals within 24 hours after the employer was notified that a person at its workplace(s) (including vendors, contractors, customers, visitors or other non-employees) is COVID-19 positive. CSHOs should also determine if the notifications included the required dates and locations and did not include any employee's name, contact information or occupation of the person who is COVID-19 positive.

2. Citation Guidance for Screening and Notification of symptoms:

- a. Paragraph 29 CFR § 1910.502(l)(i) should be cited if the employer failed to screen each employee in person or ask each employee to self-monitor before each workday and each shift.
 - Paragraph 29 CFR § 1910.502(l)(1)(ii) should be cited if the employer required COVID-19 screening test(s) and failed to provide it at no cost to employees.
- b. If the employer failed to require employees to notify the employer of COVID-19 illness, suspected infections or symptoms, then the applicable paragraph of 29 CFR § 1910.502(l)(2) should be cited.
 - If the employer has a policy requiring symptom notification, but employees fail to notify the employer of COVID-19 illness or symptoms, CSHOs should determine whether employees received training on employer-specific policies and procedures for making such notifications. If it is determined that the employee(s) did not receive training, the Area Office may cite 29 CFR § 1910.502(n)(1)(ix) which can be grouped with employee notification violations.
 - If the employer failed to notify employees or employers of other exposed employees, or failed to make a timely notification (*i.e.*, within 24 hours of becoming aware of a notifiable exposure), the Area Office may issue a citation of the specific applicable paragraph of 29 CFR § 1910.502(l)(3)(i)(A)-(C).
 - If the employer made timely notifications (*i.e.*, within 24 hours) but failed to communicate all requisite information (*e.g.*, missing exposure locations and/or dates), then the Area Office may issue an other-than-serious citation of the specific applicable paragraph

of 29 CFR § 1910.502(l)(3)(i)(A)-(C). If evidence indicates that the omission of exposure locations and/or dates contributed to a serious condition, such as additional cases of COVID-19 infections, then a serious citation may be warranted and grouped with other relevant paragraphs of this section.

- Employers shall not disclose confidential information in their notification to other employees. If the notifications included name, contact information, or occupation of infected employees, then paragraph 29 CFR § 1910.502(l)(3)(ii) may be cited.

3. Inspection Guidance for Medical Removal.

29 CFR § 1910.502(l)(4)(i)-(iv) describe the steps the employer must take for removing and keeping employees removed from the workplace if the employer knows the employee(s) meet one of the notification criterion described in paragraphs 29 CFR § 1910.502(l)(2)(i)-(iv).

- a. CSHOs should determine employer knowledge of employees' COVID-19 status by interviewing managers and employees and reviewing documents such as the OSHA 300 log, the COVID-19 log, employee and employer notification records (*e.g.*, e-mails and/or letters) and any existing screening forms.
 - The employer is considered to have knowledge of an employee's COVID-19 status if: 1) the employee notified the employer as required in notification requirements sections; 2) the employer was notified by close contacts or contact tracers; 3) the employer notified close contacts; or 4) the employer notified employers of other employees working in the facility. Employer knowledge may also be established if the employee was visibly displaying symptoms of COVID-19 during daily screenings.
- b. Employees must be immediately removed from the workplace if the employer knows they are COVID-19 positive, have been told by a licensed healthcare provider that they are suspected to have COVID-19, are experiencing the symptoms specified in 29 CFR § 1910.502(l)(2)(iii) and (iv), or were in close contact in the workplace to a person who was found to be COVID-19 positive. CSHOs should determine whether the employer is adhering to the requirement to remove workers who have been COVID-19 positive, had a COVID-19 diagnosis, suspected infection or reported symptoms as provided by paragraphs 29 CFR § 1910.502(l)(2)(iii)-(iv).

NOTE: Employers may choose to use a more comprehensive [list of COVID-19 symptoms provided by CDC](#) in deciding whether to remove or test employees who report additional symptoms that are not included in the OSHA standard.

- c. Employees who are medically removed must remain away from

the workplace until the return to work criteria in 29 CFR § 1910.502(l)(6) are met, or kept removed until the employer provides a polymerase chain reaction (PCR) test at no cost to the employee.

- The employer may require the employee(s) who were subject to medical removal to work remotely or in isolation if suitable work is available. Suitable work means any work that can be done with no contact with others. If an employee is too ill to work, remote work should not be required; and sick leave or other leave should be made available as consistent with the employer's general policies and any applicable laws.
 - CSHOs should determine through interviews and document reviews what procedures were implemented for removal (*i.e.*, whether employees were given the opportunity to work remotely or in isolation if suitable work was available.)
- d. Employers are not required to remove any employee who has been fully vaccinated (*i.e.*, 2 weeks or more following the final dose); or who recovered from COVID-19 within the past 3 months, if the employee is not COVID-19 positive and does not experience symptoms.

4. Citation Guidance for Medical Removal.

- a. If the employer failed to remove employees who are suspected of being infected or showing symptoms, are positive for COVID-19, or were notified by the employer as a close contact, then the appropriate paragraph of 29 CFR § 1910.502(l)(4)(i)-(iii) should be cited. Consider the facts of each case, such as whether the employee who had a close contact was previously vaccinated, when determining whether an employer's failure to remove the worker is citable.
- b. Citations of relevant sections should be considered on a case-by-case basis where employers removed workers but failed to fully observe the requisite follow up procedure (*e.g.*, testing) and/or timeframes for returning employees to work (*e.g.*, requiring employees to return before the return to work period has ended).

5. Inspection Guidance: Medical Removal Protection Benefits and Return to Work.

Paragraphs 29 CFR § 1910.502(l)(5)(i)-(v) require the employer to continue to provide regular pay and benefits to employees when they are removed or working remotely or in isolation due to a condition in paragraph 29 CFR § 1910.502(l)(4).

- a. Employers are required to reimburse medically removed workers up to \$1,400 per week. These requirements are modified after the

second week based on the size of company. Employers with fewer than 500 employees are required to pay medically removed employees for only two thirds of the regular pay, up to \$200 per day (\$1,000 per week in most cases) after the second week. Further, the employer's payment obligation is reduced by the amount of compensation the employee received from any other source.

- b. CSHOs should request any documentation (e.g. emails, meeting minutes, chat discussions, memos, policy statements, medical records) that would help verify that an employee who was removed, working remotely, in isolation, or not working, was on medical removal as provided by this section.
- c. CSHOs should determine through interviews and document reviews whether employees who were removed, working remotely or in isolation due to conditions in paragraph 29 CFR § 1910.502(l)(4) received the regular pay and benefits mandated per paragraphs 29 CFR § 1910.502(l)(5)(i-iv) of this section.
- d. CSHOs should determine whether the employer is appropriately compensating employees who are medically removed due to COVID-19. The determination regarding compensation for medical removal may depend on various factors including the size of the company, other sources of compensation to the employee, and payroll records.
 - If the size of the company nationwide is ten employees or less at the effective date of this section, paragraphs 29 CFR § 1910.502(l)(5)(iii) – (l)(5)(iv) do not apply.
- e. Paragraph 29 CFR § 1910.502(l)(6) requires that the employer follow guidance from a licensed healthcare provider or [CDC's "Isolation Guidance"](#) (incorporated by reference, 29 CFR § 1910.509); and CDC's "[Return to Work Healthcare Guidance](#)" (incorporated by reference in 29 CFR § 1910.509) when making employee's return to work decisions.
 - CSHOs should determine through interviews and document reviews if an employee's return to work after a COVID-19 related workplace removal followed appropriate CDC or licensed health care provider guidance.
- f. The paragraph also provides that employees must not experience adverse action when they return to work. See paragraph 29 CFR § 1910.502(l)(5)(v) for specific guidance.
 - If CSHOs determine that an employee (or former employee, if they were fired) experienced adverse action or threat of adverse action as a result of medical removal, then a referral should be made to the Whistleblower Protection Program. CSHOs will follow the steps

outlined in the anti-retaliation section of this directive.

6. Citation Guidance for Medical Removal Protection Benefits and Return to Work. See also Appendix D.
 - a. The employers with ten employees or less nationwide, are encouraged but not required to abide by 29 CFR § 1910.502(l)(5)(iii) – (l)(5)(iv).
 - b. If the employer did not pay the employee their regular rate of pay when working remotely or in isolation as part of medical removal, the Area Office may issue a citation for 29 CFR § 1910.502(l)(5)(ii). The citation will be classified as serious due to the potential for discouraging reporting COVID-19 and exposing other employees to the disease.
 - c. If an employee was returned to work prior to the CDC or health care providers guidance, then the Area Office may cite 29 CFR § 1910.502(l)(6) .

N. Vaccination.

29 CFR § 1910.502(m) requires employers to support COVID-19 vaccination for each employee through reasonable time off during work hours and paid leave (*e.g.*, paid sick leave, administrative leave, etc.) for the full vaccination series (*i.e.*, each required dose) and any side effects experienced following vaccination. Generally, OSHA presumes that, if an employer makes available up to four hours of paid leave for each dose of the vaccine, as well as up to 16 additional hours of leave for any side effects of the dose(s) (or 8 hours per dose), the employer would be in compliance with this requirement. OSHA understands that employers may be able to provide much less than four hours if employees do not need to travel for vaccinations, for example, if they are provided onsite, and that side effects will generally last less than two days, but may in some cases last longer.

1. Inspection Guidance.

- a. CSHOs should determine through interviews and document review that employers support vaccination efforts by providing reasonable time off and paid leave. CSHOs should determine through interviews whether the employer actively discourages or hinders employees from getting vaccinated.
 - Reasonable time off may include, but would not be limited to, time spent during work hours related to the vaccination appointment(s), such as registering, completing required paperwork, all time spent at the vaccination site (*e.g.*, receiving the vaccination dose, post-vaccination monitoring by vaccine provider), and time spent traveling to and from the location for vaccination (including travel to an off-site location (*e.g.*, a pharmacy). Reasonable time also may include situations in which an employee working remotely (*e.g.*, telework) or in an alternate location must travel to the

workplace to receive the vaccine.

- Employers are not obligated to reimburse employees for transportation costs (*e.g.*, gas money, train/bus fare, etc.) incurred to receive the vaccination, such as the costs of travel to an off-site vaccination location, or travel from an alternate work location to the workplace to receive a vaccination dose.
- b. CSHOs should determine when vaccination or travel for vaccination took place to confirm whether the activities took place during work hours.
- If an employee chooses to receive the vaccine outside of work hours, employers are not required to grant time and paid leave for the time that the employee spent receiving the vaccine during non-work hours. However, employers must still afford them reasonable time and paid leave to recover from any side effects that they experience during scheduled work time.

NOTE: Nothing in the ETS precludes an employer from taking steps beyond the requirements of this standard to encourage employees to get vaccinated, as appropriate under applicable laws and/or labor management contracts. The EEOC provides guidance on COVID-19 vaccination as it relates to equal employment opportunity laws. See EEOC, December 16, 2020, www.eeoc.gov/newsroom/eeoc-issues-updated-covid-19-technical-assistance-publication-3.

Employees may decline vaccination for a number of reasons, including underlying medical conditions or conscience-based objections (moral or religious). There is no requirement that employees who decline the vaccination sign a declination form.

2. Citation Guidance.

- a. If employees incurred costs such as loss of pay or were required to take unpaid leave for the vaccination or adverse effects from the vaccination, Area Offices should consider citing 29 CFR § 1910.502(m).

O. Training.

29 CFR § 1910.502(n) requires employers to provide training in an actionable manner that accommodates employee language and literacy levels. The following guidance applies:

1. Standard Guidance.

- a. 29 CFR § 1910.502(n)(1)(i)-(xii): Employers must provide training, including reasonable accommodation as required by the Americans with Disabilities Act if needed by an employee with a disability, at no cost to the employee. The employee must be paid for time spent receiving training. If the employee must travel away from the workplace to receive training, the employer is required to

pay for the cost of travel, and the employee must be paid for travel time.

- b. 29 CFR § 1910.502(n)(3): An employer must ensure training is overseen or conducted by a person knowledgeable in the covered subject matter as it relates to the duties required of employees.
- c. 29 CFR § 1910.502(n)(4): An employer could utilize a virtual or online training, but will need to ensure that the training method allows for employees to ask questions and receive answers promptly. Video- or computer -based trainings may require the employer to make available a qualified trainer to address questions after the training, or to offer a telephone hotline where employees can ask questions.

2. Inspection Guidance.

- a. Review employer-provided training materials (*e.g.*, presentation slides, signs, posters, handouts) to determine if the company provided materials that are written in languages and literacy levels that employees understand, speak and read.
- b. When the employer provided training, CSHOs should pay particular attention to the times trainings were conducted. Establish whether employees were offered training during scheduled work times and at no cost to the employee.
- c. Employees play a particularly important role in reducing exposures because appropriate application of work practices and controls limit exposure levels. Employees therefore need to be informed of the grave danger of COVID-19, as well as the workplace measures included in their employers' COVID-19 plans because those measures are necessary to reduce risk and provide protection to employees. Employees must know what specific protective measures are being utilized and be trained in their use so that those measures can be effectively implemented.
- d. The CSHO should determine, through a number of interviews, whether employees can demonstrate knowledge and comprehension of training materials and items denoted in the respective standard.
 - Document whether training was provided in a language and manner the employee could understand.
 - Determine whether employees can describe tasks and situations where exposure could occur.
 - Determine whether employees can describe PPE donning/doffing, cleaning, disinfecting, and storage procedures.
 - Determine whether employees can describe available sick leave

policies.

- Ask if employees can identify the designated Safety Coordinator for the COVID-19 Plan
- Ask if employees were offered an opportunity to ask questions and receive answers; and
- Ask whether employees can describe any changes that have occurred that would require retraining such as changes in the workplace that would increase risk to COVID-19 transmission.

3. Citation Guidance.

- a. 29 CFR § 1910.502(n) does not require the employer to maintain training records. In the event that the employer cannot provide training records, the CSHO will note accordingly and continue to gather evidence sufficient to establish any trend (*e.g.*, material review, observations, and employee interviews) establishing a violative condition.
- b. When employees received inadequate information or training (*e.g.*, training was insufficient for a significant number of employees to be able to demonstrate knowledge of the required information or employees' inability to practice safety measures), cite the applicable paragraph(s).
- c. Consider grouping violations for deficient training with a related paragraph. For example, 29 CFR § 1910.502(n)(1)(vii) requires employers to train each employee on workplace-specific policies and procedures for cleaning and disinfection. This training must be consistent with the cleaning and disinfection requirements in paragraph (j). Training must include instruction on the proper and safe use of cleaning and disinfection supplies provided by the employer. Therefore, the employer must train an employee who is tasked to clean their work area, tools or equipment on the supplies to use, as well as how to properly and safely use those supplies.
- d. The Area Office may issue a serious violation when an employer fails to educate and train their employees.

P. Anti-Retaliation.

29 CFR § 1910.502(o) requires the employer to inform each employee of their right to the protections required by this section. It also prohibits employers from discharging or in any manner discriminating against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

1. Inspection Guidance.

- a. Employers have flexibility regarding how they will inform employees of their rights and the prohibition on retaliation.

Employers are able to choose any method of informing employees, so long as each employee is apprised of the information specified in the standard. Employees can be informed in writing, verbally during a staff meeting, or using other methods. This information can be provided along with other training required under the standard, or it can be provided separately.

- b. Through management and a sufficient number of private employee interviews, CSHOs should determine if employees have been told of their rights to protection under this section.
- c. In accordance with paragraph 29 CFR § 1910.502(o)(2), employers are prohibited from discharging or discriminating against any employee for exercising their right to protections required by this section or for engaging in actions required by this section. CSHOs should gather information regarding alleged discrimination against employees for exercising their right to protections required by this section or for engaging in actions required by this section.
- d. In general, allegations of retaliation potentially violating this section will be handled on a case-by-case-basis as this section overlaps with section 11(c) of the OSH Act. However, some employees may not have the time or knowledge necessary to file a timely section 11(c) complaint or may fear additional retaliation from their employer if they file a complaint.
 - Investigations of allegations for a violation of this standard and section 11(c) should involve close collaboration between the Compliance Safety and Health Officer, Assistant Area Directors, and the Area Director in the Area Office and the Whistleblower Investigator, the Regional Supervisory Investigator, and Assistant Regional Administrators in the WPP Section.
- e. The standard allows OSHA to issue citations to employers for retaliating against employees, and require abatement including back pay and reinstatement, even if no employee has filed a section 11(c) complaint within 30 days of the retaliation. Also, this section of the standard allows OSHA to issue a single citation addressing retaliation against multiple employees.
 - However, an employee who wishes to file a complaint under section 11(c) may do so within the statutory 30-day period regardless of whether OSHA is investigating an alleged violation of the standard involving the same underlying conduct.

2. Citation Guidance.

- a. If employees have not been informed of their rights to protections required by this standard, the Area Office may issue a citation for 29 CFR § 1910.502(o)(1).

- b. If an investigation establishes evidence where the employer either discharged, or otherwise discriminated against, an employee for exercising their right to protections under this section, a determination will be made (in consultation with the complainant, where appropriate) whether to pursue a remedy under section 11(c) or through a citation under 29 CFR § 1910.502(o)(2), but not both. The Regional Administrator has the discretion to determine under which avenue the resulting remedy is ultimately pursued.

Q. Requirements at No Cost.

29 CFR § 1910.502(p) requires that the employer meet all elements of the respective standard without shifting the cost to employee(s). This provision makes clear that the employer is responsible for all costs associated with implementation of the standard.

1. Inspection Guidance.

- a. OSHA considers costs to include not only direct monetary expenses to the employee, but also the time and other expenses necessary to perform required tasks.
- b. The term “no cost” means, among other things, no out of pocket expense(s) to the employee. The preamble recognizes that required training is provided at no cost to employees. Examples of violative conditions may include, but are not limited to, an employer requiring employees to:
 - Purchase COVID-19-related protective equipment and devices;
 - Purchase COVID-19-related cleaning and/or disinfectant materials; and
 - Purchase COVID-19-related training and/or training materials.
- c. CSHOs should determine through interviews and document reviews if employees incurred any monetary cost(s) during the review of the respective standards. Documentation may include purchase receipts, or medical bills from the employee.

2. Citation Guidance.

- a. 29 CFR § 1910.502(p) will usually be cited as an other-than-serious violation when/if employees incur monetary costs associated with this section.
- b. Based on specific circumstances of a case, if the Area Office determines that it is appropriate to achieve the necessary deterrent effect, the unadjusted penalty may be up to the maximum penalty allowed for an other-than-serious violation.
- c. Violations under this paragraph may be grouped with other relevant sections (*e.g.*, 29 CFR § 1910.502(m) for costs incurred

by the employee to obtain the COVID-19 vaccination).

R. Recordkeeping.

Paragraph 29 CFR § 1910.502(q) requires the retention and availability of all versions (not drafts) of the COVID-19 plan and the establishment and maintenance of a COVID-19 log for at least as long as the ETS stays in effect. This record retention does not apply to employers with 10 or fewer employees nationwide on the effective date of this section.

1. Inspection Guidance.

- a. CSHOs should verify that the employer is maintaining all versions (not drafts) of its COVID-19 plan.
- b. CSHOs should determine whether the employer had more than 10 employees at the time of the effective date of this section. Interviews with management, employee representatives, and review of payroll records may be necessary to determine whether the employer meets the threshold for maintaining a COVID-19 log.
- c. Where logs are required, CSHOs should review the employer's COVID-19 log and verify that all required information is recorded. The CSHO should interview the person responsible for maintaining the log, management, and a sufficient number of employees to determine if the logs are correct.
 - CSHOs should examine the log and ensure that employers recorded each instance identified in which an employee is COVID-19 positive (according to the definition in the standard) regardless if it is work-related. It is important for an employer to examine COVID-19 cases among workers and respond appropriately to protect workers, regardless of whether a case is ultimately determined to be work-related. CSHOs should inquire if the employer utilized the log to aid in identifying trends of the hazard in the workplace.
 - However, the COVID-19 log should not record incidences for employees who work exclusively from home and thus could not expose others in the workplace.
- d. The CSHO shall review the employer's injury and illness records to identify recordable illnesses or symptoms among employees with exposure(s) to patients with suspected or confirmed COVID-19. The review of the OSHA 300 log can aid in pinpointing any inconsistencies on the COVID-19 log and can provide insight on personnel who should be interviewed.
 - CSHOs shall examine additional injury and illness logs and ensure that employers who are required to maintain injury/illness records under 29 CFR part 1904 continue to record all work-related confirmed cases of COVID-19 on their OSHA Forms 300, 300A,

and 301, or the equivalent forms. Note: The partial exemption for some NAICS codes in 29 CFR § 1904.2 does not apply to the recordkeeping requirements in paragraph 29 CFR § 1910.502(q) – all employers covered by this section must maintain a COVID-19 log. CSHOs must ensure the OSHA 300 log is not used as a substitute for the COVID-19 log required by this section. Note: So as not to discourage vaccination, employers are not required to record instances of adverse reactions to vaccinations on the OSHA 300 log effective through May 2022.

- e. CSHOs should verify that, at a minimum, each instance recorded on the COVID-19 log contains the following information: the employee's name; contact information; occupation; location where the employee worked; the date of the employee's last day at the workplace; the date of the positive test for, or diagnosis of, COVID-19; and, the date the employee first had one or more COVID-19 symptoms, if any were experienced, and that entries were made within 24 hours of the employer learning that an employee is COVID-19 positive.
 - The log may be kept in any manner that the employer chooses as long as the information required to be on the log is present and understandable and can be obtained and shared within the timeframes mentioned in the standard. The log must be maintained as a confidential medical record. The disclosure of personal information entered on the COVID-19 log is limited to the access provisions set forth in paragraph 29 CFR § 1910.502(q)(3). There is no requirement for the log to be kept at the establishment as long as the timeframes for availability can be met.
- f. CSHOs should verify through interviews and/or document reviews that the employer provides access to the COVID-19 log to employees and their representatives.
- g. CSHOs should also interview others not on the COVID-19 log to determine if there are any cases that should have been recorded but were not placed on the log.
 - Through interviews and document review, CSHOs should determine if employees, former employees, and their representatives have access rights to all versions (not drafts) of the written COVID-19 plan at any workplace where the employee or former employee has worked. Employees or former employees also have access to the COVID-19 log entry pertaining to their own illness(es) and to a version of the COVID-19 log that maintains employee privacy by removing personally identifiable information (*e.g.*, names, contact information and occupation) of other employees. The location where the employee worked, the

date of the employee's last day at the workplace, the date of the positive test for, or diagnosis of, COVID-19, and the date the employee first had COVID-19 symptoms must be included in the privacy-protected log.

- CSHOs should document where employers fail to provide OSHA with access to the records required to be created and maintained by this section when requested.
- The employer must provide these records (one free copy of each requested record) upon request for examination and copying not later than by the end of the next business day after the request was made.
- If an inspection reveals that a business changed ownership while the ETS is in effect, the CSHO shall inquire to determine if the employer (*i.e.*, the predecessor) transferred information on the COVID-19 log to the new owner (*i.e.*, the successor).

2. Citation Guidance.

- a. Where the employer fails to maintain all versions (not drafts) of their COVID-19 plan, the employer may be cited for a violation of 29 CFR § 1910.502(q)(2)(i).
- b. Where the employer fails to establish or maintain the COVID-19 log or fails to record entries on the COVID-19 log, the employer may be cited for a violation of 29 CFR § 1910.502(q)(2)(ii).
 - If there are no known COVID-19 positive cases at the establishment, the employer shall not be cited for not having a COVID-19 log.
 - The employer shall not be cited for recording any additional information not mandated by the standard on the COVID-19 log.
- c. When the employer fails to have all of the information required for an entry on the COVID-19 log, the deficiency should be documented and the employer may be cited for a violation of 29 CFR § 1910.502(q)(2)(ii)(A).
- d. Where the employer has not maintained the log to ensure employee privacy and confidentiality, the employer may be cited for a violation of 29 CFR § 1910.502(q)(2)(ii)(B).
- e. When the employer does not maintain the COVID-19 log for the time that the standard exists, the employer may be cited for a violation of 29 CFR § 1910.502(q)(2)(ii)(C).
- g. A citation against the previous employer may be issued if the previous employer did not transfer all of the information entered on the COVID-19 log to the new owner. This is applicable if six months has not passed since the change of ownership and if the

predecessor is still in business. The current employer may be cited if they did not retain the log if the CSHO can show that they did receive the log from the previous employer.

- h. If a work-related COVID-19 illness was not entered into the 300 log and the COVID-19 log, both standards would be cited.
- i. OSHA shall not cite for failure to comply with § 29 CFR 1904.5 and § 29 CFR 1904.7 mandates requiring employers to record worker side effects from a COVID-19 vaccination through May 2022.
- j. Where citations are issued, penalties will be proposed only in the following cases:
 - Where OSHA can document that the employer was previously informed of the requirements to keep records; or,
 - Where the employer's deliberate decision to deviate from the recordkeeping requirements, or the employer's plain indifference to the requirements, can be documented.

S. Reporting to OSHA.

29 CFR § 1910.502(r)(i) requires the employer to report work-related COVID-19 fatalities to OSHA within 8 hours of learning about the fatality. 29 CFR § 1910.502(r)(ii) requires the employer to report each work-related COVID-19 in-patient hospitalization within 24 hours of learning about the in-patient hospitalization. The criteria in 29 CFR § 1904.5 must be used to determine work-relatedness.

1. Inspection Guidance.

- a. CSHOs should gather information through employer and employee interviews, and CSHOs should review documents such as the COVID-19 log and the OSHA 300 log when documenting apparent deficiencies in the reporting requirements.
- b. CSHOs and Area Offices shall evaluate that when reporting work-related COVID-19-related fatalities or hospitalizations to OSHA, the employer followed the requirements in 29 CFR § 1904.39 except for 29 CFR § 1904.39(a)(1) and (2) and (b)(6) at <https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.39>, in accordance with 29 CFR § 1910.502(r)(2).
 - Note: An employer may “learn” of a work-related COVID-19 fatality or inpatient hospitalization when a family member or medical professional reports it to the employer or through another employee at the company. It is the employer’s responsibility to ensure that appropriate instructions and procedures are in place so that managers, supervisors, company medical personnel, as well as

other employees or agents of the company, who learn of an employee's death or in-patient hospitalization due to work-related COVID-19 have been instructed that the company must make a report to OSHA.

- c. Note: Employers must give OSHA the following information for each fatality or in-patient hospitalization: the establishment name, the location of the work-related incident, the time of the work-related incident, the type of reportable event (*i.e.*, fatality or in-patient hospitalization), the number of employees who died or were hospitalized, the names of the deceased or hospitalized employees, the employer's contact person and his/her phone number, and a brief description of the work-related incident.
- d. Note: If an employer makes a report to OSHA concerning a COVID-19 in-patient hospitalization within the 24-hour period and that employee subsequently dies from the illness, the employer does not need to make an additional fatality report to OSHA, but must still record the fatality.
- e. Note: OSHA defines in-patient hospitalization as a formal admission to the in-patient services of a hospital or clinic for care or treatment (*see* 29 CFR § 1904.39(b)(9) and (b)(10)). The determination as to whether an employee is formally admitted into the in-patient service is made by the hospital or clinic. Treatment in an Emergency Room only is not reportable.

2. Citation Guidance.

- a. When an employer fails to report within 8 hours of learning of the death of an employee resulting from a work related exposure to COVID-19, the employer may be cited for a violation of 29 CFR § 1910.502(r)(1)(i).
- b. When an employer fails to report within 24 hours of learning of a work related exposure to COVID-19 hospitalization, the employer may be cited for a violation of 29 CFR § 1910.502(r)(1)(ii).
- c. If the Area Office becomes aware of an incident required to be reported through some means other than an employer report, prior to the lapse of the 8-hour or 24-hour reporting period and an inspection of the incident is made, a citation for failure to report will normally not be issued.

Due to the COVID-19 pandemic, an OSHA Area Office may be temporarily closed to the public. If an Area Office is closed for any reason, per 1904.39(b)(1) an employer must use the OSHA 24-hour hotline at 1-800-321-6742 (OSHA) or complete and submit a [Serious Event Reporting Online Form](#) at the OSHA website, and must not make the report to OSHA by fax, email, or by leaving an Area Office voice mail.

X. Mini Respiratory Protection Program.

29 CFR § 1910.504 applies to respiratory use when such use is not required, in accordance with 29 CFR § 1910.502(f)(4)(i) and (ii), namely, when the employer either optionally provides respirators or allows employees to use their own respirators for use in lieu of required facemasks. In the first situation, employers must provide training on the use of respirators, on conducting user seal checks on tight-fitting respirators, on the reuse of respirators and instruction on when to discontinue the use of respiratory protection. In the second situation, employers must provide a notice to employees using text from 29 CFR § 1910.504(c).

The “Respiratory Protection Guidance by Activity and Standard” table in [Appendix B](#) of this directive contains a breakdown of respiratory protection usage and requirements, including a listing of the specific requirements applicable to common, foreseeable situations. Note that 29 CFR § 1910.504 only requires a user seal check and training, while medical and fit testing requirements are only performed if the employer is required to follow the Respiratory Protection Standard, 29 CFR § 1910.134.

1. Inspection Guidance.

- a. CSHOs shall determine through workplace observations and interviews whether respirators are required by 29 CFR § 1910.502(f)(2), (f)(3), or (f)(5).
- b. If respirators are not required under 1910.502(f)(2), (f)(3), or (f)(5), the CSHO shall determine whether the employer provides a respirator to an employee instead of the required facemask under 29 CFR § 1910.501(f)(4)(i). The CSHO shall determine whether the employer provided the training required by 29 CFR § 1910.504 to each employee wearing a respirator under 29 CFR § 1910.502(f)(4)(i).
 - CSHOS shall determine through interviews and document review that when the employer provides employees with respirators for use in lieu of required facemasks, the employer must provide training as described in 29 CFR § 1910.504(d)(1)(i)-(v). Note: Training is particularly important since fit testing and medical evaluation provisions are not included in 29 CFR § 1910.504.
- c. If respirators are not required under 1910.502(f)(2), (f)(3), or (f)(5), the CSHO shall determine whether the employer permits an employee who is required to wear a facemask to wear their own respirator instead of the required facemasks, under 29 CFR § 1910.502(f)(4)(ii). The CSHO shall determine whether the employer has provided to the employee a notice containing the standardized text from 29 CFR § 1910.504(c).
- d. The CSHO shall determine if employees wearing elastomeric respirators have previously been medically evaluated and found medically unable to wear a respirator, CSHOs should advise the employer of the hazard and to discontinue the practice until a new

medical evaluation is performed as required by 29 CFR § 1910.504.

- e. CSHOs should determine whether such employees using tight-fitting respirators perform user seal checks to ensure the respirator is properly sealed to the face. CSHOs should evaluate by asking employees to describe (or demonstrate) the procedures, focusing on whether the employees recognize the signs that leakage is occurring.
- f. CSHOs should ensure that employers correct any problems discovered by employees during User Seal Check procedures. If employee(s) report that a user seal check fails, CSHOs should make a determination whether the employer provided alternate models or sizes of respirators.

NOTE: In circumstances where an employer requires respirator usage in an effort to offer a higher degree of protection to workers not otherwise required to wear respirators, the employer must comply with the requirements of 29 CFR § 1910.134. Please refer to [CPL 02-00-158](#), *Inspection Procedures for the Respiratory Protection Standard*, dated June 26, 2014, for agency interpretations and enforcement policies.

- g. CSHOs should determine whether respirators used in accordance with 29 CFR § 1910.504 are being reused by healthcare employees. Employers must ensure that FFRs used by a particular employee is only reused by that employee. Note: Reuse is discouraged unless the employer is experiencing a shortage.
- h. If reuse is observed, CSHOs should verify that FFRs are only reused by the original wearer and that previously used FFRs are not shared among multiple employees.
 - Reuse of FFRs is only allowed for healthcare associated industries during times of shortages in the respirator supply chain.
- i. In the unexpected situation that an employer is asserting a shortage of respirators, CSHOs should request evidence of this claim by obtaining a daily inventory of respirators and the “burn rate” calculations along with applicable invoices and purchase orders.

NOTE: The employer may only use CDC strategies for N95 FFR shortages for a limited period of time and must take immediate steps to purchase and use other NIOSH-approved respirators, such as elastomeric respirators and PAPRs. CDC’s Strategies for Optimizing the Supply of N95 Respirators are found on the following webpage:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>.

- j. CSHOs should verify that re-used respirators are not visibly soiled or damaged; and determine how the end-user verifies the integrity

of respirator (*i.e.*, fabric, straps, seal, nose bridge); whether the employee hygienically handles the respirator and successfully completes a user seal check on the re-used respirator; and whether the respirator has been used more than five (5) days in total.

- k. CSHOs should verify the storage conditions of the respirators. Reusable respirators must be stored in a breathable container (*e.g.* paper bag), away from water or moisture for at least five (5) calendar days prior to re-use. In practice, this means that an employer must provide at least five (5) FFRs to be used on different days.

NOTE: For FFRs, the exhalation process combined with environmental factors (*i.e.*, increased temperature and/or humidity) may lead to higher moisture content in the fabric of the respirator and may promote the growth of pathogens. Respirators that are soiled or grossly contaminated with blood, respiratory secretions, or other bodily fluids, shall not be stored for later re-use.

2. Citation Guidance.

- a. If the employer did not provide affected employees who provide and use their own respirators with the notice listed at 29 CFR § 1910.504(c), the Area Office may consider issuing an other-than-serious citation.
- b. If the employer failed to provide training in accordance with the requirements of 29 CFR § 1910.504(d)(1), the Area Office may consider issuing citation(s) for any documented deficiencies listed in paragraphs 1910.504(d)(1)(i) through (v) of this section. Violations of multiple training provisions under 29 CFR § 1910.504(d)(1) should normally be grouped in a single citation.
- c. If the employer has not ensured employees are conducting user seal checks as outlined in 29 CFR § 1910.504(d)(2), the Area Office may consider issuing citation(s) for any deficiencies as listed in paragraphs 1910.504(d)(2)(i)(A) and (B). If the employer fails to correct any problems with the user seal check process, a citation for 29 CFR § 1910.504(d)(2)(ii) may be considered.
- d. If the reuse of respirators was not compliant with the requirements of 29 CFR § 1910.504(d)(3)(i), the Area Office may consider issuing citation(s) for any documented deficiencies listed in paragraphs 1910.504(d)(3)(i)(A) through (F) of this section. Violations of multiple reuse provisions under 29 CFR § 1910.504(d)(3)(i) should normally be grouped in a single citation. Deficiencies associated with the reuse of elastomeric respirators or PAPRs may be cited under 29 CFR § 1910.504(d)(3)(ii).
- e. If the employer does not require employees to discontinue use of respirators when employees report or experience signs and

symptoms that are related to their ability to use a respirator, a citation for 29 CFR § 1910.504(d)(4) should be cited. If employees are allowed to wear respirators and have previously had a medical evaluation that determined they were not medically fit to wear a respirator, a citation for 29 CFR § 1910.504(d)(4) should be cited.

XI. Drafting OSHA Citations for COVID-19 Violations.

- A. CSHOs should follow the general procedures for writing OSHA citations in the FOM, [CPL 02-00-164](#), and any specific procedures in this directive. The recommended classification of violations shall be as per the current version of the FOM, Violations, Chapter 4, and guidance set forth herein.
- B. The general procedures for classifying and grouping violations in the FOM should be followed. This document also contains some specific instructions for grouping violations of provisions in the COVID-19 ETS and other OSHA standards.
- C. Cases initiated before the effective date of the ETS should be carefully evaluated to determine whether case-specific findings and supporting employer knowledge warrant a violation under the ETS. For ongoing inspections, where the opening conference date precedes the effective date of the ETS, the Area Office may consider citations under the ETS for well-known SARS-CoV-2 control measures that should have been implemented before the issuance of the ETS, such as, but not limited to, physical distancing, barriers and hand hygiene. Where violations are subsequently found, while the inspection is still open, of unique requirements of the ETS, such as but not limited to, maintaining a COVID-19 plan, maintaining a COVID-19 log, and notifications to employees, citations should be treated on a case-by-case basis, in consultation with the Regional Office.
- D. The Area Director discretion for Gravity Based Penalty (GBP) should account for additional considerations including, but not limited to:
 - 1. Suspected or confirmed COVID-19 status of the affected employee(s), patients and residents in the facility or specific work area;
 - 2. COVID-19 vaccination status of the affected employee(s);
 - 3. Use and implementation of barriers in the workspace;
 - 4. Use and implementation of physical distancing by the affected workforce;
 - 5. Other environmental controls such as area ventilation (either forced mechanical ventilation / HVAC, or natural ventilation through the opening of doors or windows);
 - 6. Other engineering controls such as the use of Airborne Infection Isolation Rooms (AIIRs);
 - 7. Other administrative controls such as telehealth; telework or other remote work arrangements; reducing the number of people, including non-employees, in an area at one time; staggered arrival, departure, work, and break times.

8. Any updated CDC COVID-19 guidance that may impact on worker exposures.

XII. Training for OSHA Personnel.

- A. For all inspections or on-site visits where COVID-19 exposures are expected, CSHOs and OSHA consultation staff are expected to be knowledgeable of:
 1. Potential hazards which may be encountered at the site, including the potential hazards of COVID-19.
 2. Contents of the COVID-19 standard and this Direction.
 3. Knowledge of CDC guidance incorporated by reference in 29 CFR § 1910.509 and on OSHA's web page at www.osha.gov/coronavirus/ets/ibr.
 4. Appropriate PPE is to be worn. Each CSHO/OSHA consultation staff who will be expected to use PPE shall be trained in the proper care, use, and limitations of the PPE. Use of respiratory protection by CSHOs and other Agency personnel is addressed in OSHA Instruction, [CPL 02-02-054, Respiratory Protection Program Guidelines](#), July 14, 2000. Additional respiratory protection instruction may be available to OSHA personnel in the form of interim enforcement guidance such as in the most recent OSHA Memorandum, [Updated Interim Enforcement Response Plan](#). According to this guidance, the minimum levels of respiratory protection for CSHOs are a fit-tested half-mask elastomeric respirator with at least an N95-rated filter or a fit-tested, NIOSH-approved, disposable, FFR, such as an N95, since they have an assigned protection factor (APF) of 10. A fit-tested half-mask elastomeric respirator with at least an N95-rated filter is preferred as minimum protection for use in healthcare settings. Note that the CDC may regularly update its public health guidance to account for vaccinations against COVID-19, and therefore OSHA may also update its enforcement guidance.
 5. In addition to on-the-job training, CSHOs should be trained through available course work, such as offered by the OSHA Training Institute (OTI), (*e.g.*, OSHA #2341 – Biohazards; OSHA #3360 – Healthcare), and archived webinars related to COVID-19 (*e.g.*, OTI #0158 – Interim Enforcement Response Plan; OTI #0161 – SHMS CSHO Safety: Inspections During the Pandemic; OTI #0162 – NIOSH: COVID-19 and Protecting Workers; OTI #0169 - COVID-19 National Emphasis Program (NEP); OTI #0173 - COVID-19 Emergency Temporary Standard for Healthcare).

XIII. Medical Examinations for OSHA Personnel.

- A. Many of the hazards CSHOs may encounter are specifically addressed by the medical surveillance requirements in OSHA standards. In accordance with OSHA personnel policy in OSHA Instruction, [PER 04-00-005, OSHA Medical Examination Program](#), Aug. 22, 2009, Regional Administrators and Area Directors (AD) are responsible for implementing a medical examination program for CSHOs.

- B. OSHA Instruction, [CPL 02-02-054](#), *Respiratory Protection Program Guidelines*, July 14, 2000, includes medical evaluation requirements for OSHA personnel required to wear respiratory protection. The Instruction requires that CSHOs be medically evaluated and found eligible to wear the respirator selected for their use prior to fit testing and first-time use of the respirator in the workplace. CSHOs who are required to wear any respiratory protection shall be medically cleared via the CSHO Medical Examination procedures and ensure they are up to date.

XIV. Protection of OSHA Personnel.

- A. The Area Director will ensure that CSHOs evaluate potential sources of exposure and minimize transmission risk during on-site inspections. CSHOs should conduct a risk-level assessment per OSHA's most recent [Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 \(COVID-19\)](#), with available industry, company, and any known task-related information. The Area Director will ensure that a site-specific risk assessment is complete and available for review prior to opening the inspection. The site-specific risk assessment will include an exposure control plan, job-hazard analysis, and PPE hazard assessment.
1. To protect the Federal workforce and individuals interacting with the Federal workforce, and to ensure the continuity of Government services and activities, all on-duty or on-site Federal employees, on-site Federal contractors, and other individuals in Federal buildings and on Federal lands who are not fully vaccinated are required to wear a face covering (*i.e.*, cloth face coverings or surgical masks) and maintain physical distance; but all mentioned above must adhere to other public health measures, as provided in CDC guidelines. This is in accordance with [Presidential Executive Order 13991 on Protecting the Federal Workforce and Requiring Mask-Wearing](#), January 20, 2021, and the OMB memorandum M-21-15, June 10, 2021, which gives OSHA the ability to provide exceptions consistent with CDC guidelines.
 2. OSHA will continue to implement the U.S. Department of Labor's (DOL) COVID-19 Workplace Safety Plan to reduce the risk of COVID-19 transmission to OSHA CSHOs during inspections.
 3. CSHOs will take all appropriate precautions as described in OSHA's [Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 \(COVID-19\)](#). Supervisors shall ensure all staff comply with all COVID-19-related requirements developed as part of the [ADM 04-00-003: OSHA Safety and Health Management System](#).
- B. All personnel engaged in on-site inspection-related activities in healthcare must wear appropriate respiratory protection, or use face coverings at a minimum. While respirators including FFRs are recommended in most settings, this Direction permits the voluntary use of fit-tested FFRs by OSHA staff during inspection-related activities. For voluntary use of filtering facepiece respirators, OSHA staff must be provided a copy of [Appendix D](#) of the OSHA Respiratory Protection standard, 29 CFR § 1910.134

Respirators shall be selected and used in accordance with the respirator selection procedures in [CPL 02-02-054](#), *Respiratory Protection Program Guidelines*, and all requirements of the OSHA Respiratory Protection standard (*i.e.*, medically evaluated, fit-tested) shall be followed.

C. Additional Personal Protective Equipment (PPE).

CSHOs must use personal protective equipment as necessary to protect themselves against all non-COVID-19 hazards during an inspection.

1. Regional Administrators and Area Directors shall ensure that appropriate PPE is available for CSHOs.
2. In addition to respiratory protection, mentioned above, CSHOs will maintain at a minimum, goggles or face shield, disposable gloves, and disposable gowns or coveralls of appropriate size.
3. CSHOs should determine the appropriate PPE donning, doffing, and decontamination locations, where appropriate.
4. CSHOs should inquire and adhere to any facility-imposed PPE requirements.

See [FOM Chapter 3](#), Section II.C, Safety and Health Issues Relating to CSHOs. See also [ADM 04-00-003](#), OSHA Safety and Health Management System.

D. Additional CSHO precautionary guidance and inspection tools are provided in Appendix C and Appendix D of the most recent [COVID-19 NEP](#), including but not limited to:

1. Leave unnecessary equipment in the vehicle and retrieve only if necessary;
2. Place inspection equipment and materials in plastic bags when possible to prevent contamination;
3. Ensure hand sanitizer, disinfecting wipes, and bags to dispose of contaminated PPE and used materials are available in the vehicle;
4. Maximize the use of physical distancing at all times;
5. Avoid interviewing multiple employees in the same area at the same time;
6. Wash hands with soap and water or use hand sanitizers with at least 60% alcohol prior to leaving the site;
7. Practice contamination reduction techniques (*i.e.*, limit surface touching and subsequent hand-to-face touching); and
8. Avoid areas in the facility where acute patient care operations are underway, as necessary. If all alternative measures are exhausted and the CSHO must enter a high-risk area, they shall immediately stop the inspection activities and contact their Area Director/Assistant Area Director for further guidance.

E. In some instances, CSHOs may find that an employer's exposure assessment is

inadequate, has not been performed at all, the employer has not fully and properly implemented hazard controls, or a COVID-19 outbreak has occurred. In such cases, use professional judgment in anticipating exposure during a brief entry into a very high-risk work area, such as a COVID-19 patient room or area for inspection. CSHOs shall comply with the Regional or Area Office's respiratory protection program.

XV. Dates.

Effective dates: The rule is effective June 21, 2021. The incorporation by reference of certain publications listed in the rule is approved by the Director of the Federal Register as of June 21, 2021.

Compliance dates: Compliance dates for specific provisions are in 29 CFR § 1910.502(s). Employers must comply with all requirements of this section, except for requirements in paragraphs (i), (k), and (n) by July 6, 2021. Employers must comply with the requirements in paragraphs (i), (k), and (n) by July 21, 2021.

XVI. OSHA Information System (OIS) Coding Instructions.

All COVID-19-related enforcement activities (*i.e.*, inspections, complaints, and referrals, etc.) and compliance assistance interventions conducted shall be coded as "COVID-19" under the NEP Code field, as specified in the [COVID-19 NEP](#). Area Offices and State Plans following the NEP no longer use the previous "N-16-COVID-19" in the Additional Code field of OIS. The NEP code must be applied even if the establishment was not among the targeted NAICS listed in the appendices, as long as COVID-19-related hazardous conditions were investigated. However, State Plans not implementing the NEP are requested to continue using the previous N-16-COVID-19 code in the OIS for nationwide tracking purposes.

Additionally, all COVID-19-related inspections are to be coded under Inspection Category as a "Health" inspection, unless the inspection was initiated as an unprogrammed safety inspection where no COVID-19 related hazards were initially alleged, but were later found during the course of the inspection. In such a case, the inspection should be coded under Inspection Category as a "Safety" inspection.

CSHOs should also identify in OIS any COVID-19 violations or HALs using the Related Event Code (REC) field under the Additional Information Section in the violation screen. CSHOs should select "COVID-19" in the REC section. If applicable, other RECs should also be selected to relate the violation or HAL to the fatality, complaint, referral, etc. *The COVID-19 Related Event Code is in addition to the other COVID-19 coding required.*

NOTE: Until further notice, the agency will continue to track inspections conducted entirely remotely for COVID-19-related complaints, referrals, or fatalities. When an inspection is conducted entirely remotely, CSHOs shall enter the code "N-10-COVID-19 REMOTE" under the Additional Codes section in OIS for all COVID-19 related inspections that are conducted completely offsite, in addition to the code, COVID-19, for the NEP. In addition, Regions must retroactively code (if not previously done) all COVID-19-related remote inspections conducted since February

1, 2020. State Plans are strongly encouraged to begin or continue using the N-10-COVID-19 REMOTE code as well, so that data can be gathered on a nationwide basis.

Table 1, below, provides a summary of all COVID-19-related OIS codes.

Table 1. List of OIS codes for COVID-19-related inspections/activities

OIS Field	OIS Codes	Activity Type
NEP	COVID-19	All enforcement and compliance assistance activities conducted under the NEP (complaints, fatalities, referrals, inspections, etc.)
Additional Code	N-16-COVID-19	Code will only continue to be used by those State Plans that did <i>not</i> implement OSHA’s NEP
Additional Code	N-10-COVID-19 REMOTE	Code used for COVID-19-related inspections that are conducted completely off site
Additional Code	N-10-ABATEMENT DEFERRED	Inspections of establishments where there were hazards that would normally have been cited, but enforcement discretion was used to defer issuance of violation for COVID-19-related hazards (refer to Section XII.C.2. of the NEP for further guidance)
Related Event Code (REC)	COVID-19	All COVID-19-related violations and HALs

Appendix A

Additional Specifications for AIIRs and Ventilation References

See also: OSHA Directive, CPL 02-02-078, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis*, June 30, 2015, Appendix B, Testing Methods for Airborne Infection Isolation Rooms, www.osha.gov/enforcement/directives/cpl-02-02-078.

An AIIR is a single-occupancy negative pressure patient care room or enclosure (See definition of AIIR in Section IX. B. this Direction). Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually spread from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. AIIRs should be maintained under negative pressure (so that air flows under the door gap into the room). AIIRs should have an air change rate of ≥ 6 mechanical air changes per hour (ACH). Whenever feasible, the airflow rate should be raised to ≥ 12 mechanical ACH by adjusting or modifying the ventilation system or supplementing with air cleaning technologies. Achieving a total air change rate of ≥ 12 mechanical ACH should be a goal when designing new AIIRs or renovating existing AIIRs.

There should be direct exhaust of air from the room to the outside of the building or recirculation of air through a high-efficiency particulate air (HEPA) filter. The air from an AIIR should be exhausted directly to the outside of the building or, if recirculation of that air is unavoidable, passed through a HEPA filter. A HEPA filter is a filter that is at least 99.97% efficient in removing monodisperse particles of 0.3 micrometers in diameter. HEPA filters should be installed in the duct system exiting the room to remove infectious organisms from the air before the air returns to the general ventilation system. The employer should implement a scheduled maintenance program for HEPA filters that includes procedures for installing, removing, and disposing of filter elements

Maintenance on HEPA filters should be performed only by adequately trained and protected personnel, and only while the ventilation system or room-air recirculation unit is off. Employees performing maintenance and replacing filters on ventilation systems that are potentially contaminated with COVID-19 should wear appropriate respiratory protection in addition to eye and hand protection. When feasible, HEPA filters can be disinfected in a 10% bleach solution or in another appropriate bactericide before removal. In addition, filter housing should be labeled with appropriate warnings. Filters and other potentially contaminated materials should be disposed of in accordance with applicable local or state regulations. Pre-filters should be handled and disposed in the same manner as HEPA filters.

In circumstances where air from an AIIR must be recirculated back into the room (*e.g.*, where there is no general ventilation system), recirculation may be achieved by either fixed or portable room-air recirculation systems. Fixed recirculation systems are preferred to portable (freestanding) units because they can be installed with a higher degree of reliability and can have a higher airflow capacity than portable systems. Also, fixed systems reduce the potential for the short-circuiting of air as the distance between the air intake and exhaust is greater. AIIRs should be kept under negative pressure to induce airflow into the room or enclosure from all surrounding areas. Negative pressure must be monitored to ensure that air

is always flowing from the corridor (or surrounding area) into the AIIR. The negative pressure should be ≥ 0.01 inches of water gauge.

Negative pressure can be monitored using nonirritating smoke trails or other indicators to demonstrate that the direction of airflow is from the corridor or adjacent area into the AIIR. Pressure indicating equipment, such as continuous positive and negative pressure monitors, air velocity indicators, and alarms can be installed on an AIIR to verify proper room pressure.

Booths, tents, or hoods that discharge exhaust air into the room they are located in should incorporate HEPA filters at the discharge duct; the exhaust fan should be on the discharge side of the filter. If the device does not incorporate a HEPA filter, the exhaust should be exhausted directly to the outside and not recirculated.

Provisions should be made for emergency power to prevent interruptions in the performance of critical controls during a power outage. If there is no emergency power, the system should have dampers installed to isolate the AIIR or treatment room in the event of a power failure to prevent the backflow of contaminated air. If dampers are not automated, the facility should have a written procedure to initiate the timely closure of dampers if a power failure is detected.

CDC:

Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, December 30, 2005/Vol. 54/No. RR-17.

www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air

American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE):

Negative Pressure Rooms

www.ashe.org/negative-pressure-rooms

American Industrial Hygiene Association:

Reducing the Risk of COVID-19 Using Engineering Controls (September 9, 2020)

aiha-assets.sfo2.digitaloceanspaces.com/AIHA/resources/Guidance-Documents/Reducing-the-Risk-of-COVID-19-using-Engineering-Controls-Guidance-Document.pdf

Appendix B - Respiratory Protection Guidance by Activity and Standard¹

Exposure Risk Examples	Patient Status for COVID-19 (if applicable)	Respirator Use	Written Program	Medical Evaluations	Fit Testing	Training	User Seal Check	Re-use	Discontinuation	Notice
Aerosol Generating Procedures	positive / suspected or unknown ²	Employer provided. Required by 29 CFR § 1910.502(f)(3)(i)	Required to comply with 29 CFR § 1910.134							
Patient Care / All other employees	positive / suspected or unknown ²	Employer provided. Required by 29 CFR § 1910.502(f)(2)(i)	Required to comply with 29 CFR § 1910.134							
Patient Care	negative / not suspected	Employer provided in lieu of required facemask per 29 CFR § 1910.502(f)(4)(i)	Part of COVID-19 Plan	N/A	29 CFR § 1910.504(d)(1) - (d)(4)			N/A		
		Employee use their own in lieu of required facemask See 29 CFR § 1910.502(f)(4)(ii)	Part of COVID-19 Plan	N/A	N/A			29 CFR § 1910.504(c)		
Patient Care / All other required respirator use	negative / not suspected	Required use for protection against other (non-COVID) hazards/infectious agents (TB, varicella, cauterization or amputation procedures, etc.).	Required to comply with 29 CFR § 1910.134							
All employees - Facemasks required		Facemasks required See 29 CFR § 1910.502(f)(1)(i)	Part of COVID-19 Plan	N/A	N/A			N/A		
All employees – Respirators optionally used in lieu of required facemasks		Employer provided See 29 CFR § 1910.502(f)(4)(i)	Part of COVID-19 Plan	N/A	29 CFR § 1910.504(d)(1) – (d)(4)			N/A		
		Employee provides their own See 29 CFR § 1910.502(f)(4)(ii)	Part of COVID-19 Plan	N/A	N/A			29 CFR § 1910.504(c)		
All other industries for required or voluntary respirator use for protection against any respiratory hazard.		Required	Required to comply with 29 CFR § 1910.134							
		Voluntary use of FFR	29 CFR § 1910.134 Appendix D							
		Voluntary use of Elastomeric or PAPR	See 29 CFR § 1910.134(c)(2)(ii)							

Footnotes:

1. See [CPL 02-00-158](#) for enforcement of 29 CFR § 1910.134, and refer to this directive for enforcement of the ETS for COVID-19.
2. See sections on “Syndromic and Empiric Applications of Transmission-Based Precautions,” “Airborne Precautions,” and Table 2 in [CDC’s Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings \(2007\)](#) document, which is incorporated by reference in 29 CFR § 1910.509.

Appendix C

Additional Guidance for Determining Medical Removal Benefits

Citations for not providing medical removal benefits shall not identify the employee other than by job title or department unless, due the size of the establishment, that would identify the employee. Any cost that will continue to accrue until payment, such as back wages, insurance premiums, and the like should be stated as formulas—that is, amounts per unit of time, so that the proper amount to be paid the complainant is calculable as of the date of payment. For example, “The employer did not pay the surgical technician’s regular rate of pay in the amount of \$15.90 per hour, for 40 hours per week, from July 7, 2021, through the date of payment, less the customary deductions when the employee was working remotely due to COVID-19 exposure.”

In order to determine the employee’s regular rate of pay, the CSHO should request copies of the employee’s payroll records and prior year’s W-2 form from the employer and copies of pay stubs and any other relevant documentation from the employee. (The employer and the employee may redact the employee’s social security number from the copied document and if they do not, the CSHO shall keep the record confidential unless it is needed for court.) It is important to realize that circumstances have changed many employees’ incomes since the pandemic began and the CSHO needs to take extra care to determine current wages. Employees with similar job titles and seniority (if possible) should be interviewed regarding their wages to determine actual current income.

CSHOs should cite 29 CFR § 1910.502(1)(5)(ii) where the employer has failed to provide medical removal benefits. The CSHO may consult with a whistleblower protection investigator if needed to help determine how to calculate the amount owed by the employer. If the employee would have received a bonus during this time period or a medical plan, this would be factored into the regular rate of pay. Punitive damages are not to be assessed as part of this section but may fall under Section 11(c). If the employee would have left the job for any other reason than for medical removal under this section, then the counting period for the regular rate of pay will stop at the day of separation.

If the employee experienced adverse action or threat of adverse action as a result of medical removal, then a referral should be made to the Whistleblower Protection Program.