WATERVIEW NURSING CARE CENTER INFECTIOUS DISEASE / PANDEMIC EMERGENCY PLAN (PEP)

1 INTRODUCTION

As the COVID-19 pandemic surged around the world, Skilled Nursing Facilities and congregate care setting were especially at risk during this outbreak. Complicating the response further was that this pandemic was caused by a new pathogen, (novel virus), and to which there was no natural immunity or vaccination. We are still learning about how this disease is transmitted, which population is the most vulnerable and the best course of treatment. As a result of this, the State and Federal governments have enacted additional requirements for the safe operation of a home. This document lays out the required elements of new legal and regulatory responsibilities during a pandemic. All posted Policies and Procedures are current as of September 15, 2020 and are based on the current knowledge of Covid -19, CDC and DOH guidelines, regulations and NY Executive Orders as they exist. This Plan and the Policies and Procedures contained within are subject to amendment in accordance with any change to regulations, guidance and/or executive orders regarding this or any future pandemic.

2 PREPAREDNESS TASKS FOR ALL INFECTIOUS DISEASE EVENTS

2.1 Staff Education on Infectious Diseases

- The Facility Infection Preventionist (IP) in conjunction with Inservice Coordinator/Designee, must provide education on Infection Prevention and Management upon the hiring of new staff, as well as ongoing education on an annual basis and as needed should a facility experience the outbreak of an infectious disease.
- The IP/ Designee will conduct annual competency-based education on hand hygiene and donning/doffing Personal Protective Equipment (PPE) for all staff.
- The IP in conjunction with the Inservice Coordinator will provide in-service training for all staff on Infection Prevention policies and procedures as needed for event of an infectious outbreak including all CDC and State updates/guidance

(See Appendix A IPCP & Appendix B PPE Usage)

2.2 Develop/Review/Revise and Enforce Existing Infection Prevention Control, and Reporting Policies

The facility will continue to review/revise and enforce existing infection prevention control and reporting policies. The Facility will update the Infection Control Manual, which is available in a digital and print form for all staff, annually or as may be required during an event. From time to time, the facility management will consult with local Epidemiologist to ensure that any new regulations and/or areas of concern as related to Infection Prevention and Control are incorporated into the Facilities Infection Control Prevention Plans.

2.3 Conduct Routine / Ongoing, Infectious Disease Surveillance

- The Quality Assurance (QA) Committee will review all resident infections as well as the usage of antibiotics, on a monthly basis so as to identify any tends and areas for improvement.
- At daily Morning Meeting, the IDT team will identify any issues regarding infection control and

prevention.

- As needed, the Director of Nursing (DON)/Designee will establish Quality Assurance Performance Projects (QAPI) to identify root cause(s) of infections and update the facility action plans, as appropriate. The results of this analysis will be reported to the QA committee.
- All staff are to receive annual education as to the need to report any change in resident condition to supervisory staff for follow up.
- Staff will identify the rate of infectious diseases and identify any significant increases in infection rates and will be addressed.
- Facility acquired infections will be tracked/reported by the Infection Preventionist.

(See Appendix A. IPCP)

2.4 Develop/Review/Revise Plan for Staff Testing/Laboratory Services

- The Facility will conduct staff testing, if indicated, in accordance with NYS regulations and Epidemiology recommendations for a given infectious agent.
- The facility shall have prearranged agreements with laboratory services to accommodate any testing of residents and staff including consultants and agency staff. These arrangements shall be reviewed by administration not less than annually and are subject to renewal, replacement or additions as deemed necessary. All contacts for labs will be updated and maintained in the communication section of the Emergency Preparedness Manual.
- Administrator/ DON/Designee will check daily for staff and resident testing results and take action in accordance with State and federal guidance.

(See CEMP Sec 1.2 Emergency Contacts)
(See Appendix C Staff Testing)

2.5 Staff Access to Communicable Disease Reporting Tools

- The facility has access to Health Commerce System (HCS), and all roles are assigned and updated as needed for reporting to NYSDOH.
- The following Staff Members have access to the NORA and HERDS surveys: Administrator, Director of Nursing, Infection Preventionist, and Assistant Director of Nursing. Should a change in staffing occur, the replacement staff member will be provided with log in access and Training for the NORA and HERDS Survey
- The IP/designee will enter any data in NHSN as per CMS/CDC guidance

(See Appendix A. IPCP)

2.6 Develop/Review/Revise Internal Policies and Procedures for Stocking Needed Supplies

- The Medical Director, Director of Nursing, Infection Control Practitioner, Safety Officer, and other appropriate personnel will review the Policies for stocking needed supplies.
- The facility has contracted with Pharmacy Vendor (See CEMP Sec.1.2) to arrange for 4-6 weeks supply of resident medications to be delivered should there be a Pandemic Emergency.

- The facility has established par Levels for Environmental Protection Agency (EPA) approved environmental cleaning agents based on pandemic usage.
- The facility has established par Levels for PPE.

(See CEMP Section 24.7, CEMP Appendix H Emergency supplies)
(See Appendix B PPE & Appendix D Environmental Cleaning)

2.7 Develop/Review/Revise Administrative Controls with regards to Visitation and Staff Wellness

- All sick calls will be monitored by Department Heads to identify any staff pattern or cluster of symptoms associated with infectious agent. Each Dept will keep a line list of sick calls and report any issues to IP/DON during Morning Meeting. All staff members are screened on entrance to the facility to include symptom check and thermal screening.
- Visitors will be informed of any visiting restriction related to an Infection Pandemic and visitation restriction will be enforced/lifted as allowed by NYSDOH.
- A contingency staffing plan is in place that identifies the minimum staffing needs and prioritizes critical and non-essential services, based on residents' needs and essential facility operations. The staffing plan includes collaboration with local and regional DOH planning and CMS to address widespread healthcare staffing shortages during a crisis.

(See CEMP Sec. 24 Emergency Staffing & Appendix E Visitation & Screening)

2.8 Develop/Review/Revise Environmental Controls related to Contaminated Waste

- Areas for contaminated waste are clearly identified as per NYSDOH guidelines
- The facility environmental coordinator shall follow all Department of Environmental Conservation (DEC) and DOH rules for the handling of contaminated waste. The onsite storage of waste shall be labeled and in accordance with all regulations. The handling policies are available in the Environmental Services Manual. Any staff involved in handling of contaminated product shall be trained in procedures prior to performing tasks and shall be given proper PPE.
- The facility will amend the Policy and Procedure on Biohazardous wastes as needed related to any new infective agents.

(See Appendix F Regulated Medical Waste)

2.9 Develop/Review/Revise Vendor Supply Plan for food, water, and medication

- The facility currently has a 3-4 days' supply of food and water available. This is monitored on a quarterly basis to ensure that it is intact and safely stored.
- The facility has adequate supply of stock medications for 4-6 weeks.
- The facility has access to a minimum of 2 weeks supply of needed cleaning/sanitizing agents in accordance with storage and NFPA/Local guidance. The supply will be checked each quarter and weekly as needed during a Pandemic. A log will be kept by the Department head

responsible for monitoring the supply and reporting to Administrator any specific needs and shortages.

(See CEMP Appendix H Emergency Supplies)

2.10 Develop Plans to Ensure Residents are Cohorted based on their Infectious Status

- Residents are isolated/cohorted based on their infection status in accordance with applicable NYSDOH and Centers for Disease Control guidance.
- The facility Administration maintains communication with Local Epidemiologist, NYS DOH, and CDC to ensure that all new guidelines and updates are being adhered to with respect to Infection Prevention.
- The Cohort will be divided into three groups: Unknown, Negative, and Positive as it relates to the infectious agent.
- The resident will have a comprehensive care plan developed indicating their Cohort Group and specific interventions needed.

(See Appendix G Cohorting)

2.11 Develop a Plan for Cohorting residents using a part of a unit, dedicated floor or wing, or group of rooms

- The Facility will dedicate a wing or group of rooms at the end of a unit in order to Cohort residents. This area will be clearly demarcated as isolation area.
- Appropriate transmission-based precautions will be adhered to for each of the Cohort Groups as stipulated by NYS DOH
- Staff will be educated on the specific requirements for each Cohort Group.
- Residents that require transfer to another Health Care Provider will have their Cohort status communicated to provider and transporter and clearly documented on the transfer paper work.
- All attempts will be made to have dedicated caregivers assigned to each Cohort group and to minimize the number of different caregivers assigned.

(See Appendix G Cohorting)

2.12 Develop/Review/Revise a Plan to Ensure Social Distancing Measures

- The facility will review/ revise the Policy on Communal Dining Guidelines and Recreational Activities during a Pandemic to ensure that Social Distancing is adhered to in accordance with State and CDC guidance.
- The facility will review/revise the Policy on Recreational Activities during a Pandemic to ensure that Social Distancing is adhered to in accordance with State and CDC guidelines. Recreation Activities will be individualized for each resident.
- The facility will ensure staff break rooms and locker rooms allow for social distancing of staff
- All staff will be re-educated on these updates as needed

(See Appendix H Dinning & Appendix I Recreational Services)

2.13 Develop/Review/Revise a Plan to Recover/Return to Normal Operations

- The facility will adhere to directives as specified by, State and CDC guidance at the time of each specific infectious disease or pandemic event e.g., regarding how, when, which activities/procedures/restrictions may be eliminated, restored and the timing of when those changes may be executed.
- The facility will maintain communication with the local NYS DOH and CMS and follow guidelines for returning to normal operations. The decision for outside consultants will be made on a case by case basis taking into account medical necessity and infection levels in the community. During the recovery period residents and staff will continue to be monitored daily in order to identify any symptoms that could be related to the infectious agent.

(See CEMP Sec. 27 & Appendix 56 COOP Plan)

3 ADDITIONAL PREPAREDNESS PLANNING TASKS FOR PANDEMIC EVENTS

3.1 Develop/Review/Revise a Pandemic Communication Plan

- The Administrator in conjunction with the Social Service Director will ensure that there is an accurate list of each resident's Representative, and preference for type of communication.
- Communication of a pandemic includes utilizing established Staff Contact List to notify all staff members in all departments.
- The Facility will update website on the identification of any infectious disease outbreak of potential pandemic.

(See CEMP Sec. 20 Staff Notification)
(See Appendix J. Resident & Family Communication)

3.2 Develop/Review/Revise Plans for Protection of Staff, Residents, and Families Against Infection

- Education of staff, residents, and representatives
- Screening of residents
- Screening of staff
- Visitor Restriction as indicated and in accordance with NYSDOH and CDC
- Proper use of PPE
- Cohorting of Residents and Staff

(See Appendix A IPCP 7, Appendix B PPE, Appendix E Visitation & Screening, Appendix G Cohorting)

4 RESPONSE TASKS FOR ALL INFECTIOUS DISEASE EVENTS

4.1 Guidance, Signage, Advisories

- The facility will obtain and maintain current guidance, signage advisories from the NYSDOH and the U.S. Centers for Disease Control and Prevention (CDC) on disease-specific response actions.
- The Infection Preventionist/Designee will ensure that appropriate signage is visible in designated areas for newly emergent infectious agents
- The Infection Control Practitioner will be responsible to ensure that there are clearly posted signs for cough etiquette, hand washing, and other hygiene measures in high visibility areas.
- The Infection Preventionist/Designee will ensure that appropriate signage is visible in designated areas to heighten awareness on cough etiquette, hand hygiene and other hygiene measures in high visible areas.

(See Appendix L Gov't Agencies Contact)

4.2 Reporting Requirements

- The facility will assure it meets all reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYCRR 2.10 Part 2), as well as by 10 NYCRR 415.19
- The DON/Infection Preventionist will be responsible to report communicable diseases via the NORA reporting system on the HCS
- The DON/Infection Preventionist will be responsible to report communicable diseases on NHSN as directed by CMS.

(See Appendix A IPCP)

4.3 Signage (Refer to Section 4.1)

4.4 Limit Exposure

- The facility will implement the following procedures to limit exposure between infected and non-infected persons and consider segregation of ill persons, in accordance with any applicable NYSDOH and CDC guidance, as well as with facility infection control and prevention program policies.
- Facility will Cohort residents according to their infection status
- Facility will monitor all residents to identify symptoms associated with infectious agent.
- Units will be quarantined in accordance with NYSDOH and CDC guidance and every effort will be made to cohort staff.

- Facility will follow all guidance from NYSDOH regarding visitation, communal dining, and activities and update policy and procedure and educate all staff.
- Facility will centralize and limit entryways to ensure all persons entering the building are screened and authorized.
- Hand sanitizer will be available on entrance to facility, exit from elevators, and according to NYSDOH and CDC guidance
- Daily Housekeeping staff will ensure adequate hand sanitizer and refill as needed.

(See Appendix A IPCP & Appendix G Cohorting)

4.5 Separate Staffing

- The facility will implement procedures to ensure that as much as is possible, separate staffing is provided to care for each infection status cohort, including surge staffing strategies.

(See CEMP Sec. 24 Emergency Staffing & Appendix G Cohorting)

4.6 Conduct Cleaning/Decontamination

- The facility will conduct cleaning/decontamination in response to the infectious disease utilizing cleaning and disinfection product/agent specific to infectious disease/organism in accordance with any applicable NYSDOH, EPA, and CDC guidance.

(See Appendix D Environmental Cleaning)

4.7 Educate Residents, Relatives, and Friends About the Disease and the Facility's Response

- The facility will implement procedures to provide residents, relatives, and friends with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information.
- All residents will receive updated information on the infective agent, mode of transmission, requirements to minimize transmission, and all changes that will affect their daily routines.

(See Appendix A IPCP & Appendix J Communication)

4.8 Policy and Procedures for Minimizing Exposure Risk (See section 4.4)

- The facility will contact all staff including Agencies, vendors, other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents and staff.
- Consultants that service the residents in the facility will be notified and arrangements made for telehealth, remote chart review, or evaluating medically necessary services until the recovery phase according to State and CDC guidelines.

(See Appendix E Visitation / Screening)

4.9 Advise Vendors, Staff, and other stakeholders on facility policies to minimize exposure risks to residents

- Subject to any superseding New York State Executive Orders and/or NYSDOH guidance that may otherwise temporarily prohibit visitors, the facility will advise visitors and vendors to limit/discontinue visits to reduce exposure risk to residents and staff.
- Emergency staff including EMS will be informed of required PPE to enter facility
- Vendors will be directed to drop off needed supplies and deliveries in a designated area to avoid entering the building.
- The facility will implement closing the facility to new admissions in accordance with any NYSDOH directives relating to disease transmission.

(See Appendix E Visitation / Screening)

4.10 Limiting and Restriction of Visitation

- The facility will limit and or restrict visitors as per the guidelines from the NYSDOH
- Residents and Representatives will be notified as to visitation restrictions and/or limitations as regulatory changes are made.

(See Appendix E Visitation / Screening)

5 ADDITIONAL RESPONSE TASKS FOR PANDEMIC EVENTS

5.1 Ensure Staff Are Using PPE Properly

- The facility has an implemented Respiratory Protection Plan
- Appropriate signage shall be posted at all entry points, and on each residents', door indicating the type of transmission-based precautions that are needed.
- Staff members will receive re-education and have competency done on the donning and doffing of PPE.
- Infection Control rounds will be made by the DON, IP, and designee to monitor for compliance with proper use of PPE
- The facility has a designated person to ensure adequate and available PPE is accessible on all shifts and staff are educated to report any PPE issues to their immediate Supervisor

(See Appendix B PPE)

5.2 Post a Copy of the Facility's PEP

- The facility will post a copy of the facility's PEP in a form acceptable to the commissioner on the facility's public website and make available immediately upon request.
- The PEP plan will be available for review and kept in a designated area (Conference Room)

5.3 The Facility Will Update Family Members and Guardians

- The facility will communicate with Residents, Representatives as per their preference i.e. Email, text messaging, calls/robocalls, hotline and document all communication preference in the CCP/medical record.

- During a pandemic Representatives of residents that are infected will be notified daily by Nursing staff as to the resident's status.
- Representatives will be notified when a resident experience a change in condition
- Representatives will be notified weekly on the status of the pandemic at the facility including the number of pandemic infections.
- The Hotline message will be updated within 24 hours indicating any newly confirmed cases and/or deaths related to the infectious agent.
- Residents will be notified with regards to the number of cases and deaths in the facility unless they verbalize that they do not wish to be notified. This will be documented in the medical record/CCP
- All residents will be provided with daily access to communicate with their representatives. The type of communication will be as per the resident's preference i.e. video conferencing/telephone calls, and/or email.

(See Appendix J Communication)

5.4 The Facility Will Update Families and Guardians Once a Week– (See Section 3.1 Above)

5.5 Implement Mechanisms for Videoconferencing

- The facility will provide residents with no cost, daily access to remote videoconference or equivalent communication methods with Representatives
- The Director of Recreation/Designee will arrange for the time for all videoconferencing

(See Appendix I Recreational Services & Appendix J Communication)

5.6 Implement Process/Procedures for Hospitalized Residents

- The facility will implement the following process/procedures to assure hospitalized residents will be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415(i); and 42 CFR 483.15(e).
- Prior to Admission/readmission the DON/designee will review hospital records to determine resident needs and facility's ability to provide care including cohorting and treatment needs.

(See Appendix K Bed Hold During a Pandemic)

5.7 Preserving a Resident's Place

- The facility will implement processes to preserve a resident's place in a residential health care facility if such resident is hospitalized, in accordance with all applicable laws and regulations including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).

(See Appendix K Bed Hold During a Pandemic)

5.8 The Facility's Plan to Maintain at least a two-month supply of Personal Protective Equipment (PPE)

- The facility has implemented procedures to maintain at least a two-month (60 day) supply of PPE (including consideration of space for storage) or any superseding requirements under New York State Executive Orders and/or NYSDOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic.
- This includes, but is not limited to:
  - N95 respirators
  - Face shield
  - Eye protection
  - Isolation gowns
  - Gloves
  - Masks
  - Sanitizer and disinfectants (meeting EPA Guidance current at the time of the pandemic)
  - Facility will calculate daily usage/burn rate to ensure adequate PPE

(See CEMP Section 24.7, CEMP Appendix H Emergency supplies)
(See Appendix B PPE)

6 RECOVERY OF ALL INFECTIOUS DISEASE EVENTS

6.1 Activities/Procedures/Restrictions to be Eliminated or Restored

- The facility will maintain review of, and implement procedures provided in NYSDOH and CDC recovery guidance that is issued at the time of each specific infectious disease or pandemic event, regarding how, when, which activities/procedures/restrictions may be eliminated, restored and the timing of when those changes may be executed.

(See CEMP Sec. 27 & Appendix 56 COOP Plan)

6.2 Recovery/Return to Normal Operations

- The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders.
- The facility will ensure that during the recovery phase all residents and staff will be monitored and tested to identify any developing symptoms related to the infectious agent in accordance with State and CDC guidance.
- The facility will screen and test outside consultants that re-enter the facility, as per the NYS DOH guidelines during the recovery phase.

(See CEMP Sec. 27 & Appendix 56 COOP Plan)
(See Appendix C Staff Testing)

7 APPENDIX A. INFECTION PREVENTION AND CONTROL PROGRAM (IPCP)

7.1 Introduction

Waterview Nursing Care Center's infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement (QAPI) program.
The elements of the infection prevention and control program consist of co-ordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, employee education, and employee health and safety.

7.2 Coordination and Oversight

1. The infection prevention and control (IPC) program is coordinated and overseen by an infection preventionist (IP).
2. The qualifications and job responsibilities of the IP are outlined in the *Infection Preventionist Job Description*.
3. The IPC committee is responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include:
    a. Whether physician management of infections is optimal
    b. Whether antibiotic usage patterns need to be changed because of the development of resistant strains
    c. Whether there is appropriate follow up of acute infections
4. The committee meets regularly to review and revise any guidelines or policies

7.3 Policies and Procedures

1. Policies and procedures are utilized as the standards of the IPC program.
2. The IPC committee (medical Director, DNS and IP) and other key clinical and administrative staff will review the infection control policies at least annually. The review will include:
    a. Updating or supplementing policies and procedures as needed;
    b. Assessment of staff compliance with existing policies and regulations; and
    c. Any trends or significant problems since the last review.

7.4 Surveillance

1. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications.
2. Standard criteria are used to distinguish community-acquired from facility-acquired infections.

7.5 Antibiotic Stewardship

1. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.
2. Medical criteria and standardized definitions of infections are used to help recognize and manage infections.
3. Antibiotic usage is evaluated and practitioners are provided feedback on reviews.

7.6 Data Analysis

1. Data gathered during surveillance is used to oversee infections and spot trends.
2. One method of data analysis is by manually calculating number of infections per 1000 resident days.

7.7 Communication and Reporting

In accordance with Public Health Law certain diseases are reported to the NYDOH

1. NYSDOH Regulated Article 28 nursing homes:

a. Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10 NYCRR 2.10), as well as by 10 NYCRR 415.19.[1]

b. Any outbreak or significant increase in nosocomial infections above the norm or baseline in nursing home residents or employees must be reported to NYSDOH. This can be done electronically via the Nosocomial Outbreak Reporting Application (NORA). NORA is a NYSDOH Health Commerce System Application. Alternately, facilities may fax an Infection Control Nosocomial Report Form (DOH 4018) on the DOH public website.

– Facilities are expected to conduct surveillance that is adequate to identify background rates and detect significant increases above those rates. Healthcare associated infection outbreaks may also be reported to the LHD.

A single case of a reportable communicable disease or any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) must be reported to the local health department (LHD) where the patient/resident resides. In addition, if the reportable communicable disease is suspected or confirmed to be acquired at the NYSDOH regulated Article 28 nursing home, it must also be reported to the NYSDOH. This can be done electronically via the NORA, or, by faxing an Infection Control Nosocomial Report Form (DOH 4018).

c. Reports must be made to the local health department in the county in which the facility is located (as the resident's place of residence) and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately by phone.

[1] A list of diseases and information on properly reporting them can be found below.

d. Categories and examples of reportable healthcare-associated infections include:

- An outbreak or increased incidence of disease due to any infectious agent (e.g. staphylococci, vancomycin resistant enterococci, Pseudomonas, Clostridioides difficile, Klebsiella, Acinetobacter) occurring in residents or in persons working in the facility.
- Intra-facility outbreaks of influenza, gastroenteritis, pneumonia, or respiratory syncytial virus.
- Foodborne outbreaks.
- Infections associated with contaminated medications, replacement fluids, or commercial products.
- Single cases of healthcare-associated infection due to any of the diseases on the Communicable Disease Reporting list. For example, single cases of nosocomial acquired Legionella, measles virus, invasive group A beta hemolytic Streptococcus.
- A single case involving Staphylococcus aureus showing reduced susceptibility to vancomycin.
- Clusters of tuberculin skin test conversions.
- A single case of active pulmonary or laryngeal tuberculosis in a nursing home resident or employee.
- Increased or unexpected morbidity or mortality associated with medical devices, practices or procedures resulting in significant infections and/or hospital admissions.
- Closure of a unit or service due to infections.

e. Additional information for making a communicable disease report:

- Facilities should contact their NYSDOH regional epidemiologist or the NYSDOH Central Office Healthcare Epidemiology and Infection Control Program for general questions and infection control guidance or if additional information is needed about reporting to NORA. Contact information for NYSDOH regional epidemiologists and the Central Office Healthcare Epidemiology and Infection Control Program is located here: https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/regional_epi_staff.htm. For assistance after hours, nights and weekends, call New York State Watch Center (Warning Point) at 518-292-2200.
- Call your local health department or the New York State Department of Health's Bureau of Communicable Disease Control at (518) 473-4439 or, after hours, at 1 (866) 881-2809; to obtain reporting forms (DOH-389), call (518) 474-0548.
- For facilities in New York City:
  - Call 1 (866) NYC-DOH1 (1-866-692-3641) for additional information.
  - Use the downloadable Universal Reporting Form (PD-16); those belonging to NYC MED can complete and submit the form online.

2. Infection prevention/control will communicate with the Facility leadership, QA committee and healthcare personnel on issues specific to infection surveillance, prevention, and control. These issues will include, but may not be limited to:
a. Facility-associated and community acquired infection surveillance findings (site specific);
b. Compliance with performance improvement monitor(s) (i.e., hand hygiene);
c. Results of environmental rounds;
d. Relevant changes in infection prevent ion/control policies and /or guidelines

3. When a resident is referred or transferred and a facility-associated infection is identified, the infection prevention/control team will communicate with the referring and/or receiving health care facility.

7.8 Outbreak /Epidemic/Pandemic Management

1. Outbreak management is a process that consists of:
    a. Determining the presence of an outbreak
    b. Managing the affected residents
    c. Preventing the spread to other residents
    d. Documenting information about the outbreak
    e. Reporting the information to appropriate public health authorities
    f. Educating the staff, residents and healthcare representatives
    g. Monitoring for recurrences
    h. Reviewing the care after the outbreak has subsided
    i. Recommending new or revised policies to handle similar events in the future

7.9 Prevention of Infection

1. Important facets of infection prevention include:
    a. Identifying possible infections or potential complications of existing infections
    b. Instituting measures to avoid complications
    c. Educating staff and ensuring that they adhere to proper techniques and procedures
    d. Enhancing screening for possible significant pathogens
    e. Immunizing residents and staff to try to prevent illness
    f. Implementing appropriate isolation precautions when necessary, and
    g. Following established general and disease-specific guidelines such as those of the CDC.

7.10 Immunization

1. Immunization is a form of primary prevention
2. Widespread use of influenza vaccine in this nursing facility is strongly encouraged
3. Policies and procedures for immunization include the following:
    a. The process for administering vaccines;
    b. Who should be vaccinated;
    c. Contraindications to vaccinations;
    d. Obtaining consent;
    e. Monitoring for side effects of vaccination, and

f. Availability if the vaccine.

7.11 Healthcare Workers & Resident / Family Education

In an effort to educate staff and residents the facility will provide:

1. Infection prevention and control provides education, based on surveillance findings, outbreak analyses or changes in scientific knowledge / guidelines in the area of infection prevention and control to employees, residents and families as appropriate.
2. New employee orientation, in addition to orientation specific to new nursing professionals, is provided as scheduled. Mandatory educational offerings, including but not limited to bloodborne pathogen and general infection prevention/control occur no less than annually.
3. Infection prevention and control, in collaboration with other direct resident care providers, provides education to residents, families and visitors as appropriate.

7.12 Employee / Resident Health

Facility staff is screened at time of hire by employee health. Policies and procedures include:

1. Screening all staff, including LIPs for exposure and/or immunity to communicable disease
2. Referral for assessment, potential testing, immunization and/or prophylaxis all staff identified as having a communicable disease or having been exposed to a communicable disease.
3. Referral for assessment, potential testing, immunization and/or prophylaxis all staff identified as having an occupational exposure.
4. In the event a resident is exposed to a communicable disease they will be provided with or referred for assessment, testing, immunization, prophylaxis/treatment or counseling.
5. All residents are given the influenza vaccination unless they refuse or have medical contraindications
6. All residents, meeting criteria, are given the pneumococcal vaccine unless they refuse or medical contraindications.

7.13 References

Patterson Bursdall, D. & Marx, J.F. (2019). Infection Prevention in Long Term Care. Association for Professionals in Infection Control and Epidemiology (*2nd Ed*.)

8 APPENDIX B. PERSONAL PROTECTIVE EQUIPMENT (PPE)

The facility will provide the necessary Personal Protective Equipment (PPE) to its staff in order to protect the health wellbeing of staff and residents. The facility will ensure there are adequate numbers and items of PPE during a pandemic. In accordance with NYS Chapter 114 of the Laws of 2020, and based on the HERDS survey data for the period April 13-27, 2020, the facility will have on stock or on contract a 60-day supply of PPEs

In the event there is a scarcity of scarcity of PPEs in New York State, the facility will be vigilant and conscientious about proper disinfection and sanitization techniques of all provided PPEs administered to ONLY frontline workers that are in involved in direct patient care. This guideline will reinforce to preserve and extend the usage of PPEs.

8.1 Procurement, Storage & Tracking

1. The facility has an adequate supply of PPE, including types that will be kept in stock, the facility has initiated measures for procuring their own PPE supply (e.g., facemasks, N95 respirators, gowns, gloves and eye protection such as face shields or goggles and hand sanitizer.
2. The Facility has existing contracts with has existing contracts or relationships with PPE vendors to facilitate the replenishment of stock. (See CEMP Section 24.7 & Appendix H). The storage location(s) for PPE are in the South Wing.
3. The facility will communicate with local and state and federal Emergency Management to procure PPE during a pandemic to ensure adequate supplies as needed.
4. Signs are posted immediately outside of resident rooms and any pandemic designated units indicating appropriate infection control and prevention precautions and required PPE in accordance with NYS and CDC guidance.
5. Residents' rooms requiring transmission-based precautions will have isolation carts containing PPEs outside of the residents' rooms for easy accessibility.
6. The Central Supply Coordinator in conjunction with Administrator and Infection Preventionist will track PPE usage and ensure adequate PPE is accessible to staff providing care.
7. The Central Supply Coordinator/Designee will distribute PPE for each shift ensuring adequate PPE is available and restocked as needed
8. The IP and Central Supply Coordinator will calculate the burn rate (determines the number/amount of a given supply) of PPEs to ensure adequacy of supplies.

   Burn Rate = Quantity used/day
   For example, on any given day, there are approximately 200 staff that will need to wear surgical masks. On average, that number of staff will need to each change masks 5-6 times per day. So 6 masks/day x 200 employees = 1200 masks/day. This will be the burn rate – or the number of masks the facility will burn (use) per day.
9. Staff will be educated on proper hand hygiene, PPE usage and conservation (See https://repository.netecweb.org/exhibits/show/ppe-cons/ppe-cons for further conservation strategies).

9 APPENDIX C. STAFF/ VENDOR TESTING

The facility has implementing this procedure for compliance with New York EO 202.30 requiring the operators and administrators of all nursing homes to test or make arrangements for the testing of all personnel, including all employees, contract staff, medical staff, operators and administrators, for infection. Such testing must occur once per week. Any positive test result shall be reported to the Department by 5:00 p.m. of the day following receipt of such test result.

1. The Facility has an agreement with a certified lab to provide testing as available and in accordance with NYSDOH and FDA approved testing to provide test results for all tests in a timely manner. (See CEMP Sec 1.2 Emergency Contacts)
2. The Facility will ensure that testing, not provided by the facility, is reasonably accessible for its personnel.
    - Facility will offer testing to their personnel through the contracted lab.
    - Facility may direct their personnel to a local drive-through or walk-in testing site.
    - Facility shall accept documentation of testing conducted by an individual's healthcare provider.
3. The Facility shall maintain records of personnel testing and results for a period of one year.
4. All employees, contract staff, medical staff, operators, and administrators that refuse testing shall not be permitted to enter or work at the facility until such test is performed and this list shall be maintained at the security desk.
5. For staff which test positive or are symptomatic on the disease, the then current Federal and/or State guidelines will be followed
6. All staff testing positive shall be documented on the log and the number will be reported on all required submissions to NYSDOH HERDS and CDC daily report.
7. Staff will receive Inservice Education on the NH infection Testing policies/procedures.

10 APPENDIX D. ENVIRONMENTAL SERVICES – CLEANING RESIDENT ROOMS

10.1 Definitions

Cleaning: the removal of visible soil from surfaces through physical action of scrubbing with a surfactant or detergent and water.

Low-Level Disinfection: destroys all vegetative bacteria (except tubercle bacilli) and most viruses. Does not kill bacterial spores. Examples: hospital disinfectants registered with the EPA with HBV and HIV label claim (purple top wipes). These are generally appropriate for most **environmental surfaces.**

Intermediate-Level Disinfection: kills a wider range of pathogens than a low-level disinfectant. Does not kill bacterial spores. Examples: EPA-registered hospital disinfectants with a tuberculocidal claim (purple top wipes). May be considered for environmental surfaces that are visibly contaminated with blood.

Kill Claim: information about which pathogens the disinfectant kills; found on the product label.

Contact Time: the time a disinfectant should be in direct contact with a surface to ensure that the pathogens specified on the label are killed. In order words, the amount of time a surface has to stay wet after being cleansed/disinfected with the product. Example, purple top wipe, 2 minutes.

10.2 General Guidelines

1. Housekeeping surfaces (e.g. tabletops and floors) will be cleaned daily, when spills occur, and when these surfaces are visibly soiled.
2. All environments/areas (e.g. lobby, hallways, common areas, medication rooms, nurses' stations) and residents' rooms will be disinfected (or cleaned) daily and when surfaces are visibly soiled.
3. When there is an outbreak (e.g. Influenza, Norovirus), residents' rooms and other environmental surfaces (e.g. rails in hallways; elevators, to include keypads; common areas) will be disinfected and/or cleaned more often.
4. When there is a room with a known multi-drug resistant organism (MDRO), room environment will be disinfected and cleaned regularly; mops and cleaning cloths will be dedicated for use in this room only.
5. Utility rooms/porters' closets to be cleaned daily by housekeeping staff as determined by facility's schedule
6. Garbage will be removed at scheduled times per facility protocol.
7. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including:
    a. Recommended use-dilution
    b. Material compatibility
    c. Storage
    d. Shelf life, and
    e. Safe use and disposal
8. Walls, blinds and window curtains in resident areas will be cleaned at least every 3 months and when these surfaces are visibly contaminated or soiled.

9. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently.
10. Personnel should remain alert for evidence of rodent activity (droppings) and report findings to Director of EVS/Housekeeping and log in Pest Control Log Book.
11. Clean medical waste containers intended for reuse (e.g. garbage bins/pails) daily or when such receptacles become visibly contaminated with blood, body fluids or other potentially infectious materials.
12. Perform hand hygiene (wash hands with alcohol-based hand rub [ABHR] or soap and water for 20 seconds) after removing gloves.
13. Common intermediate and low-level disinfectants for smooth, hard surfaces and non-critical items include:
    a. Ethyl or isopropyl alcohol (70 - 90%)
    b. Sodium hypochlorite/household bleach (5.25-6.15% diluted 1:500 or per manufacturer's instructions)
    c. Phenolic germicidal detergent (follow product label for use-dilution)
    d. Iodophor germicidal detergent (follow product label for use-dilution)
    e. Quaternary ammonium germicidal detergent for low-level disinfection only (follow product label for use-dilution)

10.3 Equipment and Supplies

1. Environmental service cart (do not take in resident's rooms)
2. Disinfecting solution
3. Cleaning cloths
4. Mop
5. Bucket
6. Personal protective equipment (e.g. gown, mask, gloves, as needed)

10.4 Procedure

1. Gather supplies as needed
2. Prepare disinfectant according to manufacturer's recommendations
3. Discard disinfectant/detergent solutions that become soiled or clouded with dirt and grime and prepare fresh solution
4. Change cleaning cloths when they become soiled. Wash cleaning cloths daily and allow cloths to dry before reuse.
5. Clean horizontal surfaces (e.g. overbed tables, chairs) daily with a cloth moistened with disinfectant solution. Use appropriate EPA-approved disinfectant for specific pathogens. Do not use feather dusters. In the event of a novel pandemic, refer to the EPA's recommendations for appropriate cleaning/disinfecting agents.
6. Clean personal use items (e.g. lights, phones, call bells, bedrails, bed remote, etc.) with disinfection solution daily.
7. When cleaning rooms of residents on isolation precautions, use personal protective equipment (PPE) as indicated.
8. When possible, isolation rooms should be cleaned last and water discarded after cleaning room.
9. Utilize disinfectant solution based on type of precaution.

10. Clean curtains, window blinds, and walls at least every 3 months or when they are visibly soiled or dusty.
11. Clean spills of blood or body fluids as follows:
    a. Use personal protective equipment, that is, gloves (heavy duty if available)
    b. Spray area with bleach
    c. Wipe spill or splash with a cloth or paper towels
    d. Discard saturated cloth or paper towels into red "biohazard" bag
    e. Repeat as necessary until the spill or splash area is dry.
    f. Spray disinfectant solution onto the discarded cloth or paper towels inside the plastic bag.
    g. Tie the bag. If the outside of the bag becomes contaminated with blood, body fluids, secretions, or excretions, place the contaminated bag into a clean plastic bag.
    h. Place the plastic bag into a designated red container for medical waste, located in the soiled utility room on each unit.
    i. Remove gloves, discard.
    j. Wash hands with soap and water (at least 20 seconds).
12. Refer to checklist for daily room cleaning.

10.5 Terminal Room Cleanings

1. Terminal room cleaning is done when a resident is transferred, discharged, or expires.
2. Gather cleaning equipment and supplies (gloves, disinfectants, cleaning cloth, plastic trash bag, mop, bucket).
3. Prepare disinfectant according to manufacturers' recommendations
    a. Use fresh solutions for terminal and thorough cleaning of all rooms
    b. Discard solution when the procedure has been completed
4. Clean all high-touch furniture items (e.g. overbed tables, bedside tables, chairs, and beds) with disinfectant solution or appropriate wipe
5. Clean all high-touch personal use items (e.g. lights, phones, call bells, bed rails, bed remote, etc.) with disinfectant solution.
6. Discard personal (e.g. toothbrush, toothpaste, mouthwash, lotion, soaps, bodywash, etc.) and single-resident use items (e.g. thermometers)
7. Clean all equipment, if present, in room (ex: nebulizer machine, tube feeding pump, IV poles, concentrator, etc.) and return to designated storage area.
8. Refer to checklist for terminal room cleaning

10.6 References

CDC. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/tables/table1.html

CDC. Options for Evaluating Environmental Cleaning
https://www.cdc.gov/hai/toolkits/evaluating-environmental-cleaning.html

EPA. Selected EPA-Registered Disinfectants.
https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

Yale, S.L. and Levenson, S.A. (2016).

11 APPENDIX E. VISITATION AND SCREENING

During a pandemic, visitation for residents, families and resident representatives will be limited or restricted based on guidelines established by the Centers of Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH). The facility will make every effort to ensure safety and adherence to infection prevention and control strategies in order to minimize any potential spread of infection.

1. Compassionate End of Life Visitation during community lockdown may be granted depending on the governmental guidance at that time as well as the availability of PPE. Such visitors will be actively screened for temperature and other symptoms related to the disease and be given PPE to wear at all times while in the facility. If symptoms are present the visitor will not be allowed in the facility.
2. Families will be to drop off personal items, and/or food items for residents at front desk. Items will be delivered by assigned staff member with appropriate PPE
3. The facility will encourage visitors wash or sanitize their hands upon entering upon entering
4. All visitors will be encouraged to come in with their nose and mouth covered. They will be provided with mask if not.
5. Family visitors will not allow visitors past the front desk.
6. The facility will communicate this policy to residents' family member via mail, phone calls, social media posts and the information hotline.
7. All staff and authorized visitors (i.e. vendors) will be actively screened for disease symptoms including fever and respiratory symptoms at start of each shift and every 12 hours. A log of this screening will be completed upon entry to the facility.
8. Staff and authorized visitors will be required to use provided hand sanitizers/hand sink when entering the facility
9. Staff and authorized visitors (i.e. vendors) are to wear face masks at all times and practice social distancing in the facility when possible.
10. Staff and vendors will be educated on the signs and symptoms of disease and asked to self-monitor while not at work.
11. Staff and vendors will be instructed not to come to work if they exhibit a fever of ≥100.0° , have shortness of breath or a cough. Staff will call the facility prior to coming to work if they are unsure.

12 APPENDIX F. REGULATED MEDICAL (BIOHAZARD) WASTE

The facility will dispose of regulated medical waste in accordance with Chapter 738 of the Public Health law of 1993 and #10 NYCRR 70.
Also, in accordance with the above cited laws, it is the facility will receive and appropriately dispose of "sharps" (only) collected from private residences.

12.1 Definition of Regulated Medical Waste

1. "Regulated Medical Waste shall mean waste which is generated in the diagnosis, treatment or immunization of human beings…"

2. There are six (6) sub-categories within the general definition of regulated medical waste. Three (3) of these categories are not applicable to the Nursing Home setting. The three (3) categories that do apply are as follows:

1. Human Pathological Waste

This waste includes organs, body parts and body fluids. Urine is not considered regulated medical waste, unless it is submitted as a clinical specimen for laboratory testing. However, if a patient is found to have a disease which may be transmitted through urine, then the material containing this fluid, including diapers, must be considered regulated medical waste.

Incontinence Materials (diapers, etc.) are generally not considered regulated medical waste, provided that the patient does not have an infectious disease which can be transmitted by urine. Since feces always contains microorganisms and since these microorganisms, even if potentially pathogenic, cannot be transmitted from trash containers or disposable sites; therefore, fecal contaminated materials, including diapers are not considered to be regulated waste.

2. Human Blood & Body Parts

"This waste shall include discarded human blood, discarded blood components, (9e.g. serum and plasma) containers with free flowing blood or blood components or discarded saturated materials containing free flowing blood or blood components and materials saturated with blood or blood products…"

3. Sharps

This waste includes sharps used in human patient care. Sharps include syringes with attached needles, needles and lancets. Because of the potential to break and give rise to puncture or laceration wounds, glass tubes, flasks, beakers, etc., must also be considered as sharps and be disposed of accordingly.

12.2 Procedures for Managing Regulated Medical Waste

1. The soiled utility room on each unit shall contain a sealed container with a leak proof and puncture resistant bag. Both the container and the door leading to the soiled utility room shall have affixed to them the "Bio-Hazard" sign.

2. Once each day, in the morning the Housekeeping Department will pick up the bags, appropriately tie them and place these bags in approved transporting boxes located in the "Infectious Waste" storage areas. This storage area is duly marked by a "Bio-Hazard" sign. This Infectious Waste storage area is to be locked at all times and only Housekeeping and Administration have keys. Housekeeping personnel are provided with appropriate protective equipment, including gloves, aprons, etc., when handling regulated waste materials.
3. On a monthly basis, all regulated medical waste is picked up at the Home by a licensed Medical Waste Transporter.
4. The licensed Medical Waste Transporter (with whom the home maintains a written contractual agreement for services) prepares a manifest, listing the number of boxes taken. Both the name of the generator (the Home) and the name of the transporter are printed on each box. The manifest also contains name, address, and permit number of the "Disposer."
5. Within thirty (30) days of pick-up, the facility receives via U.S. mail a copy of the manifest, signed by the Disposer. These signed manifests are to be kept by the Home for at least six (6) years.

12.3 Internal Procedures for Collecting Regulated Medical Waste

1. The Director of Nursing or her designee will notify the Director of Housekeeping of the need to isolate a resident.
2. Two (2) containers, each with leak proof and puncture resistant bags and Bio-hazard labels will be provided by the Housekeeping Department and Nursing personnel will place these containers in each resident's ante-room. These containers will each be labeled as follows:

   a. Linen

   b. Trash

   Personal clothing will be placed in a leak proof and puncture resistant bags and taken directly to the soiled utility room immediately after use.

   Housekeeping personnel should not enter the isolated room unless supervised by a Registered Nurse and then only with the appropriate protective clothing and equipment.

3. Daily, these labeled bags are collected by the Housekeeping Department from the Soiled Utility Room.
   a. The **Linen** bags are stored in the Soiled Laundry Room in a secured area. These bags are picked up twice weekly by the outside laundry company and are washed in the double red bags, which are degradable.
   b. **Personal Clothing Bags** are stored in the Soiled Laundry Room until they are washed in-house, after all other laundry has been washed. Since personal clothing cannot be washed together, Laundry personnel will wear appropriate protective clothing during the sorting and handling process. After washing this clothing, the washing machine will be disinfected with Lysol liquid or bleach.
   c. **Trash bags** are placed by Housekeeping personnel in approved transportation boxes in the Infectious Waste storage area and are handled in accordance with the guidelines from the above section "Managing Regulated Waste."

12.4 Procedures for Managing Sharps/Disposable Razors Generated In-House

The primary container for discarded sharps shall be rigid, leakproof, puncture-resistant and closable, and may serve as a secondary container for purposes of transport, provided it meets the definition of a secondary container.

1. Under no circumstances shall a sharps container be filled beyond the fill line indicated on the container.
2. Sharps containers shall be removed from patient care areas to a room or area designated for regulated medical waste storage, whenever the container has reached the fill line indicated on the container. Sharps containers shall be removed from patient care areas within thirty (30) days or upon the generation of odors or other evidence of putrification, whichever occurs first, without regard to fill level.
3. Regulated medical waste, with the exception of sharps as provided in subdivision (e) of this section, may be held in patient care areas for a period not to exceed twenty-four (24) hours and at a clinical laboratory for a period not to exceed seventy-two (72) hours, at which time the waste shall be moved to a storage area.
4. Each storage area shall be adequate for the volume of regulated medical waste generated between scheduled waste pick-ups by a transporter, or, for facilities treating the waste on-site, the volume of waste that can be treated on-site within a twenty-four (24) hour period.
5. Each storage area shall:
   a. display prominent signage indicating the space is used to store regulated medical waste;
   b. be designed or equipped to prevent unauthorized access;
   c. be designed or located to protect waste from the elements, and prevent access by vermin;
   d. hold the waste at a temperature that prevents rapid decomposition and resultant odor generation;
   e. be appropriately ventilated; and
   f. be of sufficient size to allow clear separation of regulated medical waste from any other waste, whenever waste other than regulated medical waste is stored in the same area.
6. Regulated medical waste shall not be stored for a period exceeding thirty (30) days, except that a site generating under fifty (50) pounds of regulated medical waste per month and not accepting regulated medical waste for treatment from other facilities, may store waste for a period not exceeding sixty (60) days.
7. Prior to transport off-site of the generating facility for treatment elsewhere:
8. primary containers shall have affixed a label or imprint indicating the name and address of the generating facility; and
9. primary containers, except as provided in (c)(2) of this section, shall be placed in a secondary container with an affixed label or imprint, indicating the name and address of the generating facility, and such container marked prominently with signage indicating that the contents are infectious or regulated medical waste; and, if applicable, with an affixed label indicating that the contents contain or are mixed with hazardous waste, and/or toxic drug waste.
10. Sharps containers are located on each nursing unit and each medication cart

11. Sharps containers for disposable razors are also located on each nursing unit and shower area
12. Sealed Sharps containers are collected from all areas by Housekeeping personnel a minimum of monthly and as needed prior to the licensed Transporter pickup. Sealed Sharps containers are placed in approved transportation boxes and are processed in accordance with the guidelines from the above section “Managing Regulated Waste.”

12.5 Cleaning Up Spills

The following procedure is to be strictly implemented and adhered to in the event of an accidental spill of Regulated Waste as previously defined above.

1. Blood Spill Kits are located on each unit and will be utilized to clean up spills of Regulated medical Waste.
2. Additional equipment available: Mask, Goggles, Tongs (for picking up sharps), DustPan, Broom, Aprons, Germicidal Solution, and Small Sharps Container.
3. Housekeeping/ Nursing Personnel after having used this equipment to clean a spill should place same in a leak-proof bag, appropriately tie the bag and store in the Soiled Utility room for regular Housekeeping pickup.
4. The Housekeeping Department is responsible for cleaning up both small and large spills of Regulated Medical Waste. If Housekeeping Personnel have left the building, Nursing Personnel is responsible to clean both small and large spills.

13 APPENDIX G. COHORTING

A key component to prevent and control the spread of any novel infectious pathogens and to protect and treat all residents affected in accordance with regulatory requirements.

The facility will attempt to separate the residents into groups of Negative, Positive, and Unknown cohorts as recommended by NYSDOH and CDC guidelines.

Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other residents. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent.

13.1 Procedure

1. Residents will be cohorted by category: **Negative**, **Positive, Unknown** status requiring observation.
2. Residents will be assessed daily for any symptoms of the infectious agent. Symptoms check will include, but is not limited to fever, respiratory symptoms, any symptoms explicit to the specific infectious agent, or any change in condition.
3. If indicated, and when possible, laboratory and/or other testing will be conducted to detect presence of specific infectious agent.
4. The facility will create a designated area/unit for residents who have tested positive for the specific infectious agent.
5. Residents and roommates of residents who are suspected of being infected with the novel infectious agent will be placed on appropriate transmission-based precautions as necessary. If indicated, laboratory and/or other testing will be conducted to detect presence of infectious agent.
6. When feasible, the symptomatic resident will be moved to a private room on the same unit.
7. All Admissions/ Readmissions will have a review of hospital information prior to admission to determine appropriate placement in facility and if adequate infection prevention and treatment needs can be met at the facility.
8. Specific to the novel infectious agent, a screening tool will be done on all prospective admissions and re-admissions by the Admitting Department.
9. Residents who are newly admitted and develop any symptoms associated with the novel infectious agent will be transferred to the dedicated unit upon identification of symptoms.
10. Residents presenting with signs or symptoms of the novel infectious agent will be assessed by an RN and/or PMD.
11. All staff will continue to be actively screened for signs/symptoms associated with the novel infectious agent.
12. Residents and resident representatives will be notified daily of any newly confirmed (positive) cases in the facility as well as any resident deaths related to the infectious agent via the established auto hotline messaging.
13. The facility will continue to promote consistent staff and staff assignment on each unit:

- The staffing coordinator, in conjunction with the DON/RNS, will make every effort to have residents that have been ***confirmed*** to be infected with the novel infectious agent to be grouped into one assignment.
- Every effort will be made to have residents who are ***suspected*** of being infected with the novel pathogen to grouped into one assignment.
- Every effort will be made to have residents who are ***asymptomatic*** to be grouped into one assignment.

14. Residents who are confirmed of being infected with the novel disease will be placed on appropriate transmission-based precautions and have appropriate signage on their room doors. An isolation cart containing necessary PPEs will be placed outside the room for easy accessibility.
15. Should a resident require transfer to another facility/setting, indicate on the Transfer Form the type of infection and type of transmission-based precaution(s) required. Also, relay this information to the transport personnel (e.g. EMTs).

13.2 References:

CDC. (Updated 2019). 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Health Care Settings. Taken from: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

CDC. (4/30/2020). Responding to Coronavirus (Covid-10) in Nursing Homes. Taken from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

14 APPENDIX H. DINNING SERVICES DURING A PANDEMIC

The facility will promote a safe and comfortable meal service for residents to minimize the potential spread of infection and promote quality of meal service to residents. Residents and staff will be provided with education regarding hand hygiene, physical distancing, and any needed monitoring during meal service.

14.1 Procedure

1. Communal dinning may be restricted or suspended on guidance from the CDC or NYSDOH
2. Residents on each unit will be reviewed to identify any special care needs during Meal Service.
3. Residents who are capable of feeding themselves, and are not at risk for choking will have their meals served in their room.
4. Residents who are served meals in their room will be provided with education on the importance of:
    - Performing hand hygiene prior to consuming meal
    - Utilizing the call bell to alert staff of any difficulties while consuming meal (i.e. coughing, difficulty swallowing etc.)
5. Caregivers will be educated to assist/provide hand hygiene for all residents prior to meal service and to ensure that the resident's call bell is within reach.
6. Residents with specific behavioral or nutritional issues may be brought into the dining room in intervals while maintaining social distancing.
7. Residents at risk for choking or on aspiration precautions may be provided meals in the dining room, while seated six feet apart or in a central corridor where they can be observed. Suction machine must be readily available with extension cord and plugged in.
8. Residents who require spoon feeding will be served meals last and caregivers will remain with resident and assist with meal consumption.
9. Unit assignments will reflect staff members specific responsibilities during meal time:
    - Tray distribution
    - Specific residents to feed
    - Corridors/Hallways to monitor during meal
10. Trays will be delivered to units in room order rather than by table number, except for those residents eating in dining room.
11. Residents requiring to be hand fed, may eat in the dining room, spaced six apart and caregivers will only feed one resident at a time.
12. When necessary, meals may be offered in intervals to allow fewer residents in common areas, and to ensure that the food temperature is maintained within desired range.
13. Dining room tables must be sanitized after each meal is completed.
14. Representatives will be notified of changes in meal service during a pandemic via Weekly Message.

15 APPENDIX I. RECREATIONAL NEEDS DURING A PANDEMIC

The facility will promote each residents' highest level of well-being in alignment with State and Federal guidelines restricting group activities during a Pandemic. All measures will be taken to provide individualized activities of choice and to minimize the potential for transmission of the infectious agent.

15.1 Procedure

1. The Activities Director in conjunction with the resident/resident representative and IDT team will identify resident specific activities needs/preferences by interviewing residents and reviewing care plans.
2. Residents who cannot be interviewed to elicit a coherent response secondary to cognitive impairment will have individual preferences/needs be ascertained through family interview and IDT knowledge of their preferences.
3. A unit list will be made identifying each resident's Therapeutic Recreational needs to include:
    - Contact with loved ones via phone, skype, or facetime.
    - Preference for TV shows and/or movies
    - Music Therapy and Preferences
    - Talking Books and Tapes
    - Arts and Crafts along with specific supplies needed
    - Puzzles and games
    - Manipulative objects for engagement
    - One to one visitation
    - Community outreach Phone calls
4. Unit staff will be informed of each resident's recreational needs and/or preferences.
5. The Recreation staff will ensure that each resident has adequate materials for recreation as per their preference.
6. The Activities Director will provide a calendar and daily timetable for activities to include:
    - Room visits
    - Face Time/Communication with family
    - Set up of talking books and tapes
    - Music Therapy
7. The recreational Therapist on each unit will ensure that each resident is participating in recreational preferences and identify and report any problem areas/areas of concern to the IDT.
8. Resident Council will be informed of any changes in activities with input as needed.
9. If a resident has a specific request, the Activity staff assigned to the unit will notify the Director and IDT team for follow up.
10. The resident's Comprehensive Care Plan will be updated and revised as needed to reflect interventions put in place during a pandemic

16 APPENDIX J. RESIDENT AND FAMILY COMMUNICATION

The facility will make every effort to ensure and facilitate on-going communication between the residents and their loved-ones. The facility will also ensure that the new developments related to the pandemic at the facility (i.e. new positive cases, pandemic related deaths ect.) are communicated to the residents and their families by 5pm following the day they occur.

16.1 Communication between Residents and Loved Ones

1. The facility has purchased a number of tablet communication devices which will be used according to the residents needs to contact their loved ones.
2. Families/Friends will be notified about the facilities video-call capabilities and will be encouraged to coordinate with the activities department for communication with their loved ones.
3. Electronic devices will be disinfected with acceptable in-house sanitizers every after each use by the resident/patient.
4. Residents will also be encouraged to use their own personal devices to communicate with their loved ones.
5. Although, the facility activity staff will take charge in these procedures, they have limited clinical knowledge in providing the medical status of a resident and any concerned family member or guardian may need to contact and speak to a clinician or any other member of our team. Family members will be encouraged to either call the facilities main number to make their request and a member of the clinical team will make every effort to contact them before the end of the day
6. Families will also be encouraged to leave message on the information hotline where they will be responded to within 24 hours.
7. The above guidelines will be communicated to the residents at their council meetings, periodically by activity staff and via PA announcements
8. The above guidelines will be communicated to the family members via phone calls, mail, social media posts and the facilities website.

16.2 Communication between the Facility and Resident/Family Members

1. The facility will establish a Hotline in order to communicate information to residents and family members
2. The hot line will be updated with any new staff or resident pandemic positive cases, deaths or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other by 5pm the following day
3. Family members will be notified of this via mail, phone, social media posts and the facility's website.
4. Residents will be notified of this at their council meetings, periodically by activity staff and via PA announcements
5. The resident council president will also be informed any new pandemic positive resident or new pandemic related deaths by 5pm the next calendar day. The resident will be notified via PA system to contact the council president for updates.

17 APPENDIX K. BEDHOLD DURING A PANDEMIC

During a pandemic, the facility will readmit hospitalized residents safely in accordance with Federal and NYS Bed Reservation Guidance NYS code 415.3 and CMS code 483.15(d). as well as all State and Federal Infection prevention and control regulations.

17.1 PROCEDURE

1) The facility, in accordance with New York State Regulations, will reserve a bed for a resident who had been transferred to the hospital, providing the conditions below are met:

   - The facility will be able to provide the care for the resident at the time of readmission. This includes clinical treatment and/or management of infectious diseases as well as provision of appropriate transmission-based precautions.
   - The facility has the ability to group residents into appropriate cohorts.
   - The facility has an available bed in an area that can provide for residents recovering from an infectious disease.

2) Prior to readmission, the Director of Nursing/Designee will review hospital records to determine individual resident care needs. If needed a call will be placed to transferring hospital to clarify any clinical needs and/or concerns.

3) Prior to readmission, Unit Charge nurse will be informed of readmission and any specific isolation and cohorting needs of the resident.

4) For any transfers across care transitions, the RNS will document Infection status on transfer form and notify ambulance/EMT as needed.

5) If the facility cannot care for the resident based on needs, the Administrator/designee will contact the NYSDOH for guidance and inform hospital and resident representative of status.

*All Medicare or Medicaid nursing home eligible residents on leave due to hospitalization, and requiring skilled nursing facility services, will be given priority readmission for the next available bed in a semi-private room. If the facility determines that a resident who has transferred with an expectation of returning to the facility, cannot return, the appropriate discharge procedures will be followed.

18 APPENDIX L. GOVERNMENT AGENCIES CONTACT INFORMATION

New York State Department of Health
https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/regional_epi_staff.htm

New York City Department of Health and Mental Services
https://www1.nyc.gov/site/doh/index.page

Centers for Medicare and Medicaid Services
https://www.cms.gov/

Centers for Disease Control
https://www.cdc.gov/infectioncontrol/index.html

Environmental Protection Agency
https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

World Health Organization
https://www.who.int/

PPE Use and Conservation Signage
https://repository.netecweb.org/exhibits/show/ppe-cons/ppe-cons