Delhi Rehabilitation and Nursing Center (DRNC)

Infectious Disease /

Pandemic Emergency Plan

OVERVIEW

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi. The circumstances of infectious disease emergencies, including ones that rise to the level of a pandemic, vary by multiple factors including type of biological agent, scale of exposure, mode of transmission and intentionality.

The facility follows effective strategies for preventing infectious diseases. Each county Local Health Department-(LHD) has prevention agenda priorities compiled from community health assessments that can be reviewed and utilized by the facility to fully develop and plan a response for infectious disease and pandemic situations.

The circumstances of infectious disease emergencies, including ones that rise to the level of a pandemic, vary due to multiple factors, including type of biological agent, scale of exposure, mode of transmission and intentionality. Infectious disease emergencies can include outbreaks, epidemics and pandemics. The facility must plan effective strategies for responding to all types of infectious diseases, including those that rise to the higher level of pandemic.

The following Pandemic Emergency Plan outlines the hazard-specific preparedness, response, and recovery activities the facility should plan for that are unique to an incident involving infectious disease as well as those incidents that rise to the occasion of a pandemic emergency.

1. COMMUNICABLE DISEASE REPORTING

1.1 IMPORTANCE OF REPORTING

In order for the New York State Department of Health (NYSDOH) to have the ability to inform health care facilities of potential risks and preventive actions regarding communicable diseases, accurate and mandated reporting from health care facilities is needed.

It is especially important in ensuring the safety of health care facilities as it required to detect intra-facility outbreaks, geographic trends, and to identify emerging infectious diseases (EIDs).

1.2 WHAT MUST BE REPORTED

NYSDOH Regulated Article 28 nursing homes:

- 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.
- 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).**
- 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.
- 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.

- 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://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.

      https://www1.nyc.gov/assets/doh/downloads/pdf/hcp/urf-0803.pdf

DELHI
REHABILITATION
& NURSING CENTER

INFECTION PREVENTION AND CONTROL

Reporting of Selected Diseases, Conditions and Nosocomial Infections to the New York State Department of Health

Policy:

The New York State Health Code and New York State Sanitary Code require the reporting of communicable diseases/conditions to the New York State Department of Health on **Form 4018** within 24 hours after diagnosis. In addition, health care facilities should fax information concerning all reportable nosocomial-acquired infections to the department's Infection Control Program using the enclosed form. All confirmed or suspected food borne outbreaks should be reported immediately to the local health unit as well as to the Infection Prevention and Control Program.

https://health.ny.gov/forms/doh-4018.pdf

Nosocomial Outbreaks:

Multiple cases, clusters, outbreaks and/or increased incidents of nosocomial acquired infections in both residents and staff. Definitions of above shall be individually determined as per facility policies; i.e. GI Outbreak protocol, comparison to facility baselines and infection trends, and review of area prevalence rates as well as decisions made by the Infection Control Committee.

https://health.ny.gov/forms/instructions/doh-389_instructions.pdf

ADMINISTRATIVE MANUAL OF POLICIES AND PROCEDURES
DEPARTMENT: INTERDISCIPLINARY

EFFECTIVE DATE: 9/11/2020

PREPARED BY: Heather Manarren, DNS
APPROVED BY: Jeni Demarais, LNHA

NEW: X REVISED:
POLICY: X PROCEDURE: X

SUBJECT: EMERGENCY PROCEDURES for EMERGING INFECTIOUS DISEASES (EID): Including but Not Limited to COVID-19, SARS, Influenza, MERS, Ebola, & Zika

PURPOSE and APPLICATION: In response to DAL NH 20-09 complying with Chapter 114 of the Laws of 2020, **DRNC** will prepare a Pandemic Emergency Plan (PEP).

This plan supplements all existing policies and procedures of **DRNC** which remain in full force and effect. The plan is intended to enhance **DRNC** Emergency Preparedness Manual and is to be carried out in the event of possible, or confirmed, Emergent Infectious Disease and/or Pandemic. This plan addresses community-wide, emerging diseases having the potential to pose a significant public health threat and danger to the country, the state, the community, residents, families, and the staff of **DRNC.**

In the event of an outbreak by exposure to an Emerging Infectious Disease **DRNC** will:

- Maintain a safe and secure environment for residents, staff, and family.
- Sustain our functional integrity and continuity of operations.
- Integrate into the community's emergency response system as necessary.

DEFINITIONS:

The term **"emerging"** refers to infectious diseases that are reappearing, such as measles, or that are changing, like the influenza virus does every year. EIDs may cause localized epidemics, or become pandemics if given the correct environmental factors, causing significant suffering and deaths worldwide. Historical examples of ElD's include HlNl influenza, MRSA (methicillin-resistant Staphylococcus aureus) SARS, MERS, Ebola, Zika, HIV/AIDS and COVID – 19.

Emerging Infectious Diseases (EID) may also be newly evolved whose incidence in humans has increased or threatens to increase in the near future. These diseases, without restriction by national boundaries, include:

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

All Viruses constantly change and mutate. The type of Virus that can spread quickly and cause Pandemic infection is called a **"Novel Virus",** or indicative of a New Strain.

Novel and variant **influenza** A **viruses** can infect and cause severe respiratory illness, as well as multiple symptoms in humans. These **influenza viruses** are different from currently circulating human Influenza A Virus subtypes and include **Influenza viruses** from predominantly **Avian and Swine origin.**

Human infections with a" **Novel Virus"** are viruses that can be transmitted from person to person and may signal the beginning of a **pandemic event.**

Ebola: Previously known as Ebola hemorrhagic fever, is a rare and deadly disease caused by infection with one of the Ebola virus strains. Ebola can cause disease in humans and nonhuman primates (monkeys, gorillas, and chimpanzees).

Ebola is caused by infection with a virus of the family Filoviridae, genus Ebolavirus. There are five identified Ebola virus species, four of which are known to cause disease in humans. Ebola viruses are found in several African countries, but may become Pandemic

Zika: Zika virus is spread to people through mosquito bites. Outbreaks of Zika have occurred in areas of Africa, Southeast Asia, the Pacific Islands, and the Americas. Because the Aedes species mosquitoes that spread Zika virus are found throughout the world, it is likely that outbreaks will spread to new countries. In December 2015, Puerto Rico reported its first confirmed Zika virus case. In May 2015, the Pan American Health Organization (PAHO) issued an alert regarding the first confirmed Zika virus infection in Brazil. The outbreak in Brazil led to reports of Guillain-Barre syndrome and pregnant women giving birth to babies with birth defects and poor pregnancy outcomes.

Coronaviruses are enveloped RNA viruses that cause respiratory illnesses of varying severity from the common cold to fatal pneumonia.

*Coronaviruses cause much more severe, and sometimes fatal, respiratory infections in humans than other Corona viruses and have caused major outbreaks of deadly pneumonia in the 21st century:

SARS COVID-2 is a novel coronavirus identified as the cause of coronavirus disease 2019 **(COVID-19)** that began in Wuhan, China in late 2019 and spread worldwide.

MERS-CoV was identified in 2012 as the cause of Middle East respiratory syndrome (MERS).

S**ARS-CoV** was identified in 2002 as the cause of an outbreak of severe acute respiratory syndrome (SARS).These coronaviruses that cause severe respiratory infections are zoonotic pathogens, which begin in infected animals and are transmitted from animals to people. In view of Viral mutations, these viruses may be the cause of a Pandemic Outbreak.

POLICY: It is the policy of **DRNC**, pursuant to DAL NH 20-09 complying with Chapter 114 of the Laws of 2020, **DRNC** will prepare a Pandemic Emergency Plan (PEP).

PROCEDURE: The following procedural steps will be implemented to meet all requirements and regulations as set forth in response to DAL NH 20-09 complying with Chapter 114 of the Laws of 2020.

Plan General Preparedness:

The local, state, and federal health authorities will be the source of the latest information concerning Emergent Infectious Diseases (EID) and most up to date guidance on prevention, case definition, surveillance, and treatment related to a specific disease threat.

EIDs may cause localized epidemics, or become pandemics if given the correct environmental factors, causing significant suffering and deaths worldwide. In the absence of notification and identification of an EID by the Department of Health Authorities, our facility may experience an outbreak of communicable diseases necessitating a swift response.

Outbreak of Communicable Diseases Prior to a Pandemic:

EIDs may cause localized epidemics, or become pandemics if given the correct environmental factors, causing significant suffering and deaths.

Because any outbreak can lead to a pandemic disease, control measures for prompt responses are integral to our Infection Control Plan and Emergency Response.

a. **DRNC** will implement Confirmed or Suspected Outbreak of Communicable Diseases Policy and Procedure **(Attachment 1)** as needed.

b. An outbreak of most communicable diseases can be defined as one of the following:
   - One case of an infection that is highly communicable;
   - Trends that are ten (10) percent (or more) above the historical rate of infection for the facility; or
   - Occurrence of three (3) or more cases of the same infection over a specified period of time and in a defined area;
   - Anything exceeding the endemic rate, 3 or more influenza-like illness occurring within 72 hours, or a single case if unusual for the facility;
   - A single case of influenza, COVID-19, SARS, MERS, Ebola and Zika 19 is reportable to the local Department of Health.

   Note: The Administrator, Director of Nursing, Infection Preventionist (IP), and staff implements the responses described in the Plan.

Awareness of Emerging Infectious Diseases:

1. The Infection Preventionist routinely monitors public health advisories for outbreaks and ElD's. Sources of information include:

   - CDC for emerging diseases: **https://www.cdc.ghttps://www.cdc.gov/aging/emergency/index.htmov/ncezid**

   - CDC for recent outbreaks: **https://emergency.cdc.gov/recentincidents/**

   - CDC for a current outbreak list: **https://www.cdc.gov/outbreaks/index.html**

   - National Institute of Allergy and Infectious Disease: **https://www.niaid.nih.gov/diseases-conditions?f%5B0%5D=disease%3A53**

2. The IP will also inform Administration of potential risks of new infections arising in our geographic location which may result from mutations or acquired resistance to existing organisms.

3. The Pandemic Response Coordinator (Director of Nursing or Administrator) works closely with the IP and will monitor federal and state public health advisories at least weekly:

   - CDC for emerging disease: **https://www.cdc.ghttps://www.cdc.gov/aging/emergency/index.htmov/ncezid**

   - CDC for recent outbreaks: **https://emergency.cdc.gov/recentincidents/**

   - CDC for a current outbreak list: **https://www.cdc.gov/outbreaks/index.html**

4. When state or community concerns of pandemic or EID arises, *The Pandemic Response Coordinator* may contact all or any of the following contacts:
   - CDC for recent outbreaks: **https://www.cdc.gov/outbreaks/index.html**
   - State long-term care professional/trade association;
   - Local emergency and pandemic influenza preparedness groups;
   - State emergency and pandemic influenza preparedness groups;
   - Other regional emergency and pandemic influenza preparedness groups;
   - Local area hospitals; and other local healthcare providers.

Quality Assurance Committee

DRNC has developed a Special Review Infection Control and Prevention QA Committee to implement our Plan when a Pandemic is expected or declared. Members of the Committee will be responsible for the coordination and implementation of the Plan.

The following Departments will be named to the QA Committee:

- Medical Director
- Administrator
- DNS
- ADNS
- Infection Preventionist
- Director of Housekeeping
- Director of Maintenance

The Administrator and/or the DNS will identify the staff member responsible to be the "Response Coordinator" who will assist the Committee in all Infection Prevention and Control Disaster Plans.

Written Pandemic Management Plan:

a. The Facility will develop a written Pandemic Emergency Management Plan to outline the specific infection control and clinical directives to follow relative to the declaration of a **Pandemic Outbreak**. The Plan will be monitored and followed by the Medical Director, DNS, Administrator and the Infection Preventionist as well as communicated to the Attending Physicians for input regarding clinical care needs of Residents.
b. All members of the special QA Pandemic Committee and clinical staff will be educated on the Pandemic Emergency Management Plan.
c. A copy of the Pandemic Emergency Management Plan will be distributed to all department heads and will be available on each Unit for reference as needed.
d. The Pandemic Emergency Management Plan will follow all DOH, CDC, CMS and FDA Guidelines relative to the Pandemic.
e. The Pandemic Emergency Management Plan in conjunction with our Disaster Plans will be reviewed with transferring hospitals, dialysis centers, clinics etc. to ensure safe and appropriate care needs of our residents.
f. The Pandemic Emergency Management Plan will be reviewed and revised as Pandemic Guidelines are presented by DOH, CDC and CMS.
g. This facility has designated the Infection Preventionist as the "Pandemic Response Coordinator," designee will also be the Director of Nursing in the absence of the IP.
h. The Infection Preventionist/designee is responsible for communicating with the staff, residents and their families regarding the status and impact of the pandemic virus in the facility. One designated individual speaking for the facility ensures accurate and timely information.
i. Communication includes development and usage of a staffing roster to notify staff members of the pandemic outbreak. Efforts must be made, such as phone calls, social media notification, email, etc. and posted signage to alert visitors, family members, volunteers, vendors, and staff members about the status of the seasonal/pandemic virus in the facility.
j. The Infection Preventionist is responsible to maintain communications with the Office of Emergency Management, Hospitals and other providers regarding the status of a viral outbreak.

Notification Criteria: Emergency Procedure - Pandemic Viruses:

The following procedures should be utilized in the event of a Pandemic Viral or Influenza outbreak:

a. Inform all employees verbally, via phone calls, e-mails, and through posting a memorandum near the time clock and posting information on all nursing units; informing all department heads when a virus is increasing and sustaining human-to-human spread in the United States, and cases are occurring in the facility's area and state which are declared "prevalent" by the Commission of Health.

b. Notify the Administrator and Director of Nursing if they are not on the premises. Activate the Staffing Roster for staffing needs if warranted as per our directives in the Disaster Plan.
c. Facility Management staff should report to the Incident Command Post for briefing and instruction on Infection Control Procedures.
d. Activate the Incident Command System (ICS) to manage the Infection Control incident. The most qualified staff member (in regard to the Incident Command System) on duty at the time assumes the Incident Commander position.
e. Guidelines of this Pandemic Emergency Plan will be implemented and followed by all staff and will incorporate all requirements relative to Infection Control by CDC, CMS and NYSDOH Guidelines.
f. Residents, employees, contract employees, and visitors will be evaluated daily/Q shift for symptoms. Employees should be instructed to self-report symptoms and exposure.
g. All management staff will follow the Pandemic Emergency Plan in regards to managing high-risk employees and for guidelines as to when infected employees can return to work in accordance with CDC and NYSDOH Guidelines.
h. Adherence to infection prevention and control policies and procedures is critical. Signs will be posted in all areas of the facility for Infection Control Directives, Cough Etiquette, and Hand Hygiene as well as any additional IC/IP information needed. Adherence to Droplet precautions during the care of a resident with symptoms or a confirmed case of pandemic virus is a must.
i. Management will determine when to restrict admissions and visitations. Same will be communicated to the involved staff and family members as well as all involved consultants and vendors. Signage and posters will be placed at the main entrance as well as throughout the facility for awareness of any restrictions and directives.
j. The Medical Director and local and state health departments will be contacted as needed to discuss the availability of vaccines and antiviral medications, as well as any recommendations for treatments.
k. The Administrator will ensure that adequate supplies of PPE, food, water, and medical supplies are available to sustain the facility if a pandemic virus occurs at the facility and interrupts normal deliveries.
l. Residents and employees will be cohorted as necessary to prevent transmission and designated units will be identified and maintained for affected Residents.
m. The Administrator and DNS will implement contingency staffing plans as needed.
n. Residents and employees will be screened daily and Q shift to identify exposure to pandemic virus.
o. Viral testing will be done in conjunction with MD directives and DOH/CDC requirements

Staff Training:

a. All staff members will be trained on the facility Pandemic Emergency Plan and related policies and procedures for Infection Control and transmission precautions as part of Disaster Planning and staff awareness. Same will be on Orientation, as well as if outbreak is suspected or as identified by CDC, CMS or NYSDOH.
b. Staff will be educated on Infection Control Plan following CDC Guidelines as well as education on signs/symptoms of the diseases and care protocols which will be incorporated into our Management Plan.
c. Education and Communication will also be sent to Family members and significant others regarding our Management Plans and new directives for care; as well as notification of change regarding their loved one.

Education and Training:

a. The facility's designated In-Service RN is responsible for coordinating education and training on seasonal and Pandemic Viruses. NYSDOH, CMS and hospital-sponsored resources are researched, as well as usage of web-based training programs. The website www.cdc.gov is considered as a resource and the Facility will download applicable information for education.
b. Education and training of staff members regarding infection prevention and control precautions, standard and droplet precautions, as well as respiratory hygiene/cough etiquette should be ongoing to prevent the spread of infections, but particularly at the first point of contact with a potentially infected person with seasonal/pandemic virus. Facility will follow NYSDOH and CDC Guidelines.
c. Education and training should include the usage of language and reading-level appropriate, informational materials such as brochures, posters, as well as relevant policies. Such materials should be developed or obtained from www.cdc.gov.

d. Informational materials should be disseminated during, before, and during seasonal/pandemic outbreaks, and as conditions change.
e. CMS Targeted COVID -19 Training is mandatory for **DRNC**

CMS Targeted COVID-19 Training for Frontline Nursing Home Staff

The training for frontline staff, called "CMS Targeted COVID-19 Training for Frontline Nursing Home Staff" covers five topics separated into five modules. These modules address some of the most common concerns found by surveyors and strike teams regarding basic infection control and prevention.

The modules are focused on the most urgent needs of frontline nursing home staff and they include:

Module 1: Hand Hygiene and PPE
Module 2: Screening and Surveillance
Module 3: Cleaning the Nursing Home
Module 4: Cohorting
Module 5: Caring for Residents with Dementia in a Pandemic

CMS Targeted COVID-19 Training for Management

The training for management, called "CMS Targeted COVID-19 Training for Nursing Home Management" covers 10 topics separated into 10 modules. These modules are comprehensive, focusing on infection control and cleanliness but also larger institution-wide issues like implementation of telehealth, emergency preparedness, and vaccine delivery. They include:

Module 1: Hand Hygiene and PPE
Module 2: Screening and Surveillance
Module 3: Cleaning the Nursing Home
Module 4: Cohorting
Module 5: Caring for Residents with Dementia in a Pandemic
Module 6: Basic Infection Control
Module 7: Emergency Preparedness and Surge Capacity
Module 8: Addressing Emotional Health of Residents and Staff
Module 9: Telehealth for Nursing Homes
Module 10: Getting Your Vaccine Delivery System Ready

The training is available on the CMS Quality, Safety & Education Portal:
https://qsep.cms.gov/welcome.aspx

Pandemic Virus Management Plan / Surveillance and Detection

a. The Pandemic Virus Response Coordinator will be appointed and is responsible for monitoring public health advisories (federal and state) and updating the Pandemic Virus Committee, particularly when pandemic virus has been reported and is nearing the specific geographic location. www.cdc.gov will be utilized daily as a resource and recommendations will be followed in conjunction with CMS and DOH requirements.
b. A protocol has been developed specifically to monitor the seasonal influenza-like illnesses in residents and staff during the influenza season, as well as any other Viral illness outbreak which tracks illness in residents and staff
    - The Admission policy includes that residents admitted during periods of seasonal Influenza should be assessed for symptoms of seasonal influenza and receive a flu vaccine.
    - A system will be implemented to monitor residents and staff daily for symptoms of seasonal influenza, as well as confirmed cases of influenza and other viral illnesses that have been emergent.
    - Information from the monitoring systems is utilized to implement prevention interventions, such as isolation precautions or cohorting as well as notification procedures

*** Note: The above procedures are the same for all Pandemic Viral Outbreaks**

Facility Communications

Public Health and Other Agencies:

a. The Pandemic Influenza Response Coordinator is responsible for communications with the public health authorities during a declared pandemic outbreak.

*Local Health Department contact information:

Delaware County Department of Health
111 Main Street
Delhi, NY 13753
607-832-5000

DRNC Regional Office: Capital District
Long Term Care
875 Central Ave
Albany, NY 12206
518-408-5372
518-402-0362

State Health Department contact information:
New York State Department of Health
175 Green St, Albany, NY 12202
(518) 447-4580

Family/Designated Representative Communication *(See Effective Communication P&P)*

Family members and responsible parties are notified prior to an outbreak that visitation may be restricted during an outbreak to protect the safety of their loved ones

a. The Communication Plan will designate a staff member on each unit to update designated family members of residents infected with the pandemic infectious disease at **least once per day** *and* **upon a change in the resident's condition**; this information will be documented in the EMR and/or Communication Log.
b. Communication will be given to all residents and designated representatives **once per week** on the number of infections and deaths at the facility; via our website, email or phone calls.
c. Our plan will provide all residents with daily access to free remote video conferencing, or similar communication methods, with designated family members; and by electronic means or other method selected by each designated representative. The Director of Recreation/designee will be responsible to coordinate.

Infection Prevention and Control:

a. **DRNC** will develop a plan for hospitalization and readmission of residents to the facility for management of the pandemic infectious disease.
b. **DRNC's** plan will comply with all applicable State and federal laws and regulations, including but not limited to 10 NYCRR, 415.19, 415.3 and 415.26, as well as 42 CFR 483.15.
c. Infection prevention and control policies will require staff to use Contact and Droplet Precautions (i.e., gowns, mask and (face shield as suggested) for close contact with symptomatic residents).
d. Respiratory hygiene/cough etiquette, and Hand Hygiene will be practiced at all times by all staff
e. Cleaning and disinfection for transmission prevention during pandemic virus follows the general principles used daily in health care settings (1:10 solution of bleach in water), or other EPA approved sanitizers.
f. **DRNC** will develop procedures to cohort symptomatic residents or groups using one of more of the following strategies:

Signage will be placed upon entry to units to identify designated floors and precautions being implemented:

- Restricting symptomatic residents and their exposed roommates to their room;
- There will be no sharing of bathrooms by residents outside of the Cohorted areas;
- Privacy Curtains will be kept closed;
- Closing units where symptomatic and asymptomatic residents reside, i.e.; restricting all residents to a specific unit, for management and surveillance of symptoms;
- Develop criteria for closing units or placing the entire facility on lockdown to new admissions during pandemic viral or influenza outbreak;
- Residents will be informed of Infection Control procedures and necessity;
- Staff will ensure Visitor Restrictions are enforced per policy daily;
- Clinical care policies and procedures for treatment of ill residents and those under suspicion will be developed in conjunction with the medical director. All Clinical staff will be educated on the Clinical Care Protocols which will be outlines in the Pandemic Management Plan.
- The Infection Preventionist/designee will maintain a daily line list per unit of all residents with a confirmed or suspected viral illness. Same will include all needed information for reporting to NYSDOH and other Federal Agencies as mandated.

Occupational Health

a. Practices are in place that addresses the needs of symptomatic staff and facility staffing needs, including:
   - Handling staff members who develop symptoms while at work.
   - Staff testing as mandated by DOH
   - Determining when staff may return to work after having Pandemic viral illness

b. 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.
c. Health Care Personnel will be educated to self-assess and report symptoms of pandemic virus/ influenza before reporting to duty.
d. Mental health services or faith-based resources will be available to provide counseling to staff during a pandemic as needed and available.
e. Influenza vaccinations of staff are encouraged and monitored for any influenza outbreaks.
f. High-risk employees (pregnant or immuno-compromised) will be monitored and managed by placing them on administrative leave or altering their work assignments in accordance with Pandemic Management Plan

PPE Usage and Storage:

a. In conjunction with our Disaster Plan, the Facility will ensure a Six (6) month supply and storage of all needed PPE in accordance with CDC, including but not limited to:
   - N95/KN95 Respirators
   - Face shield and/or Goggles
   - Gowns/isolation gowns
   - Gloves
   - Face masks
   - Hand Sanitizer
   - Sanitizer and disinfectants in accordance with current EPA Guidance

b. The Infection Preventionist/designee will identify need in accordance with affected residents and ensure availability of PPE in designated areas;
c. PPE will be monitored for appropriate use and appropriate infection control interventions to prevent disease transmission;
d. The DOH will be notified of any surge in identified infections and concerns regarding availability of PPE; needs of Residents and staff regarding use will be anticipated and evaluated throughout the pandemic.

Preparedness of Supplies and Surge Capacity including PPE

- A member of the QA Committee has been assigned to assess the need and availability of all PPE during a Pandemic. The Administrator and /or the DNS will ensure that all needed supplies are available and kept in a secure location.
- Quantities of essential PPE, food, materials, medical supplies, and equipment have been determined to

sustain the facility for a six-week pandemic. A predetermined amount of supplies are stored at the facility or satellite location, and the Pandemic Coordinator will be responsible for ensuring availability.

- Housekeeping will be responsible for ensuring Hand Hygiene equipment is available daily throughout the Facility.
- Housekeeping will also be responsible for disinfection of units in conjunction with all Infection Prevention Policies, including terminal cleaning of rooms where positive residents were transferred or expired.
- Plans for Surge Capacity will include strategies to help increase hospital bed capacity in the community.
- Agreements have been established with area hospitals for admission of patients to the facility to facilitate utilization of acute care resources for more seriously ill patients.
- Facility space has been identified that could be adapted for use as expanded inpatient beds and information has been provided to local DOH for implementation and awareness.
- Capacity and need will be determined for deceased residents as needed, including a space to serve as a temporary morgue.

Vaccinations and Antiviral Usage

a. The Centers for Disease Control (CDC) and the Health Department will be contacted to obtain the most current recommendations and guidance for the usage, availability, access, and distribution of vaccines and other antiviral medications during a pandemic.
b. Guidance from the State Health Department will be sought to estimate the number of staff and residents who are targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. A plan is in place to expedite delivery of vaccine or antiviral prophylaxis.
    - Facility space has been identified that could be adapted for use as expanded inpatient beds and information has been provided to local DOH for implementation and awareness.
    - Capacity and need will be determined for deceased residents as needed, including a space to serve as a temporary morgue.

Plan for preserving a resident's place at the facility when a resident is hospitalized during a Pandemic

a. In accordance with 18 NYCRR 505.9 (d) (6) and 42 CFR 483.15(e) **DRNC** will reserve a room in the facility when a resident is hospitalized during a pandemic.

KEY POINTS

*** The Facility will follow all DOH/CDC /CMS requirements daily as notified and respond with revisions to our plans accordingly.**

*** Clinical Care Protocols, developed as part of our Pandemic Emergency Management Plan, will be attached to the Emergency Preparedness manual as indicated and needed.**

ADMINISTRATIVE MANUAL OF POLICIES AND PROCEDURES
DEPARTMENT: INTERDISCIPLINARY

EFFECTIVE DATE: 9/11/2020

PREPARED BY: Heather Manwarren, DNS
APPROVED BY: Jeni Demarais, LNHA

NEW: X REVISED:
POLICY: X PROCEDURE: X

SUBJECT: LOCAL THREAT OF EMERGENT INFECTIOUS DISEASE: PLAN INITIATION

POLICY: This Plan goes into effect when our facility is notified by public health authorities that an Emergent Infectious Disease is likely to, or already has, spread to the **DRNC** community:

1. Upon notification, the IP immediately initiates research of the ElD's specific signs, symptoms incubation period, route of infection with the Transmission Based Protocol, the risks of exposure, and other pertinent recommendations for skilled nursing care centers as provided by the *CDC, Occupational Health and Safety Administration (OSHA,)* and other relevant local, state and federal public health agencies.

2. The IP notifies the following team members:
   - Administrator
   - Director of Nursing
   - The Medical Director
   - Facility Pharmacist
   - The designated Pandemic Response Coordinator

3. If the EID is transmitted via airborne route:
   Airborne precautions are used for patients who have diseases that are spread by the airborne droplet nuclei route. Airborne droplet nuclei are tiny droplets that can travel long distances in the air. Airborne isolation will be nearly impossible to implement at **DRNC** and most other long-term care facilities. To be effective, the facility must have designated rooms that can accommodate a resident on airborne isolation (i.e., an ***Airborne Infection Isolation Room*** [AIIR]). In the event of an airborne EID, we shall implement procedures listed below to the extent possible to create a protective environment.

- **DRNC** does not have an Airborne Infection Isolation Room (AIIR) and cannot provide adequate airborne precautions and isolation.
- The IP immediately notifies the Local Department of Health, **Delaware** Department of Health (office of Emergency) and the New York State Department of Health and Human Services for instructions.
- Suspected infected residents, and staff, are placed in a separate room, or with cohorts, with the doors closed.
- Suspected infected persons will be temporarily housed and transported to an appropriate hospital or facility as described in Policies Isolation - Categories of Transmission-Based Precaution.
- Nursing staff will place a surgical mask over the mouth and nose of any resident with a suspected or confirmed EID spread by airborne route.
- This facility will not collect sputum samples from these residents.

4. After consulting with the Medical Director, The IP and Pandemic Response Coordinator assumes the following tasks:
   - Review and revise any internal Infection Control Policies as required to address the epidemiologic characteristic of the suspected or confirmed EID.
   - Inventory, and increase as necessary, medications stock, PPE in accordance with the mode of transmission, and appropriate environmental cleaning agents as indicted by the confirmed threat.

5. As time permits, the IP will educate staff on anticipated symptoms, basic Infection Prevention, surveillance, and methods of controlling the EID. This includes the use of the correct PPE, determined precautions with isolation strategy, and proper hand hygiene.

6. The designated Pandemic Response Coordinator and/or Facility Administrator provides education concerning the facility's strategy to families and residents as needed.
7. In accordance with the determined route of infection, and as approved by the Facility Administrator, informative signs regarding respiratory and cough etiquette, hand hygiene, and other preventative strategies, are placed at the entry of the facility. Ill persons must not enter the facility.
8. Depending on the instructions and guidance from the public health agencies - local and state health departments, CDC, and OSHA- the facility Administrator may consider closing the facility to new admissions and limit, or even prohibit visitors.
9. In lieu of lock-down, we will ensure that staff, and/or new residents are not at risk of spreading the EID into the facility through screening for exposure risk and signs and symptoms PRIOR to admission of a new resident and/or allowing new staff persons to report to work.
10. The IP, with the guidance of public health authorities--local, state, and federal--will develop an Exposure Control Plan for the EID and educate all staff to it. The plan must include:

    - Reporting any suspected exposure to the EID while off duty to their supervisor and public health.
    - Precautionary removal of employees who report an actual or suspected exposure to the EID.
    - Self-screening for symptoms prior to reporting to work.
    - Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.

11. <u>Housekeeping and Environmental Controls</u>:

- Our facility will follow current CDC guidelines for environmental cleaning **specific to the EID** in addition to routine cleaning policies for the duration of the threat.

12. <u>Engineering Controls</u>:

- Our facility will utilize appropriate physical plant alterations such as use of private rooms for high-risk residents and isolation, plastic barriers, and curtain barriers.
- Clean utility rooms for sanitation stations are located on every unit. The soiled utility rooms on each unit will be used as a special area for contaminated waste as recommended by local, state, and federal public health authorities.

Attachment 1

ADMINISTRATIVE MANUAL OF POLICIES AND PROCEDURES
DEPARTMENT: INTERDISCIPLINARY

EFFECTIVE DATE: 9/11/2020

PREPARED BY: Heather Manwarren, DNS
APPROVED BY: Jeni Demarais, LNHA

NEW: X REVISED:
POLICY: X PROCEDURE: X

SUBJECT: Suspected or Confirmed Outbreak of Communicable Diseases within Facility

POLICY: Suspected and Confirmed Communicable Disease Outbreaks within DRNC will be promptly identified and appropriately handled. Early recognition of suspected residents allows for timely initiation of appropriate infection prevention and control measures.

Early identification of residents with severe illness allows for optimized supportive care treatments and safe, rapid referral and admission to the hospital.

POLICY INTERPRETATION: An outbreak of communicable disease is defined as one or more cases of confirmed infection.

PROCEDURE: What to do if a resident is suspected of having a communicable disease**:**

1. Whether or not an EID has been confirmed in the community or in our facility, when a resident or an on-duty staff member exhibits symptoms of the EID, the Infection Preventionist shall:
   - Place the persons in an isolation room observing the appropriate transmission-based precautions (TBP).
   - Notify the local agency/agencies responsible and contact the Medical Director.
   - Resident will be considered to be a Person Under Investigation (PUI). In consultation with the New York State DOH, residents should be evaluated on a case-by-case basis to determine the need for testing.
   - In accordance with the EID's mode of transmission the IP will initiate the proper Transmission Based Protocol and compile information for controlling exposure of the EID to residents.

2. DRNC must immediately contact the New York State Department of Health. While awaiting further direction, the resident must be isolated in a separate room with the door closed. In this context, staff attending to the resident/person under investigation (PUI), until and if they are transferred to the hospital or until they are given further direction by the New York State Department of Health, should follow CDC guidelines for the selection, use, and disposal of personal protective equipment (PPE) (including gloves, isolation gown, and mask) and should maintain social distancing of at least 6 feet from the resident/ person under investigation (PUI) except for brief necessary actions.
   - Local Health Department (LHD) contact information is available at: https://www.health.ny.gov/contact/contact_information/
   - Providers who are unable to reach the LHD can contact the NYSDOH Bureau of Communicable Disease Control at 518-473-4439 during business hours or the NYSDOH Public Health Duty Officer at 1-866-881-2809 evenings, weekends, and holidays.
   - NYSDOH will assist healthcare providers, facilities and LHDs to collect, store, and ship specimens appropriately, including during afterhours or on weekends/holidays.

3. Infection Preventionist/designee and health care practitioner must be immediately informed of a resident suspected of having COVID – 19 infection. A log of Person(s) under infection (PUI) will be maintained and resident will be added to the respiratory surveillance line list.

4. The Medical Director is responsible for Working with the Attending Physician(s) and the health department to determine the need for laboratory specimens and/or diagnostic tests.

5. Information gathered on the line list should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

6. When determined by the public authorities and the Medical Director that care is beyond the scope of DRNC, the suspected infected person will be transferred via emergency medical services to O'Connor Hospital part of Mary Imogene Basset under the guidance of public health authorities. This is done as soon as possible.

7. The receiving facility should be alerted to the resident's suspected or confirmed communicable disease prior to the transfer and precautions to be taken. Transfer Communication Tool should be completed in electronic medical record (Point Click Care) and a copy sent with resident to transferring hospital. Pending transfer, place a facemask on the resident and isolate him/her in a room with the door closed.

Employer Considerations of Staff Exposure

1. The facility Administer and the Director of Nursing must protect our residents and employees from preventable exposure and transmission of an EID, while maintaining adequate staffing for resident care.

2. In determining the precautions taken to protect our residents, Administration will consider the boundaries and requirements under the Occupational Safety and Health Administration (OSHA), Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state or federal laws.

   Protecting our residents and our employees shall be of paramount concern. To accomplish this during a threat of, or a confirmed, EID, Management shall take into account:

   - The degree of frailty of the residents in our care center;
   - The likelihood of the infectious disease being transmitted to the residents and employees;
   - The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces)
   - The precautions which can be taken to prevent the spread of the infectious disease and
   - Other relevant factors

   Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents and other employees.

3. Actions taken will be applied uniformly to all staff in like or similar circumstances.
4. Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.
5. Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.
6. Generally, accepted scientific procedures, whenever available, will be used to determine the level of risk posed by an employee.
7. Permit employees to use sick leave, vacation time, and FMLA where appropriate while they are out of work.
8. Permit employees to return to work when cleared by a licensed physician, however, additional precautions may be taken to protect the residents.
9. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline.

COMMUNICABLE DISEASE: PERSONS UNDER INVESTIGATION (PUI)

DATE:	RESIDENT NAME:	CRITERIA & CLINICAL FEATURES CONSISTENT WITH PUI:

2.0 COMMUNICATION

2.1 EXTERNAL NOTIFICATION PROCEDURES

Under the PEP, facilities must include plans and/or procedures that would enable them to (1) provide a **daily update** to authorized family members and guardians *and* **upon a change in a resident's condition**; and (2) update all residents and authorized families and guardians **at least once per week** on the number of pandemic-related infections and deaths, including residents with a pandemic-related infection who pass away for reasons other than such infection (e.g., COVID positive residents who pass away for reasons other than COVID-19).

These updates must be provided electronically or by such other means as may be selected by each authorized family member or guardian. This includes a method to provide all residents with daily access, at no cost, to remote videoconference or equivalent communication methods with family members and guardians.

ADMINISTRATIVE MANUAL OF POLICIES AND PROCEDURES

DEPARTMENT: INTERDISCIPLINARY

EFFECTIVE DATE: 5/4/2020

PREPARED BY: Heather Manwarren, DNS

APPROVED BY: Jeni Demarais, LNHA **NEW:** **REVISED:X**

POLICY: X PROCEDURE: X

SUBJECT: EFFECTIVE COMMUNICATION WITH RESIDENTS & FAMILIES DURING PANDEMIC

POLICY: Effective communication between DRNC, residents and their families is essential to safe, quality care during a pandemic . To mitigate the potential emotional impact on residents, families, loved ones and guardians, DRNC will implement a communication protocol to be utilized during any pandemic.

DRNC shall notify family members or next of kin for all residents if any resident tests positive for a communicable infectious disease or if any resident suffers a communicable disease related death, within 24 hours of such positive test result or death.

PROCEDURE:

1. Demonstrate transparency and maintain routine communication with residents in-person, if possible, and with families, either via email, social media (i.e. Facebook), facility website another electronic platform, regarding DRNC efforts to prevent the spread of communicable disease (**Attachment 1**).
2. **Express Empathy:** Communicable disease outbreaks can cause fear and disrupt daily lives. Lesser-known or emerging diseases such as Zika, Ebola, COVID – 19 cause more uncertainty and anxiety. Acknowledging what residents and families are feeling and their challenges shows that you are considering their perspectives when you give recommendations.
3. **Show Respect:** Respectful communication is particularly important when people feel vulnerable. Respectful communication promotes cooperation and rapport. Acknowledge different cultural beliefs and practices about communicable diseases and work with communities to adapt behaviors and promote understanding. Do not dismiss fears or concerns. Give resident and families a chance to talk and ask questions.

Establishing explicit reporting requirements for long-term care (LTC) facilities to report information related to Communicable Disease cases among facility residents and staff is imperative, the following **Procedure** will be implemented:

1. Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of:
   - Either a single confirmed infection of a communicable disease, or
   - Three or more residents or staff with new-onset of symptoms consistent with communicable occurring within 72 hours of each other.

   This information must:

- Not include personally identifiable information;
- Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
- Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either:

    - Each time a confirmed communicable disease infection is identified, or
    - Whenever three or more residents or staff with new onset of symptoms consistent with a communicable disease must occur within 72 hours of each other.

The preamble to the rule states that facilities are not expected to make individual calls. Providers may use general communication platforms easily available to residents, representatives and families such as listservs, website postings, and recorded telephone messages.

A record of communication will be maintained for reference and validation **(Attachment 4).**

2. If DRNC does not have an inividual in the facility that is suspected of having or has been diagnoses with a communicable disease , residents should be periodically met with and communication should be maintained with families regarding the DRNC status and measures being taken to protect the residents and staff from such communicable disease. Communication can be with residents in-person, if possible, and with families, either via email, social media (i.e. Facebook), facility website another electronic platform and/or in writing **(Attachment 2).** A record of communication will be maintained for reference and validation **(Attachment 4).**

3. DRNC will facilitate ongoing family contact on a cadence that mirrors previous visitation frequencies. DRNC will help residents use FaceTime or similar video apps or set up a skype-enabled computer in a private area so that family members can arrange to have a "visit" at a time that's convenient for them and the resident.

   Helping residents to keep their connections to their families and loved ones alive during the COVID- 19 pandemic will be crucial to helping residents navigate their fears and anxieties.

4. Listen carefully to questions and concerns, use local language and speak slowly. Answer any questions and provide correct information about communicable disease, you may not have an answer for every question: a lot may be unknown about such communicable disease and it is okay to admit that.

5. Be an active listener despite the chaos and urgent demands going on around you.
   - Acknowledge emotions and feelings they have.
   - Reinforce commitment to doing your best to meet their needs.
   - Reassure that you will be able to manage pain.

6. Provide a simple, honest and clear picture of resident's condition and potential implications of treatment choices, if appropriate.

7. It is okay to touch, or comfort suspected and confirmed communicable disease residents when wearing PPE.

Communication with Residents & Families: Advanced Directives:

Ensuring compassionate care during a pandemic, can be a challenge. Advance care planning or end-of-life conversations can be difficult in the best of circumstances, let alone the current environment with restrictions, heightened emotions, and scarce resources. The following steps should be followed to ensure residents' psychological, social, physical, emotional and spiritual needs are met during a pandemic.

1. Make sure residents' advance directives are up to date and contain correct contact information.
2. Check all residents' records to get a list of which residents have executed advance directives such as Do Not Resuscitate orders, Medical Orders for Life Sustaining Treatment (MOLST) or Physician Orders for Life Sustaining Treatment (POLST), Living Wills, or Durable Medical Powers of Attorney (health care agents).
3. For residents with executed advance directives, as status' change, follow the goals of care and preferences as indicated in those documents. However, affirming their wishes and goals in light of the pandemic can helpful.
4. For residents who are a full code or do not have advance directives, having a conversation to understand the resident's values, goals and preferences is beneficial, even if the resident or family in the case of an incapacitated resident, does not want to execute an advance directive document. Document the conversation and take appropriate follow up actions.
5. During a pandemic, there will be residents that are at the end-of-life unrelated to the particular communicable disease. Assess to determine if the resident's condition has elevated to an end-of-life event (i.e., is this resident's condition reversible or irreversible, and what does that mean in meeting the needs of that resident).
6. Educate residents and families on the risks and benefits of hospitalizations. This should include what it means if a hospital surge is happening, which may mean care in hallways, emergency rooms, or temporary holding areas such as gyms or parking lots.

3.0 PEP Infection Control

The facility must develop pandemic infection control plans for staff, residents, and families, including plans for (1) developing supply stores and specific plans to maintain, or contract to maintain, at least a two month (60 day) supply of personal protective equipment based on facility census, including consideration of space for storage; and (2) hospitalized residents to 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 NTCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80.

Additional infection control planning and response efforts and that should be addressed include:

- Incorporating lessons learned from previous pandemic responses into planning efforts to assist with the development of policies and procedures related to such elements as the management of supplies and PPE, as well as implementation of infection control protocols to assist with proper use and conservation of PPE.
- All personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents. COVID-specific guidance on optimizing PPE and other supply strategies is available on CDC's website:

  https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

  Supplies to be maintained include, but are not limited to:
  - N95 respirators;
  - Face shield;
  - Eye protection;
  - Gowns/isolation gowns;
  - gloves;
  - masks; and
  - sanitizers and disinfectants

  https://www.epa.gov/coronavirus/epa-guidance-disinfecting-cleaning-and-addressing-water-quality-challenges-related

Other considerations to be included in a facility's plans to reduce transmission regard when there are only one or a few residents with the pandemic disease in a facility:

- Plans for cohorting, including:
  - Use of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, such as at the end of a hallway.
  - Discontinue any sharing of a bathroom with residents outside the cohort
- Proper identification of the area for residents with COVID-19, including demarcating reminders for healthcare personnel; and
- Procedures for preventing other residents from entering the area.

4.0 Other PEP Requirements

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ADMINISTRATIVE MANUAL OF POLICIES AND PROCEDURES
DEPARTMENT: INTERDISCIPLINARY

EFFECTIVE DATE: 5/27/20

PREPARED BY: Heather Manwarren, DNS **NEW: REVISED: X**
APPROVED BY: Jeni Demarais, LNHA **POLICY: PROCEDURE: X**

SUBJECT: COVID -19 HOSPITAL DISCHARGES AND ADMISSIONS TO NURSING HOMES

BACKGROUND: On May 10, 2020, Governor Andrew M. Cuomo Signed Executive Order ("EO") 202.30 that includes, as applicable and without limitation the Directive of the Commissioner of Health where in accordance with 10 NYCRR 415.26, Nursing Homes must only accept and retain those residents for whom the facility can provide adequate care. Pursuant to the executive order, hospitals must test any patient who may be discharged to a Nursing Home for COVID – 19 using a molecular test for SARS – Cov-2 RNA. No Hospital shall discharge a patient who has been diagnosed with COVID -19 to a NH or ACF, until the patient has received one negative test result using such testing method.

POLICY: During this global health emergency, DRNC will comply with the directive of the Commissioner of Health issued May 10, 2020 titled "Hospital Discharges and Admissions to Nursing Homes and Adult Care Facilities"

PROCEDURE:

1. DRNC must confirm that the resident is medically stable for discharge and that resident has received one negative test result (Molecular test for SARS – Cov – 2 RNA) for COVID -19.

2. DRNC cannot accept a resident(s) who have been diagnosed with COVID – 19 for admission from a hospital until verification of a negative test has been received.

3. DRNC will not deny admission of a resident based solely on a resident's COVID-19 diagnosis with the exception of residents of hospitals who have not yet tested negative.

4. Newly admitted or readmitted residents should be monitored for evidence of COVID-19 for 14 days after admission/readmission despite having a negative test for COVID -19. Upon admission or readmission to the facility, resident(s) will be placed on precautionary quarantine. A droplet precautions are be posted on residents room door to alert staff of the residents status of "precautionary quarantine." Resident(s) will be monitored for symptoms consistent with COVID – 19 for the duration of the precautionary quarantine. Staff should follow standard precautions with mask for residents who are on precautionary quarantine.

   In an effort to optimize PPE during the COVID-19 pandemic, eye wear are excluded for residents who are on precautionary quarantine and will be utilized for residents whose COVID – 19 status is unknown, PUI's and those who are confirmed COVID - 19 positive or during an outbreak as directed by NYSDOH.

5. Newly admitted or readmitted residents should wear a facemask or cloth face covering to contain secretions when healthcare personnel are in room and during transports out of room. If residents cannot tolerate a facemask or cloth face covering, they should be encouraged to use tissues to cover their mouth and nose while out of their room.
6. Transport and movement of the resident outside of the room should be limited to medically essential purposes.

7. Resident(s) can be transferred out of single room to a semi-private room if they remain afebrile and without COVID – 19 symptoms for 14 days after their last exposure (date of admission).

8. If resident has new onset symptoms consistent with COVID -19, they will be considered to be a PUI and will be isolated, placed on contact/droplet precautions and cared for using COVID-19 PPE (KN95 or N95, isolation gown, gloves and eye protection [face shield or safety glasses/goggles]) *** See P&P for Suspected & Confirmed COVID-19 within the facility.**

   Resident should be transferred to a private room (as possible) with the door closed and with private bathroom (as possible). If a private bathroom is not available, resident should utilize a bed side commode and/or bed pan and/or urinal. Resident should be provided a cloth or procedural mask for source control and should be educated to wear it at all times as tolerated; with emphasis when healthcare personnel are in room and during transport out of room.

   If resident is cohorted with another PUI, engineering controls should be implemented where possible. Privacy curtains should be pulled between residents and room/bathroom doors should be kept close when possible.

5.0 Recovery for All Infectious Disease Events

DRNC will maintain review of, and implement procedures provided in NYSDOH CDC recovery guidance which 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.

The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders.

Helpful Link:

https://www.cms.gov/files/document/covid-nursing-home-reopening-recommendation-faqs.pdf

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Helpful - Quick General References for an EID

- Be aware of and review federal, state and local health department pandemic influenza plans. Incorporate appropriate actions from these plans into workplace disaster plans.

- Prepare and plan for operations with a reduced workforce.

- Work with your suppliers to ensure that you can continue to operate and provide services.

- Develop a sick leave policy that does not penalize sick employees, thereby encouraging employees who have influenza-related symptoms (e.g., fever, headache, cough, sore throat, runny or stuffy nose, muscle aches, or upset stomach) to stay home so that they do not infect other employees. Recognize that employees with ill family members may need to stay home to care for them.

- Identify possible exposure and health risks to your employees. Are employees potentially in contact with people with influenza such as in a hospital or clinic? Are your employees expected to have a lot of contact with the general public?

- Minimize exposure to fellow employees or the public. For example, will more of your employees work from home? This may require enhancement of technology and communications equipment.

- Identify business-essential positions and people required to sustain business-necessary functions and operations. Prepare to cross-train or develop ways to function in the absence of these positions. It is recommended that employers train three or more employees to be able to sustain business-necessary functions and operations, and communicate the expectation for available employees to perform these functions if needed during a pandemic.

- Plan for downsizing services but also anticipate any scenario which may require a surge in your services.

- Recognize that, in the course of normal daily life, all employees will have non-occupational risk factors at home and in community settings that should be reduced to the extent possible. Some employees will also have individual risk factors that should be considered by employers as they plan how the organization will respond to a potential pandemic (e.g., immuno-compromised individuals and pregnant women).

- Stockpile items such as soap, tissue, hand sanitizer, cleaning supplies and recommended personal protective equipment. When stockpiling items, be aware of each product's shelf life and storage conditions (e.g., avoid areas that are damp or have temperature extremes) and incorporate product rotation (e.g., consume oldest supplies first) into your stockpile management program.

- Make sure that your disaster plan protects and supports your employees, customers and the general public. Be aware of your employees' concerns about pay, leave, safety and health. Informed employees who feel safe at work are less likely to be absent.

- Develop policies and practices that distance employees from each other, customers and the general public. Consider practices to minimize face-to-face contact between employees such as e-mail, websites and

teleconferences. Policies and practices that allow employees to work from home or to stagger their work shifts may be important as absenteeism rises.

- Organize and identify a central team of people or focal point to serve as a communication source so that your employees and customers can have accurate information during the crisis.

- Work with your employees and their union(s) to address leave, pay, transportation, travel, childcare, absence and other human resource issues.

- Provide your employees and customers in your workplace with easy access to infection control supplies, such as soap, hand sanitizers, personal protective equipment (such as gloves or surgical masks), tissues, and office cleaning supplies.

- Provide training, education and informational material about business-essential job functions and employee health and safety, including proper hygiene practices and the use of any personal protective equipment to be used in the workplace. Be sure that informational material is available in a usable format for individuals with sensory disabilities and/or limited English proficiency. Encourage employees to take care of their health by eating right, getting plenty of rest and getting a seasonal flu vaccination.

- Work with your insurance companies, and state and local health agencies to provide information to employees and customers about medical care in the event of a pandemic.

- Assist employees in managing additional stressors related to the pandemic. These are likely to include distress related to personal or family illness, life disruption, grief related to loss of family, friends or coworkers, loss of routine support systems, and similar challenges. Assuring timely and accurate communication will also be important throughout the duration of the pandemic in decreasing fear or worry. Employers should provide opportunities for support, counseling, and mental health assessment and referral should these be necessary. If present, Employee Assistance Programs can offer training and provide resources and other guidance on mental health and resiliency before and during a pandemic.

Definitions:

Pandemic -- A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

Isolation - Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.

Quarantine - Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

Helpful Websites:

https://www.osha.gov/Publications/influenza_pandemic.html

http://www.cahfdisasterprep.com/PreparednessTopics/PandemicInfluenza.aspx

https://emergency.cdc.gov/coca/index.asp

http://emergency.cdc.gov/health-professionals.asp

http://emergency.cdc.gov/recentincidents/

https://www.train.org/cdctrain/search

Ebola Online Resources:

CDC Ebola Resources for State and Local Public Health Partners

CDC resources include updated personal protective equipment (PPE} guidance for health care personnel

http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance-clinically-stable-puis.html

and an Ebola Concept of Operations (ConOps} planning template + additional references:

https://www.cdc.gov/cpr/documents/ebola-concept-of-operations-planning-template-8-20-2015.pdf

https://www.cdc.gov/cpr/readiness/phep.htm

https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html

- Updated Case Counts

https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/case-counts.html

- Frequently Asked Questions for Guidance on Personal Protective Equipment to Be Used by Healthcare Workers During Management of Patients with Confirmed Ebola or Persons Under Investigation (PUI) for Ebola Who are Clinically Unstable or have Bleeding, Vomiting or Diarrhea in U.S. Hospitals,Including Procedures for Donning and Doffing PPE:

https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html