

# **COVID-19 & INFLUENZA**

## **EMERGENCY/DISASTER PREPAREDNESS AND RESPONSE PLAN-2020**



## SCHERVIER NURSING CARE CENTER

### COVID-19 AND INFLUENZA EMERGENCY (DISASTER) PREPAREDNESS PLAN TABLE OF CONTENTS

<u>TITLE</u>	<u>PAGE NUMBER</u>
<b>SECTION I. GENERAL INFORMATION .....</b>	<b>3</b>
CORONAVIRUS PREVENTION AND CONTROL.....	3
EMERGENCY NUMBERS.....	5
DEPARTMENT EMERGENCY CALL LISTINGS.....	6
ORIENTATION AND TRAINING OF THIS PLAN .....	7
<b>SECTION II. CMS CHECKLIST.....</b>	<b>8</b>
CMS CHECKLIST FOR LTC FACILITIES.....	8
<b>SECTION III. POLICIES.....</b>	<b>15</b>
COVID-19 GENERAL POLICY .....	15
COVID-19 TESTING POLICY .....	19
RETURN TO WORK POLICY.....	21
COVID-19 PERSONAL PROTECTIVE EQUIPMENT (PPE) POLICY .....	23
COVID-19 ACCEPTING AND RETAINING RESIDENTS POLICY .....	24
COVID-19 ADMISSION POLICY.....	25
COVID-19 FAMILY NOTIFICATION POLICY .....	27
COVID-19 COHORTING RESIDENTS POLICY .....	28
DISCONTINUATION OF TRANSMISSION BASED PRECAUTIONS.....	29
COVID-19 VISITATION POLICY .....	32
COVID-19 VISITATION SUSPENSION POLICY .....	33
COVID-19 COMMUNICATION TO STAFF .....	34
COVID-19 COMMUNICATION SAMPLE LETTER.....	35
COVID-19 POSTMORTEM CARE POLICY .....	36
COVID-19 STAFFING POLICY.....	37
COVID-19 CHECKLIST AND EDUCATION .....	38
COVID-19 REOPENING POLICY .....	40
COVID-19 CDC GUIDELINES- OPTIMIZING PPE .....	41
<b>SECTION IV: PANDEMIC INFLUENZA PREPAREDNESS AND RESPONSE PLAN.....</b>	<b>43</b>
<b>SECTION V: CDC GUIDELINES AND PUBLICATIONS.....</b>	<b>60</b>
COVID-19 TESTING GUIDELINES IN NURSING HOMES .....	60
PREPARING FOR COVID-19 IN NURSING HOMES.....	62
COVID-19 DEFINITIONS .....	70
RESOURCES AND REFERENCES .....	71

## **Section I. General Information**

### **Coronavirus Prevention and Control**

#### **Policy Statement**

To ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including SARS-CoV-2, the virus that causes COVID-19. Signs and symptoms include sputum production, headache, hemoptysis, and diarrhea. The incubation time is believed to be approximately 7-14 days and the virus may be transmitted from asymptomatic patients. The length of time the virus can live on surfaces is not clear at present. Elderly and those with chronic medical conditions have demonstrated more severe illness than other populations at this time.

#### **Modes of transmission**

- By being in close contact with another person approximately 3 feet.
- Through respiratory droplets produced with and infected person coughs or sneezes.
- By touching a surface or object with virus on it and the touching your mouth, nose or eyes.

#### **Visitor**

- Symptoms may include fever of 100.4 or greater, cough, shortness of breath and sore throat.
- Visitors with history of travel especially travel outside to countries or areas affected with COVID-19
- The Schervier Multidisciplinary Planning Committee advises any visitors exhibiting these symptoms not to visit residents at this time.
- A sign/notice will be posted at the facility entrance area to alert visitors not to visit if they have respiratory symptoms including fever of 100.4 or greater, cough, or shortness of breath and sore throat.

Resident with signs and symptom of respiratory illness will be screened and Infection Control Procedures will be followed.

#### **Resident procedures**

If resident has fever of 100.4 or greater with cough, shortness of breath and sore throat, nursing staff and/or trained personnel will place a facemask on the resident and isolate him/her in an observation room with the door closed.

- Notify MD and family of symptoms found during assessment.
- Follow MD orders for symptoms observed.
- If MD orders transfer call 911 and notify hospital ER of symptoms of possible COVID -19 and that transferred resident may require airborne isolation.
- Only personnel providing direct care to suspected resident should enter the room and required PPE (gown, mask/face shield, gloves.)
- The infection preventionist and/or designated personnel will promptly notify state or local public health authorities of patients with known or suspected COVID-19 (i.e., PUI).

#### **Healthcare Worker**

- The infection preventionist will follow all employees who exhibit any symptoms related to COVID-19.
- Employees who exhibit symptoms of acute respiratory illness are recommended to stay home and not return to work until free of fever without using fever altering medications and are cleared by the primary care physician

#### **Training and Education**

1. The Infection Preventionist, staff education coordinator and or Director of Nursing Services will train and educate staff.
2. All staff will receive job- or task-specific education and training on preventing transmission of infectious agents, including COVID-19, associated with healthcare during orientation to the facility.

3. This information will be updated periodically during ongoing education and training programs.
4. Competency will be documented initially and repeatedly, as appropriate, for the specific staff positions.
5. Staff employed by outside employers must meet these education and training requirements through programs offered by the outside employer or by participation in the healthcare facility's program.
6. Key aspects of coronavirus and its prevention will be emphasized to all staff, including:
  - a. Coronavirus infection signs, symptoms, complications, risk factors and complications;
  - b. Central role of administrative controls such as hand washing, respiratory hygiene and cough etiquette, sick policies, and precautions during aerosol-generating procedures.
  - c. Appropriate use of personal protective equipment
  - d. Use of engineering controls and work practices including infection control procedures to reduce exposure.

**References:**

<https://www.cdc.gov/infectioncontrol/guidelines/index.html>

## Emergency Numbers

Department	Name	Phone Number
Administrator	Yosef Spierer	347-668-6597
Director of Nursing	Santhamma Varghese	914-826-5907
Medical director	Peyman Younesi	310-709-1236
Assistant Director of Nursing/Infection Control Professional	Lora Lly Mary Palarpalar	914-320-3230
Director of Social Services	Franca Martino-Starvaggi	914-806-7539
Human Resources Manager	Jo Ann Gonzales	917 853-4719
Admissions and Marketing Director	Carol Rivera	646-770-7934
Director of Environmental Services	Gerard DeLuca	201-887-1482
Facilities Manager	Ron Gibbs	347-731-6109
Activities Director	Nereida Moreno	(917) 251-9691
Director of Therapy	Hazel Ayirebi	646-541-2308
Staff Development	Uduak Ikiddeh	718-514-4222
RN Supervisor	Adeluisa Edano/Isabel Villaester/Jaspreet Kaur	347-931-1449
Ambulance (Emergency)	911	911
Police (Emergency)	911	911
Fire Department (Emergency)	911	911
Borough Police	50th Precinct	(718) 543-5700
Fire Department	FDNY Engine 81/Ladder 46	911
Poison Control Center	(800) 222-1222	311
Emergency Management		718-881-1180
Department of Health New York		866-881-2809
Department of Health (Local)		(718) 267-2170
Ambulance services	SeniorCare EMS	(718) 430-9700
Ambulance services	Citywide Ambulance	(718) 597-6100
Ambulance services	RCA Ambulance Service	(718) 273-3555
Hospital Emergency Rooms	NewYork-Presbyterian/Columbia University Medical Center	212-305-5437
Hospital Emergency Rooms	Montefiore Medical Center Moses Campus	718-920-4321
Medical/Surgical Suppliers	Innovative Supply	732-363-3001
Pharmacy (Main)	Pharmscript LLC	(888) 319-1818
Healthcare Associations	New York State Health Facilities Association	518.462.4800
Emergency O <sub>2</sub> Supplier	Praxair	800-645-4633
Internet and Phone	On-Time IT Solutions, Inc.	(845) 492-2083

### **Department Emergency Call Listings**

1. Emergency call listings for each department shall be maintained and updated on a regular basis.
2. Each department Director is responsible for having an approved call listing available.
3. The departmental call listing will have the departmental manager's home phone and a listing of phone numbers to be used in calling in staff.
4. A full set of emergency call names of key personnel are kept in the Emergency Preparedness Manuals

## **Orientation and Training of this Plan**

### **POLICY:**

All new staff of Schervier Rehabilitation and Nursing Center will receive initial Covid-19 Orientation and annual in service training thereafter through online training sessions and throughout the year as determined by the Infection Control Professional (ICP).

1. Initial Employee Review – The Infection Preventionist will meet with new employees through orientation and give handouts related to Covid-19 for employee to read and sign in their orientation records.
2. The Infection Preventionist will schedule periodic reviews of new regulations
3. Each department supervisor is responsible for specific training for their department.
4. The Infection Preventionist, staff education coordinator and or Director of Nursing Services will train and educate staff.
5. All staff will receive job- or task-specific education and training on preventing transmission of infectious agents, including COVID-19, associated with healthcare during orientation to the facility.
6. This information will be updated periodically during ongoing education and training programs.
7. Competency will be documented initially and repeatedly, as appropriate, for the specific staff positions.
8. Staff employed by outside employers must meet these education and training requirements through programs offered by the outside employer or by participation in the healthcare facility's program.
9. Key aspects of coronavirus and its prevention will be emphasized to all staff, including:
  - e. Coronavirus infection signs, symptoms, complications, risk factors and complications;
  - f. Central role of administrative controls such as hand washing, respiratory hygiene and cough etiquette, sick policies, and precautions during aerosol-generating procedures.
  - g. Appropriate use of personal protective equipment
  - h. Use of engineering controls and work practices including infection control procedures to reduce exposure.

## SECTION II: CMS CHECK LIST

### Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings

U.S. Department of Health and Human Services Centers for Disease Control and Prevention Nursing homes and other long-term care facilities can take steps to assess and improve their preparedness for responding to coronavirus disease 2019 (COVID-19). Each facility will need to adapt this checklist to meet its needs and circumstances based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation). This checklist should be used as one tool in developing a comprehensive COVID-19 response plan. Additional information can be found at [www.cdc.gov/COVID-19](http://www.cdc.gov/COVID-19). Information from state, local, tribal, and territorial health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility's COVID-19 plan. Comprehensive COVID-19 planning can also help facilities plan for other emergency situations.

This checklist identifies key areas that long-term care facilities should consider in their COVID-19 planning. Long-term care facilities can use this tool to self-assess the strengths and weaknesses of current preparedness efforts. Additional information is provided via links to websites throughout this document. However, it will be necessary to actively obtain information from state, local, tribal, and territorial resources to ensure that the facility's plan complements other community and regional planning efforts. This checklist does not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19.

A preparedness checklist for hospitals, including long-term acute care hospitals is available.

<https://www.cdc.gov/coronavirus/2019-ncov/downloads/hospital-preparedness-checklist.pdf>

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings:

<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF):

<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-carefacilities.html>

#### 1. Structure for planning and decision making

- COVID-19 has been incorporated into emergency management planning for the facility.
- A multidisciplinary planning committee or team has been created to specifically address COVID-19 preparedness planning.

Schervier Multidisciplinary Planning Committee

- Members of the planning committee include the following:



Department	Name	Phone Number
Administrator	Yosef Spierer	347-668-6597
Director of Nursing	Santhamma Varghese	914-826-5907
Medical director	Peyman Younesi	310-709-1236
Assistant Director of Nursing/Infection Control Professional	Lora Lly Mary Palarpalar	914-320-3230
Director of Social Services	Franca Martino-Starvaggi	914-806-7539
Human Resources Manager	Jo Ann Gonzales	917 853-4719
Admissions and Marketing Director	Carol Rivera	646-770-7934
Director of Environmental Services	Gerard DeLuca	201-887-1482
Facilities Manager	Ron Gibbs	347-731-6109
Activities Director	Nereida Moreno	(917) 251-9691
Director of Therapy	Hazel Ayirebi	646-541-2308
Staff Development	Uduak Ikiddeh	718-514-4222
RN Supervisor	Adeluisa Edano/Isabel Villaester/Jaspreet Kaur	347-931-1449

### 1. Development of a written COVID-19 plan.

- A copy of the COVID-19 preparedness plan is available at the facility and accessible by staff.
- Relevant sections of federal, state, regional, or local plans for COVID-19 or pandemic influenza are reviewed for incorporation into the facility's plan.
- The facility plan includes the Elements listed in #3 below.
- The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

### . Elements of a COVID-19 plan

#### General:

- A plan is in place for protecting residents, healthcare personnel, and visitors from respiratory infections, including COVID-19, that addresses the elements that follow.
- A person has been assigned responsibility for monitoring public health advisories (federal and state) and updating the COVID-19 response coordinator and members of the COVID-19 planning committee when COVID-19 is in the geographic area. For more information, see <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

Department	Name	Phone Number
Administrator	Yosef Spierer	347-668-6597
Director of Nursing	Santhamma Varghese	914-826-5907
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Assistant Director of Nursing/Infection Control Professional	Lora Lly Mary Palarpalar	914-320-3230
Director of Social Services	Franca Martino-Starvaggi	914-806-7539
Human Resources Manager	Jo Ann Gonzales	917 853-4719
Admissions and Marketing Director	Carol Rivera	646-770-7934
Director of Environmental Services	Gerard DeLuca	201-887-1482
Facilities Manager	Ron Gibbs	347-731-6109
Activities Director	Nereida Moreno	(917) 251-9691
Dietary Director	Chris Kane	917-991-9253

Director of Therapy	Hazel Ayirebi	646-541-2308
Purchasing Director	Harry Preisler	845-243-0658
Staff Development	Uduak Ikiddeh	718-514-4222
RN Supervisor	Adeluisa Edano	347-931-1449

- The facility has a process for inter-facility transfers that includes notifying transport personnel and receiving facilities about a resident's suspected or confirmed diagnosis (e.g., presence of respiratory symptoms or known COVID-19) prior to transfer.
- The facility has a system to monitor for, and internally review, development of COVID-19 among residents and healthcare personnel (HCP) in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting), see CDC guidance on respiratory surveillance: <https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf>.
- The facility has infection control policies that outline the recommended Transmission Based Precautions that should be used when caring for residents with respiratory infection. (In general, for undiagnosed respiratory infection, Standard, Contact, and Droplet Precautions with eye protection are recommended unless the suspected diagnosis requires Airborne Precautions; see: <https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html>.) For recommended Transmission-Based Precautions for residents with suspected or confirmed COVID-19, the policies refer to CDC guidance; see: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.
- The facility periodically reviews specific IPC guidance for healthcare facilities caring for residents with suspected or confirmed COVID-19 (available here: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>) and additional long-term care guidance (available here: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-carefacilities.html>).

### **Facility Communications:**

Key public health points of contact during a COVID-19 outbreak have been identified. (Insert name, title, and contact information for each.)

Local health department contact: New York Metropolitan Regional Office - New York City - Long Term Care  
Phone: (212) 417-4999

Fax: (212) 417-6551

State health department contact:

Metropolitan Area Regional Office  
NYS Department of Health  
145 Huguenot Street  
New Rochelle, NY 10801-5228  
Phone: (914) 654-7149  
Fax: (914) 654-7169

State Long-Term Care Professional/Trade Association: New York State Health Facilities Association  
33 Elk Street, Suite 300  
Albany, NY 12207-1010

Phone: 518.462.4800  
Fax: 518.426.4051  
Email: info@nyshfa.org

- A person has been assigned responsibility for communications with public health authorities during a COVID-19 outbreak.

Yosef Spierer, Administrator 347-668-6597

- Key preparedness (e.g., Healthcare coalition) points of contact during a COVID-19 outbreak have been identified.

Yosef Spierer, Administrator -347-668-6597

Ron Gibbs, Facilities Manager - 347-731-6109

Santhamma Varghese, Director of Nursing - 914-826-5907

Franca Martino-Starvaggi – Director of Social Work - 914-806-7539

- A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility. (Having one voice that speaks for the facility during an outbreak will help ensure the delivery of timely and accurate information.)
- Contact information for family members or guardians of facility residents is up to date.
- Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., consultants, sales and delivery people) about the status of COVID-19 in the facility.
- A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals and hospital emergency medical services, relevant community organizations—including those involved with disaster preparedness) with whom it will be necessary to maintain communication during an outbreak. Attach a copy of contact list.
- A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during an outbreak.

### **Supplies and resources:**

The facility provides supplies necessary to adhere to recommended IPC practices including:

- Alcohol-based hand sanitizer for hand hygiene is available in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
- Sinks are well-stocked with soap and paper towels for hand washing.
- Signs are posted immediately outside of resident rooms indicating appropriate IPC precautions and required personal protective equipment (PPE).
- Facility provides tissues and facemasks for coughing people near entrances and in common areas with no-touch receptacles for disposal.
- Necessary PPE is available immediately outside of the resident room and in other areas where resident care is provided.
- Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
- Trash disposal bins should be positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room.

- Facility ensures HCP have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- The facility has a process to monitor supply levels.

The facility has a contingency plan that includes engaging their health department and healthcare coalition when they experience (or anticipate experiencing) supply shortages. Contact information for healthcare coalitions is available here:

<https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx>

### **Identification and Management of Ill Residents:**

- The facility has a process to identify and manage residents with symptoms of respiratory infection (e.g., cough, fever, sore throat) upon admission and daily during their stay in the facility, which include implementation of appropriate Transmission-Based Precautions.
- The facility has criteria and a protocol for initiating active surveillance for respiratory infection among residents and healthcare personnel. CDC has resources for performing respiratory surveillance in long-term care facilities during an outbreak, see: <https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf>
- Plans developed on how to immediately notify the health department for clusters of respiratory infections, severe respiratory infections, or suspected COVID-19.
- The facility has criteria and a protocol for: limiting symptomatic and exposed residents to their room, halting group activities and communal dining, and closing units or the entire facility to new admissions.
- The facility has criteria and a process for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units.

### **Considerations about Visitors:**

- The facility has plans and material developed to post signs at the entrances to the facility instructing visitors not to visit if they have fever or symptoms of a respiratory infection.
- The facility has criteria and protocol for when visitors will be limited or restricted from the facility.
- Should visitor restrictions be implemented, the facility has a process to allow for remote communication between the resident and visitor (e.g., video-call applications on cell phones or tablets) and has policies addressing when visitor restrictions will be lifted (e.g., end of life situation). For more information about managing visitor access and movement in the facility see: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/controlrecommendations.html>

### **Occupational Health:**

- The facility has sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill healthcare personnel (HCP) to stay home.
- The facility instructs HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection, as a part of routine practice.
- The facility has a process to actively screen HCP for fever and symptoms when they report to work.
- The facility has a process to identify and manage HCP with fever and symptoms of respiratory infection.
- The facility has a plan for monitoring and assigning work restrictions for ill and exposed HCP. (See: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>)
- The facility has a respiratory protection plan that includes medical evaluation, training, and fit testing of employees.

**Education and Training:**

- The facility has plans to provide education and training to HCP, residents, and family members of residents to help them understand the implications of, and basic prevention and control measures for, COVID-19. Consultant HCP should be included in education and training activities.
- A person has been designated with responsibility for coordinating education and training on COVID-19 (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance).

Uduak Ikiddeh, Clinical Educator, 718-548-1700

- Language and reading-level appropriate materials have been identified to supplement and support education and training programs to HCP, residents, and family members of residents (e.g., available through state and federal public health agencies such and through professional organizations), and a plan is in place for obtaining these materials. Plans and material developed for education and job-specific training of HCP which includes information on recommended infection control measures to prevent the spread of COVID-19, including: ,
  - Signs and symptoms of respiratory illness, including COVID-19.
  - How to monitor residents for signs and symptoms of respiratory illness.
  - How to keep residents, visitors, and HCP safe by using correct infection control practices including proper hand hygiene and selection and use of PPE. Training should include return demonstrations to document competency.
  - Staying home when ill.
  - HCP sick leave policies and recommended actions for unprotected exposures (e.g., not using recommended PPE, an unrecognized infectious patient contact).
- See: “Strategies to prevent the spread of COVID-19 in long-term care facilities,” available at: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spreadin-long-term-care-facilities.html>
- The facility has a plan for expediting the credentialing and training of non-facility HCP brought in from other locations to provide resident care when the facility reaches a staffing crisis.
- Informational materials (e.g., brochures, posters) on COVID-19 and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic.

**Surge Capacity:****Staffing**

- A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents’ health status, functional limitations, disabilities, and essential facility operations.
- A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during a COVID-19 outbreak.

Jenniffer Powell, Staffing Coordinator, 718-548-1700

- Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility “staffing crisis” and appropriate emergency staffing alternatives, consistent with state law.
- The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.

**Consumables and durable medical equipment and supplies**

- Estimates have been made of the quantities of essential resident care materials and equipment (e.g.,

intravenous pumps and ventilators, pharmaceuticals) and personal protective equipment (e.g., masks, respirators, gowns, gloves, and hand hygiene products), that would be needed during an eight-week outbreak.

- Estimates have been shared with local, regional, and tribal planning groups to better plan stockpiling agreements.
- A plan has been developed to address likely supply shortages (e.g., personal protective equipment), including strategies for using normal and alternative channels for procuring needed resources.
- A strategy has been developed for how priorities would be made in the event there is a need to allocate limited resident care equipment, pharmaceuticals, and other resources.
- A process is in place to track and report available quantities of consumable medical supplies including PPE.

**Postmortem care:**

- A contingency plan has been developed for managing an increased need for postmortem care and disposition of deceased residents.
- An area in the facility that could be used as a temporary morgue has been identified.
- Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.

## SECTION III: POLICIES

### Covid-19 General policy

**POLICY:** It is the policy of Schervier Nursing Care Center that, this guidance is based on the currently limited information available about COVID-19 related to disease severity, transmission efficiency, and shedding duration.

**PURPOSE:** To keep residents and staff from COVID-19 virus.

### **PROCEDURE**

#### **Responsibility**

Nursing/Social Services/Medical

#### **A. Action**

1. When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedures).
2. Take steps to ensure all persons with symptoms of suspected 2019-nCoV or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit.
3. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use facemasks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
4. Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at entrances.
5. Patient Placement and Quarantine

Nursing/Social Services/Medical

All

#### Instructions

- a. Residents identified to have COVID-19 should be placed on contact and droplet isolation.
- b. All admission will be placed to the dedicated units
  - All admission with confirmed COVID19 will be cohorted with same COVID19 resident if single room is not available.
  - All resident with suspected COVID19 cannot be cohorted with resident with confirmed COVID19 resident.
  - All negative COVID19 admission/readmission is/ are admitted to designated unit. Readmitted resident will be transferred back to their respective unit after 14 days of surveillance.
  - Communal dining will be discontinued and residents will be provided meals in the dining rooms, resident lounges and in their rooms complying with social distancing laws

Nursing

- c. All residents with confirmed COVID19 needs to be on CONTACT and DROPLET ISOLATION.
- d. All staff who enters the room of resident(s) who on isolation should wear appropriate PPEs (face shield, face mask, gown, and gloves).

Administration

- e. All residents with confirmed Covid19 need to be provided with mask.
- f. Activities to all residents with confirmed COVID19 will be provided in their respective rooms.

#### 6. Environmental:

- a) Facility disinfect / clean high



touch surfaces (knobs, had rails, tables etc..) on regular basis throughout the day, at a minimum twice a day with increase amount warranted based on facility activity.

- b) Facility will ensure ample amount of alcohol-based gel dispensers as well as a system keep full and reFady for use by staff and visitors

7. Interfacility spread:

- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- Report any possible COVID-19 illness in residents and employees to the local health department, including your state Healthcare-Associated Infections coordinator.

8. Screening

- Employees & Compassionate Visitors will be screened upon entrance to the facility for COVID – 19, as per “COVID-19 Employee Screening Tool”.

Nursing/Social Services/Medical

9. Patient Placement:

- g. Residents identified to have COVID-19 should be placed in an AIIR(Airborne Infection Isolation Room) or isolation room until transfer to the hospital or healthcare facility equipped with treating such infections and reported to local Board of Health.

All

10. Environmental:

- c) Facility disinfect / clean high touch surfaces (knobs, had rails, tables etc..) on regular basis throughout the day, at a minimum twice a day with increase amount warranted based on facility activity

- d) Facility should ensure ample amount of alcohol-based gel dispensers as well as a system keep full and ready for use by staff and visitors

## Nursing

### 11. Interfacility spread:

- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- Report any possible COVID-19 illness in residents and employees to the local health department, including your state Healthcare-Associated Infections coordinator.

## Administration

## **Covid-19 Testing policy**

**POLICY:** It is the policy of Schervier Rehab and Nursing Center that, all residents and employees will be tested as required by the TN department of health for COVID-19 and symptoms will be monitored closely to prevent spread of infections related to COVID-19.

**PURPOSE:** To protect all residents and staff and to keep all residents and staff away from contracting COVID-19 virus and to provide a safe environment for residents and staff.

### **PROCEDURE**

#### **Responsibility**

Nursing/Administration/Medical

#### **B. Action**

1. Schervier Rehab and Nursing Center will execute a contract and use services from a TN department of health approved laboratory for conducting Polymerase Chain Reaction (PMR) test to diagnose active infection for COVID-19 for residents and employees using a nasal or oral swab.
2. Facility will maintain all testing documents including weekly test logs, test results, consent/refusal form etc. for a minimum of six (6) months and present to regulatory agencies upon request.
3. All positive and "false positive" cases will be reported to TN department of health and other agencies as required.
4. Infection control nurse or other nurses with additional training will be used to collect nasal or oral swabs from residents and employees using appropriate precautions and personal protective equipment (PPE).
5. Informed consent will be received from all residents/responsible party and employees for initial and ongoing tests.
6. All refusals will be documented for appropriate follow up
7. Initial baseline testing will be completed for all residents and employees before June 30, 2020
8. If an employee refuse to complete Polymerase Chain Reaction (PMR) test should bring documentation from a TN department of health approved laboratory indicating negative test results within the past 7 days or written documents from the licensed physician indicating antibody test results and the employee is not at risk or contagious.
9. Employees are required to test weekly. If an employee is on vacation or away from

work, testing should be completed within 72 hours upon return to work or bring a copy of the negative test result from any TN department of health approved laboratory completed within the last 72 hours.

### **Return to work policy**

#### **POLICY:**

It is the policy of Schervier Rehab and Nursing Center that, healthcare professionals who are tested positive or showing signs and symptoms will be monitored closely to prevent spread of infections related to COVID-19 and will be allowed to work only as they become negative and or exhibiting no more signs and symptoms of COVID-19. This guidance is based on the CDC guidelines and currently available information about COVID-19

#### **PURPOSE:**

To protect all residents and staff and to keep all residents and staff away from contracting COVID-19 virus.

#### **PROCEDURE**

##### **Responsibility**

Nursing/Social Services/Medical

##### **C. Action**

Healthcare personnel (HCP) with confirmed COVID-19, or who have suspected COVID-19 (e.g., developed symptoms of a respiratory infection [e.g., cough, sore throat, shortness of breath, fever] but did not get tested for COVID-19) shall return to work based on following criteria.

##### **Sym HCP with suspected or confirmed COVID-19**

A. Symptom-based strategy Exclude from work until:

- At least 3 days (72 hours) have passed **since recovery** defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed **since symptoms first appeared**

C. B. Test-based strategy

D. Exclude from work until:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens)

**2. Laboratory-confirmed COVID-19 who have not had any symptoms**

**A. Time-based strategy.**

Exclude from work until:

10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the **symptom-based** or **test-based strategy** should be used.

**B. Test-based strategy**

Exclude from work until:

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens).

**Return to Work Practices and Work Restrictions**

After returning to work, HCP should:

1. Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline.
2. Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

## **Personal Protective Equipment (PPE)**

### **PURPOSE:**

To ensure that personal protective equipment (PPE) is provided for all staff at the facility, including surgical-grade facemasks, gloves, gowns, and eye protection (e.g. goggles or face shield) when interacting with COVID-19 suspected or confirmed residents as per DOH/CDC guidelines.

### **Policy:**

Staff will be provided proper PPE when interacting with COVID-19 suspected or confirmed residents as per DOH/CDC guidelines.

### **Procedure:**

1. Prior to entering areas where residents are suspected or confirmed with COVID-19, each staff member will be provided with the proper PPE to follow infection prevention and control guidelines.
2. Extra supplies are readily available in the 4<sup>th</sup> floor nursing office if the need arises. Staff can contact the nursing supervisor for supplies as needed.
3. The facility keeps an internal count of PPE, to ensure that there is enough supply for all staff who need it.
4. Education provided to staff on the proper usage, procedure, and sequence, for donning, removing and discarding PPE.

## **COVID - 19 - Accepting and Retaining Residents**

### **PURPOSE:**

The Facility will only accept and retain residents for whom it can provide adequate care, and who have a negative molecular test for SARS-Cov-2 RNA. With the exception of patients of hospitals who have not yet tested negative, the facility will not deny admission of a resident based solely on a resident's COVID-19 diagnosis.

### **Policy:**

The goal of the facility is to provide care to those who we can properly care for. The facility will not deny admission of a resident based solely on a resident's COVID-19 diagnosis.

### **Procedure:**

1. Prior to admission of any resident to the facility, the facility will review paperwork related to the resident, i.e. PRI & Screen, and will only accept the resident if the facility deems that they have the capacity to provide proper care to the resident.
2. If it is found that the potential admission has a hx of COVID – 19, it will not impact the decision as to whether to admit the patient or not.



## **Admission policy related to Covid-19**

**POLICY:** It is the policy of Schervier Rehab and Nursing Center that, all new and re-admissions will be monitored closely to prevent spread of infections related to COVID-19. This guidance is based on the currently limited information available about COVID-19 related to disease severity, transmission efficiency, and shedding duration.

**PURPOSE:** To protect all new and re-admissions and to keep all residents and staff away from contracting COVID-19 virus.

### **PROCEDURE**

#### **Responsibility**

Nursing/Social Services/Medical

#### **Action**

1. All new and re-admission residents will be placed in a private/isolation room for at least first 14 days.
2. Universal precautions and isolation guidelines provided by CDC will be followed
3. Resident rooms will be kept closed as much as possible
4. Facility will limit social and group activities such common dining areas, group recreational activities, group rehab therapy etc.
5. Visitors and non-essential staff visit will be restricted during this period
6. When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedures).
7. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use facemasks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.

Nursing/Social Services/Medical

8. Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at entrances

All

9. Environmental:
  - Facility disinfect / clean high touch surfaces (knobs, hand rails, tables etc..) on regular basis throughout the day, at a minimum twice a day with increase amount warranted based on facility activity
  - Facility should ensure ample amount of alcohol-based gel dispensers as well as a system keep full and ready for use by staff and visitors

Nursing

10. Interfacility spread:

- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- Report any possible COVID-19 illness in residents and employees to the local health department, including your state Healthcare-Associated Infections coordinator.

Administration

## **COVID – 19 - Notifying Family Members or Next of Kin**

### **PURPOSE:**

To notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death.

### **Policy:**

That the facility will notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such.

### **Procedure:**

1. Upon learning of a new COVID -19 positive result, or a death which has been determined to be related to COVID – 19, the family members or next of kin will be alerted.
2. When there are any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death, all family members or next of kin will be advised via an automated phone message.

## **COVID - 19 - Separating Residents into Cohorts**

### **PURPOSE:**

The facility will separate residents into cohorts of positive, negative, and unknown as well as separate staffing teams to deal with COVID-positive residents and non-positive residents.

### **Policy:**

The facility will cohort residents of the same COVID – 19 status, to mitigate the risk of the spread of COVID -19. Additionally, staff will also be kept in teams to further mitigate the risk.

### **Procedure:**

1. All residents will be tested for COVID -19 via nasal swab.
2. Those who are found to be positive will be transferred to the dedicated 1<sup>st</sup> floor, for a period of at least 2 weeks.
3. Those who are positive, negative, and unknown, will be cohorted to minimize infection spread.
4. Whenever possible, staff will remain on the same unit, to avoid cross contamination.
5. Residents on the 1<sup>st</sup> floor who are found to be negative, after 2 weeks and are asymptomatic for 3 days, will be moved to another floor, where they match the appropriate COVID – 19 status.
6. As per CDC guidelines, newly admitted residents or those who show new symptoms should be tested. If tested negative, “However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE.”
7. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).
8. Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.

## Discontinuation of Transmission based precautions related to Covid-19

### **POLICY:**

It is the policy of Schervier Rehab and Nursing Center that, all residents tested positive or showing signs and symptoms will be monitored closely to prevent spread of infections related to COVID-19 and will discontinue transmission based precautions as they become negative and or exhibiting no more signs and symptoms of COVID-19. This guidance is based on the CDC guidelines and currently available information about COVID-19 related to disease severity, transmission efficiency, and shedding duration.

### **PURPOSE:**

To protect all residents and staff and to keep all residents and staff away from contracting COVID-19 virus.

### **PROCEDURE**

#### **Responsibility**

Nursing/Social Services/Medical

#### **E. Action**

10. The decision to discontinue Transmission-Based Precautions for residents with confirmed COVID-19 should be made using either a test-based strategy or a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or time-based strategy.

#### **11. Symptom-based strategy**

a. At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,

b. At least 10 days have passed *since symptoms first appeared*

#### **12. Test-based strategy**

a. Resolution of fever without the use of fever-reducing medications **and**

b. Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**

c. Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens)

**13. Residents with laboratory-confirmed COVID-19 who have not had any symptoms** should remain in Transmission-Based Precautions until **either:**

#### **a. Time-based strategy**

10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test.

Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

**b. *Test-based strategy***

Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hour's apart (total of two negative specimens).

14. The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 patient can be made based upon having negative results from at least one FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA.

15. If a higher level of clinical suspicion for COVID-19 exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.

16. If a patient suspected of having COVID-19 is never tested, the decision to discontinue Transmission-Based Precautions can be made based upon using the *symptom-based strategy*

17. If discharged to home:

- Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions. The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations.

18. If discharged to a nursing home or other long-term care facility (e.g., assisted living facility), AND

- Transmission-Based

Precautions *are still required*, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.

- Transmission-Based

Precautions *have been discontinued*, but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline.

- Transmission-Based

Precautions *have been discontinued* and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

## **Visitation Policy**

**POLICY:** It is the policy of Schervier Rehab and Nursing Center that, visitors and non-essential services will be monitored closely and restricted to prevent spread of infections related to COVID-19. This guidance is based on the currently limited information available about COVID-19 related to disease severity, transmission efficiency, and shedding duration.

**PURPOSE:** To protect all residents and staff away from contracting COVID-19 virus.

### **PROCEDURE**

#### **Responsibility**

1. Nursing/Social  
Services/Administration

#### **Action**

2. All visitors and non-essential services will be monitored and restricted until further notice to prevent spread of infections related to COVID-19
3. A sign will be posted at the front entrance about the visitation restrictions
4. Family member/responsible party will be contacted via phone and or mail to notify visitation restrictions
5. Family member/responsible party will be updated periodically about the status
6. If a resident is actively dying and or in special need for family visitation, special arrangements will be made on a case by case basis
7. Communication from the family members to the residents will be conveyed appropriately
8. Family members are encouraged to use facility phone numbers, skype, facetime, social media and other communication methods to keep in touch with the loved ones
9. Facility uses one entrance for all visitors and it is monitored closely
10. Basic health screening including set of questionnaire will be used to identify potential risk
11. Body temperature for all visitors will be checked using a non-contact thermometer
12. All visitors will be encouraged to sign in and out upon entrance and exit of the facility
13. Universal precautions and isolation guidelines provided by CDC will be followed
14. Resident rooms will be kept closed as much as possible



## **COVID-19 Visitation Suspension**

### **PURPOSE:**

To ensure suspension of all visitation except when medical necessary (i.e. visitor is essential to the care of the patient or is providing support in imminent end-of-life situations) or for family members of residents in imminent end-of-life situations, and those providing Hospice care. This policy will be reviewed when new guidance is received from the NYS DOH, CDC or other governing body.

### **Policy:**

To ensure that only personnel who are medical necessary (i.e. visitor is essential to the care of the patient or is providing support in imminent end-of-life situations) or for family members of residents in imminent end-of-life situations, and those providing Hospice care are allowed in the facility, to minimize the risk of spreading the COVID – 19 virus within the facility and in the community. This policy will be reviewed when new guidance is received from the NYS DOH, CDC or other governing body.

### **Procedure:**

1. Signage posted at the entrance to the facility, alerting every one of the facility policies regarding visitation suspension.
2. Residents, families and primary contacts have been notified of our policy.
3. Upon entering the facility, everyone's temperature is taken, and a series of questions is asked, to determine if they are showing sign or symptoms of COVID – 19. If they have a temperature or other symptoms, they will be asked to leave.
4. All of those who are deemed necessary to enter the facility, as per the above, are provided proper PPE to ensure safety, and infection control.
5. All will be instructed to properly perform proper hand hygiene during, and prior to leaving the facility.

## Communication to staff

Below are the guidelines that have been recommended by the CDC and other top agencies as to how best prepare for the COVID-19:

- Cover your mouth and nose with a tissue when you cough or sneeze
- Wash your hands often with soap and water for at least 20 seconds.
  - Take care to scrub between fingers and beneath fingernails
  - Carry and use hand sanitizers when soap and water is unavailable
- Avoid touching your eyes, nose and mouth with unwashed hands
- Avoid sharing personal items.
- Clean all “high-touch” surfaces (*counters, tabletops, doorknobs, phones, keyboards, etc.*) on a daily basis
  - Daily wipe-down of cell phones, as they tend to be devices, we take almost everywhere with us
- Follow CDC's recommendations for using face masks, which should be worn only by people who show symptoms of COVID-19 to help prevent the spread of the disease
- Monitor our residents with fever, cough or shortness breath for additional respiratory evaluation and treatment.
- Keep residents and employees informed on preventive measures. Provide staff education as needed
- Employee with respiratory infection may be allow to stay home
- PPE will be available
- Follow CDC guidelines and DOH directive
- Signs posted in key areas to advise everyone of proper protocol

To be sure, these might be things we don't do *every* day, but are common sense ways to prevent the spread of any germs. A little extra vigilance on all our parts will go a long way toward keeping our residents and communities safe. The greatest risk continues to be to the elderly and those with previously compromised immune systems. Most of those who even contract COVID-19 will fight it off naturally. It is always important to stay calm and reach out to others for support if you feel in need.

Thank you,

Yosef Spierer, LNHA  
Administrator  
Date: March 5, 2020

Santhamma Varghese  
DNS/Infection Preventionist  
Date: March 5, 2020

## Help us to keep our residents safe from COVID-19 (Sample letter)

A message from:

Dear Residents, Families, Friends, Volunteers:

We are committed to keeping our residents safe and we need your help. The virus causing Coronavirus Disease 2019 (abbreviated COVID-19) can cause outbreaks in nursing homes. Many of our residents are elderly and may have medical conditions putting them at a very high risk of becoming sick, or even severely ill, with COVID-19. Visitors and healthcare personnel (HCP) are the most likely sources of introduction of the virus that causes COVID-19 into a facility. To protect our vulnerable residents, even before COVID-19 is seen in our community, we are immediately taking the following aggressive actions to reduce the risk of COVID-19 in our residents and staff:

1. Effective immediately: We are restricting all visitation. All visitation is being restricted except for certain compassionate care situations, such as end of life situations. These visitors will first be screened for fever and respiratory symptoms. We know that your presence is important for your loved one but, per guidance from the Centers for Disease Control and Prevention (CDC), this is a necessary action to protect their health. We are introducing alternative methods of visitation (such as Skype and FaceTime) so that you can continue to communicate with your loved ones. Visitors who are permitted to enter the building will be required to frequently clean their hands, limit their visit to a designated area within the building, and wear a facemask. As the situation with COVID-19 is rapidly changing, we will continue to keep you updated.
2. We are monitoring healthcare personnel and residents for symptoms of respiratory illness. Non-essential healthcare personnel and volunteers are now restricted from entering the facility. Healthcare personnel will be actively monitored for fever and symptoms of respiratory infection. Ill healthcare personnel will be asked to stay home. You may see healthcare personnel wearing facemasks, eye protection, gown, and gloves in order to prevent germs from spreading and help keep residents safe. Healthcare personnel will clean their hands frequently. We are assessing residents daily for fevers and symptoms of respiratory infection in order to quickly identify ill residents and implement additional infection prevention activities. When ill residents are identified, they will be monitored closely, asked to stay in their rooms or wear a mask.
3. We are limiting activities within the facility. We are cancelling all group activities within the building and all community outings. We will be helping residents to practice social distancing, including during meals, and to frequently clean their hands. We encourage you to review the CDC website for information about COVID-19, including its symptoms, how it spreads, and actions you can take to protect your health:  
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

Thank you very much for everything you are doing to keep our residents and facility staff safe and healthy. We continue to monitor the situation in our community; we will keep you informed about any new precautions we think are necessary to keep your loved one safe. Please contact us with additional questions at .....

Sincerely,

### **Postmortem care Policy**

#### **POLICY:**

It is the policy of Schervier Rehab and Nursing Center that, facility will act appropriately to provide postmortem care using infection control protocols from CDC and use proper disposition protocols of dead body, reducing the risk of exposure to communicable pathogens following the death of patients with COVID-19 Coronavirus

#### **PURPOSE:**

To delineate appropriate precautions for reducing the risk of exposure to communicable pathogens following the death of patients with COVID-19 Coronavirus

1. Notify attending physician of death. Notification shall include communicable disease status, if known.
2. Notify family member/responsible party of the death
3. Notify local health department/coroner's office or other agencies as required
4. Prepare the body for postmortem care following the guidelines from CDC for prevention and control of infections related to COVID-19 Coronavirus.
5. Check to ensure that the patient identification tag has been labeled as to isolation or precautionary status when appropriate.
6. Place the patient's personal belongings in a plastic bag, send to the morgue or store in an isolation room
7. The Standard Precautions policy shall be followed for any and all contact with blood or body fluids.
8. It shall be the responsibility of the RN to pronounce death, if physician is not available onsite and place a tag on the deceased patient, preferably on the great toe, who at the time of death, requires isolation or is suspected of having COVID-19 Coronavirus.
9. The tag shall be made from card stock paper and shall be no smaller than five (5) centimeters by ten (10) centimeters. All tags shall include the words "COMMUNICABLE DISEASE-BLOOD/BODY SUBSTANCE PRECAUTIONS REQUIRED" in letters no smaller than six (6) millimeters in height. The name of the deceased person shall be written on the tag. The tag shall remain affixed to the body until the preparation of the body has been completed, and received by the mortuary
10. Ensure that the body is fully sealed in an impermeable body bag before being removed from the isolation room or area, and before being transferred to the mortuary, funeral home or temporary morgue to avoid leakage of body fluid.
11. Transfer the body to the mortuary, funeral home or temporary morgue as soon as possible after death to minimize the risk for exposure to COVID-19 Coronavirus to other residents and staff.
12. When properly packed in the body bag, the body can be safely removed for storage in the mortuary, funeral home or temporary morgue.
13. If an autopsy is being considered, the body may be kept in refrigeration in the mortuary and the autopsy conducted only when a safe environment can be provided

## **Staffing policy**

**POLICY:** It is the policy of Schervier Rehab and Nursing Center that, facility will act appropriately to staff in case of emerging a staffing crisis related to COVID-19. This guidance is based on the currently limited information available about COVID-19 related to disease severity, transmission efficiency, and shedding duration.

**PURPOSE:** To provide nursing care and protect all residents and staff from contracting and spreading of COVID-19 virus.

### **Employee Preparedness**

Emergency response and recovery operations can be stressful for affected residents and employees in addition to the families of both. Our employees may be requested to report to their work site and provide services related to COVID-19 virus and recovery operations in addition to their normally assigned duties. Supervisors, co-workers, and residents share an expectation that medical services will proceed uninterrupted and that medical needs generated by the COVID-19 virus impact will be addressed. Preparedness planning in this facility should be recognized as a shared responsibility between nursing home leadership and staff.

### **Staffing During COVID-19 Outbreak Emergency**

#### **Staff Recall**

Schervier staff may be called in and/or availability may be requested by a pre-designated staff person. The individuals contacted may be asked to report for duty immediately or be scheduled for future shifts during the emergency. Emergency contact list for staff is updated periodically maintained at the nursing office.

#### **Emergency Employee Call-Ins**

All staff in regular, temporary and pool positions should contact their immediate supervisor or manager if they are unable to report to duty as scheduled.

All approved Paid Time Off (PTO) days during an outbreak event may be cancelled. Employees should be available to report for duty if it is safe and feasible to do so.

Staff will be encouraged to bring the following to the facility:

- Staff identification
  - Medications/personal items
  - Money: cash and change for vending
  - Flashlight with extra batteries
  - Critical personal phone numbers
  - Battery-operated cell phone charger
- Staff Responsibility

Staff will be deployed and rotated, as deemed appropriate by the IC, during the duration of the disaster; work in various assigned shifts; and/or provide non-routine duties.

#### **Staff Support**

To the extent that the facility's needs permit, space may be provided for staff to stay at the facility during the disaster. Reasonable sleeping and showering areas will be assigned to off-duty staff. Food will be provided in the cafeteria from a limited menu. Food for residents will be the priority.

#### **Agency and outside staff**

Facility will contact and coordinate additional staffing as needed through local staffing agencies and other healthcare providers such as hospitals, nursing homes, clinics, hospice agencies, home healthcare agencies etc. Credential verifications and other eligibility criteria to work in long term care facilities will be followed and training will be provided as needed.

## **Covid-19 Check list and education**

### **Admissions, Readmissions, and Residents**

#### **Admission, Readmission**

- ☐ Review with Admission and Nursing Teams that referrals for admission are to be reviewed to assure they do not have active cultures pending for COVID-19. Any referrals with active cultures pending will be held from admission until negative results are obtained.
- ☐ Review with Nursing Team the use of the CDC Clinical Criteria for COVID-19 Persons Under Investigation upon admission/readmission to the facility.
- ☐ Review with Nursing Team, the requirement to implement transmission-based precautions for residents admitted/readmitted with a communicable disease.

#### **Residents**

- ☐ Host Resident Council Meeting to review the following:
  - ☐ Encourage hand and respiratory hygiene, as well as cough etiquette.
    - Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
  - ☐ Avoid touching your eyes, nose, and mouth.
  - ☐ Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- ☐ Review with Nursing Team:
  - ☐ Residents will be assessed for changes in status consistent with symptoms of respiratory illness. The CDC Clinical Criteria for COVID-19 PUIs will be completed with a change in status that includes symptoms consistent COVID-19.
  - ☐ Physicians will be made aware of residents with symptoms of:
    - Fever
    - Cough
    - Shortness of breath
  - ☐ Appropriate transmission-based precautions will be implemented for residents with a communicable disease.
  - ☐ Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).

#### **Preventing the Spread of Infection**

- ☐ Assure that there are hand cleaning stations upon entrance to the facility.
  - ☐ Main entrance
  - ☐ Reception desk
  - ☐ Employee entrance
  - ☐ Near time clock
  - ☐ Dietary entrance
  - ☐ Copy room
  - ☐ Conference room
  - ☐ Dining Rooms
- ☐ Post signage
  - ☐ Symptoms of COVID-19
    - Main Entrance
  - ☐ Stop the Spread of Germs
    - All Entrances
  - ☐ Stay Home If You Are Sick
    - Employee Time Clock

- Nurses Stations
- ☐ Cover Your Cough
  - Entrances, elevators, throughout the center
- ☐ Assure cleaning products and alcohol-based hand sanitizer are readily available and in use
  - ☐ Education to all staff to clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- ☐ Assure CDC recommendations for using a facemask use are followed.
  - ☐ CDC does not recommend that people who are well wear a facemask to protect themselves from respiratory diseases, including COVID-19.
- ☐ Provide PPE supplies.
  - ☐ Post signage on the doorways outside of the resident room that clearly describe the use of type of precautions needed and required PPE.
  - ☐ Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident room.
  - ☐ Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.
- ☐ Encourage visitors who are sick to stop visiting
  - ☐ Arrange with the facility alternate ways to visit family members, like Skype, phone calls and email.
- ☐ Complete and send resident/family letter

## **Employees**

- ☐ Schedule employee meetings for all shifts, all departments.
  - ☐ Actively encourage sick employees to stay home:
    - Employees who have symptoms of acute respiratory illness are recommended to stay home and not come to work. Employees should notify their supervisor and stay home if they are sick.
    - Do not require a healthcare provider's note for employees who are sick with acute respiratory illness to validate their illness or to return to work.
  - ☐ Separate sick employees:
    - CDC recommends that employees who appear to have acute respiratory illness symptoms upon arrival to work or become sick during the day should be separated from other employees and be sent home immediately. S
  - ☐ Additional Measures:
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act (ADA).
  - ☐ Educate all staff that the facility has an Infectious Disease Response Plan that will be implemented as appropriate.
- ☐ Complete and send Employee Letter

## Nursing Home Reopening Recommendations

Given the critical importance in limiting COVID-19 exposure in nursing homes, decisions on relaxing restrictions should be made with careful review of a number of facility-level, community, and State factors/orders, and in collaboration with State and/or local health officials and nursing homes. Because the pandemic is affecting communities in different ways, State and local leaders should regularly monitor the factors for reopening and adjust their plans accordingly.

Factors that should inform decisions about relaxing restrictions in nursing homes include:

- Case status in community: State-based criteria to determine the level of community transmission and guides progression from one phase to another. For example, a decline in the number of new cases, hospitalizations, or deaths (with exceptions for temporary outliers).
- Case status in the nursing home(s): Absence of any new nursing home onset<sup>1</sup> of COVID-19 cases (resident or staff), such as a resident acquiring COVID-19 in the nursing home.
- Adequate staffing: No staffing shortages and the facility is not under a contingency staffing plan.
- Access to adequate testing: The facility should have a testing plan in place based on contingencies informed by the Centers for Disease Control and Prevention (CDC).

At minimum, the plan should consider the following components:

- The capacity for all nursing home residents to receive a single baseline COVID19 test. Similarly, the capacity for all residents to be tested upon identification of an individual with symptoms consistent with COVID-19, or if a staff member tests positive for COVID-19. Capacity for continuance of weekly re-testing of all nursing home residents until all residents test negative; The capacity for all nursing home staff (including volunteers and vendors who are in the facility on a weekly basis) to receive a single baseline COVID-19 test, with re-testing of all staff continuing every week (note: State and local leaders may adjust the requirement for weekly testing of staff based on data about the circulation of the virus in their community);
- Written screening protocols for all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors; o An arrangement with laboratories to process tests. The test used should be able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR)) with greater than 95% sensitivity, greater than 90% specificity, with results obtained rapidly (e.g., within 48 hours). Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection.
- A procedure for addressing residents or staff that decline or are unable to be tested (e.g., symptomatic resident refusing testing in a facility with positive COVID-19 cases should be treated as positive).
- Universal source control: Residents and visitors wear a cloth face covering or facemask. If a visitor is unable or unwilling to maintain these precautions (such as young children), consider restricting their ability to enter the facility. All visitors should maintain social distancing and perform hand washing or sanitizing upon entry to the facility.
- Access to adequate Personal Protective Equipment (PPE) for staff: Contingency capacity strategy is allowable, such as CDC's guidance at Strategies to Optimize the Supply of PPE and Equipment (facilities' crisis capacity PPE strategy would not constitute adequate access to PPE). All staff wear all appropriate PPE when indicated. Staff wear cloth face covering if facemask is not indicated, such as administrative staff.
- Local hospital capacity: Ability for the local hospital to accept transfers from nursing homes



## CDC Guidelines on Optimizing Supply of PPE and Other Equipment during Shortages

Personal protective equipment (PPE) is used every day by healthcare personnel (HCP) to protect themselves, patients, and others when providing care. PPE helps protect HCP from many hazards encountered in healthcare facilities.

The greatly increased need for PPE caused by the COVID-19 pandemic has caused PPE shortages, posing a tremendous challenge to the U.S. healthcare system. Healthcare facilities are having difficulty accessing the needed PPE and are having to identify alternate ways to provide patient care.

**Surge capacity** refers to the ability to manage a sudden increase in patient volume that would severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of PPE during the COVID-19 response. To help healthcare facilities plan and optimize the use of PPE in response to COVID-19, CDC has developed a [Personal Protective Equipment \(PPE\) Burn Rate Calculator](#).

The [Personal Protective Equipment \(PPE\) Burn Rate Calculator](#) is a spreadsheet-based model that will help healthcare facilities plan and optimize the use of PPE for response to coronavirus disease 2019 (COVID-19).

To use the calculator, enter the number of full boxes of each type of PPE in stock (gowns, gloves, surgical masks, respirators, and face shields, for example) and the total number of patients at your facility. The tool will calculate the average consumption rate, also referred to as a “burn rate,” for each type of PPE entered in the spreadsheet. This information can then be used to estimate how long the remaining supply of PPE will last, based on the average consumption rate. Using the calculator can help facilities make order projections for future needs.

Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve PPE supplies along the continuum of care.

- **Conventional capacity:** measures consisting of engineering, administrative, and PPE controls that should already be implemented in general infection prevention and control plans in healthcare settings.
- **Contingency capacity:** measures that may be used temporarily during periods of anticipated PPE shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility’s current or anticipated [utilization rate](#), there may be uncertainty if future supply will be adequate and, therefore, contingency capacity strategies may be needed.
- **Crisis capacity:** strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known PPE shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facility’s current or anticipated [utilization rate](#).

CDC’s optimization strategies for PPE offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted. Contingency and then crisis capacity measures augment conventional capacity measures and are meant to be considered and **implemented sequentially**. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices.

Decisions to implement contingency and crisis strategies are based on these assumptions:

1. Facilities understand their current PPE inventory and supply chain
2. Facilities understand their PPE [utilization rate](#)
3. Facilities are in communication with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional supplies
4. Facilities have already implemented conventional capacity measures

5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

HCP and facilities—along with their healthcare coalitions, local and state health departments, and local and state partners—should work together to **develop strategies that identify and extend PPE supplies**, so that recommended PPE will be available when needed most. When using PPE optimization strategies, training on PPE use, including [proper donning and doffing procedures](#), must be provided to HCP before they carry out patient care activities.

## **SECTION IV**

### **Title: Pandemic Influenza Preparedness and Response**

#### **Policy statement-**

A pandemic is a global disease outbreak. An Influenza pandemic occurs when a new influenza virus emerges for which there is little or no immunity in the human population, begins to cause serious illness and then spreads easily person –to-person worldwide. Planning for pandemic influenza is essential to minimize a pandemic's impact. An influenza pandemic is a sustained crisis. A pandemic may come and go in waves, each of which can last for six to eight weeks. Due to the uncertainty of the nature of pandemic, pandemic plans must be flexible with integrated processes for reviewing current recommendations and updating the plan accordingly. This plan shall be a part of the Facility Disaster Preparedness Plan.

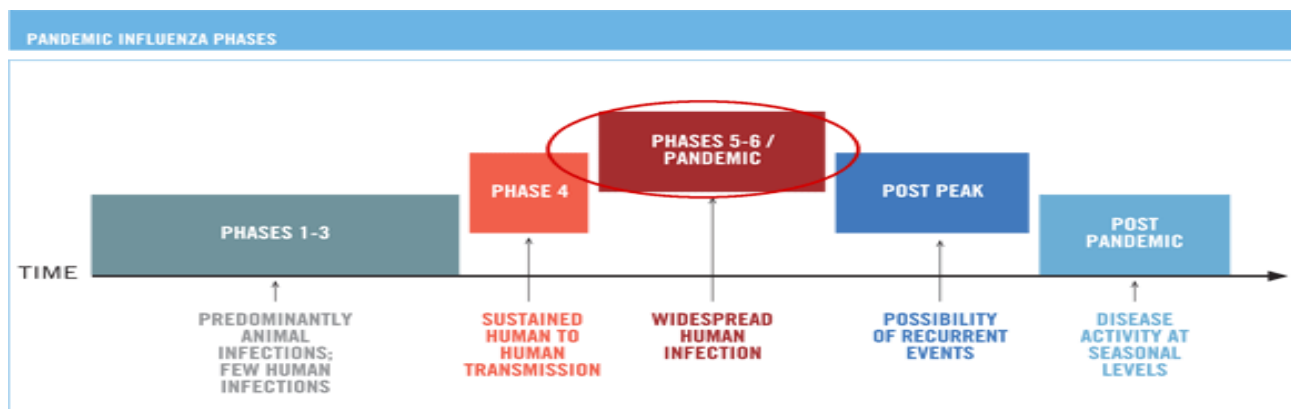
#### **Objective:**

Provide information and resources as a guide for influenza pandemic in order for the facility to continue operation and care of the residents. As part of this preparedness we shall follow response stages that relate to the World Health Organization (WHO) response stages.

#### **Index:**

- 1. Pandemic Influenza Planning Committee and Response Coordinator-**
- 2. Authorization to implement plan-**
- 3. Organizational Structure-**
- 4. Surveillance and Detection of the presence of Pandemic Influenza-**
- 5. Communication Plan (During a Pandemic outbreak at our facility)-**
- 6. Education and Training-**
- 7. Plan for managing residents and visitors with pandemic influenza- Infection Control Measures.**
- 8. Respiratory Protection and other PPE requirements-**
- 9. Use and administration of vaccines and antiviral drugs-**
- 10. Staffing and other related occupational issues-**
- 11. Supplies (purchasing and distribution)-**
- 12. Bed Surge Capacity and Mortuary Issues-**
- 13. Essential Operations-**

## World Health Organization (WHO) Pandemic Alert Phases:



In nature, influenza viruses circulate continuously among animals, especially birds. Even though such viruses might theoretically develop into pandemic viruses, in **Phase 1** no viruses circulating among animals have been reported to cause infections in humans.

In **Phase 2** an animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans, and is therefore considered a potential pandemic threat.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

**Phase 4** is characterized by verified human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause “community-level outbreaks.” The ability to cause sustained disease outbreaks in a community marks a significant upwards shift in the risk for a pandemic. Any country that suspects or has verified such an event should urgently consult with WHO so that the situation can be jointly assessed and a decision made by the affected country if implementation of a rapid pandemic containment operation is warranted. Phase 4 indicates a significant increase in risk of a pandemic but does not necessarily mean that a pandemic is a forgone conclusion.

**Phase 5** is characterized by human-to-human spread of the virus into at least two countries in one WHO region. While most countries will not be affected at this stage, the declaration of Phase 5 is a strong signal that a pandemic is imminent and that the time to finalize the organization, communication, and implementation of the planned mitigation measures is short.

**Phase 6**, the pandemic phase, is characterized by community level outbreaks in at least one other country in a different WHO region in addition to the criteria defined in **Phase 5**. Designation of this phase will indicate that a global pandemic is under way.

During the **post-peak period**, pandemic disease levels in most countries with adequate surveillance will have dropped below peak observed levels. The post-peak period signifies that pandemic activity appears to be decreasing; however, it is uncertain if additional waves will occur and countries will need to be prepared for a second wave.

Previous pandemics have been characterized by waves of activity spread over months. Once the level of disease activity drops, a critical communications task will be to balance this information with the possibility of another wave. Pandemic waves can be separated by months and an immediate “at-ease” signal may be premature.

In the **post-pandemic period**, influenza disease activity will have returned to levels normally seen for seasonal influenza. It is expected that the pandemic virus will behave as a seasonal influenza A virus. At this stage, it is important to maintain surveillance and update pandemic preparedness and response plans accordingly. An intensive phase of recovery and evaluation may be required.

*The following Matrix would be used to determine the actions required at our facility, during the various*

*phases..*

Phase	Actions
<b>WHO Phase 1</b>	<ul style="list-style-type: none"><li>• Continual monitoring of virus outbreak around the world and within our facility.</li></ul> <p>Monitor by checking World Health Organizations and Federal Government current pandemic phase via <a href="http://www.pandemicflu.gov">www.pandemicflu.gov</a>.</p> <ul style="list-style-type: none"><li>• Preparedness planning and preparation in progress.</li><li>• Develop planning and decision making strategies for responding to pandemic influenza.</li><li>• Maintain preparedness focus.</li><li>• Monitor levels of basic supplies on hand that will be needed for pandemic.</li><li>• Work with local planning committees to integrate with community, state and national pandemic plans and training.</li><li>• Participate in pandemic influenza response exercises and drills on local level if offered. Incorporate lessons learned into pandemic disaster response plans.</li><li>• Understand how to access state and federal information and supplies, and to ensure communication with local, state, and federal health and security agencies.</li><li>• Identify supply chain issues and develop alternatives as needed.</li><li>• Develop written plans to address such things as- disease surveillance, isolation and quarantine practices, communication, monitoring, education, security, facility access, health for staff, Use and administration of vaccines and antiviral drugs, facility surge capacity, supply chains (purchase, distribution and transportation of supplies), mortuary issue (storage, etc).</li></ul>

<b>WHO Phase 2 and 3</b>	<b>Phase 2-</b>	<ul style="list-style-type: none"> <li>• <b>Maintain preparedness focus.</b></li> <li>• <b>Continue to monitor WHO phase.</b></li> <li>• <b>Continual monitoring of virus outbreak around the world.</b></li> <li>• <b>Prepare to activate facility pandemic influenza plans, as necessary.</b></li> <li>• <b>Continue education of proper hand washing, sneezing, coughing.</b></li> <li>• <b>Educate staff on traveling and using precautions while traveling.</b></li> <li>• <b>Review and update contact information of residents.</b></li> <li>• <b>Have all Management staff and supervisors review pandemic policy and procedures as well as all PHI infection control Policies.</b></li> <li>• <b>Read over (for informational purpose) and review- OSHA, pandemic Influenza Preparedness and response Guidance for Healthcare Workers and Healthcare employers.</b>  <a href="http://www.osha.gov/Publications/OSHA_pandemic_health.pdf">http://www.osha.gov/Publications/OSHA_pandemic_health.pdf</a> </li> <li>• <b>Read over (for informational purpose) and review- World Health Organization Interim Infection Control Guideline for Health Care Facilities.</b>  <a href="http://www.who.int/csr/resources/publications/AI_Inf_Control_Guide_10May2007.pdf">http://www.who.int/csr/resources/publications/AI_Inf_Control_Guide_10May2007.pdf</a> </li> <li>• <b>Continue to Monitor supply levels; begin to order more of staple items, such as masks, gloves, gowns, cleaning supplies, food items, etc. -attach department and facility lists and monitor them closely.</b></li> </ul>
	<b>Phase 3-</b>	<ul style="list-style-type: none"> <li>• <b>Communicate information on status of our pandemic plan and preparedness to staff, residents, and families.</b></li> <li>• <b>Communicate with staff to alert them to personal home preparedness.</b></li> <li>• <b>Communicate our pandemic plan with staff.</b></li> <li>• <b>Communicate with family members to alert them of home preparedness and not to visit if sick, as well as proper hand washing.</b></li> <li>• <b>Review Respiratory Requirements and Protection and Begin fit testing (as per OSHA requirements) of staff for respirator use (N95 or others) when federal government is at a stage 2.</b></li> </ul>

**WHO  
Phase 4**

- **Maintain preparedness focus.**
- **Continue to monitor WHO phase.**
- **Continual monitoring of virus outbreak around the world.**
- **Monitor influenza-like symptoms of residents and take measures to distance them from others.**
- **Prepare to activate facility pandemic influenza plans, as necessary.**
- **Continue to communicate information to staff, residents, families.**
- **Continue education of proper hand washing, sneezing, coughing.**
- **Continue communication with staff to alert them to personal home preparedness.**
- **Continue communication with staff of our pandemic plan.**
- **Review and update contact information of residents.**
- **Continue communication with family members to alert them of home preparedness and not to visit if sick, as well as proper hand washing.**
- **Continue fit testing of staff for respirator.**
- **Implement visitation restrictions to those that have traveled out of the country.**
- **Continue to Monitor supply levels, begin to order more of staple items, such as masks, gloves, gowns, cleaning supplies, food items, etc.- see attached supply lists and update as necessary.**
- **Order additional supplies of items needed and stockpile.**
- 
- **Continue to use the OSHA, pandemic Influenza Preparedness and response Guidance for Healthcare Workers and Healthcare employers and the World Health Organization Interim Infection Control Guideline for Health Care Facilities for information and guidance.**

[http://www.osha.gov/Publications/OSHA\\_pandemic\\_health.pdf](http://www.osha.gov/Publications/OSHA_pandemic_health.pdf)

[http://www.who.int/csr/resources/publications/AI\\_Inf\\_Control\\_Guide\\_10May2007.pdf](http://www.who.int/csr/resources/publications/AI_Inf_Control_Guide_10May2007.pdf)

<p><b>WHO Phase 5 and 6</b></p>	<ul style="list-style-type: none"> <li>• <b>Continue to monitor WHO phase.</b></li> <li>• <b>Continual monitoring of virus outbreak around the world.</b></li> <li>• <b>Heighten surveillance of residents and staff for influenza-like illness.</b></li> <li>• <b>Enforce Policy of staff working sick.- Go home, stay home.</b></li> <li>• <b>Begin social distancing measures with residents if suspected or known cases exist in the facility.</b></li> <li>• <b>Identify and isolate potential pandemic influenza residents.</b></li> <li>• <b>Implement infection control practices to prevent influenza transmission and monitor staff and residents for nosocomial transmission.</b></li> <li>• <b>Ensure rapid and frequent communication between other healthcare facilities</b></li> <li>• <b>Activate facility pandemic influenza plans to protect staff and residents.</b></li> <li>• <b>Implement Visitation Restrictions if necessary.</b></li> <li>• <b>Recognize deficiencies such as potential staffing shortages, lack of written guidelines and develop targets for improvement.</b></li> <li>• <b>Cross-train staff to provide for a contingency workforce.</b></li> <li>• <b>Continue to Monitor supply levels, begin to order more of staple items, such as masks, gloves, gowns, cleaning supplies, food items, etc.- see attached supply lists and update as necessary.</b></li> <li>• <b>Order additional supplies of items needed and stockpile.</b></li> </ul>
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<b>WHO Post Peak and Post Pandemic</b>	<ul style="list-style-type: none"> <li>• <b>Continue surveillance of residents and staff for influenza- like illness.</b></li> <li>• <b>Review pandemic influenza plan based on experience during the first pandemic wave. Incorporated lessons learned into preparation for subsequent pandemic waves.</b></li> <li>• <b>Identify and anticipate resource and supply chain issues.</b></li> <li>• <b>Continue to emphasize communication between healthcare facilities, state health departments to identify subsequent pandemic waves.</b></li> <li>• <b>Return to normal facility operations as soon as possible.</b></li> </ul>
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## Written Plan-

### 1. Pandemic Influenza Planning Committee and Response Coordinator-

- The planning committee shall be comprised of the following and shall oversee the facility's pandemic influenza preparedness. Include Name, Title and contact information.
  - Administrator
  - Director of Nursing/ Infection Control
  - Director of Environmental Services
  - Food Service Manager Manager
  - Pharmacy Representative
  - Physical Therapy Representative
  - Resident/Family Representative
  - Others
- This committee shall meet on an as needed basis and at least annually.
- There shall be a Pandemic Influenza Response Coordinator to facilitate and implement the plan and to provide feedback to this committee.

The Coordinators are:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

#### The coordinator shall-

- Help implement the pandemic influenza preparedness plan throughout the facility;
- Maintain contact with state and regional pandemic influenza preparedness groups;
- Attend regional meetings, workshops and training sessions to obtain information on pandemic influenza preparedness and coordinate the facility's plans with other pandemic influenza plans;
- Monitor public health advisories on a weekly basis (or more often, as necessary);
- Participate in facility surveillance of influenza-like illness and confirmed disease (in collaboration with the Infection Control Coordinator);
- Oversee communication with residents and family members regarding the status and impact of pandemic influenza in the facility ;

- G. Coordinate the training of facility staff .
- H. Maintain committee roster, including names, titles, department and contact information;
- I. Be involved in the discussion of local plans for inter-facility communication during a pandemic.

## **2. Authorization to implement plan-**

The persons authorized to implement any part of this plan, shall be- Executive Director or Director of Nursing.

## **3. Organizational Structure-**

The organizational structure and chain of command during a Pandemic event shall be the following- Executive Director, Director of Nursing, Infection Control, Director of Environmental Services, RN on duty. A more detailed Chain of Command may need to be established as conditions require.- See the Incident Command Policy in Disaster Manual for more details and guidelines on Incident Command.

## **4. Surveillance and Detection of the presence of Pandemic Influenza-**

- Pandemic Influenza Response Coordinators shall monitor on a weekly basis (or more often, as necessary) the public health advisories (federal and state), and providing updates of any changes to Pandemic Influenza Planning Committee along with the risk management committee the status of pandemic influenza around the world. This can be done by sending email notifications, written notification or verbally.

For tracking information, see-(<http://www.pandemicflu.gov/>) or

<http://www.cdc.gov/flu/weekly/fluactivity.htm>

- The DON, Infection Control person shall monitor daily (as per Dept. of Health guidelines) any seasonal influenza-like illness in residents, including new admissions and staff to detect stressors that may affect operating capacity, including staffing and supply needs.
- Infection control Coordinators shall utilize Presbyterian Senior Living Infection control policies on Surveillance for Healthcare-Associated Infections and Surveillance for Infections/Infectious Diseases to evaluate, monitor and report any infectious or potentially infectious cases of Influenza of Residents and staff to the Pandemic Influenza Response Coordinator and a report be made during facility monthly Infection Control meetings.
- This tracking shall be shared with other administrative staff during daily morning meetings.
- Proper communication of any suspected or know Influenza illness of resident(s) shall be given to staff to take precautions necessary as outlined in the Corporate infection control policy and table.
- Staff are encouraged to not report to work if experiencing the symptoms of influenza as listed below and to stay home until no more symptoms exist.

NOTE: CDC recommendations and as per PSL Corporate----

### **Management of ill healthcare personnel**

Healthcare personnel should not report to work if they have a febrile respiratory illness.

In communities where novel H1N1 transmission is occurring, healthcare personnel who develop a febrile respiratory illness should be excluded from work for 7 days or until symptoms have resolved, whichever is longer.

In communities without novel H1N1 transmission, healthcare personnel who develop a febrile respiratory illness and have been working in areas of the hospital where swine influenza patients are present, should be excluded from work for 7 days or until symptoms have resolved, whichever is longer.

In communities where novel H1N1 transmission is not occurring, healthcare personnel who develop febrile respiratory illness and have not been in areas of the facility where swine influenza patients are present should

follow facility guidelines on returning to work.

### **How long should I stay home if I'm sick?**

CDC recommends that you stay home for at least 24 hours after your fever is gone except to get medical care or for other things you have to do and no one else can do for you. (Your fever should be gone without the use of a fever-reducing medicine, such as Tylenol®.) You should stay home from work, school, travel, shopping, social events, and public gatherings.

- Department Directors and Supervisors shall be aware of any staff that report or appear to be ill and have the Symptoms as listed below. If suspect staff person may have Influenza they should be evaluated by the Director of Nursing, Infection Control or RN on duty to determine if they should be sent home and/or asked to see family physician for diagnosis.

### **Symptoms**

Influenza illness can include any or all of these symptoms: fever, muscle aches, headache, lack of energy, dry cough, sore throat, and possibly runny nose. The fever and body aches can last 3-5 days and the cough and lack of energy may last for 2 or more weeks. Influenza can be difficult to diagnose based on clinical symptoms alone because the initial symptoms of influenza can be similar those caused by other infectious agents including, but not limited to, *Mycoplasma pneumoniae*, adenovirus, respiratory syncytial virus, rhinovirus, parainfluenza viruses, and *Legionella* spp.

- Enhanced surveillance (e.g., virologic testing) of residents and staff with influenza-like illness will be considered on a case-by case basis in collaboration with the local public health department. Determination of enhanced surveillance will be based on the clinical presentation of symptoms, risk factors for exposure to novel influenza viruses, and current CDC recommendations.
- If an influenza outbreak in the facility is suspected, virologic testing of residents may be used to determine the best course of managing the outbreak.
- All novel A influenza viruses identified by laboratory analysis will be reported to the local public health department and the CDC as a Nationally Notifiable Disease.
- Assessment of influenza-like symptoms is included in the evaluation of newly admitted residents. Current CDC Guidelines for isolation precautions will be followed to determine the appropriate placement of newly admitted residents with influenza-like illness or confirmed disease.

### **5. Communication Plan (During a Pandemic outbreak at our facility)-**

- Key public Points of contact during an influenza pandemic are-

#### **Local Health Department Contact: New York Metropolitan Regional Office - New York City - Long Term Care**

Phone: (212) 417-4999

Fax: (212) 417-6551

#### **State Health Department Contact:**

Metropolitan Area Regional Office

NYS Department of Health

145 Huguenot Street

New Rochelle, NY 10801-5228

Phone: (914) 654-7149

Fax: (914) 654-7169

- Director of Nursing, Administrator or Infection Control shall be responsible for communicating with public health authorities during a pandemic.

- Pandemic Coordinators or another as assigned by the coordinator shall be responsible for overseeing communicating information to staff, residents, family members and the public regarding the status and impact of pandemic influenza in the facility.
- Social Services directors shall review contact information for family members or guardians of residents of all levels of care to be sure they are up-to-date and forward to Pandemic Influenza Response Coordinator.
- Various communication methods will be utilized to rapidly disseminate information regarding the current or changing status of pandemic influenza in the facility. The Pandemic Influenza Response Coordinators or Executive Director will determine the most appropriate communication methods (signs, phone trees, internet, etc.) for the situation.

The Pandemic Influenza Response Coordinators or Administrator shall determine when to post visual alerts at the entrances to the facility (main, loading dock, lower receiving entrances). restricting entry of persons who have been exposed to or have symptoms of pandemic influenza and to alert anyone coming into our facility about the status of pandemic influenza in the facility.

## **6. Education and Training-**

1. The Pandemic Influenza Response Coordinators, shall be responsible for coordinating education and training on pandemic influenza (e.g. identifies and facilitates access to available programs, maintains a record of personnel attendance). This education and training shall include information on infection control measures to prevent the spread of pandemic influenza.
- Staff training on disaster preparedness and pandemic influenza includes the following components:
    - a. Understanding and using the disaster communications plan, including how to access information about the situation through various means of communication (e.g., phone trees and internet);
    - b. State and local emergency management agency contacts;
    - c. Organizational chart and chain of command during a disaster;
    - d. Performance shifts during disasters – roles of management, clinical and non-clinical staff, and practitioners;
    - e. Communication with residents and family during disasters;
    - f. Quarantine and/or visitor restrictions during infectious disease outbreaks;
    - g. Control measures, including vaccinations and infection control precautions, to prevent infection and control outbreaks of influenza and other communicable diseases;
    - h. Signs and symptoms of influenza; and
    - i. The implications of a pandemic influenza at the facility and community levels.
  - Local (e.g., health department, hospital-based) and long-distance (web-based) training opportunities have been identified and may be utilized for additional staff training. Refer [WWW.CDC.gov/flu/professionals/training/](http://WWW.CDC.gov/flu/professionals/training/)

## **7. Plan for managing residents and visitors with pandemic influenza- Infection Control Measures.**

1. Early prevention of influenza outbreak consists of the following measures:
  - j. Training clinical staff in the modes of transmission of the influenza virus;

- k. Training residents, families and non-clinical staff on the symptoms of influenza and standard infection control precautions (e.g., handwashing, respiratory hygiene/cough etiquette, etc.);
  - l. Vaccination of residents and staff;
  - m. Early detection of influenza cases in the facility;
  - n. Use of antiviral medications to treat ill persons, as recommended by current clinical practice guidelines;
  - o. Isolation of infected residents in private rooms or cohort units;
  - p. Use of appropriate barrier precautions during resident care; and
  - q. Restriction of visitors who have been exposed to or are symptomatic of influenza.
2. Follow Corporate policies on Infection control.- which include the following.
- a. Exposure Control plan
  - b. Outbreak Plan
  - c. Isolation-Initiating
  - d. Isolation-Visitors
3. Implement additional Housekeeping procedures to prevent spread of influenza with increased cleaning measures of common areas, nurse stations, lounges, activities, chapel, and dining areas.
4. If pandemic influenza is detected in the geographic region of the facility, the following measures will be taken to prevent or delay the introduction of the virus to the facility:
- a. Display signs and/or posters (in appropriate languages) at the entry to the facility restricting entry by any persons who have been exposed to or have symptoms of pandemic influenza; refer- [WWW.CDC.gov/flu/professionals/infectioncontrol/index.htm](http://WWW.CDC.gov/flu/professionals/infectioncontrol/index.htm) and [WWW.CDC.gov/flu/groups.htm](http://WWW.CDC.gov/flu/groups.htm)
  - b. Train staff to visually and verbally screen visitors at facility entry points for respiratory symptoms of pandemic influenza;
  - c. Provide a telephone number for family and visitors to call for information regarding prevention and control strategies for pandemic influenza;
  - d. Screen all employees for influenza-like illness before coming on duty and send any symptomatic employees home;
  - e. Implement liberal absentee policies, according to corporate policy and recommendation, for employees to encourage those who have been exposed to or have symptoms of pandemic influenza to stay at home; and
  - f. Increase resident surveillance for influenza-like illness. Notify local or state health department if a case is suspected.
5. If an outbreak of pandemic influenza occurs within the facility, strict adherence to standard and transmission-based precautions and other infection control measures will be implemented according to the most current CDC recommendations for pandemic influenza.
6. Administrator shall determine when to enforce visitor limitations and if facility should be closed to new admissions.
- a. Beginning with Phase 5- all visitors may be questioned at main entrance if they have recently traveled out of the country, if they have, they shall not be permitted to enter the facility.
  - b. Beginning with Phase 6--all visitors may be stopped at main entrances to determine if they present signs of being ill. Any with sneezing, cough, runny nose, fever, etc. shall be denied

access to the facility.

7. Director of Nursing shall determine if/when residents should be cohorted by using one or more of the following strategies.

- 1) Confining symptomatic residents and their exposed roommates to their room.
- 2) Placing symptomatic residents together in one area of the facility.

The areas that are used for Isolation should have negative air pressure- this can be done by placing fans at the entrance to the cluster area and slightly opening a window or two in that area to force air into the cluster area.

- 3) Closing clusters where symptomatic and asymptomatic residents reside (i.e., restricting all residents to an affected cluster, regardless of symptoms).

NOTE: This should also include, where possible, staff who are assigned to work in affected clusters will not work in other clusters.

8. Discontinue communal gatherings such as Activity functions, Common area dining, Physical Therapy having multiple residents at one time, Church Services. If there is a need to have multiple residents and/or staff together there shall be distancing measures implemented (minimum of 6 feet between) and sanitizers to wipe surfaces after use.

## **8. Respiratory Protection and other PPE requirements-**

### **1. Types of Respiratory Protection-**

- a. Face masks- Used as a physical barrier to protect from hazards such as splashes of large droplets of blood or body fluids. Face masks are not designed or certified to prevent the inhalation of small airborne contaminants.
- b. Disposable face piece- such as the N95, N99 or P100. OSHA respiratory protection program needs to be followed including fit testing.
- c. Reusable elastomeric respirator- has a flexible, rubber-like face piece with either permanent or removable filter cartridges. OSHA respiratory protection program needs to be followed including fit testing.

### **2. Staff Protection- Respiratory protection of staff shall be provided in varying levels based on the level of risk.**

*Very High Risk-* (RN's and LPN's shall be classified under the Very High Risk)

Staff members performing aerosol-generating procedures on known or suspected pandemic influenza residents or collecting respiratory tract specimens from known or suspected pandemic influenza residents.

*High Risk-* (Aides, Housekeepers, Activity staff, Some Dietary Staff, and Maintenance if working in room) Those working closely with (either in direct contact or within 6 feet of) residents known or suspected to be infected with pandemic influenza virus.

*Medium Risk-* (Receptionists, Some office staff)

Employees with high-frequency close contact (within 6 feet) with the general population.

3. Resident protection- During periods of pandemic influenza activity in the community, facemasks should be offered as part of a respiratory hygiene/cough etiquette strategy to residents who are coughing and/or sneezing, have a fever or have other symptoms of influenza-like illness.

If tolerated, facemasks should be worn by these residents until:

- a. It is determined that the resident does not have either pandemic influenza or another respiratory infection that requires precautions to prevent respiratory droplet transmission; or
  - b. The resident has been appropriately isolated, either by placement in a private room or by placement in a room with other resident with the same infection (i.e., cohorting). Once isolated, the resident does not need to wear a facemask unless transported outside the room. Note: it is estimated by OSHA that will need 1 mask per resident per day.
4. Visitor protection- Only those deemed “essential” visitors will need to have facemasks provided to them during pandemic periods.
5. Estimating the quantity of each type of Respirator needed per worker during a Pandemic period.
  - a. Very High Risk- \*N95- 1 per worker per aerosol generating procedure or  
\*Elastomeric Respirator- 1 per worker with 3 or more sets of filters per worker.
  - b. High risk- \*N95’s- 4 per worker per shift x 120 day period = 480 N95’s per exposed worker or  
\*Elastomeric Respirator- 1 reusable respirator plus 3 sets of filters per exposed Worker.
  - c. Medium Risk- 2 facemasks per employee per shift x 120 day period = 240 facemasks per exposed worker.
6. Respirators shall be removed from the back of the head forward and not grasped by the mask itself, this is to prevent contamination and breathing of any contamination on the mask itself.
7. If there is a need to re-use (due to a shortage of supplies, etc.) a N95 or similar normally disposable respirator they also should be wiped with a disinfectant inside and outside of the mask and let air dry. After removal- re-usable respirators should be wiped entirely with a disinfectant solution such as Clorox or similar to decontaminate them.

**Having stated that reuse may be considered but only under dire conditions, APIC recommends organizations should develop priorities as follows: as of May 2009.**

If supplies are insufficient or unavailable:

#### **N-95**

☐ Reuse N95 as long as possible, taking care with contamination: If a sufficient supply of respirators is not available during a pandemic, employers and employees may consider reuse as long as the device has not been obviously soiled or damaged (e.g., creased or torn), and it retains its ability to function properly. This practice should only be considered under the most dire of conditions.

Surgical and procedure masks do not offer appropriate respiratory protection against small particle aerosols (droplet nuclei) and should not be used unless particulate respirators are not available when dealing with diseases transmitted by the airborne route; if a particulate respirator is not available, use a tightly-fitting mask.

#### **Surgical and procedure masks**

1. If supplies of N-95 (or higher) respirators are no longer available, surgical masks can provide benefits against large droplet exposure, and should be worn for all healthcare patient activities.
2. Select surgical masks that can be tied tightly or have elastic straps (not ear loop masks that do not form a seal).
3. Disposable medical masks should fit the user's face tightly and be discarded immediately after use. If the mask gets wet or dirty with secretions, it must be changed immediately.
4. Proper surgical mask or respirator use and removal includes the following:
  - Prior to putting on a respirator or surgical mask, wash hands thoroughly with soap and water or use an alcohol-based hand sanitizer to reduce the possibility of inadvertent

contact between contaminated hands and mucous membranes.

- If worn in the presence of infectious persons, a respirator or surgical mask may become contaminated with infectious material; therefore, avoid touching the outside of the device to help prevent contamination of hands.

- Once worn in the presence of an [infected] patient the surgical mask or disposable N-95 respirator should be removed and appropriately discarded.

- After the surgical mask or respirator has been removed and discarded, wash hands thoroughly with soap and water, or use an alcohol-based hand sanitizer.

□□ If supplies of FDA-approved healthcare surgical/procedure masks become absolutely unavailable, APIC recognizes that:

- Controversies exist regarding how to proceed when supplies of N-95 or higher level respirators, FDA-approved healthcare surgical/procedure masks or even FDA-approved respirators for public health emergencies, intended for general public use are depleted/unavailable.

- Review of the scientific literature identified a published letter detailing construction of a handmade, reusable cotton mask. This type of mask may provide some level of protection, based on anecdotal and/or limited evidence 8-10 No recommendation can be made but decision makers should be aware of such potential resources

- No evidence about the effectiveness of non-FDA-approved masks (fabric masks or masks intended to filter dust and mist from wood, metal, and masonry work) in preventing infectious disease spread has been found in the literature to date. As such, no recommendation for their use can be made.

Regardless of the availability of respirators or surgical masks, environmental control measures, respiratory hygiene/cough etiquette and extreme vigilance with proper hand hygiene are critical in minimizing the likelihood of exposure.

Research into respiratory protection is continuing and ICPs should keep abreast of developments from CDC/HHS, FDA, and IOM concerning the use of masks and respirators developed for the public in the likelihood of a pandemic or other conditions requiring respiratory protection.

8. Other PPE that may be needed shall be Vinyl or latex gloves, disposable gowns and eye protection.

## **9. Use and administration of vaccines and antiviral drugs-**

1. ADON shall monitor and coordinate influenza vaccination and antiviral use of personnel in conjunction with Director of Nursing.

a. CDC and State Health Department websites shall be checked as needed (at least weekly) to obtain the most current recommendations and guidance for the use, availability, access and distribution of vaccines and antiviral medications during a pandemic.

b. HHS guidance shall be used to estimate the number of staff and residents who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. See- [www.hhs.gov/pandemicflu/plan/sub6.html](http://www.hhs.gov/pandemicflu/plan/sub6.html) and [www.hhs.gov/pandemicflu/plan/sup7.html](http://www.hhs.gov/pandemicflu/plan/sup7.html).

c. Director of Nursing shall determine and administer the delivery of influenza vaccine or antiviral prophylaxis to residents and staff as recommended by the State Health Dept.



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“Pharmacy” – Will coordinate and work closely with our facility and state public health officials to provide medication and protective equipment in the event of a pandemic emergency. The have medications used to manage influenza available should we identify a medical need. Procedures as defined by the public health officials and the resident’s medical condition, will dictate dispensing of the medications. Should our facility identify any suspected cases we should notify our assigned Account Manager immediately to ensure all protocols and treatments are followed in accordance with recommended CDC guidelines.

#### **10. Staffing and other related occupational issues-**

1. Pandemic Influenza Response Coordinators shall see staff education is performed by all department directors to self-assess and report symptoms of pandemic influenza before reporting to duty and to enforce not working if ill.
2. The Department Director has been designated as the staff person responsible for assessing and coordinating staffing needs during a pandemic influenza outbreak in the facility. As part of this responsibility, the Department Directors, in collaboration with the Pandemic Influenza Response Coordinator, shall:
  - a. Estimate the minimum number and type of staff needed to care for a single resident with influenza complications on a single day; and
  - b. Develop strategies for reducing the gap between available staff and staffing needs as the number of pandemic influenza residents increases and staff members become ill or remain home to take care of affected family members. Such strategies may include:
    1. Assigning resident-care responsibilities to administrative staff;
    2. Recruiting retired healthcare workers;
    3. Utilizing nursing and medical students; and/or
    4. Using resident family members in an ancillary capacity.

May pull staff from other departments or outside church volunteers, to help according to Department of Health regulations, and do minimal tasks such as changing of beds, water distribution, general minor care such as washing residents face/hands, help set up so they can do their own hygiene if capable.

NOTE: a quick training on how to feed and the Heimlich maneuver before assisting with meals would need to take place before being able to feed if DOH regulations allow.

4. Director of HR shall conduct a daily assessment of staffing status and needs during an influenza pandemic.

5. Administrator along with HR Director shall work with corporate staff and Department of Health to determine the applicability of declaring a facility “staffing crisis” and appropriate emergency staffing alternatives, consistent with state Law.

6. Minimum staffing levels required as determined by Department Directors-  
Housekeeping- there shall be a minimum of (3) Housekeepers available during 7-3 shift.  
Laundry- There shall be a minimum of (1) during 7-3 shift and (1) during 3-11 shift.

Maintenance- There shall be a minimum of (1) Maintenance during 7-3.

Nursing- RN- 7-3, - 18 staff. 3-11, - 5 staff and 11-7, - 4 staff

LPN- 7-3, 13 staff, 3-11, - 10 staff, and 11-7 – 8 staff

Nurse Aides- 7-3, 49 staff, 3-11 45 staff, 11-7 30 staff

Dietary- Day - 13 staff, Evening, 9 staff

Activities- -Day, 3 staff, Evening, 2 staff

Administration- (1) Receptionist at main entrance, other Admin staff positions are not critical and most can be covered by other admin staff.

7. Department Directors need to be aware of a possibility of altering work locations and assignments of staff or staff not being able to report to work that are increased risk for influenza complications (e.g., pregnancy, immunocompromised workers).

8. During Pandemic period there may be a need to provide accommodation (food and sleeping arrangements) for staff family members so staff are able to commit extra time to provide resident care without the worry of how their families are being provided for.

9. Food Service Manager shall have adequate food supplies on hand to not only provide meals to the residents but staff and volunteers that may need to stay multiple shifts.

## **11. Supplies (purchasing and distribution)-**

1. Each department head shall be responsible to submit to Pandemic Influenza Response Coordinators a list for their department of on hand supplies and projected needed supplies during a six-week pandemic. (e.g., masks, gloves, hand hygiene products, food, water, cleaning products, toilet tissue, hand towels, facial tissues, medical supplies)..

2. Each department shall begin stockpiling non-perishable supplies immediately and monitor these supplies along with increasing these supplies as pandemic influenza stages progress to get to the 6-week supply level. Department heads shall work with suppliers to address likely supply shortages and have contingency plans.

3. Masks and gloves shall be stockpiled at a central location (storage area adjoining Resident storage in Oaks basement). This stockpile shall be monitored by Pandemic Influenza Response Coordinator and maintained as needed.

4. See attached lists of supply needs for Dietary, Nursing SL, Nursing AL and Environmental Services.

- PPE
- Medical Equipment/Supplies i.e. O2, Air Mattress, Shroud, Nasal Cannulas,
- Backup Fuel
- Flashlight/Batteries/Extension Cords
- Radios
- Back up Water
- Emergency Food Supply
- Garbage/Waste Disposal Supplies
- Motors, Pumps
- IV Supplies/Equipment
- Cellular Phone
- NYPD OEM Radio

- Backup Phone/Internet
- Rehabilitation Equipment

5. When stockpiling items, be aware of each product's shelf life and storage conditions. Stockpiles of supplies should be placed in clean, secure, temperature-controlled environment to prevent damage or contamination of the supplies (e.g., avoid storage areas that are damp or have temperature extremes). Where possible, incorporate product rotation (e.g., consume the oldest supplies first) into stockpile management system. Masks may or may not have expiration dates listed; however, product shelf- life should be taken into consideration to assure adequate inventory of supplies.

6. Distribution of supplies needed during a Pandemic Event shall be made according to need and as directed by Department Director or designee. It is important to not waste supplies as there most likely will be a shortage of some items along with difficulty in replacing them.

7. Dietary Food Supplies-

1. Will continue to utilize cycle menu as long as suppliers are able to deliver orders.
2. In the event deliveries are stopped we will utilize on hand food (average 12 day supply) to supply minimal adequate nutrition to all residents and staff. Dietary supplements will be utilized to help.
3. Will continue to sanitize and reuse china as long as staffing permits. If staffing is not available to wash and sanitize dishware, we will begin use of disposable dinnerware, which is stocked to a 10 day supply.
4. Dietician and CDM will create daily menus using in house foods to provide the best nutritional offerings.

## 12. Bed Surge Capacity and Mortuary Issues-

1. Director of Nursing shall develop alternative care plans for residents who need acute care services when hospital beds become unavailable.
2. Director of Nursing shall develop plans to help increase hospital bed capacity.
  - a. Agreements with Hospital's for admission to our facility of non-influenza patients to facilitate utilization of acute care resources for more seriously ill patients.
  - b. Identify facility space that could be adapted for use as expanded inpatient beds and provide information to local and regional planning contacts.
3. Director of Nursing in conjunction with Director of Environmental Services shall plan to manage the need for post mortem care and disposition of deceased residents.
4. Director of Nursing shall identify with assistance from Environmental Services- an area to be used as a temporary morgue.

## 12. Essential Operations-

1. The Pandemic Influenza Response Coordinators shall collaborate with local emergency management agency, other healthcare providers and equipment suppliers in an attempt to maximize shared resources during a pandemic outbreak.
2. During a Pandemic Outbreak we need to be sure all main systems are functioning properly- Including HVAC, Plumbing, Electrical in order to provide continued care to our residents.

## SECTION V

### CDC Publications/guidelines related to Covid-19

#### CDC Publication: Testing Guidelines for Nursing Homes

Nursing home residents are at high risk for infection, serious illness, and death from COVID-19. Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as [viral testing](#)) among residents in nursing homes. Viral testing of residents in nursing homes, with authorized nucleic acid or antigen detection assays, is an important addition to other [infection prevention and control](#) (IPC) recommendations aimed at preventing SARS-CoV-2 from entering nursing homes, detecting cases quickly, and stopping transmission. This guideline is based on currently available information about COVID-19 and will be refined and updated as more information becomes available.

Testing conducted at nursing homes should be implemented in addition to [recommended IPC measures](#). Facilities should have a plan for testing residents for SARS-CoV-2. Additional information about the components of the testing plan are available in the CDC guidance titled [Preparing for COVID-19 in Nursing Homes](#).

Testing practices should aim for rapid turnaround times (e.g., less than 24 hours) in order to facilitate effective interventions. Testing the same resident more than once in a 24-hour period is not recommended. Antibody (serologic) test results generally should not be used as the sole basis to diagnose an active SARS-CoV-2 infection and should not be used to inform IPC actions.

While this guidance focuses on testing in nursing homes, several of the recommendations such as testing residents with signs or symptoms of COVID-19 and testing asymptomatic close contacts should also be applied to other long-term care facilities (e.g., assisted living facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental disease, and psychiatric residential treatment facilities).

For additional guidance addressing other non-healthcare settings, refer to the CDC guidance addressing [Communities, Schools, Workplaces and Events](#). Guidance for testing healthcare personnel (HCP) is available in the [Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2](#).

#### Diagnostic Testing

##### Testing residents with signs or symptoms of COVID-19.

- At least daily, take the temperature of all residents and ask them if they have any [COVID-19 symptoms](#). Perform viral testing of any resident who has signs or symptoms of COVID-19.
  - Clinicians should use their judgment to determine if a resident has signs or [symptoms](#) consistent with COVID-19 and whether the resident should be tested. Individuals with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Some may present with only mild symptoms or [other less common symptoms](#).
  - Clinicians are encouraged to consider testing for other causes of respiratory illness, such as influenza, in addition to testing for SARS-CoV-2.



**Testing asymptomatic residents** with known or suspected exposure to an individual infected with SARS-CoV-2 including close and expanded contacts (e.g., there is an outbreak in the facility).

- Perform expanded viral testing of all residents in the nursing home if there is an outbreak in the facility (i.e., a new SARS-CoV-2 infection in any HCP or any [nursing home-onset](#) SARS-CoV-2 infection in a resident).
  - A single new case of SARS-CoV-2 infection in any HCP or a [nursing home-onset](#) SARS-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with SARS-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing viral testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents

quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent SARS-CoV-2 transmission.

- When undertaking facility-wide viral testing, facility leadership should expect to identify multiple asymptomatic and pre-symptomatic residents with SARS-CoV-2 infection and be prepared to cohort residents. See [Public Health Response to COVID-19 in Nursing Homes](#) for more details.
- If viral testing capacity is limited, CDC suggests first directing testing to residents who are close contacts (e.g., on the same unit or floor of a new confirmed case or cared for by infected HCP).
- See [Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes](#) for additional details.

**Initial (baseline) testing of asymptomatic residents** without known or suspected exposure to an individual infected with SARS-CoV-2 is part of the recommended reopening process.

- Perform initial viral testing of each resident in a nursing home as part of the recommended [reopening process](#).
- In any nursing home, initial viral testing of each resident (who is not known to have previously been diagnosed with COVID-19) is recommended because of the high likelihood of exposure during a pandemic, transmissibility of SARS-CoV-2, and the risk of complications among residents following infection.
- The results of viral testing inform care decisions, infection control interventions, and placement decisions (e.g., cohorting decisions) relevant to that resident.

### Testing to determine resolution of infection

- A [test-based strategy](#), which requires serial tests and improvement of symptoms, could be considered for discontinuing Transmission-Based Precautions earlier than the [symptom-based strategy](#). However, in most cases, the test-based strategy results in prolonged isolation of residents who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. A test-based strategy could also be considered for some residents (e.g., those who are [severely immunocompromised](#)) in consultation with local infectious diseases experts if concerns exist for the resident being infectious for more than 20 days. In all other circumstances, the symptom-based strategy should be used to determine when to discontinue Transmission-Based Precautions.

### Repeat Testing in Coordination with the Health Department

Non-diagnostic testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 (apart from the initial testing referenced above).

- After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and [HCP](#) and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state health department.
- Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or [HCP](#) for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.
  - If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral testing demonstrates no transmission beyond a limited number of units.

## CDC Publication: Preparing for COVID-19 in Nursing Homes

### Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including multidrug-resistant organisms (e.g., Carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP).

Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices.

The Centers for Medicare and Medicaid Services (CMS) recently issued [Nursing Home Reopening Guidance for State and Local Officialspdf iconexternal icon](#) that outlines criteria that could be used to determine when nursing homes could relax restrictions on visitation and group activities and when such restrictions should be reimplemented. Nursing homes should consider the current situation in their facility and community and refer to that guidance as well as direction from state and local officials when making decisions about relaxing restrictions. When relaxing any restrictions, nursing homes must remain vigilant for COVID-19 among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.

This guidance has been updated and reorganized according to core IPC practices that should remain in place even as nursing homes resume normal practices, plus additional strategies depending on the stages described in the [CMS Reopening Guidancepdf iconexternal icon](#) or at the direction of state and local officials. This guidance is based on currently available information about COVID-19 and will be refined and updated as more information becomes available.

These recommendations supplement the CDC's [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#) and are specific for nursing homes, including skilled nursing facilities.

### Additional Key Resources:

- [Considerations for the Public Health Response to COVID-19 in Nursing Homes](#)
- [Interim Testing in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel](#)
- [Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes](#)
- [Considerations for Memory Care Units in Long-Term Care Facilities](#)
- [Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19](#)

### Core Practices

These practices should remain in place even as nursing homes resume normal activities.

Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program.

- This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the

IPC program based on the resident population and facility service needs identified in the [facility risk assessment](#).

- CDC has created an [online training course](#) that can be used to orient individuals to this role in nursing homes.

**Report COVID-19 cases, facility staffing, and supply information to the [National Healthcare Safety Network \(NHSN\) Long-term Care Facility \(LTCF\) COVID-19 Module](#) weekly.**

- CDC's NHSN provides long-term care facilities with a customized system to track infections and prevention process measures in a systematic way. Nursing homes can report into the four pathways of the LTCF COVID-19 Module including:
  - Resident impact and facility capacity
  - Staff and personnel impact
  - Supplies and personal protective equipment
  - Ventilator capacity and supplies
- Weekly data submission to NHSN will meet the [CMS COVID-19 reporting requirements.pdf](#)

**Educate Residents, Healthcare Personnel, and Visitors about COVID-19, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves.**

- Provide information about [COVID-19](#) (including information about signs and symptoms) and strategies for [managing stress and anxiety](#).
- Regularly review CDC's [Infection Control Guidance for Healthcare Professionals about COVID-19](#) for current information and ensure staff and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility. Including consultants is important, since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of COVID-19.
  - Reinforce sick leave policies, and remind HCP not to report to work when ill.
  - Reinforce adherence to standard IPC measures including [hand hygiene](#) and [selection and correct use of personal protective equipment \(PPE\)](#). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.
    - CDC has created training modules for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
  - Educate HCP about any new policies or procedures.
- Educate residents and families on topics including information about COVID-19, actions the facility is taking to protect them and/or their loved ones, any visitor restrictions that are in place, and actions residents and families should take to protect themselves in the facility, emphasizing the importance of hand hygiene and source control.
- Have a plan and mechanism to regularly communicate with residents, families and HCP, [including if cases of COVID-19 are identified among residents or HCP](#).

**Implement Source Control Measures.**

- HCP should wear a facemask at all times while they are in the facility.
  - When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. [Guidance on extended use and reuse of facemasks](#) is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required.



- Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above cloth face coverings should not be placed on children under 2.
- Visitors, if permitted into the facility, should wear a cloth face covering while in the facility.

### **Have a Plan for Visitor Restrictions.**

- Send [letters or emails](#) to families reminding them not to visit when ill or if they have a [known exposure](#) to someone with COVID-19.
- Facilitate and encourage [alternative methods for visitationpdf icon](#) (e.g., video conferencing) and communication with the resident
- Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry.
  - Screen visitors for fever ( $T \geq 100.0^{\circ}\text{F}$ ), [symptoms consistent with COVID-19](#), or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility.
- Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.
- Have a plan for when the facility will implement additional restrictions, ranging from limiting the number of visitors and allowing visitation only during select hours or in select locations to restricting all visitors, except for compassionate care reasons (see below).

### **Create a Plan for Testing Residents and Healthcare Personnel for SARS-CoV-2.**

- Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as [viral testing](#) or test) among residents and HCP in nursing homes.
- The [plan](#) should align with state and federal requirements for testing residents and HCP for SARS-CoV-2 and address:
  - [Triggers](#) for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, response to a resident or HCP with COVID-19 in the facility, routine surveillance)
  - Access to tests capable of detecting the virus (e.g., polymerase chain reaction) and an arrangement with laboratories to process tests
    - Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection and should not be used to inform IPC action.
  - Process for and capacity to perform SARS-CoV-2 testing of all residents and HCP
  - A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until [symptom-based criteria](#) are met for a symptomatic resident who refuses testing)
- Additional information about testing of residents and HCP is available:
  - [CDC Strategy for COVID-19 Testing Nursing Homes](#).
  - [Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes](#)

### **Evaluate and Manage Healthcare Personnel.**

- Implement [sick leave policies](#) that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Create an inventory of all volunteers and personnel who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
- As part of routine practice, ask HCP (including consultant personnel and ancillary staff such as environmental and dietary services) to regularly monitor themselves for fever and symptoms consistent with COVID-19.



- Remind HCP to stay home when they are ill.
- If HCP develop fever ( $T \geq 100.0^{\circ}\text{F}$ ) or [symptoms consistent with COVID-19](#) while at work they should inform their supervisor and leave the workplace. Have a [plan](#) for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers).
- HCP with suspected COVID-19 should be prioritized for testing.
- Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.
  - **Actively take their temperature\*** and document absence of [symptoms consistent with COVID-19](#). If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
  - \*Fever is either measured temperature  $>100.0^{\circ}\text{F}$  or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations.
  - HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.
- Develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
  - CDC has created guidance to assist facilities with [mitigating staffing shortages](#).
  - For guidance on when HCP with suspected or confirmed COVID-19 may return to work, refer to [Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 \(Interim Guidance\)](#)

### **Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices.**

- Hand Hygiene Supplies:
  - Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). Unless hands are visibly soiled, an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations.
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory Hygiene and Cough Etiquette:
  - Make tissues and trash cans available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
- Personal Protective Equipment (PPE):
  - Perform and maintain an inventory of PPE in the facility.
    - Identify [health department](#) or [healthcare coalition](#) contacts for getting assistance during PPE shortages. The Supplies and Personal Protective Equipment pathway in the [NHSN LTCF COVID-19 Module](#) can be used to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of PPE conservation strategies).
    - Monitor daily PPE use to identify when supplies will run low; use the [PPE burn rate calculator](#) or other tools.
  - Make necessary PPE available in areas where resident care is provided.
    - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.
    - Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
  - Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
  - Implement [strategies to optimize current PPE supply](#) even before shortages occur, including bundling resident care and treatment activities to minimize entries into resident rooms. Additional strategies might include:

- [Extended use](#) of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
  - Care must be taken **to** avoid touching the respirator, facemask, or eye protection. If this must occur (e.g., to adjust or reposition PPE), HCP should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others.
- [Prioritizing gowns](#) for activities where splashes and sprays are anticipated (including aerosol-generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP.
  - If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., *Clostridioides difficile*)
- Implement a process for decontamination and reuse of PPE such as face shields and goggles.
- Facilities should continue to assess PPE supply and current situation to determine when a return to standard practices can be considered.
- Implement a [respiratory protection program](#) that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
- Environmental Cleaning and Disinfection:
  - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas;
  - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
    - Use an EPA-registered disinfectant from [List N external icon](#) on the EPA website to disinfect surfaces that might be contaminated with SARS-CoV-2. Ensure HCP are appropriately trained on its use.

### **Covid floor/unit:**

- Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
  - Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive).
  - Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated.
- Have a [plan](#) for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them).

- Additional information about cohorting residents and establishing a designated COVID-19 care unit is available in the [Considerations for the Public Health Response to COVID-19 in Nursing Homes](#)

### **New Admissions and Readmissions Whose COVID-19 Status is Unknown.**

- Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected.

### **Evaluate and Manage Residents with Symptoms of COVID-19.**

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever ( $T \geq 100.0^{\circ}\text{F}$ ) and [symptoms consistent with COVID-19](#). Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below.
  - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures  $>99.0^{\circ}\text{F}$  might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or  $\geq 3$  residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
  - Contact information for the healthcare-associated infections program in each state health department is available here: <https://www.cdc.gov/hai/state-based/index.html>
  - Refer to CDC [resources](#) for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of patients with COVID-19 is described in the [Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\)](#). CDC has also developed guidance on [Evaluating and Reporting Persons Under Investigation \(PUI\)](#).
- If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#). This guidance should be implemented immediately once COVID-19 is suspected
  - Residents with suspected COVID-19 should be prioritized for testing.
  - Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
    - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
    - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
  - Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the

- face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
    - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms.
  - If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.
    - While awaiting transfer, residents should be separated from others (e.g., in a private room with the door closed) and should wear a cloth face covering or facemask (if tolerated) when others are in the room and during transport.
    - [All recommended PPE](#) should be used by healthcare personnel when coming in contact with the resident.
  - Because of the higher risk of unrecognized infection among residents, universal use of [all recommended PPE](#) for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is newly identified in the facility; this could also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.
  - For decisions on removing residents who have had COVID-19 from Transmission-Based Precautions refer to the [Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19](#)

### **Additional Strategies Depending on the Facility's Reopening Status**

These strategies will depend on the stages described in the CMS Reopening Guidance or the direction of state and local officials.

#### **Implement Social Distancing Measures**

- Implement aggressive social distancing measures (remaining at least 6 feet apart from others):
  - Cancel communal dining and group activities, such as internal and external activities.
  - Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene.
  - Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas.
- Considerations when restrictions are being relaxed include:
  - Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate.
  - Allowing for safe, socially distanced outdoor excursions for residents without COVID-19, including those who have fully recovered. Planning for such excursions should address:
    - Use of cloth face covering for residents and facemask by staff (for source control) while they are outside
    - Potential need for additional PPE by staff accompanying residents
    - Rotating schedule to ensure all residents will have an opportunity if desired, but that does not fully disrupt other resident care activities by staff
    - Defining times for outdoor activities so families could plan around the opportunity to see their loved ones

## Implement Visitor Restrictions

- Restrict all visitation to their facilities except for certain compassionate care reasons, such as end-of-life situations.
  - Send letters or emails to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations.
  - Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.
  - Post signs at the entrances to the facility advising that no visitors may enter the facility.
  - Decisions about visitation for compassionate care situations should be made on a case-by-case basis, which should include careful screening of the visitor for fever or [symptoms consistent with COVID-19](#). Those with symptoms should not be permitted to enter the facility. Any visitors that are permitted must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.
- Considerations for visitation when restrictions are being relaxed include:
  - Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).
  - Schedule visitation in advance to enable continued social distancing.
  - Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).

## Healthcare Personnel Monitoring and Restrictions:

- Restrict non-essential healthcare personnel, such as those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers from entering the building.
  - Consider implementing telehealth to offer remote access to care activities.

## Definitions:

- **Healthcare Personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).
- **Source Control:** Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Cloth face covering:** Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer.
- **Facemask:** Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.
- **Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.
- **Nursing home-onset SARS-CoV-2 infections** refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:
  - Residents who were known to have COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
  - Residents who were placed into Transmission-Based Precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.



## **RESOURCES- for reference only**

- CDC Publication: “Preparing for Covid-19 in Nursing Homes”  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
- CDC publication: “Coronavirus Disease 2019 (COVID-19): Supporting Your Loved One in a Long-Term Care Facility”<https://www.cdc.gov/coronavirus/2019-ncov/downloads/supporting-loved-one-in-long-term-care-facility.pdf>
- U.S. Department of Health and Human Services' Centers for Disease Control and Prevention  
[www.bt.cdc.gov/planning/index.asp](http://www.bt.cdc.gov/planning/index.asp)
- CDC- Federal Centers for Disease Control Coronavirus website:  
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- CMS/CDC Checklist: [https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist\\_3\\_13.pdf](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf)
- WHO  
<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
- National Institute for Occupational Safety and Health (NIOSH):  
<http://www.cdc.gov/niosh/homepage.html> <http://www.cdc.gov/niosh/bldvent/2002-139.html>
- U.S. Government  
<http://www.firstgov.gov>
- U.S. Environmental Protection Agency (EPA)  
<http://www.epa.gov/epahome> -
- Federal Emergency Management Agency (FEMA)  
<http://www.fema.gov>  
<http://www.fema.gov/hazards>
- OSHA's Emergency Preparedness & Response information  
[www.osha.gov/SLTC/smallbusiness/sec10.html](http://www.osha.gov/SLTC/smallbusiness/sec10.html)
- OSHA's Evacuation Plans & Procedures information  
[www.osha.gov/SLTC/etools/evacuation/alarms.html](http://www.osha.gov/SLTC/etools/evacuation/alarms.html)
- U.S. Postal Service  
[http://www.usps.com/news/2001/press/pr01\\_1010tips.htm](http://www.usps.com/news/2001/press/pr01_1010tips.htm)
- U.S. Department of Transportation (DOT) Emergency Response Guidebook:  
<http://hazmat.dot.gov/pubs/erg/gydebook.htm>
- U.S. Transportation Security Administration:  
<http://www.tsa.gov>
- American Red Cross:  
<http://www.redcross.org>