BROOKHAVEN REHABILITATION
& HEALTH CARE CENTER

Brookhaven Rehabilitation & Health Care Center
250 Beach 17th St, Far Rockaway, NY 11691
(718) 471-7500

TITLE: PANDEMIC-EMERGENCY PLAN	
ISSUED BY: ADMINISTRATION	
EFFECTIVE DATE: MARCH 2020	REVIEWED: APRIL 2020, SEPTEMBER 1, 2020, FEBRUARY 2022 MARCH 2023, OCTOBER 2023
DISTRUBUTION: ALL DEPARTMENTS	

Overview:

A pandemic presents a unique challenge to long-term care because it can be a drawn-out incident, taking several weeks or months to conclude. An effective response to a pandemic requires: collaborating with local healthcare coalitions and response partners, planning for increased admits or surge at the facility, and gathering crucial information on an ongoing basis from multiple agencies and authorities and disseminating same to key staff. Awareness of the facility's capacities and staff's capabilities will allow the facility to respond to a dynamic and fast-paced situation such as infectious or vector-borne diseases. A pandemic, by definition, will be a widespread—even national—event, so close coordination and cooperation with local, county, state public health agencies; and private sector health care facilities will be necessary and vital.

Impact Potential:

A pandemic poses significant threat to the facility's critical systems. A pandemic can quickly overwhelm a facility's normal capacity to provide timely and accessible care and services. Because of the ease with which an infectious disease may be transmitted, the facility should anticipate quickly becoming a site of intensive exposure for staff and non-infected residents. Breaks in procedure or unanticipated exposures may overwhelm the facility, for example, by exposing personnel and requiring quarantine of the facility or specific units within the facility. For this reason, it will be incumbent upon the facility to quickly assess and prepare for staffing shortages from community quarantine and competing family interests; depleted supplies of vaccines and antivirals; stretched bed capacity and operational space required for resident care or quarantine.

1. Definitions

Emerging Infectious Disease (EID)—infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:

i. New infections resulting from changes or evolution of existing organisms; ii. Known

infections spreading to new geographic areas or populations; iii. Previously unrecognized

infections appearing in areas undergoing ecologic transformation;

iv. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

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

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

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

1.1 Helpful Websites

https://www.osha.gov/Publications/influenza_pandemic.html
http://www.cahfdisasterprep.com/PreparednessTopics/PandemicInfluenza.aspx
http://emergency.cdc.gov/coca/index.asp http://emergency.cdc.gov/health-professionals.asp
http://emergency.cdc.gov/recentincidents/ http://www.nebraskamed.com/biocontainment-unit/ebola
https://cdc.train.org/DesktopShell.aspx?tabId=62&goto=browse&browse=learningseries&lookfo
r=2177

2. General Preparedness for Emergent Infectious Diseases (EID)

a. The facility's emergency preparedness program will include a response plan for a communitywide infectious disease outbreak such as pandemic influenza. This plan will:

i. build on the workplace practices described in the facility's existing infection prevention and control policies;

ii. include administrative controls (screening, isolation, visitor policies, and employee absentee plans;

iii. address environmental controls (isolation rooms, plastic barriers sanitation stations, and special areas for contaminated wastes); iv. address human resource issues such as employee leave;

v. be compatible with the facility's business continuity plan;

vi: be cognizant of experience with prior pandemic response, incorporating previous best practices, and adopt protocols outlined in guidance that are specific to the pathogen and/or illness circulating at the time of outbreak.

b. Clinical leadership will be vigilant and stay informed about EIDs around the world. They will keep administrative leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.

c. As part of the emergency preparedness plan, the facility will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, eye goggles or other eye protection, surgical masks, assorted sizes of disposable N95 respirators, and gloves. In addition, the facility wili maintain a supply of hand sanitizer and EPA-approved disinfectants as part of this emergency stockpile. The amount that is stockpiled will minimally be enough for 60days, with supply needs based on facility census—not capacity—and will include considerations of storage space, cost, and availability. In the absence of existing NYSDOH guidance or regulations during a pandemic episode, the facility will make use of the CDCs PPE burn rate calculator to determine supply needs:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.htmt

d. The facility will develop plans with their vendors for re-supply of food, medications, sanitizing agents, and PPE in the event of a disruption to normal business including an EID outbreak. The facility will work in conjunction with its larger corporate structure and designated purchasing agent to procure additional supplies.

e. The facility will regularly train employees and practice the EID response plan through drills and exercises as part of the facility's emergency preparedness training

3. Local Threat

a. Once notified by the public health authorities at either the federal, state and/or local level that the EID is likely to or already has spread to the facility's community, the facility will

activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency, and/or the local public health authorities.

b. The facility's Infection Preventionist (IP), in coordination with the facility's Medical Director, will research the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state, and federal public health agencies.

c. Working with advice from the facility's Medical Director, local and state public health authorities, and others as appropriate, the Administrator, and/or designee(s), will review and revise internet policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.

d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.

e. If EID is spreading through an airborne route, then the facility will activate its respiratory protection plan to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.

f. Provide residents and families with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information.

g. Brief contractors and other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents.

h. Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along will the instruction that anyone who sick must not enter the building.

i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the facility, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work.

j. Self-screening — Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:

i. Reporting any suspected exposure to the EID while off duty to their supervisor and/or public health.

ii. Precautionary removal of employees who report an actual or suspected exposure to the Ell).

iii. Self-screening for symptoms prior to reporting to work.

iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.

k. Self-isolation - in the event there are confirmed cases of the EID in the local community, the facility may consider closing to new admissions and/or limiting visitors based on the advice of local public health authorities.

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

m. Engineering controls — The facility will utilize appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

n. Subject to any superseding New York State Executive Orders and/or NYSDOH guidance that may otherwise temporarily prohibit visitors, the facility will advise visitors to limit visits to reduce exposure risk to residents and staff.

o. If necessary, and in accordance with applicable New York State Executive Orders and/or NYSDOH guidance, the facility may opt to close the facility to new admissions, limit visitors when there are confirmed cases in the community, and/or to screen all permitted visitors for signs of infection. In the event of facility closure to visitors or changes in visiting procedures, all residents and designated resident representatives/legal guardians will be notified in writing, the facility's emergency hotline will be activated and updated with this same information, and this information will be disseminated to the residents' extended circle of family and friends and the community-at-large via social media.

4. Suspected Case in the Facility

a. Place a resident who exhibits symptoms of the EID in an isolation room and notify local public health authorities. If an on-duty staff person exhibits symptoms of the EID, immediately send them home and advise them to consult their personal physician for further guidance.

b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious resident to the appropriate acute care center via emergency medical services as soon as possible.

c. If the suspected infectious resident requires care while awaiting transfer, follow facility policies for isolation procedures, including all recommended PPE for staff at risk of exposure.

d. Keep the number of staff assigned to enter the room of the isolated resident to a minimum. Ideally, only specially-trained staff and prepared (i.e. vaccinated, medically-cleared, and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.

e. If feasible, ask the isolated resident to wear a facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated resident unless it advised otherwise by public health authorities.

f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.

g. Implement the isolation protocol in the facility (isolation rooms, co-horting, cancelation of group activities and social dining) as described in the facility's infection prevention and control plan and/or recommended by local, state, and/or federal public health authorities.

h. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

i. Residents of the facility who are hospitalized for the infectious disease will be evaluated for return to the facility when deemed medically stable by the hospital. The Director of Nursing, or designee, will review the Patient Review Instrument (PRI), hospital discharge summary, and any other relevant hospital records to ensure the facility can safely care for the resident. Depending upon the testing available and current guidance in place from NYSDOH, CMS, CDC, and/or local health agencies, a negative test result for the infectious disease may also be required prior to returning to the facility and/or temporary isolation may be required for a period of time upon the resident's return. In accordance with all applicable rules and regulations, a vacant bed will remain available for a resident's anticipated/eventual return.

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5. Employer Considerations

a. Facility leadership will consider its requirements under OSHA, Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), Americans with Disabilities Act (ADA), and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and other employees shall be of paramount concern. Facility leadership shall take into account:

i. The degree of frailty of the residents in the facility;

ii. The likelihood of the infectious disease being transmitted to the residents and employees;

iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces) iv. The precautions which can be taken to prevent the spread of the infectious disease;

v. Other relevant factors.

b. Once these factors are considered, facility leadership, in consultation with the facility's Infection Preventionist, will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.

c. Apply whatever action is taken uniformly to all staff in like circumstances.

d. Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.

e. Make reasonable accommodations for employees, such as permitting employees to work from home if their job description permits this.

f. Generally-accepted scientific procedures, whenever available, wilt be used to determine the level of risk posed by an employee.

g. Permit employees to use sick leave, vacation time, and FMLA where appropriate while they are out of work.

h. Permit employees to return to work when cleared by a licensed physician or upon a negative test result (if testing is available), however, additional precautions may be taken to protect the residents.

i. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to progressive discipline and/or not permitted to work.

j. The facility's licensed Administrator will ensure that this Pandemic Emergency Plan (PEP) is reviewed at least annually in conjunction with its annual review of the facility's Comprehensive Emergency Management Plan (CEMP).

k. The facility's licensed Administrator will ensure that this Pandemic Emergency Plan (PEP) is posted to the facility's public website no later than 9-15-20. In addition, this PEP will be posted publicly in the facility's central, accessible main lobby for review—and copies (both paper and PDF electronic files) will be available immediately upon request.

PANDEMIC ROLES AND RESPONSIBILITIES:

ADMINISTRATOR / INCIDENT COMMANDER

- Because of the sustained nature of a pandemic, activation of the full emergency plan may not be necessary—or only necessary for a short time—as both internal and external circumstances arise and evolve. Determine if the situation can be handled within normal operations, otherwise consider activating the Command Center and assigning positions to manage the specific incident.

- Establish a Pandemic-Specific Response Team, consisting of (at minimum) the facility's Administrator, Medical Director, Infection Preventionist, Director of Nursing, Director of Environmental Services, and other members of the interdisciplinary team as deemed appropriate. The Pandemic Specific Response Team will meet as often as is necessary—up to and including daily, formally and informally—during a community and/or facility outbreak to monitor, share current CDC and NYSDOH literature and memorandums, develop and revise policies and procedures, and take emergency measures as necessary.

- Promptly alert key facility staff and community agencies including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected cases of infection.

- Communicate and collaborate with public health authorities and local municipalities.

- Promptly notify state or local public health authorities of known or suspected infections in accordance with existing or emerging Department of Health and/or CDC guidelines.

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- Create a pandemic-specific binder to collect all relevant documents (including communications to residents and families) for review by regulatory and local health agencies.

- Update the facility's Hazard Vulnerability Assessment (HVA).

- Consider limitation or suspension of outside visitors. Ensure that all actions taken to manage visitor access and resident movement within the facility in order to mitigate resident exposure to community sources of potential contagion are documented in policy and procedure.

- Ensure that the appropriate key clinical staff members have access to all relevant communicable disease reporting tools and understand all outbreak-specific reporting requirements. These include, but are not limited to: Health Electronic Response data System (HERDS) surveys, Nosocomial Outbreak Reporting Application (NORA), and the CDC's National Healthcare Safety Network (NHSM).

- Develop a process for communicating with and providing updates to residents and family members. Document that process in a pandemic-specific policy and procedure. At minimum, such communication plan will include (but will not be limited to):

- Provision for a daily update and update in the event of a change in condition to designated resident representatives and legal guardians for any resident infected with the pandemic infectious disease by one of the following: the resident's attending physician; a licensed nurse; or the resident's assigned social worker. Such updates, including the date and time of the communication, will be documented in the resident's
  EMR;

- Provision for a weekly update to all residents and designated resident representatives/legal guardians that includes the number of pandemic-related infections and deaths, including residents with a pandemic-related infection who pass away for reasons other than the infection itself.
- Provision for these communications will be provided electronically and by other means selected by designated resident representatives and legal guardians, including: updated messages on the facility's designated emergency hotline (516 -224--7566; group text messages sent via EZ Text (PRN); written communications provided via email or snail mail; through in-person visits (residents) or telephone calls (families).

- Residents will be provided daily, no-cost access to iPads with video chat capabilities to enable face-to-face communication with loved ones. Therapeutic Recreation staff and Social Workers will be available to assist residents with these electronic devices.

- Upon the abatement of the pandemic event, the facility will implement return-to-normal procedures provided in NYSDOH and CDC recovery guidance issued for each specific infectious disease or pandemic event, regarding how, when, and which activities, procedures, and restrictions may be eliminated and/or restored and the timing of when those changes may be executed. The facility will incorporate communication regarding any relevant recovery activities in its weekly updates to residents and their designated resident representatives/legal guardians and share with staff and community stakeholders as relevant and indicated.

HUMAN RESOURCES

- With input from the Administrator and Department Heads, create a pandemic-specific emergency staffing policy.

- The pandemic-specific emergency staffing policy should address (at a minimum) employee scheduling, provisional and temporary employees, mandating of employees, re-assignment of employees or tasks, training and competency assistance, and any additional actions taken to mitigate staffing shortages.

- Gather data from Department Heads daily with regard to employees who call out sick and communicate those to the Director of Nursing and/or Infection Preventionist to assist in tracking employee illness.

FOOD AND NUTRITIONAL SERVICES

- Consider suspension of communal dining in accordance with CDC and/or local health department recommendations and mandates.

- The Director of Food and Nutritional Services (DFNS) will anticipate and plan for temporary disruption in the food supply chain. The DFNS will order an extra (1) week's worth of dry and frozen food, (3) weeks' worth of paper goods to ensure ability to provide disposables to isolation rooms, and 600 extra gallons of potable water.

- With input from the Administrator and Director of Nursing, create a pandemic-specific suspension of communal dining policy.

INFECTION PREVENTIONIST

- Parkview has a designated full-time Infection Preventionist (RN) who has completed specialized training in infection prevention and control. The Infection Preventionist is a member of the facility's Quality Assessment and Assurance (QAA) Committee and reports to the committee on a regular basis (but at least quarterly).

- The Infection Preventionist (IP) is responsible for the facility's activities aimed at preventing the pandemic-specific infection by ensuring that sources of infections are isolated to limit the spread of infectious organisms. The IP will systematically collect, analyze, and interpret daily resident data in order to plan, implement, evaluate, and disseminate appropriate health practices within the facility.

- The IP will activate specific surveillance, screening, and reporting as instructed by Centers for Disease Control and Prevention (CDC), state agency, and/or the local public health authorities. In the absence of those instructions, the IP will develop and update daily a line listing of all resident illness associated with the pandemic in conjunction with the Medical Director. The IP will maintain records of all daily line listings and proof of any required reporting to external agencies/entities.

- The IP, in coordination with the Medical Director, Director of Nursing, Director of Environmental Services, and other relevant members of the IDT, will develop a pandemic-specific infection control plan and policy to prevent potential transmission of the pandemic-specific infectious pathogen. This plan includes (at minimum):

- Cohorting of residents according to their infection status—positive, suspected, negative, and unknown—to limit exposure between infected and non-infected residents, in accordance with current applicable NYSDOH and CDC pandemic-specific guidance; o Depending upon the number of active infections, use of a specific unit or part of a unit to cohort those confirmed positive residents and discontinuance of shared bathrooms or shower rooms with residents outside the cohort area; o Limit to the extent possible and practical staff assigned to each of these areas to minimize cross-contamination; o Proper identification of cohort areas, including demarcating

reminders for healthcare personnel; o If appropriate cohorting efforts cannot be established or sustained, the Administrator will notify the regional Department of Health office and request further guidance; o Development of proper medical protocols to treat and/or manage symptoms of the infectious disease by the Medical Director;

- If and when testing for the EID is available, coordinate with the facility's contracted lab (currently Centers & Lenco) to obtain the necessary supplies and services to test residents and employees at a frequency established by the NYSDOH, CMS, and/or CDC.
  Execute supplemental contractual agreement if necessary.
  - Depending upon the nature of the infectious disease or pandemic-specific pathogen, the IP and Director of Environmental Services will develop specific policies and procedures to address the cleaning of occupied isolation rooms, terminal cleaning of isolation rooms, cleaning and disinfecting of high-touch surface areas, and an overall infectious disease or pandemic-specific housekeeping plan that includes (at a minimum): the regular cleaning and disinfection of resident rooms, common areas, and shared equipment; the proper handling of linens (both clean and soiled); the regular checking that sinks are well-stocked with soap and paper towels for handwashing and that all hand sanitizing stations are refilled with an appropriate alcohol-based hand sanitizer; the usage of hospital-grade products with EPA-approved emerging viral pathogens claims.

NURSING ADMINISTRATION

- Institute a system for resident symptoms monitoring consistent with the prevalent symptoms of the pandemic-specific illness.

- Educate all staff on the basics of the pandemic-specific pathogen, including clinical signs and symptoms, exposure risks, and basics of infection prevention including hand washing and personal hygiene.

- Educate all staff on the use of standard, contact, and droplet precautions with eye protection, as well as correct use of appropriate PPE for persons with respiratory illness, including proper donning and doffing.

- Guidance on implementing recommended infection prevention practices is available in CDC's free online course — The Nursing Home Infection Preventionist Training — which includes resources checklists for facilities and employees to use.

https://www.cdc.gov/longtermcare/training.html

- Evaluate medications and other supplies on hand, and plan appropriately if deliveries will be delayed or prevented due to pandemic-related travel restrictions.

- In conjunction with the facility's Central Supply Coordinator, evaluate supplies of PPE, and plan appropriately if deliveries will be delayed or if the supply chain is interrupted. Work with the facility's local Office of Emergency Management (OEM), state agency (NYSDOH), and professional associations (NYSHFA, AHCA) to source PPE in the event of a local, state, and/or nationwide shortage.

- In consultation with the facility's Infection Preventionist, will develop a policy and procedure for the screening of employees and tracking system for employees who present with symptoms of the pandemic-specific illness or those who test positive (if and when such testing for the pandemic-specific illness is developed and available).

SOCIAL SERVICES

- As assigned by the Administrator, communicate directly with resident representatives and other family members on behalf of residents and the facility. Document such communications in the resident's EMR.

- Provide supportive visits and/or phone calls to residents to address social isolation in the event of the suspension of visitation and/or group dining and activities. Minimize panic by clearly explaining risks of the pandemic-specific illness to residents and efforts by the facility to respond to the pandemic.

- Serve as a triage point for incoming calls from family members to minimize disruption to the nursing units. Address questions or concerns—or route to the appropriate party.

- Treat anxiety in unexposed residents who are experiencing somatic symptoms with reassurance.

- Provide support and active listening as needed to fearful or anxious employees.

- Develop and implement a pandemic-specific psychosocial care plan for all residents.

- Assist in the development of a policy and procedure for the management of decedent personal effects and—in the event of deaths—work with families to secure timely funeral arrangements and, if necessary, with local funeral homes to assist with body retrieval and temporary storage.

ENVIRONMENTAL SERVICES

- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.

- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for the infectious disease/pandemic-specific pathogen.

- Execute isolation-related room transfers as directed and in accordance with established policy.

- Ensure that tissues and waste receptacles are widely available and all sinks are well-stocked with soap and paper towels for hand washing.

- Ensure that hand-sanitizer stations are checked frequently and refilled as necessary.

- In the event of PPE shortages, make provisions to procure, distribute, and launder cloth gowns.

- Review and revise as needed the facility's existing environmental controls, such as areas for contaminated waste, to minimize the spread of infection.

THERAPEUTIC RECREATION

- Therapeutic Recreation staff may need to increase the frequency of one-to-one visits, especially in situations in which the specific pandemic may necessitate limited or suspended visiting hours or restrictions to or cancellation of group activities.

- In the event of mandated or necessary limitations on or suspensions of outside visitors and entertainers and/or limitations on or cancellation of group activities, assist in the development of a policy and procedure to address the provision of alternate leisure time activities.

- Assist in the provision of alternate means of communication with family members and friends outside the facility in the event of limitations on or suspensions of outside visitors. These may include (but are not limited to): letter writing, sending emails, virtual visits using FaceTime or Skype, or coordinating window visits.

RECEPTION / SECURITY / PLANT OPERATIONS

- In the event of the suspension of visitors to the facility, enforce strict adherence to the policy.

- Control entrances and exits to the building for staff, visitors, and deliveries.

- Plant Operations should temporarily re-design the front lobby using partitions and crowd control ropes to create physical barriers that restrict access past the employee/visitor screening station to help minimize unauthorized access.

- Plant Operations will direct all deliveries to be brought to the loading dock and left outside the doors for facility staff to bring in and manage distribution.

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Policy and Procedure	**Covid-19**
Revised: 3/2020, 9/2020, 3/2021, 7/2021, 1/2022, 10/2022, 2/2023, 6/2023, 11/2023	

BACKGROUND

SARS-CoV-2, commonly known as COVID-19, is primarily a viral respiratory infection. It is most commonly spread between people who are in close proximity to each other (within 6 feet). It spreads through respiratory droplets or small particles produced when an infected person coughs, sneezes, sings, talks or breathes. Droplets can also land on surfaces and inanimate objects and spread when soiled hands touch the eyes, nose and mouth. The incubation period is between 2-14 days. Symptoms of the virus include fever, cough, shortness of breath, severe respiratory infection, as well as nausea and diarrhea.

POLICY

The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19. The facility will follow and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the New York State Department of Health (NYSDOH), to identify and prevent the spread of the SARS-CoV-2 virus.

DEFINITIONS

Close Contact: refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period.

Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Up to Date: a person has received *all* recommended Covid-19 vaccines.

PROCEDURE

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GENERAL/CORE PRINCIPLES OF COVID-19 PREVENTION

- The facility will provide education to staff to address:
  - Staying home from work when sick
  - Identifying signs/symptoms of Covid-19 in resident and reporting same to appropriate personnel
  - Reviewing standard and transmission-based precautions; review appropriate identifiers (e.g., signage)
  - Reviewing appropriate use of personal protective equipment (donning and doffing)
  - Hand hygiene
  - Reviewing respiratory etiquette
- The facility will provide education to visitors by the following means:
  - Posting visual alerts (e.g., signs and posters) at entrances and in strategic places (e.g., lobby, elevators, cafeterias, that include instructions about current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene)
  - Posting visual alerts of *recommended* actions (e.g., stay home of sick) to prevent transmission to others if they have any of the following:
    - A positive viral test for SARS-CoV-2
    - Symptoms of Covid-19, or
    - A close contact with someone with SARS-CoV-2 infection
- The facility may choose to actively screen staff and visitors for symptoms of Covid-19
- The facility will reinforce cleaning and disinfection procedures to include:
  - Cleaning/disinfecting multiple-use equipment in between use for each resident (e.g., blood pressure cuffs, glucometer, stethoscopes, etc.)
  - Increasing cleaning and disinfection of high-touch surfaces (both inside and outside of resident care areas) including contact/dwell times for products used for disinfection.

MONITORING AND EVALUATION OF FACILITY RESIDENTS

- Routinely monitor all residents upon admission and at least daily for fever x 72 hours for signs and symptoms consistent with Covid-19 infection as well as any change in condition.
- Ask residents to immediately report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection.

- Identification, early work-up, including testing as indicated, and treatment will be initiated by clinical staff for all residents with suspected or confirmed COVID-19.

MANAGEMENT OF NEW and RE-ADMISSIONS and RESIDENTS OOP <24 HOURS

- Empiric transmission-based precautions is not necessary for new or re-admission or residents who leave the facility for <24 hours (e.g., for medical appointments, community outings).
- Patients/Residents who leave the facility for longer than 24 hours will be managed as an admission.
- Testing of a patient/resident on admission or re-admission is at the discretion of the facility, or as advised by the local health department.
    - Facility may utilize local metrics (e.g., increase in Covid-19 related hospital admissions or increase in ICU beds occupied by Covid-19 patients) that could reflect increasing community respiratory viral activity to determine if testing is warranted.

MANAGEMENT OF RESIDENTS WITH KNOWN COVID-19 INFECTION

- Place resident in a single-person room. If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for Covid-19, residents should remain in their current location.
    - The door should be kept closed if safe to do so.
    - Ideally, the resident should have a dedicated bathroom.
- Initiate contact and droplet precautions and place signage by room door to reflect same.
- Staff to utilize full PPE (gown, fit-tested N95 mask, eye protection, and gloves) when entering room.
- Dedicated or disposable patient care equipment will be utilized when feasible.
    - Shared equipment will be cleaned and disinfected using an appropriate EPA-registered disinfectant.
- Monitor resident for worsening/change in condition.
    - Document assessment of symptoms, vital signs, and oxygen saturation via pulse oximetry at least Q shift to quickly identify residents who require transfer to a higher level of care
- Encourage residents to wear face mask (as tolerated) for source control until symptoms resolve or, for those who never developed symptoms, until the meet the criteria to end isolation.

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- Limit transport and movement of the patient/resident outside of the room to medically essential purposes.

DURATION OF TBP FOR RESIDENTS WITH COVID-19 INFFECTION

- In general, patients/residents who are hospitalized for Covid-19 infection will be maintained on TBP for the time period described for patients with severe to critical illness.
- Facility may use symptom-based or test-based strategy to discontinue TBPs
    - **Symptom-based strategy**:
        - Patients with **mild to moderate illness** who are ***not*** **moderately to severely immunocompromised**:
            - At least 10 days have passed *since symptoms first appeared* **and**
            - A least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
            - Symptoms (e.g., cough, shortness of breath) have improved
    - Patients who were **asymptomatic** throughout the infection and are ***not*** **moderately to severely immunocompromised**:
        - At least 10 days have passed since the date of their first positive viral test
    - Patients with **severe to critical illness** and who are ***not*** **moderately to severely immunocompromised**:
        - At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
        - A least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
        - Symptoms (e.g., cough, shortness of breath) have improved
- Patients/residents who are **moderately to severely immunocompromised**:
    - Use of a test-based strategy and, if available, consultation with an infectious disease specialist to determine when TBP can be discontinued for these residents.
    - **Test-based strategy**
        - Patients/residents who are **symptomatic**
            - Resolution of fever without the use of fever-reducing medications **and**
            - Symptoms (e.g., cough, shortness of breath) have improved, **and**
            - Results are negative from at least 2 consecutive respiratory specimens collected 48 hours apart using an antigen or molecular test

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        - Patients/residents who are asymptomatic
            - Results are negative from at least 2 consecutive respiratory specimens collected 48 hours apart using an antigen or molecular test
- If symptoms recur (e.g., rebound), patients/residents will be placed back into isolation until they again meet the symptom-based criteria to discontinue TBP.

MANAGEMENT OF RESIDENTS <u>SUSPECTED</u> OF COVID-19 INFECTION OR WITH <u>CLOSE-CONTACT EXPOSURE</u>

- Place resident in a single-person room
    - If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for Covid-19, residents should remain in their current location.
    - The door should be kept closed if safe to do so.
    - Ideally, the resident should have a dedicated bathroom.
- If **symptomatic**:
    - Initiate empiric transmission-based precautions (TBP)
    - Perform viral tests for Covid-19
        - If using NAAT or PCR test, a single negative test is sufficient. If a higher level of clinical suspicion exists, confirm with a second NAAT or PCR
        - If using an antigen (rapid) test, a negative result should be confirmed by either a negative NAAT/PCR test or second antigen test taken 48 hours after the first negative test.

- If **asymptomatic**:
    - Empiric use of TBP is not necessary while being evaluated for SARS-CoV-2 following close contact with someone with SAR-CoV-2 infection, ***unless***
        - Patient/resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
        - Patient/resident is moderately to severely immunocompromised
        - Patient/resident is resident is resident on a unit with others who are moderately to severely immunocompromised
        - Patient/resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.
    - Perform a series of 3 viral tests for Covid-19
        - Test immediately (but not earlier than 24 hours after the exposure), on day 3 if previous test negative, and on day 5 after the 2nd negative test

- Encourage patients/ residents to wear face mask, as tolerated, for source control

TESTING and REPORTING

- A single case of Covid-19 is considered an outbreak. In the event of an outbreak, the facility will conduct testing in accordance with the most current CDC recommendations.
  - When testing is initiated due to potential/known close contact or higher-risk exposure, test all exposed residents on day 1, day 3 and day 5.
    - If all results are negative during any round of testing, no further action is necessary.
    - If results indicate any positive cases during any round of testing, initiate outbreak testing every 3-7 days x14 days until there are no new positives.
    - If using antigen tests, may consider testing every 3 days.
  - *When SARS-CoV-2, influenza virus, and respiratory syncytial virus are co-circulating in the community, test for all 3 viruses.
  - Testing is not required for residents and staff who are asymptomatic and have recovered from Covid-19 infection within the prior 30 days. Testing will be considered for those who have recovered in the prior 31-90 days.
    - Use an antigen test instead of a molecular test.
- Testing of visitors is at the discretion of the facility.
  - Visitors may continue to use either PCR testing or antigen testing.
  - Facility cannot deny visitor the right to visit if they do not have a Covid-negative test.
- Point of Care Antigen tests that have resulted positive will be reported to NYSDOH ECLRS as directed by NYSDOH by 1:00PM of the day following receipt of the results.
- All staff and residents testing positive shall be documented on respective line lists and the results will be reported on all <u>required</u> submissions to the CDC via NHSN (at least weekly) and NYSDOH via HERDS (daily reporting Mon through Friday)
- Facility to complete a Nosocomial Outbreak Report (NORA) via the NYS Health Commerce System (HCS) at the time of the identification of any new case.

NOTIFICATION OF RESIDENTS AND HEALTHCARE REPRESENTATIVES

- The nurse will notify the physician, resident, and/or resident representative(s) when a resident is suspected of or has confirmed Covid-19 infection. The nurse and/or physician

will discuss with the resident and/or resident representative(s) the treatment/management plan.

- Inform residents, their representatives, and families of those residing in facilities by 5PM the next calendar day following the occurrence of either a single confirmed infection of Covid-19, or 3 or more residents or staff with new-onset respiratory symptoms occurring within 72 hours of each other.
    - *Per CMS 23-13-ALL, as of 5/12/2023, CMS will no longer enforce the above notification requirement even though this reporting is expected.

EMPLOYEE RETURN TO WORK CRITERIA

- HCP with even mild symptoms will be prioritized for viral testing with NAAT (nucleic acid) or Antigen test
    - If using NAAT, a single negative test is sufficient.
    - If using an antigen test, a negative result should be confirmed by either a negative NAAT or second negative antigen test taken 48 hours after the first negative test.

HCP with Covid-19 Infection:

- HCP with **mild to moderate illness** who are ***not*** moderately to severely immunocompromised may return to work after the following criteria has been met:
    - At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work OR 10 days if testing is not performed or if a positive test at day 5-7, AND
    - At least 24 hours have passed since last fever without the use of fever-reducing medications, AND
    - Symptoms (e.g., cough, shortness of breath) have improved.
        - *Either a NAAT or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.
- HCP who were **asymptomatic** throughout their infection and are ***not*** moderately to severely immunocompromised may return to work after the following criteria have been met:
    - At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

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    - *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later
- HCP with severe to critical illness who are ***not*** moderately to severely immunocompromised may return to work after the following criteria have been met:
    - At least 10 days and up to 20 days have passed *since symptoms first appeared,* **and**
    - At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
    - Symptoms (e.g., cough, shortness of breath) have improved.
    - The **test-based strategy** may be used to inform the duration of work restriction.
        - **Symptomatic**:
            - Resolution of fever without the use of fever-reducing medications, **and**
            - Improvement in symptoms (e.g., cough, shortness of breath), **and**
            - Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT
        - **Asymptomatic**
            - Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

HCP with Covid-19 Exposure

- Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include:
    - HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure.
    - HCP is moderately to severely immunocompromised.
    - HCP cares for or works on a unit with patients who are moderately to severely immunocompromised.
    - HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.
- If work restriction is recommended, HCP may return to work after either of the following time periods:
    - HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following a higher-risk exposure is negative.

  - If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.
- Following a higher-risk exposure, HCP should:
  - Have a series of three viral tests for SARS-CoV-2 infection.
    - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
    - Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
  - Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
  - Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact employee health or immediate supervisor to notify and arrange for medical evaluation and testing.
- HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

MASK AS UNIVERSAL SOURCE CONTROL

- Masks as universal source control is at the discretion of the facility or as advised by the local health department.
  - As directed by NYSDOH guidance, facility may utilize local metrics (e.g., increase in Covid-19 related hospital admissions or increase in ICU beds occupied by Covid-19 patients) that could reflect increasing community respiratory viral activity to determine if testing is warranted.
- The facility may allow individuals to use a mask or respirator based on *personal preference*, informed by their perceived level of risk for infection based on their recent

activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.
    - If using *N95 respirators as source control*, fit testing is not required. Refer to facility's Respiratory Protection Program and OSHA's guidelines Appendix D.
- Mask as *PPE* will be utilized for individuals who have suspected or confirmed Covid-19 or other respiratory infection as well as for those individuals who had a close contact exposure (resident and visitors) or a higher-risk exposure (healthcare personnel) with someone with SARS-CoV-2 infection for 10 days after the exposure.
    - NIOSH-approved fit-tested N95 masks are required when caring for patients/residents with suspected or confirmed Covid-19 infection.
    - Refer to facility's Respiratory Protection program Policy.
- Masks as *source control* <u>will</u> be utilized in areas/units experiencing a Covid-19 outbreak until no new cases have been identified for a period of 14 days.
- When used solely for source control, masks may be used for an entire shift unless they become soiled, damaged, or hard to breathe through.
- *If masks (e.g., N95) are used as *PPE* during the care of a patient/resident with Covid-19 infection (or droplet precautions), they should be removed and discarded after the patient/resident care encounter and a new one should be donned.

VISITATION

- Facility will utilize the core principles of infection prevention to promote safe visitation and decrease the risk of Covid-19 spread.
- The facility will allow the number of visitors based on the ability to adhere to infection control principles, including the ability to maintain physical distancing between residents and visitors, as applicable.
- Facility visitation may be conducted through a variety of means - in resident rooms, outdoors (weather permitting), designated visitation spaces, and virtually.
- The facility will post signage in highly visible areas (e.g., entrances, exits, elevator banks, etc.) with instructions for infection prevention, including Covid-19 (example, hand hygiene, cough etiquette, physical distancing, immunizations, etc.).
- Residents on transmission-based precautions may still receive visitors. Visitors will be cautioned of the potential risks associated with visiting.
    - In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated).
- Visitors who have had close contact with someone with Covid-19 infection or those with confirmed Covid-19 infection or compatible symptoms will be advised to *defer* non-

urgent in-person visits until they meet the CDC criteria for healthcare settings to end isolation.

- To limit movement in the facility during visitation while there is an outbreak investigation, the following guidelines will be followed:
  - Visitor(s) will go directly to the resident's room or designated area.
  - If a resident shares a room, the facility will attempt to facilitate in-room visitation while adhering to the core principles of infection prevention as related to Covid-19.
  - Visitors will be encouraged to wear a mask and physically distance themselves from other residents and staff, when possible.

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