Harris Hill HCF

Comprehensive Emergency Management Plan

Harris Hill HCF

2699 Wehrle Dr. Williamsville, NY 14221

www.mcguiregroup.com

Emergency Contacts

The following table lists contact information for public safety and public health representatives for quick reference during an emergency.

Table 1: Emergency Contact Information

Organization	Phone Number(s)
Local Fire Department	Lancaster Volunteer Fire Department- (716) 683-1901
Local Police Department	Lancaster Police Department - (716) 683-2800
Emergency Medical Services	911
Local Office of Emergency Management (Erie County)	716-858-6578
NYSDOH Regional Office (Buffalo Office)	716-847-4320
NYSDOH Duty Officer	866-881-2809
New York State Watch Center (Warning Point) (Non-Business Hours)	518-292-2200

Plan Approval

This Comprehensive Emergency Management Plan (CEMP) has been approved for implementation by:

_____ _____

[Name] [Date]
[Title and Organization]

_____ _____

[Name] [Date]
[Title and Organization]

Record Of Changes

Version #	Implemented By	Revision Date	Description of Change
n/a	*Steve Mercurio, Administrator*	*8/22/20*	*Updated all sections to reflect plan format and legislative changes.*
1	Danielle Reusch – Administrator	7/26/2021	Review and Update
2	Danielle Reusch – Administrator	7/1/2022	Review and Update
3	Danielle Reusch	12/5/2022	Review and update

Record of External Distribution

Date	Recipient Name	Recipient Organization	Format	Number of Copies
11/2018	*Greg Butcher's Office*	*Erie County Office of Emergency Management*	*Digital (Email)*	*1*

Introduction

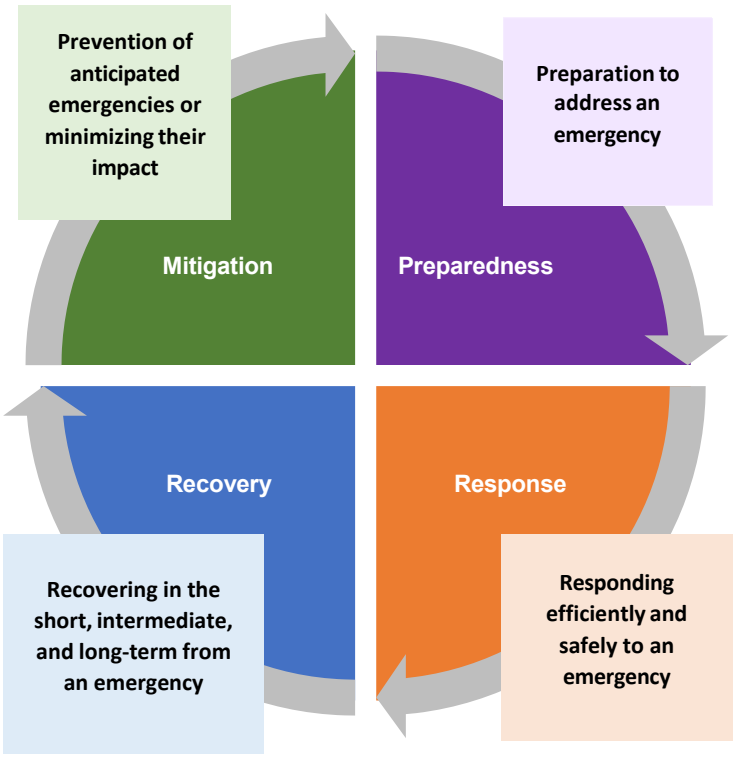
To protect the well-being of residents, staff, and visitors, the following all-hazards Comprehensive Emergency Management Plan (CEMP) has been developed and includes considerations necessary to satisfy the requirements for a Pandemic Emergency Plan (PEP). Appendix K of the CEMP has been adjusted to meet the needs of the PEP and will also provide facilities a form to post for the public on the facility's website, and to provide immediately upon request. The CEMP is informed by the conduct of facility-based and community-based risk assessments and pre-disaster collaboration with the following stakeholders:

- Facility leadership team
- Erie County Emergency Services
- Lancaster PD
- Lancaster Volunteer Fire Department
- WNY Mutual Aid Plan

This CEMP is a living document that must be reviewed on an annual basis, and updated as needed.

Purpose

The purpose of this plan is to describe the facility's approach to mitigating the effects of, preparing for, responding to, and recovering from natural disasters, man-made incidents, and/or facility emergencies.



Scope

The scope of this plan extends to any event that disrupts, or has the potential to significantly disrupt, the provision of normal standards of care and/or continuity of operations, regardless of the cause of the incident (i.e., man-made or natural disaster).

The plan provides the facility with a framework for the facility's emergency preparedness program and utilizes an all-hazards approach to develop facility capabilities and capacities to address anticipated events.

An Incident Command System (ICS) framework will act as the operational component of this CEMP. The ICS framework allows for maximum flexibility and scalability and is capable of utilizing a facility's present resources onsite to manage any type and size disaster.

Situation

Risk Assessment

The facility conducts an annual risk assessment (i.e. Hazard Vulnerability Assessment –HVA) to identify which natural and man-made hazards pose the greatest risk to the facility (i.e., human and economic losses based on the vulnerability of people, buildings, and infrastructure).

The facility conducted a facility-specific risk assessment on 9/3/20 and determined the following hazards may affect the facility's ability to maintain operations before, during, and after an incident:

- Fire
- Extreme heat and/or cold
- Infectious disease (i.e. COVID 19, MRSA, C diff, etc.)
- Winter storm/severe weather
- Loss of essential services (electric, gas, water, sewage, communications)
- Hurricane/coastal storms
- High winds/tornado
- Flooding (internal and external)
- Missing resident
- Labor action (i.e. strike, work stoppage)
- Active Shooter/threat
- Intruder onsite
- Chemical, Biological, Nuclear disaster
- Bomb threat
- Incoming surge of residents from the community

This risk information serves as the foundation for the plan—including associated policies, procedures, and preparedness activities all of which are contained within this multipart document.

Mitigation Overview

The facility conducts an annual risk assessment (i.e. Hazard Vulnerability Assessment –HVA) to identify which natural and man-made hazards pose the greatest risk to the facility (i.e., human and economic losses based on the vulnerability of people, buildings, and infrastructure).

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Planning Assumptions

This plan is guided by the following planning assumptions:

- Emergencies and disasters can occur without notice, any day, and on any shift.
- Emergencies and disasters may be facility-specific, local, regional, or state-wide.
- Local and/or state authorities may declare an emergency.
- The facility may receive requests from other facilities for resource support (supplies, equipment, staffing, or to serve as a receiving facility).
- Facility security may be compromised during an emergency.
- The emergency may exceed the facility's capabilities and external emergency resources may be unavailable. The facility is expected to be able to function without an influx of outside supplies or assistance for 72 hours.
- Power systems (including emergency generators) could fail.
- During an emergency, it may be difficult for some staff to get to the facility, or alternately, they may need to stay in the facility for a prolonged period of time.

Notification and Activation

Hazard Identification

The facility may receive advance warning about an impending natural disaster (e.g., hurricane forecast) or man-made threat (e.g., law enforcement report), which will be used to determine initial response activities and the movement of personnel, equipment, and supplies. For no-notice incidents (e.g., active shooter, tornado), facilities will not receive advance warning about the disaster, and will need to determine response activities based on the impact of the disaster.

The Incident Commander may designate a staff member to monitor evolving conditions, typically through television news, reports from government authorities, and weather forecasts.

All staff have a responsibility to report potential or actual hazards or threats to their direct supervisor.

Activation

Upon notification of hazard or threat—from staff, residents, or external organizations—the senior-most on-site facility official will determine whether to activate the plan based on one or more of the triggers below:

- The potential for a significant disruption to normal clinical and/or business operations
- The facility has determined to implement a protective action.
- The facility is serving as a receiving facility.
- The facility is testing the plan during internal and external exercises (i.e., fire drills, disaster drills, etc.).

If one or more activation criteria are met and the plan is activated, the senior-most on-site facility official—or the most appropriate official based on the incident—will assume the role of “Incident Commander” and operations proceed as outlined in this document.

Staff Notification

Once a hazard or threat report has been made, an initial notification message will be disseminated to staff in accordance with the facility's communication plan.

Department Managers or their designees will contact on-duty personnel to provide additional instructions and solicit relevant incident information from personnel (e.g., status of residents, status of equipment).

Once on-duty personnel have been notified, Department Managers will notify off-duty personnel if necessary and provide additional guidance/instruction (e.g., request to report to facility).

Department personnel are to follow instructions from Department Managers, keep lines of communication open, and provide status updates in a timely manner.

External Notification

Depending on the type and severity of the incident, the facility may also notify external parties (e.g., local office of emergency management, resource vendors, relatives and responsible parties) utilizing local notification procedures to request assistance (e.g., guidance, information, resources) or to provide situational awareness.

The NYSDOH Regional Office is a mandatory notification recipient regardless of hazard type, while other notifications may be hazard-specific. **Table 4** provides a comprehensive list of mandatory and recommended external notification recipients based on hazard type.

Table 2: Notification by Hazard Type

M = Mandatory
R = Recommended

Notification Recipient	Example Hazard	Active Threat	Winter Storm	Coastal Storm	Intruder Alert	Water Disruption	Earthquake	Extreme Cold	Extreme Heat	Fire	Flood	CBRNE	Infectious Disease / Pandemic	Labor Action	IT/Comms Failure	Power Outage	Tornado/High Wind	Loss of Resident
NYSDOH Regional Office	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Facility Senior Leader	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Local Emergency Management	R	M	R	R	□	R	M	□	□	□	R	R	R	□	□	□	R	□
Local Law Enforcement		M	□	R	M	□	R	□	□	M	R	M	□	R	□	□	□	R
Local Fire/EMS		M	□	R	□	R	M	R	R	M	R	M	□	□	□	R	R	R
Local Health Department	R	M	M	M	□	M	M	M	M	M	M	M	M	M	M	M	M	M
Off Duty Staff		R	□	R	□	□	R	□	□	□	□	□	□	□	□	□	□	□
Relatives and Responsible Parties		□	□	□	□	□	R	□	□	□	□	□	M	□	□	□	□	M
Resource Vendors		□	R	R	□	R	R	R	R	R	R	R	□	R	R	R	R	□
Authority Having Jurisdiction		□	□	R	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Mutual Aid Plan Operation Ctr		R	R	R	□	□	R	□	□	R	R	R	□	□	□	□	R	□
TMG Leadership		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M

*Notifications as they relate to this chart are only documenting the **immediate need** to update the parties above. For example, responsible parties would rarely be updated during the onset of the disaster. Rather, they would all be notified at an appropriate time after the emergency has been stabilized.

Mobilization

Incident Management Team (IMT)

Upon plan activation, the Incident Commander will activate some or all positions of the Incident Management Team, which is comprised of pre-designated personnel who are trained and assigned to plan and execute response and recovery operations.

Incident Management Team activation is designed to be flexible and scalable depending on the type, scope, and complexity of the incident. As a result, the Incident Commander will decide to activate the entire team or select positions based on the extent of the emergency.

Table 5 outlines suggested facility positions to fill each of the Incident Management Team positions. The most appropriate individual given the event/incident may fill different roles as needed.

Table 3: Incident Management Team - Facility Position Crosswalk

Incident Position	Facility Position Title	Description
Incident Commander	Highest ranking management team member onsite during the individual incident.	Leads the response and activates and manages other Incident Management Team positions.
Public Information Officer	TMG Director of Communications	Provides information and updates to visitors, relatives and responsible parties, media, and external organizations.
Safety Officer	Environmental Services Manager (ESM) or Asst. ESM/Housekeeping Manager	Ensures safety of staff, residents, and visitors; monitors and addresses hazardous conditions; empowered to halt any activity that poses an immediate threat to health and safety.
Operations Section Chief	Director of Nursing or next highest ranking Nursing Dept. Manager	Manages tactical operations executed by staff (e.g., continuity of resident services, administration of first aid).
Planning Section Chief	Director of Quality and Education and Lead Resident Care Coordinator along with Staffing Coordinator	Collects and evaluates information to support decision-making and maintains incident documentation, including staffing plans.
Logistics Section Chief	Food Service Director or Admissions Director	Locates, distributes, and stores resources, arranges transportation, and makes alternate shelter arrangements with receiving facilities.

Incident Position	Facility Position Title	Description
Finance/Admin Section Chief	TMG Finance Dept. Representatives and VP of Administration along with facility Business office, Payroll and Human Resource (HR) managers.	Monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

It is important to understand that multiple different individuals based on their knowledge and/or availability can fill each Incident Management Team (IMT) position. The flexibility of the plan allows IMT positions to be filled by individuals currently onsite for the emergency, rather than being dependent upon a small group of specific individuals.

Command Center

The Incident Commander will designate a space, e.g., facility conference room or other large gathering space, on the facility premises to serve as the centralized location for incident management and coordination activities, also known as the "Command Center."

The designated location for the Command Center is the **Front Conference Room** and the secondary/back-up location is the **Activities Room**, unless circumstances of the emergency dictate the specification of a different location upon activation of the CEMP, in which case staff will be notified of the change at time of activation.

Response

The Incident Commander will convene activated Incident Management Team members in the Command Center and assign staff to assess designated areas of the facility to account for residents and identify potential or actual risks, including the following:

- Number of residents injured or affected;
- Status of resident care and support services;
- Extent or impact of the problem (e.g., hazards, life safety concerns);
- Current and projected staffing levels (clinical, support, and supervisory/managerial);
- Status of facility plant, utilities, and environment of care;
- Projected impact on normal facility operations;
- Facility resident occupancy and bed availability;
- Need for protective action; and
- Resource needs.

Staffing

Based on the outcomes of the assessment, the Planning Section Chief along with the facility Staffing Coordinator will develop a staffing plan for the operational period (e.g., remainder of shift). The Operation Section Chief will execute the staffing plan by overseeing staff execution of response activities. The Finance/Administration Section Chief along with facility payroll and HR managers will manage the storage and processing of timekeeping and related documentation to track staff hours.

Recovery

Recovery services focus on the needs of residents and staff and help to restore the facility's pre-disaster physical, mental, social, and economic conditions.

Recovery services may include coordination with government, non-profit, and private sector organizations to identify community resources and services (e.g., employee assistance programs, state and federal disaster assistance programs, if eligible). Pre-existing facility- and community- based services and pre-established points of contact are provided in **Table 8**.

Table 4: Pre-Identified Recovery Services

Service	Description of Service	Point(s) of Contact
Physical Plant Related Repairs/Reconstruction/Cleanup/Waste removal	Repair or replacement of physical plant components damaged or destroyed during the emergency.	▪ TMG: Robert Bratton
Trauma/Grief Counseling	Trauma/grief counseling or other necessary social services for residents and/or staff members mentally/emotionally affected by emergency situation.	▪ TMG: Sarah Pietrowski
Emergency Staffing Services	Provision of critical/additional staffing in order to meet care requirements or backfill current staff affected by the emergency situation.	▪ TMG: Sue Grigg

Ongoing recovery activities, limited staff resources, as well as the incident's physical and mental health impact on staff members may delay facility staff from returning to normal job duties, responsibilities, and scheduling.

Resuming pre-incident staff scheduling will require a planned transition of staff resources, accounting for the following considerations:

- Priority staffing of critical functions and services (e.g., resident care services, maintenance, dining services).
- Personal staff needs (e.g., restore private residence, care for relatives, and attend memorial services, mental/behavioral health services).
- Continued use or release of surge staffing, if activated during incident.

Demobilization

As the incident evolves, the Incident Commander will begin to develop a demobilization plan that includes the following elements:

- Activation of re-entry/repatriation process if evacuation occurred;
- Deactivation of surge staffing;
- Replenishment of emergency resources;
- Reactivation of normal services and operations; and
- Compilation of documentation for recordkeeping purposes.

Infrastructure Restoration

Once the Incident Commander has directed the transition from incident response operations to demobilization, the facility will focus on restoring normal services and operations to provide continuity of care and preserve the safety and security of residents.

Table 9 outlines entities responsible for performing infrastructure restoration activities and related contracts/agreements.

Table 5: Infrastructure Restoration Activities

Activity	Responsible Entity	Contracts/Agreements
Internal assessment of electrical power.	Environmental Services Manager and/or Danielle Reusch	▪ Agreement with Lehigh Construction to coordinate
Clean-up of facility grounds (e.g., general housekeeping, removing debris and damaged materials).	Environmental Services Manager and/or Danielle Reusch	▪ Nick Marchewka to coordinate outside contractors based on specific needs.
Internal damage assessments (e.g., structural, environmental, operational).	Danielle Reusch	▪ Danielle Reusch to coordinate outside contractors based on specific needs.
Clinical systems and equipment inspection.	Facility Administrator	▪ Health Systems Services for clinical equipment inspection.
Strengthen infrastructure for future disasters (if repair/restoration activities are needed).	Facility Administrator with and/or Danielle Reusch	▪ n/a

Activity	Responsible Entity	Contracts/Agreements
Communication and transparency of restoration efforts to staff and residents.	Facility Administrator	▪ n/a
Recurring inspection of restored structures.	Facility Administrator and ESM	▪ n/a

Resumption of Full Services

Department Managers will conduct an internal assessment of the status of resident care services and advise the Incident Commander and/or facility leadership on the prioritization and timeline of recovery activities.

Special consideration will be given to services that may require extensive inspection due to safety concerns surrounding equipment/supplies and interruption of utilities support and resident care services that directly impact the resumption of services (e.g., food service, laundry).

Staff, residents, and relatives/responsible parties will be notified of any services or resident care services that are not available, and as possible, provided updates on timeframes for resumption. The Planning Section Chief will develop a phased plan for resumption of pre-incident staff scheduling to help transition the facility from surge staffing back to regular staffing levels.

Resource Inventory

Full resumption of services involves a timely detailed inventory assessment and inspection of all equipment, devices, and supplies to determine the state of resources post-disaster and identify those that need repair or replacement.

All resources, especially resident care equipment, devices, and supplies, will be assessed for health and safety risks. Questions on resource damage or potential health and safety risks will be directed to qualified service technicians and/or the original manufacturer for additional guidance.

Information Management

Critical Facility Records

Critical facility records that require protection and/or transfer during an incident include:

- Resident medical records
- Staff personnel files

The Facility maintains a complete record for each resident in accordance with accepted professional standards and practice. The facility shall protect and safeguard both its medical records and employee personnel records.

The record will be:

- Complete
- Accurately documented
- Readily accessible; and
- Systematically organized

1. Clinical Records are retained for six (6) years from the date of discharge or death or for residents who are minors, for three (3) years after the resident reaches the age of majority (18).

2. The Facility safeguards clinical record information against loss, destruction, or unauthorized use.
   ▪
3. Closed and/or thinned Medical records will be stored in a locked room and protected from fire, water damage, insects, and theft.

4. Medical records of permanently discharged residents will be stored separately, labeled alphabetically for easy identification, and protected from fire, water damage, insects, and theft.

5. Medical records of inpatients will be stored at the nurse's station and maintained on the desk or chart holder when not in use.

6. The Facility maintains a complete record for each resident in accordance with accepted professional standards and practice.

7. The Facility keeps confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

   - Transfer to another health care institution;
   - Law;
   - Third party payment contract; or
   - The resident

8. The Facility:

   - Permits each resident to inspect his or her records on request; and
   - Provides copies of the record to each resident no later that 48 hours after a written request from a resident or such greater period as State statue may permit, at a reasonable photocopying cost.

9. The clinical record contains:

   - Sufficient information to identify the resident
   - An interdisciplinary record of the resident's assessments
   - The interdisciplinary plan of care and services provided
   - The results of any preadmission screening conducted by the State
   - Progress notes by all practitioners and professional staff caring for the resident including Consultants
   - Reports of all diagnostic tests and results of treatments and procedures ordered for the resident

10. All entries in the Medical Records System are kept current at all times and kept in a place convenient for use by authorized personnel.

11. All reports are entered promptly in the appropriate section in the Medical Record System, dated and signed by the person providing the service.

Personnel Records

- In compliance with Section 415 of the State Hospital Code, the operator shall maintain "personnel records for each employee, including the administrator, containing all available pre-employment information and an employment record for each payroll period."
- Access to information contained with-in the employee file is granted as outlined.

PROCEDURE:

1. The employee personnel file shall include the following:
   <u>Personnel file:</u>

   Employment application
   Emergency contact form
   Returned reference checks
   Completed I-9 form
   Completed W-4 form
   License/Certification
   Record of orientation & Job specific orientation
   Employee attendance cards
   Evaluation forms/Competency evaluations
   counseling statements
   Reference requests for information
   Payroll deduction information
   Signed job description
   All miscellaneous information related to employment

   <u>Medical File:</u>

   Pre-employment physical

Annual health screen

Immunization record

Disability/workers compensation information

Education File:

In-service Records

2. Current employee files will be kept on site for duration of employment.

3. Terminated employee files are kept on site for two years and off site for six (unless employee has had an exposure incident as defined by OSHA.

4. Only authorized payroll personnel and the Administrator or his/her designee will have access to personnel records.

*If computer systems are interrupted or non-functional, the facility will utilize paper-based recordkeeping in accordance with internal facility procedures.

Tracking Evacuated Residents

The facility will use the New York State Evacuation of Facilities in Disasters System ("eFINDS") and the Resident Evacuation Critical Information and Tracking Form to track evacuated residents and ensure resident care is maintained. See Annex K for further details regarding the e FINDS system.

Resident Confidentiality

The facility will ensure resident confidentiality throughout the evacuation process in accordance with the Health Insurance Portability and Accountability Act Privacy Rule (Privacy Rule), as well as with any other applicable privacy laws. Under the Privacy Rule, covered health care providers are permitted to disclose protected health information to public health authorities authorized by law to collect protected health information to control disease, injury, or disability, as well as to public or private entities authorized by law or charter to assist in disaster relief efforts.

Tracking Facility Personnel

The facility will use the Kronos clock system and/or the NHICS Form 252 - Section Personnel Time Sheet to track facility staff.

Staff Accountability

Staff accountability enhances site safety by allowing the facility to track staff locations and assignments during an emergency. Staff accountability procedures will be implemented as soon as the plan is activated.

The facility will utilize the Kronos system and the NHICS Form 252 - Section Personnel Time Sheet to track the arrival and departure times of staff. During every operational period (e.g., shift change), Department Managers or designees will conduct an accountability check to ensure all on-site staff are accounted for.

If an individual becomes injured or incapacitated during response operations, Department Managers or designees will notify the Incident Commander to ensure the staff member's status change is reflected in the NHICS Form 206 - Staff Injury Plan.

Non Facility Personnel

The Incident Commander will coordinate with the facility Medical Director to ensure that appropriate credentialing and verification processes are followed for the utilization of clinical volunteers. Throughout the response, the Director of Quality/Education and/or the Lead Resident Care Coordinator will track non-facility personnel providing surge support along with their respective duties and the number of hours worked. NHICS Form 253 - Clinical Volunteer Staff Registration form will be used to document approved/credentialed clinical volunteers, and NHICS Form 252 - Section Personnel Time Sheet will be utilized to track and verify their time. Form 252 will also be used to track non-clinical volunteers as well.

Communications

As part of CEMP development, the facility conducted a communications assessment to identify existing facility communications systems, tools, and resources that can be utilized during an incident and to determine where additional resources or policies may be needed.

Primary (the best and intended option) and alternate (secondary back-up option) methods of communication are outlined in **Table 9.**

Table 6: Methods of Communication

Mechanism	Primary Method of Communication	Alternate Method of Communication
Landline telephone	☒	☐
Cell Phone	☒	☐
Text Messages	☒	☐
Email	☒	☐
News Media	☐	☒
Radio Broadcasts	☐	☒
Social Media	☐	☒
Runners	☐	☒
Facility Website		
Robo Calls	☐	☒
Satellite Phone	☐	☒

Mechanism	Primary Method of Communication	Alternate Method of Communication
Walkie Talkies	☐	☒

All forms of communication directed to the news media or other members of the public will be coordinated and approved by the TMG Communications Department. All internal communication, as well as external communications with stakeholders such as Emergency Services, Police/Fire Officials, DOH, etc. will be coordinated and approved by the Incident Commander.

Upon plan activation, the Incident Commander may designate a staff member as the Public Information Officer to serve as the single point of contact for the development, refinement, and dissemination of internal and external communications.

Key Public Information Officer Functions include:

- Develops and establishes mechanisms to rapidly receive and transmit information to local emergency management;
- Develops situational reports/updates for internal audiences (staff and residents) and external audiences;
- Develops coordinated, timely, consistent, and reliable messaging and/or tailor pre-scripted messaging;
- Coordinates, in concert with the IC, direct resident and relative/responsible party outreach, as appropriate; and
- Addresses rumors and misinformation.

Staff Communications

The facility maintains an updated employee roster listing the names of all staff members, including emergency contact information in the facility payroll system as well as in the TMG Corporate Payroll System. To prepare for impacts to communication systems, the facility also maintains redundant forms of communication with on-site and off-site staff. The facility will ensure that all staff are familiar with internal communication equipment, policies, and procedures.

Staff Reception Area

Depending on the nature of the incident, the facility may choose to establish a staff reception area (e.g., in a break room or near the time clock) to coordinate and check-in staff members as they arrive to the facility to support incident operations.

The staff reception area also provides a central location where staff can receive job assignments, checklists, situational updates, and briefings each time they report for their shift. Implementing a sign-

in/sign-out system at the staff reception area will ensure full staff accountability. The staff reception area also provides the Incident Commander with a central location for staffing updates and inquiries.

Resident Communication

Upon admission, annually, and prior to any recognized threat, the facility will educate residents and responsible parties on the CEMP efforts. Resident communication may include:

- Admission Documents and paperwork
- Website postings
- Resident Council Meetings
- Annual Facility Mailings
- Robo-calls

During and after an incident, the Incident Commander—or Public Information Officer, if activated—will establish a regular location and frequency for delivering information to staff, residents, and on-site responsible parties (e.g., set times throughout the day), recognizing that message accuracy is a key component influencing resident trust in the facility and in perceptions of the response and recovery efforts.

Communication will be adapted, as needed, to meet population-specific needs, including memory-care residents, individuals with vision and/or hearing impairments, and individuals with other access and functional needs.

External Communications

Under no circumstances will protected health information be released over publicly-accessible communications or media outlets. All communications with external entities shall be in plain language, without the use of codes or ambiguous language.

TMG

The facility will coordinate all messaging with The McGuire Group to ensure external communications are in alignment with corporate policies, procedures, and brand standards. Prior to an incident, the facility will coordinate with The McGuire Group to ensure an on-site facility staff member(s) has authorization and approval to disseminate messages.

Families/Guardians

The facility maintains a list in Point Click Care of all identified authorized family members and guardian's (responsible parties') contact information, including phone numbers and email addresses. Such individuals will receive information about the facility's preparedness efforts upon admission.

During an incident, the facility will notify responsible parties about the incident, status of the resident, and status of the facility by phone and/or other appropriate forms of communication depending on the nature of the incident. Additional updates may be provided on a regular basis to keep residents relatives/responsible parties apprised of the incident and the response.

The initial notification message to residents' primary point of contact (e.g., relative) will include the following information:

- Nature of the incident;
- Status of resident;
- Restrictions on visitation; and
- Estimated duration of protective actions
- Direct contact information for the designated facility liaison assigned to each resident

When incident conditions do not allow the facility to contact residents' relatives/responsible parties in a timely manner, or if primary methods of communication are unavailable, the facility will utilize local or state health officials, the facility website, and/or a recorded outgoing message on voicemail, among other methods, to provide information to families on the status and location of residents.

Media/General Public

During an emergency, the facility will utilize traditional media (e.g., television, newspaper, radio) and social media (e.g., Facebook, Twitter) to keep relatives and responsible parties aware of the situation and the facility's response posture.

The Incident Commander—or Public Information Officer, if activated—may assign a staff member to monitor the facility's social media pages and email account to respond to inquiries and address any misinformation.

Administration

As part of the facility's preparedness efforts, the facility conducts the following tasks:

- Identify and develop roles, responsibilities, and delegations of authority for key decisions and actions including the approval of the CEMP;
- Ensure key processes are documented in the CEMP;
- Coordinate annual CEMP review, including the *Annexes for all hazards*;
- Review and update, if needed, the facility HVA
- Ensure CEMP is in compliance with local, state, and federal regulations; and
- Continued dialogue with community partners such as Lancaster Volunteer Fire Department and Lancaster PD for training and educational purposes.

Finance

The McGuire Group Financial Operations Department has established policies and procedures for the management of facility finances and accounting before, during and after an emergency situation.

Incident Response

Financial functions during an incident include tracking of personnel time and related costs, initiating contracts, arranging for personnel-related payments and Workers' Compensation, tracking of response and recovery costs, and payment of invoices.

The Finance/Administration Section Chief or designee will account for all direct and indirect incident-related costs from the outset of the response, including:

- Personnel (especially overtime and supplementary staffing)
- Event-related resident care and clinical support activities
- Incident-related resources
- Equipment repair and replacement
- Costs for event-related facility operations
- Vendor services
- Personnel illness, injury, or property damage claims
- Loss of revenue-generating activities
- Cleanup, repair, replacement, and/or rebuild expenses

Logistics

Logistics functions prior to an incident include identifying and monitoring emergency resource levels, and executing mutual aid agreements, resource service contracts, and memorandums of understanding. These functions will be carried out pre-incident by the Administrator or their designee.

Response

To assess the facility's logistical needs during an incident, the Logistics Section Chief or designee will complete the following:

- Regularly monitor supply levels and anticipate resource needs during an incident;
- Identify multiple providers of services and resources to have alternate options in case of resource or service shortages; and
- Coordinate with the Finance Section Chief to ensure all resource and service costs are being tracked.
- Restock supplies to pre-incident preparedness levels,
- Coordinate distribution of supplies to service areas.

Plan Development and Maintenance

To ensure plans, policies, and procedures reflect facility-specific needs and capabilities, the facility will conduct the following activities:

Table 7: Plans, Policies, and Procedures

Activity	Led By	Frequency
Review and update the facility's risk assessment.	Facility Administrator/Danielle Reusch	Annually or more frequently with necessary changes.
Review and update contact information for response partners, vendors, and receiving facilities.	Facility Administrator/Danielle Reusch	Annually or as response partners, vendors, and host facilities provide updated information.
Review and update contact information for staff members and residents' emergency contacts.	Payroll manager – staff Julie Steiner Medical records managers – residents – Chrissy Culp	Annually or as staff members provide updated information.
Review and update contact information for residents' point(s) of contact (i.e., relatives/responsible parties).	Medical Records Managers and Social Services Department	At admission/readmission, at each Care Plan Meeting, and as residents, relatives, and responsible parties provide updated information.
Post clear and visible facility maps outlining emergency resources at all nurses' stations, staff areas, hallways, and at the front desk.	Environmental Services Manager – Robert Bratton	Annually
Maintain electronic versions of the CEMP in folders/drives that are accessible by others.	Facility Administrator Danielle Reusch	Annually
Revise CEMP to address any identified gaps.	Facility Administrator Danielle Reusch	Upon completion of an exercise or real-world incident.
Inventory emergency supplies (e.g., potable water, food, resident care supplies, communication devices, batteries, flashlights,	Environmental Services Manager – Robert Bratton and Food Service Director – Susan Scott	Quarterly

Protective Actions

The Incident Commander may decide to implement protective actions for an entire facility or specific populations within a facility. A brief overview of protective action options is outlined in **Table 11**. For more information, refer to the *NYSDOH Evacuation Plan Template*, *NYSDOH Healthcare Facility*

Evacuation Center Metropolitan Area Regional Office Region Facility Guidance Document for the 2018 Coastal Storm Season, and the *NYSDOH Healthcare Facility Evacuation Center Manual*.

Protective Action		Potential Triggers	Authorization
Defend-in-Place	**Defend-in-Place** is the ability of a facility to safely retain all residents during an incident-related hazard (e.g., flood, severe weather, and wildfire).	▪ Unforeseen disaster impacts cause facility to shelter residents in order to achieve protection.	▪ May be initiated by the Incident Commander **ONLY** in the absence of a mandatory evacuation order. ▪ Does not required NYSDOH approval.
Shelter-in-Place	**Shelter-in-Place** is keeping a small number of residents in their present location when the risks of relocation or evacuation exceed the risks of remaining in current location.	▪ Disaster forecast predicts low impact on facility. ▪ Facility is structurally sound to withstand current conditions. ▪ Interruptions to clinical services would cause significant risk to resident health and safety.	▪ Can only be done for coastal storms. ▪ Requires pre-approval from NYSDOH prior to each hurricane season and re-authorization at time of the incident.
Internal Relocation	**Internal Relocation** is the movement of residents away from threat within a facility.	▪ Need to consolidate staffing resources. ▪ Consolidation of mass care operations (e.g., clinical services, dining). ▪ Minor flooding. ▪ Structural damage. ▪ Internal emergency (e.g., fire). ▪ Temperature presents life safety issue.	▪ Determined by facility based on safety factors. ▪ If this protective action is selected, the NYSDOH Regional Office must be notified.
Evacuation	**Evacuation** is the movement of residents to an external location (e.g., a receiving facility) due to actual or anticipated unsafe conditions.	▪ Mandatory or advised order from authorities. ▪ Predicted hazard impact threatens facility capacity to provide safe and secure shelter conditions. ▪ Structural damage. ▪ Emergency and standby power systems failure resulting in facility inability to maintain suitable temperature.	▪ Refer to the *NYSDOH Evacuation Plan Template.*

Protective Action		Potential Triggers	Authorization
Lockdown	**Lockdown** is a temporary sheltering technique used to limit exposure of building occupants to an imminent hazard or threat. When "locking down," building occupants will shelter inside a room and prevent access from the outside.	▪ Presence of an active threat (e.g., active shooter, bomb threat, suspicious package). ▪ Direction from law enforcement.	▪ Determined by facility based on the notification of an active threat on or near the facility premises.

Resource Management

Additionally, the facility maintains an inventory of emergency resources and corresponding suppliers/vendors, for supplies that would be needed under all hazards, including:

- Generators
- Fuel for generators and vehicles
- Food and water for a minimum of 72 hours for staff and residents
- Disposable dining supplies and food preparation equipment and supplies
- Medical and over-the-counter pharmaceutical supplies
- Personal protective equipment (PPE), as determined by the specific needs for each hazard
- Emergency lighting, cooling, heating, and flashlights/lanterns
- Resident movement equipment (e.g., stair chairs, bed sleds, lifts)
- Durable medical equipment (e.g., walkers, wheelchairs, oxygen, beds)
- Linens, gowns, privacy plans
- Housekeeping supplies, disinfectants, detergents
- Resident specific supplies (e.g., identification, medical risk information, medical records, physician orders, Medication Administration Records, Treatment Administration Records, Contact Information Sheet, last 72 hours of labs, x-rays, nurses' notes, psychiatric notes, doctor's progress notes, Activities of Daily Living (ADL) notes, most recent History and Physical (H&P), clothing, footwear, and hygiene supplies)
- Administrative supplies
- Critical tools and maintenance/physical plant related equipment (hand/power tools for emergency repairs, air compressor, snow removal equipment, extension cords, dollies, gas powered water pumps, voltage detector, batteries (all sizes), pry bars, sledge hammer)
- Cell phones, chargers and two way radios
- Facility satellite phone

The facility's resource inventory will be updated annually, or as needed to ensure that adequate resource levels are maintained, and supplier/vendor contact information is current.

Resource Distribution and Replenishment

During an incident, the Incident Commander—or Logistics Section Chief, if activated—will release emergency resources to support operations. The Incident Commander—or Operations Section Chief, if activated—will ensure the provision of subsistence needs.

- The Incident Commander—or Planning Section Chief, if activated—will track the status of resources used during the incident. When defined resource replenishment thresholds are met, the Planning Section Chief will coordinate with appropriate staff to replenish resources, including:
- Procurement from alternate or nontraditional vendors
- Procurement from communities outside the affected region
- Resource substitution
- Resource sharing arrangements with mutual aid partners
- Request for external stockpile support from healthcare associations, local emergency management. Resource replenishment from TMG Corporate stockpile

Resource Sharing

In the event of a large-scale or regional emergency, the facility may need to share resources with mutual aid partners or healthcare facilities in the community, contiguous geographic area, or across a larger region of the state and contiguous states as indicated.

Emergency Staffing

If off-duty personnel are needed to support incident operations, the facility will conduct the following activities in accordance with facility-specific employee agreements:

Table 8: Off-Duty Personnel Mobilization Checklist

Off-Duty Personnel Mobilization Checklist	
☐	The senior most on-site facility official will confirm, with Administrator, that mobilization of off-duty personnel is permissible (e.g., overtime pay).
☐	Once approved, Department Managers will be notified of the need to mobilize off-duty personnel.
☐	Off-duty personnel will be notified of the request and provided with instructions including: ▪ Time and location to report ▪ Assigned duties ▪ Safety information ▪ Resources to support self-sufficiency (e.g., water, flashlight)
☐	Once mobilized, off-duty staff will report for duty as directed.

☐	If staff are not needed immediately, staff will be requested to remain available by phone.
☐	To mobilize additional off-duty staff, the facility may need to provide additional staff support services (e.g., childcare, respite care, pet care). These services help to incentivize staff to remain on site during the incident, but also need to be carefully managed (e.g., reduce liability, manage expectations).
☐	Coordinate to provide transportation services (facility vehicles, Uber, taxi services, etc.) to staff members willing to report, but do not have a means of transportation.

Other Job Functions

In accordance with employment contracts, collective bargaining agreements, etc., an employee may be called upon to aid with work outside of job-prescribed duties, work in departments or carry out functions other than those normally assigned, and/or work hours in excess of (or different from) their normal schedule. Unless temporarily permitted by an Executive Order issued by the Governor under section 29-a of Executive Law, employees may not be asked to function out-of-scope of certified or licensed job responsibilities.

The Incident Management Team will request periodic updates on staffing levels (available and assigned). In addition to deploying clinical staff as needed for resident care activities, non-medical assignments from the labor pool may include:

- Security augmentation
- Runners / messengers
- Switchboard support
- Clerical or ancillary support
- Transportation/drivers
- Resident information, monitoring, and one-on-ones, as needed
- Preparing and/or serving meals, snacks, and hydration for residents, staff, visitors, and volunteers
- Cleaning and disinfecting areas, as needed
- Laundry services
- Recreational or entertainment activities
- Providing information, escorts, assistance, or other services to relatives and visitors
- Other tasks or assignments as needed within their skill set, training, and licensure/certification.

In accordance with employment contracts, collective bargaining agreements, etc., and at the determination of the Incident Commander, all or some staff members may be changed to 12-hour emergency shifts to maximize staffing. These shifts may be scheduled as around regular work hours, in six or 12-hour shifts, or as needed to meet facility emergency objectives.

Surge Staffing

If surge staffing is required—for example, staff has become overwhelmed—it may be necessary to implement surge staffing (e.g., TMG Float Pool, staffing agencies).

The facility may coordinate with pre-established credentialed volunteers included in the facility roster or credentialed volunteers associated with programs such as Community Emergency Response Team (CERT), Medical Reserve Corps (MRC), and ServNY.

The facility will utilize emergency staffing as needed and as identified and allowed under executive orders issued during a given hazard/emergency.

Emergency Power Systems

In the event of an electrical power disruption causing partial or complete loss of the facility's primary power source, the facility is responsible for providing alternate sources of energy for staff and residents (e.g., generator).

In accordance with the facility's plans, policies, and procedures, the facility will ensure provision of the following subsistence needs through the activation, operation, and maintenance of permanently attached onsite generators:

- Maintain temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;
- Emergency lighting;
- Fire detection and extinguishing, and alarm and life safety systems; and
- Sewage and waste disposal.

Onsite generators and associated equipment and supplies are located, installed, inspected, tested, and maintained in accordance with the National Fire Protection Association's (NFPA) codes and standards.

In extreme circumstances, incident-related damages may limit generator and fuel source accessibility, operability, or render them completely inoperable. In these instances, an urgent or planned evacuation will be considered if a replacement generator cannot be obtained in a timely manner.

Training and Exercises

To empower facility personnel and external stakeholders (e.g., emergency personnel) to implement plans, policies, and procedures during an incident, the facility will conduct the following training activities:

Table 9: Training

Activity	Led By	Frequency
Conduct comprehensive orientation to familiarize new staff members with the CEMP, including PEP specific plans, the facility layout, and emergency resources.	HR Manager Kenneth Ford and Director of Quality and Education Bobbi Humphrey	Orientation held on the first day of employment.
Incorporate into annual educational update training schedule to ensure that all staff are trained on the use of the CEMP, including PEP specific plans, and core preparedness concepts.	Director of Quality and Education – Bobbi Humphrey	Annually and as needed
Maintain records of staff completion of training.	Director of Quality and Education – Bobbi Humphrey	Ongoing
Ensure that residents are aware appropriately of the CEMP, including PEP specific plans, including what to expect of the facility before, during, and after an incident.	Facility Administrator – Danielle Reusch	Upon admission and minimally on an annual basis Repeat briefly at time of incident.
Identify specific training requirements for individuals serving in Incident Management Team positions.	Facility Administrator Danielle Reusch	Ongoing
Determine appropriate exercises and drills (based on HVA) to properly simulate emergency situations.	Facility Administrator Danielle Reusch	Ongoing

To validate plans, policies, procedures, and trainings, the facility will conduct the following exercise activities:

Table 10: Exercises

Activity	Led By	Frequency
Conduct, at minimum, one operations-based exercise (e.g., full-scale or functional exercise). The WNY Mutual Aid drill is completed annually, and will satisfy this requirement.	Facility Administrator Danielle Reusch	Annually

Activity	Led By	Frequency
Conduct, at minimum, one discussion-based exercise (e.g., tabletop exercise).	Facility Administrator Danielle Reusch	Annually

Documentation

In alignment with industry best practices for emergency preparedness, the facility will maintain documentation and evidence of course completion through the use of sign in sheets, NHICS Form 201 – Incident Briefing and Operational Log and After Action Reports. These forms will be used for all disaster drills as well as real time emergency situations.

After Action Reports

The facility will develop After Action Reports to document lessons learned from tabletop and full-scale exercises and real-world emergencies and to demonstrate that the facility has incorporated any necessary improvements or corrective actions.

After Action Reports will document what was supposed to happen; what occurred; what went well; what the facility can do differently or improve upon; and corrective action/improvement plan and associated timelines.

Infectious Disease/Pandemic Emergency

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

The following Infectious Disease/Pandemic Emergency Checklist outlines the hazard-specific preparedness, response, and recovery activities the facility should plan for that are unique to an incident involving infectious disease as well as those incidents that rise to the occasion of a pandemic emergency. The facility should indicate for each checklist item, how they plan to address that task.

The Local Health Department (LHD) of each New York State county, maintains prevention agenda priorities compiled from community health assessments. The checklist items noted in this Annex include the identified LHD priorities and focus areas. Nursing homes should use this information in conjunction with an internal risk assessment to create their plan and to set priorities, policies and procedures.

A summary of the key components of the PEP requirements for pandemic situations is as follows:

- development of a Communication Plan,

o development of protection plans against infection for staff, residents, and families, including the maintenance of a 2-month (60 day) supply of infection control personal protective equipment and supplies (including consideration of space for storage), and

o A plan for preserving a resident's place in and/or being readmitted to a residential health care facility or alternate care site if such resident is hospitalized, in accordance with all applicable laws and regulations.

Finally, any appendices and documents, such as regulations, executive orders, guidance, lists, contracts, etc. that the facility creates that pertain to the tasks in this Annex, and/or refers to in this Annex, should be attached to the corresponding Annex K of the CEMP Toolkit rather than attached here, so that this Annex remains a succinct plan of action.

Infectious Disease/Pandemic Emergency Checklist	
Preparedness Tasks for <u>all Infectious Disease Events</u>	
☐ Required	Provide staff education on infectious diseases (e.g., reporting requirements (see Annex K of the CEMP toolkit), exposure risks, symptoms, prevention, and infection control, correct use of personal protective equipment, regulations, including 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80), and Federal and State guidance/requirements Facility utilizes multiple different presentation methods for infectious disease education such as: • Face to face presentation • Video education • Webinars • Hands on training and observation • 1 on 1 teaching and mentoring
☐ Required	Develop/Review/Revise and Enforce existing infection prevention, control, and reporting policies. The TMG Best Practices Committee is charged with the management of all infection control related policies and procedures. All policies are reviewed on a regular basis and updated to reflect current industry standards, best practices and all regulatory requirements.
☐ Recommended	Conduct routine/ongoing, infectious disease surveillance that is adequate to identify background rates of infectious diseases and detect significant increases above those rates. This will allow for immediate identification when rates increase above these usual baseline levels. See Annex K
☐ Recommended	Develop/Review/Revise plan for staff testing/laboratory services See Annex K
☐ Required	Review and assure that there is, adequate facility staff access to communicable disease reporting tools and other outbreak specific reporting requirements on the Health Commerce System (e.g., Nosocomial Outbreak Reporting Application (NORA), HERDS surveys

	See Annex K
☐ Required	Develop/Review/Revise internal policies and procedures, to stock up on medications, environmental cleaning agents, and personal protective equipment as necessary. (Include facility's medical director, Director of Nursing, Infection Control Practitioner, safety officer, human resource director, local and state public health authorities, and others as appropriate in the process) See Annex K
☐ Recommended	Develop/Review/Revise administrative controls (e.g., visitor policies, employee absentee plans, staff wellness/symptoms monitoring, human resource issues for employee leave). See Annex K
☐ Required	Develop/Review/Revise environmental controls (e.g., areas for contaminated waste) See Annex K
☐ Required	Develop/Review/Revise vendor supply plan for re-supply of food, water, medications, other supplies, and sanitizing agents. The facility has executed agreements with local vendors to supply the following critical items in an emergency situation: • US Foods and Upstate Milk – food and water • ProCare – medication • Medline – medical supplies and equipment • Chudy Paper Co. – disinfection and cleaning supplies
☐ Required	Develop/Review/Revise facility plan to ensure that residents are isolated/cohorted and or transferred based on their infection status in accordance with applicable NYSDOH and Centers for Disease Control and Prevention (CDC) guidance See Annex K
☐ Recommended	Develop plans for cohorting, including using of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, and discontinuing any sharing of a bathroom with residents outside the cohort. See Annex K
☐ Recommended	Develop/Review/Revise a plan to ensure social distancing measures can be put into place where indicated See Annex K
☐ Recommended	Develop/Review/Revise a plan to recover/return to normal operations when, and as specified by, State and CDC guidance at the time of each specific infectious disease or pandemic event e.g., regarding how, when, which activities /procedures /restrictions may be eliminated, restored and the timing of when those changes may be executed. See Annex K – reopening plan.
Additional Preparedness Planning Tasks for <u>Pandemic Events</u>	
☐	***In accordance with PEP requirements,*** Develop/Review/Revise a Pandemic Communication Plan

Required	that includes all required elements of the PEP See Annex K
☐ Required	***In accordance with PEP requirements,*** Development/Review/Revise plans for protection of staff, residents and families against infection that includes all required elements of the PEP. See Annex K
Response Tasks for <u>all Infectious Disease Events</u>:	
☐ Recommended	The facility will implement the following procedures to obtain and maintain current guidance, signage, advisories from the NYSDOH and the U.S. Centers for Disease Control and Prevention (CDC) on disease-specific response actions, e.g., including management of residents and staff suspected or confirmed to have disease: See Annex K
☐ Required	The facility will assure it meets all reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYCRR 2.10 Part 2), as well as by 10 NYCRR 415.19. (See Annex K of the CEMP toolkit for reporting requirements). See Annex K
☐ Required	The facility will assure it meets all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting See Annex K
☐ Recommended	The Infection Control Practitioner will clearly post signs for cough etiquette, hand washing, and other hygiene measures in high visibility areas. Consider providing hand sanitizer and face/nose masks, if practical.
☐ Recommended	The facility will implement the following procedures to limit exposure between infected and non-infected persons and consider segregation of ill persons, in accordance with any applicable NYSDOH and CDC guidance, as well as with facility infection control and prevention program policies See Annex K
☐ Recommended	The facility will implement the following procedures to ensure that as much as is possible, separate staffing is provided to care for each infection status cohort, including surge staffing strategies: See Annex K
☐ Recommended	The facility will conduct cleaning/decontamination in response to the infectious disease in accordance with any applicable NYSDOH, EPA and CDC guidance, as well as with facility policy for cleaning and disinfecting of isolation rooms.
☐ Required	The facility will implement the following procedures to provide residents, relatives, and friends with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information. See Annex K
☐ Recommended	The facility will contact all staff, vendors, other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents This facility regularly communicates its policies regarding exposure risks to all critical vendors' i.e. medical suppliers, food suppliers, emergency building related contractors, providers, etc.
☐	Subject to any superseding New York State Executive Orders and/or NYSDOH guidance that may

Required	otherwise temporarily prohibit visitors, the facility will advise visitors to limit visits to reduce exposure risk to residents and staff. If necessary, and in accordance with applicable New York State Executive Orders and/or NYSDOH guidance, the facility will implement the following procedures 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: See Annex K
Additional Response Tasks for <u>Pandemic Events</u>:	
☐ Recommended	Ensure staff are using PPE properly (appropriate fit, don/doff, appropriate choice of PPE per procedures) See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will follow the following procedures to post a copy of the facility's PEP, in a form acceptable to the commissioner, on the facility's public website, and make available immediately upon request: The facility will have the properly formatted PEP posted on the organization's website no later than 9/15/20.
☐ Required	**In accordance with PEP requirements,** the facility will utilize the following methods to update authorized family members and guardians of infected residents (i.e., those infected with a pandemic-related infection) at least once per day and upon a change in a resident's condition: See Annex K
☐ Required	***In accordance with PEP requirements***, the facility will implement the following procedures/methods to ensure that all residents and authorized families and guardians are updated at least once a week on the number of pandemic-related infections and deaths at the facility, including residents with a pandemic-related infection who pass away for reasons other than such infection: See Annex K
☐ Required	***In accordance with PEP requirements***, the facility will implement the following mechanisms to provide all residents with no cost daily access to remote videoconference or equivalent communication methods with family members and guardians: See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following process/procedures to assure hospitalized residents will be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); and 42 CFR 483.15(e): See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following process to preserve a resident's place in a residential health care facility if such resident is hospitalized, in accordance with all applicable laws and regulations including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e): See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following planned procedures to maintain or contract to have at least a two-month (60-day) supply of personal protective equipment (including consideration of space for storage) <u>or any superseding</u>

	Requirements under New York State Executive Orders and/or NYSDOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic. As a minimum, all types of PPE found to be necessary in the COVID pandemic should be included in the 60-day stockpile. This includes, but is not limited to: – N95 respirators – Face shield – Eye protection – Gowns/isolation gowns – Gloves – Masks – Sanitizer and disinfectants (meeting EPA Guidance current at the time of the pandemic) See Annex K
Recovery for <u>all Infectious Disease Events</u>	
☐ Required	The facility will maintain review of, and implement procedures provided in NYSDOH and CDC recovery guidance that is issued at the time of each specific infectious disease or pandemic event, regarding how, when, which activities/procedures/restrictions may be eliminated, restored and the timing of when those changes may be executed. See Annex K
☐ Required	The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders See Annex K

Facility Overview

The facility overview provides an immediate reference sheet about each facility (or individual buildings within a facility's campus) for use when communicating with external parties during an emergency (e.g., law enforcement, fire department, emergency management officials).

LOCATION AND CONTACT INFORMATION	
Name of Facility	Harris Hill HCF
Address	2699 Wehrle Dr, Williamsville, NY 14221
Cross Streets	Transit and Harris Hill
Telephone	716-632-3700
Fax	716-632-5083
Email	n/a
Website	www.mcguiregroup.com
CONSTRUCTION	
Construction Type	Type 2 (NFPA 220) Non combustible
Year Building Constructed	1992 expansion 2006
Number of Floors (above/below grade)	1
Square Footage	+/-7,264 square feet

Facility Floor Plan

CAPACITY AND STAFFING	
Non-Traditional Surge Space	Resident lounges and dining areas
Number of Facility-Owned Vehicles (including accessible spots/seats)	3 vehicles – 18 passenger seats and 3 accessible spots
UTILITY AND SERVICE PROVIDERS	
Electric Provider	NYSEG
Local Water Provider	Erie County Water Authority
Telephone Provider	Verizon
Internet Service Provider	Spectrum
Generator Services	Penn Power
Propane	n/a
Plumbing	John W Danforth Company
Elevator	n/a
HVAC Equipment	Tri R Mechanical Services
Fire Equipment/Sprinklers	Great Lakes Building Systems

See form NHICS FORM 258 | FACILITY RESOURCE DIRECTORY for updated contact numbers for above service providers.

Hazard Vulnerability Assessment

HVA Tools

The Centers for Medicare and Medicaid Services (CMS) requires healthcare facilities to conduct annual facility-specific risk assessments to identify and assess potential hazards and their impacts. HVAs are used to estimate the hazards (and associated risks) that are most likely to occur and/or may affect a facility's ability to maintain operations and services. The results of the analysis can be used to prioritize planning, mitigation, response, and recovery projects and initiatives.

HVA Process

The following outlines the process and recommendations for conducting a facility-specific HVA:

Convene Staff with Facility-Specific Knowledge

Conducting an HVA requires an in-depth knowledge of facility preparedness and response capabilities. In addition, understanding the capabilities of response partners is another important piece of completing an HVA. As a result, staff possessing this knowledge should be involved in the HVA process, including:

- Facility Senior Leader
- Lead Clinical Staff
- Head of Administration/Finance
- Communications Staff
- Environmental Services/Plant Operations Leadership

Completing the HVA can be done by a single knowledgeable staff member or as a collaborative process with multiple staff members. For example, multiple staff members can complete an individual HVA, then they can be compared to validate each assessment and a consensus can be reached using the variety of assessments.

Identify Facility-Specific Hazards

In order to complete an HVA, staff must know the hazards which might affect their facility. The list of hazards can be developed through a variety of means, including:

- Historical knowledge of hazards
- Subjective predictions of hazards
- Using predetermined hazards in HVA tools
- Using local emergency plans to determine hazards (also known as a "community-based assessment"). Examples of these plans, which can be obtained from your Local Office of Emergency Management, include:
  - Hazard Mitigation Plans
  - Emergency Operations Plans
  - Threat and Hazard Identification and Risk Assessment

Assess Hazards

The risk each hazard poses to the facility is determined through a variety of factors. The table below presents each factor and the considerations to make when evaluating them.

Table 3: HVA Considerations

Hazard Factor	Considerations
Probability	▪ Current local and regional plans ▪ Manufacturer/vendor statistics ▪ Subjective evaluations or best estimate
Human Impact	▪ Potential for staff, resident, or visitor injury or death ▪ Emotional or psychological impact ▪ Local cultural norms
Property Impact	▪ Cost to replace ▪ Cost to set up temporary replacement ▪ Cost to repair ▪ Time to recover
Business Impact	▪ Business interruption ▪ Staff unable to report to work ▪ Violation of contractual agreements, regulatory standards ▪ Interruption of critical supplies ▪ Reputation and public image ▪ Financial impact or burden
Preparedness	▪ Status of current plans ▪ Staff training completion status ▪ Availability of alternate sources for critical resources
Internal Response	▪ Emergency resource levels ▪ Durability/longevity of resources (without replenishment) ▪ Internal resources ability to withstand disasters ▪ Availability of backup systems
External Response	▪ Types of agreements with community agencies ▪ Relationship with local and state agencies ▪ Relationship with local healthcare facilities ▪ Relationship with community volunteers ▪ Vendor pre-incident response plans and contracts

Facility Profile and Building Features

Single Story Type II Non Combustible

Built in 1992. Expansion in 2006

74,264 sq. feet

Natural Gas

Heat; electric baseboard heaters inside resident rooms.

Natural gas fed boilers with roof top air handlers for hallways.

700 gallon hot water tanks on site

Cooling; Roof top A/C units that feed common hallways

Pharmacy

Resident Population*

Licensed for 192 beds

Long term care units

Subacute and orthopedic rehabilitation and recovery, hip, knee, pulmonary, post-surgical and wound care therapies, physical and occupational therapy, pain management, intravenous antibiotics, electrical stimulation for wound healing, and bariatric care

* see facility assessment for full description of resident population.

Generator

80 kw Onan Generator; Natural Gas located outside facility

Tested / Inspected weekly

Powers red outlets, every other light in common hallway, air handler hear in hallways only, Refrigerator and freezer in kitchen

Powers only certain rooftop air handling units.

A/C in selected areas when on emergency power

Stop Over Point

Evacuation Site

Sister Facilities located within the McGuire group

HAZARD AND VULNERABILITY ASSESSMENT TOOL
NATURALLY OCCURRING EVENTS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPAREDNESS/DRILLS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Tornado	2	3	3	3	2	2	1	**52%**
Severe Thunderstorm	3	1	1	1	1	1	1	**33%**
Snow Fall	3	1	1	1	1	1	1	**33%**
Blizzard	3	1	1	2	1	1	1	**39%**
Ice Storm	3	1	1	2	1	1	1	**39%**
Earthquake	1	2	3	3	2	1	1	**22%**
Heat/Humidity	3	2	1	1	1	1	1	**39%**
Drought	2	1	1	1	1	1	1	**22%**
lood, External	1	1	1	2	1	1	1	**13%**
Wild Fire	1	1	1	1	1	1	1	**11%**
Landslide	0							**0%**
Hurricane	1	1	1	1	1	1	1	**11%**
Subsidence	0							**0%**
Epidemic	1	1	0	3	2	1	1	**15%**
ERAGE SCORE	**1.50**	**1.00**	**0.94**	**1.31**	**0.94**	**0.81**	**0.75**	**16%**

RISK = PROBABILITY * SEVERITY		
0.16	**0.50**	**0.32**

reat increases with percentage.

HAZARD AND VULNERABILITY ASSESSMENT TOOL
TECHNOLOG EVENTS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
ctrical Failure	3	1	0	1	1	1	1	**28%**
erator Failure	1	3	2	3	2	1	1	**22%**
portation Failure	2	1	0	2	1	1	1	**22%**
ater Shortage	2	2	1	2	1	1	2	**33%**
unications Failure	2	1	0	1	1	1	1	**19%**
mation Systems Failure	2	1	0	2	2	2	1	**30%**
ire, Internal	3	3	3	3	1	1	1	**67%**
ood, Internal	3	1	1	2	1	1	1	**39%**
mat Exposure, Internal	1	2	1	3	1	2	1	**19%**
pply Shortage	1	2	0	2	1	1	1	**13%**
ral Gas Failure	1	1	1	3	2	2	2	**20%**
RAGE SCORE	**1.11**	**0.95**	**0.47**	**1.26**	**0.74**	**0.74**	**0.68**	**10%**

RISK = PROBABILITY * SEVERITY		
0.10	**0.37**	**0.27**

t increases with percentage.

HAZARD AND VULNERABILITY ASSESSMENT TOOL
HUMAN RELATED EVENTS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Flu / Facilitywide Illness	3	3	0	2	1	1	1	**44%**
Terrorism, Biological	1	3	2	3	2	2	1	**24%**
VIP Situation	1	1	0	1	3	2	1	**15%**
Hostage Situation, Person w/Weapon, Active Shooter	3	3	1	3	2	2	2	**72%**
Civil Disturbance	1	1	0	1	2	2	2	**15%**
Labor Action	1	2	0	3	2	2	2	**20%**
Missing Resident	3	3	0	2	2	1	1	**50%**
Bomb Threat	2	2	2	2	2	2	1	**41%**
AVERAGE	**1.50**	**1.80**	**0.50**	**1.70**	**1.60**	**1.40**	**1.10**	**25%**

RISK = PROBABILITY * SEVERITY
0.25 0.50 0.50

Threat increases with percentage.

HAZARD AND VULNERABILITY ASSESSMENT TOOL
EVENTS INVOLVING HAZARDOUS MATERIALS

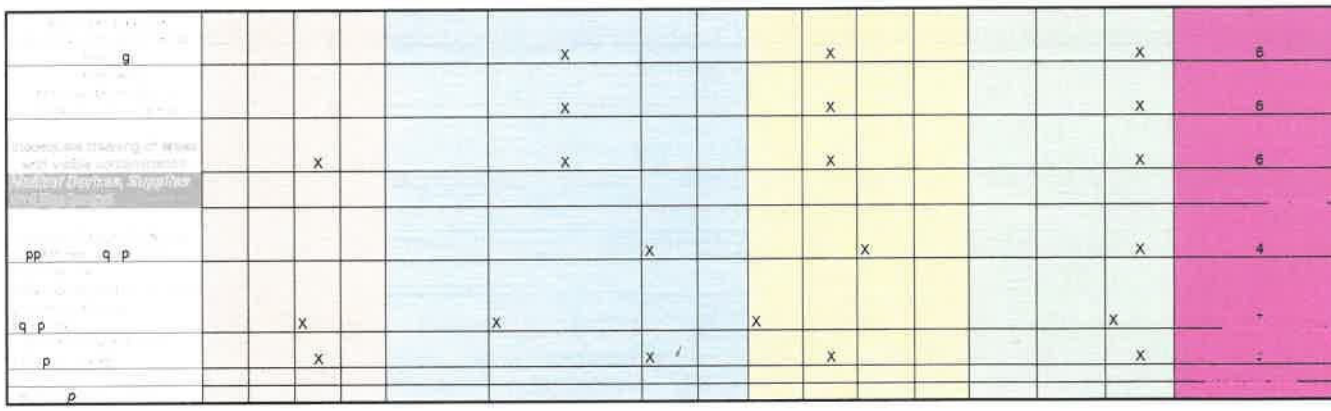
EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, effectivness, resouces*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Hazmat Incident *(From historic events at your LTC with >= 5 victims)*	1	3	1	3	1	2	1	**20%**
Small Casualty Hazmat Incident *(From historic events at your LTC with < 5 victims)*	1	3	1	2	1	2	1	**19%**
Chemical Exposure	2	2	1	2	1	2	1	**33%**
Terrorism, Chemical	1	3	1	3	2	2	2	**24%**
Radiologic Exposure, External	1	3	1	3	2	2	2	**24%**
Terrorism, Radiologic	1	3	1	3	2	2	2	**24%**
AVERAGE	**0.78**	**1.89**	**0.67**	**1.78**	**1.00**	**1.33**	**1.00**	**11%**

RISK = PROBABILITY * SEVERITY		
0.11	**0.26**	**0.43**

**Threat increases with percentage.*

Name of Facility
Infection Prevention and Control
Risk Assessment

EVENT	PROBABILITY OF OCCURRENCE (How likely is this to occur)				RISK LEVEL OF FAILURE (What would be the most likely)				POTENTIAL CHANGE IN CARE (Will treatment/care be needed for resident/staff)				PREPAREDNESS (Are processes in place and can they work)			RISK LEVEL (score of 8 or >are considere highest priority for improvement efforts
Score	High	Med	Low	None	Life Threatening	Permanent Harm	Temp Harm	None	High	Med	Low	None	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
						External Factors (Community, Demographics)										
Risk of TB in the community			X		X				X						X	8
Identify other risk factors in the community based on geographic location (coast, mountains etc.																
						Internal Factors (Facility Related)										
Facility Associated Infection(s)																
Symptomatic urinary tract infection (SUTI)		X					X		X						X	7
Influenza like illness		X					X		X						X	7
Pneumonia		X					X		X						X	7
LRTI (bronchitis)		X					X		X						X	7
Cellulitis/soft tissue infection		X					X		X						X	7
Scabies			X				X		X						X	6
Gastroenteritis		X					X		X						X	7
Norovirus		X					X		X						X	7
Clostridium difficile			X				X		X						X	6
CoronaVirus	X				X				X					X		11
Conjunctivitis			X				X		X						X	6
Antibiotic Stewardship																
Lack of leadership support for antibiotic stewardship				X			X				X				X	3
Inadequate written policies for stewardship				X			X				X				X	3
Unable to determine antibiotic usage report from pharmacy			X				X				X				X	4
Unable to retrieve report summarizing antibiotic resistance patterns (antibiogram)			X				X				X				X	4
Exposure Related																
Lack of accessible hand sanitizer/PPE	X				X					X					X	9
Non-compliance with hand hygiene			X				X			X					X	5
No written plan to manage outbreaks				X	X					X					X	6
Inadequate compliance with Standard Precautions			X			X				X					X	6
Inadequate compliance with Contact Precautions			X			X				X					X	6
Inadequate compliance with Respiratory Hygiene/Cough Etiquette			X			X				X					X	6
Inadequate compliance with injection safety			X			X				X					X	6
Inadequate utilization of engineering controls to remove exposure from work activity			X			X				X					X	6
Healthcare personnel																
Lack of compliance with influenza immunization			X				X			X					X	5
Lack of notification or employee with illness/disease				X			X	X		X					X	5
Non-compliance with annual TB screening			X		X				X						X	6
Non compliance with mandatory education			X				X			X					X	5
Resident/Family																
Lack of TB screening for resident at time of admission			X		X				X						X	8
Lack of compliance with influenza immunization			X				X			X					X	5
Lack of compliance with pneumococcal vaccine			X				X			X					X	5
Lack of resident compliance with personal hygiene		X					X				X			X		6
Lack of family compliance with facility policies		X					X			X				X		7
Inadequate resident/family education			X				X				X			X		5
Environment																
Inadequate cleaning and disinfection of resident room			X			X				X					X	6



The Incident Command System (ICS) is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in domestic incident management activities. It is used for a broad spectrum of emergencies, from small to complex incidents, both natural and manmade, including acts of catastrophic terrorism. **ICS is organized around five major functional areas: command, operations, planning, logistics, and finance/administration.**

An ICS enables integrated communication and planning by establishing a manageable span of control. An ICS divides an emergency response into five manageable functions essential for emergency response operations: Command, Operations, Planning, Logistics, and Finance/Administration. The figure below shows a typical ICS structure.

A disaster scenario can affect a nursing home at any time. It is, therefore, important for all facilities to be prepared to handle a variety of different types and severity levels of emergencies. An ICS allows a facility to have the flexibility to adapt to any type of emergency, and gives personnel the ability to manage operations during that emergency regardless of the type or severity level. The Nursing Home Incident Command System (NHICS) was developed specifically to address the many unique challenges faced by nursing home personnel during a potential disaster situation. The NHICS utilizes the nationally accepted NIMS framework to address situation/issues that arise during an emergency at a Nursing Home. The goals in developing a Nursing Home Incident Command System (NHICS) include the following:

- Customization of a well-developed and tested incident management system for use by non-traditional health care partners
- Incorporation of assets and resources of the nursing home community into all-hazard emergency management
- Development of nursing-home-specific planning and response tools for emergency management
- Introduction to and utilization of incident action planning for nursing homes
- Development and implementation guidance for use of an incident management system that promotes collaboration and interoperability

NHICS is designed to help avoid the following issues related to mismanagement of emergent situations:

- Inadequate communication because of conflicting terminology or inefficient or improper use of technology

- Lack of a standardized management structure that would allow integration, command and control, and workload efficiency
- Lack of personnel accountability
- Lack of a systematic planning process

NHICS is designed to meet these challenges by:

- Being effectual in managing all emergency, routine, or planned events, of any size or type, and by establishing a clear chain of command
- Allowing personnel from different agencies or departments to be integrated into a common structure that can effectively address issues and delegate responsibilities
- Provide needed logistical and administrative support to operational personnel
- Ensure key functions are covered and eliminate duplication

The fundamental features of the ICS include:

1. Common terminology/clear text

The use of common terminology provides for a clear message and sharing of information. It avoids the use of codes, slang, or discipline- specific nomenclature that may not be clearly understood by all planning and response partners. A common terminology helps to define the common organizational structure: as an example, the identification of sections, section chiefs, and branch directors. Another key benefit of common terminology is the ability to share resources in the response, such as personnel to oversee incident management or operations. By using consistent terminology, the opportunity to develop memorandums or agreements to share personnel is enhanced.

2. Modular organization

The ICS structure begins from the top and expands as needed by the event. Positions within the structure are activated as dictated by the incident size or complexity. As complexity increases, the ICS organization expands. Only those functions or positions necessary for an incident are activated.

3. Management by objectives

The Incident Commander initiates the response and sets the overall command and control objectives. The mission of the response is defined for all members of the response team through a clear understanding of the organization's policy and direction. This includes an assessment of the incident from the current situation to projected impacts. To meet the overall mission, or command objectives, individual sections will establish incident objectives as well as the strategies to achieve these objectives through clear tactics. Because emergency response is not "business as usual," clearly defined objectives will allow staff to focus on the roles in the response, avoiding duplication of efforts or omission of critical actions.

4. Incident Action Planning

The development of objectives is documented in the Incident Action Plan (IAP). A written plan provides personnel with direction for taking actions based on the objectives identified in the IAP and reflects the overall strategy for incident management while providing measurable strategic operations

for the operational period. To ease this process, ICS forms are designed and developed for nursing homes and are contained within the NHICS guidebook.

5. Manageable span of control

A key concept in ICS is maintaining a span of control that is both effective and manageable. Because emergency events are not business as usual situations, the span of control for operations that are not routine should be kept at an effective number. Within ICS, the optimum span of control is one supervisor to five reporting personnel. If the number falls outside these ratios, the incident management team should be expanded or consolidated.

6. Pre-designated incident locations/facilities

In the planning stages, planners should determine the location of their response and coordination sites, including the coordination and command sites. Within ICS, sites are identified for both scene and regional coordination, such as staging areas, command posts, triage locations and emergency operations centers. Planners within the nursing home or long-term care facility should identify sites for ICS management, staging areas for receipt of supplies and equipment, evacuation sites if the infrastructure is unsafe, and so on.

7. Resource management

Resources used in the response are categorized as *tactical* and *support*. Tactical resources include personnel and major equipment available or potentially available for use in the response. Support resources are all other resources to support the incident, including food, equipment, communications, supplies, vehicles, etc. It is critical in the response to understand the availability and status of both tactical and support resources. It is important to have a clear picture of current and needed resources when working within the medical mutual aid system in the jurisdiction of state, allowing those providing the response support to provide the necessary assets through a clear understanding of current capability.

8. Integrated communications

There are three elements within integrated communications: modes, plans and networks. The modes include the hardware systems that transfer information, such as radios, facility owned cell phones, and pagers. Plans should be developed in advance on how to best use the available modes through a clear and concise communication policy and plans (for example, determining who can use radios and what information should be communicated). The networks identified within the jurisdiction will determine the procedures and processes for transferring information internally and externally.

9. Common command structure

The ICS provides for a common command structure that identifies core principles for an efficient chain of command. *Unity of Command* dictates that each person within the response structure reports to only one supervisor. A *single command* exists when a single agency or discipline responds to an event; for example, the fire service at a warehouse fire is commanded by a fire captain or chief. When multiple agencies or disciplines are working together at a scene, there is a *unified command* structure that allows for coordination in response actions. For nursing homes, this may occur when the facility is the scene of

the incident, such as a fire. The nursing home administration and the fire command work together in a unified command structure.

Incident Management Team

Incident Management Functions

It is important to understand that ICS is a management system-not an organizational chart. It is predicated on a number of principal tenets:

- Every incident or event requires that certain management functions be performed. The problem encountered is evaluated, a plan to remedy the problem is identified and implemented, and the necessary resources assigned. Management by Objectives (MBO) is thus a critically important component to the successful implementation of an incident command system and involves the inclusion of both control and operational period objectives.
- The ICS organization frequently does not correlate to the daily administrative structure of the agency or nursing home. This practice is purposeful and done to reduce role and title confusion. Those positions activated in the response come together to serve as the **Incident Management Team (IMT),** whose purpose is to respond to and recover from the event through coordinated objectives and tactics.
- Position titles within the IMT should remain unchanged; this promotes interoperability between response partners, allowing for sharing of personnel resources among organizations.
- The IMT structure consists of the command, general, branch and unit staff, with sections clearly identified by the roles and responsibilities they carry out.
- The **Incident Commander** is the only position always activated in an incident regardless of its nature. In addition to Command, which sets the objectives, devises strategies and priorities, and maintains overall responsibility for managing the incident, there are four other management functions.
- **Operations** conducts the tactical operations (e.g., resident services, clean-up) to carry out the plan using defined objectives and directing all needed resources.
- **Planning** collects and evaluates information for decision support, maintains resource status information, prepares documents such as the Incident Action Plan, and maintains documentation for incident reports.
- **Logistics** provides support, resources, and other essential services to meet the operational objectives set by Incident Commander.
- **Finance** monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

In traditional Incident Command, there are five sections: Command, Operations, Planning, Logistics, and Finance. The Incident Commander Position is the only one that is always activated in an emergency and in small scale incidents, the Incident Commander may be able to accomplish all five management functions without the activation of additional positions. On larger incidents effective management may require that the Incident Commander establish one or more of the four other functions and appoint Section Chiefs with the overall goal to maintain the span of control and meet the needs of the facility based on the available resources. An important feature of the incident command system is its scalability. NHICS positions are assigned to personnel as indicated by the situation, and may be activated or deactivated as the incident unfolds and the needs change or become more clearly defined.

Building the IMT

The development of the IMT is based on the essential elements of ICS. The system is scalable and flexible, and uses a modular organization to respond to the event. As previously stated, **the Incident Commander is the only position that is always activated.** Activating additional positions is considered when the event duration increases, when situational information provides insight on the possible impact to the facility and when the span of control is exceeded. Management tools have been developed to help determine the need for activating additional positions; these tools (Job Action Sheets, Forms, and Incident Response Guides) should be customized by individual facilities based on their staffing and possible response actions.

**Position titles within the IMT define the role and the tasks assigned to that role. Titles identify the hierarchy within the chain of command. Job Action Sheets break down the roles and responsibilities of each position title.

These titles include:

Commander: there is only one commander position during the incident response, this being the Incident Commander.

Officers: officers are part of the command section. In NHICS, the officer roles are the Liaison Officer, Public Information Officer, Medical Director/Specialist and Safety Officer. Each of these positions report directly to the Incident Commander.

Chiefs: oversight for the section is provided by a Section Chief.

Directors: branches may be activated under the sections to maintain the chain of command and provide specific duties and actions as identified by the position title. For example, within the Operations Section, there is a Resident Services Branch and an Infrastructure Branch, with oversight provided by Directors.

Leaders: units may be activated within a branch when there is a specialized but complex set of duties that relate to a specific assignment. The person assuming responsibility for a Unit is a Leader.

***Not all of the ICS positions need to be active in each incident. The ICS structure is meant to expand and contract as the scope of the incident requires. For small-scale incidents, only the incident commander may be assigned. Command of an incident would likely transfer to the senior on-scene officer of the responding public agency when emergency services arrive on the scene. Command transfers back to the facility when the public agency depart.*

NHICS Incident Management Team:

Command

The **Incident Commander** is the only position that is always activated. The Incident Commander activates and directs the response through the development of command objectives to direct the response. In many cases, the Incident Commander may be the only position that is activated. A critical responsibility of the Incident Commander is the decision to evacuate the facility. Based on the incident hazard that causes evacuation, this can be a difficult decision and is based on overall situational information, the projected impact, the threat to life and property, and the capability for safe evacuation.

The Incident Commander (IC) is responsible for all aspects of the response, including developing incident objectives and managing all incident operations.
Unless specifically assigned to another member of the Command or General Staffs, these responsibilities remain with the IC. Some of the more complex responsibilities include:

- Assess the situation
- Establish immediate priorities especially related to the safety of residents, emergency responders and any other individuals affected by the incident in question.
- In charge of the organization's on-scene response
- Stabilize the incident by ensuring life safety and managing resources efficiently and cost effectively.
- Determine the incident objectives and strategy; identify information needed or required by others; ensure planning/strategy meetings are held and attend as needed
- Determine incident objectives and strategy to achieve those objectives.
- Establish and monitor incident organization.
- Approve the implementation of the written (or verbal) Incident Action Plan (IAP).
- Ensure adequate health and safety measures are in place at all times.
- Maintain command until public agencies arrive and assume command or when relieved at start of next operational period
- Order warning of persons at risk or potentially at risk to take appropriate protective actions
- Notify or verify internal teams, departments, public agencies, regulators, contractors and suppliers have been notified
- Appoint others to incident command positions as needed
- Brief staff on current organization and activities; assign tasks; schedule planning meeting
- Coordinate activities with the EOC; identify priorities and activities; provide impact assessment for business continuity, crisis communications and management
- Review requests for resources; confirm who has authority to approve procurement; approve all requests for resources as required
- Provide information to and coordinate with crisis communications or media relations team
- Terminate the response and demobilize resources when the situation has been stabilized

Safety Officer

The **Safety Officer** within the Command Staff is responsible for overall safety of the response actions, modifying or suspending operations if the conditions are unsafe to continue. Example: the facility may be forced to evacuate all or part of the building due to an imminent roof collapse. The Safety Officer should evaluate the site where residents are moved to, ensuring that this location as well as the route to the new location is free of hazards.

The Safety Officer's role is also to develop and recommend measures to the IC for assuring resident/personnel health and safety and to assess and/or anticipate hazardous and unsafe situations. The Safety Officer also develops the Site Safety Plan, reviews the Incident Action Plan for safety implications, and provides timely, complete, specific, and accurate assessment of hazards and required controls.

Key Responsibilities:

- Identify and assess hazardous situations; prevent accidents
- Prepare safety plan; ensure messages are communicated
- Stop unsafe acts; correct unsafe conditions

Liaison Officer

The **Liaison Officer** serves as the link for the facility with external partners, and to serve as the point of contact for assisting and coordinating activities between the IC and various outside agencies and groups. This position provides information to external response agencies such as NYDOH, emergency management officials, first responders, and other agencies as identified by the facility during planning and response.

Key Responsibilities:

- Point of contact with outside agencies and companies
- Monitors operations to identify inter-organizational problems

Information Officer's

The **Information Officer's** role is to develop and release information about the incident to the news media, incident personnel, and other appropriate agencies and organizations.

Key Responsibilities:

- Notify spokespersons and Crisis Communications Team
- Develop information for use in media briefings
- Obtain IC's and management approval for all news releases
- Conduct periodic media briefings
- Arrange for tours, interviews and or briefings
- Monitor and forward useful information to the media

Medical Director

The **Medical Director** is the person with specific expertise in clinical areas such as infectious disease, trauma management, and medical ethics who may be asked to provide the Incident Command staff with needed advice and coordination assistance. This role may be filled by persons outside of the facility but ideally will be filled by the facility's Medical Director who has familiarity with the resident population, and the disaster plan for the facility. The **Medical Director** reports to the Incident Commander; however, in actual event, this specialist may work directly with operations personnel providing advice or guidance in the clinical response activities.

NHICS Incident Management Team: Operations

Many incidents that occur involve altered conditions of care for the residents. There could be environmental changes such as loss of power and/or poor air quality that will require emergency measures to protect residents from harm. There also could be injured or ill residents and staff who will require first aid and/or an environment that needs immediate cleaning or repair. These critical actions become the responsibility of the Operations Section who will be responsible for managing the tactical objectives outlined by the Incident Commander.

The Operations Section is responsible for managing tactical operations at the incident site directed toward reducing the immediate hazard, saving lives and property, establishing situation control, and restoring normal conditions. Incidents can include acts of terrorism, severe winter weather, wild land and urban fires, floods, hazardous material spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other incidents requiring an emergency response.

Because of its functional unit management structure, the ICS is applicable across a spectrum of incidents differing in size, scope, and complexity. The types of agencies that could be included in the Operations Section include fire, law enforcement, public health, public works, and emergency services, working together as a unit or in combinations, depending on the situation. Many incidents may involve private individuals, companies, or nongovernmental organizations, some of which may be fully trained and qualified to participate as partners in the Operations Section.

Incident operations can be organized and executed in many ways. The specific method selected will depend on the type of incident, agencies involved, and objectives and strategies of the incident management effort. The ICS offers extensive flexibility in determining the appropriate approach using the factors described above.

Operations Key Responsibilities:

- Manage all tactical operations during the incident
- Assist in the development of the operations portion of the Incident Action Plan
- Ensure safe tactical operations for all responders (in conjunction with any assigned Safety Officer)
- Request additional resources to support tactical operations
- Expedite appropriate changes in the operations portion of the Incident Action Plan
- Maintain close communication with the Incident Commander

The **Operations Section** staff are responsible for all operations directly applicable to the primary mission of the incident response. Operations staff typically consists of nine positions. Oversight of this Section is by a Chief. Additional positions include a Resident Services Branch Director, and an Infrastructure Branch Director. Under these two branches, the unit positions of Nursing, Psychosocial, Admit/Transfer & Discharge, Dietary, Environmental, and Physical Plant/Security may be activated depending on the situation.

The **Operations Section Chief** oversees all tactical operations carried out within the response and implements the IAP. He/she will activate the additional positions based on the needs of the event, as well as the availability of qualified personnel to fill the positions. If a position is needed but there is

insufficient staffing to fill that position, the functions of that position are assumed by the highest position activated in that section.

The **Resident Services Branch Director** is responsible for the continuation of resident services as well as the provision of care to residents, staff and visitors who are injured or become ill due to the incident. The **Resident Services Branch Director** may assign staff to ensure continuation of resident services, including rehabilitation and clinical services as provided by the facility. The Resident Services Branch Director must also ensure that residents are accounted for and tracked, and that services needed to sustain operations are identified and provided.

The **Infrastructure Branch Director** is responsible for the continuation of those services that support the care in the facility including dietary, housekeeping, power, lighting, water, sewage, and other essential services. The **Infrastructure Branch Director** may also be required to assess the structural soundness of the facility in the event of an assault on the building such as from an earthquake, tornado, or fire, and then advise the Operations Section Chief on the capacity of the structure to sustain occupancy.

The **Physical Plant/Security Unit Leader** under the Infrastructure Branch is responsible for ensuring that the nursing home and the surrounding grounds are secure during the response. This may include traffic control as well as lock- down of the facility due to security threats, structural damage or infectious disease outbreaks. Planning should address the use of facility personnel to perform this role but also the integration of local law enforcement and/or private security firms if needed.

Within these established positions in the IMT, staff in day-to-day positions may continue their tasks and actions, reporting their status to the applicable branches. For example: the facility housekeeper(s) may report observed damages after a flood to the Infrastructure Branch Director. Those personnel who provide resident services, such as physical or occupational therapy, may report their status to the Resident Services Branch Director.

NHICS Incident Management Team: Planning

When sufficient staff are available, and when the impact of the event is sustained, the **Planning Section** or “thinkers” may be activated. The role of the Planning Section within the NHICS Incident Management Team is to gather and validate information from both internal and external sources. The **Planning Section** must also gather, analyze, and track situational response data, providing up-to-date and accurate information regarding residents, staff, supplies, and equipment and other resources, and projecting the ability to sustain operations based on the current and future status. This section consists of three positions: The Planning Section Chief, Situation Unit Leader and Documentation Unit Leader.

The Planning Section is responsible for collecting, evaluating, and disseminating tactical information pertaining to the incident. This section maintains information and intelligence on the current and forecasted situation, as well as the status of resources assigned to the incident. The Planning Section prepares and documents IAPs and incident maps and gathers and disseminates information and intelligence critical to the incident. The Planning Section may include a number of technical specialists to assist in evaluating the situation and forecasting requirements for additional personnel and equipment.

Planning Section Key Responsibilities:

- Conduct and facilitate planning meetings

- Supervise preparation of the Incident Action Plan
- Determine need for technical experts from within the company or outside as well as specialized resources to support the incident
- Coordinate with business continuity and senior management teams
- Assemble information on alternative strategies and plans
- Assess current and potential impacts on people, property, environment
- Compile and display incident status information

The **Planning Section Chief** oversees the section and determines the need for activation of the **Situation Unit** and **Documentation Unit**. As outlined in NIMS, the Planning Section will "collect, evaluate, and disseminate incident situation information and intelligence to Incident Command." They will also be responsible for preparing status reports, displaying various types of information, and developing the Incident Action Plan (IAP). The effectiveness of the Planning Section has a direct impact on the availability of information needed for the critical, strategic decision-making done by the Incident Commander and the other General Staff positions.

The **Situation Unit Leader** will be responsible for writing and maintaining incident updates based on internal and external events, including those related to patient tracking and bed tracking. The status of supplies and equipment, both those available and in use for the response will be tracked by the Situation Unit Leader.

Multiple types of information should be documented during an incident. This information may originate from the incident scene, in one of the nursing home's operating service areas, or from the (facility) Command Center. The Planning Section will take the lead in coordinating documentation efforts. The role of the **Documentation Unit Leader** is to work with other members of the incident management team to document the incident. They also are responsible for archiving the documents created during the response.

Multiple methods of documentation will likely be used during an incident. Written documentation will be the primary method of information recording. Each Incident Management Team position is tasked with maintaining their own log of issues, actions, and outcomes.

NHICS Incident Management Team: Logistics

The Logistics Section is considered the "getters" for the response. Logistics provides the necessary services and support to sustain operations during the emergency response. This section identifies and inventories current resources including supplies, equipment, and personnel, and obtains those additional items needed to support operations.

The Logistics Section meets all support needs for the incident, including ordering resources through appropriate procurement authorities from off-incident locations. It also provides facilities, transportation, supplies, equipment maintenance and fueling, food service, communications, and medical services for incident personnel. The Logistics Section is led by a Section Chief, who may also have a deputy. Having a deputy is encouraged when all designated units are established at an incident site. When the incident is

very large or requires a number of facilities with large numbers of equipment, the Logistics Section can be divided into two branches.

The Logistics Team consists of eight positions including the Chief, the Service and Support Branch Directors, and the Communication/Hardware, IT/IS, Supply, Staffing/Scheduling, and Transportation Units. This section's responsibilities include personnel/manpower, supplies, equipment, pharmaceuticals, and vehicles. The Logistics Section works closely with the Operations Section, responding to supply requests and their acquisition based on the needs of the response. During pre-event planning, a staging area (or areas) should be established and identified in the Emergency Operations Plan (EOP). The staging area will be a central location, large enough to allow for the collection of personnel, vehicles, and equipment/supplies needed in the response. The Logistics Section Chief, with the assistance of the Support Branch Director provides oversight and direction at the staging area(s), maintaining an inventory of those supplies.

The **Logistics Section Chief** oversees the provision of services and support to sustain current operations and the operational response to the incident.

There are two branches within the **Logistics Section:** Service and Support.

The **Service Branch** will ensure the preservation of those essential services; of communications and information technology. Under the Service Branch Director, the Communications and IT/IS Unit Leaders may be activated to assist with this function. The Logistics Section **Support Branch** organizes and maintains the facility's supplies, equipment, transportation and labor pool in support of the residents, staff, and staff dependents in accordance with facility policy. The Support Branch must also account for those resources used and requested for operations. Under the Support Branch Director, the Supply, Staffing/Scheduling, and Transportation Unit Leaders may be activated to assist with this function.

Pre-incident planning should identify critical items that may be needed for various responses based on annual completion of a Hazard Vulnerability Analysis. The on-hand inventory documentation should be kept current and readily available for use when needed.

During a response, needed items that are not "in-house" may be obtained from off the shelf stores or through standard ordering procedures, emergency procurement contracts, mutual aid agreements between facilities, corporate support, and/or requests to the local Emergency Operations Center – Emergency Support Function #8-Health and Medica

Key Logistics Section Responsibilities:

- Provides resources to stabilize the incident and support personnel, systems and equipment:
- Workspace or facilities for incident management staff
- Media briefing center
- Transportation
- Communications equipment
- Food, water, shelter and medical care
- Ensures Incident Command Post and other facilities have been established as needed
- Assesses communications needs and facilitates communications between teams/personnel/agencies

- Attends planning meetings; provides input to Incident Action Plan
- Provides updates on resources (availability, response time, deployment)
- Estimates and procures resources for the next operational period

NHICS Incident Management Team: Finance/Administration

When there is a specific need for financial, reimbursement (individual and agency or department), and/or administrative services to support incident management activities, a Finance/Administration Section is established. Under the ICS, not all agencies will require such assistance. In large, complex scenarios involving significant funding originating from multiple sources, the Finance/Administrative Section is an essential part of the ICS. The Finance/Administration Section must also account for lost revenue associated with the response and recovery and ensure thorough investigation and documentation of incident-related claims.

The **Finance/Administration Section Chief** oversees the costs and expenditures incurred by the response actions, including the purchasing of supplies and equipment. In addition to monitoring multiple sources of funds, the Section Chief must track and report to the IC the financial "burn rate" as the incident progresses. This allows the IC to forecast the need for additional funds before operations are affected negatively. The Section Chief may also need to monitor cost expenditures to ensure that statutory rules that apply are met. Close coordination with the Planning Section and Logistics Section is also essential so that operational records can be reconciled with financial documents. The Finance/Administration Section Chief will determine, given current and anticipated future requirements, the need for establishing specific subordinate units. In some of the functional areas (e.g., procurement), an actual unit need not be established if it would consist of only one person. In such a case, a procurement technical specialist would be assigned in the Planning Section instead. Because of the specialized nature of finance functions, the Section Chief should come from the agency that has the greatest requirement for this support. Additionally, the Finance/Administration Section Chief must assist in the screening of volunteers who will be assigned to duties during the response.

Finance/Administration Team Key Responsibilities:

- Manages all financial aspects of the incident
- Provides financial and cost analysis information as requested
- Create accounts for claims and costs; coordinates with Logistics
- Tracks worker time and costs for materials and supplies
- Documents claims for damage, liability and injuries
- Notifies risk management/insurance to initiate claims reporting
- Provides incurred and forecasted costs at planning meetings
- Provides oversight of financial expenditures, new leases, contracts and assistance agreements to comply with corporate governance

The **Time Unit Leader** ensures that all staff and volunteers who are utilized in the response efforts account for their hours and assists with the screening of volunteers or newly recruited staff if possible before they are assigned to any resident areas.

The **Procurement/Claims/Costs Unit Leader** works closely with the Logistics Section to obtain those supplies and equipment needed for the response. The costs of items procured in the response will be documented, with projections for ongoing costs that may be incurred in the response and recovery phases. The position is also responsible for coordinating all claims and compensations related to response and recovery efforts. These may include insurance and government claims related to the response as well as compensation claims related to employee, visitor, or resident injury or illness.

Position Crosswalk

To further explain the roles within the IMT, suggested facility positions that may fill the IMT roles have been identified. The identification of traditional facility positions to fill the IMT roles provides a source of discussion in the planning stage. A key step in this process is to review the roles and responsibilities of the position as identified in the Job Action Sheet, and identify the most skilled person to fill the role.

The following chart is a list of ***suggested*** persons to fill the IMT roles.

ICS POSITION	NURSING HOME POSITION
Incident Commander	**Administrator/TMG VP**
Medical Director/Specialist	Medical Director
Public Information Officer	Marketing Coordinator
Liaison Officer	Administrator
Safety Officer	ESM
Operations Section Chief	**Director of Nursing**
Resident Services Branch Director	Asst. Director of Nursing (LTC)
Nursing Unit Leader	Unit Coordinator
Psychosocial Unit Leader	Social Worker
Admit/Transfer & Discharge Unit Leader	Admissions Coordinator/RCC Lead
Infrastructure Branch Director	Maintenance/Housekeeping supervisor
Dietary Unit Leader	FSD
Environmental Unit	Maintenance/Housekeeping Supervisor
Physical Plant/Security Unit Leader	Maintenance
Planning Section Chief	**Administrator**
Situation Unit Leader	Medical Records Staff
Documentation Unit Leader	Medical Records Staff
Logistics Section Chief	**Director of Quality**
Service Branch Director	ESM/TMG IT
Communication Hardware Unit Leader	Maintenance /TMG IT
IT/IS Unit Leader	TMG IT

Support Branch Director	Asst Director of Nursing (Sub Acute)
Supply Unit Leader	Housekeeping Sup or Central Supply
Staffing/Scheduling Unit Leader	Staffing Coordinator
Transportation Unit Leader	Activity Director
Finance/Admin Section Chief	**VP Finance**
Time Unit Leader	Payroll/TMG
Procurement /Costs / Claims Unit Leader	ESM/TMG AP

Establishing an Area Command

An Area Command is established when the complexity of the incident and incident management span-of-control considerations so dictate. Generally, the Incident Commander for the emergency makes the decision to establish an Area Command.

The purpose of an Area Command is either to oversee the management of multiple incidents that are each being handled by a separate ICS organization or to oversee the management of a very large or complex incident that has multiple incident management teams engaged.

This type of command is generally used when there are a number of incidents in the same area and of the same type, such as two or more HAZMAT spills or fires. These are usually the kinds of incidents that may compete for the same resources. When incidents are of different types and/or do not have similar resource demands, they are usually handled as separate incidents or are coordinated through an EOC.

Area Commands are particularly relevant to public health emergencies, given that these events are typically not site specific, not immediately identifiable, geographically dispersed, and evolve over time ranging from days to weeks. Such events as these, as well as acts of biological, chemical, radiological, and nuclear terrorism, call for a coordinated intergovernmental, private-sector, and nongovernmental organization response, with large-scale coordination typically conducted at a higher jurisdictional level.

Incident Action Planning and Incident Command System Forms

In developing the response to the event, certain steps should be taken to guide the response. These steps are part of the Incident Action Planning. The incident planning process is a core concept of ICS and takes place regardless of the incident size or complexity. This planning involves six essential steps:

1. Understanding the nursing home's policy and direction

The command and general staff, in developing the response actions to undertake, must first understand the facility policy and purpose.

For example, the nursing home may be active in community medical disaster planning and have developed plans to provide first aid services during the emergency. This policy should be established in written policy and be clearly understood by the Incident Management Team as an established response action.

2. Assessing the situation

Situational intelligence is critical in developing the response actions, providing insight to the impact, and projecting the span of the event. Nursing homes should have access to established mechanisms and systems within the community (city, county, regional, or state) that will provide and verify situational information. Another component in assessing the situation is determining the potential impact on the facility itself, based on current resident and employee status, the status of the building(s) and grounds, and the ability to maintain resident services.

3. Establishing incident objectives

The Incident Commander sets the overall command objectives for the response. He/she sets the direction for the response actions, setting the mission of the nursing home in the emergency response.

For example, in an incident involving power failure, ensuring the safety of the residents and employees is the highest priority. The Incident Response Guides provide examples of objectives that apply to the response based on the cause. These may be used in the Incident Action Planning process.

4. Determining appropriate strategies to achieve the objectives

After the Incident Commander has set the command objectives, the section chiefs then determine the appropriate strategies to undertake in the response. This provides a plan of action for each section, clearly identifying actions and duties while ensuring that there is no duplication of efforts. Objectives should be developed that provide clear direction and clearly define what is to be done. For example, assessing the building for structural damage after an earthquake is a clear objective to be carried out.

5. Giving tactical direction and ensuring that it is followed

Tactical directions provide the responders with the actions to be taken, and identifies the resources needed to complete the task. For example, assessing the facility after a blizzard will require the necessary tools such as protective equipment, checklists to document the assessment, etc. Actions undertaken should be assessed for their effectiveness, with the objectives and directions adapted if they are unsuccessful.

6. Providing necessary back-up

When tactical direction is initiated, support is needed to meet the objectives. This may include revision of the actions taken in the response, the assignment of additional resources (personnel, supplies and equipment) as well as the revision of tactical objectives.

Management by Objectives: Example

The foundation of healthcare incident action planning is Management by Objectives (MBO). The Incident Commander sets the overall command objectives for the response and recovery. Through this process, staff within operations, logistics, and planning are given a clear direction to follow and will then develop strategies for their respective sections. Consider the following example that demonstrates the application of command objectives and strategies. A community-wide infectious disease outbreak impacts the nursing home through illness of residents and staff. The outbreak must be contained, and local health authorities advise restrictions on visitations to nursing homes, hospitals, long-term care, and residential facilities. At the nursing home, the emergency operations plan has been activated, as over

50% of the residents and almost 35% of the facility staff are ill. The Incident Commander identifies the command objectives for this response as:

1. Ensure the safety of residents, visitors, and staff
2. Continuation of essential resident services and provision of medical care as needed

For the Operations Section (those who provide care to residents and maintain the facility infrastructure) the strategies and tactics that meet the command objectives include:

1. Command Objective: Ensure the safety of residents, visitors, and staff
    a. Strategy: Restriction of visitors to residents
        i. Tactic: Notify residents and family members of restricted visitation to prevent possible spread of infectious disease
        ii. Tactic: Post signage of restricted visitation
        iii. Tactic: Consolidate all entry into facility to one portal to control visitors
2. Command Objective: Continuation of essential resident services and provision of medical care as needed
    a. Strategy: Cancellation of nonessential services in order to utilize available staff for essential resident services
        i. Tactic: Identify nonessential services that can be cancelled or postponed; reassign staff to essential services or to an on-site labor pool

For the Logistics Section, whose role is to provide the necessary supplies and equipment to support Operations, the strategies and tactics may include:

1. Command Objective: Ensure the safety of residents, visitors, and staff a.

    Strategy: Provide infection control supplies as needed and

    Directed.

    i. Tactic: Inventory all available infection control supplies, including gloves and masks, currently available

Documenting the Objectives, Strategies and Tactics: The Incident Action Plan (IAP)

The Federal Emergency Management Agency (FEMA) has developed ICS forms that can be utilized in Incident Action Planning. The forms provide a documentation tool that directs the response and archives the objectives, strategies, and tactics. It is also used as a method for documenting the personnel, supplies, and equipment used in response and recovery phases.

Key information on the NHICS forms

Incident Name: The event that triggers the activation of the emergency operations plan and the incident management team structure is given a specific name that is then recorded on all ICS forms. If the event affects only the nursing home, the Incident Commander will identify the name. For example, a fire at the facility may be named Nursing Home Fire. If the incident occurs outside of the nursing home, the lead agency or local emergency management will name the incident. This name will be widely communicated, and allow for all response and recovery actions to be tracked under one name. For example, if there is a wildfire that triggers the evacuation of the nursing home, the incident name will come from the lead agency (the fire service) for the response. This incident name should be used on all ICS forms produced by the nursing home, providing clear documentation of the evacuation in response to the external event.

Operational Period: This refers to the amount of time it is projected to take to meet the strategies and tactics identified in the response. The operational period does not need to correspond to shift hours. The operational period may be revised to a longer or shorter period based on the incident, the response actions, and the evaluation of efforts undertaken. There is one Incident Commander for the operational period. Turnover of incident management team positions and new strategies and tactics signals a new operational period. It is the role of the Incident Commander to set the operational period.

Recording of time and date: The time used on all forms is based on a 24-hour clock. For example, 10 o'clock in the morning is documented at 1000 while

10 o'clock at night is documented at 2200. Standardizing everyone's watches and clocks at the outset of an operational period will help to insure reporting time accuracy.

Dates are expressed in a year / month / day format. For example, June 18, 2009 is written as 2009-06-18.

Names and Titles: Position titles have been identified for NHICS that are consistent with standard incident command system terminology. These include Commander, Section Chiefs, Branch Directors, and Unit Leaders. This allows for positions to be shared with other organizations, and also enhance communication among response partners through the use of common terminology.

In documenting the response on the NHICS forms, the names of persons filling the IMT positions should include the full name.

Prepared by: Each form identifies the position within the Incident Management Team responsible for completing the form. This task is also reflected on the Job Action Sheet for each position.

Facility Name: The name of the nursing home or long-term care facility that is utilizing the form is documented. This allows for information to be shared with other response partners or with other facilities that may be part of a larger consortium.

Approved by: On some forms, the completion of the form for accuracy and applicability may be reviewed by another position within the IMT. This will be noted on each form, with space provided for signatory approval.

Purpose and Copies: In the footer section of each form there is guidance provided on the purpose of each form and the routing or distribution of each form. Nursing homes may elect in the planning stage to review the routing of forms, providing customization in the distribution.

Legibility: As with all documentation in healthcare, writing should be legible. Beyond guiding the response, ICS forms may be used in recovery, review of the response, and financial reimbursement. The documentation should be legible, providing a clear message for all response partners internal and external of the nursing home.

NHICS Incident Action Planning Forms

For use in Incident Action Planning by nursing homes, 18 individual forms have been created. Each form has a specific purpose in both directing and documenting the response.

NHICS Form 201: Incident Briefing and Operational Log

The Incident Briefing contains the initial overview of the event, including the cause, the initial impact, the actions taken, and other critical information. This form is completed by the Incident Commander and should provide a clear and succinct overview of the situation to incident management team members. Then, this form can be used for the Command and General staff as their Operational Log to document assignments and key actions taken in their section/branch during the event. Each person with a Command or General staff assignment should complete an operational log, documenting their assignment, actions taken, critical information received, and other key information and decisions as determined by the individual. This critical chronology of information serves multiple functions: as a record of the work performed during the operational period; as a personnel log to assist with reimbursement; as a guide for the after-action review; and as a resource tool for personnel assuming the same position in follow-up operational periods.

NHICS Form 202: Incident Objectives

As previously noted, the Incident Commander sets the overall command objectives for the response. These are documented on NHICS form 202. The incident name and operational period, as first identified on NHICS form 201, are repeated on NHICS form 202. Weather conditions are documented on this form, in consideration of any operations that may be impacted by inclement weather, such as heat, rain, extreme cold, etc. As an example of the importance of weather conditions, consider a nursing home evacuation due to power failure. If there is extremely hot weather predicted for the next 12 hours, it may not be safe to move residents to an external location to await transportation. The Logistics Section may be required to provide shelter from the heat if residents must wait outside for prolonged periods.

General safety information is also reflected on NHICS form 202. In the example above, safety information may include use of tents or overhead shelters for staging of residents, directions to drink water and watch for signs of heat exposure to residents and staff.

A separate section is available to indicate any attachments to the form; some examples are contained but there is opportunity here for customization. For example, if a local health alert is issued in response to an infectious disease outbreak, the guidance from the health officer may be attached here. This is a key reference document in the development of strategies and tactics identified for the event response.

The Incident Commander will approve all information contained on

NHICS form 202. The Planning Chief has the responsibility for completing the form; if this role has not been activated or cannot be filled, the Incident Commander assumes the responsibility.

NHICS Form 203: Organization Assignment List

This form provides a documentation tool that reflects those positions on the Incident Management Team chart that are activated in the response, and the nursing home personnel currently assigned to the position. In larger facilities, a representative from the nursing home may respond to the (external) Emergency Operations Center (EOC) within the jurisdiction. This position should be documented on the form.

NHICS Form 205: Incident Communications Plan

Communications are an integral element of the response, and are most often cited as a failure in the response. This form allows for clear assignment of available technology, including radios, telephones, pagers, and other devices. Facilities may elect in the planning stage to complete this form with the systems and technology currently available. Decisions may also be made in the planning stage concerning the assignment of response specific to technology and tools. For example, if the nursing home has 4 two-way radios available for use in the response, these may be indicated on the form along with the IMT position to which each radio is assigned.

NHICS Form 206: Staff Injury Plan

In some cases, the care of ill or injured employees must be considered. If there is infrastructure damage to the facility that causes injuries to staff or if there is an infectious disease outbreak that requires assessment and prophylaxis of employees, the nursing home may need to care for its staff. NHICS form 206 documents these actions, providing clear direction as to the location of occupational health services and accountability for protection of employees.

NHICS Form 207: Organizational Chart

Similar to the information contained on NHICS form 203, position assignments are documented in a visual organization chart / incident management team format that can be distributed to appropriate personnel.

NHICS Form 213: Incident Message Form

Clear documentation of messages received and sent in activation is important both for ensuring critical information flow and follow-up actions taken. The person sending the message should document legibly the request being made, including the need for follow-up of actions taken. Persons receiving messages should use the form to document actions taken as requested and provide answers to messages. This form may also be used for documentation of telephone or radio messages received, again serving as a tool to record requests and actions. The NHICS form 213 may be produced on NCR (non- carbon) paper, allowing for multiple copies of the messages to be routed accordingly. When used effectively, this allows for message archive without the use of a copy machine.

NHICS Form 251: Facility System Status Report

This form can and should be customized to the individual nursing home. Used when there is structural damage (power failure, earthquake, severe weather, and fire) key information is gathered on the infrastructure of the facility. This will aid in determining the capability of the facility to sustain operations, as well as provide clues to system recovery for engineers.

NHICS Form 252: Section Personnel Time Sheet

This form is used when an alternative staff time tracking system is needed due to power failure or other incident related conditions. This form can also be used to document the persons assigned to IMT positions, facilitating cost projections and financial reimbursement when possible.

NHICS Form 253: Volunteer Staff Registration

This form is used to document those non-nursing home personnel who respond and are assigned to the nursing home in support of operations. This form is used to document the screening of volunteers through reference or criminal background checks and/or credentialing if feasible, and then is used to track these persons to facilitate financial reimbursement when possible.

NHICS Form 256: Procurement Summary Report

This form is used by the Finance/Administration Section to track all supplies and equipment procured in the response and recovery phase, providing an ongoing cost assessment tool for current and projected operations.

NHICS Form 257: Resource Accounting Record

A major component in a successful response that utilizes outside resources is the ability to track and account for supplies and equipment used. This form provides a tracking tool for those items, allowing for rapid identification of what is being used in the response and what is still needed.

NHICS Form 258: Facility Resource Directory

The resource directory can be customized in the planning stage to identify those current resource partners, such as transportation services and supply vendors, as well as those resources that may only be used in an emergency such as emergency management officials, health officials, and repair services. It is critical during the response to have accurate contact information, with redundancies of

information. This data can be collected well in advance of an event, and may serve to identify those response partners within the jurisdiction of the nursing home that can be engaged in planning.

NHICS Form 259: Master Facility Casualty and Fatality Report

In the event of resident injury or death, this form may be used to report to local health and emergency management officials, as defined within the jurisdiction. In planning, the release of information should be discussed, identifying those agencies or individuals to whom potentially confidential information will and will not be released.

NHICS Form 261: Incident Action Safety Analysis

All Incident Action Plans contain a safety analysis. This form directs the Safety Officer to identify those potential hazards and direct mitigation efforts to lessen the risk of injury or illness. For example, in a power failure it may be advised to restrict all residents to their rooms to prevent falls in areas where lighting is limited. This is information that would be documented, with the assignment of restriction of resident movement assigned to branches.

Emergency Resident Tracking/Evacuation Tracking

In the event the facility receives residents or other individuals from the response or as transfers from another facility or hospital, or evacuation is necessary, please refer to the Efinds policy and procedure (8.2.13.2).

Facility Command Center

It will be important that an area be designated within the nursing home to serve as the Facility or Nursing Home Command Center. Conference rooms are often used for this purpose. The room ideally should be in a secure location and suitable in size to accommodate the anticipated number of personnel filling IMT positions who will operate from this area. Access to phones, computers with internet capability, printers, fax machine, and general supplies (paper, pencils, etc.) will be important. Having a large whiteboard for documentation and projection capability may be helpful. Convenient access to bathrooms and food will also be important.

Space should be organized so each command position has a desk area and access to available technology. Persons assuming a command role should be easily identified by use of vests or other suitable clothing item (i.e. hat, armband).

If staffing allows, assigning persons to serve as assistants to those in charge has been shown to be invaluable. They can assist by answering phones and documenting key pieces of information.

Incident Action Plan

An incident action plan (IAP) formally documents incident goals (known as control objectives in NIMS), operational period objectives, and the response strategy defined by incident command during response planning. It contains general tactics to achieve goals and objectives within the overall strategy, while providing important information on event and response parameters. Equally important, the IAP facilitates

dissemination of critical information about the status of response assets themselves. Because incident parameters evolve, action plans must be revised on a regular basis (at least once per operational period) to maintain consistent, up-to-date guidance across the system.

The following should be considered for inclusion in an IAP:

- Incident goals (where the response system wants to be at the end of response)
- Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives)
- Response strategies (priorities and the general approach to accomplish the objectives)
- Response tactics (methods developed by Operations to achieve the objectives)
- Organization list with ICS chart showing primary roles and relationships
- Assignment list with specific tasks
- Critical situation updates and assessments
- Composite resource status updates
- Health and safety plan (to prevent responder injury or illness)
- Communications plan (how functional areas can exchange information)
- Logistics plan (e.g., procedures to support Operations with equipment, supplies, etc.)
- Responder medical plan (providing direction for care to responders)
- Incident map (i.e., map of incident scene)
- Additional component plans, as indicated by the incident.

The facility’s Emergency Preparedness Management Plan's scope is to provide for a program that ensures effective response to disasters or emergencies affecting the environment of care. As stated above, an Incident Command System framework will be utilized to manage/respond to all emergent situations that may affect the facility.

The objective of the Emergency Preparedness Plan is to effectively manage a disaster.

- The goals of the Emergency Preparedness Management Plan includes the following:
    - Utilize Incident Command System (ICS) to manage individual emergency situations as per attached ICS policy.

- Providing education to personnel on the elements of the Emergency Preparedness Management Program and ICS program;

- Establishing and implementing procedures in response to an assortment of disasters;

- Identifying alternate sources for supplies and services in the event of a disaster.

RESPONSIBILITY

The Safety Officer in conjunction with the Administrator in conjunction with the director of Environmental Services is responsible for developing, implementing, and monitoring the Emergency Preparedness Program at this facility. The facility's Incident Commander (See ICS Policy) will activate the emergency management system as needed for all emergent situations.

SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF DISASTERS

This facility has developed specific procedures in response to potential disasters that may occur. (The samples included in this manual are intended to be used as a guideline for development of facility-specific disaster policies, i.e., Bomb Threat, Earthquake Response Procedure Policy, Tornado, Severe Weather, Work Stoppage, Loss of Resident, Loss of Communications, and emerging infectious diseases. All variety of potential incidents will be managed through the facility Incident Command System.

DEFINE AND INTEGRATE THE FACILITY'S ROLE WITH THE COMMUNITYWIDE EMERGENCY PREPAREDNESS EFFORTS

- Implementation of the facilities Emergency Preparedness Plan will be conducted at least semiannually (and no less than four months apart or more than eight months apart), either in response to a disaster or as a planned drill.
- This facility cooperates with all local, county and state disaster preparedness drills. The Organization is a member of the countywide emergency preparedness system and coordinates with other agencies any large scale drills.
- The facility ICS protocol will be utilized to allow for seamless integration into the community wide Emergency Management System.

Notification of External Authorities

- The facility shall have two-way radio or cellular equipment and operators, which are familiar with the equipment. External communication will be mostly with Emergency Control Centers.

NOTIFICATION OF PERSONNEL WHEN EMERGENCY RESPONSE MEASURES ARE INITIATED

- In an emergency, which is so widespread to be considered a disaster and/or involving mass casualties, all facility personnel, regardless of position are expected to report to the facility for duty as soon as it is feasible to travel. Each department director maintains a current callback list of all employees. Once the emergency preparedness plan has been activated, the department director will assign a staff member to initiate the callback list.

- Facility volunteers will be asked to leave the facility and not participate in emergency events. The facility will utilize and rely on its sister facilities and corporate employees in the event of an emergency. A Disaster Liaison facilities contact information staff listing is maintained by the Payroll Department and distributed periodically to the facility Administrators. If such need arises, the Administrator will notify the corporate office who will assist in coordination of resources and sister facility staff assistance.

- Please see below for the 1135 waiver regarding Medical/Professional Volunteers.

- In the event there is excess personnel, the Command Post will communicate with department directors regarding rescheduling of personnel for future needs. The medical staff will report to the Incident Commander for assignments.

- See Emergency Preparedness Delegation of Responsibilities Policy. Incident Management Team Roles Policy.

ASSIGNMENT OF PERSONNEL IN EMERGENCIES TO COVER ALL NECESSARY STAFF POSITIONS

- All personnel reporting to the facility in the event of a disaster shall report to the Incident Commander to sign in. Personnel who have been directed to report to their assigned unit will do so all others will be assigned to areas where help is needed. Personnel may not necessarily be assigned to their regular duties. Personnel will be asked to perform various jobs or working hours, which will be considered vital to an effective operation.

MANAGEMENT OF SPACE, SUPPLIES AND SECURITY

- Essential supplies, equipment, food, water and utilities must be provided to meet shelter requirements for up to two weeks. Procedures are in place for the procurement of additional supplies in an emergency. At the time the Emergency Preparedness Plan is activated, the Maintenance Department Personnel on duty will be responsible for locking all exits and entrances. Employees are required to wear nametags or carry cards identifying them as employees. Only persons with proper identification shall be admitted to the facility during an emergency.
- Emergency Delivery of supplies-The facility maintains a 5 day supply of medical supplies on hand. In the event of an emergency, the facility takes precedence for delivery of medical supplies

for resident services. In the event of power outages, the facility's last order will be repeated and delivered as soon as possible and in concert with the usual deliver. Should additional supplies be required, the facility can phone in orders and supply trucks will be on standby for delivery.

- US Foods Emergency Provisions
  - U.S. Foods Buffalo will keep Emergency/Disaster Plan documents on file for any customer wishing to participate.
  - In the event of an Emergency/Disaster the Customer should contact US Foods to arrange for shipment of their Emergency Order.
  - In the event of a local Production System failure, US Foods has a redundant system in place to handle order entry and warehouse functions. In the event of a local disaster, U.S. Foods has sister distribution facilities ready to help supply product, equipment, personnel and computer services if necessary. In the event of a disaster, our National Processing Center in Greenville, SC, our data is maintained in disaster recovery centers thought the U.S that will enable us to keep functioning. In the event of an usfood.com catastrophic failure, our customer service teams can take orders over the phone.
  - US Foods commits to:
    - Refrigerated/Freezer Truck (U.S. Foods Buffalo, Inc. will make available when possible or assist in making rental arrangements)
    - Flexible delivery schedule
    - Cooking Supplies - Steamtable Trays, Sterno, Etc.
    - Food Supplies: Cereals, Non-Fat Dry Milk, Instant Foods, Canned Juices, Bottled Water, Portion Control Items, Supplements
  - In the event of an in-house disaster, the above accommodations will be made within twenty-four hours; however, if the disaster is external, food and/or supplies will be delivered within forty-eight hours.
  - If a disaster should strike our facility, U.S. Foods Buffalo will use, as needed, our facilities in the East and/or West areas to provide service and delivery to your location.

EVACUATION OF THE FACILITY

- When a situation arises requiring evacuation of patients from threatened or affected areas; safety of lives is the facility's primary concern. Authority to order an evacuation is vested only in the Incident Commander or his/her designee. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and neighboring facilities to transfer patients as necessary. All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the facility.

- Universal Transportation assistance (TAL) are utilized to help streamline and coordinate planned evacuations. TAL classifications are used to assess the types of resources needed (bus, vans, ambulances) by each patient during a planned evacuation. TAL tags are located in the facility evacuation tote located in a designated area within the facility.

- See Emergency Preparedness Evacuation Procedure.

ESTABLISHING AN ALTERNATE CARE SITE WHEN THE ENVIRONMENT CANNOT SUPPORT ADEQUATE PATIENT CARE

- Formal agreements are in place so that, patients may be transferred to a facility that can provide adequate patient care. The following agreements are in place:
    - Ambulance contract agreements for transfer of patient between facilities.
    - Transfer agreements will be made between neighboring facilities.
    - Vendors will be contracted for special needs or arrangements.
- See Emergency Preparedness Evacuation Policy.

MANAGEMENT OF PATIENTS DURING EMERGENCIES (I.E., SCHEDULING, MODIFICATION OR DISCONTINUATION OF SERVICES, CONTROL OF PATIENT INFORMATION AND PATIENT TRANSPORTATION)

- Upon activation of the Emergency Preparedness Plan, normal admission requirements will be abolished. Initially, admissions to the facility will be limited to those whose survival depends upon services obtainable only through facility bed care.

Alternate Sources of Essential Utilities

The facility will provide for alternative sources of essential utilities including:

- An emergency source of electrical power capable of operating all essential electrical equipment and a plan for failure of back up generators;
- An alternate source of safe water;
- An alternate means of waste disposal in the event of sewage system failure;
- Sufficient fuel to last for at least two weeks of expanded operation.

Backup Communication System

The Facility will provide for alternate communication methods in the event of a failure. Two-way radio equipment and facility owned cell phones shall be available in the event of a disaster.

Alternate Roles and Responsibilities of Employees during Emergencies

Employees may not be assigned to their regular duties. Employees will be asked to perform various jobs, which will be considered vital to the effective operation of the facility. Employees will be assigned duties based on the needs of the facility.

Orientation and Education Program for those Who Implement the Plan

Personnel will attend orientation upon hire and an annual update of their specific roles and responsibilities and the skills they require to perform their duties during a disaster. Inservice education will be given on the back-up communication system and obtaining supplies/equipment in the event of a disaster.

Performance Standards

There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The organization will develop and establish performance measures and related outcomes, in a collaborative fashion, based those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:

- The measure can identify the events it was intended to identify;
- The measure can detect changes in performance over time;
- The measure allows for comparison over time within the organization or between the organization and other entities;
- The data intended for collection are available; and
- Results can be reported in a way that is useful to the organization.

- On an ongoing basis, monitor performance regarding actual or potential risk related to one or more of the following:
  - Staff knowledge and skills,

- Level of staff participation,
- Monitoring and inspection activities,
- Emergency and incident reporting, or
- Inspection, preventive maintenance, and testing of safety equipment;
- Other performance measures and outcomes will be established based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Administrator or the organization.

- To identify opportunities for improvement, follow the organization's improvement methodology.

- Should a team approach be necessary for performance and process improvement to occur, the facility will follow the organization's performance improvement guidelines for improvement team member selection (QOC, QOL, QOWL, QOE). Determination of team necessity will be based on those priority issues listed (high risk, volume and problem prone situations and sentinel event occurrence). Should team development be deemed necessary, primarily, team members will be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.

- Performance improvement monitoring and outcome activities will be presented to the Administrator by the Director of Environmental Services at least on a quarterly basis, with a report of performance outcome forwarded to the Continuous Performance Improvement Committee and Governing Body quarterly.

- The following performance measures may be used:
  - Percent of staff able to demonstrate knowledge and skill of their role and expected participation in the Emergency Preparedness Plan/ICS.
  - Percent of staff able to demonstrate knowledge of their responsibilities during a drill.
  - Number of emergency preparedness drills conducted within specified time span.

ANNUAL EVALUATION OF THE EMERGENCY PREPAREDNESS PLAN'S OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS

- The performance and effectiveness of the Emergency Preparedness Management Program shall be reviewed by the organization, the Continuous Quality Improvement Committee and Administration.

ACTIONS UNDER 1135 WAIVER

1. For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of department/section, Medical Staff membership or clinical privileges or allied health professional (AHP) status or practice prerogatives, shall be permitted to do, and shall be assisted by Facility personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. All efforts will be made to obtain a Medical Staff member with appropriate clinical privileges. Clinical privileges granted under an emergency situation shall terminate when a Medical Staff member with appropriate clinical privileges becomes available or the emergency ceases.

2. Emergency privileges in case of a disaster will be granted in accordance with the following:
    a. Consistent with the current Facility Emergency/ Disaster Credentialing Policy (Facility Disaster Policy) clinical privileges or practice prerogatives may be granted when the Facility Incident Command System (ICS) plan has been activated and the Facility is unable to handle the immediate patient needs. This includes events of a bioterrorism attack or any other type of disaster situation whereby Volunteer Practitioners and AHPs, as those terms are defined in the Facility Disaster Policy, may require disaster credentialing.
        i. Medical Records will set up a satellite post in the Medical Staff Services Department or other appropriate area where non-credentialed Volunteer Practitioners and AHPs will check in.

3. Emergency privileging for disaster situations is specialty-specific and Volunteer Practitioners or AHPs shall not carry out any clinical activities for which they do not already hold clinical privileges or practice prerogatives at another facility.

Procedure:

1. Upon presentation to the campus, Volunteer Practitioners and/or AHPs shall be directed to the Facility Representative responsible for disaster credentialing under the ICS plan. Volunteer Practitioners and/or AHPs must sign in and present required identification as follows: a valid government issued photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following:
    a. A current facility photo ID badge that clearly identifies the person's professional designation;
    b. A current license, certificate, or registration to practice;
    c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

d. Identification that indicates that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
e. Identification of Volunteer Practitioners by current Facility Medical Staff member(s) who possess personal knowledge regarding the Practitioner's ability to act as a practitioner during a disaster, and of Volunteer AHPs by current Facility Medical Staff member(s) or AHPs who possess personal knowledge regarding the AHP's qualifications.

2. Required documentation on the Disaster Clinical Privileges Approval Form: The Volunteer Practitioner shall include all of the following information on the Disaster Clinical Privileges Approval Form:
   a) Name of Practitioner or AHP (printed and signed)

   b) Specialty or AHP Category

   c) Office Address and Phone Number

   d) Professional License/Certificate/Registration Number and Expiration Date

   e) Driver's License or Passport Number and Expiration Date

   f) Date of Birth

   g) Name of Professional Liability Insurance Carrier and Limits of Liability

   h) Name of Professional School and Year of Graduation

   i) Facility Affiliation(s) and Staff Status

3. Verification Process:

The Facility Representative shall verify professional licenses /certificates/registrations as follows:

1. Primary Source Verification: Query the appropriate licensing/certification/registration board online, and print verification if possible.
2. If computer access is not available, a copy (if possible) of the Practitioner's or AHP's professional license/certificate/registration and driver's license or other identification shall be made and attached to the Disaster Clinical Privileges Approval Form. If a copier is not available, the Facility Representative shall perform a visual verification of the above documents, and document such verification.
3. If primary source verification of professional licensure/certification/registration cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control and completed no later than seventy-two hours from the time the Volunteer Practitioner or AHP presented to the campus. In extraordinary circumstances when primary source verification cannot be completed within seventy-two hours (e.g., no means of communication or lack of resources), it shall be accomplished as soon as possible. In this extraordinary circumstance, the following must be documented:
   a. Why primary source verification could not be performed in the required timeframe;
   b. Evidence of the Practitioner's or AHP's demonstrated ability to continue to provide adequate care, treatment, and services;
   c. Attempt(s) to rectify the situation as soon as possible.

4. The Medical Staff Credentialing Department shall query the National Practitioner Data Bank and other sources as needed as soon as the emergency situation has been contained.
5. Primary source verification shall not be required if the Volunteer Practitioner or AHP has not provided care, treatment and services under the Disaster Clinical Privileges Approval Form, as appropriate.

a. Who May Grant Disaster Clinical Privileges/Practice Prerogatives: Medical Director or their designees may grant Disaster Clinical Privileges or Practice Prerogatives. The option to grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or AHPs shall be made on a case-by-case basis in accordance with the immediate needs of the Facility's patients, based on the qualifications of the Volunteer Practitioners and/or AHPs.

6. Temporary Badges:

a. So that they may be readily identified, Volunteer Practitioners and/or AHPs shall be issued badges containing the following information:

1. Name
2. Licensure
3. Specialty or AHP category
4. Practicing with Disaster Clinical Privileges, as appropriate
5. Oversight:

The Medical Staff shall oversee the care, treatment, and services provided by a Volunteer Practitioner or AHP who has been granted Disaster Clinical Privileges. Oversight shall be accomplished whenever possible by partnering the Practitioner or AHP with a current credentialed Facility Medical Staff member or AHP, as appropriate, to observe or mentor the Volunteer Practitioner or AHP. If partnering is not possible, oversight shall be by clinical record review. A Volunteer Practitioner or AHP may be assigned additional responsibilities by the Medical Director as designated under the ICS plan.

b. Continuation of Disaster Clinical Privileges: The Facility shall make a decision within seventy-two hours regarding the continuation of a Volunteer Practitioner's or AHP's Disaster Clinical Privileges, based on information obtained regarding the professional performance of the Volunteer Practitioner or AHP.

c. Termination of Disaster Clinical Privileges: A Practitioner's or AHP's Disaster Clinical Privileges shall be terminated immediately in the event that any information received through the verification process or otherwise indicates adverse information or suggests the Practitioner or AHP is not capable of exercising Disaster Clinical Privileges. Disaster Clinical Privileges are time-limited and shall expire automatically at the time the Administrator or designee declares the disaster to be over, or that the services of Volunteer Practitioners or AHPs are no longer required.

B. Section 1135 Waivers

1. Section 1135 waiver(s) applies when a major disaster or emergency is declared and the Secretary of HHS has declared a public health emergency.

a. Facility must implement its disaster protocol and Mutual aide as outlined in Manual 8-2.

b. Facility must notify CMS through the appropriate State Survey Agency when it implements its disaster protocol.

c. The Secretary exercises his or her waiver power under Section 1135 to cover the area in which the Facility is located.

d. The Facility Administrator/Incident Commander will complete the 1135 waiver form when applicable and as declared by the Secretary.

e. Waivers typically end no later than the termination of the emergency periods, or 60 days from the date the waiver or modification is first published, unless otherwise extended by the Secretary for additional periods of up to 60 days.

f. Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive medical screening and examination in an alternative location pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances. EMTALA requirements are effective only if actions under the waiver do not discriminate in the basis of a patient's source of payment or ability to pay.

g. Waivers for Emergency Medical Treatment and Labor Act (EMTALA) and HIPPA requirements are limited to a seventy-two-hour period beginning with the implementation of the Facility's disaster protocol or, in the case of a pandemic infectious disease, until the termination of the declaration of the public health emergency.

h. Under the waiver, the Secretary authorizes SNF coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the SNF benefits acute care nature. The facility will accept beneficiaries who have not met the qualifying stay and are eligible to access part A benefits under the waiver.

2. The 1135 waiver of the Facility's requirements will apply only for the period during which the waiver has been authorized by the Secretary of HHS.

This facility utilizes an Emergency Management Committee to oversee the management and updating of the facility's CEMP.

RESPONSIBILITIES OF THE EMERGENCY MANAGEMENT COMMITTEE (EMC):

The EMC and its members, jointly and separately, shall meet monthly and assume responsibility for the facility's Emergency Management/Preparedness Program (EMP).

The Safety Committee shall inform itself of standards for Emergency Preparedness incorporated in the Department of Health; Code of Federal Regulations Title 29; Occupational Safety and Health Act (OSHA); and be thoroughly versed in the Emergency Management related sections of The Life Safety Code (NFPA 101 2012 edition) and The Health Care Facilities Code (NFPA 99 2012 Edition). It shall acquaint itself with the functioning of the facility, its employees and environments. It shall apply this information to design, implement, maintain and advance the facility's Emergency Management Program.

The EMC will develop written policies and procedures as needed in order to ensure that the facility's Emergency Management Program is viable, up to date and compliant with current codes and regulations.

The EMC will report in writing pertinent findings and recommendations to the Administration, Medical and Nursing Staffs and all departments as needed.

Periodic inspections of the facility and grounds shall be conducted for the purpose of assuring compliance with the facility Emergency Preparedness Program. The EMC shall:

- Meet monthly and shall record its activities. Summaries of all activities shall be forwarded to Administration and Department Heads.
- Report quarterly to Administration, on the key Emergency Preparedness initiatives.
- Review/update facility Hazard Vulnerability Assessment (HVA) on an annual basis
- Act as organizational "Risk Team" and review/update facility "NFPA 99 Risk Assessments" as per NFPA 99 (2012 Ed) minimally on an annual basis or as needed to address changes in facility systems and/or equipment.
- Work with Education Department to in-service all facility staff on new and ongoing Emergency Preparedness initiatives.

RESPONSIBILITIES OF ADMINISTRATION:

Toward fulfillment of the general and specific emergency preparedness goals of the Facility, the Administrator shall:

- Assure the formation and development of the EMC.

- Appoint a chairperson who is qualified and the members to the EMC.

- Provide Administration representation on the EMC. Ensure the participation and representation on the EMC.

- Assure that the facility's emergency preparedness policies and plan is reviewed and shared at resident council minimally on an annual basis.

- Assure that the facility's emergency preparedness policy family/responsible party notification flyer is included with the facility admission packet for all new residents

The duty of the administrator shall be to convene the EMC, assure the maintenance of appropriate records, assure timely follow-up of actions and business of the EMC, supervise inspection, survey activity and report recommendations and actions, and act as liaison with the community Emergency Management Personnel and other agencies as needed on matters relative to Emergency Preparedness.

The Administrator/designee has authority and responsibility to convene the EMC outside of the regular meeting schedule as needed to ensure that any newly arising Emergency Preparedness related issues are addressed by the committee in a timely manner.

RESPONSIBILITIES OF DEPARTMENT DIRECTORS:

The role of the Department Directors in our EMP is vitally important. The EMP through verbal and/or in writing shall alert departments or services of Emergency Management issues that require intervention.

The following responsibilities lie with the Department Directors:

- Implement and organize Emergency Preparedness activities and tasks for department.

- Develop techniques and procedures for specific operations.

- Select and train employees.

    - Each Department Director is responsible to verify and ensure that staff members are able to effectively demonstrate their roles/responsibilities within the EMP for their particular position.

- It is the responsibility of the EMC to ensure that Department Directors have a thorough knowledge of the EMP and apply on-the-job instructions for all employees.

- Supervise and evaluate employee performance.

- Cooperate with the EMC in the promotion of its activities.

- Assist in monitoring Emergency Preparedness recommendations as outlined by the EMC and/or organization.

Utilize the following checklist as guidance for activation of the facility CEMP.

Task		Completed By
☐	Upon notification of hazard or threat from staff, residents, or visitors, activate the CEMP.	Incident Commander
☐	Activate the Communications Plan.	Incident Commander
☐	Notify staff of CEMP activation and the hazard or threat through the facility receptionist and/or overhead paging system.	Incident Commander
☐	Assess the potential or actual impact of the incident on residents, staff, and the facility.	Incident Commander along with situation specific staff.
☐	Direct Incident Management Team to convene at designated Command Center location.	Incident Commander
☐	Based on the hazard and using the "Notification by Hazard Type" table in the CEMP, conduct required notifications.	Staff to be assigned based on nature of incident and real time resource levels.
☐	Set-up the facility's Command Center. *Refer to section below checklist for more information.*	Staff to be assigned based on nature of incident and real time resource levels.

Task		Completed By
☐	Deliver briefing to Incident Management Team, and other staff as appropriate, on the incident including: ▪ Extent or impact of the problem (e.g., hazards, life safety concerns) ▪ Number of residents injured or affected ▪ Status of resident care and ancillary services ▪ Current and projected staffing levels ▪ Status of facility plant, utilities, and environment of care.	Incident Commander
☐	Develop an Incident Action Plan to establish goals and objectives to guide incident response throughout the next operational period. Operational period duration will be determined by Incident Commander (e.g., 12 hours, shift change).	Incident Commander along with Planning Section Chief and Safety Officer
☐	Prepare and distribute position-specific checklists for the Incident Management Team to use during incident response.	Planning Section Chief
☐	Establish a meeting schedule for Incident Management Team to maintain situational awareness of incident and response operations.	Planning Section Chief
☐	Notify residents and their relatives or responsible parties of hazard information and response actions.	Designated by Incident Commander at time of incident via Incident Action Plan
☐	Task facility staff with completing additional tasks to meet established response goals and objectives.	Incident Management Team
☐	Continue to collect information about incident and its current or projected impacts and perform position duties as assigned.	Incident Management Team

Command Center

The facility Command Center serves as the central location for the Incident Management Team to conduct the following activities:

- Plan and execute emergency operations;
- Exchange information (e.g., briefings, check-in meetings); and
- Store incident-related documentation.

Prior to an incident, facilities should consider the following when identifying a primary and contingency location for the Command Center:

- Located within the facility (e.g., not off-site);
- Provide space for tables and chairs; and
- Provide access to computers/internet and communications equipment (e.g., landline telephones, cell phones).

After an incident, if the pre-identified locations are rendered unusable—or if incident conditions require the Command Center to be relocated—the facility can utilize nearby facilities, or if absolutely necessary, a vehicle to serve as an off-site, mobile Command Center.

Incident Management Team (IMT) Position Checklist

The following checklists outline the responsibilities of each Incident Management Team position. They should be adapted as needed based on the internal policies and procedures of the facility.

INCIDENT COMMANDER	
☐	Activate the CEMP and necessary Incident Management Team positions.
☐	Analyze potential threats or hazards (e.g., weather forecast, law enforcement intelligence) and assess potential or impacts on residents, staff, and the facility. Incident Management Team to assist.
☐	Brief the Incident Management Team on the nature of the problem, immediate issues, and the initial plan of action.
☐	Evaluate expected or actual facility damage and assign staff to conduct a thorough site assessment. Incident Management Team to assist.
☐	In accordance with local plans or procedures, notify emergency management, law enforcement, and fire officials of incident conditions for situational awareness and to relay critical needs.
☐	Facilitate regular briefings to review the status of response operations. Request status reports from staff on resident health and safety.
☐	Observe the Incident Management Team for signs of stress and exhaustion and provide rest periods.
☐	Determine the appropriate protective action based on the presence of potential or actual hazards to resident safety and well-being. Incident Management Team to assist.
☐	Share regular updates with residents and staff to maintain situational updates. Incident Management Team to assist.

INCIDENT COMMANDER	
☐	Authorize procurement and distribution of resources.

PUBLIC INFORMATION OFFICER	
☐	Obtain briefing from Incident Commander and TMG Leadership representatives.
☐	Draft initial message for notification of relatives and responsible parties regarding facility and resident status.
☐	Answer inquiries from residents' relatives and responsible parties, the general public, and the media and direct questions/requests to appropriate individuals. Incident Management Team members will assist with resident and family questions/concerns.
☐	Develop and disseminate status updates to be reviewed and approved by the Incident Commander and TMG Leadership before dissemination to relatives and responsible parties, media, and the public.
☐	Provide guidance to other Incident Management Team members on the appropriate release of information to requesting entities.
☐	Develop regular status updates to keep staff informed of the incident and facility status. Updates will be communicated to staff with the help of the Incident Management Team.
☐	Assist in the development and distribution of signage as needed.
☐	Communicate concerns to the Incident Commander, as needed.

SAFETY OFFICER	
☐	Obtain briefing from Incident Commander.
☐	Conduct site assessment to determine safety risks of the incident to residents, staff, and visitors.
☐	Document the treatment plan for injured or ill staff. This will be completed in concert with a senior clinical team member designated by the Incident Commander.

☐	Post non-entry signs around unsafe areas.
☐	Evaluate building or incident hazards and identify vulnerabilities.
☐	Assess operations and practices of staff, terminate any unsafe activity, and recommend corrective actions to ensure safety of residents, staff, and visitors.
☐	Direct laundry and housekeeping staff to: ▪ Ensure adequate supplies of linens, blankets, and pillows. ▪ Ensure emergency linens are available for soaking up spills and leaks.
☐	Direct food and dietary staff to: ▪ Provide and prepare food as needed during an emergency. ▪ Ensure gas appliances are turned off before evacuating.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

OPERATIONS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Assign staff to assess the facility and resident well-being.
☐	Determine how facility clinical/resident care related services will continue as routinely as possible, including the provision of: ▪ Routine nursing services and documentation ▪ Medication dispersal per resident schedules. ▪ Routine hygienic and nutritional care for residents.
☐	Arrange for the provision of and/or documentation, transfer, and transportation critical medical services, such as dialysis and oxygen therapy, and emergency discharges for at-risk residents.
☐	Maintain resident and staff accountability.
☐	Secure resident records during shelter-in-place operations.

OPERATIONS SECTION CHIEF	
☐	Assess pharmacy supplies and contact pharmacy, as needed, to determine: ▪ Cancellation of deliveries. ▪ Availability of backup pharmacy. ▪ Availability of medical supplies.
☐	Evaluate clinical staffing needs and activate additional staff, as needed. Work with Planning Section Team for activation of additional staff.
☐	Direct nursing, rehabilitation and Social Services staff to: ▪ Tend to physical and emotional needs of residents. ▪ Assist in clearing rooms and hallways, exits, etc. ▪ Support movement of residents during an evacuation.
☐	For receiving facility operations, ensure proper management of arriving residents and their records, including documentation of triage, treatment, and disposition of emergency admits.
☐	Document resident injuries (and action plan to ensure treatment) or deaths.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

PLANNING SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Document Incident Management Team position assignments and contact information for all positions. Utilize NHICS forms 258 Facility Resource Directory, 207 Organization Chart and 203 Organization Assignments for the above information.
☐	Assist Incident Commander with planning response actions for next operational period (e.g., shift).
☐	Ensure backup and protection of existing data including paper-based and digital systems.
☐	Maintain all historical information and records related to the incident.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

LOGISTICS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Distribute resource request forms to each Incident Management Team member. Document the request, use, return, and condition of resources used to respond. Utilize NHICS form 257 Resource Accounting Record for this task.
☐	Ensure the following resources are mobilized, assigned, and tracked: ▪ Staff and Surge Support ▪ Emergency Supplies ▪ Communications Equipment ▪ Food and Water ▪ Transportation
☐	Document volunteer sign-in and sign-out for each operational period (e.g., shift). This will be completed in concert with facility Staffing Coordinator and HR Manager.
☐	Request Incident Commander approval to activate emergency service related vendor agreements for additional resources.
☐	Communicate concerns to the Incident Commander, as needed.

FINANCE/ADMINISTRATION SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Initiate protection of, or move/relocate facility records, as needed. Completed in concert with facility medical records and Business office representatives.
☐	Maintain incident cost tracking and analysis, including the documentation, retrieval, safeguarding and distribution of cash, credit card, and receipt/invoice processes. Business office manager will coordinate with TMG Financial Operations Representatives to manage this process.
☐	Document and track facility-wide personnel work hours worked relevant to the emergency. Facility Payroll and HR Managers will coordinate with TMG VP of Administration.
☐	Contact insurance company to notify them of the incident and identify and document requirements for submitting damage/claim reports. TMG Financial Operations Representatives.

FINANCE/ADMINISTRATION SECTION CHIEF	
☐	Consult with government officials regarding reimbursement regulations, requirements, and forms. TMG Financial Operations Representatives.
☐	Approve and submit a financial status report to the Incident Commander summarizing cost-to-date financial data relative to personnel, supplies, and miscellaneous expenses. Only as requested.
☐	Ensure that required financial and administrative documentation is properly prepared and maintained.
☐	Process invoices received.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

Demobilization Checklist

Tasks	
Activate repatriation process.	
☐	Refer to the *NYSDOH Evacuation Plan Template* for further guidance.
☐	Ensure compliance with all local and NYSDOH requirements regarding inspections, remediation actions, and conditions for approval of repatriation.
☐	Receive approval from NYSDOH to reopen the facility as well as any necessary local municipality approvals.
☐	Initiate repatriation plans and procedures.
Deactivate IMT positions and surge staffing.	
☐	Determine if there is an adequate number of facility personnel to meet remaining incident needs.
☐	Deactivate IMT positions that are no longer needed.
☐	Reduce surge staff (e.g., off-duty personnel, volunteers, contract support) and provide guidance on close-out procedures (e.g., where to submit documentation).
Return or restore emergency resources.	

Tasks	
☐	Estimate current and anticipated resource requirements.
☐	Determine which facility-owned resources need to be returned to storage locations in the facility; or replenished/repaired for future incidents.
☐	Determine processes for transitioning borrowed resources back to sending facility/provider.
☐	Reactivate normal services and operations.
☐	Determine when it is safe to resume normal operations after conferring with the local authority, NYSDOH Regional Office, fire department, law enforcement, public health, and/or any other response authority.

Stakeholder Engagement

This tool describes the relationships facilities should strive to build with local response partners during pre-incident planning. Building a better relationship with these agencies will streamline incident response and information sharing. Trying to construct these relationships will be considerably more difficult during the middle of an incident.

County Office of Emergency Management

Forming a partnership with the County Office of Emergency Management is one of the more important relationships a facility can build within the community. Emergency management agencies are often the source of the most current and up to date information regarding incidents and hazards.

Establishing a line of communication with the local office of emergency management will help streamline critical information sharing and coordination with facilities. In addition, emergency management agencies can provide opportunities to better prepare for incidents through informational materials, trainings and exercises.

The following table outlines suggested action items for developing and maturing relationships with emergency management agencies.

Office of Emergency Management	
☐	Establish point of contact at the County Office of Emergency Management. (Note: A list of county-specific agencies is available at http://www.dhses.ny.gov/oem/contact/map.cfm)

Office of Emergency Management	
☐	Clarify protocol and mechanisms for accessing information from the County Office of Emergency Management, including: ▪ Resource availability throughout the region ▪ Pre-determined location list ▪ Current available services and utilities ▪ Hazard forecasts ▪ Mass notification systems
☐	Understand jurisdiction's response processes and capabilities, including available resources and response priorities in a large disaster.
☐	Identify available opportunities for training and exercises with the County Office of Emergency Management.
☐	Identify critical information that the facility should relay to the County Office of Emergency Management before and during a disaster (e.g., facility status, number of residents needing transport, or infrastructure status).
☐	Seek County Office of Emergency Management input on CEMP development.

Fire Department and Law Enforcement

Enhancing relationships with first responder agencies are also critical to expediting the response process. These agencies will often be the first of the group to support facilities and relay critical incident information.

The following table outlines suggested action items for maturing relationships with fire department and law enforcement agencies.

Fire Department and Law Enforcement	
☐	Establish point of contact at fire department, emergency medical services, and law enforcement agency.
☐	Identify what critical information should be relayed to fire department, emergency medical services, and law enforcement agencies before, during, and after a disaster.
☐	Identify opportunities for training and exercises with fire department and law enforcement agencies.

Fire Department and Law Enforcement	
☐	Solicit fire department and law enforcement agency input on recommendations to expedite response and recovery actions, including pre-staging equipment/resources, best ingress and egress from facility, and debris removal to restore emergency access.

Corporate Organization

If the facility is part of a larger multi-facility system, the facility should coordinate with its parent organization to ensure pre- and post-incident activities adhere to corporate policies, and to ensure the facility is appropriately empowered to execute incident management functions (e.g., permissions for external messaging, clarification of branding standards).

Community Stakeholders

Facilities are encouraged to build relationships with additional community stakeholders to assist with the disaster response and recovery. Some examples of the assistance that can be provided include volunteer support, surge staffing, and resources.

Community stakeholders may be different for every facility, but may include resource providers and vendors (e.g., transportation providers, fuel); local subject matter experts (e.g., engineering, finance and recovery, sustainability and mitigation); and volunteer resources.

The table below outlines potential volunteer resources that may be utilized to augment or supplement facility staff and operations prior to, during, or after an emergency.

Entity	Description and Skills
ServNY	Administered by the NYSDOH Office of Health Emergency Preparedness, ServNY is an online registration system for licensed healthcare professionals to volunteer when local and regional resources are exhausted. Volunteers are notified of staffing requests via phone or email. ServNY may also be activated by: ▪ County Office of Emergency Management submits a request to the New York State Office of Emergency Management, which sends the request to Emergency Support Function-8 State Health Desk, and then to the NYSDOH Emergency Preparedness; or ▪ Direct order of the NYSDOH Commissioner or designee.
Community Emergency Response Team (CERT)	Community volunteers that are trained in disaster preparedness and basic disaster response skills. These skills include: ▪ Fire Suppression ▪ Simple Triage and Rapid Treatment – Airway obstruction – Bleeding – Shock – Basic first aid – Establishing a medical treatment area ▪ Light Search and Rescue ▪ Team Organization
Medical Reserve Corps (MRC)	MRC volunteers are imbedded in ServNY. Volunteers include practicing and retired medical and public health professionals. MRC volunteers can support response capabilities such as: ▪ Disaster medical support ▪ Health screenings ▪ Vaccination clinics ▪ Medical facility surge capacity ▪ Planning, logistical, and administrative support

Communications Plan

A communications plan helps facilities maintain situational awareness throughout the duration of an incident and enables facilities to share information effectively across the organization, as well as with any external partners who may be supporting the response.

Objectives

- Ensure communication policies, roles, and activities are clearly defined and well-understood by staff.
- Ensure internal and external communications are accurate, timely, and informative.
- Provide frequent updates to residents, staff, relatives/responsible parties to mitigate concerns and manage expectations.
- Only share known/confirmed information (i.e., do not speculate).
- Utilize one unified voice to avoid confusion or misinformation.

Implementation

Communications Checklist	
Preparedness	
☐	Designate and train personnel to serve as Public Information Officer prior to an incident (i.e., during normal operations). Potential training courses include: ▪ FEMA IS-29: Public Information Officer Awareness (Free Online Course) ▪ FEMA IS-42: Social Media in Emergency Management (Free Online Course)
☐	Develop and refine pre-scripted messaging that can be tailored for incident use.
☐	Determine primary and redundant forms of communication: ▪ Primary forms include landline-dependent communications such as telephones and cellphones. ▪ Redundant forms are not dependent on functioning landline communication (e.g., include two-way radios, satellite radios).
☐	Ensure multiple personnel have administrative access, training, and policies and procedures to the facility's website, social media accounts, and voicemail system.
☐	Maintain up-to-date contact information for designated notification parties for all residents (e.g., relatives/responsible parties).
☐	Maintain up-to-date contact information for all staff.
☐	Clarify approval processes for internal and external messaging content (e.g., peer review, senior leader final approval).
Incident Response	
☐	Request an updated on the incident from the Incident Management Team:

Communications Checklist	
	▪ What happened? ▪ What is the status of residents and personnel? ▪ When will the incident be resolved?
☐	Inform internal audiences (e.g., personnel) about incident updates before informing external audiences.
☐	Provide office personnel (e.g., receptionist) with guidance on where to direct incoming inquiries (e.g., media, personnel, relatives/responsible parties, vendors).
☐	Maintain a log of incoming calls, including: ▪ Name of caller ▪ Name of publication or media source ▪ Phone number ▪ Email address ▪ General nature of inquiry and any deadlines
☐	Develop a press release (or official facility statement) to post on facility website and social media pages.
☐	Update the facility's voicemail recording to provide alternative contact information if the facility is evacuated and/or to field incoming inquiries.

Pre-scripted Messages

Depending on the situation, numerous forms of alerts and warnings may be required to reach staff, residents, relatives and responsible parties, and the media.

It is vital to have several staff members who are solely responsible for fielding calls from residents' relatives and responsible parties and who are familiar with pre-scripted messaging usage. Only authorized spokespersons (e.g., Public Information Officer) should manage media and public inquiries.

Internal Pre-Scripted Messaging

To facilitate timely and effective communications, the use of pre-scripted messaging templates can aid facilities to tailor for incident-specific messaging. During an incident, the facility will manage or coordinate the development and dissemination of these messages.

Immediate Messaging

Please note that for incidents that pose an immediate threat to health or safety (e.g., active threat or fire), messaging should be short and direct (i.e., "Intruder Alert Main Entrance," or in the case of fire, "Code Red

Zone 5").

CEMP Activation

The following process will be used for on-duty staff members who will be needed to fill Incident Management Team positions:

> On duty staff will be contacted directly and/or via overhead page. They will be told where to report and then will receive further information upon arrival.

The following process will be used for off-duty staff members who will be needed to support incident operations:

> Off duty staff will be contacted directly and provided with all necessary situational information. Staff will be given all role assignments, obligations and their individual reporting structure along with appropriate team member contact information.

Informing the Residents

Resident care personnel are responsible for informing their residents of the incident. It is important to accommodate for the unique needs of each resident and provide messaging appropriate to each resident's level of understanding.

> Social Services staff will coordinate the process of informing facility residents of the emergent situation. Based on need and specific circumstances, other facility personnel may need to be involved in resident updates. Social Services staff will inform the Incident Commander of the needs and the IC will assign additional staff accordingly.

Informing Staff about Evacuation to Receiving Facility

> On duty staff will be informed of all evacuation related information and protocols through the standard Incident Command System reporting structure. Incident Management Team members will notify and update their direct reports, and those individuals will update their direct reports. This process will continue until all appropriate staff has been updated.

Informing Residents about Evacuation to Receiving Facility

> The Incident Commander will assign appropriate facility staff to work in concert with Social Services in order to properly notify each resident of the impending evacuation and relocation. Social Services Staff will coordinate with assigned support staff to ensure that any residents with communication issues or other special needs are properly updated.

External Pre-scripted Messages

Robo-Call/Website Posting/Social Media Message

Example Message

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations have been initiated to manage the incident. [Provide high level information on residents' status]. We are taking extensive actions to protect residents. [For your safety and that of others, please do not attempt to come to the facility]. [In the event of evacuation, add] *For resident safety and well-being, residents are being evacuated to [Location].*

For more information, please contact [Name, Title] at [Phone/Email].

Proactive Communication to Relatives and Responsible Parties

When communicating with relatives and responsible parties it is important to provide high level information on the status of residents. If it is known that certain residents have been injured, or there are fatalities, stress the seriousness of the incident but do not release resident information until the status of injured residents and fatalities can be confirmed and the incident is contained.

Proactive communications with families and responsible parties will be conducted via Robo-Call utilizing the pre scripted message above or an alternate message if needed. Families and responsible parties will be contacted individually with more specific information once the situation permits such actions. At that time, appropriate staff members will be assigned to contact specific resident responsible parties in order to communicate high level facility information as well as resident specific information. Staff will also provide responsible parties with the name and contact information for their assigned facility liaison. On a go forward basis, all facility/responsible party communications will be conducted via the assigned facility liaison.

Communications with the Public

The facility should notify media outlets of the incident as deemed necessary by the Incident Commander. Only the Public Information Officer and authorized facility spokespersons should communicate with the public.

Key principles of communicating with the media and public are:

- Be knowledgeable. Know the facts before reporting out.
- Be strategic in what information is shared.
- Be credible. Do not try to distort facts to protect the facility. The facility will be held responsible for any misinformation that is provided by the Public Information Officer.
- Be accessible to inquiries; be transparent.
- Avoid statements such as "no comment" or other language that may appear deceptive. This will invite the public to draw their own misinformed conclusions.
- Be proactive. Control messaging that is released and do not let the media and public distort messaging. Correct any rumors that arise.
- Be flexible. Ensure the audience understands that the situation is unfolding, and information will be shared as it is made available.
- Be calm and collected.
- Be sure to provide contact information where the media and public can direct inquiries.

Protective Action Decision Support

Facilities should use sound decision-making criteria when considering which protective action to implement (e.g., evacuate, defend-in-place). The following questions can be used to arrive at a decision.

Protective Action Considerations	
Information and Intelligence	
☐	Have local authorities issued protective action guidance?
☐	Have adjacent counties/municipalities protective action guidance?
☐	What is the status of traffic near the facility?
☐	What is the acuity of the current resident population?
☐	What is the status of receiving facilities?
☐	What is the capacity of receiving facilities to receive residents?
☐	Have send-receive arrangements been put in place and verified?
Anticipated Impacts	

Protective Action Considerations	
☐	What are the anticipated impacts on the facility?
☐	What is the forecasted external temperature for the next seven days?
☐	What facility infrastructure might be affected?
☐	Are there any anticipated life safety issues?
Resource Levels	
☐	What are staffing levels?
☐	Have surge-staffing options been implemented?
☐	What is the status of medical, pharmaceutical, and resident care supplies?
☐	What is the status of food and water?
☐	What is the status of generators and fuel levels?
☐	What is the status of transportation resources?
☐	Have any vendors/service provider agreements been activated?

After Action Review Process

Following every exercise or real-world incident, it is vital to capture best practices, lessons learned, and areas for improvement in an After-Action Report (AAR). Plans, policies, and procedures should be updated to incorporate and address the outcomes outlined in each report.

After-Action Review Process	
☐	**Designate a staff member**(s) to conduct the After-Action Review process and solicit information for the AAR through: ▪ Post-incident/exercise discussions and evaluations. ▪ Surveys and feedback forms from the Incident Management Team, staff, residents, responsible parties, and emergency supply vendors, and local emergency management providers.

After-Action Review Process	
☐	**Describe the event**, be it a real-world incident or an exercise. Include as much detail as possible. Questions to consider: ▪ When and where did the event occur? How long did the response last? ▪ What was the nature and magnitude of the event? (For exercises, what is the summary of exercise activities?) ▪ How did the incident impact residents, services, and the facility/facilities?
☐	Select the **focus areas** for the AAR based on areas needing improvement.
☐	Under each focus area, describe **areas for improvement**. Questions to consider: ▪ What gaps, barriers, or challenges emerged? ▪ What resources were needed that were not available? ▪ What disruptions to services occurred? ▪ How well did personnel understand their roles and responsibilities?
☐	Identify next steps for **improving future responses**. If possible, develop an improvement plan outlining priority levels, responsible parties, and estimated timelines for implementation. Provide additional training to cover areas of weakness.

After Action Report Template

Event	Event Date
[Incident/Exercise Name]	**[Date]**
Event Description	
[Brief description of incident/exercise]	
Strengths	
▪ **[Placeholder]** ▪ **[Placeholder]** ▪ **[Placeholder]**	
Areas for Improvement	

Event	Event Date
[Incident/Exercise Name]	**[Date]**
Event Description	
[Brief description of incident/exercise]	
Strengths	
▪ **[Placeholder]** ▪ **[Placeholder]** ▪ **[Placeholder]**	
Improvement Plan	

Issue/Area for Improvement	Corrective Action	Responsible Party	Start Date	Completion Date

Resource Management

Resource Considerations

Before a disaster occurs, it is important to have send-receive agreements in place; have lists of vendors and service providers; and have all necessary information about site generator systems on hand. This information is vital to the internal facility response, can help first responders, and can set accountability. When determining which resources may be necessary for facility preparedness, consult the considerations below:

Generators

- What reporting processes are in place in the event that a generator fails inspection, is not properly maintained, or fails a test?
  - Facility has current protocols in place to engage Penn Power and Frey Electric in the event of emergency generator failure. Penn Power is capable of providing the facility with an appropriately sized mobile generator set. The time to produce the generator will depend on its current location, but the time will not exceed 2 hours. Frey Electric will provide electricians to connect the mobile generator to the facility emergency panel at the time of delivery.
- What positions are routinely trained on the process of establishing emergency power to the building?
  - The emergency generator and transfer switch are designed and set to automatically (10 seconds or less) establish emergency power in the event of a loss of adequate electrical power to the facility. The transfer switch can also be operated manually by a properly trained individual if necessary.
  - Who is responsible for performing this task?
    - The Environmental Services Manager trains all Maintenance personnel on the proper procedures for establishing emergency power.
- What procedures are in place to troubleshoot generator system failures?
  - In light of safety concerns, only a factory trained technician or licensed electrician are authorized to adequately troubleshoot and/or repair the emergency generator. Penn Power and Frey Electric are available 24/7 to address these types of issues.
- How long can emergency power be sustained before having to replenish fuel if tank is full?
  - The facility generator operates on natural gas, and therefore, it can sustain emergency power indefinitely as long as the natural gas service remains operational through the utility.
- What systems, capabilities, and/or resources will be impacted if power is lost and emergency power is unable to be secured (e.g., food, water, ventilation)?
  - All heating, cooling, mechanical ventilation, refrigeration, hot water systems, laundry systems, some cooking equipment, EMR, oxygen manifold and mobile concentrators, fire alarm system once backup battery expires, lighting, emergency lighting and exit signs once backup batteries expire, most computer systems, internet/wifi and the main switchboard. Facilities with sewage lift stations, sewage grinders, macerating pumps, sump pumps, ejector pumps and fire pumps (electrical and pneumatic types) will lose service.
  - **Facilities with elevators - All elevator equipment will not be operational. Any multistory facilities that rely on any type of water distribution system other than gravity fed will need a protocol for water delivery to the uppermost floors.*
  - Equipment/services that will remain operational without electrical service are some cooking equipment, cell phone communications, two way radios, portable oxygen tanks, battery work lamps and lanterns, cold water services, all plumbing system components other than pumps, sewer systems, natural draft ventilation, fire protection sprinkler system and hood mounted fire suppression system. **(Multistory facilities that rely on fire pumps to feed the sprinkler system on upper floors will lose this service.)*

Fuel

- Is the emergency fuel source municipal fuel or local/on-site fuel?
  - Utility company's infrastructure supplies emergency natural gas.
- What is the current onsite fuel storage capacity?
  - n/a

Potable Water

- Where is potable water stored on site?
  - 1 main potable water sources feed the facility system. The main feeds enter the facility from Wehrle Drive. Potable water source is protected by individual Reduced Pressure Zone (RPZ) assemblies to prevent potential source contamination. The facility has (1) 700 gallon storage tanks on site, both of which are constantly fed via the main municipality source. These tanks are located in the facility boiler room, and can be isolated from both the main feed as well as the rest of the facility if necessary. An emergency supply of potable water is stored in the service hall storage "cage."
- What potential barriers are there to reaching the potable water during an emergency?
  - n/a
- Will potable water storage be safe from contamination by flood waters or severe storms?
  - Facility storage tanks can be isolated as needed to protect from internal plumbing system contamination. They are also constructed to resist infiltration of water and contaminants through the tanks and piping from exterior sources.
- Who manages the potable water storage? - Environmental Services Manager

Transportation

- Which types of vehicles are immediately available to the facility?
  - (2) 2 passenger, 2 w/c vans, (1) 1 Passenger 2 w/c van
- Are facility-owned vehicles maintained?
  - Yes - regularly
- Where can facility-owned vehicles access fuel?
  - Minimal fuel is available on site (less than 10 gallons)
  - Mobil is located approx. 0.8 north of the facility at the cross section of Transit Rd and Main Street.
  - Speedway is located approx. 1.8 miles south of the facility at Transit Road and Genesee Rd.
  - Sunoco is located approx. 1.4 miles east of the facility at Harris Hill and Genesee Rd.
- How many and which staff can operate facility-owned vehicles?
  - 6 staff members
  - Philip Maras, John Carrigan, Ernest Johnson, Richard English, Crytal Gulla, David Spahr
  - Where are copies of operator licenses kept?
    - Licenses are kept on file with HR

Medication/Pharmacy Services during Emergency Conditions:

Medication/treatments will be supplied by PharMerica.
The agreement between the facility and PharMerica is on file with the Administrator.

PROCEDURE

1. Medications/treatments will be obtained from PharMerica in accordance with the policies and procedures outlined in this manual.

2. Should any problems arise with the Pharmaceutical Services provided, the contact person will be the Supervising Pharmacist at PharMerica.

3. Medication/treatments may be obtained from an alternate pharmacy provided that the pharmacy can provide medication/treatments in accordance with all facility policies and procedures and State and Federal codes, rules and regulations.

Medication Procurement
EMERGENCY SITUATIONS

In an emergency situation defined by the Commissioner's Ruling Public Health Law Section 3321:
Any health care facility which is licensed by the Department as a class 3 institutional dispenser or any retail pharmacy which is licensed by the State, and which health care facility or retail pharmacy is also duly registered with the United States Drug Enforcement Administration (DEA), is exempt from the licensing requirements for the sale of a controlled substance stock by a pharmacy to a pharmacy provided such sale is solely to meet the immediate needs of the pharmacy receiving the controlled substance.

An immediate need exists when the facility or retail pharmacy is not capable of preparing a controlled substance medication or does not have a controlled substance in stock and immediate administration or dispensing of the drug is necessary for proper treatment.

This ruling shall only apply to transfers or sales of stocks of controlled substances. Transfers or sales of other prescription medications are governed by the State Education Law.

A pharmacy, under the direct supervision of the pharmacist, may sell or transfer schedule III, IV or V controlled substances to another authorized pharmacy pursuant to a written request submitted by the purchasing pharmacy or facility on business stationery. All such requests shall indicate the name and address of the requesting pharmacy, the name and address of the pharmacy furnishing the controlled substance, the DEA registration number of both pharmacies, date of the request, and the name, strength, dosage form and quantity of the controlled substance being requested.

Schedule II controlled substances shall be ordered only on an official DEA 222 order form or any successor form and/or methodology authorized by the U.S. DEA. All controlled substance requests must be signed and dated by both the furnishing and the requesting pharmacist.

The pharmacy (vendor) furnishing the requesting pharmacy (vendee) shall provide the vendee pharmacy with an itemized list of the drugs sold or transferred and shall include the name and address of the vendor pharmacy, the name and address of the vendee pharmacy, DEA numbers of both pharmacies, date of the sale or transfer and name, strength, dosage form and quantity of controlled substances being sold or transferred. Upon receipt of the controlled substance, the vendee pharmacist shall sign and date the itemized list of drugs sold or transferred.

The vendor pharmacy and the vendee pharmacy shall maintain all required records of such transfers and request in a separate file or in such a manner as will make them readily available for inspection by authorized representatives of the Bureau of Narcotic Enforcement, New York State Health Department and/or the United States Drug Enforcement Administration or other law enforcement officials authorized by law to inspect such records.

PROCEDURE

1. In the event that a controlled substance ordered for the resident is not available or not normally stocked in the facility pharmacy and cannot be changed to an equivalent controlled substance on hand in the pharmacy, the supervising pharmacist/designee obtains the ordered controlled substance from PharMerica or back up retail pharmacy.
2. The supervising pharmacist/designee calls PharMerica first to ensure that they have the ordered controlled substance on hand. If the ordered controlled substance is not available at PharMerica, the back up pharmacy is called.

3. For all Schedule III, IV and V controlled substances, the supervising pharmacist/designee completes an Emergency controlled substance Request Form (4F.16.A-E) which includes: the facility pharmacy name and address, the name and address of the pharmacy furnishing the controlled substance, DEA Registration number of both pharmacies, date of the request and the name, strength, dosage form and quantity of the controlled substance being requested.
4. For all Schedule II controlled substances, the supervising pharmacist/designee completes a DEA 222 order form. The form must be signed and dated by both the furnishing and receiving pharmacies.
5. Upon courier delivery of the requested controlled substance, the supervising pharmacist/designee verifies the contents against the manifest/invoice. The manifest/invoice includes: an itemized list of the controlled substance(s), name and address of the vendor pharmacy, name and address of the facility pharmacy, DEA numbers of both pharmacies, date of the sale or transfer, name, strength, dosage form and quantity of the controlled substance(s).
6. After reconciliation of the controlled substance(s), the supervising pharmacist/designee signs and dates the invoice/manifest and keeps a copy.
7. A copy of the manifest/invoice is maintained in the facility pharmacy in a separate binder.

Emergency Medication Box

POLICY

An emergency medication box will be available at each nursing unit. The box will contain medications that may be necessary for resident therapy during an emergency. In addition to the medications found in the emergency medication box, the nursing unit designated as the first aid station will contain a limited supply of specialized injectable medications.

PROCEDURE

1. The contents of each Emergency Box are recommended by the Facility Quality Assurance Committee and approved by the Medical Director, Director of Nursing and Consultant Pharmacist.

2. The Emergency Box will not contain any controlled substances.

3. The Emergency Box is maintained in the medication room of each nursing unit and kept locked at all times.

4. The Special Unit ER Box and the IV Solution Supply is kept on the sub-acute/designated unit.

5. The contents of the Emergency Box are identical on all nursing units, with the exception of the kit stored on the first aid unit of the facility, in which additional injectable medications are stored.

6. A list of Emergency Box and Special Unit ER Box contents is attached to the top of each box. An expiration date for the entire box is marked on the lock of the box. This indicates the date that the first item contained in the box expires.

7. In the event the Emergency Box/Special unit ER Box/IV solution supply is used:

    a. The Emergency Boxes are only used for emergency situation and is signed out accordingly by the nurse.

Emergency Medication Service

Medication/treatments will be supplied by PharMerica. PharMerica has 24 hour services available via on-call at the local pharmacy and/or its sister sites.

The agreement between the facility and PharMerica is on file with the Administrator.

In the event that PharMerica is unable to provide medication(s), the facility has entered into agreement with McKesson pharmacy to provide such services.

The facility is equipped with emergency medication kits (E-Kits) in dedicated locations available 24/7. Such E-Kits provide critical medications. Please refer to E-Kit policy.

PROCEDURE

1. The facility can reach a pharmacist any time of the day.

2. Medications/treatments will be obtained from PharMerica in accordance with the policies and procedures outlined in this manual. Each medication unless otherwise specified is filled for a 30 day cycle.

3. For medication orders, the facility can call the pharmacy directly during normal business hours (8 AM to 9:30 PM) at 716-631-2433. Should any problems arise with the Pharmaceutical Services provided, the contact person will be the Supervising Pharmacist at PharMerica.

4. After hours "Emergency Service" will be described as the need for a medication that is not contained in the Emergency Box and must be administered for any emergency or STAT new orders:

    a. after hours a pharmacist can be reached at 716-481-6931
    b. pharmacist will call back within 1 hour

5. Medication/treatments may be obtained from an alternate pharmacy provided that the pharmacy can provide medication/treatments in accordance with all facility policies and procedures and State and Federal codes, rules and regulations.

6. McKesson Pharmaceutical may be used as back up in the event that PharMerica is unable to provide service.

Glossary

Term	Definition
Activation	To begin the process of mobilizing a response team, or to set in motion an emergency operations (response) or recovery plan, process, or procedure in response to incident or exercise.
Automatic Sprinkler	Ceiling sprinklers are located throughout the facility and are activated by heat, thereby setting off the water flow and the alarm.
Defend-in-Place	The ability of a facility to safely retain their residents in an incident-related situation (e.g., flood, severe weather, wildfire). This is also known as “hunkering down” during an event.
Demobilization	The orderly, safe, and efficient return of an incident resource to its original location and status.
Evacuation	Organized, phased, and supervised dispersal or removal of people from dangerous or potentially dangerous areas, and their reception and care in safe areas.
Evacuation Holding Area	Temporary refuge for residents and staff during a facility evacuation, and if needed, point of embarkation for transport for longer-term evacuations.
Evacuee	A person removed or moving from areas threatened or struck by a disaster.
Fire Alarm	Loud ringing of bells, which may be activated by detectors, sprinklers, or manually, to alert residents and staff. When the bells sound, one of the systems has been activated and an emergency is occurring.
Fire Doors	These doors cut off a wing or a portion of a wing from adjoining areas to prevent drafts, which carry smoke, and retards the spread of fire.
Hazard	Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Term	Definition
Hazard Vulnerability Analysis	A systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or "vulnerability," is related to both the impact on organizational function and the likely service demands created by the hazard impact.
Incident Action Plan	An oral or written plan, containing objectives that reflect the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.
Incident Command System	A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.
Incident Management	The broad spectrum of activities and organizations providing effective and efficient operations, coordination, and support applied at all levels of government, utilizing both governmental and nongovernmental resources to plan for, respond to, and recover from an incident, regardless of cause, size, or complexity.
Incident Management Team	The Incident Management Team is comprised of pre-designated personnel who are assigned to plan and execute response and recovery operations. Incident Management Team activation is designed to be flexible and scalable depending on the type, scope, and complexity of the incident. As a result, the Incident Commander may decide to activate the entire team or select positions, based on the extent of the emergency.
Lockdown	A security measure taken during an emergency to prevent people from leaving a facility, and to prevent an active threat (one or more persons) from entering a facility.

Term	Definition
Mitigation	Activities providing a critical foundation in the effort to reduce the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster and providing value to the public by creating safer communities. Mitigation seeks to fix the cycle of disaster damage, reconstruction, and repeated damage. These activities or actions, in most cases, will have a long-term sustained effect.
Operational Period	The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually they last 12-24 hours.
Preparedness	A continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response. Preparedness focuses on the following elements: planning; procedures and protocols; training and exercises; personnel qualification and certification; and equipment certification.
Receiving Facility	A facility that has entered into agreement with another facility (nursing home, adult care facility, hospital, etc.), offering to host residents and staff for some part of an emergency response.
Response	Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes.
Recovery	The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, non-governmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.
Secure Area	An area that has been checked and verified to be clear of fire/danger, with windows and doors closed, equipment shut down, and hallways free of obstacles.

Term	Definition
Shelter-in-Place	NYSDOH defines shelter-in-place as the protective action strategy of keeping a small number of residents in their present location when the risks of relocation or evacuation exceed the risks of remaining in current location. Can only be done for coastal storms. Requires pre-approval from NYSDOH prior to each hurricane season and pre-authorization at the time of the incident. Please refer to the 2019 Evacuation Plan.
Situational Awareness	Is the ability to identify, process, and comprehend the essential information about an incident to inform the decision-making process in a continuous and timely cycle and includes the ability to interpret and act upon this information.
Smoke Detector	Smoke detectors are located on ceilings throughout the facility and respond to smoke thereby setting off the alarm.
Threat	Natural or manmade occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property.

For all Hazard Annexes below the NYSDOH Regional Office is to be notified during normal business hours. **For events that occur on nights, weekends or holidays, notify the NYSDOH Duty Officer at 866-881-2809**.

Hazard Annex A: Active Shooter/Active Threat

An active threat is an individual or group of individuals actively engaged in killing or attempting to kill people in a confined and populated area, often through the use of firearms.

CODE WORD *I* COMMUNICATION: Active Shooter

STANDARD

The McGuire Group is strongly committed to its residents and employees in the provision of a safe, healthy and secure environment.

In the event of an active shooter incident, the facility will follow a systematic approach to keep residents and staff out of harm's way. In the end, individuals will have to make decisions based on their assessment of the situation in how to best maximize the protection of life and tactics to employ.

Active shooter incidents are defined as: those where an individual is "actively engaged in killing or attempting to kill people in a confined and populated area." Active shooter incidents may occur inside or outside a building.

Practices:

1. Prevention
    a. Identify and report their supervisor concerning behaviors: paranoid ideas, delusional statements, changes in personality or performance, disciplinary problems on site, depressed mood, suicidal thoughts, non-specific threats of violence, increased isolation or odd/bizarre behavior, and interest in or acquisition of weapons. Potential threats include: staff significant others, disgruntled current or former employees, family members of residents, etc.
    b. Encourage staff to report to their supervisor any real or potential threats or concerns regarding possible violent actions from spouses, ex-spouses, significant others, etc.
    c. Gather as much information about the situation as possible from the reporter, including a description of individual (photos if available), make and model of vehicle, etc, and contact police immediately if the person is seen on the property or in the immediate area.
    d. If a direct threat of violence is made towards the facility, the Administrator/designee is immediately notified and contacts police.
2. Internal Procedure

a. When an active shooter is identified by the facility, the front desk receptionist/designee is notified immediately.

b. The front desk receptionist/designee pushes the “panic” button (when appropriate to notify local law enforcement) located at the front desk and when able, announces “active shooter” and the location where the shooter is. The announcement is made 3 times.

c. If the active shooter enters the facility at a different location other than the front door, call 911.

d. All people inside the facility should engage the Run-Hide-Fight continuum based on their individual set of circumstances.

    i. RUN if there is an accessible escape path; attempt to evacuate residents, visitors, and staff away from the immediate area of the active shooter, if safe to do so. Be sure to:

        1. Have an escape route and plan in mind.
        2. Leave your belongings behind.
        3. Help others escape if possible.
        4. Keep your hands visible.
        5. Follow the instructions of any police officers.
        6. Do not attempt to move wounded people.
        7. If unable to evacuate residents, place residents in rooms and close doors. Do not stay behind because others won’t go.

    ii. HIDE if unable to evacuate. Find a location to hide where the active shooter is less likely to see you. Your hiding place should:

        1. Be out of the active shooter’s view.
        2. Provide protection if shots are fired in your direction.
        3. Not trap you or restrict your options for movement.
        4. To prevent and active shooter from entering your hiding place: lock and barricade doors, turn off lights, close blinds, turn off radios or other sound emitting devices, silence cell phones, keep out of sight and take adequate cover (concrete walls, thick desks, filing cabinets) and remain quiet.
        5. Remain in place until given an all-clear by identifiable law enforcement.
        6. If evacuation and hiding are not possible: remain calm, dial 911 to alert police to active shooter’s location (if you cannot speak, leave line open and allow dispatcher to listen.

    iii. FIGHT- as a last resort. Fight when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

        1. Acting as aggressively as possible against the shooter.
        2. Throwing items and improvising weapons.
        3. Yelling.
        4. Committing to your actions.

3. External Procedure
    a. Gather members of the IMT at the ICC (Incident Command Center) and inform them of the situation. Share information including descriptions of the individual, vehicle, etc. Make plans to "lockdown" and contact police immediately if the person is seen on the property or in the immediate area.
    b. Lockdown procedures:
        i. All entrance doors and windows locked to the extent possible.
        ii. Curtains/blinds closed.
4. Responding when law enforcement arrives:
    a. Remain calm and follow office instructions.
    b. Put down any items in your hands.
    c. Immediately raise your hands and spread your fingers.
    d. Keep hands visible at all times.
    e. Avoid making quick movements towards officers.
    f. Avoid pointing, screaming or yelling.
    g. Do not stop officers for help or direction when evacuating, just proceed in the direction from which the officers are entering the premises.
    h. Information to provide to officers:
        i. Location of active shooter, if known.
        ii. Number of shooters.
        iii. Physical description of shooters.
        iv. Number and type of weapons.
        v. Number of potential victims.
        vi. Number of staff members on duty.
        vii. Number of residents in facility.
        viii. Number of visitors/vendors in facility.
5. Departmental responsibilities:
    a. Administrator/Designee:
        i. Ensure that 911 has been called.
        ii. Ensure that a code Active Shooter has been announced when able and has included a specific location.
        iii. For incidents external to the building, institute building "lockdown" with a focus on preventing people from exiting the building into harm's way.
        iv. For incidents internal to the building, secure doors if possible, to prevent additional people from entering the building into harm's way. However, do not post staff at doors.

v. Establish the ICC when the situation permits. Ideally the ICC will have access to the cameras to visualize where the active shooter is.

vi. Provide a facility liaison to the police department at the police command post or alternate location as requested.

vii. Provide for resident, staff and visitor accountability to the extent possible.

viii. Report any missing persons to police.

ix. If necessary, contact staff on next shift and provide information based on police guidance.

x. Make provisions to notify families/responsible parties of and casualties or injuries.

xi. At the direction of the police, an "Active Shooter All Clear" will be announced. All effected personnel will be contacted immediately and debriefed.

xii. Establish and off-site media center in conjunction with police.

xiii. When appropriate, ensure the following notifications are made to: off duty staff, resident families/responsible parties, local/state Department of Health.

xiv. Consider need for off-site reunification center where residents, visitors and staff can be picked up.

b. Maintenance responsibilities:

i. Prevent others from entering as area where the active shooter may be.

ii. Secure doors, if appropriate to isolate incident.

iii. Secure building entrances and exits. Focus on keeping people from entering the building for internal incidents and from leaving the building for external incidents.

iv. Meet responding police and provide them with the incident location, number of shooters, number of victims, type and number of weapons being used, individuals still in the area, identity and description of the shooter(s), if possible.

v. Be prepared to provide floor plans and keys to responding police officers.

vi. Be prepared to shut down utilities as requested by police.

vii. Identify phone extensions in the closest proximity of the shooter/hostage taker and provide to police.

viii. Identify internal door locking systems and provide access information to police.

ix. Identify surveillance and recording systems monitoring the area of the incident. Provide to police.

6. Initial Recovery Operations

a. Keep the scene secure. Follow police instructions.

i. Isolate and protect the scene and evidence.

ii. Do not alter the scene or try to investigate the crime or incident. The police will provide you with actions/procedures to follow.

b. Document everything while it is still fresh in your mind.

c. Utilize Nursing, Social Work and Pastoral Care staff to assess, treat and calm persons involved in the incident.

d. Post-incident critical stress debriefing should take place. Consider using and EAP.

e. All persons involved in the incident should remain available to talk to the police.

Hazard Annex B: Winter Storm/Severe Weather

1. In the event of a severe snowstorm which limits the ability of staff to report to work and impedes deliveries of food supplies, the building Supervisor will be responsible for implementing the following procedures to ensure residents' health and safety are maintained.
2. Notify Administrator, D.N.S., and other department heads if not currently in the building.
3. Staff on duty when snow storm begins are to remain on duty until released by their department head, while a staff person assigned begins calling in all available personnel, beginning with those living in close proximity to the facility.

4. Transportation
    1. The Incident Commander may delegate the responsibility for obtaining and/or coordinating transportation to the Logistics Section Chief.
    2. It will be the responsibility of the Logistics Section Chief to:
        a. Obtain and maintain accurate information on bus availability and driving conditions.
        b. Coordinate car pools, when requested, for employees trying to come to the facility, and for employees who have been released from duty and who are attempting to go home.
        c. Maintain a list of employees or others who have volunteered to lend and/or drive four-wheel drive vehicles for transportation of staff or supplies.
        d. Maintain contact, if necessary, with local government or other agencies to obtain emergency transportation.
        e. Remind all employees traveling during restricted driving periods to have there ‘Emergency Personnel’ sticker adhered to their windshield.
    3. Notify staff that a three (3) day emergency supply of food and disposable paper products is on hand in the Dietary department. Follow policy for Emergency situation Meals. (See Attachment)
    4. Determine that adequate supplies of linen and disposable incontinent products are on hand. Instructions for running the washers and dryers are contained in this manual in the event Laundry staff is not available.
    5. Determine that an adequate supply of medications are on hand. Contact Pharmacy for any necessary medications prior to onset of what is predicted to be a severe snowstorm.
    6. Contact community agencies i.e. Police, Fire Department, Red Cross etc, for assistance in obtaining emergency supplies, medications, and transporting staff. In addition, staff members who own four wheel drive vehicles will be requested to transport staff members to facility.
    7. As additional staff members report to work, relieve those employees who have been working the longest.
    8. Notify the N.Y.S. Department of Health.

Hazard Annex C: Coastal Storms/Hurricanes

Coastal storms and hurricanes may arrive as tropical depressions (maximum sustained winds of 38 mph or less), tropical storms (maximum sustained winds of 39-73 mph), or hurricanes (maximum sustained winds of 74 mph or more, ranging from Category 1-5). Hazards associated with coastal storms include: flooding; flying debris; extreme winds and tornados; torrential rain; and power outages due to downed trees and power lines.

1. Administrator or designee will make rounds to ensure normal operation, safety precautions and to check for flooding and damage.
2. Stay away from windows and outside walls. Evacuate residents to corridors, close doors, and shut down utilities.
3. If flooding occurs, Maintenance will remove by extractor.
4. Supplies will be placed in area where flooding does not occur.

If there is a hurricane WATCH OR WARNING we will:

1. Ensure that the Dietary Department has a three (3) day supply of food.
2. Run a full load test on the generator.
3. Check all resident medications to ensure that there is a three (3) day supply.
4. Ensure that there is a three (3) day supply of all essential nursing supplies.
5. Move equipment to alternate areas, if necessary. Check and secure all outside items, (i.e. tables, chairs, etc) Check all gutters and roof drains.
6. Ensure that we have a three (3) day supply of linen. Ensure that we have on hand extra blankets.
7. Ensure that alternate means of storage is designated in case of flooding.
8. Buy all necessary emergency equipment, (flashlights, tape, batteries, etc.)
9. Review Disaster Manual and emergency evacuation procedure.

Hazard Annex D: Intentionally Left Blank

Hazard Annex E: Earthquake

Earthquakes cannot be predicted and are considered "no-notice" incidents. Hazards associated with earthquakes include: tsunami (flooding); power outages; fires, and landslides.

A general approach to be followed in the event of an earthquake is as follows:

1. Remain calm. Do not panic or run through or outside the building. The greatest point of danger is just outside doorways and close to outer structure walls due to the hazard of falling debris.
2. If you are in the building, remain where you are. If possible, take cover under a desk, table, or bench, or in doorways, hallways, or against inside walls. These areas are the most sound structurally during an earthquake.

. Keep visitors, patients, and other employees out of stairwells and elevators.

4. Instruct residents in beds to remain in their beds.

5. Reassure and assist patients and visitors.

6. Do not abandon your residents.

7. If you are outside, stay away from the building. Stay clear of walls, electric poles, downed wires, and trees. Check all utilities and electrical equipment and use telephones only for emergencies.

8. Encourage everyone to remain in place for a few minutes after the initial shock as aftershocks may occur.

9. Above all, use good judgement.

10. Following the earthquake employees shall assess damages specific to their assigned areas and report all hazards to their supervisor. This information shall be reported to the Incident Commander for revaluation and corrective action as needed.

11. Shut down gas service at all meter locations until utility technicians can inspect and determine it is safe to reenergize the system.

Hazard Annex F: Extreme Cold

Extreme cold can occur independent of any snow, ice, or storm systems. Extreme cold events involve an extended period with temperatures at or below 32°F. The risk to health and personal safety during extreme cold is exacerbated by utility service interruption or loss. Therefore, the facility maintains its building systems ahead of any extreme weather projections. The facility acknowledges and prepares for the possibility of short staffing due to road conditions.

- Activate facility's CEMP and Facility Incident Commander (IC) if warranted.
- Assess residents for signs of distress and/or discomfort.
- Conserve heat wherever possible by closing doors and set air handling units to recirculate indoor air instead of using 100% outside air.
- Initiate actions to safely increase resident comfort, e.g., provide additional blankets and/or keeping residents in their rooms with the doors closed to retain heat (be sure to carefully monitor the temperature of residents); offer warm liquids (keeping in mind relevant dietary modifications/restrictions), etc. Contact vendors for additional supplies/equipment if appropriate.
- Do not leave residents unattended near a heat source.
- If the internal temperature of the facility remains low and potentially jeopardizes the safety and health of residents, consider re-location to a warmer part of the facility (i.e. sun side of the building) or evacuation to another facility.

Hazard Annex G: Extreme Heat

Extreme heat events are defined as periods when the heat index is 100°F or higher for one or more days, or when the heat index is 95°F or higher for two or more consecutive days. Prolonged periods of this heat accompanied by high humidity create a dangerous situation for vulnerable populations. Elderly residents and those with chronic medical conditions such as cardiopulmonary conditions, high blood pressure and residents with mental illness are at increased risk for heat exhaustion, heat stroke and heat cramps.

- Activate facility's CEMP and Facility Incident Commander (IC) if warranted.
- Assess residents for signs of distress and/or discomfort.
- Call 9-1-1 if any resident appears to be suffering from heat-related illness such as heat cramps, heat exhaustion or heat stroke.
- Consider re-locating residents to a cooler part of the facility (i.e. shaded side of building or lower floors in the case of multistory facilities)
- If the outdoor temperature is cooler than the internal facility temperature, consider opening windows and using fans to bring cooler air into the building. If the outdoor temperature is not cooler, keep the windows closed and shades drawn.
- Set air handling units to recirculate indoor air instead of using 100% outside air.
- If the internal temperature of the facility remains high and potentially jeopardizes the safety and health of residents, consider evacuation to another facility.
- Provide cool washcloths and cooling fans for air circulation.
- Encourage residents to drink fluids to maintain hydration.

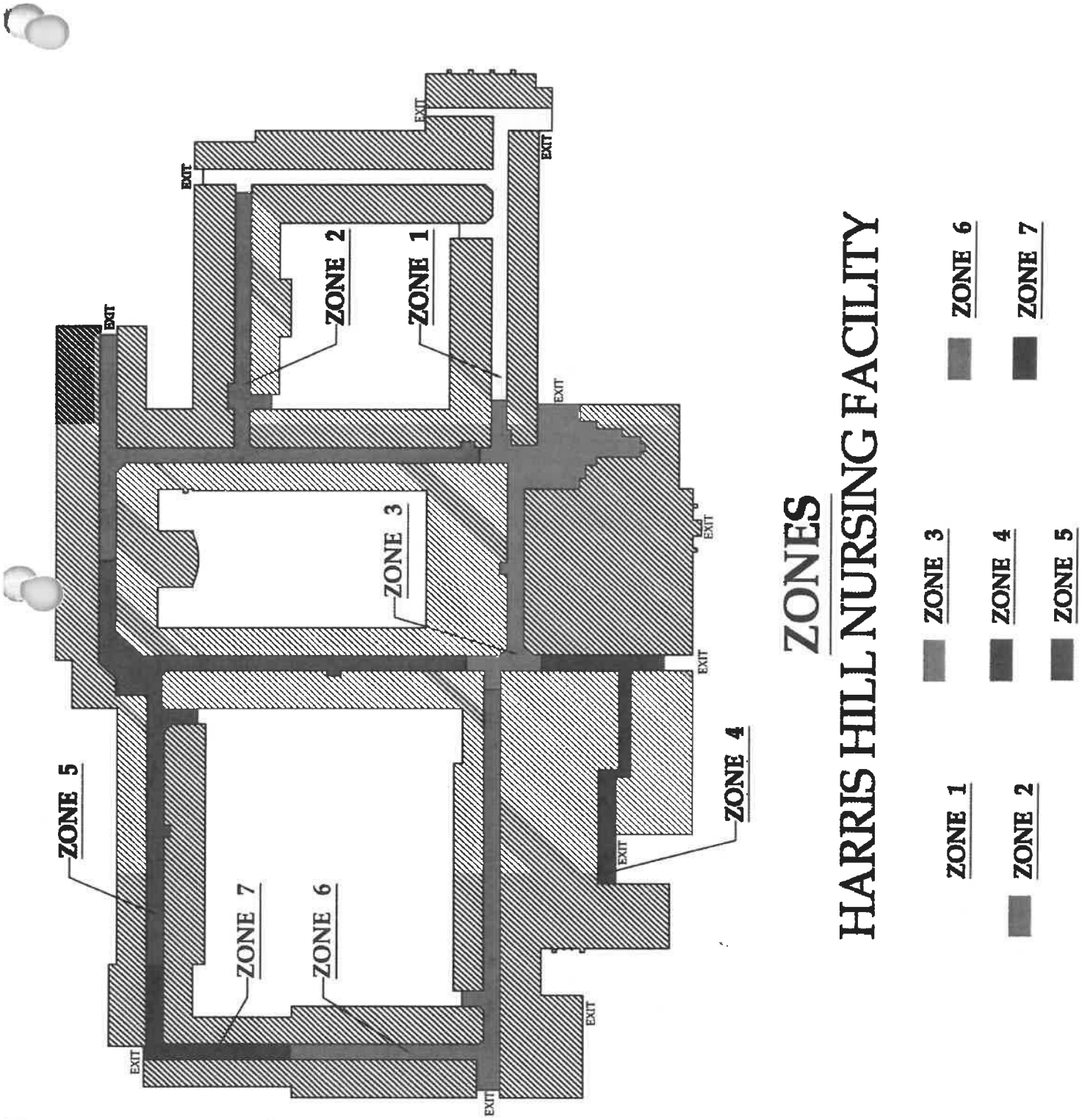
Hazard Annex H: Fire

Fires may occur within the facility or may be a result of external fire activity.

Fire Procedures

Fire Zones

IF YOU DISCOVER A FIRE:



R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone, placing residents into rooms.

E. **Evacuate** to the nearest safe area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. **Oxygen shut-down:**
   a. When a fire scene involves oxygen in use, staff nurses shut off the oxygen at the wall supply (by removing the flow meter) or turning portable tank valve to off position.
   b. Main valve for emergency OXYGEN AND VACUUM is shut off per direction of the Fire Department, Administrator, or Nursing Supervisor.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

II... <u>RESPONSE TO THE ALARM</u>

OR HEARING "*CODE RED*" BEING CALLED OUT

A. Staff in the Immediate Area:

- Assist in the **evacuation** of the fire room and close the door to the fire room.
- **Close doors** and windows to remaining rooms in the fire zone, placing residents into safe rooms
- **Clear corridor** of equipment - **Do not** place equipment into occupied resident rooms

• Turn off fans.

B. Receptionist (8 a.m. - 8 p.m.) / Nursing Supervisor (other times):

• **Page** location of fire

• Place back-up **phone call** to the fire department (911)

NOTE: If you are notified by telephone (and no fire alarm was sounded) - notify/send someone to the area to pull the fire alarm.

C. Receptionist (8a.m. – end of work shift) / Nursing Supervisor (end of reception shift – 8 a.m.)

• Meet the fire department and inform them of the entry door that will bring them directly into the fire area without going against the resident evacuation flow, per facility floor plan.

D. Administrator, Director of Nursing, Assistant Director of Nursing, Director of Education, Maintenance, Nursing Supervisor:

• **Respond** to the fire area

E. Nursing Staff:

• Respond to <u>resident care area</u> fires as follows:

All Shifts: 1 Nurse and 1 CNA should respond from each non-fire unit. Designated Nurse and CNA will be assigned as Unit responders at the beginning of each and every shift on a daily basis.

F. (11 p.m. - 7 a.m.) Nursing Supervisor and Predetermined Designee:

• Respond to alarms originating from non-resident areas

G. Nursing Supervisor/DON:

- Act as Incident Commander and activate the facility's Incident Command System (ICS) in the Administrator's absence.
  • Set up **Control Station**. The Control Station will be responsible for directing additional staff to the fire area or to other areas within the building, as necessary. The Control Station will be located as follows:

    Resident Care Area: nearest nurse's station

    Non-resident Care Area: front lobby

  • Verify headcount of residents and staff evacuated from the fire area. Report results to the Command Post (Administrator/Fire Chief).

  • Communication with Command Post will take place by means of telephones

H. Administrator:

- Act as Incident Commander and activate the facility's Incident Command System (ICS) as per facility ICS policy.
  • Establish a **Command Post** if evacuation of rooms other than the fire room is taking place. The Administrative Command Post will be set up at the fire department's Incident Command Post location.

  • Verify that a headcount of residents and staff has taken place from the fire area. Inform the Incident Commander of the results.

    NOTE: Communication between the Control Station and the Command Post will take place by means of telephone

I. All Other Staff:

• Follow department-specific procedures.

III... EXTENDED EVACUATION:

A. GENERAL CONCEPT:

• First stage of resident evacuation will be horizontally past the fire/smoke door.

• Non-resident departments will evacuate to the department's designated assembly point.

• If evacuation of the floor or building is necessary, this shall take place from the non-fire side of the building, using the exit farthest from the fire. Building evacuation will be a fire department/administrative decision.

• See Department-Specific Procedures

B. FIRE IN RESIDENT CARE AREAS:

Evacuation of the remaining rooms in the smoke compartment should take place at the decision of the Incident Commander. All residents must have been removed from the corridor and all room doors closed. Evacuation should only take place if:

a) The fire has **not** been extinguished

AND

b) There is **little** or **no** smoke in the corridor

If directed to evacuate by the Incident Commander:

• The staff members will begin evacuating the rooms on both sides of the fire room first, followed by the room across from the fire room. This will be followed by the remaining rooms in the compartment

• The residents will be moved to the adjacent side of the fire/smoke barrier doors, per the evacuation direction diagram.

Departmental Fire Procedures

Activities

If you discover a fire on your area:

Rescue anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone, placing residents into rooms.

E. **Evacuate** to the nearest safe area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Report fire to the person in charge. Go to your assembly point.

3. Oxygen shut-down: shut off the oxygen at the wall supply (by removing the flow meter) or turning portable tank valve to off position.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

5. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

II... ASSEMBLY POINT: MAIN DINING ROOM

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for. Report results to the Incident Commander.

III... IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Remain with any residents behind a closed door and reassure them. Await further instructions.
- Be prepared to potentially receive residents from the Dining Room.

DEPARTMENTAL FIRE PROCEDURES

ADMINISTRATIVE OFFICES

(ADMINISTRATIVE SECRETARY, ADMISSIONS, BUSINESS OFFICE, PAYROLL, MEDICAL RECORDS, RESIDENT CARE COORDINATOR, STAFFING COORDINATOR)

I.. IF YOU DISCOVER A FIRE IN YOUR AREA

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone.

E. **Evacuate** to the nearest safe area. .

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Report fire to the person in charge. Go to your assembly point.

3. Mark the doors with a red magnet indicating that the room has been evacuated. Red

magnets for this purpose are stored on the frame of each door.

4. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

II.. ASSEMBLY POINT: MAIN DINING ROOM

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for. Report results to the Incident Commander.

III.. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Remain at the reception area and await further instructions.

- Remain with any residents in the Solarium and reassure them.

DEPARTMENTAL FIRE PROCEDURES

DIETARY DEPARTMENT

I.. IF YOU DISCOVER A FIRE IN YOUR AREA

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone.

E. **Evacuate** to the nearest safe area. .

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Report fire to the person in charge. Go to your assembly point.

3. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

II.. ASSEMBLY POINT: MAIN DINING ROOM

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for. Report results to the Incident Commander.

III.. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Shut-down kitchen cooking equipment
- Close doors in the area
- Report to the Main Dining Room and await further instructions

DEPARTMENTAL FIRE PROCEDURES

LAUNDRY DEPARTMENT / PRINT SHOP

I.. IF YOU DISCOVER A FIRE IN YOUR AREA

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone.

E. **Evacuate** to the nearest safe area. .

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Report fire to the person in charge. Go to your assembly point.

3. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

II.. ASSEMBLY POINT: MAIN DINING ROOM

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for. Report results to the Incident Commander.

III.. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Shut down laundry equipment.
- Close doors in your area
- Report to the Main Dining Room and await further instructions.

DEPARTMENTAL FIRE PROCEDURES

MAINTENANCE

I.. IF YOU DISCOVER A FIRE IN YOUR AREA

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone.

E. **Evacuate** to the nearest safe area. .

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

II.. EVACUATION SITE FOR MAINTENANCE OFFICE STAFF - MAIN DINING ROOM

Upon arrival at the evacuation site, conduct a headcount to verify that all staff are accounted for. Give results to the Incident Commander.

III. .. AT THE SOUND OF ALARM

- Report to the fire location
- Assist in closing doors and clearing halls
- Assist in evacuating residents, as directed by the person in charge of the area
- Shut down utilities, as directed by the fire department.

NOTE: Do not shut off oxygen and other medical gases until conferring with Charge Nurse/Sub-Acute Coordinator.

- **DEPARTMENTAL FIRE PROCEDURES**

NURSING

I... IF YOU DISCOVER A FIRE IN YOUR AREA

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone, placing residents into rooms.

E. **Evacuate** to the nearest safe area. .

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

3. **Oxygen shut-down:**
   a. When a fire scene involves oxygen in use, staff nurses shut off the oxygen at the wall supply (by removing the flow meter) or turning portable tank valve to off position.
   b. Main valve for emergency OXYGEN AND VACUUM is shut off per direction of the Fire Department, Administrator, or Incident Commander.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

II.. IF EVACUATION OF THE AREA IS ORDERED

This is to be done under the direction of the Incident Commander.

1. Residents from the fire compartment to be moved to the adjacent side of the fire/smoke doors, per evacuation diagram.

2. The rooms adjacent to the fire room shall be evacuated first, followed by the room opposite the fire room. The remaining rooms in the compartment shall then be evacuated.

SEE ATTACHED MEDICAL EQUIPMENT GUIDELINE.

4. Following the evacuation, verify that all residents/staff are accounted for. Report results to the Incident Commander.

III.. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

• Respond to **resident care area** fires as follows:

All Shifts: 1 Nurse and 1 CNA should respond from each non-fire unit. Designated Nurse and CNA will be assigned as Unit responders at the beginning of each and every shift on a daily basis.

• Staff remaining are to place residents in rooms, closing doors and windows. Clear equipment from corridors. Do not place equipment into occupied resident rooms.

• For alarms originating in non-resident areas between 11 p.m. and 7 a.m., the Nursing Supervisor and 1 pre-designated nursing department employee will respond.

NOTE: If you are out of your normally assigned work area at the time of the alarm, return as quickly as possible.

MEDICAL EQUIPMENT BREAKDOWN PROCEDURES

Catheter drainage bag: Place drainage bag on resident.

Option: Disconnect catheter from drainage tubing.

CPM exercise machine: Disconnect from electrical outlet.

Feeding pump assembly: Remove tubing from pump. Remove bag from pole and place next to resident.

Option: Disconnect feeding line from NG-tube or G-tube.

IV: Clamp line or leave it open (at the discretion of the nurse). Remove bag from pole and place on bed.

IV with pump:

If pump is not needed:

Remove IV tubing from pump. Remove bag from pole and place on bed.

If pump must be taken:

Option 1: Disconnect pump from electrical outlet, remove pump and bag from pole and place on bed.

Option 2: Disconnect pump from electrical outlet and move pole with bed.

Oxygen: Shut off flowmeter and remove mask or cannula from resident.

Option: Pull line off flowmeter.

OR

Disconnect flowmeter from wall outlet and take with resident. This is based on time available and ease of removing the flowmeter from the wall connection.

Restraints: Cut or untie straps, or remove restraint from resident.

Suction: Disconnect line from top of suction canister.

Traction: If bed needs to be lowered, do so while breaking down medical equipment - **before** unplugging bed. If traction assembly will not fit through the door, unfasten or cut ropes and remove resident from bed.

CHARGE NURSES

I.. IF THE FIRE IS ON YOUR UNIT

A. Ensure that:

□ Fire room has been evacuated

□ Door(s) to fire room have been closed

□ Fire alarm has been activated and a page made identifying the fire location

□ All residents have been removed from hall and doors closed

□ All equipment has been removed from the hall (not placed in occupied rooms)

B. Make decision regarding further evacuation, using the following guidelines:

□ If fire **has** been extinguished, no further evacuation is necessary. Have staff reassure residents.

□ If corridor smoke conditions would **not** be tolerable for residents, do not evacuate. Inform fire department of smoke concerns upon their arrival.

□ If fire has **not** been extinguished and corridor conditions **are** tolerable, begin evacuation as follows:

1. Residents from the fire compartment to be moved to the adjacent side of the fire/smoke doors, per evacuation diagram.

2. Have staff evacuate the rooms adjacent to the fire room first, followed by the room opposite the fire room. The remaining rooms in the compartment shall then be evacuated.

3. Mark the door to the room with a red magnet to indicate that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

4. Account for residents and staff once all are relocated. Report results to the Control Station.

NOTE: Charge nurse to direct removal of residents' charts to safe area.

Charge Nurse Procedures……cont.

II.....IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

A. Direct appropriate staff to respond to fire area.

B. Direct remaining staff in securing unit by putting residents into rooms, closing windows/doors, clearing halls, etc.

C. Once unit is secured direct staff to make rapid rounds, checking on and reassuring residents.

D. Upon hearing page indicating that alarm has originated from an area that evacuates to your particular unit, direct staff in preparing to receive residents by clearing space for arriving residents. Position one staff member at the entrance to the unit to direct staff arriving with evacuated residents to appropriate areas of receiving unit.

E. Ensure initial care of residents who have been evacuated to your

NURSING DIRECTOR/SUPERVISOR

A. Upon activation of the fire alarm, report immediately to the fire scene and ensure that nurse in charge of the fire area is carrying out his/her responsibilities.

B. If the fire has not been extinguished, establish a Control Station at the nearest nurse's station. If the fire is in a nonresident area, establish Control Station at the front lobby.

C. Send additional staff to the fire area, if necessary.

D. Ensure adequate staffing of other areas of the building, especially the area to which the residents are being evacuated.

E. Verify that each unit/department from the fire area has accounted for all residents/staff. Report results to the Command Post, along with any changes in conditions. The Command Post is with the Fire Chief.

F. Keep the non-fire areas informed of the situation, as applicable.

G. Notify off duty staff (Administration, Maintenance) as appropriate.

H. Ensure residents' charts have been removed to a safe area.

DEPARTMENTAL FIRE PROCEDURES

OT/PT DEPARTMENT

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone, placing residents into rooms.

E. **Evacuate** to the nearest safe area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Report fire to the person in charge. Go to your assembly point.

3. **Oxygen shut-down:** shut off the oxygen at the wall supply (by removing the flow meter) or turning portable tank valve to off position.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

5. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

II.. ASSEMBLY POINT: MAIN DINING ROOM

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for. Report results to the Incident Commander.

III.. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Remain with any residents behind a closed door and reassure them. Await further instructions.
- Be prepared to potentially receive residents from the area of the fire.

- **DEPARTMENTAL FIRE PROCEDURES**

  PHYSICIANS / DENTISTS / RESPIRATORY THERAPIST/CONSULTANTS

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone, placing residents into rooms.

E. **Evacuate** to the nearest safe area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Report fire to the person in charge. Go to your assembly point.

3. **Oxygen shut-down:** shut off the oxygen at the wall supply (by removing the flow meter) or turning portable tank valve to off position.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

5. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

II... FOLLOW EVACUATION PROCEDURES FOR DEPARTMENT YOU ARE IN

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for. Report results to the Incident Commander.

III... IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Remain with any residents behind a closed door and reassure them. Await further instructions.

DEPARTMENTAL FIRE PROCEDURES

SOCIAL WORK / SPEECH THERAPY /

HOUSEKEEPING / BEAUTICIAN

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone, placing residents into rooms.

E. **Evacuate** to the nearest safe area.

NOTES:

1. If the fire is small and you know you can put it out **quickly**, do so using available sources (bed spread, blanket, sheet, fire extinguisher, etc.). Otherwise, do not attempt to extinguish the fire. Shut the door and leave it closed. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

2. Report fire to the person in charge. Go to your assembly point.

3. **Oxygen shut-down:** shut off the oxygen at the wall supply (by removing the flow meter) or turning portable tank valve to off position.

4. Mark the doors with a red magnet indicating that the room has been evacuated. Red magnets for this purpose are stored on the frame of each door.

5. Order of the above steps is somewhat flexible. However, the evacuation of the room's occupant(s) and confinement of the fire shall be the top priorities.

II... FOLLOW EVACUATION PROCEDURES FOR DEPARTMENT YOU ARE IN

NOTE: Upon arrival at evacuation site, the person in charge of the department shall verify that all staff are accounted for. Report results to the Incident Commander.

III... IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

- Remain with any residents behind a closed door and reassure them. Await further instructions.

DEPARTMENTAL FIRE PROCEDURES

VISITORS

During a fire alarm, visitors will be addressed as follows:

1. Staff persons (Receptionist/Security, etc) monitoring entrances will not allow any non-staff persons into the facility until an all clear is heard.

2. Visitors with residents will remain with them until an all clear has sounded or staff guide you to a safe area.

3. Visitors other than family members shall be asked to leave the building until the alarm is all clear.

4. Staff members who arrive early and are not clocked in shall be considered visitors.

DEPARTMENTAL FIRE PROCEDURES

VOLUNTEERS / STUDENTS

I.. IF YOU DISCOVER A FIRE IN YOUR AREA

R. **Rescue** anyone in the room while calling out "Code Red, location..." for assistance. Close the door to the fire room and any room connecting doors. Place the orange “fire” tag on the door to signify the ‘fire room’. Orange “fire” tags are located in every fire extinguisher cabinet.

A. **Alarm -** activate the fire alarm. Page the fire location.

C. **Confine** the fire by closing all remaining doors and windows in the fire zone, placing residents into rooms.

E. **Evacuate** to the nearest safe area. .

II.. IF ALARM SOUNDS FROM ELSEWHERE IN THE BUILDING

• Go to the person in charge of the area where you are and await further instructions.

Hazard Annex I: Flood

Floods may be the result of coastal, lake, river, inland, or indoor flooding.

This facility is prepared to respond to a flood. This includes in-service staff training and flood related disaster planning.

1. Floods are the most common and widespread of all natural disasters. Most communities in the United States can experience some degree of flooding after spring rains, heavy thunderstorms, or winter snow thaws.

2. Most floods develop slowly over a period of days. Flash floods, however, are like walls of water that develop in a matter of minutes. Flash floods can be caused by intense storms or dam failure.

3. Flood Watch – Flooding is possible. Tune to local radio and television stations for additional information.

4. Flood Warning – Flooding is already occurring or will occur soon. Take precautions at once. Be prepared to go to higher ground. If advised, evacuate immediately.

    Emergency flood proofing measures that can be implemented if necessary. Facility Incident Commander will determine if and/or when these measures will be enacted.

    1. Building walls with sandbags.

    2. Constructing a double row of walls with boards and posts to create a "crib," then filling the "crib" with soil.
    3. Constructing a single wall by stacking small beams or planks on top of each other.
    4. Evaluating the need for backup systems, such as:

        1. Portable pumps to remove flood water.
        2. Alternate power sources such as generators or gasoline-powered pumps.
        3. Battery-powered emergency lighting.

5. Activate the Incident Command System (ICS) to manage the incident. The most qualified staff member (in regard to the Incident Command System) on duty at the time assumes the Incident Commander position.

6. Notify the Administrator and Director of Nursing if they are not on the premises.

7. Facility Incident Management Team report to the Incident Command Post for a briefing and instructions.

8. The Incident Commander decides whether to flood proof (see emergency flood proofing measures above) or evacuate based on geographical location and history of flooding of the facility.

9. Coordinate all internal emergency operations with the local authorities. They will be able to quickly assist in controlling the situation provided that a good line of communication is established between them and the Incident Commander.

10. Once the flood watch/warning has been cancelled and the Incident Commander has determined the dangerous situation has passed, emergency operations can begin to disengage.

11. Only declare the situation "under control" after the local authorities have concluded emergency operations and the Incident Commander has declared the situation "safe."

12. Account for all residents and staff members.

Hazard Annex J: Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE)

CBRNE incidents occur when a hazardous substance is released into the environment, causing potential harm to the staff and residents of the facility. CBRNE emergencies are particularly dangerous for facilities, as populations are typically confined indoors with compromised health and immune systems. Released toxic substances, even in small amounts, can further weaken the health and well-being of residents.

1. A ***chemical disaster*** is any in which harmful vapors or toxic vapors become airborne.
2. A ***biological disaster*** is any in which biological (bacteria, virus, spores) are released into the air.
3. A ***nuclear/radiological disaster*** is any in which nuclear contaminates become airborne.

The highest-ranking person currently in the facility, should be notified immediately when the facility is informed of the threat of a possible chemical or nuclear disaster. The facility would be notified by the police or fire department. The highest ranking member will assume the role of Incident Commander and will activate the ICS (Incident Command System)

Safety measures should be taken immediately upon notification of threat.

1. A command post may be established at the reception desk in the front lobby or any other appropriate area designated by the Incident Commander. The Incident Commander will assemble the Incident Management Team and begin to implement safety measures as follows:

    a) Close all windows tightly and lock them;
    b) Turn off all exhaust fans and air conditions.
    c) Close and lock all doors leading in or out of the building. Once closed, the doors should be sealed with silver duct tape, which is kept in the Maintenance Shop.
    d) Assure that any resident with any breathing disorder has access to an oxygen tank.
    e) Seal interior hallway doors of the boiler room and the generator room with the silver duct tape.
    f) Do not allow anyone in or out of the building until the condition has cleared.

2. The Incident Commander shall assign personnel to:

    a. Assist on resident units, if necessary
    b. Close all windows and doors
    c. Assist in sealing the required doors
    d. Assist in getting extra oxygen tanks on the units.

3. To obtain information on the status of the condition, call the local Disaster Preparedness Office and/or monitor news broadcasts on radio and television.

4. After notification of the condition clearing, announce an "All Clear".

5. Evaluation the facility to find if anyone in the facility is having respiratory distress. If necessary, that person may have to be sent to a hospital for further evaluation.

POINTS TO REMEMBER

Once a disaster is declared and the doors are locked and sealed, no one (staff, volunteers, visitors nor neighbors) will be allowed to enter nor leave the facility until the condition has cleared and has been declared under control by the Local City Officials or other appropriate government agency.

Hazard Annex K: Infectious Disease

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

The facility follows effective strategies for preventing infectious diseases. Each county Local Health Department-(LHD) has prevention agenda priorities compiled from community health assessments that can be reviewed and utilized by the facility in fully developing your CEMP Annex E, planning and response checklist for infectious disease and pandemic situations. The information within this Annex includes the identified priorities and focus areas.

Communicable Disease Reporting:

- NYSDOH is charged with the responsibility of protecting public health and ensuring the safety of health care facilities.
- Reporting is required to detect intra-facility outbreaks, geographic trends, and identify emerging infectious diseases.
- The collection of outbreak data enables the NYSDOH to inform health care facilities of potential risks and preventive actions.
- Reporting facilities can obtain consultation, laboratory support and on-site assistance in outbreak investigations, as needed.

What must be reported?

NYSDOH Regulated Article 28 nursing homes:

- Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10 NYCRR 2.10), as well as by 10 NYCRR 415.19.
- Any outbreak or significant increase in nosocomial infections above the norm or baseline in nursing home residents or employees must be reported to NYSDOH. This can be done electronically via the Nosocomial Outbreak Reporting Application (NORA). NORA is a NYSDOH Health Commerce System Application. Alternately, facilities may fax an Infection Control Nosocomial Report Form (DOH 4018) on the DOH public website.
  - Facilities are expected to conduct surveillance that is adequate to identify background rates and detect significant increases above those rates. Healthcare associated infection outbreaks may also be reported to the LHD.

  A single case of a reportable communicable disease or any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) must be reported to the local health department (LHD) where the patient/resident resides. In addition, if the reportable communicable disease is suspected or confirmed to be acquired at the NYSDOH regulated Article 28 nursing home, it must also be reported to the NYSDOH. This can be done electronically via the NORA, or, by faxing an Infection Control Nosocomial Report Form (DOH 4018).
- Reports must be made to the local health department in the county in which the facility is located (as the resident's place of residence) and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately by phone.
- Categories and examples of reportable healthcare-associated infections include:
  - An outbreak or increased incidence of disease due to any infectious agent (e.g. staphylococci, vancomycin resistant enterococci, Pseudomonas, Clostridioides difficile, Klebsiella, Acinetobacter) occurring in residents or in persons working in the facility.

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

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

PEP Communication Requirements

As per the requirements of the PEP, a facility must develop external notification procedures directed toward authorized family members and guardians of residents.

To adequately address this requirement, the facility will need to develop a record of all authorized family members and guardians, which should include secondary (back-up) authorized contacts, as applicable.

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

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

PEP Infection Control Requirements

In addition to communication-related PEP requirements address above, the facility must develop pandemic infection control plans for staff, residents, and families, including plans for (1) developing supply stores and specific plans to maintain, or contract to maintain, at least a two-month (60 day) supply of personal protective equipment based on facility census, including consideration of space for storage; and (2) hospitalized residents to be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80.
.

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

- Incorporating lessons learned from previous pandemic responses into planning efforts to assist with the development of policies and procedures related to such elements as the management of supplies and PPE, as well as implementation of infection control protocols to assist with proper use and conservation of PPE.
- All personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents. COVID-specific guidance on optimizing PPE and other supply strategies is available on CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Supplies to be maintained include, but are not limited to:
  - N95 respirators;
  - Face shield;
  - Eye protection;
  - Gowns/isolation gowns;
  - gloves;
  - masks; and
  - sanitizers and disinfectants (EPA Guidance for Cleaning and Disinfecting):

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

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

Other PEP Requirements

PEP further requires that facilities include a plan for preserving a resident's place at the facility when the resident is hospitalized. Such plan must comply with all applicable State and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).

Facility PEP Structure and Details

The organization uses a coordinated process to reduce the risks of endemic and epidemic nosocomial infections in residents and health care workers.

Policy & Procedure Regarding General Infection Control:

The primary purposes of this facility's infection prevention and control program (IPCP) is to establish guidelines to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Perform surveillance investigation and monitoring to present the onset and spread of infection;

A. The facility establishes an infection prevention and control program (IPCP) that must follow accepted national standards and include, at a minimum, the following elements:

   1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to § 483.70(e) and following accepted national standards;

   2. Written standards, policies, and procedures for the program, which must include, but are not limited to:

      (i) A system of surveillance designed to identify possible communicable diseases or infections

before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

- (iv) When and how isolation should be used for a resident; including but not limited to:
  (a) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
  (b) A requirement that the type and duration of isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease;

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact; Alcohol Based handrub is preferred over soap and water in all clinical situations except when hands are visibility soiled, or after caring for residents with known or suspected C-difficile or norovirus during an outbreak; and

(vii) The education of staff, volunteers, visitors and other individuals providing services under a contractual arrangement on the IPC standards, policies and procedures.

3. Environmental cleaning and disinfection including the resident's care environment and shared care equipment with agents effective against identified organism or products on an EPA-registered microbial list.
   a. The facility assures education provided to appropriate staff and access to adequate supplies/proper instruction for staff responsible for cleaning pieces of equipment.

4. An Antibiotic Stewardship Program that includes:
   (i) Antibiotic use protocols
   (ii) A system for monitoring antibiotic use
   (iii) A system for recording incidents identified under the facility's IPCP and the corrective actions by the facility.

B. Infection Preventionist. The facility must designate a healthcare professional as the IP (the facility may designate more than one IP) who is responsible for the facility's IPCP. The IP must work at least part-time at the facility, and must have primary professional training in nursing, medical technology, microbiology, epidemiology or other related field and can be qualified by education, training, experience or certification.

C. IP participation on quality assessment and assurance committee. The individual designated as the IP must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.

D. The facility conducts an infection control risk assessment in accordance with infection control professional organizations. The assessment is reviewed annually and as needed and updated accordingly.

E. The IPCP is reviewed annually and analyzed to ensure the effectiveness of the IPCP and update the program as necessary.

Procedure:

1. Proper hand washing technique;
2. An annual employee Health Screen;
3. Maintain a safe, sanitary, & comfortable environment for personnel, residents, visitors, & the general public;
4. General immunization screening for residents and employees;
5. Inservice education at the time of hire, annually, and as indicated by individual circumstances;
6. Establish guidelines to follow in the implementation of infection control precautions;
7. Establish guidelines to follow in implementing Standard and Transmission Precautions for the handling of blood, body fluids, secretions, excretions, mucous membranes and nonintact skin;
8. Visitor restriction during cold/flu breakout within the community.
9. The State Department of Health will be notified of an outbreak within a facility.
10. Employees will be observed by supervisory personnel for cold symptoms, open lesions, appropriate dress code, and restrained hair.
11. Demonstrate proper storage, transport and handling of linen.
12. The Quality Improvement and the Infection Control Committees, have adopted these infection prevention and control policies and procedures. The policies as outlined herein best reflect the needs and operational requirements of this facility in the prevention of transmission of infections and communicable diseases as set forth in current OBRA, OSHA, and CDC guidelines and recommendations.

Policy & Procedure Regarding Surveillance:

The facility has an established system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility.

"Surveillance" *refers to the ongoing, systematic collection, analysis, interpretation, and dissemination of data to identify infections and infection risks, to try to reduce morbidity and mortality and to improve resident health status.*

Surveillance consists of the following:

- When and to whom possible incidents of communicable diseases or infection should be reported.
- Collection of Data
- Identify possible communicable diseases or infection
- Determination of whether an infection is present (by use of criteria)
- Tabulation and consolidation of data
- Evaluation, analysis, and interpretation of data
- Dissemination of the above information to appropriate persons
- Establishment of standard and transmission-based precautions to prevent the spread of infection.

Surveillance usually focuses on the number of various types of infections in the facility (OUTCOME Surveillance) but may also include observation and evaluation of compliance with policies and procedures and other aspects of infection control which relate to the occurrence and spread of infection (PROCESS surveillance).

1. ***Process Surveillance***

Process surveillance reviews practices directly related to resident care in order to identify whether the practices comply with established prevention and control procedures and policies based on recognized guidelines. Examples of this type of surveillance include monitoring of compliance with:

• Minimizes exposure to a potential source of infection;
• Uses appropriate hand hygiene prior to and after all procedures;12
• Ensures that appropriate sterile techniques are followed; for example, that staff:
  Use sterile gloves, fluids, and materials, when indicated,13 depending on the site and the procedure;14
  Avoid contaminating sterile procedures;15 and
  Ensure that contaminated/non-sterile items are not placed in a sterile field.

• Uses Personal Protective Equipment (PPE) when indicated;16
• Ensures that reusable equipment is appropriately cleaned, disinfected, or reprocessed; and
• Uses single-use medication vials and other single use items appropriately (proper disposal after every single use).

2. ***Outcome Surveillance***

Outcome surveillance is designed to identify and report evidence of an infection. The process consists of collecting/documenting data on individual cases and comparing the collected data to standard written definitions (criteria) of infections. The IP or other designated staff reviews data (including residents with fever or purulent drainage, and cultures or other diagnostic test results consistent with potential infections) to detect clusters and trends. Other sources of relevant data may include antibiotic orders, laboratory antibiograms (antibiotic susceptibility profiles), medication regimen review reports, and medical record documentation such as physician progress notes and transfer summaries accompanying newly admitted residents.

Surveillance includes information on the following:

- Health Care associated Infections
- Infections/conditions present on admission to the facility.
- Infections/conditions present on readmission to the facility, but not present or incubating when the resident was transferred from the nursing home.

Surveillance includes information on infections in personnel as well as residents.
The criteria or definitions of infection for surveillance purposes are approved by the Quality Improvement Committee.

Concurrent, prospective surveillance is preferable rather than retrospective surveillance (review of residents' clinical records).

Surveillance data should be collected primarily from regular (at least once a week) rounds of resident care units. Additional information is gathered directly from resident care personnel. Other data may be derived from nurses' and physicians' notes, laboratory reports, medication records, and other parts of the residents' clinical record.

After analysis of the data, it should be used to plan infection control activities, detect outbreaks or epidemics, direct inservice education, and identify individual resident problems in need of intervention. The surveillance system enables the facility to analyze clusters and/or significant increases in the rate of infection.

Note: Facility layout documents may be used to record occurrence of clusters.
Approaches may include, but are not limited to the following:

1. Surveillance of all residents in the facility.

   - Infection rates are calculated periodically (monthly, quarterly, and yearly).
   - Rates are calculated as per determined annual threshold rates.
   - Surveillance provides threshold data.

- Surveillance provides comparative data (e.g., comparison with previous months and seasons, comparison of resident care units).

2. Surveillance of microorganisms shown on cultures.

- Not a good indicator of the number of infections in the facility.
- Review and analysis of culture sensitivities may serve as an alert to a problem (e.g., multiresistant organisms, cross-contamination).

3. Surveillance of high risk residents

- Residents with catheters, tracheostomies, tube feedings, IV's, open lesions, etc.
- Immunocompromised residents.
- Residents at high risk for skin problems.

4. Miscellaneous surveillance may serve as an alert to a problem.

- Surveillance of residents being transferred to hospitals.
- Surveillance of residents who have expired.

Policy Regarding Handling of Linen:

Linen and laundry is handled, stored and processed in a manner to prevent the spread of infection and contamination.

- Linen and laundry is handled, stored, processed and transported in a manner to prevent the spread of infection and contamination of clean linen.
- All linen collection & transport containers are labeled with a BIOHAZARD STICKER.

Procedure for Standard Non-precaution Linen:

Soiled linen being laundered is handled in the following manner:

1. Bins will be picked up from the soiled workroom and transported to laundry as per facility schedule.

2. The Nursing staff will sort soiled linen into the appropriate labeled bins:

3. Linen with bowel movement or other bulk substance should be rinsed immediately to prevent staining.

4. Prior to doing a scheduled collection run, laundry or maintenance personnel shall go to laundry and pick up a clean collection bin as needed and take it to the soiled workroom.

5. Bins and Barrels will be picked up from the soiled workroom and transported to laundry as per facility schedule.

PROCEDURE for HAMPER SYSTEM:

Soiled linen being processed via the Hamper System is handled in the following manner:

1. Each unit has a supply of bags for use in the Hamper System. Bags are replenished by Laundry personnel as needed.

2. The Nursing staff will sort soiled linen into the appropriate labeled hampers:
    - Sheets & pillow cases
    - Towels & washcloths.
    - Personal Clothing
    - Bibs

3. Nursing staff is to empty the hamper when no more than ¾ full.

4. The bags are tied and knotted prior to placing in the transport collection bin.

5. Nursing staff will then reline the hampers with clean bags.

Precaution Linen

To prevent cross-contamination of infection to residents, staff, visitors and the environment.

1. Nursing will notify all departments involved with resident care when a resident is placed on linen precautions or isolation.

2. When a patient/resident is placed on linen precautions or isolation, Housekeeping/Laundry will provide Nursing with a linen hamper, canvas/mesh outer bags, and yellow infectious bags.

3. Nursing will place the linen hamper in the resident's room, along with a supply of canvas/mesh bags.

4. Attach the canvas/mesh bag to the linen hamper stand.

5. All soiled linen is placed in the hamper. Staff must be careful to keep soiled linen away from their uniform. Soiled linen also must never be placed on the floor.

6. Close the canvas/mesh bag when ½ full and also at the end of each shift.

7. Remove the closed bag from the hamper. Take it to the door of the room. A second person outside of the room shall have a large yellow plastic bag cuffed over their hands. The canvas/mesh bag is then placed inside of the yellow plastic bag, being careful not to contaminate the outside of the outer bag. The cuff of the outer bag is then lifted up and the bag is tied.

8. The staff member outside the room places it in the laundry barrel labeled "ISOLATION LINEN"; and returns the "Isolation Linen" barrel to the soiled utility room.

9. The soiled laundry is transported to the Laundry room by Maintenance and/or Housekeeping/Laundry personnel on a regular basis throughout the day.

10. Follow established handwashing procedures throughout this entire process.

Policy Regarding Emerging Infectious Diseases:

(EIDs) are those whose incidence in humans has increased in the past 2 decades or threaten to increase in the near future. These diseases, which respect no national boundaries, can challenge efforts to protect humans as prevention and control recommendations may not be immediately available. The occupational safety and health community can prepare for these unpredictable disease outbreaks and prevent disease transmission with resources such as the Centers for Disease Control and World Health Organization for protecting workers, particularly healthcare workers, nurses, doctors, and first responders.

Examples of EIDs include but, are not limited to:

- Ebola - viral hemorrhagic fever of humans and other primates caused by ebolaviruses.
- Zika Virus – transmitted to humans by mosquitoes
- Chikungunya Virus - transmitted to humans by mosquitoes
- Avian Influenza – normally affects birds but can be transmitted to workers who are in contact with infected poultry
- Swine Influenza - caused by the H1N1 virus strain, which started in pigs
- SARS – Severe Acute Respiratory Syndrome
- MERS - Middle East Respiratory Syndrome
- COVID 19

Standard:

The organization uses a coordinated process to reduce the risks of endemic and epidemic infections in residents and health care workers.

Policy:

The facility will follow the infection prevention and control program (IPCP) to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Procedure:

- In the case of a known or suspected outbreak of an EID, the Infection Preventist and Director of Nursing, in conjunction with the Medical Director will determine if the situation presents a threat to the health of other residents, staff members or visitors.
- The diagnosis will be verified using diagnostic testing and symptom evaluation.
- Detailed information, such as recent travel locations and contact with infected person(s)/livestock, will be obtained as able from any symptomatic resident, staff member or visitor to determine the specific source of the EID.
- Isolation and special infection precautions will be carried out in accordance with CDC guidelines as modified for nursing homes. CDC's standard precautions and disease-specific systems are the

basis of the isolation and infection precautions policies and procedures in this facility. These systems take into consideration the source of infection, possible susceptible persons, and the methods of transmission of the disease. These systems are designed to protect residents, staff members, and visitors.

- Control measures will be put into place which includes but, is not limited to isolation of ill residents, entire rooms or units, cohorting of residents, staff or both, restriction of visitors, removal of staff from duty, restriction of transfers, admissions and services.
- All available resources will be utilized to provide medical attention and personal care to infected or symptomatic residents and staff members.
- The EID will be reported via HPN/ NORA as defined by the NYSDOH reporting requirements. Contact will be made with the DOH by phone, as indicated. Directives will be followed to treat and contain the EID.
- Infected residents and staff members will be transferred to a hospital or local treatment center if indicated.
- Focused education will be provided by the clinical team, as indicated. Each department manager is informed of what will be expected of the department.
- Summary of the outbreak investigation and infection control/treatment measures implemented will be documented and presented to the Quality Improvement Committee.

POLICY:
It shall be the policy to utilize accepted infection control methods to prevent and control the spread of a respiratory illness caused by novel Coronavirus (COVID-19), in all of the organization's facilities.
PURPOSE:
The primary goals of COVID-19 prevention and control in long-term care facilities are:
1. Preventing the transmission of COVID-19 to residents, staff, and visitors while preserving the quality of life for residents with COVID-19.
2. Screening all hospital patients for COVID-19, prior to admission or re-admission to our facilities.
BACKGROUND:
COVID-19 is the abbreviated name for novel Coronavirus Disease 2019 that first emerged in China but, has spread worldwide and become a pandemic.
COVID-19 is a viral illness that is spread from person to person by respiratory droplets between those who are in close contact with one another (about 6 feet).
While there is not yet evidence for spread from surfaces or objects (fomites), this may also be a possible mechanism of transmission.
Symptoms may be mild or severe appearing as soon as 2 days or as long as 14 days after exposure.
Symptoms include fever, dry cough, shortness of breath, nasal congestion, rhinitis, sore throat, and diarrhea.
Some who are infected remain asymptomatic. Up to 80% of infected people recover without any need to seek care.
Some develop severe illness (typically in the second week of illness) and at present it is estimated that approximately 2% will die from the virus. Older adults and patients with comorbid conditions are at an increased risk for more severe illness.
The CDC is monitoring the pandemic and working closely with federal, state, and local health departments to continue to provide updated information.
2
NOTE: Refer to the "COVID-19 Vaccination Programs Policy" for details regarding the SARS-CoV-2 (COVID-19) Vaccine.
PROCEDURE:
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Section 1: Surveillance

Actively monitoring for COVID-19 is an important aspect of the ongoing infection control program in long-term care facilities. Surveillance for COVID-19 will include:

1. Pre-admission screening to determine if in the last 10 days the patient has been in close contact with any individual known or suspected to be infected with COVID-19.
2. Screening and testing of any current resident or staff member exhibiting signs or symptoms.
3. Regular review of test results for COVID-19 obtained as part of care to identify residents and staff members with COVID-19 by the facility Infection Preventionist.

4. Monitoring the monthly frequency of COVID-19 in the facility by the facility Infection Preventionist. These data will be utilized to define threshold levels that would prompt additional investigation or enhanced control measures.

Section 2: Testing Protocols

Below are 2 different Testing Protocols. Follow specific protocol based on facility location and designated laboratory.

Protocol 1 – PCR Lab Testing:

1. If any resident develops fever and/or cough or any compatible acute respiratory signs/symptoms (i.e. fatigue, acute change in functional status with no explanation, shortness of breath/dyspnea, sore throat, chills, nasal symptoms) immediately apply a face mask on the resident and initiate Contact and Droplet Precautions.
2. Complete Testing Protocol:

Obtain Antigen Test

Work-up of infection includes other tests for treatable bacterial causes of infection as indicated for the resident – CBC with differential count, procalcitonin, CMP, Chest Xray, urinalysis, and urine culture. If STAT chest X-ray is positive for pneumonia, obtain urine for Legionella antigen and sputum for Legionella.

Protocol 2 - Sofia SARS or BD Veritor or BinaxNOW Antigen Testing:

1. Where available, approved for use to test residents and staff for COVID-19/2019-nCoV based on DOH guidance.
2. Point of care testing which provides automated and objective results in 15 minutes using nasopharyngeal or nasal swab specimens.
3. Refer to the Sofia SARS or BD Veritor or BinaxNOW Antigen Testing Policies for further details.

Section 3: Test Shortage/Availability

1. Test shortage/availability – If the 48-hour turnaround time to get tests done cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments.

Section 4: Known or Suspected Case

1. For a resident with an undiagnosed respiratory infection or in quarantine status: staff must follow Standard, Contact, and Droplet Precautions (i.e. surgical mask, gloves, isolation gown) with eye protection (goggles or face shield) when caring for a resident unless the suspected diagnosis requires Airborne Precautions (i.e. tuberculosis). A gown is not
4
necessary if there will be no direct contact with the resident or their immediate environment such as during meal and medication pass. A gown is also not required for vital signs and glucometer checks.
2. For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection (goggles or face shield) and an N95 or higher-level respirator if available. A facemask is an acceptable alternative if a respirator is not available. When COVID-19 is identified in the facility, staff wear all recommended Source Control (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).
3. Any suspected/positive case should avoid nebulizer treatments when possible, given the risk.
4. Any suspected/positive case should have BiPAP/CPAP use avoided for 14 days if a viral filter is unavailable, unless otherwise ordered by the physician.
5. The local health department will be notified as directed of any confirmed resident, staff member or visitor case of COVID-19.
6. The infected resident will remain in his/her room on precautions with the door closed. Resident will be moved to a private room unless option is not available. Efforts will be made to minimize movement of the infected resident within the facility.
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 according to current testing guidelines (refer to policy section regarding Isolation Areas/Units/Rooms). Efforts to provide private room will be made when able.
8. Residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19 may be grouped or cohorted. The CDC recommends that residents are placed in locations designated to care for COVID-19 residents, to prevent the transmission of COVID19 to other residents.
9. Any resident that has fever/respiratory symptoms and is being worked up will have a red indicator on the door to alert staff.
10. All new admissions/readmission will remain under surveillance for COVID-19 according to current guidelines (refer to policy section regarding Isolation Areas/Units/Rooms).

Transmission based precautions are not necessary for asymptomatic residents regardless of vaccine status. Testing on days 1, 3, and 5 is required with use of source control.

Quarantine is not required for new admissions/readmissions regardless of

vaccination status if asymptomatic. Transmission based precautions may be initiated per facility discretion.
Testing is required on days 1,3 and 5.
11. If able, cohort new admissions/readmissions that are not up-to-date with all recommended COVID-19 vaccine doses in a block of rooms.
12. Source Control (Personal Protective Equipment {PPE}) including gloves, gown, N95 Respirator or approved equivalent, eye protection (goggles or face shield) must be utilized for any healthcare worker entering COVID positive rooms.
13. A surgical mask will be worn by all staff, students, contractors, and visitors. Extended wear of facemasks is permitted. Facemasks should be changed when soiled or wet and when staff members go on breaks. Facilities will bundle care and minimize the number of health care providers and other staff who enter rooms to reduce the number of personnel requiring facemasks.
14. Residents with confirmed or possible COVID-19 infection should wear a facemask when heath care providers or other direct care providers enter their rooms unless such is not tolerable.
5
15. Active health screening including temperature, respirations, pulse oximetry of all residents will be implemented as directed. During a facility outbreak, each resident's (both COVID and Non-COVID) oxygen saturation levels will be obtained every 4 hours.
16. The pneumococcal vaccination will be re-offered to residents who previously declined.
17. Psychosocial and emotional needs of residents will be monitored during visitor restriction and social distancing period. Residents will be assisted with phone calls and video communication with family members and friends, as needed.
18. An approved EPA disinfectant will be used to clean all communication devices (i.e. phones, iPads) between residents. Such devices will be separated per team and not be shared between COVID-19 positive (or suspected) and other residents (COVID-19 negative or observation status).

Section 5: COVID-19 Treatment

There are still no published clinical guidelines for SNF COVID-19 treatment. We now update our approach to skilled nursing facility management of COVID-19 to include the available treatment with monoclonal antibodies, after the FDA issued Emergency Use Authorization (EUA). (See References, EUA Fact Sheet) According to the National Institute of Health, adjunctive therapy is advocated by clinicians and there are multiple ongoing studies evaluating the use of vitamin and mineral supplements both in the prevention and treatment of SARS-CoV-2 infection.
1 Specific
antiviral treatments Remdesivir and convalescent plasma are available only in the hospital setting. Among the anti-inflammatory options for COVID-19, only dexamethasone is available in the SNF setting. Other investigational anti-inflammatory drugs such as the interleukin IL-6 pathway inhibitors like tocilizumab are being evaluated in clinical trials. The following is Treatment Guidance.

1. Prophylactic Treatment of All Residents

Vitamin C

o Rationale:
Vitamin C is an essential water soluble vitamin that acts as a cofactor and antioxidant. Residents may require more Vitamin C in states of oxidative stress such as serious infections or sepsis. As an antioxidant and free radical scavenger with anti-inflammatory properties, Vitamin C influences cellularimmunity and vascular integrity. Researchers have studied the effect of Vitamin C in residents with sepsis.2-5
o Treatment: Residents may be started on Vitamin C 500 mg twice a day per provider preference.

Zinc

o Rationale:
Zinc is an essential trace element that is crucial for growth, development, and

maintenance of immune function. The role of zinc in antiviral immunity has been extensively studied. Increased intracellular zinc concentrations blocks the replication in a number of RNA viruses.
6
6
Zinc deficiency may affect persons even in developed countries and zinc status is a critical factor that can influence antiviral immunity and a person is most at risk of acquiring viral infections if zinc deficient.7
Zinc levels are not available to measure. The relationship between zinc and COVID-19, including how zinc deficiency affects COVID-19 severity and whether zinc supplements would improve residents with COVID-19 are being studied.
8
o Treatment: Residents may be started on Zinc 220 mg (equals 50 mg elemental zinc) once a day per provider preference.
o Provider must review if the resident is already taking zinc in other supplements, such as multiple vitamins or AREDS supplements which contain zinc.
o Do not exceed 50 mg elemental zinc a day. The optimal dose of zinc for prophylaxis for COVID-19 has not been established.
o Long term zinc supplementation may cause copper deficiency. Provider must determine the optimal duration for zinc supplementation during the outbreak.
Vitamin D
o Rationale:
Vitamin D has major effects on nearly all cells of the immune system.
9 As
the Vitamin D receptor is expressed on immune cells such as B cells, T cells and antigen-presenting cells such as dendritic cells and macrophages and because these cells can synthesize the active form of Vitamin D, Vitamin D also has the potential to modulate innate and adaptive immune responses.10
Low plasma level of Vitamin D 25-OH appears to be an independent risk factor for COVID-19 infection and hospitalization.
11 Vitamin D deficiency
has been associated with higher mortality in severe COVID-19.
1
In the
United States, per the NIH, Vitamin D deficiency is more common in older adults and residents with obesity and hypertension and these factors have been associated with worse outcomes in residents with COVID-19.
13
Low Vitamin D levels have been associated with an increased risk of community acquired pneumonia in older adults.
14
Vitamin D supplementation was shown to protect against acute respiratory tract infections.
15
o Treatment:
For residents who are receiving Vitamin D3 for maintenance or for previously diagnosed Vitamin D deficiency, continue their usual Vitamin D3 dosing.
For residents who are not previously diagnosed with Vitamin D deficiency, obtain Vitamin D 25-OH level. If deficient, treat with Vitamin D3 50,000 units once a week for 8 weeks and recheck Vitamin D 25-OH level. Goal
7
is therapeutic level of Vitamin D 25-OH above 30 to 60 ng/ml. Providers

may opt for daily dosing of Vitamin D3 for 2 weeks to rapidly achieve a normal Vitamin D 25-OH level.
For residents, whose advance directives indicate no further bloodwork or whose providers determine that obtaining Vitamin D 25-OH level is not recommended, may treat the resident with 1000 units to 2000 units daily if consistent with goals of care.
2. Treatment for COVID-19 Positive Residents without Symptoms
Vitamin C
o Rationale - as above
o Treatment: Residents may be started on Vitamin C 500 mg twice a day per provider preference.
Zinc
o Rationale - as above
o Treatment:
Residents may be started on Zinc 220 mg (equals 50 mg elemental zinc) once a day for 4 weeks per provider preference.
Provider must review if the resident is already taking zinc in other supplements, such as multiple vitamins or AREDS supplements which contain zinc.
Do not exceed 50 mg elemental zinc a day. The optimal dose of zinc for the treatment of COVID-19 has not been established.
Vitamin D
o Rationale - as above
o Treatment:
For residents who are receiving Vitamin D3 for maintenance or for previously diagnosed Vitamin D deficiency, continue their usual Vitamin D3 dosing.
For residents who are not previously diagnosed with Vitamin D deficiency, obtain Vitamin D 25-OH level. If deficient, treat with Vitamin D3 50,000 units once a week for 8 weeks and recheck Vitamin D 25-OH level. Goal is therapeutic level of Vitamin D 25-OH above 30 to 60 ng/ml.
Providers may opt for daily dosing of Vitamin D3 for 2 weeks to rapidly achieve a normal Vitamin D 25-OH level.
For residents, whose advance directives indicate no further bloodwork or whose providers determine that obtaining Vitamin D 25-OH level is not recommended, may treat the resident with 1000 units to 2000 units daily if consistent with goals of care.
8
Oral Hydration protocol if appropriate, while monitoring fluid status.
Critical to monitor intake. Our experience In April-May 2020 with COVID-19 in the elderly in the SNF has been that COVID-19 causes decreased appetite and oral intake. Some elderly residents may not have overt gastrointestinal symptoms of nausea and may present with the subtle sign of decreased appetite. If noted to have decrease in appetite and fluid intake, switch to #3 (Treatment for COVID-19 Positive Residents within 48 hours of symptoms) below.
Evaluate if nebulized medications can be switched to inhalers to avoid aerosolizing the virus.
If nebulized bronchodilators are necessary for bronchospasm, follow all infection control measures and SOURCE CONTROL with face shield and N95 during and after administration of nebulized treatment
Residents who are receiving anticoagulants or antiplatelet therapies for underlying conditions should continue these medications.
3. Treatment for COVID-19 Positive Residents within 48 hours of Symptoms
Vitamin C, Zinc and Vitamin D the same as above, #2.
May consider adding Melatonin 3 to 10 mg HS, per provider preference.

o Rationale - Melatonin which has antioxidant and anti-inflammatory activities, has potential as an adjunct therapy to reduce the proinflammatory cytokine storm and neutralize generated free radicals to preserve cellular integrity.
16, 17 There may be
synergistic activity between Vitamin D and melatonin for the prevention and treatment of pulmonary infection by COVID-19.
18
Hydration is critical to preventing Acute Kidney Injury (AKI portends clinical decline and increased risk of mortality in this SNF population.)
o For residents with CHF or hyponatremia at baseline, may hold off hydration.
o For residents with fatigue and decreased oral intake, provider may start Clysis or IV hydration on day 1 or 2. Use clinician judgment and do not wait for abnormal labs to develop such as elevated BUN/CRE or decrease in GFR.
o Review medication regimen: if hydration with clysis/IV is indicated, hold the resident's diuretics, and monitor closely.
VTE prophylaxis - Rationale: high rates of thrombosis and thromboembolic events have been observed during the COVID-19 pandemic, and indicate a poor prognosis. In January 2020, the WHO issued interim guidance recommending daily LMWH for residents hospitalized with COVID-19. The Society for Post-Acute and Long-Term Care Medicine has published guidance for Anticoagulation of Residents with COVID-19 in PALTC. Balance the benefit of reducing risk of thrombosis against the risk of clinically significant bleeding.
19
o For residents who have no contraindication for anticoagulation, with low bleeding risk, it may be appropriate to start LMWH Enoxaparin (Lovenox) 40 mg SQ Daily or Apixaban (Eliquis) 2.5 mg twice a day.
9
o Optimal duration of anticoagulation is unknown; for high risk, consider 45 days.
Review psychotropics. Residents who have obvious fatigue from COVID-19 or decreased oral intake may benefit from reduction of dosage of psychotropics or in a case-to-case basis, may benefit from holding of psychotropics while being followed closely.
Evaluate if nebulized medications can be switched to inhalers to avoid aerosolizing the virus.
If nebulized bronchodilators are necessary for bronchospasm, follow all infection control measures and SOURCE CONTROL with face shield and N95 during and after administration of nebulized treatment.
Monitor for signs of bacterial superimposed infection. Treat with empiric antibiotic as necessary if bacterial infection is suspected.
Pulse oximetry every 4 hours. If pulse ox is less than 94% on room air (defined as hypoxemia) or for residents with chronic hypoxemia, a decrease from baseline of greater than 3%, review again goals of care, MOLST. Consider transfer to the hospital for early treatment with IV Remdesivir or convalescent plasma.
o If the resident has a Do not Transfer to Hospital order, or the resident and HCP want infacility care first, then start oral dexamethasone.
o Dexamethasone 6 mg orally daily for maximum 10 days.20
Monitor possible adverse effects of steroid - hyperglycemia, secondary infections, or psychiatric effects.
Consider PUD prophylaxis with famotidine 20 mg daily (if the resident is not already receiving a proton pump inhibitor or H2 blocker)
Use Acetaminophen as antipyretic. Avoid NSAIDS.
May continue ace-inhibitors and statins.
4. Treatment for COVID-19 Positive Residents beginning greater than 48 hours after symptom development.
Same as #3.
*References for above treatment guidance are located at the end of this policy.
Treatment with Oral Antivirals

Oral antivirals work by interfering with several steps in the reproductive process of SARS-CoV-2 to prevent efficient replication of the virus in host cells.
Two COVID-19 oral antiviral therapies have received Emergency Use Authorization from the U.S. Food and drug Administration (FDA), Paxlovid (Pfizer) and molnupiravir (Merck).
o Paxlovid and molnupiravir reduce the risk of hospitalization and death by 88% and 30% respectively, in residents at high-risk for severe COVID-19 when started early after symptom onset.
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o Paxlovid is the preferred product and is available for patients age 12 years and older.
o Paxlovid is not recommended for residents with severe kidney (eGFR <30 mL/min) or liver (Child-Pugh Class C) impairment. Dosage adjustments are needed for residents with moderate renal impairment. Providers should discuss with residents with kidney or liver problems.
o Paxlovid has established and other potentially significant drug interactions. Refer to the Paxlovid EUA Fact Sheet for drugs that contraindicate the use of Paxlovid.
o Molnupiravir should be considered for patients age 18 years and older for whom alternative FDA- authorized COVID-19 treatment options are not accessible or clinically appropriate.
o Molnupiravir is not recommended for use during pregnancy. Based on findings from animal reproductive studies, it may cause fetal harm when administered to pregnant individuals. Females under age 50 must consult with physician prior to taking this medication.
COVID-19 rebound after Paxlovid Treatment is characterized by a recurrence of symptoms or a new positive viral test after having tested negative. If this occurs, the individual should:
o Restart isolation for at least 5 days. The individual can end their re-isolation period after 5 full days if fever has resolved for 24 hours (without the use of fever-reducing medication) and symptoms are improving.
o Wear a mask for a total of 10 days after rebound symptoms started. (Some continue to test positive after day 10 but, are considerably less likely to shed infectious virus.)
o Be clinically re-evaluated if symptoms persist or worsen.
o Note: Re-testing is only recommended in those who received Paxlovid treatment if symptoms recur between days 2-8 after initial recovery.
Section 6: Treatment with Monoclonal Antibodies
Monoclonal antibodies are authorized by the FDA for treatment of non-hospitalized COVID-19 patients with mild to moderate COVID-19 symptoms who are at high risk for progression to severe COVID-19 illness including hospitalization and death.
Bebtelovimab is currently authorized by the FDA for treatment of COVID-19. The other monoclonal antibodies, bamlanivimab plus etesevimab and casirivimab plus imdevimab and sotrovimab are currently not authorized in the U.S. for the treatment of COVID-19 due to prevalence of omicron subvariants.
The symptomatic resident who has a diagnostic test for SARS-CoV-2, for whom alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate, is a candidate for monoclonal antibody treatment. The resident must be within 7 days of symptom onset for bebtelovimab and meet the Criteria of the FDA EUA (emergency use authorization).
High Risk as defined by at least one of the following criteria:
o Older age (for example, age ≥65 years of age)
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o Obesity or being overweight (for example, BMI >25 kg/m2 , or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts
o Chronic kidney disease
o Diabetes
o Immunosuppressive disease or immunosuppressive treatment
o Cardiovascular disease (including congenital heart disease) or hypertension
o Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma

[moderate-to-severe], interstitial lung disease, cystic fibrosis, pulmonary hypertension)
o Sickle cell disease
o Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
o Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)
The medical provider (MD/APP) must evaluate the resident within 24-48 hours of monoclonal antibody treatment and complete the Monoclonal Antibody Packet which includes the following:
o Checklist of Criteria met under EUA.
o Completed medical provider note - may attach a printed PCC note
o Documentation that the resident/health care proxy was informed that monoclonal antibody therapy is an unapproved drug that is authorized for use under Emergency Use Authorization.
o Resident/health care proxy informed of alternatives to receiving monoclonal antibody therapy
o Resident/health care proxy was provided the "Fact Sheet” for Patients, Parents and Caregivers" Emergency Use Authorization for the monoclonal antibody
o Signed Consent
Monoclonal antibody treatment will be administered in a dedicated section of the nursing facility or in the resident’s room. After the treatment of monoclonal antibodies, the resident will receive 1-hour post treatment monitoring.
Registered Nurses certified/trained to administer monoclonal antibody treatments will be with the resident at all times. A medical provider must be onsite at the facility during the entire duration.
Emergency medications in the crash cart will be available at the facility: methylprednisone, diphenhydramine and epinephrine.
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The Monoclonal Antibody Packet and the vital signs monitoring record from the treatment will be kept on file separately for future audit of regulatory bodies.
**References for above Monoclonal Antibody Treatment are located at the end of this policy.
NYS Guidance on Prioritization of Treatment
While supplies remain low, adhere to the NYS DOH guidance on prioritization of antiSARS-CoV-2 therapies fortreatment and prevention of severeCOVID-19 and prioritize
therapies for people of any eligible age who are moderately to severely immunocompromised regardless of vaccination status or who are age 65 and older and not up to date with all recommended vaccine doses with at least one risk factor for severe illness.
Section 7: Resident Transfer
1. Hospital transfer will be required for severely symptomatic residents or any resident that requires an Airborne Isolation (negative pressure) room.
2. If an essential appointment (i.e. MD appointment, dialysis) is scheduled during the time the resident is being monitored for COVID-19, the resident must be checked for fever/symptoms prior to transport. If the resident is febrile or experiencing any other symptoms possibly related to COVID-19, the situation must be discussed with the attending medical provider prior to transporting the resident.
3. The resident and any individual accompanying the resident are to wear a procedure mask and eye protection (goggles or face shield).
4. If a resident with suspected or confirmed COVID-19 requires transfer to another facility, this fact will be documented on the transfer documents and if possible a phone call will be placed to the receiving facility.
5. Facility must also alert emergency medical services of suspected or confirmed diagnosis.
6. Upon return from an ER evaluation or essential appointment (i.e. MD appointment, dialysis),

the resident may return to the green room if appropriate SOURCE CONTROL was worn and there is no known
or suspected respiratory infection.
7. LTC facilities may transfer or discharge residents to another LTC facility solely for the following cohorting purposes:
Transferring residents with symptoms of respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents;
Transferring residents without symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19; as well as providing treatment or therapy for other conditions as required by the resident's plan of care

Section 8: Hospital Discharges

1. No hospital shall discharge a patient to a Nursing Home unless the facility administrator has first certified that they are able to provide that patient with adequate care.

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Section 9: Guidance for Discontinuation of Transmission-Based Precautions

Duration of Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection

In general, asymptomatic patients do not require empiric use of Transmission-Based Precautions (TBP) while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These patients should still wear source control and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.

Examples of when TBP following close contact may be considered include:

- Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Patient is moderately to severely immunocompromised
- Patient is residing on a unit with others who are moderately to severely immunocompromised
- Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

- Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
- If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection

The following are criteria to determine when Transmission-Based Precautions could be discontinued for patients with SARS-CoV-2 infection and are influenced by severity of symptoms and presence of immunocompromising conditions. Patients should self-monitor and seek re-evaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these patients should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.

In general, patients who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time described for patients with severe to critical illness. Refer to section 10 of this policy.

In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for patients.

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Criteria for 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
 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
Patients who were asymptomatic throughout their 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
 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 as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.
The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific patients. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)
Patients who are moderately to severely immunocompromised may produce replicationcompetent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.
 Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.
The criteria for the test-based strategy are:
Patients who are symptomatic:
 Resolution of fever without the use of fever-reducing medications and
 Symptoms (e.g., cough, shortness of breath) have improved, and
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 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
Patients who are not symptomatic:
 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.
NOTE: Clinical judgement shall be used to determine when testing should begin taking into consideration illness severity and clinical symptoms.
Section 10: Assessing Risk for Severe Disease
1. Older age and certain chronic medical conditions have been associated with more severe illness and higher mortality from COVID-19:
Age ≥65 years
Residence in a nursing home or long-term care facility
Immunocompromised state, including solid organ transplant, HIV infection, other immune deficiency, immunosuppressant medication including systemic corticosteroids
Chronic lung disease, including chronic obstructive pulmonary disease (COPD), moderate to severe asthma, cystic fibrosis, pulmonary fibrosis
Cardiovascular disease
Cancer
Hypertension
Obesity (body mass index [BMI] ≥30 kg/m2)

Diabetes mellitus
Chronic kidney disease
Chronic liver disease
Cerebrovascular disease
Neurologic disorders, including dementia
Tobacco use disorder
Hematologic disorders, including sickle cell disease and thalassemia
Pregnancy

2. Time course and development of dyspnea:

For any resident with suspected or confirmed COVID-19, establish the illness timeline: the first day symptoms began, the presence of dyspnea, and the day of dyspnea onset. While mild dyspnea is common, worsening dyspnea, particularly dyspnea at rest, and more severe chest discomfort/tightness are concerning symptoms and suggest the development or progression of pulmonary involvement. The trajectory of dyspnea over the days following its onset is particularly important, as significant worsening and acute respiratory distress syndrome (ARDS) can manifest soon after the onset of dyspnea; in studies among residents who develop ARDS, progression to ARDS occurred a median of 2.5 days after onset of dyspnea. In residents at high risk for severe illness, outreach efforts should be focused particularly on the days following the onset of dyspnea to assess for any worsening of respiratory status.

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3. Assessment to categorize dyspnea by severity:

Mild dyspnea – Dyspnea that does not interfere with daily activities
Moderate dyspnea – Dyspnea that creates limitations to activities of daily living.
Severe dyspnea – Dyspnea that causes shortness of breath at rest, renders the resident unable to speak in complete sentences.

4. Oxygenation assessment:

For any resident with an oxygen saturation of ≤ 94 percent on room air, nurse must notify medical provider for evaluation.

For any resident with an oxygen saturation of < 90 percent on room air, assess for transfer to ED for evaluation for severe COVID disease if consistent with advance directives/MOLST. (If the resident has limitations for Do Not Transfer, call the medical provider immediately for evaluation and consider starting Dexamethasone.)

Oximetry should only be considered within the context of the resident's overall clinical presentation; a normal oxygen saturation level cannot be used to exclude clinically significant respiratory involvement in a resident with concerning symptoms such as progressive or severe dyspnea or high overall acuity level. In addition, although normal oximetry can be reassuring, there is no guarantee that respiratory status will not deteriorate as the illness progresses.

5. Assessment of overall acuity level

In addition to the evaluation of respiratory status, assess the resident's overall acuity level in regards to orthostasis, dizziness, fall, hypotension, mental status change (i.e. lethargy, confusion, change in behavior, difficulty in rousing), observed cyanosis, and urine output. While mild orthostasis symptoms may be addressed with instruction to increase fluids. Mental status changes, falls, cyanosis, hypotension, anuria, and chest pain suggestive of an acute coronary syndrome are concerning and warrant in-person evaluation.

6. Criteria for ED evaluation and likely hospital admission — Refer residents with one or more of the following features to the ED for further management and likely hospital admission:

Severe dyspnea (dyspnea at rest, and interfering with the ability to speak in complete sentences) (see 'Dyspnea assessment' above)
Oxygen saturation on room air of ≤ 90 percent, regardless of the severity of dyspnea (see 'Oxygenation assessment' above)
Concerning alterations in mentation (i.e., confusion, change in behavior, difficulty in

rousing) or other signs and symptoms of hypoperfusion or hypoxia (i.e. falls, hypotension, cyanosis, anuria, chest pain suggestive of the acute coronary syndrome) (see 'Assessment of overall acuity level' above)
Reference: UpToDate.com
Defining Illness
SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)
1. Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
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2. Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
3. Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
4. Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
Section 11: CPR Guidance
CPR creates significant additional risk of contracting COVID-19 due to viral aerosolization. Consider CPR appropriateness. Balance CPR need with protecting rescuers.
Additional precautions are required when performing CPR during this pandemic. Use the following steps if CPR is necessary for any resident suspected or diagnosed with COVID-19:
1. COVID-19 suspect or confirmed status of the resident will be clearly communicated before initiating CPR.
2. Don PPE including an N95 respirator, gown, gloves, and face shield.
3. Close the door to the resident's room before performing CPR. Move other residents away from the area (i.e. hallways and transportation routes out of the facility).
4. Ensure that only 2 healthcare professionals if possible, with appropriate SOURCE CONTROL are present in the room while CPR is being administered.
5. Spread a clear plastic sheet over the resident, including the resident's head.
6. If ventilation is to be conducted, utilize a bag-valve mask with a HEPA filter under the plastic sheet. If N95 respirators are unavailable, perform hands-only CPR without ventilation until EMS arrives.
7. Viral particles can remain suspended in the air with a half-life of approximately 1 hour and can be inhaled by those nearby. Open the window in resident's room and keep room door closed with no entry for minimally 2 hours after CPR is performed.
Section 12: Communication
Based on DOH and CMS Guidance
1. Positive Test Result or COVID-19 Related Death:
If a resident tests positive for COVID-19 and/or succumbs to the virus, the family or next of kin will be notified as soon as practical but, not to exceed 24 hours (or by 5pm the next calendar day, whichever is sooner).
If any resident tests positive for COVID-19 or if any resident suffers a COVID-19 related death, the family or next of kin of ALL residents will be notified as soon as practical but, not to exceed 24 hours of such positive result or death (or by 5pm the next calendar day, whichever is sooner).
2. Updates on Condition:
The family or next of kin of a COVID-19 positive resident will be updated at least once per day and if a change in condition occurs.
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3. Cumulative Weekly Updates:
ALL residents and family or next of kin of ALL residents will be updated once per week on the number of infections and deaths at the facility.
4. CMS Guidance:

Facilities must inform residents, their representatives, and families by 5pm the next calendar day following the occurrence of either: a single confirmed infection of COVID-19; or 3 or more resident or staff with new-onset of respiratory symptoms that occur within 72 hours of each other. Also, cumulative updates to residents, their representatives and families must be provided at least weekly by 5pm the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified; or whenever 3 or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Section 13: Facility Reporting to CDC's NHSN (National Healthcare Safety Network)

The information will be used to monitor trends in infection rates and inform public health policies. Information reported will be shared with CMS and will be retained and publicly reported to support protecting the health and safety of residents, personnel, and the general public. Reporting is required on a weekly basis.

Section 14: Managing Resident Deaths

To ensure the most appropriate removal of decedents from the facility and proper handling of personal effects, utilize the following practices:

1. Family members will be encouraged to determine a funeral home prior to admission. If a preplanned funeral contract has been executed, this will be indicated in the medical record.
2. In the event of the resident's death, the family will be contacted prior to calling the funeral home. Families are notified as soon as possible but, within 24 hours of the death.
3. In cases where there is no funeral provider selected by the family, the county may be contacted for direction as needed.
4. A form of identification will be attached to the body (i.e. toe tag) if there is no wrist band.
5. The decedent will be placed into a body bag or pouch prior to moving the body to any other location or release to the funeral director or coroner/examiner.
6. Matching identification will be attached to the outside of the body bag or pouch.
7. Personal effects such as eyeglasses, dentures and hearing aids will be bagged and labeled for the funeral home and placed next to the body.
8. Other personal effects will be disinfected as appropriate with a sanitizing solution that contains at least 70% alcohol.
9. Important items or keepsakes that cannot be easily sanitized, must be placed in plastic bags before storing in boxes/bins.
10. SOURCE CONTROL will be worn when handling personal effects of the deceased resident. All infection control practices including hand hygiene will be followed.
11. The items will be labeled and retained for the family. Proper tracking, storage, and handling of all personal effects will be followed.
12. Family members should be encourage to wait at least 7 days before unpacking items.
13. In cases where long term storage of personal effects is necessary, the items will be stored in a clean, secure location.
14. Soiled clothing and bed linens will be laundered prior to storage. Items that are wet or contaminated with body fluids will be properly discarded.
15. A list of personal effects given to the funeral director and/or those stored or given to a family member will be documented accordingly.

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Guidance to families regarding resident death:

1. In addition to communicating the resident's funeral home arrangements, the family is encouraged to provide clear instructions regarding the handling of personal effects upon death.
2. Families are advised of the facility policies regarding death notification and visitation. Visitation of the decedent's body will be allowed using proper infection control practices including face covers for all persons involved.
3. Families are informed that if no funeral home is selected, the decedent will be released to the county authority.

DOH requirement for testing/reporting after a resident's death
1. Any resident with symptoms of COVID-19 or who has been exposed to COVID-19 will be tested for the COVID-19 virus, along with any other clinically appropriate testing. Also, whenever a resident expires in the facility, where in the professional judgement of the nursing home clinician there is a clinical suspicion that COVID-19 was a cause of death, but no such test was performed in the 14 days before death, the facility will administer a COVD19 test within 48 hours after death, along with any other clinically appropriate testing.
2. COVID-19 testing will be performed using rapid testing methodologies to the extent available.
3. The facility will report the death to the Department immediately after and only upon receipt of such test results through the HERDS.
4. No test will be administered if the responsible party objects to such testing.
5. The facility will request assistance from the State DOH if unable to perform such testing expeditiously.
Section 15: Emergency Medication Pass
1. During the COVID-19 emergency, at the discretion of the Medical Director and Director of Nursing, when staffing is considered critical non-essential medications and treatments can be held per policy. Every effort will be made to avoid omitted and delayed doses of critical medicines.
Section 16: In-House Salon Services
1. Testing and Screening of Beautician
The beautician, whether a facility employee or contracted, will be tested per CMS guidelines.
The analyzer or otherwise may be used.
2. Sanitizing and PPE (Source control)
Hand sanitizer will be available in the salon. Both the resident and beautician must use hand sanitize upon entry and exit.
All residents must be screened for s/s of COVID-19 and temperature will be obtained immediately prior to the appointment. This will be recorded on the Beauty Salon Temperature Log.
All beauticians must wear a facemask and face shield at all times.
The salon will be cleared of non-essential items, magazines etc.
Gloves, capes, and aprons are available in the salon for use as indicated. These are one-time-use items per resident and must be discarded.
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Full disinfection of equipment workstation salon is required between residents. A full disinfection of the salon is required at the end of the day as well as at the initiation of any salon service scheduled for the following day. This is documented on the Salon Disinfection Log.
3. Physical Distancing
Designated staff will be assigned to transport to and from the salon.
One resident is permitted in the salon at a time.
There will be no waiting area outside of the salon.
The door to the salon must be closed while services are being provided.
Signage will be posted outside the salon with applicable guidelines to remind others to adhere to proper hygiene, social distancing rules, appropriate use of PPE and cleaning/disinfecting protocols.
4. Contracted beautician
Will sign an acknowledgment agreeing to the guidelines.
5. The Beauty Salon Audit tool will also be utilized to assure compliance.
Section 17: CMS Definition of Facility Staff
1. For the purposes of this policy, 'facility staff' is defined as employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aid training programs or from affiliated academic institutions. This definition applies but, is not limited to screening, testing, guidance

for returning to work and testing refusals as outlined below.

Section 18: Screening of Facility Staff

1. All staff will be screened, including temporal scanning for fever, prior to entry into the facility. In the event the staff member is symptomatic, the individual will be restricted from entering.
2. Staff screening must be completed every 8 hours therefore, if working a double a second temperature check must be completed. The Healthcare Worker Daily Alert form will be completed should a staff member have a fever AND respiratory symptoms at the screening check or develop symptoms during work.
3. If Facility staff performing health checks, they must wear facemasks.
4. Nursing students are permitted but, must wear a mask, until otherwise directed by the facility Administrator and/or Infection Preventionist.
5. Supervision will be provided for all provisional staff members/new hires. Safety and proper infection control practices are paramount.
6. Staff who have signs and symptoms of respiratory infection while on-the-job, should:
1. Immediately stop work, apply a facemask and obtain a COVID test;
2. Inform the facility Infection Preventionist and include information on individuals, equipment, and locations the person came in contact with.

Electronic Screening Kiosk

1. For facilities that use an electronic screening kiosk, the iPad must be disinfected between staff and visitor check ins and staff and visitors must use hand sanitizer before and after use.
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2. If disinfecting between users, alcohol or Clorox wipes are the only acceptable product. Bleach wipes cannot be used.
3. Stylus pens may be used and are also disinfected between users.
4. In the event the iPad malfunctions or if an electronic screening kiosk is not in use, a paper screening log is keep at the sign in area.

Section 19: CMS Requirement for COVID-19 Testing

1. 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.
2. Level of community transmission refers to facility's county level of COVID-19 transmission. This metric uses two indicators for categorization (1. Total number of new cases per 100,000 persons within the last 7 days and 2. Percentage of positive diagnostic and screening nucleic acid amplification tests (NAAT) during the last 7 days), which can be found on the Centers for Disease Control and Prevention (CDC) COVID-19 Integrated County View site at https://covid.cdc.gov/covid-data-tracker/#county-view.
3. When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak investigation (as specified below).

Table 1: Testing Summary

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, regardless of vaccination status, with signs or symptoms must be tested.	Residents, regardless of vaccination status, with signs or symptoms must be tested.
Newly identified COVID19 positive staff or resident in a facility that can identify close contacts		

Test all staff, regardless of vaccination status, that had a higher-risk exposure with a COVID-19 positive individual.	
Test all residents, regardless of vaccination status, that had close contact with a COVID-19 positive individual.	
Newly identified COVID19 positive staff or resident in a facility that is unable to identify close contacts	
Test all staff, regardless of vaccination status, facilitywide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility).	
Test all residents, regardless of vaccination status, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility).	
Routine testing	Not generally Recommended
	Not generally recommended

4. Staff with symptoms or signs of COVID-19, regardless of vaccination status, must be tested as soon as possible and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidance "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2." Staff who do not test positive for COVID-19 but have symptoms should follow facility policies to determine when they can return to work.

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5. Residents who have signs or symptoms of COVID-19, regardless of vaccination status, must be tested immediately. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance. Once test results are obtained, the facility must take the appropriate actions based on the results.

Testing of Staff and Residents During an Outbreak Investigation

1. An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP are discontinued. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission.

2. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing.

Focused/Broad Testing - If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide

or group-level (e.g., unit, floor, or other specific area(s) of the facility). Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.

3. For individuals who test positive for COVID-19, repeat testing is not recommended to discontinue TBP or work restrictions. A symptom-based strategy is intended to replace the need for repeated testing.

4. In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days; however, Testing may be considered between days 31-90 and if performed during this time, an antigen test versus a NAAT covid test is recommended.

"Facility staff" includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. For the purpose of testing "individuals providing services under arrangement and volunteers," facilities should prioritize those individuals who are regularly in the facility (e.g., weekly) and have contact with residents or staff. We note that the facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source (e.g., their employer or on their own). However, the facility is still required to obtain documentation that the required testing was completed during the timeframe that corresponds to the facility's testing frequency as described in Table 1 above.

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Instruct facility staff, regardless of their vaccination status, to report any of the following criteria to occupational health or another point of contact designated by the facility so they can be properly managed: o a positive viral test for SARS-CoV-2, o symptoms of COVID-19, or o a higher-risk exposure to someone with SARS-CoV-2 infection.

Refusal of Testing

1. Staff Refusal - Staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member, who is not up-to-date, and refuses testing, the staff member will be restricted from the building until the procedures for outbreak testing have been completed. The facility will follow occupational health and local jurisdiction policies with respect to any asymptomatic staff.

2. Resident Refusal - Residents (or resident representatives) may exercise their right to decline COVID-19 testing in accordance with the requirements under 42 CFR § 483.10(c)(6). In discussing testing with residents, staff will use person-centered approaches when explaining the importance of testing for COVID-19. Ensure that residents who have signs or symptoms of COVID-19 and refuse testing are placed on TBP until the criteria for discontinuing TBP have been met. If outbreak testing has been triggered and an asymptomatic resident refuses testing, the facility will thoroughly monitor to ensure the resident maintains appropriate distance from other residents, wears a face mask, and practices effective hand hygiene until the procedures for outbreak testing have been completed.

3. Clinical discussions about testing may include alternative specimen collection sources that may be more acceptable to residents than nasopharyngeal swabs (e.g., anterior nares). Providing information about the method of testing and reason for pursuing testing may facilitate discussions with residents or resident representatives.

4. Residents who refuse testing may require TBP based on symptoms or vaccination status. For further information, see CDC guidance "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes."

Documentation of Testing

1. Facilities must demonstrate compliance with the testing requirements. To do so, facilities will do the following:

• For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results

were obtained, and the actions the facility took based on the results.
• Upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests (see section “Testing of Staff and Residents During an Outbreak Investigation” above).
• Document the facility’s procedures for addressing residents and staff that refuse testing or are unable to be tested and document any staff or residents who refused or were unable to be tested and how the facility addressed those cases.
• When necessary, such as in emergencies due to testing supply shortages, document that the facility contacted state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
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Additional Testing Information
1. Any positive test result must be reported to the Department by 1:00pm of the day following receipt of such test results, in accordance with existing reporting protocols and mechanisms.
2. Any personnel with positive test results must remain home in isolation, in accordance with all guidance and directives of the state and local health departments.
3. Records of personnel testing and results will be maintained for a period of 1 year.
NOTE: Refer to “COVID-19 Employee Testing Policy” for additional details.
Section 20: Symptom-Based Strategy for Return-to-Work
HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays.
When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.
 If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.
 If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.
For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses.
 Return to Work Criteria for HCP with SARS-CoV-2 Infection
The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of wellfitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.
HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have 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 (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
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HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could 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).

*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 could 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 as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)

HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

Guidance for Return-to-Work During Critical Staffing Shortage

Critical Staffing shortages are determined based on but, not limited to individual facility needs, current furloughed employees, current vacant positions, resident population, census.

Exposures that might require testing and/or restriction from work can occur both while at work and in the community. Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure.

Other exposures not classified as higher-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth. When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission.

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For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged1 close contact2 with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection3 and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)4
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

Following a higher-risk exposure, HCP should:

- Have a series of three viral tests for SARS-CoV-2 infection.

o 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.

o Due to challenges in interpreting the result, 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 wellfitting source control, monitoring themselves for fever or symptoms consistent with COVID19, 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 their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

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 could 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.

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 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.

In addition to above:

 HCP should 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 contact their established point of contact (e.g., occupational health program) to 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.

Footnotes:

1. For this guidance, an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.

2. For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARSCoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

3. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious:

a. For individuals with confirmed COVID-19 who developed symptoms, consider the

exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions
b. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.
i. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with SARS-CoV-2 infection, facemasks still confer some level of protection to HCP, which was factored into this risk assessment if the patient was also wearing a cloth mask or facemask
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Section 21: Crisis Strategies to Mitigate Current or Imminent Staffing Shortages that Threaten Provision of Essential Patient Services
1. Facilities with an actual or anticipated inability to provide essential patient services despite instituting contingency strategies according to the DOH guidance will notify NYSDOH of their need to follow CDC crisis capacity strategies.
2. Until further direction is given, facilities will call the Surge and Flex Operations Center at 917-909-2676 to notify NYSDOH of the need to move to “crisis” strategies with a description of mitigation strategies already employed and a description of crisis strategies regarding HCP return-to-work which they intend to implement and their planned prioritization strategy.
3. Before moving to crisis strategies:
The facility must ensure that they have strategies in place to mitigate HCP staffing shortages, including appropriate Contingency strategies as outlined in CDC’s Strategies to Mitigate Healthcare Personnel Staffing Shortages.
Facilities should ensure that the criteria for identifying higher risk HCP exposures in healthcare settings are applied properly according to CDC guidance (e.g., missing PPE or inappropriate wearing of SOURCE CONTROL while caring for a patient with suspected or confirmed COVID-19 or during aerosol-generating procedures).
Section 22: OSHA COVID-19 Safety Coordinator/Plan Requirement
The OSHA Emergency Temporary Standard (ETS) for COVID-19 requires that facilities designate a workplace COVID-19 Safety Coordinator. Such coordinator must be identified in the plan. Duties include:
1. Implement and monitor the COVID-19 plan
2. Knowledgeable in infection control principles and practices as they apply to the workplace and employee job operations
3. Having authority to ensure compliance with all aspects of the COVID-19 plan
The facility Infection Preventionist will be designated as the COVID-19 Safety Coordinator.
OSHA COVID-19 Plan
1. Per OSHA Emergency Temporary Standard (ETS) for COVID-19, facilities are required to seek input from non-managerial employees and their representatives, if any, in hazard assessment and development and implementation of the COVID-19 plan.
2. The facility must conduct a facility-specific hazard assessment to identify potential workplace hazards related to COVID-19. The assessment will be conducted initially and whenever changes at the workplace create a new potential risk of employee exposure to COVID-19.
3. The facility must monitor the workplace to ensure the ongoing effectiveness of the COVID19 plan and update it as needed.
4. The facility must address the hazards identified in the assessment and implement policies and procedures to:
Minimize the risk of transmission of COVID-19 for each employee.

Effectively communicate and coordinate the plan with employees of different employers who share the same physical location (i.e. lab, radiology, consultants).
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Ensure each employee is protected and adjust the COVID-19 plan to address any particular COVID-19 hazard presented by other employees. (This requirement does not apply to delivery people, messengers and other employees who only enter the facility briefly to drop off or pick up items.)
Notify the controlling employer when those employees are exposed to conditions at that facility.
OSHA Safety Meetings Requirement
1. The Safety Committee will include at least 3 non-managerial staff encompassing both nursing and ancillary staff members.
2. The Safety Committee Meeting is held minimally on a quarterly basis.
3. COVID-19 will be a topic on the agenda at facility Safety Meetings. Methods for soliciting input include but, are not limited to:
Safety Meetings
Safety Committees
Conversations between managers and non-managerial employees
Negotiations with bargaining agent, if applicable
Employee surveys
OSHA Employee Training Requirement
1. The facility will provide training:
When changes occur that affect the employee's risk of contracting COVID-19 at work (i.e. new job task);
Policies and procedures are changed; or
There is an indication that the employee has not retained the necessary understanding or skill.
2. The training will be overseen by an employee who is knowledgeable in the covered subject matter as it relates to the employee's job duties.
OSHA Recordkeeping Requirement
1. A COVID-19 Log will be maintained to record each instance identified by the facility in which an employee is COVID-19 positive, regardless of whether the instance is connected to exposure to COVID-19 at work.
2. The information on the COVID-19 Log is recorded within 24 hours of the facility learning that the employee is COVID-19 positive and is maintained as confidential medical record information. The information will not be disclosed except as required by the ETS or other federal law.
OSHA Employee Notification Requirement
1. The facility will require that each employee promptly notify the facility when the employee:
Is COVID positive (confirmed positive test for; or has been diagnosed by a licensed healthcare provider with COVID-19; or
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Has been told by a licensed healthcare provider that they are suspected to have COVID-19; or
Is experiencing recent loss or taste and/or smell with no explanation; or
Is experiencing both fever (> 100.4° F) and new unexplained cough associated with shortness of breath.
2. The facility will provide notification to employees of COVID-19 exposure in the workplace:
When the facility is notified that a person who has been in the facility (including employees, clients, patients, residents, vendors, contractors, customers, delivery people and other visitors, or other non-employees) is COVID-19 positive, the facility within 24 hours:
Notify each employee who was not wearing a respirator and any other

required SOURCE CONTROL and has been in close contact with the person in the facility. The notification must include the fact that the employee was in close contact with someone with COVID-19 along with the date that contact occurred.

Notify all other employees who were not wearing a respirator and any other required SOURCE CONTROL and worked in a well-defined portion of the facility (i.e. particular floor/unit) in which that person was present during the potential transmission period. The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic individuals, 2 days prior to test specimen collection) until the time the individual is isolated. The notification must specify the date(s) the individual with COVID-19 was in the workplace during the potential transmission period.

Notify other employers whose employees were not wearing respirators or any other required SOURCE CONTROL and have been in close contact with that person, or worked in a well-defined portion of the facility (i.e. particular floor/unit) in which that person was present, during the potential transmission period (defined previously). The notification must specify the date(s) the individual with COVID-19 was in the workplace during the potential transmission period and the location(s) where the individual with COVID-19 was in the facility.

These notifications will not include any employee's name, contact information or occupation.

NOTE: Also refer to Respiratory Protection Program and OSHA Recording and Reporting Policies.

Section 23: Residents Who Leave The Facility For Less Than 24 Hours

1. Residents who leave the facility will be reminded to follow all recommended IPC practices including source control, physical distancing, and hand hygiene and to encourage those around them to do the same.

Individuals accompanying residents (i.e. transport personnel, family members) will also be educated about these IPC practices and should assist the resident with adherence.

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2. For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.

3. Upon the resident's return, residents will be screened upon return for signs or symptoms of COVID-19:

• If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, see the CDC's guidance for residents who have had close contact for next steps regarding testing and quarantine.

 In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (i.e. for medical appointments, community outings with family or friends) and do not have close contact with someone with SARSCoV-2 infection.

4. The facility will consider quarantining residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended IPC measures.

5. Residents who leave the facility for 24 hours or longer will be managed as a new admission/readmission.

Section 24: New Admissions and Residents Who Leave the Facility For Greater Than 24 Hours

1. Testing is recommended at admission and, if negative, again 48 hours after the first

negative test and, if negative, again 48 hours after the second negative test (days 1,3 and 5). In general, admissions in counties where Community Transmission levels are high should be tested upon admission; admission testing at lower levels of Community Transmission is at the discretion of the facility.

2. Residents should also be advised to wear source control for the 10 days following their admission. Residents who leave the facility for 24 hours or longer should generally be managed as an admission.

3. Empiric use of Transmission-Based Precautions is generally not necessary for asymptomatic residents admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings.

Section 25: Source Control (PPE)

1. The facility must possess and maintain at least a 60-day supply of all necessary items of PPE sufficient to protect facility staff, consistent with DOH/CDC guidance. The PPE can be stored at the facility or in a separate storage unit that the facility (or its corporate network) has the right to access as needed and the facility has a sufficient supply of PPE on hand to cover resident needs until such time that the off-site PPE can be accessed.

2. PPE stored in offsite central supply is available 24 hours a day/7 days a week. Corporate Security Associates will be contacted in the event PPE is needed at a facility. An Associate will make delivery arrangements with the corporate van/designated service.

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3. The facility Administrator/designee will compare existing inventories of PPE (face shields, gowns, gloves, masks, N95 respirators) against the required inventories to determine the quantities needed to be on hand. Optimize and conserve PPE where appropriate as supply chain interruptions have been noted due to the high demand.

4. 60-day stockpile of PPE is based on the following requirements:

Single gloves – the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the facility's operating certificate, multiplied by 24;

Gowns – the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the facility's operating certificate, multiplied by 3;

Surgical masks – the applicable positivity rate, multiplied by the number of certified beds as indicated on the facility's operating certificate, multiplied by 1.5;

N95 respirator masks – the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the facility's operating certificate, multiplied by 1.4;

5. Applicable positivity rate is defined as the greater of the following positivity rates:

The facility's average COVID-19 positivity rate, based on reports made to the Department, during the period of April 26, 2020 through May 20, 2020; or

The facility's average COVID-19 positivity rate, based on reports made to the Department, during the period of January 3, 2021 through January 31, 2021; or

20.15%, representing the highest Regional Economic Development Council average COVID-19 positivity rate, as reported to the Department, during the periods April 26, 2020 through May 20, 2020 and January 3, 2021 through January 31, 2020.

6. Facilities that identify a shortage of PPE, should use existing plans and vendor agreements to procure additional assets, by taking the following steps:

Use existing vendor agreements and procurement plans to place orders for quantities needed by type and size of PPE.

Activate existing Mutual Aid Agreements to obtain available support from those partners.

Notify County Office of Emergency Management (OEM) when all existing agreements are exhausted and supply needs exceed those available from these sources.

Coordinate with County OEM to identify and utilize other existing county resources.

Notify the respective Department's Regional Office of ongoing need.

If all local resources have been exhausted, submit a request, via your County OEM, to the state OEM. The request should include as much detail as available, but include at a minimum the following elements:

Type and Quantity of PPE by size
Point of Contact at the requesting facility or system
Delivery location
Date request is needed to be filled by
Record of pending orders
OEM contacts:
Erie County:
Gregory J. Butcher, Deputy Commissioner
Office: 716-858-2944
Gregory.butcher@erie.gov
Niagara County (Northgate): Daniel
Leven
daniel.leven@niagaracounty.com
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Suffolk County (Brookhaven):
OEM: 631-852-4900
Michigan Region 2 North (Autumn Woods):
Rachiel Clay, Assistant Regional Coordinator
Office: 248-759-4748
Mobile: 586-216-1270
rclay@region2north.com
CDC Strategies for Optimizing Supply of PPE
If all efforts to obtain PPE through vendors and local Office of Emergency Management are exhausted or unsuccessful, healthcare providers should refer to CDC guidance entitled “Strategies for Optimizing the Supply of PPE.”
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
1. Eye Protection
Implement extended use of eye protection. Wear the same protection for multiple residents. Change only when soiled or damaged.
Use non-disposable, re-usable goggles, or face shields. Using CDC or DOH accepted protocols, clean and disinfect the goggle or face shield between uses.
Use non-medical or medical safety glasses that cover the sides of the eyes.
Reprocess disposable eye protection for re-use. If there are no manufacturer’s instructions, use instructions suggested by the CDC.
While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles, using a clean cloth saturated with neutral detergent solution or cleaner wipe.
Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
Wipe the outside of the face shield or goggles with clean water or alcohol to remove residue.
Fully dry (air dry or use clean absorbent towels).
Remove gloves and perform hand hygiene.
2. Gowns
Restrict sterile surgical gowns to use during sterile procedures.
Use coveralls, if available.
Use gowns and coveralls approved in other countries.
Implement extended use of gowns or coveralls for cohorted residents with COVID-19. Similarly, implement extended use of gowns or coveralls for residents without symptoms of COVID-19. Change gowns or coveralls only when soiled, wet or after interacting with a resident with other transmissible diagnoses (i.e. C diff, targeted multidrug-resistant organisms, Candida auris).
Use cloth isolation gowns that can be laundered.
Re-use gowns with no visible soiling for care of residents with COVID-19.
Prioritize gowns for aerosol-generating procedures, activities possibly involving

splashes or sprays, high-contact activities, and for the care of residents with non COVID-19 transmissible diagnoses (i.e. C diff, multidrug-resistant organisms, Candida auris).
Use other items of clothing, such as disposable laboratory coats, cloth resident gowns, cloth laboratory coats, disposable aprons, or combinations thereof.
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3. Facemasks
Implement extended use of facemasks. Wear the same facemask for multiple residents with confirmed COVID-19 without removing between residents. Change only when soiled, wet or damaged and per facility policy. Do not touch the facemask.
Use expired facemasks.
Prioritize facemasks for HCP rather than as source control for residents. Have residents use tissues or similar barriers to cover their mouth and nose.
Implement limited re-use of facemasks. Do not touch outer surface of the facemask, fold so outer surface is inward, assign to a single HCP and store in a breathable container between uses. Always perform hand hygiene immediately after touching the facemask.
If available, use portable HEPA filters or ventilated headboards to decrease risk of HCP without adequate respiratory protection.
Prioritize facemasks for sterile procedures, when splashes or sprays are anticipated with prolonged close contact with a potentially infectious resident and (if respirators are not available) for aerosol-generating procedures or similar procedures with potential for uncontrolled respiratory secretions.
Use a face shield covering the entire front and sides of the face.
Use cloth masks or other homemade masks (i.e. bandanas, scarves) for HCP is not recommended. If used, they should be used with a face shield. It is unknown whether cloth masks provide effective source control for infectious residents.
4. N95 Respirators
Implement extended use of N95 respirators. Wear the same respiratory for multiple residents without removing between residents. Change only when soiled, wet, damaged, or difficult to breathe through. Do not touch the respirator.
Implement limited re-use for residents with tuberculosis, for which contact transmission is not a concern. Assign to a single HCP and store in a breathable container between uses.
Use expired N95 respirators.
Use respirators approved in other countries.
Implement limited re-use for residents with COVID-19, if possible with decontamination between uses. If not decontaminated, an important risk is that virus on the outside of the respirator might be transferred to the wearer's hands leading to transmission to the health care personnel or other people. It is crucial to avoid touching the respirator while worn and during or after doffing and to perform rigorous hand hygiene. Assign to a single HCP and store in a breathable container between uses.
Prioritize use of N95 respirators to higher risk activities.
If available, use portable HEPA filters or ventilated headboards to decrease risk of HCP without adequate respiratory protection.
Conventional Capacity Strategies for PPE
1. Use PPE according to product labeling and local, state and federal requirements.
2. Use PPE alternatives that offer equivalent or higher protection.
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Contingency Capacity Strategies for PPE
1. Selectively cancel elective and non-urgent procedures and appointments for which specific PPE is typically used by the HCP.
2. Shift PPE supplies from disposable to re-usable devices where applicable.
3. Implement extended use of PPE.
Crisis Capacity Strategies for PPE

1. Cancel all elective and non-urgent procedures and appointments for which specific PPE is typically used by the HCP.
2. Use PPE devices beyond the manufacturer-designed shelf life during resident care activities.
3. When PPE supplies are unavailable, consider using alternatives that have not been evaluated as effective.
4. Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 residents.
5. Designate convalescent HCP for provision of care to known or suspected COVID-19 residents.

Section 26: Preventing Illness

1. The best way to prevent illness is to avoid being exposed to this virus and properly using/wearing PPE when needed.
2. The CDC recommends the following actions to help prevent the spread of respiratory diseases, including:

Perform hand hygiene with alcohol-based hand rub before and after all resident contact, contact with potentially infectious material, and before applying and removing PPE, including gloves. Use soap and water if hands are visibly soiled.

Hand hygiene-when being assisted by staff, resident hand hygiene is performed after toileting and before meals.

Avoid close contact with people who are symptomatic. For residents with COVID-19, close contact includes being within approximately 6 feet of the resident for prolonged periods of time or having direct contact with the resident's infectious secretions (i.e. sputum, blood, serum and respiratory droplets).

Avoid touching your eyes, nose, and mouth.

Screen staff, visitors, and vendors per above guidance.

Cover your cough or sneeze with a tissue, then properly dispose of the tissue.

Clean and disinfect frequently touched objects and surfaces (i.e. medication carts, nurses station, care equipment, etc.) using an approved disinfectant spray or wipe.

Section 27: Isolated Areas/Units/Rooms

1. A designated area/unit(s)/room is isolated from the rest of the facility. This area is designated if a resident tests positive for COVID-19.
2. The designated area is referred to as a red room. Any residents on another unit that test positive for COVID may be moved to the designated area until the series of COVID testing is complete.

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3. Only designated essential staff should enter the designated COVID rooms.
4. Staff will don full PPE including N-95 mask, face shield/goggles and gown before entering the red room.

Conventional Method - Gowns are single use; one per resident per episode of care.

Conservative Method – Gowns may be worn as extended use and do not need to be changed when going from resident to resident. Gowns are changed if wet, soiled, or damaged and when leaving a red area.

Gloves are changed in between residents.

N-95 mask covered with a surgical mask, face shield/goggles; The surgical mask must be changed when going from resident to resident. If conserving due to supply shortages, the N-95 mask and face shield/goggles can be cleaned and stored for extended use.

5. COVID-19 positive residents will be cohorted within the red rooms. An indicator will be placed on positive COVID resident's rooms.

Red Rooms

1. PPE:

Gown* - changed between residents

Gloves - changed between residents

N-95 mask with surgical mask over the N-95 mask - The surgical mask must be changed between COVID positive residents.

Eye Protection (goggles or face shield) - not required to be changed between residents
2. In red rooms, gowns must be worn for medication and meal pass. Use of gowns can be extended as long as there is no contact with resident's environment during that medication or meal pass. If contact occurs, the gown should be doffed and a new gown applied to continue with the medication or meal pass.
3. Gloves are worn and changed with each medication and tray pass. (For example, when at the tray cart, use hand sanitizer, don gloves, obtain and deliver tray, doff gloves, return to tray cart and repeat.)
4. If you need to move equipment or carts from red rooms:
End user wipes
Runner wipes
5. Staff working in red rooms will be provided with a dedicated area for breaks/lunches, separate from the rest of the staff. Social distancing of at least 6 feet will be maintained in the designated area and masks will be worn when not eating or drinking.
6. Given residents are on Droplet Precautions, showers will not be provided in red rooms. In lieu of showers, bed baths will be provided.
7. Residents in red rooms will not share a bathroom with residents outside the cohort.
* Per epidemiologist, gown use may be extended on large COVID units if the supply/burn rate dictates a need for crisis strategies.
Transmission Based Precaution (TBP) Rooms:
1. COVID status is unconfirmed; full PPE:
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Gown is changed after caring for a resident
Surgical mask or higher
Eye protection (goggles or face shield) when providing direct care.
Gloves are changed between residents regardless of status
2. Residents with exposure to a COVID-19 positive resident (roommate of a positive resident), new admission/readmission if indicated, PUI or other as determined by the care team may be transferred to TBP rooms.
TBP are required for new admissions/readmissions who have not had a SARS CoV-2 infection within the last 30 days and are symptomatic.
TBP are not required for new admissions/readmissions if the resident is asymptomatic.
NOTE: The above applies as long as they have not had prolonged close contact with someone with COVID-19 infection in the prior 10 days.
TBP may be considered per facility discretion.
3. Guidance on showers for residents in TBP rooms:
Residents should wait in their room not in the shower area.
There should be one resident using the shower at a time.
Staff should use a gowns, gloves, and mask.
Residents should wear a mask during transport. Mask can be removed while showering.
Consider a hand-held shower head to control spray.
Each resident should use their own products (soap and shampoo).
If a dispenser system is used assure you are following manufacture guidelines to safely dispense products and not cause cross contamination.
Clean and disinfect all shower surfaces between use.
4. Gowns and gloves must be removed and hand hygiene performed before leaving a resident in TBP room, before moving to another non-positive resident in a TBP room.
5. A gown is not necessary if there will be no direct contact with the resident or their immediate environment such as during meal and medication pass. A gown is also not required for vital signs and glucometer checks.
Section 28: Emergency Staffing Strategies
1. Feeding Assistant Training Program - Staff may be cross-trained to feed/assist residents with meals. The Feeding Assistant Skills Competency Checklist will be used to document completion of the program. Skills include but, are not limited to:

Feeding Techniques
Assistance with feeding and hydration
Communication and interpersonal skills
Appropriate response to resident behavior
Safety and emergency procedures, including the Heimlich Maneuver
Infection Control
Residents Rights
Recognizing changes in residents that are inconsistent with their normal behavior and importance of reporting changes to the supervisory nurse
Providing dining assistance only for residents without complicated feeding problems
Working under the supervision of a licensed nurse
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2. Nursing Aide Training Program – Newly hired staff and current staff who wish to be trained as nursing aides, will participate in a 5-day training program. The program will be taught by a nurse educator who will ensure competency in all required skills. Training includes classroom instruction, mentor shadowing and hands-on practice/re-demonstration. The NA Competency Checklist will be used to document completion of the program. Skills include but, are not limited to:
Infection control/hand hygiene
Indirect care
Transferring
Dressing
Oral care
Perineal care
Partial bed bath
Hygiene/shaving/nail care
Catheter care
Obtaining temperature, pulse, and respirations
Range of Motion
3. Universal Worker- Non-clinical staff members may be cross-trained to complete tasks that do not require professional licensure. Universal workers will be supervised by a designated staff member of the specific department where they are assigned. Tasks include but, are not limited to:
Tray pass
Feeding/assisting residents with meals
Kitchen/dish room helper
Laundry services
Housekeeping/Environmental
Maintenance helper
Administrative duties
Section 29: Environmental/Cleaning
1. Signage - Facility should post signage (in multiple languages, if needed) at entrances regarding visitor restrictions.
2. Essential deliveries and vendors will be received at the rear door to unload supplies, etc. Every effort will be made to prevent them from entering the facility.
3. Environmental cleaning with an approved disinfectant identified to sanitize against human COVID-19 (i.e. Bleach) will be completed daily, or when visibly soiled and for terminal cleaning after infection has resolved.
4. Treatment Room - If used for resident exams or treatments (i.e. dental, podiatry), the treatment room must be disinfected between residents. Only residents in green rooms may enter the treatment room.
5. Frequently Touched Surfaces such as doorknobs, handrails, countertops, etc. will be disinfected daily throughout the facility.
6. Room cleaning – An approved disinfectant will be used for cleaning the rooms of residents with COVID-19. Attention should be given to bedside tables, handrails, call buttons,

windowsills, and toilets. Once a resident is asymptomatic their room should undergo terminal cleaning as if a new resident was to occupy the room. Mop heads will be changed between TBP rooms.

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7. Room cleaning after move – Allow 1 hour before accessing a positive resident's room after moved, unless a roommate is present. In that case, disinfection should be completed as soon as possible. Once allowable, the room is cleaned using the fogger or traditional disinfection with approved products, paying special attention to high touch surfaces, bathroom, etc. Room curtains are removed.

8. Hand Sanitizer will be available in designated locations throughout the facility and resident rooms. Supplies of hand sanitizer will be routinely monitored and replenished.

9. Medical Equipment - Sharing of medical equipment will be limited as much as possible. All equipment will be disinfected between residents.

10. Physical and recreational therapy equipment - The hands of residents with COVID-19 will be cleaned before the resident uses recreational or therapy equipment. Standard facility procedures will be followed for routine cleaning and disinfection of recreational and therapy equipment used by residents with COVID-19.

11. Trash disposal - Standard facility procedures for trash disposal will be followed; no special handling is necessary.

12. Shared Bathrooms, Showers, Tubs, etc.- Shared bathrooms, tubs and showers will be cleaned and disinfected per standard facility procedure after use by residents with COVID-19. It may be practical to bathe residents with COVID-19 after other residents have completed their bathing or in room using a sponge bath.

13. Supervision of Environmental Cleaning – Housekeeping staff will be supervised to ensure proper cleaning/disinfecting procedures are being followed. In-servicing will be provided as indicted.

14. Dishes, glasses, eating utensils, etc. - All re-usable equipment is properly sanitized after every use. Standard Precautions are followed.

15. Laundry - Standard precautions will be used for the handling of laundry from residents with COVID-19. EPA-approved products are used on the warmest appropriate setting according to manufacturer's instructions. No shaking of linens in order to minimize the possibility of dispersing virus through the air. Laundry bins/hampers and carts are routinely disinfected.

16. Staff Education - The facility has mandatory continuing education programs for staff regarding standard infection control techniques as well as additional techniques such as Contact or Droplet Precautions.

17. Resident, Family, Visitor Education

Residents and their families and visitors will be educated regarding COVID-19 and all necessary precautions to be taken, including hand hygiene and methods to limit environmental contamination. Family and visitors will be required to perform hand hygiene before entering and leaving the room of a resident with COVID-19.

Family/visitors will follow facility precautions policy.

Staff will provide families, visitors, and other residents additional support to alleviate their concerns and to ensure that they understand COVID-19.

Section 30: Visitation Guidance for Nursing Homes

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. Regardless of how visits are conducted, certain core principles and best practices reduce the risk of COVID-19 transmission:

Core Principles of COVID-19 Infection Prevention

Facility should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare

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settings to end isolation. For visitors who have had close contact with someone with COVID-19

infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).

• Visitors must undergo symptom check upon entering the facility, regardless of vaccination status, and will be denied entry if they report: symptoms of COVID-19 or a positive viral test for SARS-CoV-2 in the prior 10 days or close contact with someone with SARS-CoV-2 in the prior 10 days.

 All visitors two years of age and older and able to medically tolerate a face covering/mask shall continue to be required to wear a face covering/mask in healthcare facilities, regardless of vaccination status until the Commissioner' Determination is modified or rescinded.

 CMS strongly encourages all visitors to become vaccinated and facilities should educate and also encourage visitors to become vaccinated.

 Visitor testing and vaccination can help prevent the spread of COVID-19 and facilities may ask about a visitors' vaccination status.

 The facility must continue to make every effort to verify that visitors have received a negative SARS-CoV-2 test result within one day prior to visitation for antigen tests and within two days prior to visitation for PCR tests. Visitors may continue to use either PCR testing or antigen testing. Any PCR or antigen test used must either have Emergency Use Authorization by the U.S. Food and Drug Administration (FDA) or be operating per the Laboratory Developed Test requirements by the CMS.

 Facilities can offer to conduct onsite testing of visitors, if practical, but must have up-to-date policies and procedures in place to review and report results of SARS-COV-2. This does not apply to compassionate caregiving visitors who are visiting in anticipation of the end of a resident's life or in the instance of a significant mental, physical, or social decline or crisis of a resident, nor should it apply to emergency medical services (EMS) personnel.

• Hand hygiene (use of alcohol-based hand rub is preferred).

• Disposable face mask (covering mouth and nose) and physical distancing at least six feet between people, in accordance with CDC guidance. Visitors who wish to wear a cloth mask will be asked to wear their cloth mask over a disposable mask.

• Instructional signage throughout the facility and proper visitor education on COVID19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face mask, specified entries, exits and routes to designated areas, hand hygiene).

• Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit.

• Appropriate staff use of Personal Protective Equipment (PPE).

• Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)

• Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO20- 38-NH)

1. These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes, and should be adhered to at all times. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.

2. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By

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following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance. Visitation should be allowed QSO 20-39.

Outdoor Visitation

CDC COVID-19 Integrated County View site at https://covid.cdc.gov/covid-datatracker/#county-view.

Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. However, weather

considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor Visitation

1. Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.
2. Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents.
3. Facilities should ensure that physical distancing can still be maintained during peak times of visitation (e.g., lunch time, after business hours, etc.). Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission.

Face Coverings and masks during visits:

If the nursing home's county COVID-19 community transmission is high, everyone in a healthcare setting should wear face coverings or masks.

If the nursing home's county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility may choose not to require visitors wear face coverings or masks while in the facility, except during an outbreak. The facility's policies regarding face coverings and masks should be based on recommendations from the CDC, state and local health departments, and individual facility circumstances.

Regardless of the community transmission level, residents and their visitors when alone in the resident's room or in a designated visitation area, may choose not to wear face coverings or masks and may choose to have close contact (including touch). Residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit.

If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.

Additional information on levels of community transmission is available on the CDC's COVID-19 Integrated County View webpage.

NOTE: CDC states that Community Transmission is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is strain on the

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healthcare system, including its workforce, and better protect the vulnerable individuals seeking care in these settings. The Community Transmission metric is different than the COVID-19 Community Level metric used for non-healthcare settings. Nursing homes should use the Community Transmission Level metric not the Community Level metric.

While not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors. In these cases, visits should occur in the resident's room and the resident should wear a wellfitting facemask (if tolerated). Before visiting residents, who are on TBP, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention. Facilities may offer well-fitting facemasks or other appropriate PPE, if available; however, facilities are not required to provide PPE for visitors.

Indoor Visitation during an Outbreak Investigation

1. An outbreak investigation is initiated when a single new case (i.e., a new COVID-19 case among residents or staff) to determine if others have been exposed. To swiftly detect cases, facilities are to adhere to CMS regulations and guidance for COVID-19 testing, including routine unvaccinated staff testing, testing of individuals with symptoms, and outbreak testing.
2. When a new case of COVID-19 among residents or staff is identified, a facility should immediately (but not earlier that 24 hours after exposure, if known) begin outbreak testing in accordance with CMS QSO 20-38-NH REVISED and CDC guidelines.
3. While it is safer for visitors not to enter the facility during an outbreak

investigation, visitors must still be allowed in the facility. While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention.

4. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room and physically distance themselves from the other residents and staff, when possible. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

Compassionate Care Visits

1. Compassionate care visits are allowed at all times. Previously during the PHE, there were some scenarios where residents should only have compassionate care visits. However, visitation is now allowed at all times for all residents, in accordance with CMS regulations.

2. There are few scenarios when visitation should be limited only to compassionate care visits. In the event a scenario arises that would limit visitation for a resident (e.g., a resident is severely immunocompromised and the number of visitors the resident is exposed to needs to be kept to a minimum), compassionate care visits would still be allowed at all times. CMS expects these scenarios to be rare events.

Personal Caregiving Visitors

1. The facility will ask residents, or their designated representatives in the event the resident lacks capacity, at time of admission or readmission, or for existing residents

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which individuals the resident elects to serve as their personal caregiving visitor during declared local or state health emergencies.

2. A resident is entitled to designate at least two personal caregiving visitors at one time.

3. The facility will maintain a record of the resident's designated personal caregiving visitors in the resident's medical record and will document when personal caregiving and compassionate caregiving is provided.

4. As part of its ongoing review of a resident's needs, the facility will regularly inquire of all current residents, or their designated representative if the resident lacks capacity, whether the facility's current record of designated personal caregiving visitors remains accurate, or whether the resident, or their designated representative if the resident lacks capacity, wishes to make any changes to their personal caregiving visitor designations.

5. The facility will update the resident's record with the date the facility sought updates from the resident and indicate any changes to the resident's personal caregiving visitor designations. Such inquiries will be made no less frequently than every six months and upon a change in the resident's condition; upon review of a facility's visitation policies and procedures, the Department may also require the facility inquire of any resident whether the facility's current record of designated personal caregiving visitors remains accurate.

6. The facility will require all personal caregiving visitors to adhere to infection control measures established by the facility and consistent with any guidelines from the Department, or in the absence of applicable Department guidance, consistent with long term care facility infection control guidelines from the U.S. Centers for Disease Control and Prevention.

Required Visitation

1. Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f)(4)(v). In previous nursing home visitation guidance during the PHE, CMS outlined some scenarios related to COVID-19 that would constitute a clinical or safety reason for limited visitation. However, there are no longer scenarios related to COVID-19 where visitation should be limited, except for certain situations when the visit is limited to being conducted in the resident's room or the rare event that visitation is limited to compassionate care.

2. A nursing home must facilitate in-person visitation consistent with the applicable CMS

regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, per 42 CFR § 483.10(f)(4), which states "The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident," would constitute a potential violation and the facility would be subject to citation and enforcement actions.
3. As stated above, there are still risks associated with visitation and COVID-19. However, the risks are reduced by adhering to the core principles of COVID-19 infection prevention. Furthermore, we remind facilities and all stakeholders that, per 42 CFR §483.10(f)(2), residents have the right to make choices about aspects of his or her life in the facility that are significant to the resident. Visitors, residents, or their representative should be made aware of the potential risk of visiting and necessary precautions related to COVID-19 in order to visit the resident.
4. If a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk (e.g., in the resident's room), the resident must be allowed to receive visitors as he/she chooses.
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Access to the Long-Term Care Ombudsman
1. As stated in previous CMS guidance QSO-20-28-NH (revised), regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid-certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident.
2. If an ombudsman is planning to visit a resident who is in TBP or quarantine, or a resident who is not up-to-date with all recommended COVID-19 vaccine doses, in a nursing home in a county where the level of community transmission is substantial or high in the past 7 days, the resident and ombudsman should be made aware of the potential risk of visiting, and the visit should take place in the resident's room.
3. Representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If the resident or the Ombudsman program requests alternative communication in lieu of an in-person visit, facilities must, at a minimum, facilitate alternative resident communication with the Ombudsman program, such as by phone or through use of other technology.
4. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by State law.
Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs
1. 42 CFR § 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000).
2. P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person." 42 CFR § 51.42(c); 45 CFR § 1326.27.
3. If the P&A is planning to visit a resident who is in TBP or quarantine, or resident who is not up-to-date with all recommended COVID-19 vaccine doses in a county where the level of community transmission is substantial or high in the past 7 days, the resident and P&A representative should be made aware of the potential risk of visiting

and the visit should take place in the resident's room.
4. Each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (Section 504) and the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 et seq. (ADA). For example, if communicating with individuals who are deaf or hard of hearing, it is recommended to use a clear mask or mask with a clear panel. Face masks should not be placed on anyone who has trouble breathing or is unable to wear a mask due to a disability, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
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5. If a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention. Any questions about or issues related to enforcement or oversight of the non-CMS requirements and citations referenced above under this section subject heading should be referred to the HHS Office for Civil Rights (Toll-free: 800-368-1019) (TDD toll-free: 800-537-7697), the Administration for Community Living (202-401-4634), or other appropriate oversight agency.
Entry of Healthcare Workers and Other Providers of Services
1. All healthcare workers must be permitted to come into the facility as long as they are not subject to a work exclusion or showing signs or symptoms of COVID-19.
2. In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance.
3. EMS personnel do not need to be screened, so they can attend to an emergency without delay.
4. All staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.
Communal Activities, Dining and Resident Outings
1. While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.
2. The safest approach is for everyone, regardless of vaccination status, to wear a face mask while in communal areas of the facility. For more information, see the Implement Source Control section of the CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic."
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3. Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices including wearing a face mask, physical distancing, and hand hygiene and to encourage those around them to do the same.
4. Upon the resident's return, nursing homes should take the following actions:
• Screen residents upon return for signs or symptoms of COVID-19.
o If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, test the resident for COVID19, regardless of vaccination status. Place the resident on quarantine if the
resident is not up-to-date with all recommended COVID-19 vaccine doses.
o If the resident develops signs or symptoms of COVID-19 after the outing, test

the resident for COVID-19 and place the resident on Transmission-Based Precautions, regardless of vaccination status.
• A nursing home may also opt to test residents, who are not up-to-date with all recommended COVID-19 vaccine doses. without signs or symptoms if they leave the nursing home frequently or for a prolonged length of time, such as over 24 hours.
• Facilities might consider quarantining residents, is not up-to-date with all recommended COVID-19 vaccine doses, and leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention measures.
• Monitor residents for signs and symptoms of COVID-19 daily.
5. Residents who leave the facility for 24 hours or longer should generally be managed as a new admission or readmission, as recommended by the CDC's "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes." Please note that there are exceptions to quarantine, including for residents who are up-to-date with all recommended COVID19 vaccine doses.

Section 31: Policy References

1. Centers for Disease Control and Prevention (CDC) - cdc.gov/coronavirus/2019
2. World Health Organization (WHO)
3. NY State Department of Health (NYSDOH)
4. Centers for Medicare and Medicaid Services (CMS)
5. The Society for Post-Acute and Long Term Care
6. NY State Health Facilities Association (NYSHFA)
7. Greater NY Health Care Facilities Association (GNYHCFA)
8. American Health Care Association (AHCA)
9. AMDA - The Society for Post-Acute and Long-Term Care Medicine
10. Governor Andrew Cuomo NYS Executive Order # 202.30, 202.40, 202.68, 202.73, 202.88
11. US Food and Drug Administration (FDA)
12. OSHA COVID-19 Emergency Temporary Standard

Section 32: *Treatment Guideline References

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Hazard Annex: Loss of Essential Services (Electric, Gas, Water, Communications, Computer Systems)

A. Water

1. Notify the Fire Department of loss of water, as the sprinkler system will not function.

2. If the water loss is widespread, the Local Water Division should be contacted and an estimate obtained as to how long it will be until water pressure is restored.

3. If it is expected that the facility would be without water pressure for more than 4 hours, then:

   (1) The Milk Vendor should be contacted for potable water for drinking and cooking, and
   a) The facility will have on file a current letter from their dairy company explaining t

availability of an emergency water supply to the facility.

b) If the *dairy* company is unable to provide water 7 days a week, *24* hrs. per day, other arrangements should be made with:

i) a local supermarket open 24 hrs. per day that carries bottled water and/or

ii) a local "spring water" distributor

(2) The Department of Health Complaint Hotline should be notified.

4. If arrangements cannot be made for an emergency water supply, all unnecessary use of water should be restricted or discontinued. The Disaster Coordinator may have to:

1. Assign personnel to take water to the units in pails.
2. Cancel meetings or other functions, which might bring additional people into the facility.
3. Cancel the use of whirlpool tubs by the therapy department.
4. Cancel hairdresser appointments.
5. Extra sources of liquids that will be available on the premises are juices, milk, soft drinks, and water, to be rationed so all persons have one quart per day for three days. If advance notice is available, fill bathtubs and add 4 oz. of Clorox per tub.
6. A priority cooking list will be followed per dietary policy.

The facility will maintain a supply of potable water according to the following formula:

- 2 liters per resident per day X 3 days.
- 6 liters per resident for bathing and hand washing X 3 days.

The facility stores minimally 50 gallons of bottled water plus 700 gallons of potable water in the hot water tanks.

B. SEWAGE SYSTEM

1. If sewer system is intact, toilets can often be force flushed by pouring a pail of water into the tank.
2. Identify any potential areas of the facility that have a functioning drain line. Transport residents to this area to use the restroom.
3. Temporarily suspend showers and move to bed baths.
4. Attempt to minimize the amount of liquids entering the drains until the line is unclogged.

If sewer system is completely blocked:

1. Line toilets with plastic bag and have a tight cover, or utilize a full commode if available.
2. Provide a seat for bagged toilets using commode seats and/or shower chairs.
3. After each use, pour a small amount of disinfectant into bags.
4. Provide a pit for disposal of sewage from portable containers. If it becomes necessary, a remote area outside of the building should be set aside for storage of

sewage.

SEWER BACKUP (Dietary)

In the event of sewer back-up, in the Dietary Department, all food production and service in the department will be evaluated until the problem has been corrected and the area has been thoroughly sanitized.

PROCEDURE

A. Notification

1. The Dietary Department Supervisor will contact the Maintenance department of the sewer back-up as soon as it occurs.

2. Maintenance will be responsible for correcting the problem or for contacting an outside plumbing company or service.

3. If the back-up is noticed early enough all moveable unaffected equipment would be removed from the effected area immediately.

B. Clean Up

1. After the problem has been resolved, the dishmachine and three section sink will be drained and refilled with fresh water. The third section of the sink will be filled with a hot water and strong bleach solution (1/2 and 1/2).

2. All dishes, pots, pans, and/or utensils in the affected area are to he thoroughly washed and sanitized.

3. The floor will be mopped up of the entire backup sewer. The contaminated mop head will be removed, and placed in a trash bag and disposed of. A "shop-vac" may also be used if back-up is excessive.

4. A new mop head will be used to re-mop the affected area of the floor using a bleach solution (3/4 cup bleach in 1 gallon warm water).

5. All shelves, tables, (including legs), lowerators and walls in the effected area will be sanitized with a 1/2 and 1/2 solution of hot water and bleach.

6. Food production may resume only after the above sanitizing has been completed.

7. Any food items in the affected area must be checked for contamination, open or wet containers must be disposed of.

C. GAS

1. **HEAT (also see protocol for extreme cold)**
   a. Complete loss-transfer residents if necessary depending on weather and length of time of loss.
   b. Revert to another supply or means of heat if necessary.
   c. CONSERVATION:
      1) Shut down unnecessary rooms.
      2) Wear several layers of loose fitting clothes.
      3) Group residents into larger rooms or their own, whichever is better.
      4) Keep residents occupied with bingo, cards, exercise programs, sing-a-longs, etc.
   d. Contact the Red Cross (886-7500) and Salvation Army (883-9800) and other facilities for extra blankets if necessary.

2. **COOKING**
   a. There are enough edibles that do not require cooking to service the home for three (3) days. Emergency menus have been developed.

INSTITUTE THE FOLLOWING MEAL PLAN FOR THE UPCOMING MEAL:

BREAKFAST: Orange Juice (4) ozs.
Cold Cereal and 1 carton of milk (8) ozs.
Coffee (If electric power is available) (8) ozs.
Toast & margarine (If electric power is available) or
Bread & margarine

DINNER & SUPPER MEALS

Soup (Any kind) 4 oz.

Cold cut (1oz.) and cheese (1oz.) of peanut butter & jelly sandwich
Tossed salad with dressing (1/2 c. – 1 oz.)
Ice cream or canned fruit (1/2 c.)
Coffee, tea, milk

- All of the above menus will depend on if you have gas, electric power and manpower to use.

- If there is no electrical power or the auxiliary generator is on, do not use the dish machine. Use only disposable paper products.

- Be concerned with special diets and puree diets. If at all possible, make puree foods for each meal. Use the (RED) emergency electrical outlet to operate the blender if auxiliary generator is operating.

- If necessary, recruit help from other departments to assist in the preparation of and service of food to the residents.

D. ELECTRICITY

Loss of electrical services may be the result of natural disasters, industrial accidents at power generation facilities, or damage to power transmission systems. Natural hazards and weather-related incidents that often cause with power outages include: coastal storms; floods; tornados; and blizzards/ice storms.

a. In the event of a power failure, the emergency generator will come on automatically. Should it fail to do so, generator may be turned manually by following directions on generator. If the generator still will not start, contact the Penn Power to either repair generator promptly or provide facility with a rental generator.
b. The electrical outlets in the hallways marked with red plates are on generator power. The heat will remain on with generator power.
c. Cooking - some lights in the kitchen and the dishwasher will not function on emergency power and adjustments will be made to deal with these losses.
d. Oxygen Concentrators - In the event of an electrical interruption and the facility is on generator power:
    1. Either switch residents who are on Concentrators and use a portable emergency tank of 02 or,
    2. Plug 02 Concentrator into an emergency power wall socket (indicated by a red outlet cover) Extension cords are available in Maintenance.
    3. In the event the generator fails, all residents using 02 concentrators will be placed on portable emergency 02 tanks.

E. **FIRE SAFETY** In the event of loss of power, smoke doors will close but all alarm bells and heat and smoke detectors located throughout the building will remain operational. In this event, the staff shall:

1. Increase frequency of nursing rounds to assure that resident needs are being met, as well as fire safety.

2. In the event of fire, normal procedures must be followed, however, since the P.A. system will be inoperable, in order to alarm the rest of the building, a runner must be sent to the Incident Command Center, and from there to all other units, to assure that all staff are aware of the situation.

F. **POINTS TO REMEMBER**

1. Flashlights are at each nursing station. If power loss occurs during the night, the Nursing Supervisor should make sure that all staff are aware of the location of the flashlights and that all flashlights are functional.

2. Additional flashlights, lanterns and/or batteries are available through the

Maintenance Department or Emergency Tote.

3. Nursing staff must identify all residents requiring special care and/or treatments by use of equipment such as suctioning machines, feeding pumps, etc. and consider them for possible transfer to a hospital should there be the potential for a sustained power outage.

4. Nursing staff may have to utilize the use of a Mechanical Lift to remove residents from the whirlpool tubs.

5. If power loss occurs during the winter or cold weather, the staff should:
    a. Conserve heat by closing all windows and drapes throughout the building and doors to common areas (i.e., dining rooms, lounges, etc.).
    b. Distribute additional blankets to residents.

7. Dietary may need additional personnel to:
    a. Deliver food to residents via the stairs(if applicable).
    b. Prepare food (i.e., manually cut, mix, dice, etc.)
    c. Manually wash dishes, utensils and equipment. Disposable dishes and silverware should be used, if possible. Dietary staff should keep the refrigerator/freezer doors shut as much as possible to keep food cold, and should utilize fresh foods before opening canned goods so as to minimize waste and spoilage (see Disaster Plan – Dietary Three Day Disaster Menu).

8. Dietary Staff should remember that even though the gas stove and fixed fire extinguisher over the stove would still be operational, the exhaust fan in the kitchen would not operate. Hence, it may be advisable to open the kitchen windows if able, in order to vent smoke and assure adequate airflow.

9. Ancillary staff should be available to assist Nursing and Dietary departments in the delivery of direct services to residents. Disbursement of ancillary staff is to be determined by the Disaster Coordinator.

10. When power fails and lights go out, good common sense should prevail. **Remain calm.** If with a resident, provide reassurance and proper care. Proceed to the Nursing station slowly and carefully, removing any objects from the hallway. Provide reassurance for any residents or visitors and ask them to remain where they are. Once at the Nursing Station, await further instructions from the nurse in charge. The nurse in charge should not send a runner to the Command Post unless they have a particular emergency. Floors should wait for a runner sent from the Command Post to inform them of the situation and give further instructions.

11. Flashlights and an extra box of batteries are kept in the Maintenance office. There are battery-powered radios available on the premises and electric radios can be plugged into an emergency outlet if needed.

4. COMMUNICATIONS/ CELLULAR TELEPHONE

a. Phones may be used to make in-house calls as they are on emergency power.
b. Facility owned cellular phones may be used as back-up for emergency calls.
c. There is a designated landline at the Reception Desk for use during power outages as well as a facility cell phone in the Nursing Supervisor's office.

IT Systems

IT/Communications systems failure can impact the following critical systems: computer network; telephone network; on-site data storage; medical devices; medication replenishment; and HVAC system.

An IT/communications failure incident may hinder standard notification methods. Alternate forms of notification with staff, residents and external agencies include: pagers, hand-held radios, runners, personal cell phones, and social media.

STANDARD: The facility maintains documentation of residents status and progress with care.

POLICY:

- A server is defined as a computer that provides one or more services to multiple users or other computers.
- In the event that the operation of any server causes disruption to network services, the Information Technology and Clinical Information Services support staff will take action to rectify the situation.
- In order to maintain continuity of clinical documentation, alternate documentation systems will be implemented as per COMPUTERIZED MEDICAL RECORDS Policy 10.14

PROCEDURE:

Planned Downtime:

1. Advanced notification (more than 72 hours) of facility staff via e-mail to Administrator, DNS (minimally) & the Administrative Secretary for posting in the Supervisors office. Also, a reminder notice will be sent the day of scheduled down-time.
2. Planned downtime (*less than 10 minutes*) will be scheduled after 4:30 PM.
3. Planned downtime (*in excess of 10 minutes*) will be scheduled after 11:30 PM.
4. Adjustments to the above noted time-frames will be approved by the Vice President.
5. The CIS Coordinator an/or AR Systems Coordinator will generate the e-mail.

Unplanned Downtime: An e-mail notice will be sent notifying administrative staff of software affected as well as identification of problem, proposed resolution and estimated time programs will not be accessible. IT Services will then notify the CIS Coordinator an/or AR Systems Coordinator immediately.

IT staff will notify Facility via phone:

1. Business hours M – F: IT staff or CIS staff will contact the Administrative Secretary by phone who will then make an announcement that Care Organizer is not available.
2. After business hours: IT staff or CIS Trainer will contact the Nursing Supervisor who will then make an announcement that Care organizer is not available.

IT staff will notify facilities via e-mail: HelpDesk will generate an E-mail notice (set for high importance "**!**") to the following:

- Vice President
- CIS Training
- Facility(s) Administrator & Director of Nursing
- TMG MSA Coordinator
- AR Manager & AR Systems Coordinator

Logging of Planned or Unplanned downtime:

1. A record of Clinical Downtime (both planned & unplanned) will be recorded by IT, CIS and/or A/R coordinators in Public Folders *Disruption of Services File*. Whoever identifies the incident is responsible for logging the downtime.
2. Log will contain the following:
   a. date/time of service disruption
   b. Cause of disruption of services
   c. Services affected
   d. Resolution

POLICY:

- Computerized records are an acceptable form of medical record management.
- Computerized records may be used by this facility in lieu of hard provided they are **clear, complete, accurate, timely and properly authenticated.**
- **C**opying & Pasting from previous Progress Notes in not an acceptable standard of practice and is not sanctioned by TMG policy.

PROCEDURE:

1. The administrator, in conjunction with the Director of HIM and Quality Assurance Committee, will review and approve requests for and implementation of computerized medical record systems as progress is made in this direction.

2. Only personnel with a "need to know" are issued a password and will be permitted access to the resident's medical records. Restrictions will apply to ability to document in the Electronic Medical Record (EMR).

3. The System Analyst and department head will determine what areas the individual needs access to on the computer system. This access must be approved by the Chief Financial Officer and Administrator prior to being authorized and established.

4. When personnel changes occur, or if there is reason to believe that unauthorized access has occurred, the System manager will be notified by the Personnel Office for user name and password inactivated.

5. To prevent unauthorized access, password changes will be made at the discretion of the Administrator.

1. Authorized Federal and State survey agencies may be authorized entry into the computerized medical records.

8. The computerized medical record system of this facility:

   a. has safeguards to prevent unauthorized access;

   b. has individual identifiers to assure only authorized persons enter appropriate data;

   c. records each entry (date/time) into the medical record at the time of entry;

   d. will not permit a change in the record once it has been recorded. Exceptions: resident demographic changes; information changes on resident Face Sheet; financial status changes, as permitted in hand-written records.
   e. controls what sections/areas each identifier may access.

ELECTRONIC SIGNATURE:

Facility system and software products including electronic signatures are protected against modification. Each provider is given a username and password unique and accessible only by that provider. The provide bears the responsibility for the authenticity of the information for which they have attested to. In the event

that the provider did not electronically sign a document or suspects tampering, immediate notification to the Corporate Compliance officer is required. Suspension of the account will take place and immediate investigation conducted.

LOSS OF ELECTRONIC MEDICAL RECORD SERVICES:

In the event connectivity to the TMG servers is lost, the following alternate documentation systems will be implemented:

1. Progress Notes:

a. Access to TMG servers will be established and Progress Notes for the past 24 hours will be printed and placed in each resident's medical record.
b. In the event that the EMR is not accessible for an extended period of time and permission has been given to convert to manual (handwritten) progress notes, documentation will be completed using the Interdisciplinary Progress Note form. NOTE: Permission to convert to the ELECTRONIC CONVERSION NOTE is given only when it has been determined that the computer system will be down for an extended period of time, or unavoidable at a critical documentation time such as around change of shifts. FOLLOWING APPROVAL BY TMG/HCS COMPUTER SUPPORT PERSONNEL the Interdisciplinary Progress Note form is utilized for hand written notes.
c. Interdisciplinary Progress Notes are retained on the unit.
d. Upon restoration of computer service the progress notes may be entered into the computer by each discipline. The note will be identified as an "Electronic Conversion Note for " with the original date (and time if applicable) of the hand written note. This process may be waived if services are lost for an extended period of time in which case, the Interdisciplinary Progress Notes are filed in the nursing section of the medical record.

(sample of form)

INTERDISCIPLINARY PROGRESS NOTE

Name: _____ Physician: _____

Last, First MR#: _____

DATE	HOUR	**Due to the computer system being down, notes have been hand written for the times documented below.**	**EMR DATE & INITIAL**

2. Access to TMG Servers:

a. Computer/Server access will be established via facility phone line in a central, secure location as designated by the facility Administrator.
b. Central EMR access will be granted to all authorized staff on a 24 hour basis.

3. ***Care Plans*** will be printed and placed in the unit care plan binder.

Hazard Annex M: Influx/Surge of Residents from Community

In the event of a wide spread emergency and/or disaster the facility may be asked to take in additional non-acute patients from area hospitals so that they may take care of more acute patients. In this case family members may be called upon to care for their family members at home temporarily. A family member will be asked if they are willing and/or able to assist in this capacity upon admission.

POLICY:

- The Social Worker will ascertain if the resident can return to a family member's residence on a temporary basis and note this on the Care Plan.

- All Sub-acute patients are assumed to be able to surge to their previous location in the community.

PROCEDURE:

Activation and Preparation

Initial Contact to Receive Residents

- Phone contact with the facility may be through an automatic messaging communication system or via a personal call. When an automatic message is received, the individual taking the call should immediately document the entire message. If receiving a personal call, the call should be forwarded to the on-site individual in-charge of the facility at the time. When receiving a personal call, attempt to obtain the following information:
    - Sending facility name, contact phone number(s) and contact name
    - Total number of arriving residents
    - Estimated time of arrival
    - Gender breakdown
    - Number of arriving residents requiring wandering precautions
    - Arriving residents requiring specialized medical needs (isolation, dietary, infection control)
    - Resident medical equipment needs (cannot accept residents on life support or ventilator)
    - Quantity and type of medical equipment arriving with residents
    - Quantity and type (clinical or not) of staff arriving with residents
    - Will medications accompany residents
    - Will charts accompany residents
    - Need for the receiving facility to provide transportation (identify what type of transportation is available and any specialized capacity)
- Relay all information to the on-site individual in-charge of the facility at the time.

Internal Notification

- Notify the Administrator and/or the Director of Nursing Services.
- Administrator/Designee – Contact department heads and Medical Director.

Incident Command

- Activate Incident Command System.
- Identify Incident Command Center location
- Utilize Nursing Supervisor Cell Phone as Command Center contact number.

Census and Resident Capacity

- Determine the up-to-date facility census and identify the number of open conventional beds and types of beds (sub-acute, dementia, isolation, etc.).

- If the total number of arriving residents can be addressed through open beds within the licensed bed capacity of the facility, review **Utilizing Existing Licensed Beds.**
- If the total number of arriving residents exceeds the open beds available within the licensed bed capacity, review **Surging Beyond Licensed Bed Capacity**.

Staffing

- Determine the need to call-in additional staffing.
- Attempt to identify the quantity and type (RN, LPN, CNA, Ancillary) of staff that may be provided by the sending facility. They may work in tandem with facility staff or may provide all clinical care without assistance. Additional ancillary staff such as food service, housekeeping and maintenance will probably be required throughout the situation. Any non-clinical staff can work in an Ancillary Staff capacity as needed.
- Maintain staff to resident ratios necessary to meet resident needs throughout the duration of the situation.

Supplies

- Conduct a baseline inventory of all supplies with specific focus on the following departments:
    - Food Service – types and quantity of food and beverage
    - Nursing – types and quantity of medical equipment (pumps, oxygen cylinders/concentrators, oxygen tubing/cannulas/masks, etc.) and medications
    - Housekeeping / Laundry – quantity of linens
    - Maintenance – types and quantities of beds, mattresses, privacy dividers, etc.

  Reference: **Influx / Surge Equipment Storage Worksheet (**8.2.13.1.A**)**

- Assess the type and quantity of equipment / supplies that will be arriving from the evacuating facility if possible.
- Contact other TMG facilities and/or facility vendors to request additional supplies as necessary. Reference: **Influx / Surge Supply Vendor List**. (8.2.13.1.B)

External Communications

- Initially communicate with the NY Department of Health.
    - Notify DOH of impending surge of evacuated residents.
    - Report number of residents to be received, sending facility name/contact and current census (before arrival of surge residents)
    - Request permission to surge beyond licensed bed capacity if necessary.
    - Provide on-going periodic updates as necessary.
- Update point of contact from sending facility regarding surged resident status.
- Establish protocol with sending facility for periodic contact/updates to surged resident responsible parties and attending physicians. Sending facility may be temporarily unable to contact responsible parties, therefore, receiving facility may need to coordinate updates.
- Notify key stakeholders as appropriate including Local Office of Emergency Management, Local Fire & EMS, and the facility Ombudsmen. Provide on-going periodic updates as necessary.

Resident Triage

- Establish a triage area located in Main Dining Room.
- Administrator will designate an individual to oversee the set-up and operations of the triage area.
- Ensure adequate staffing and supplies at the triage location. The following staff/supplies should be included during the triage process:
    - Staffing
        - Nursing / Resident Care (triage, managing care)
        - Social Work
        - Food Service (food and beverage)
        - Administrative (tracking and documentation)
    - Supplies
        - Chairs / wheelchairs
        - Pens, paper, nametags, charting materials
        - Food and beverage
        - Medications
        - Portable oxygen (cylinders, tubing, cannulas, etc.)
        - Blood pressure cuffs and stethoscopes
        - Standard precautions equipment
        - Hand sanitizer
- Document the arrival of all residents as they enter the triage area.
    - Utilize **Influx of Residents Log (8.2.13.1.C)**
    - Utilize eFinds system as per facility/TMG policy (8.13.2)
- Triage each arriving resident. If arriving residents do not arrive with a completed Resident Evacuation Tag (Disaster Tag), attempt to minimally collect and document the following information on each resident:
    - Name
    - Age
    - Responsible party
    - Medical diagnosis
    - Medication allergies
    - Other known allergies
    - Diet restrictions / last meal
    - Medications / last administered
    - Mental status
    - Mobility
    - Hearing impairments
    - Dialysis needs
    - Special precautions, procedures or equipment
    - Valuables with the resident
- Complete an initial nursing assessment of each arriving resident. Review any available medical records that accompanied the resident. Include as part of the assessment of arriving residents a determination of any history of unsafe behaviors that will require an increased level of supervision (i.e. elopement, aggressive behaviors, and resident to resident altercations). Establish an interim plan of care for each resident as appropriate. Establish a new chart if necessary.

Food and Nutrition

- Modify planned menus as necessary to accommodate the additional residents.
- Maintain food supplies and provide meals for residents, additional staff, and possibly families.

Media and Families

- Administrator will designate an individual to prepare and provide statements to the media and to families.
- Coordinate statements with the evacuating facility and emergency agencies.
- Separate staging locations (internal or external) for media and family members should be established.
- Attempt to unify families / responsible parties with residents as quickly as possible.

Resident Tracking

- Communicate with the sending facility the total number of residents received along with the specific name of each resident received.
- Utilize NYDOH eFinds system to track location of all residents.
- Surged residents must be scanned into eFinds at every step of the transfer process.
    - Leaving the sending facility
    - Arrival at stop over point (if necessary)
    - Departure from the stop over point
    - Arriving at the receiving facility
    - Departure from the receiving facility
    - Return to the original sending facility

- Resident tracking tags, if utilized, should be with the resident at all times throughout the transfer process.

Arriving Staff and Staff Credentialing

- Review and confirm arriving staff have ID badges provided by the facility where they are employed.
- Log in sending facility staff as they arrive.
- Facility/TMG staff will punch in to Kronos upon arrival at the facility.
- Provide temporary facility ID if necessary.
- Administrator/designee will determine where and to whom arriving staff are to report.
- Disaster privileges/credentialing to incoming medical/clinical personnel may be granted upon presentation of a valid government issued photo ID (i.e. driver's license or passport), and any of the following:
    - A current picture ID or other ID card from a Hospital / NH / AL / RH.
    - A current license certification or registration to practice and a valid picture ID issued by a state, federal or regulatory agency.
    - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corps (MRC).

- Identification indicating that the individual has been granted authority to render resident care in emergency circumstances. Such authority having been granted by a federal, state or municipal entity.
- Presentation by current organizational staff member(s) with personal knowledge of the practitioner's identity.
- Refer to Policy 8.2.01 Emergency Preparedness Plan for 1135 waiver for additional information for Medical Volunteers.

Finance

- Administrator/designee will monitor all costs and resources utilized throughout the duration of the situation.
- Maintain receipts for purchases directly related to the situation.

Utilizing Existing Licensed Beds

Resident Placement

- Admissions/Supervisor will verify the quantity and location of open beds throughout the facility.
  - Do not consider beds that are being held for a confirmed admission.
- Ensure available rooms / beds are prepped for use.
- When feasible, utilize open beds that are proximal to each other to avoid scattering surged residents throughout the facility.

Continuing Care

- Monitor received resident behaviors and psychological status. Provide additional medically related social services support as needed.
- Incorporate into resident activities as appropriate.
- Communicate with attending physicians as necessary.
- Provide consistent services and support to residents facility wide.
- Coordinate transportation needs for clinical services such as dialysis, medical appointments, etc. as needed.
- Monitor the impact of the influx on existing residents. Provide additional medically related social services support as necessary.

Surging Beyond Licensed Bed Capacity

Resident Placement

- Verify the quantity and location of open beds throughout the facility. Utilize open beds as the first phase of resident placement. The establishment of surge areas will address the second phase of resident placement.
  - Do not consider beds that are being held for a confirmed admission.
- When feasible, utilize open beds that are proximal to each other to avoid scattering residents throughout the facility.

OPTIONS FOR INCREASING CAPACITY

- Identify options to transform non-sleeping areas into temporary sleeping / resident care areas. The following areas are appropriate to convert into sleeping areas:
  - Activity Rooms
  - Lounges
  - Dining Rooms
  - Conference Rooms
  - Therapy Rooms
  - Administrative offices

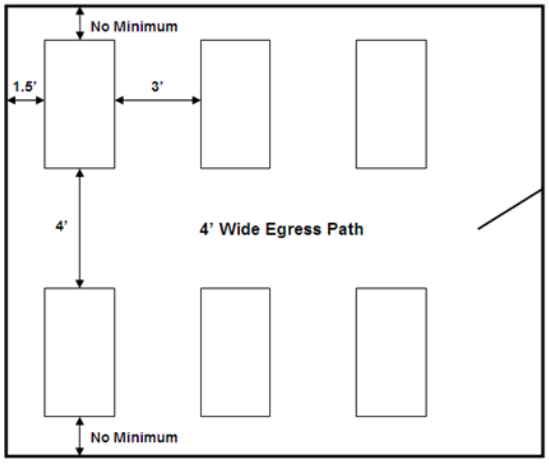
  Reference: **Surge Planning Worksheet**

- Identify areas served with emergency power to support residents requiring critical electric medical equipment.

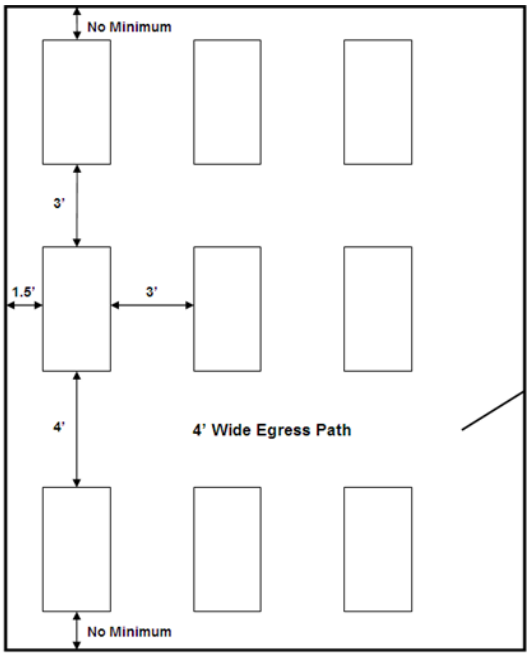
Surge Area Set Up

- Based on the **Surge Planning Worksheet** (8.2.13.1.D), set-up surge locations based on priority. Utilize internal available supplies first. Utilize the following options to obtain additional supplies as needed:
  - Vendors
  - Supplies from the resident sending facility
  - Other TMG Facilities
  - Local Office of Emergency Management/Emergency Response Organizations
- Establish groupings of beds or medical cots. Medical cots should only be used as a second option and after a proper nursing assessment has deemed a cot to be appropriate. As a last alternative, in an emergent situation, use mattresses for a short period of time until beds or cots can be obtained. Always consider resident needs based on the nursing assessment (particularly as it relates to bed sore concerns). Examples of emergent situations include:
  - Situations where immediate sheltering is needed. This may include an isolated single facility evacuation or a regional event resulting in evacuation.
  - Situations affecting infrastructure and transportation routes. This may include situations where extended travel is unsafe due to road conditions and/or weather conditions.
  - Situations that limit transportation resources. This may include scenarios where transportation resources (including EMS) are overwhelmed and transport over extended distances is impractical.
- Place privacy dividers between beds, cots or mattresses.
- Provide night lighting in each surge area.

- Provide call devices for each resident (tap bells will be necessary in areas not serviced by an electronic nurse call system).
- Designate toilet and wash sink locations for each established surge area.
- Provide storage areas for resident belongings and personal needs equipment. Key personal belongings such as eye glasses, hearing aids, prosthesis, dentures, etc. should be located proximal to the resident. Other items such as clothing, shoes, etc. Should be labeled/identified and may be stored in a separate location.
- Establish one or more provisional work station(s) located within or near surge areas.
- Provide constant (24/7) clinical staffing in surge areas located outside of normal resident care areas.
- Ensure all surge arrangements do not impede egress or reduce life safety. Consider the following guidelines:
  - Maintain three (3) feet between beds/cots/mattresses
  - Maintain four (4) foot egress paths to the exit access corridor
  - Maintain 1.5 feet between the perimeter wall and the side of a bed/cot/mattress.
    - See sample diagram below:



Sample Layout #1



Sample Layout #2

Medications and Medical Records

- The Director of Nursing and Pharmacy Consultant will develop and designate specific storage locations for resident medications and medical records.
- Normal controlled substance security standards must be maintained at all times.
- Account for all medications.

Continuing Care

- Monitor resident toilet needs and ensure proper staff is available to accompany residents to toilet facilities.
- Attempt to limit resident to toilet ratios to 10:1
- Develop a bathing schedule based on the available bathing facilities as needed.
- Maintain infection control standards. Provide an appropriate level of isolation / containment as needed.
- Monitor resident psychological status. Provide additional social services support as needed.
- Provide resident activities.
- Coordinate transportation needs for clinical services such as dialysis, medical appointments, etc. as needed.
- Communicate with attending physicians as necessary.
- Administrator/Designee will establish a process for constant monitoring of surge areas.

Hazard Annex N: Bomb Threat

1. Receipt of Bomb Threat

a. Telephone Communication

1. Should a bomb threat be received by telephone, the person taking the call shall immediately institute the following procedures:
    a. Remain calm. Do not panic.
    b. Keep the caller on the line as long as possible.
    c. Record, as near as possible, every word spoken by the person calling. (Utilize the "Directions for BOMB THREAT Telephone Communication" form 8.2.08.A)
    d. If the caller does not give the location of the bomb, or when it is set to detonate, ask the caller to give you this information.
    e. Tell the caller that the building is occupied and serious injury or death could result if this information is not obtained.
    f. Listen for any strange or unusual background noises such as music playing, motors running, traffic sounds, etc., which might be helpful in providing clues to determine from where the call was made.
    g. Determine whether the voice is male or female, familiar or unfamiliar, and listen for any accents, speech impairments, nervousness, etc.
    h. Record as much information as you possibly can. You may not be able to get everything, but **do** get all you can.

i. Remember, remain calm. Do not panic. Panic will cause confusion.

2. Immediately after the caller hangs up, contact the **Police Department** (Dial 911) and relay as much information as possible.
3. Once the police department has been notified, contact the person in charge at the time, and relay to him/her all information received and that the Police Department has been notified.

b. Other Communication or Sources:

(1) Whenever a Bomb Threat is received by means other than telephone communication, the person receiving the information shall immediately contact the **Police Department** and relay to them as much information as possible.

(2) Once the police department has been notified, contact the Administrator, Supervisor, or the person in charge at the time, and relay all such information to him/her.

(3) As much information as can be ascertained from the bomb threat shall be recorded on the appropriate forms.

(4) All information pertaining to the bomb threat shall be provided to the authorities when they arrive on the scene.

(5) **All** threats shall be treated as an actual bomb placement within the building and proper procedures shall be implemented immediately.

2. Evacuation Procedures:

a. The person in charge at the time, shall make the determination whether or not to evacuate the premises when a bomb threat is received.
b. The decision **not** to evacuate the premises shall be determined by the advice received from local law enforcement agencies having jurisdiction over such matters. Their input shall be given a great deal of consideration when the decision to evacuate or not becomes necessary.
c. When the decision has been made to evacuate the premises*,* **EXIT ROUTES** to be **used,** shall **first** be inspected and declared safe for evacuation**. This must be completed prior to ordering evacuation.** (Evacuation shall be conducted in accordance with our procedures outlined in Appendix A of this chapter.)
d. When evacuation has been ordered **only** those **exits** declared **safe** should be used.
e. Pre-assigned personnel, or as may be assigned, shall be responsible for assuring that exit routes are safe.
f. Evacuation procedures must be conducted in an orderly manner to assure the safety and well being of all those on the premises.
g. During evacuation procedures, if possible, leave all windows and doors **open.** This will minimize damage in the event an explosion occurs.
h. Once evacuation is ordered all persons shall assemble in their designated assembly areas.
i. Once persons have assembled **no one is to return to the building, for any reason, until an "ALL CLEAR" has been given by authorities conducting the search.**

3. Alarm Signals:

j. Code Alarm Bomb Threats shall be announced over the intercom, or by word of mouth, throughout the entire building.

k. Sounding the Alarm-Evacuation of Premises

- When evacuation is ordered, you must evacuate **only** through those **exits** declared safe.
- The person in charge shall have the responsibility of assuring that all persons have been evacuated from the premises prior to leaving the building.

4. Floor Plans:

a. A floor plan of this building has been designed to show the general layout and is located in the Fire Manual.

b. The floor plan indicates all exits, storage rooms, boiler rooms, maintenance and work areas, hazardous areas, restrooms, lounges, office areas, and assembly areas.

c. Floor plans are posted so that all persons may have the opportunity to review such plans from time to time.

5. Availability of Keys:

a. The facility designee, or person in charge, shall make available to search parties all keys to locked rooms being searched.

b. The person in charge, may assist search commanders during the search so that his/her knowledge of the keys and floor area can be used to expedite the search.

6. Chain of Command:

a. The chain of command shall be followed by all personnel during bomb threat procedures.

b. The person in charge at the time a bomb threat is received, shall remain in charge until someone higher up in the chain of command arrives and relieves them or until the local authorities arrive and take command of the situation.

7. Law Enforcement Responsibility:

a. Immediately upon arriving at the scene, the person in charge shall relinquish all authority to the search commander and provide any assistance or information needed.

b. The local law enforcement agency, having jurisdiction over such matters, shall be responsible for the orderly search of the building and investigation of bomb threats received.

8. Locating Suspicious Objects:

a. Should a suspicious object be located, do not move, jar or touch the object or anything attached to it. Leave it exactly the way you found it.

b. Immediately upon discovering a suspicious object, notify the search team leader and follow the instructions.

c. Once the search commander or search team leader has arrived at your location, the decision shall be made as to whether or not to continue searching for other objects.

d. If the decision is to continue searching, the area in which the object is located shall be roped oft if the object has not been removed, and only authorized law enforcement officials shall remain or have access to the area.
e. **Remember, follow the instructions of the search commander or search team leader. Do not attempt to do anything else.**

9. Removal of Suspicious Objects:

a. Once the search is completed, or has been terminated by the search commander, all employees participating in the search shall leave the premises, unless otherwise instructed by the search commander, and return to the assembly areas designated during the evacuation process.
b. Only authorized law enforcement officials shall remain in the building during the removal of the suspicious object(s) and such agencies shall direct the removal as quickly as possible.
c. A pre-selected area, designated for removing the object(s) found, shall be designated, by the search commander, **prior** to the removal of such object(s). This area shall be away from designated assembly areas, as many buildings as possible, and shall be kept clear of all unauthorized personnel at all times.

10. Notification of Area Hospitals:

a. When a Bomb Threat is received, the person in charge, or his/her designee, shall notify area hospitals that the office has received a Bomb Threat and a possibility of injuries exists.
b. The person making such calls shall relay **only** that information, and **shall not** answer any questions related to the Bomb Threat at all.
c. When an **"ALL CLEAR"** has been given to re-enter the building, the person in charge, or his/her designee, shall notify area hospitals that the alert has been canceled and that no injuries exist.

11. All Clear Signals:

a. After the search has been completed, and/or the suspicious object(s) have been removed, an **"ALL CLEAR" shall be announced** by the search commander.
b. No person(s) shall be allowed to re-enter the building, **for any reason,** until an **"ALL CLEAR"** signal has been issued.

12. Telephone Procedures:

a. The person answering the telephone shall not give out any information, unless so authorized, concerning the Bomb Threat to any caller. Simply state, "I'm sorry, I'm not authorized to release that information." If such calls persist, refer the caller to the office manager or person in charge.
b. Telephone lines must remain open so that emergency information can be relayed without necessary delays.
c. Utilize the "Directions for BOMB THREAT Telephone Communication" form 8.2.08.A.

13. Areas to be Searched in the Event of a Bomb Threat

All resident rooms, bathrooms, offices, tub rooms, central storage area, boiler/maintenance rooms, nourishment rooms, medication rooms

- Cupboards
- Drawers
- Closets/clothing
- Waste containers
- Refrigerators
- Linen Barrels
- Laundry/Trash Chutes
- Lockers
- Desks
- File Cabinets
- Autoclave
- Tubs/Showers
- Fire Extinguisher Boxes

Directions for BOMB THREAT Telephone Communication

Should a bomb threat be received by telephone, the person taking the call shall immediately institute the following procedures:

a. **Remain calm**. Do not panic. Contact Supervisor or Security, IF POSSIBLE
b. **Keep the caller on the line** as long as possible.
c. **Record, as near as possible, every word spoken** by the person calling.

Telephone Record of Bomb Threat – Questions

- Note exact time of call: _____
- When will the bomb go off? _____
- Where is the bomb? _____
- What kind of bomb is it? _____
- Why was it placed? _____

Tell them people are in the area who will get hurt. Tell the caller that the building is occupied and serious injury or death could result if this information is not obtained.

- Ask who is calling: _____
- Ask their location: Close - Inside Building - Far - Phone Booth _____

Listen for any strange or unusual background noises *such as music playing, motors running, traffic*

sounds, paging, airplanes etc.

- Voice: Accent / Intoxicated / Stutter / Slur / Lisp / Other _____
- Attitude : Rational / Nervous / Calm / Angry _____
- Caller's Identification: Male / Female, Under 20 / Over 20 / Over 32 _____
  Black / White / Hispanic / Other: _____

Did caller seem familiar with the building, such as: it is on the sub-acute unit or unit A? _____

Atmosphere, rain, thunder: _____

Additional Comments:

_____
_____
_____
_____
_____

Immediately after the caller hangs up, contact the **Police Department** (Dial 911) and relay as much information as possible. Once the police department has been notified, contact the person in charge at the time, and relay to him/her all information received and that the Police Department has been notified.

8.2.08.A

Hazard Annex O: Tornado/High Winds

A tornado is a violently rotating column of air touching the ground, usually attached to the base of a thunderstorm. Winds of a tornado may reach 300 miles per hour. Damage paths can be in excess of one mile wide and 50 miles long.

High Wind Warning: Issued by the NWS when high wind speeds may pose a hazard or be considered life threatening. The criteria for this warning varies from state to state. In many states, the criteria is sustained non-convective (not related to thunderstorms) winds greater than or equal to 40 mph lasting for one hour or longer, or winds greater than or equal to 58 mph for any duration.

Tornado Watch: Issued by the NWS to alert the public that conditions are favorable for the development of tornadoes in and close to the watch area. These watches are issued with information concerning the watch area and the length of time they are in effect.

Tornado Warning: Issued by the NWS to warn the public that a tornado has been sighted by storm spotters, law enforcement, or has been indicated by radar. These warnings are issued with information concerning where the tornado is presently located and which communities are in the anticipated path of the tornado.

TORNADO WATCH

GENERAL ACTIONS APPLICABLE TO ALL DEPARTMENTS AND STAFF

- Monitor on-going weather conditions and reports. Monitor via the radio, television, internet, and/or weather radio.
- Review locations and quantities of emergency supplies for possible use (i.e. linens, water, food, medical supplies, pharmaceuticals, flashlights, batteries, etc.).
- If there is adequate time to respond, request/obtain additional supplies as appropriate.
- Identify safe areas (inside hallways and windowless rooms) within the building where patients and staff could be placed during a Tornado Warning.

ADMINISTRATION / INCIDENT COMMANDER

- Activate the Incident Command System and establish a Command Center to monitor and manage the situation.
- Monitor on-going weather conditions and reports. Monitor via the radio, television, internet, and/or weather radio.
- Communicate throughout the building/campus that a “tornado watch” is in effect. Provide continual updates on weather conditions and reports.
- Ensure all departments/units have tornado procedures available for review and implementation.
- Consider the need to alter current staffing. Monitor shift changes. Encourage staff to remain in the building if exterior conditions may be dangerous.

MAINTENANCE / ENVIRONMENTAL SERVICES

- Conduct a sweep of the exterior of the building/campus. Where practical, secure items that could serve as projectiles in a tornado or high wind situation (i.e. chairs, tables, trash receptacles, signs, etc.).
- Where applicable, temporarily remove or secure exterior canopies, antennas and satellite dishes.
- Isolate or remove any chemicals that can react violently with each other (refer to MSDS).

- Review how to shut down utilities should it be necessary. Ensure necessary tools are available.
- Inspect the generator and generator transfer switch(s). Assess battery lighting.
- Time permitting, top off generator fuel, if necessary.
- Ensure that all exterior doors and windows are latched.
- Determine the need to cover or tape any unique door/window assemblies.
- Brace large doors at shipping and receiving docks.
- Ensure that roof and outdoor drains are free from debris in order to handle heavy rains.
- Fill tubs and sinks with water.
- Consider enhancing on-site staffing.

NURSING

- Conduct a sweep of the exterior of the building/campus and bring all patients, visitors and staff back into the building.
- Close all windows, window curtains / blinds, and cubicle curtains.
- Remove items from window ledges and pictures from walls. Remove other items that may serve as a projective within a room. Secure items in closets or other enclosed spaces.
- Place beds in low position.

TORNADO WARNING

GENERAL ACTIONS APPLICABLE TO ALL DEPARTMENTS AND STAFF

- Closely monitor weather reports, tornado warning areas, and information on tornado location(s) and predicted paths. Monitor via the radio, television, internet, and/or weather radio.
- If the building is in or near the projected path of a tornado, place patients into corridors and/or windowless rooms.

ADMINISTRATION / INCIDENT COMMANDER

- Closely monitor weather reports, tornado warning areas, and information on tornado location(s) and predicted paths. Monitor via the radio, television, internet, and/or weather radio.
- Communicate throughout the building/campus that a “tornado warning” is in effect. Provide continual updates on whether or not a tornado is anticipated to affect the building/campus.
- If the building is in or near the projected path of a tornado, instruct staff to place patients into corridors and/or windowless rooms.

NURSING

- Place patients into internal corridors or windowless rooms if time permits.
- If patients are sitting in chairs, place a pillow on their laps. For patients who must be in the prone position, slide the patient and mattress to the floor.

- If moving all patients is not practical, cover them with blankets, pillows, etc. to provide protection from flying debris.

RECOVERY

ADMINISTRATION / INCIDENT COMMANDER

- Communicate with local emergency services regarding your status and needs.
- Request an assessment of the structure.
- Activate the Full Building Evacuation Plan if the structure can no longer support patient care.
- Assess departmental operations.
- Assess staffing needs. Initiate disaster staffing procedures as necessary.
- Assess communication abilities and needs.
- Prepare communications to families and media regarding facility status.
- Determine what other procedures may need to be implemented. This may include (but not limited to):
  - Loss of HVAC (air conditioning or heating)
  - Loss of Water
  - Loss of Cooking
  - Loss of Communications
  - Loss of Electric
  - Loss of Sewer (Toilet)
  - Loss of Natural Gas
  - Contamination of The Outside Air
  - Hazardous Materials / Chemical Spill
  - Disaster Staffing

MAINTENANCE / ENVIRONMENTAL SERVICES

- Secure utilities as necessary.
- Perform an immediate assessment of structural damage in the area. Report findings to the Command Center.
- Monitor emergency generator if it is being utilized.

NURSING

- Perform an immediate assessment of patients, visitors and staff for injuries.
- Triage and treat as appropriate.
- Move patients away from damaged areas as best as possible.

Hazard Annex P: Loss of Resident/Missing Resident

To facilitate the resident's prompt and safe return to his or her unit.

POLICY:

- All staff will be able to follow an organized plan to enable us to locate a missing resident as quickly as possible.
- To ensure proper notification of the resident's family, the facility's administration and local authorities.

DEFINITION:

Elopement is the act of a resident who exits the facility property and grounds, unsupervised and without staff knowledge or permission.

ELOPEMENT RESPONSE TEAM:

The members of the Search Team include the following:

- ***During normal business hours*** All staff including Department Heads & Supervisors.

- ***Off hours/Weekends*** all nursing personnel and any other available staff, i.e., Housekeeping, Maintenance, and Dietary.

PROCEDURE:

1. As soon as a resident/patient is reported missing, the team leader on duty will alert all staff on duty via that page system. The code words will be:

   "Dr. Walker on unit ___ room ___" (repeat a second time and concurrently call the front desk.)

NOTE: The Security Officer in the reception area can announce **"Dr. Walker assistance needed front desk"** for assistance if needed with a Wandergaurded resident that is attempting to exit the building.

2. On hearing the page, all facility staff will begin a three person search team of the nursing units and their work area as noted below under "unit search"

Unit Search

This search starts at the opposite corridors of the nursing unit, room by room, and concludes at the nursing station. All rooms and closets, lavatories, utility rooms and storerooms on the unit are included in the search. The corridors are searched simultaneously, with at least one person assigned per corridor, by the charge nurse, to search each of the two corridors. The Administrator (or designee) is notified of the search.

Departmental Search

Dietary searches the kitchen, main dining room, dietary storerooms. Departmental/office staff conduct a search of their immediate work areas as well as any adjacent offices/rooms. Maintenance also verifies the correct functioning of door alarms. (In the absence of departmental/office staff, the nursing supervisor designates employees to conduct the searches.)

3. Maintenance or other persons as directed by the Administrator (or designee) will be sent to search the indoor service areas and the outside grounds as noted below under "Outside Facility Search":

Outside Facility Search

To ensure a timely search, and impede the possibility of injury, the Administrator (or designee) immediately sends staff outside:

- one will head immediately to the main road
- one to the back of the building
- one to the parking area (and adjacent lot of applicable) checking all the cars.

4. In the event the individual has not been found, it is the responsibility of the supervisor to notify the Administrator and Director of Nursing Services should they be off duty.

5. If the resident is not located within a reasonable period of time (as determined by the Administrator (or designee), the police and family are notified. Authorities will be provided with a picture of the resident.

6. The Administrator (or designee) continues a coordinated search with the police and community resources until the resident is found.

7. Pictures of residents assessed as high risk to wander out of the building will be kept at the front desk. Copies of available pictures will be made and distributed to staff members as indicated.

8. When resident is found:

   Upon location of or return of the resident to the facility, the supervising nurse should:

   - Examine the resident for injuries
   - Contact the attending physician and report findings and conditions of the resident
   - Notify the residents legal/designated representative
   - Notify search teams (if applicable) that the resident has been found – page "Dr. Walker all clear" x 2
   - Complete an Accident/Incident form
   - Make appropriate entries into the resident's Medical Record
   - Update/revise the care Plan as indicated

The code alert system is utilized to deter resident elopement, for residents with a history of elopement. Maintenance staff, nursing supervisor or staff in close proximity will respond to door alarm and ensure that resident did not elope.

Annex Q: Labor Action/Work Stoppage (Strike) Plan

1. A Work Stoppage is a serious matter. This plan is to ensure provisions for the continuation of vital services for the residents.

2. When a Work Stoppage is imminent, the Administrator or designee, will meet with all key employees and request that they make arrangements to stay at the facility for the duration of the stoppage and carry on pre-planned duties assigned to them.

3. Department Heads will prepare to stock adequate supplies in advance due to possible obstruction of delivery by striking employees. Supplies are to include, but not limited to, food, vital medical supplies and disposable linens. Food items will be of the type that requires a minimum of preparation. All supplies will be secured in the appropriate storage areas under lock and key.

4. Maintain a list of all current residents stating their County of residence, method of payment,

responsible party, address and phone number. This list will be kept current in the Business Office.

5. See Sure Plan (8.2.13.1) for responsible party notification and determination if the family is able to take the resident home, or help with care in the facility, in case of Work Stoppage, if a Work Stoppage is imminent.

6. Maintain a list of facilities with whom we have Transfer Agreements and appropriate transportation providers to facilitate elective and emergency discharges and admissions during the strike period. See WNY Mutual Aid Plan

7. The facility will make arrangements to assure that solid and medical waste are properly removed and disposed of.

8. Contact commercial nursing and employment agencies and give advance notice that we may need their service during this period, and will keep a list of area agencies.

9. The facility will maintain a list of positions and FTE's by position and number of persons. Maintain current up-to-date record of all employees, complete with their position, address and phone number, in the Personnel/Payroll office.

10. Maintain a list of all associated voluntary organizations, volunteers and phone numbers. The Activities Director will contact these agencies and persons and apprise them of the imminence of a strike and determine who will be available to help.

11. The Administrator will apprise the local OHSM by telephone of the possibility of a strike.

12. Vehicles for transportation of staff, volunteers, supplies and waste disposal will be rented from Avis Rent A Car 800-331-1212.

13. The Director *of* Environmental Services will arrange for O2 delivery to ensure adequate supply.

14. If a Work Stoppage or Strike occurs, the Administrator's office will serve as the command post from which all control and direction of operation will funnel during the labor dispute. A copy of this policy, with all attachments, will be kept there for guidance and control. Front office personnel will man telephones to contact families, volunteers, employees, ambulance companies, local hospitals, Fire Department, Police Department and contact OFISM to keep them informed of progress of problems. The Administrator/designee will make a decision at which point to suspend admissions. The decision for emergency discharge of critically ill residents who require more skilled care than we can provide with family, will be made by the Medical Director in conjunction with the Director of Nursing and the attending physicians according to procedure for discharge of residents during emergency situation.

15. To provide security, all exterior doors will be on alarm and only designated persons will open the locked doors to prevent admittance of any hostile party. If necessary, the facility will employ a temporary guard(s). All persons who enter the building will be required to provide identification, which will be checked and recorded, noting time entered and departed. Employees will be cautioned not to use the facility parking lots and will be met at a rendezvous point and will be transported by car

or rented vehicles. If supplies are needed, all suppliers will be directed to meet rented vehicles at a rendezvous point. The local police Department will be notified of meeting site and times, for the protection of vendors, volunteers and employees.

16. Only vital services will be provided during the emergency. The priorities of direct resident care will be determined by the Director of Nursing, with the guidance of the Medical Director.

17. All temporary and key employees will be oriented and trained by the appropriate Department Head as follows:

    a. Director of Nursing - Temporary nurse's aides and nurses, volunteers and key employees assigned to resident care.
    b. Food Service Manager - Temporary staff, volunteers, key employees assigned to dietary duties.
    c. Director of Environmental services - All temporary staff, volunteers and key employees assigned to laundry, housekeeping, maintenance and security duties.
    d. Administrative Secretary - All temporary staff, volunteers, and key employees assigned to communication duties with employees, residents, relatives and other persons and agencies.

18. If the situation should deteriorate to such an extent as to constitute a threat to remaining residents' health or safety, the Administrator/designee, will arrange for the transfer of the residents to local hospitals and nursing Care facilities. See WNY Mutual Aid Plan.

19. Prior to and during a strike situation, any released information and to whom this will be released, will be at the discretion of the Administrator. No other person, unless directed by the Administrator, will make public any information in regards to the facility or the strike.

Annex R: Intruder/Unauthorized Entry

STANDARD

The McGuire Group has a strong commitment to its residents and employees to provide a safe, healthy and secure work environment.

In the event of an unauthorized individual(s), the facility will follow a systematic approach to keep residents and employees out of harm’s way.

PROCEDURE:

1. When an unauthorized individual(s) is identified in the facility, the front desk receptionist/designee is notified immediately.

2. The front desk receptionist pushes the 'panic' button (when appropriate to notify local law enforcement) located at the front desk and when able announces…"Intruder Alert" and the location that the unauthorized individual is. The announcement is said three times.

3. The front desk receptionist/designee sends out an e-mail to 'All facility' users, notifying them of the unauthorized intruder and the location.

4. Designated staff members as identified by the facility Administrator report immediately to the location.

    a. All other staff, residents, family members and volunteers do not enter the location of the unauthorized individual(s).

    b. Staff, residents, family members and/or volunteers in the area vacate immediately via the nearest exit or corridor away from the location of the unauthorized individual(s).

5. The Administrator determines when the situation is under control and the individual(s) is no longer a threat. The front desk receptionist/designee is notified and announces 'Intruder Alert all clear'.

Reference Disaster Manual-Active Shooter.

Tips/Training for designated staff reporting to the location of the unauthorized individual:

Do	**Do Not**
Project calmness, move and speak slowly, quietly and confidently.	Use styles of communication that generate hostility such as apathy, brush off, coldness, condescension, going strictly by the rules or giving the run-around.
Be an empathetic listener: Encourage the person to talk and listen patiently.	Reject all of the individual's demands from the start.
Focus your attention on the other person to let them know you are interested in what they have to say.	Pose in challenging stances such as standing directly opposite someone, hands on hips or crossing your arms.
Maintain a relaxed yet attentive posture and position yourself at a right angle rather than directly in front of the other person.	Avoid any physical contact, finger pointing or long periods of fixed eye contact.
Acknowledge the person's feelings. Indicate that you can see he/she is upset.	Make sudden movements, which can be seen as threatening. Notice the tone, volume and rate of your speech.

Ask for small, specific favors such as asking the person to move to a quieter area.	Challenge, threaten, or dare the individual. Never belittle the person or make him/her feel foolish.
Establish ground rules if unreasonable behavior persists. Calmly describe the consequences of any violent behavior.	Criticize or act impatiently toward the agitated individual.
Use delaying tactics, which will give the person time to calm down.	Attempt to bargain with a threatening individual.
Be reassuring and point out choices. Break big problems into smaller, more manageable problems.	Try to make the situation seem less serious than it is.
Accept criticism in a positive way. When a complaint might be true, use statements like "You are probably right" or "It was my fault." If the criticism seems unwarranted, ask clarifying questions.	Make false statements or promises you cannot keep.
Ask for his/her recommendations. Repeat back to him/her what you feel he/she is requesting of you.	Try to impart a lot of technical or complicated information when emotions are high.
Arrange yourself so that the individual cannot block your access to an exit.	Take sides or agree with distortions.
	Invade the individual's personal space. Make sure there is a space of three feet to six feet between you and the person.

Annex S: Emergency Evacuation of Facility

All residents will be evaluated for appropriate disposition.

POLICY:

- Those residents temporarily discharged from the facility will be considered on temporary leave.
- The current clinical record should be maintained intact on the resident care unit. Business Office records should have this notation on them as well.
- Resources from the WNY Health Care Mutual Aid Plan will be used as applicable.
- Refer to e-FINDS policy (8.2.13.2) for resident tracking.
- Planned evacuations will utilize the transportation assistance classification system.

PROCEDURE:

1. Each resident's chart should have:
   - A physician's order granting temporary leave and
   - A nurse's note stating the date, time, destination, mode of transportation and who accompanied by (if applicable).
2. In the event of a declared emergency alert, each resident's plan of care will provide direction for "surge" plan as per policy and be utilized to determine the appropriate Transportation Assistance level (TAL).
3. Utilization of the E-finds system will be used when able. See policy 8.2.13.2
4. Residents will be tagged at the holding area:
   a. One tag will identify the residents name and any newly acquired injury such as burns or fractures. Residents assessed to be at risk for elopement will also be identified by this tag These tags are available with pins and marking pen in a designated area within the facility.
   b. One tag will be affixed during a planned evacuation utilizing the universal Transportation assistance (TAL) classifications to help streamline and coordinate. TAL classifications are used to assess the types of resources needed (bus, vans, ambulances) by each patient during a planned evacuation. TAL tags are located in the facility evacuation tote located in a designated area within the facility. Staff members will identify which TAL to affix via the care plan.
   c. Staff members will be stationed at every exit door during the evacuation process in order to prevent potential resident elopement.
   d. Staff members will be assigned to accompany any resident assessed to be an elopement risk during the entire transit process (i.e. from the facility to the stop over point, at the stop over point, from the stop over point to the receiving facility and back to the sending facility one clearance has been given to reoccupy).

5. A list of all residents on temporary leave will be distributed as follows:
   a. (Western New York)
      New York Sate Department of Health
      Office of Health Systems Management
      584 Delaware Avenue
      Buffalo, New York 14202

      (Long Island)
      New York State Department of Health
      Office of Health Systems Management
      320 Carlton Avenue, Suite 5000
      Central Islip, NY 11722

   b. Administrator

   c. All Facility Department Heads

6. Medications while on Temporary Leave:An adequate supply of medication will be obtained and full written instructions for their daily administration will be given to the family/designated representative.

NOTE: Each resident must have a physician's order, which specifically states those medications he/she wants administered to the resident when on temporary leave.

7. Readmission to the facility only requires a nurse's note stating the date, hour and condition of the resident upon returning from temporary leave.

8. Nursing care measures, medications, and treatments of residents remaining in the facility:

   a. An immediate evaluation of all residents remaining in the facility should be carried out by the Nursing Staff and the Attending Physician/Medical Director. This will serve as a guide for care during the period of emergency. Separate order sheets, MAR's and Treatment sheets may be made out for this period of time.

   b. Medications that are to be administered to residents remaining in the facility may be administered by the following persons:
      - Medical Director
      - Director of Nursing, Assistant Director of Nursing, Unit Coordinators, Charge Nurses
      - Licensed Agency RN's and LPN's

eFinds

All residents will be evaluated for appropriate disposition. eFINDS provides a solid foundation for registering and updating patient/resident location information during a public health event, such as a storm, flood, non-natural incident or practice exercise/drill.

POLICY:

An Evacuation kit is maintained in the Administrator's office. The Kit contains:

- Bar code scanner
- Preprinted barcode wrist bands
- Laptop (where applicable)
- Mutual Aid Plan
- Wrist Bands identifying patients/residents scanned

In the event of an emergency, eFind wrist bands are applied on all residents. When scanning is completed (as described below), a second wristband (red and/or 'Scanned') is placed on the resident/patient

signifying that they have been scanned and are in the eFinds system.

Actions of an evacuating facility:

- Register patient/resident (HPN Admin user only)
- Update patient/resident (HPN Admin user only)
- Generate barcodes spreadsheets (HPN Admin user only)

- Actions of a receiving facility:
  - Update patient/resident

PROCEDURE:

Access the HCS, access the Evacuation of Facilities in Disaster system, select your current location and submit.

-Quick Search

Click Home on the e-finds menu .

Scan a barcode, enter a barcode number or enter first or last name in Quick Search (located on the top right).

Locate the correct resident record.

Click the Barcode (serial ID) link.

Verify: Patient/Resident is found. You can update the information.

Click Update Patient/Resident.

-Register Multiples

Click on Register Patient/Resident>Multi Patient/Resident Input.

Verify Evacuation Operation and Select Intended Destination.

Enter number of barcodes needed.

Click Generate Fillable Spreadsheet.

Enter known information, such as name, DOB, and the Intended Destination organization type and locations.

Click Save all Patient/Resident.

Verify message: Successfully saved (# being evacuated) Patient/Resident and click barcode to view patient/resident information.

-Register with Scanner

Scan a barcode OR click Register Patient/Resident>With Scanner.

Confirm message: Barcode is located. You can register a new Patient/Resident.

If time allows, enter First and Last name, DOB, Gender etc.

Verify Evacuation Operation is correct OR select operation from the list.

Verify Patient/Resident current location is correct.

Select the Intended Destination Organization Type.

Select the Intended Destination from dropdown list.

Enter Bulk Group; such as Bus # or transportation description.

Click Register. If required fields are not complete, you will receive an error message; Click override to bypass the error message and continue.

Confirm message: Patient/Resident info is updated.

-Update Multiples

Click Update Patient/Resident>Multi Patient/Resident Update.

Verify your location.

Select and Action Type:

Releasing Patient/Resident from this location; OR
Change Operation for Patient/Resident at this location
Select the Intended Destination.
Enter the Bulk Group, for example transport via bus.
Click Load All Patient/Resident.
Select All OR Update for each patient or resident.
Click Release Selected Patient/Resident.
Verify message: Successfully updated (#) Patient/Resident.

-Generate Log

Click Manage Barcodes>Generate Barcode Spreadsheet.
Select or verify current location.
Enter the number of barcodes you will need.
Select the PDF if you want a scannable barcode log OR select EXCEL for the upload patient/resident option.
Click Generate.
Print the PDF or Save the Excel spreadsheet to your computer

-Upload File

Click Register Patient/Resident>Patient/Resident Upload File
Verify Evacuation Operation and current location.
Click Browse.
Locate the Excel file with saved patient or resident information.
Hint: search nys_e-FINDS file name with facility id, date and time.
Click Open to add file.
Click Upload.
Verify the patient or resident Information is updated, and edit the information as needed.
Click Save All Patients/Residents.

-Update with Scanner

Click Update Patient/Resident> With Scanner.
Scan the barcode and click Submit if necessary.
Confirm message: Barcode is located. You can register new Patient/Resident with it OR Patient/Resident is found. You can update the information.
Enter or confirm the information, including Evacuation Operation and the current patient or resident location.
Click Register, Update or Override.
Confirm message: Patient/Resident info is updated.

-Update without Scanner

Click Update Patient/Resident>Multi Patient/Resident Update.
Verify your location.
Select Checking in Patients/Resident into this location.
Verify the patient or resident is correct.
Click Select All OR Update for each patient or resident being received.
Click Check in Selected Patient/Resident.
Confirm message: Successfully updated (correct #) of Patient/Resident.

Resources: https://apps.health.ny.gov/pub/ctrldocs/e-finds.html

Addendum: Shelter in Place Protocol

This facility plans for sheltering in place well in advance of a crisis or disaster situation.

Policy Implementation

1. The facility identifies and assesses the length of time it can realistically support SIP before a decision is made to fully evacuate.
2. The following potential situations have been identified, in which sheltering in place might be necessary:
    1. Winter storm/severe weather
    2. CBRNE events
    3. High wind/tornado
    4. Extreme cold
    5. Other potential SIP events will be determined by the Incident Commander at the appropriate time.
3. The following areas within the facility have been identified as suitable spaces that are structurally sound and away from potential exposure areas for residents, staff, and visitors to seek shelter:
    1. All (3) facility resident dining areas (primary sites)
    2. Main Solarium and unit lounges (alternate sites)
4. Surge Capacity Assessment – The facility will determine how many individuals it can safely shelter, as the facility may have to shelter staff members, staff members' immediate family members, as well as serve as a receiving "host" facility to other facilities. This determination is referred to as a Surge Capacity Assessment.
5. This facility also realizes that hospitals may have to transfer patients to the facility during catastrophic events if they reach overcapacity. This is integrated into the Surge Plans for hospitals.
6. All factors that may cause a secondary event following the initial need to shelter in place are considered (for example, a building collapse post-tornado).
7. The facility considers all materials and inventory items specific to sheltering in place (for example, plastic sheeting, tarps, duct tape, extra blankets and pillows, etc.) that may be needed to facilitate the SIP procedure in reference to a contaminated or hazardous environment outside of the facility.
8. The facility has identified all aspects of the facility's physical plant and infrastructure that need to be evaluated during and immediately following the shelter in place procedure to ensure the safety of residents, staff, and visitors.

The facility will have adequate food, supplies, pharmaceuticals, medical supplies and water for residents and staff to shelter in place for minimally 72 hours. Sleeping quarters, shower facilities and associated supplies will also be available as necessary. Details below:

1. Sleeping Quarters
   The Incident Commander will assign a person to arrange sleeping quarters for staff members, volunteers and visitors.
   a. P.T. and O.T. rooms, residents' sitting rooms and offices may be utilized as sleeping quarters.
   b. Linens, blankets and pillows may be obtained through the Housekeeping Department.
   c. Extra mattresses may be located in Maintenance.
   d. Wake up calls should be arranged depending on staffing needs.

2. Shower Facilities
   Staff showers are available on each nursing unit. Supplies of soap, towels, washcloths, toothpaste and brushes, etc. should be made available at the shower area.

Annex T: Blizzard

STANDARD:

Blizzard - a severe snowstorm with high winds and low visibility.

POLICY:

All emergency and safety procedures will be followed in the event of a blizzard or other weather-related occurrence. The facility staff in conjunction with corporate support will provide/arrange dispatch, staff transportation services and onsite assistance as needed/practicable. State, county and/or local emergency services will be contacted for assistance as indicated.

PROCEDURE:

1. **Communication**
   a. Facility staff in conjunction with corporate administrative assistants/designees will serve as central dispatchers. The dispatchers will assign team members to facilities prior to weather event and communicate to all.

2. **Emergency Staffing**

   a. Essential staff who arrive early to ensure they are on site when needed will be compensated at time and half.
   b. Compensation associated with delaying the release of a staff member at the end of their shift to keep them on site will be provided at time and a half.
   c. Paying for sleep time will be provided at straight time pay.
   d. Staff member incentive will be provided for those who work for the duration by a flat rate per day in addition to pre-determined compensation or prorated Storm Coverage holiday hours.
   e. Transportation to/from the facility will be provided as able. Snow mobile transportation may be utilized if available in the area of the storm.
   f. Cots, sleeping arrangements and showering space for staff will be established by facility Administrator/designee.

   g. Toiletry/hygiene items will be provided to staff as needed.

h. Charging stations and extra phone chargers will be provided so that staff can keep in touch with their families during the storm.
i. As able, child care will be arranged during work hours if needed for staff members with school age children.

3. Parking Lot Safety

a. The facility staff in conjunction with corporate environmental services team/designee will provide plow service communication and coordination. They will ensure there is a clear path in/out of parking lots and the facility.
b. Plowing and snow removal of the lots will not be a priority at the height of the storm.

4. Food Supply

a. Simple staff meals will be planned and provided as needed. Disposable eating supplies may be used.
b. An emergency supply of pre-portioned fruits, juices etc. will be on hand so that in the event of blizzard, time is not spent portioning foods.

5. DOH Notification

a. The Department of Heath will be notified of any loss of essential services and/or emergency conditions as indicated.