NEW YORK STATE OF OPPORTUNITY. Department of Health

GreenField Health & Rehabilitation Center

Comprehensive Emergency Management Plan

Part II

2020

GreenField Health & Rehabilitation Center
5949 Broadway
Lancaster, New York 14086

Instructions

The NYSDOH Comprehensive Emergency Management (CEMP) Template is a tool to help facilities develop and maintain facility-specific CEMPs. For 2020, Appendix K has been updated to include guidance and formatted to provide a form to comply with the new requirements of Chapter 114 of the Laws of 2020 for the development of a Pandemic Emergency Plan (PEP).The plan template is designed to help facilities easily identify the information needed to effectively plan for, respond to, and recover from natural and man-made disasters. All content in this template should be reviewed and tailored to meet the needs of each facility.

Refer to *Part 1 – Instructions* for additional information about completion of this template.

Refer to *Part 3 – Toolkit* for supplementary tools and templates to inform CEMP development and implementation.

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	716-683-0385
Local Police Department	716-683-2800
Emergency Medical Services	○ 716-882-8400 716-683-3282
Fire Marshal	716-681-7111
Local Office of Emergency Management	○ 716-898-3696 716-858-7937
NYSDOH Regional Office (Business Hours)[1]	518-408-5300
NYSDOH Duty Officer (Business Hours)	866-881-2809
New York State Watch Center (Warning Point) (Non-Business Hours)	518-292-2200

[1] During normal business hours (non-holiday weekdays from 8:00 am – 5:00 pm), contact the NYSDOH Regional Office for your region or the NYSDOH Duty Officer. Outside of normal business hours (e.g., evenings, weekends, or holidays), contact the New York State Watch Center (Warning Point).

Approval and Implementation

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

_____ _____

Meghan Schobert
Administrator, GreenField Health & Rehabilitation Center

_____ _____

Nicholas Kwasniak
Executive Director of Environmental Services

Record of Changes

Table 2: Record of Changes

Version #	Implemented By	Revision Date	Description of Change
1.0	*Meghan Schobert*	*9/15/2020*	*Implementation*

Record of External Distribution

Table 3: Record of External Distribution

Date	Recipient Name	Recipient Organization	Format	Number of Copies
May 1, 2020	*Jim Doe*	*Local Office of Emergency Management*	*Digital (Email)*	*1*

Table of Contents

1 Background

1.1 Introduction

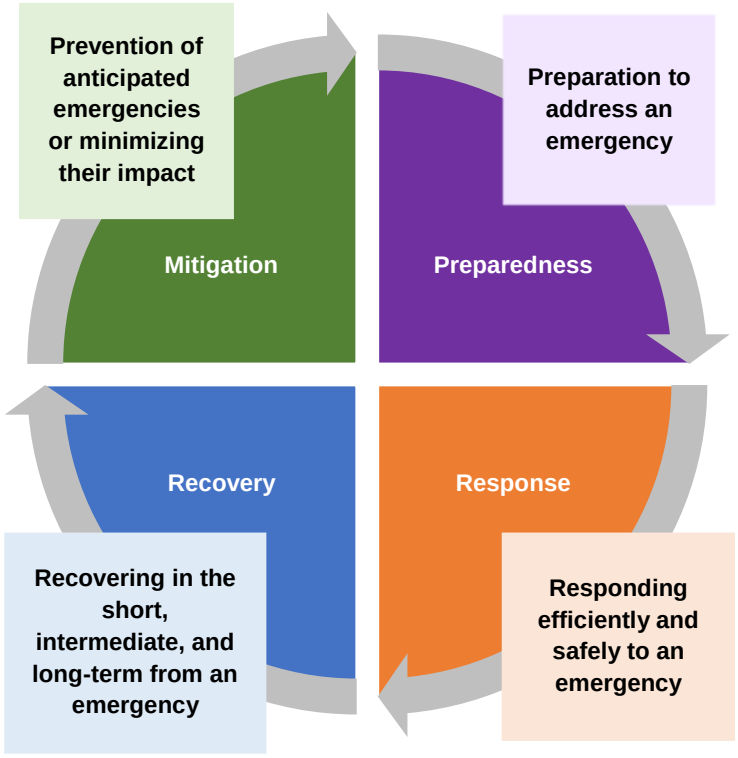
To protect the well-being of residents, staff, and visitors, the following all-hazards Comprehensive Emergency Management Plan (CEMP) has been developed and includes considerations necessary to satisfy the requirements for a Pandemic Emergency Plan (PEP). Appendix K of the CEMP has been adjusted to meet 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 Executive Director of Environmental Services, Director of Plant Operations, Mutual Aid, Lord of Life, and local and state-level government agencies.

This CEMP is a living document that will be reviewed annually, at a minimum, in accordance with *Section 7: Plan Development and Maintenance*.

1.2 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.

Figure 1: Four Phases of Emergency Management



1.3 Scope

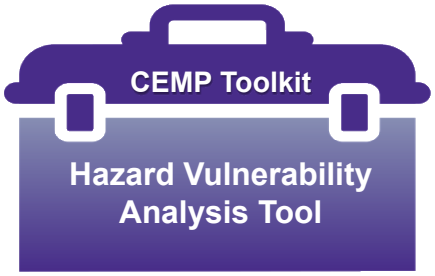
The scope of this plan extends to any event that disrupts, or has the potential to significantly disrupt, the provision of normal standards of care and/or continuity of operations, regardless of the cause of the incident (i.e., man-made or natural disaster).

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.

As a campus with multiple facilities, this plan should be utilized as needed campus-wide and under the direction of Mutual Aid.

1.4 Situation

1.4.1 Risk Assessment[2]



The facility conducts an annual risk assessment 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 August 2020 and determined the following hazards may affect the facility's ability to maintain operations before, during, and after an incident:

- Ranked #1 Risk – Corona Virus
- Ranked #2 Risk – Snow Emergency
- Ranked #3 Risk – Loss of Heating System
- Ranked #4 Risk – Loss of Air Conditioning Service/High Heat Situation
- Ranked #5 Risk – *See Fire Safety Policy*
- Ranked #6 Risk – See *Active Shooter Policy*

This risk information serves as the foundation for the plan—including associated policies, procedures, and preparedness activities.

[2] The Hazard Vulnerability Analysis (HVA) is the industry standard for assessing risk to healthcare facilities. Facilities may rely on a community-based risk assessment developed by public health agencies, emergency management agencies, and Health Emergency Preparedness Coalition or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment.

1.4.2 Mitigation Overview

The primary focus of the facility's pre-disaster mitigation efforts is to identify the facility's level of vulnerability to various hazards and mitigate those vulnerabilities to ensure continuity of service delivery and business operations despite potential or actual hazardous conditions.

To minimize impacts to service delivery and business operations during an emergency, the facility has completed the following mitigation activities:

- Development and maintenance of a CEMP;
- Procurement of emergency supplies and resources;
- Establishment and maintenance of mutual aid and vendor agreements to provide supplementary emergency assistance;
- Regular instruction to staff on plans, policies, and procedures; and
- Validation of plans, policies, and procedures through exercises.[3]

For more information about the facility's fire prevention efforts (e.g., drills), safety inspections, and equipment testing, please refer to the GreenField Health & Rehabilitation Center Fire Safety Plan and 24 Hour Fire Watch Policy.

1.5 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.

[3] Refer to the "Training and Exercises" section of this plan for additional information about pre-incident trainings and exercises.

- See Emergency Preparedness Procedures List for additional assumptions.

2 Concept of Operations

2.1 Notification and Activation

2.1.1 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.

2.1.2 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 provision of normal standards of care and/or continuity of operations is threatened and could potentially cause harm.
- 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 (e.g., fire drills).
- See Western New York Regional Mutual Aid Plan.

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.

2.1.3 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.

2.1.4 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*: Notification by Hazard Type*** provides a comprehensive list of mandatory and recommended external notification recipients based on hazard type.

Table 4: Notification by Hazard Type

M = Mandatory
R = Recommended

Notification Recipient	Example Hazard	Active Threat[4]	Blizzard/Ice Storm	Coastal Storm	Dam Failure	Water Disruption	Earthquake	Extreme Cold	Extreme Heat	Fire	Flood	CBRNE[5]	Infectious Disease / Pandemc	Landslide	IT/Comms Failure	Power Outage	Tornado	Wildfire
NYSDOH Regional Office[6]	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	□
Local Emergency Management	R	□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Local Law Enforcement		□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Local Fire/EMS		□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Local Health Department	R	□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Off Duty Staff		□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Relatives and Responsible Parties		□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Resource Vendors		□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Authority Having Jurisdiction		□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□
Regional Healthcare Facility Evacuation Center		□	M	M	M	M	□	M	M	M	M	□		□	M	M	M	□

[4] "Active threat" is defined as an individual or group of individuals actively engaged in killing or attempting to kill people in a populated area. Example attack methods may include bombs, firearms, and fire as a weapon.

[5] "CBRNE" refers to "Chemical, Biological, Radiological, Nuclear, or Explosive"

[6] To notify NYSDOH of an emergency during business hours (non-holiday weekdays from 8:00 am – 5:00 pm), the Incident Commander will contact the NYSDOH Regional Office (518) 408-5300. Outside of normal business hours (e.g., evenings, weekends, or holidays), the Incident Commander will contact the New York State Watch Center (Warning Point) at 518-292-2200. The Watch Command will return the call and will ask for the type of emergency and the type of facility (e.g. hospital, nursing home, adult home) involved. The Watch Command will then route the call to the Administrator on Duty, who will assist the facility with response to the situation.

2.2 Mobilization

2.2.1 Incident Management Team

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.

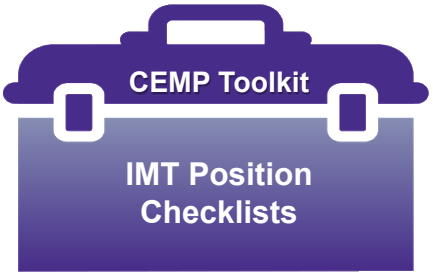


Table 5 outlines suggested facility positions to fill each of the Incident Management Team positions. The most appropriate individual given the event/incident may fill different roles as needed.

Table 5: Incident Management Team - Facility Position Crosswalk

Incident Position	Facility Position Title	Description
Incident Commander	○ Meghan Schobert Administrator	Leads the response and activates and manages other Incident Management Team positions.
Public Information Officer	○ Christopher Koenig Chief Executive Officer	Provides information and updates to visitors, relatives and responsible parties, media, and external organizations.
Safety Officer	○ Nicholas Messina Safety 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	○ Dana Algeri Director of Nursing	Manages tactical operations executed by staff (e.g., continuity of resident services, administration of first aid).

Incident Position	Facility Position Title	Description
Planning Section Chief	○ Dana Algeri Director of Nursing	Collects and evaluates information to support decision-making and maintains incident documentation, including staffing plans.
Logistics Section Chief	○ Meghan Schobert Administrator	Locates, distributes, and stores resources, arranges transportation, and makes alternate shelter arrangements with receiving facilities.
Finance/Admin Section Chief	○ Laurie Jankowski Chief Financial Officer	Monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

If the primary designee for an Incident Management Team position is unavailable, **Table 6** identifies primary, secondary, and tertiary facility personnel that will staff Incident Management Team positions.

While assignments are dependent upon the requirements of the incident, available resources, and available personnel, this table provides initial options for succession planning, including shift changes.

Table 6: Orders of Succession

Incident Position	Primary	Successor 1	Successor 2
Incident Commander	Administrator	Director of Nursing (DON)	Assistant Director of Nursing (ADON)
Public Information Officer	Chief Executive Officer	Executive Director of Marketing &	Administrator
Safety Officer	Safety Manager	Human Resources Department	Maintenance
Operations Section Chief	DON	ADON	Inservice Coordinator
Planning Section Chief	DON	ADON	Inservice Coordinator
Logistics Section Chief	Administrator	DON	ADON
Finance/Admin Section Chief	Chief Financial Officer	Controller	Accounts Receivable

2.2.2 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 Auditorium of GHRC and the secondary/back-up location is Conference 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.

2.3 Response

2.3.1 Assessment

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.

2.3.2 Protective Actions

Refer to **Annex A: Protective Actions** for more information.

2.3.3 Staffing

Based on the outcomes of the assessment, the Planning Section Chief 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 will manage the storage and processing of timekeeping and related documentation to track staff hours.

2.4 Recovery

2.4.1 Recovery Services

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 7**.

Table 7: Pre-Identified Recovery Services

Service	Description of Service	Point(s) of Contact
NYSDOH	Directs and oversees patient care and research to long-term care facilities.	○ Gloria Duffey gloria.duffey@health.ny.gov
Mutual Aid	Plans and supports emergency response personnel in conjunction with local EMS organizations.	716-684-1232
FEMA	Responds and provides recovery and disaster preparedness in a time of need.	716-683-6363

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.

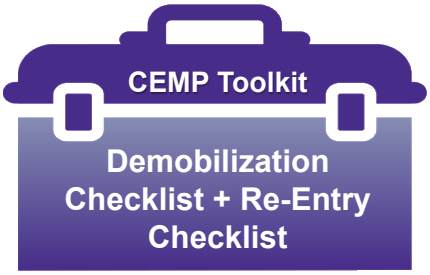
Resuming pre-incident staff scheduling will require a planned transition of staff resources, accounting for the following considerations:

- 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, attend memorial services, mental/behavioral health services).
- Continued use or release of surge staffing, if activated during incident.

2.4.2 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;[7]
- Deactivation of surge staffing;
- Replenishment of emergency resources;
- Reactivation of normal services and operations; and
- Compilation of documentation for recordkeeping purposes.



2.4.3 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 8 outlines entities responsible for performing infrastructure restoration activities and related contracts/agreements.

Table 8: Infrastructure Restoration Activities

Activity	Responsible Entity	Contracts/Agreements
Internal assessment of electrical power.	Maintenance	N/A
Clean-up of facility grounds (e.g., general housekeeping, removing debris and damaged materials).	Grounds Department	N/A
Internal damage assessments (e.g., structural, environmental, operational).	Maintenance	N/A
Clinical systems and equipment inspection.	Maintenance	N/A

[7] Refer to the *NYSDOH Evacuation Plan Template* for more information about repatriation.

Activity	Responsible Entity	Contracts/Agreements
Strengthen infrastructure for future disasters (if repair/restoration activities are needed).	Maintenance	N/A
Communication and transparency of restoration efforts to staff and residents.	Maintenance	N/A
Recurring inspection of restored structures.	Maintenance	N/A

2.4.4 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.

2.4.5 Resource Inventory and Accountability

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 the original manufacturer for additional guidance.

3 Information Management

3.1 Critical Facility Records

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

- Point Click Care – Point Click Care is our primary electronic health record (HER). Point Click Care is a cloud-based software that we can access remotely. Point Click Care handles the backing up of this data. EMAR information is backed up every hour to an onsite server in case of an emergency situation.
- Rehab Optima – Rehab Optima is our therapy software that we can access remotely. Rehab Optima is a cloud-based software that handles the backing up of this data. Rehab Optima integrates with Point Click Care
- Deitech – Dietech is our dietary software. This is also a cloud-based software that we can access remotely. Deitech integrates with Point Click Care
- Paycom – Staff information is located in Paycom software. Paycom software is a cloud-based program which is backed up on a regular basis by Paycom. We can send notifications to staff through Paycom software.
- OnShift – OnShift is used for scheduling our nursing department. This is a cloud-based software. We have the ability to send out notifications to staff through OnShift.

Our facility has a combination of onsite and cloud-based servers for maintaining electronic records. All onsite servers are backed up every four hours to a backup device. And weekly backup is stored at an alternative site.

Current resident paper charts are located on the units in a secure area. Discharged residents are kept in our Medical Records office in a secure area.

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

3.2 Resident Tracking and Information-Sharing

3.2.1 Tracking Evacuated Residents

The facility will use the New York State Evacuation of Facilities in Disasters System ("eFINDS")[8] and the Resident Evacuation Critical Information and Tracking Form[9] to track evacuated residents and ensure resident care is maintained.

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. The Privacy Rule also permits disclosure of protected health information in other circumstances. Private counsel should be consulted where there are specific questions about resident confidentiality.

3.3 Staff Tracking and Accountability

3.3.1 Tracking Facility Personnel

The facility will use the New York State Evacuation of Facilities in Disasters System ("eFINDS")[10] and the Resident Evacuation Critical Information and Tracking Form[11] to track staff.

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[8] eFINDS is a secure, confidential system intended to provide authorized users with real-time access to the location of residents evacuated during an emergency event. The system is to be used to log and track residents during an urgent or non-emergent evacuation. See Appendix K of the *NYSDOH Evacuation Plan Template* for further information and procedures on eFINDS.

[9][9] The Resident Evacuation Critical Information and Tracking Form is a standardized form utilized to provide pertinent individual resident information to receiving facilities and provide redundant tracking during the evacuation process, including repatriation. See Appendix L of the *NYSDOH Evacuation Plan Template* for the complete form.

10 see HIPAA privacy rule information in CEMP toolkit, Annex K) or: https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/hipaa-privacy-emergency-situations.pdf

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3.3.2 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 Paycom 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 Paycom.

3.3.3 Non-Facility Personnel

The Incident Commander—or Logistics Section Chief, if activated—will ensure that appropriate credentialing and verification processes are followed. Throughout the response, the Incident Commander—or Planning Section Chief, if activated—will track non-facility personnel providing surge support along with their respective duties and the number of hours worked.

4 Communications

4.1 Facility Communications

As part of CEMP development, the facility conducted a communications assessment to identify existing facility communications systems, tools, and resources that can be leveraged 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 9: Methods of Communication

Mechanism	Primary Method of Communication	Alternate Method of Communication
Landline telephone	☐	☐
Cell Phone	☐	☐
Voice over Internet Protocol (VOIP)	☐	☐
Text Messages	☐	☐
Email	☐	☐
News Media	☐	☐
Radio Broadcasts	☐	☐
Social Media	☐	☐
Runners	☐	☐
Weather Radio	☐	☐
Emergency Notification Systems[12]	☐	☐
Facility Website		
	☐	☐

4.1.1 Communications Review and Approval

Communication is reviewed by management and/or executive level staff prior to dissemination. Necessary communication during an incident will be reviewed by at least one Incident Management Team member prior to dissemination via Paycom and/or CliniConex.

[12] An emergency notification system is a one-way broadcast, sometimes coordinated by a third-party vendor, and is not required by NYSDOH.

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;
- Conducts direct resident and relative/responsible party outreach, as appropriate; and
- Addresses rumors and misinformation.

4.2 Internal Communications

4.2.1 Staff Communication

The facility maintains an electronic payroll system that contains a list of all staff members, including emergency contact information, on Paycom, a web-based software application.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.

4.2.2 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.

4.2.3 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

documentation, Resident Council meetings, and communication from both the Social Work and Nursing departments.

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.

4.3 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.

4.3.1 Corporate/Parent Organization

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

4.3.2 Authorized Family and Guardians

The facility maintains a list [insert name of facilty's resource list of all identified authorized family member's and guardian's (responsible parties') contact information, including phone numbers and email addresses at Point Click Care (Electronic Medical Record [EMR] system). 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 sending mass notification through CliniConex. Additional updates may be provided on a regular basis to keep residents relatives/responsible parties apprised of the incident and the response.

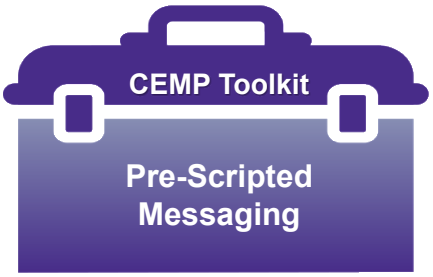
The initial notification message to residents' primary point of contact (e.g., relative) will include the following information:

- Nature of the incident;
- Status of resident;
- Restrictions on visitation; and
- Estimated duration of protective actions

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.

4.3.3 Media and 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.

5 Administration, Finance, Logistics

5.1 Administration

5.1.1 Preparedness

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*;
- Ensure CEMP is in compliance with local, state, and federal regulations.

5.2 Finance

5.2.1 Preparedness

Finance functions prior to an incident include identifying key areas that could be impacted by emergency. These include staffing, supplies, equipment, contracted services and other expenses. Finance will also identify how these items can be tracked and monitored utilizing existing software and/or excel spreadsheets.

5.2.2 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

5.3 Logistics

5.3.1 Preparedness

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.

5.3.2 Incident 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.

6 Plan Development and Maintenance

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

Table 10: Plans, Policies, and Procedures

Activity	Led By	Frequency
Review and update the facility's risk assessment.	Director of Plant Operations	Annually
Review and update contact information for response partners, vendors, and receiving facilities.	Director of Plant Operations	Annually or as response partners, vendors, and host facilities provide updated information.
Review and update contact information for staff members and residents' emergency contacts.	Human Resources Department	Annually or as staff members provide updated information.
Review and update contact information for residents' point(s) of contact (i.e., relatives/responsible parties).	Director of Social Work	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.	Director of Plant Operations	Annually
Maintain electronic versions of the CEMP in folders/drives that are accessible by others.	Director of Plant Operations	Annually
Revise CEMP to address any identified gaps.	Administrator	Upon completion of an exercise or real-world incident.
Inventory emergency supplies (e.g., potable water, food, resident care supplies, communication devices, batteries, flashlights,	Director of Plant Operations	Quarterly

7 Authorities and References

This plan may be informed by the following authorities and references:

- Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288, as amended, 42 U.S.C. 5121-5207)
- Title 44 of the Code of Federal Regulations, Emergency Management and Assistance
- Homeland Security Act (Public Law 107-296, as amended, 6 U.S.C. §§ 101 et seq.)
- Homeland Security Presidential Directive 5, 2003
- Post-Katrina Emergency Management Reform Act of 2006, 2006
- National Response Framework, January 2016
- National Disaster Recovery Framework, Second Edition, 2016
- National Incident Management System, 2017
- Presidential Policy Directive 8: National Preparedness, 2011
- CFR Title 42, Chapter IV, Subchapter G, Part 483, Subpart B, Section 483.73, 2016
- Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006
- March 2018 DRAFT Nursing Home Emergency Operations Plan – Evacuation
- NYSDOH Healthcare Facility Evacuation Center Manual
- Nursing Home Incident Command System (NHICS) Guidebook, 2017
- Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule
- NYSDOH Healthcare Facility Evacuation Center Metropolitan Area Regional Office Region Facility Guidance Document for the 2017 Coastal Storm Season
- NFPA 99 – Health Care Facilities Code, 2012 edition and Tentative Interim Amendments 12-2, 12-3, 12-5, and 12-6
- NFPA 101 – Life Safety Code, 2012 edition and Tentative Interim Amendments 12-1, 12-2, 12-3, and 12-4
- NFPA 110 – Standard for Emergency and Standby Power Systems, 2010 edition and Tentative Interim Amendments to Chapter 7
- 10 NYCRR Parts 400 and 415
- NYS Exec. Law, Article 2-B
- Public Health Service Act (codified at 42 USC §§ 243, 247d, 247d-6b, 300hh-10(c)(3)(b), 311, 319)
- Cybersecurity Information Sharing Act of 2015 (Pub. L. No. 114-113, codified at 6 U.S.C. §§ 1501 et seq.)
- Chapter 114 of the Laws of New York 2020.
- See Fire Safety & Emergency Plans for additional references.

Annexes

Annex A: 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*.

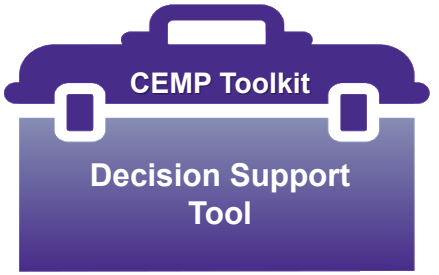


Table 11: Protective Actions

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, 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.

Protective Action		Potential Triggers	Authorization
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.*
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.

Annex B: Resource Management

1. Preparedness

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
- Propane tanks
- 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 communications equipment
- 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

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

2. 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.

3. 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.

4. Emergency Staffing

4.1. Off-Duty Personnel

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 12: Off-Duty Personnel Mobilization Checklist

Off-Duty Personnel Mobilization Checklist	
☐	The senior most on-site facility official will confirm 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).

☐	

4.2. 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
- 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.

4.3. Surge Staffing

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

Annex C: Emergency Power Systems

1. Capabilities

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,[13] 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 systems; and
- Sewage and waste disposal.

2. Resilience and Vulnerabilities

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.

[13] CMS requires healthcare facilities to accommodate any additional electrical loads the facility determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies, and procedures. It is up to each facility to make emergency power system decisions based on its risk assessment and emergency plan.

Annex D: Training and Exercises

1. Training

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 13: 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.	Inservice Coordinator	Orientation held within 14 days 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.	○ Inservice Coordinator	Upon hire and annually thereafter.
Maintain records of staff completion of training.	Inservice Coordinator	Annual
Ensure that residents are aware appropriately of the CEMP, including PEP specific plans, including what to expect of the facility	Nursing Department	Repeat briefly at time of incident.

Activity	Led By	Frequency
before, during, and after an incident.		
Identify specific training requirements for individuals serving in Incident Management Team positions.	○ Inservice Coordinator	○ Annual

2. Exercises

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

Table 14: Exercises

Activity	Led By	Frequency
Conduct one operations-based exercise (e.g., full-scale or functional exercise). [14]	Inservice Coordinator	Annually
Conduct one discussion-based exercise (e.g., tabletop exercise).	Inservice Coordinator	Annually

3. Documentation

3.1. Participation Records

In alignment with industry best practices for emergency preparedness, the facility will maintain documentation and evidence of course completion through annually conducted inservice trainings.

3.2. 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.

[14] If a facility activates its CEMP due to a disaster, the facility is exempt from the operational exercise for the year ending November 15. A facility is only exempt if the event is fully documented, a post-incident after action review is conducted and documented, and the response strengths, areas for improvement, and corrective actions are documented and maintained for three (3) years. However, the secondary requirement for a tabletop exercise still applies.

Annex E: 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.

This checklist also includes all elements required for inclusion in the facility's Pandemic Emergency Plan (PEP), as specified within the new subsection 12 of Section 2803, Chapter 114 of the Laws of 2020, for infectious disease events that rise to the level of a pandemic.

To assure an effective, comprehensive and compliant plan, the facility should refer to information in Annex K of the CEMP Toolkit, to fully understand elements in the checklist including the detailed requirements for the PEP.

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

- development of a Communication Plan,

- 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

- 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. Staff education is provided through our Director of Inservice on an annual and biannual basis.
☐ Required	Develop/Review/Revise and Enforce existing infection prevention, control, and reporting policies. *See Attachments 1 through 7.*
☐ 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.
☐ Recommended	Develop/Review/Revise plan for staff testing/laboratory services.
☐ 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. Staff has access to our organization's Intranet, which provides all policies, procedures, and inservice training tools 24/7. The Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) have access to the Health Commerce System and are cross-trained to download all pertinent data in a time of need or absence.
☐ Required	Develop/Review/Revise internal policies and procedures, to stock up on medications, environmental cleaning agents, and personal protective equipment as necessary. The Incident Management Team includes the facility Administrator, Medical Director, Director of Nursing, Safety Officer, and other appointed staff to assist in developing, implementing and assessing infection control policies and procedures.
☐ Recommended	Develop/Review/Revise administrative controls (e.g., visitor policies, employee absentee plans, staff wellness/symptoms monitoring, human resource issues for employee leave).
☐ Required	Develop/Review/Revise environmental controls (e.g., areas for contaminated waste). *See Attachment 11.*

☐ Required	Develop/Review/Revise vendor supply plan for re-supply of food, water, medications, other supplies, and sanitizing agents. *See Attachment 8* regarding re-supply of food. *See Attachment 12* regarding re-supply of medications.
☐ 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 Attachments 9 and 10.*
☐ 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.
☐ Recommended	Develop/Review/Revise a plan to ensure social distancing measures can be put into place where indicated.
☐ 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.
☐	
☐	
Additional Preparedness Planning Tasks for <u>Pandemic Events</u>	
☐ Required	***In accordance with PEP requirements,*** Develop/Review/Revise a Pandemic Communication Plan that includes all required elements of the PEP. The Incident Management Team will oversee communication with the facility and all outside organizations and agencies to assist with operations through the pandemic event. *See Comprehensive Emergency Management Plan Toolkit* for additional details on processes and procedures.
☐ 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. The Incident Management Team will oversee communication with the facility and all outside organizations and agencies to assist with operations through the pandemic event. *See Comprehensive Emergency Management Plan Toolkit* for additional details on processes and procedures.
☐	
☐	
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. Appropriate signage displayed outside patient/resident room based on diagnosis.
☐ 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). This information is communicated on a daily basis through our NYSDOH primary contact.
☐ Required	The facility will assure it meets all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting. This information is communicated on a daily basis by the Administrator or Director of Nursing (DON).
☐ 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.
☐ 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. Within our facility, Green, Yellow, and Red Zones are created based on infection status of patients/residents. Staff are allocated to those units and provide care to the respective patients/residents through the end of the precaution period.
☐ 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. The facility's policy is to contact the patient/residents' family members once a week to provide an update on the status of the outbreak.
☐ 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.
☐ Required	Subject to any superseding New York State Executive Orders and/or NYSDOH guidance that may otherwise temporarily prohibit visitors, the facility will advise visitors to limit visits to reduce exposure risk to residents and staff. 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 Attachment 13.*
☐	
☐	
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)**.**
☐ 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 PEP will be reviewed on an annual basis and uploaded to the facility's public website.
☐ 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. The facility has invested in a mass notification system, CliniConex, that is connected to our Point Click Care (PCC) and notifies the primary contact and appropriately documents in PCC when the call has been made.
☐ 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. Under these circumstances, a staff member of our Social Work or Nursing Department would contact the family of the patient/resident immediately and provide the update.
☐ 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. Our facility purchased six new iPads to increase the number of tools available for our Activities Department to help facilitate communication between patients/residents and their family members.
☐ 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). In accordance with NYSDOH guidelines, our facility will always admit and/or readmit a patient/resident based on their healthcare needs. If for any reason, the facility determined it was unable to meet the needs of the patient/resident (i.e. critical staffing, lack of nursing supplies, etc.) the hospital would be contacted and directed to arrange care at another facility.
☐	***In accordance with PEP requirements,*** the facility will implement the following process

Required	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). Currently, the patient/resident and/or their family member is contacted to determine their bedhold status. Even if the family declines, we make every effort to readmit the patient/resident when they are ready to discharge from the hospital.
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following planned procedures to maintain at least a two-month (60-day) supply of personal protective equipment (including consideration of space for storage) or any superseding requirements under New York State Executive Orders and/or NYSDOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic. 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)
☐	
☐	
Recovery for all Infectious Disease Events	
☐ 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.
☐ Required	The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders
☐	
☐	

Attachment I

Niagara Lutheran Health System and Affiliates		Program Application: NLHS NLHRC GHRC √ GC GM NLHF GT
Policy Manual: Infection Control	Prepared by: Director of Nursing	
Latest Revision Date: 02/10	Supersedes: Isolation and Special Precautions	
Approved By: Executive Management Team	**Approval Date: 03/09/2020**	
Subject: Transmission Based Precautions	Page 1 of 4	

STANDARD:

Transmission based precautions are carried out in accordance with the Center of Disease Control (CDC) guidelines. CDC's Standard Precautions (which incorporates and extends previous CDC recommendations for Universal Precautions), Airborne Precautions, Droplet Precautions, and Contact Precautions are the basis of the isolation and infection precautions policies and procedures in this facility. CDC guidelines have been modified for long term care facilities. Standard Precautions are always in effect for all residents. Additional precautions will be initiated as needed.

POLICY:

It is the responsibility of the Infection Control Nurse or designee to implement transmission based precautions in accordance with CDC guidelines.

PROCEDURE:

A. Overview

Precautions take into consideration the source of infection, possible susceptible persons and methods of transmission of the disease.

Precautions are designed to protect patients/residents, employees and visitors. They will remain in effect until the person is no longer infectious.

Details of specific precautions are included in separate policies in this manual.

The Infection Control Nurse or designee provides instruction on transmission based precautions during orientation of all new employees and volunteers and on a regular and ongoing basis.

When appropriate, patient/residents, visitors, and family members are instructed on transmission based precautions by the Infection Control Nurse or designee.

See attached chart for guidelines.

B. Procedure

The appropriate precautions are utilized when the Infection Control Nurse or designee has determined that these measures are necessary.

A physician order is required for initiating isolation but not for precautions.

Infected patients/residents are isolated only to the degree needed to isolate the infecting organism. It is usually more appropriate to use the term "precaution" rather than isolation.

The Patient/Residents comprehensive care plan and Kardex will be updated to reflect the type of precautions required (contact, droplet, or both)

24-hour report will be updated to reflect the type of precautions, the anticipated duration, and why they are needed

C. Education

Further information related to specific diseases and infections can be found in the Table of Infections and Precautions in this manual.

REFERENCES:

Centers for Disease Control and Prevention. Unpublished information: outline for revision of CDC's isolation recommendations, 1994.

Garner, JS, Simmons BP, CDC guideline for isolation precautions in hospitals. Infect Control 1983; 4:245-325.

Centers for Disease Control. Recommendations for prevention of HIV transmission in health-care settings. MMWR 1987; 36(No. 2S):3S-18S.

Centers for Disease Control. Update: universal precautions for prevention of transmission of human immunodeficiency virus, hepatitis B virus, and other bloodborne pathogens in health-care settings. MMWR 1988; 37:379-382, 387-388.

Department of Labor, Occupational Safety and Health Administration Federal Register. 29 CFR Past 1910.1030 Occupational Exposure to Bloodborne Pathogens; Final Rule

Transmission Based Precaution Guidelines

Diagnosis	Requires Private Room	Requires:			Dining/ Meals		Therapy		Activities		May Visit Hairdresser		Precautions Lifted D/C'd
		Gloves	Gown	Mask	In Room	Dining Area	In Room	In Clinic	In Room	Common Areas	Yes	No	
MRSA or VRE - Respiratory (i.e. Nares)	YES	YES	NO	YES	YES	NO	YES	YES (with mask)	YES	NO		NO	3 Days Post Antibiotic, cultures taken - If Negative, Precautions Lifted/ Discontinued
- Covered Wound	YES	YES	NO	NO	YES	YES	YES	YES	NO	YES	YES		
- Uncovered Wound (i.e.. ear/face)	YES	YES	NO	NO	YES	NO	YES	NO	YES	NO		NO	
- Urine Contained (i.e.. Foley or continent)	NO	YES	NO	NO	YES	YES	YES	YES	YES	YES	YES		
-Urine not contained	YES	YES	NO	NO	YES	NO	YES if cont.	YES if cont.	YES if cont.	NO	YES if cont.		
ESBL	YES	YES (when in contact with pt.)	YES (when in contact with pt.)	NO	YES	NO	YES	NO	YES	NO		NO	Same as MRSA/VRE
C-Diff	YES	YES	YES (for pt. care)	NO	YES	NO	YES	YES (unless incont.)	YES	NO	If last pt of day		Post -antibiotic if no symptoms present- precautions lifted
Head Lice	YES	YES (when in contact w/pt)	YES (when in contact w/pt.)	NO	YES	NO	YES	NO	YES	NO		NO	Both are 2 step process: following 2nd treatment, MD will reassess and determine if/when precautions are lifted
Scabies	YES	YES (when in contact	Long Sleeves for Tx & change	NO	YES	NO	YES	YES (end of	YES	NO		NO	After 1st Treatment is washed off.

		w/pt.)	bed linens					session)					

Notes: Residents with :
1. Like condition may share same room.
2. Above chart is a Guideline; each patient will be assessed to assure their individual needs are addressed and other resident/staff safety is optimized.

Coronavirus

WHAT IS CORONA VIRUS?

A viral respiratory illness which can be transmitted from the contact with the secretions of an infected person.

Symptoms: Cough, runny nose, sore throat, temperature above 100 degrees, occasionally diarrhea is seen in those infected. In most it is a little worse than the common cold but not as bad as the flu.

HAND WASHING IS THE BEST PREVENTATIVE MEASURE

Who does it affect?

Anyone can get the Corona Virus, this strain is affecting the elderly the most. Paying close attention to changes in status of the patients/residents is VERY important.to initiate precautions as soon as possible

OUR PREVENTATIVE MEASURES

Restricting visitation

Doors being locked starting 3/9/20

Employees will enter at front door and will be screened for symptoms

TRANSMISSION

The Corona Virus is transmitted because it takes 2-14 days to develop symptoms, so often people are contagious before they are sick

It is important to avoid contact with anyone from an area that has confirmed cases of Corona Virus

REMINDERS

Wear Proper Protective Equipment and Use Correct Isolation Precautions

Use masks properly: on and off with ear loops DO NOT TOUCH FRONT OF MASK

Keep the mask on over your entire nose and mouth

Wash your hands often

Never wear isolation gowns/ gear out into the hallway

If you are sick or have a fever off 100 degrees STAY HOME

Attached 2

Niagara Lutheran Health System and Affiliates		Program Application:
Section: Infection Control	Policy # IC -	NLHS GHRC √ GC GM NLHF GT
Issue Date: 10/1998	Revision Date: 12/2017	
Prepared By: Director of Nursing		
Approved By: Quality Assurance Committee	Approval Date: 12/2017	
Policy Subject: **CLASSIFICATION OF INFECTION/INFECTION CRITERIA**	Page 1 of 9	

STANDARD:

Effective measures are developed to prevent, identify, and control infections acquired or brought into the long-term care facility from the community for the purpose of producing early, uniform identification and reporting.

POLICY:

It is the responsibility of the Infection Control Nurse (ICN) or his/her designee to establish guidelines for identification and reporting of infections.

PROCEDURE:

A. Definitions:

1) Definitions of nosocomial infections for surveillance purposes provide for early, uniform identification and reporting of infections.

2) A community acquired infection is one that is present or incubating at time of admission.

3) Signs and symptoms (S&S) of infection must be present within 72 hours of admission. There may be exceptions to this guideline (e.g., chicken pox); however, this decision is made by the infection control chair or infection control nurse.

4) A nosocomial infection is one that was not present or was not incubating at time of admission. Resident does not exhibit S&S of infection during the first 72 hours of admission.

5) The reactivation of latent endogenous organism (e.g., vaicella-zoster) is considered a nosocomial infection.

CRITERIA FOR INFECTIONS:

These criteria, a basic part of the surveillance program, are used to determine infections in the absence of any other known reason for the signs and symptoms. In order to be counted in the surveillance statistics, infections must meet these criteria.

These criteria are intended for surveillance purposes only and are not intended to be used as a basis for medical diagnosis or treatment.

INFECTION/SITE	CRITERIA	CONDITIONS AND COMMENTS
RESPIRATORY TRACT INFECTION		
COMMON COLD SYNDROME	MUST HAVE at least 2 of the following: Runny nose or sneezing Stuffy nose (nasal congestion) Fever, postnasal drip, headache and myalgia (muscle aches) Sore throat, hoarseness or difficulty swallowing Dry cough New swollen or tender glands in neck (cervical lymphadenopathy)	Fever may or may not be present. Symptoms must be acute and not related to allergy (seasonal or medication).
INFLUENZA-LIKE ILLNESS	MUST HAVE fever (greater than or equal to 100 degrees F taken at any site) MUST HAVE at least 3 of the following: Chills Diarrhea, vomiting Headache or eye pain Myalgia's (muscle aches) Malaise or loss of appetite Sore throat Dry cough	This diagnosis can be made only during influenza season (November to April). During this season, if criteria for influenza-like illness and another upper or lower respiratory tract infection are met at the same time, only the diagnosis of influenza-like illness should be recorded.

INFECTION/SITE	CRITERIA	CONDITIONS AND COMMENTS
RESPIRATORY TRACT INFECTION (CONTINUED)		
PNEUMONIA	MUST HAVE chest X-Ray demonstrating pneumonia, probable pneumonia, or infiltrate. MUST HAVE at least 2 of the following: Cough Increased sputum production Fever (>100 degrees F) Pleuritis chest pain Rales, rhonchi, wheezes on chest exam One of more of the following: New shortness of breath, increased respiratory rate (>24/minute), worsening of mental or functional status.	This diagnosis can be made only if no chest X-Ray was done, or if an X-Ray did not confirm the presence of pneumonia.
OTHER LOWER RESPIRATORY TRACT INFECTION (BRONCHITIS, TRACHEOBRONCHITIS)	MUST HAVE at least 3 of the following: Cough Increase sputum production Fever (>100 degrees F) Pleuritic chest pain Rales, rhonchi, wheezes on chest exam, fremitus, ego phony, focal consolidation One or more of the following: New shortness of breath, increased respiratory rate (>24/minute), worsening of mental or functional status.	This diagnosis can be made only if no chest X-Ray was done, or if an X-Ray did not confirm the presence of pneumonia.

INFECTION/SITE	CRITERIA	CONDITIONS AND COMMENTS
URINARY TRACT INFECTION (INCLUDES ONY SYMPTOMATIC UTI)		
UTI IN RESIDENT WITHOUT CATHETER	MUST HAVE at least 3 of the following: Fever (>100 degrees F) or chills Burning pain in urination, or frequency or urgency Flank or suprapubic pain or tenderness Change in character of urine New onset or worsening of mental or functional status New or increased incontinence	This category includes only symptomatic urinary tract infections. Because many Residents have bacteria in their urine as a baseline status, surveillance for asymptomatic bacteriuria is not recommended.
UTI IN RESIDENT WITH CATHETER	MUST HAVE at least 2 of the following: Fever (>100 degrees F) or chills Flank or suprapubic pain or tenderness Change in character of urine New onset or worsening of mental or functional status	Because the most common occult infectious source of fever in catheterized Residents is the urinary tract, the combination of fever and worsening of mental or functional status in such Residents meets the criteria for a UTI. However, care should be taken to rule out other causes of these symptoms. If a catheterized Resident with only fever and worsening mental or functional status meets criteria for infection at a site other than the urinary tract, only the diagnosis of infection at this other site should be made.

INFECTION/SITE	CRITERIA	CONDITIONS AND COMMENTS
GASTROINTESTINAL TRACT INFECTION		
Gastroenteritis	MUST HAVE at least 1 of the following: 3 or more loose or watery stools above what is normal for Resident within a 24 hour period. 2 or more episodes of vomiting within a 24 hour period with or without a fever or Both of the following: Stool culture positive for a pathogen (Salmonella, Shigella, E. coli 0157:H7, Campylobacter) or a toxin assay positive for C. difficile toxin, AND At least 1 of the following: Nausea, vomiting, diarrhea, abdominal pain or tenderness	Care must be taken to rule out noninfectious causes of symptoms. For instance, new medications may cause diarrhea and vomiting.
SKIN INFECTION		
Cellulitis/Soft Tissue/Wound	MUST HAVE at least 1 of the following: Pus at a wound, skin or soft tissue site 4 or more of the following: Fever (>100 degrees F taken at any site) Worsening mental/functional status Heat at site Redness at site Swelling at site Tenderness or pain at site Serious drainage from site assay positive for C. difficile toxin, AND At least 1 of the following: Nausea, vomiting, diarrhea, abdominal pain or tenderness	Note: The presence of pus, by itself, meets the criteria for infection. Without the presence of pus, at least 4 of the other signs and symptoms must be present. This category includes infected pressure sores, stasis, ulcers, etc.

INFECTION/SITE	CRITERIA	CONDITIONS AND COMMENTS
SKIN INFECTION (CONTINUED)		
Fungal Skin Infection	MUST HAVE BOTH: A maculopapular rash, and Either physician diagnosis or lab confirmation	Maculopapular rash: reddened area with both flat and elevated lesions.
Herpes Simplex	MUST HAVE BOTH: A vesicular rash, and Either physician diagnosis or lab confirmation	Vesicular rash: rash consisting of small blisters
Herpes Zoster (Shingles)	MUST HAVE BOTH: A vesicular rash, and Either physician diagnosis or lab confirmation	Vesicular rash: rash consisting of small blisters (blisters may become large, with surrounding red areas, in herpes zoster).
Scabies	MUST HAVE BOTH: A maculopapular and/or itching rash, and Either physician diagnosis or lab confirmation	Care must be taken to assure that a rash is not allergic or secondary to skin irritation. Lab diagnosis consists of microscopic examination of skin scrapings.
EYE, EAR, NOSE AND MOUTH INFECTION		
Conjunctivitis	MUST HAVE at least 1 of the following: Pus from one or both eyes, present for > 24 hours Conjunctival redness, with or without itching or pain, present for at least > 24 hrs.	Symptoms must not be due to allergy or trauma to the conjunctiva. Conjunctiva: mucous membrane covering eyeball.
Ear Infection	MUST HAVE at least 1 of the following: Diagnosis by physician of ear infection Drainage from one or both ears (nonpurulent drainage must be accompanied by additional symptoms such as ear pain or redness)	Includes infections of external ear (otitis externa), middle ear (otitis media), or internal ear (otitis intern, labyrinthitis, vestibular neuronitis).
Mouth or Peri-Oral Infection (Including Oral candidiasis)	MUST HAVE: Diagnosis by physician or dentist	

INFECTION/SITE	CRITERIA	CONDITIONS AND COMMENTS
SYSTEMIC INFECTION		
Primary bloodstream infection -	MUST HAVE at least 1 of the following: 2 or more blood cultures positive with the same organism Diagnosis by physician of ear bloodstream infection (bacteremia)	More detailed criteria for bloodstream infections are not given for the following reasons: (1) Resident will in all likelihood, be in hospital for diagnosis; and (2) reports of laboratory work and Resident's condition when in hospital are frequently unavailable to LTCF's.
Unexplained Febrile Episode - -	MUST HAVE: Documentation in medical record of fever of >100 degrees F on TWO or more occasions at least 12 hours apart in any 3-day period, with no known infectious or noninfectious cause.	

A) Additional Notes/Conditions/Comments:

* Change in character or urine: any significant change of the gross character of the urine (e.g., new bloody urine, foul odor, or increased amount of sediment) or in the microscopic character (e.g. new pyuria, or microscopic hematuria)

* Fremitus: a sensation felt by a hand placed on the chest wall that vibrates during speech.

* Ego phony: an increased resonance of voice sounds heard when auscultating the lungs.

* Maculopapular Rash: a red rash with both flat red areas (macules) and small bumps (papules).

* In order to determine microscopic changes, results of a previous urinalysis must be available.

* Changes in functional status: a significant change in the Resident's ability or willingness to carry out activities of daily living - examples: new incontinence, new inability to walk to dining room, increase difficulty in transfers

* Change in mental status: a significant change in the Resident's cognitive function - examples: increased level of confusion, new unwillingness to participate in activities.

* Diagnosis by a physician (as used in criteria for herpes zoster, scabies, etc.) may consist of a written physician's note, a nurse' note stating that the physician made a diagnosis, or in a verbal report from either physician or a nurse that a specific diagnosis has been made

* For purposes of these criteria, fever is defined as a single temperature, taken by any route, of > 100 degrees F (38 degrees C)

* Malaise: a feeling of generalized discomfort or uneasiness, or being "out-of-sorts".

* Pleuritic chest pain: Caused by inflammation of the pleua (lining of the lung); a sharp pain felt at any site over the rib cage, brought on or made much worse by deep breathing.

* Purulent: containing pus

* Serous: watery (as opposed to purulent)

* Suprapubic: in the area of the bladder, in the central lower area of the abdomen

References:

McGeer A and the Canadian Consensus Group. Definitions of infections for use in long term care facilities (LTCF's). Presented at 3rd International Conference on Nosocomial Infections, Atlanta, Georgia - August 2, 1990

McGeer A. Campbell B, Emori TG, etal. Definitions of infection for surveillance in long term care facilities. Am J. Infect Control 1991; 19:1-7.

Center for Disease Control and Prevention: Adult Treatment Recommendations (2017, October 03). Retrieved November 08, 2017, from http://www.cdc-gov/antibiotic-use/community/for-hcp/outpatient-hcp/adult-treatment-rec.html

REVISION DATE:

10/1998
12/2017

CLEAN HANDS COUNT

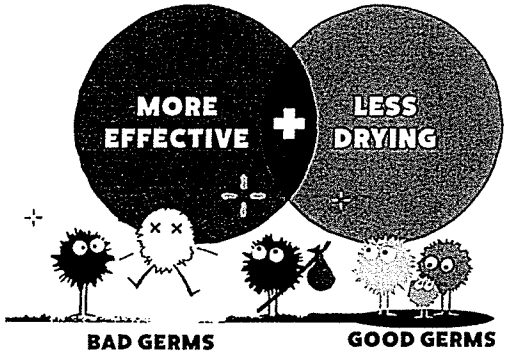
FOR HEALTHCARE PROVIDERS

KNOW THE TRUTH TO PROTECT YOURSELF AND PROTECT YOUR PATIENTS

TRUTH:

Alcohol-based hand sanitizer is more effective and less drying than using soap and water.

THE NITTY GRITTY:
Compared to soap and water, alcohol-based hand sanitizers are better at reducing bacterial counts on hands and are effective against multidrug-resistant organisms (e.g., MRSA). Additionally, alcohol-based hand sanitizers cause less skin irritation than frequent use of soap and water.



TRUTH:

Using alcohol-based hand sanitizer does NOT cause antibiotic resistance.

THE NITTY GRITTY:
Alcohol-based hand sanitizers kill germs quickly and in a different way than antibiotics. There is no chance for the germs to adapt or develop resistance.

TRUTH:

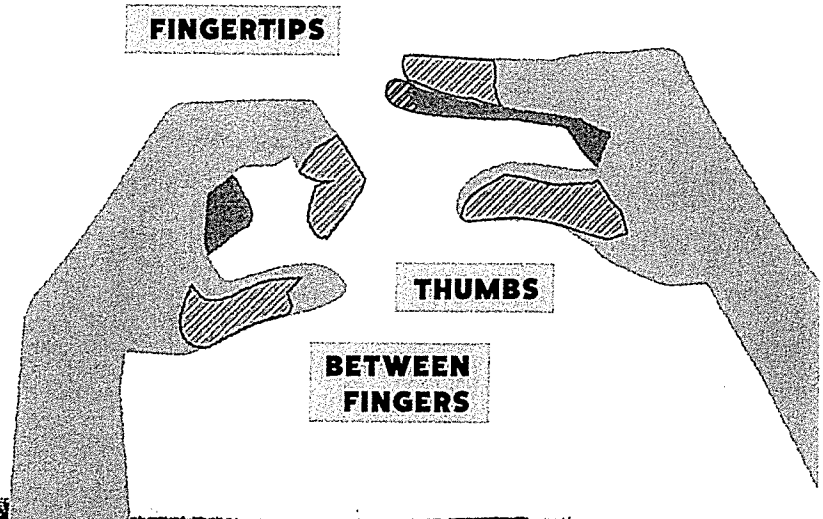
Alcohol-based hand sanitizer does not kill *C. difficile*, but it is still the overall recommended method for hand hygiene practice.

THE NITTY GRITTY:
Always use gloves when caring for patients with *C. difficile*. In addition, when there is an outbreak of *C. difficile* in your facility, wash your hands with soap and water after removing your gloves.

TRUTH:

Some healthcare providers miss certain areas when cleaning their hands.

THE NITTY GRITTY:
Using alcohol-based hand sanitizer becomes a habit and sometimes healthcare providers miss certain areas:



Attachment 3

Niagara Lutheran Health System and Affiliates		Program Application: NLHS NLHRC GHRC √ GC GM NLHF GT
Policy Manual: Infection Control	Prepared by: Director of Nursing	
Latest Revision Date: 03/20	Supersedes:	
Approved By: Executive Management Team	**Approval Date: 03/09/2020**	
Subject: Contact Precautions	Page 1 of 2	

STANDARD:

The facility will comply with recommendations from the CDC to utilize Standard Precautions to reduce the risks of endemic and epidemic nosocomial infections in residents and health care workers.

POLICY:

It is the responsibility of the Infection Control Nurse or designees to initiate and ensure that contact precautions are properly implemented. All staff, directly or indirectly, involved in patient/resident care are responsible for following Contact Precautions in conjunction with Standard Precautions.

Contact Precautions are to be used in conjunction with Standard Precautions for specified patients/residents known or suspected to be infected or colonized with highly infectious or epidemiologically important pathogens. There are three types of recommended transmission based precautions: airborne, droplet, and contact.

The purpose of Contact Precautions is to reduce the risk of transmission of epidemiologically important micro-organisms by direct or indirect contact. Contact precautions apply to specified patients known or suspected to be infected or colonized with epidemiologically important micro-organisms which are transmitted by direct or indirect contact, including but not limited to: Clostridiodes difficile, ESBL, CRE, VRE, MRSA, Shingles, and Scabies.

PROCEDURE:

- A Private room is indicated. In general patients/residents infected with the same organism may share a room. During outbreaks, patients/residents with the same respiratory clinical syndrome may share a room.

- Wear gloves (clean, non-sterile gloves are adequate) when entering the room of a patient/resident who is infected or colonized with the above described micro-organisms. (Extensive environmental contamination with some of these organisms has been noted in some studies). During the course of caring for a patient/resident, a change of gloves may be necessary after contact with material that may contain high concentrations of the micro-organism (e.g., stool).

- Wear a gown (a clean, non-permeable non-sterile gown is adequate) when entering the room of the patient/resident if substantial contact with them or environmental surfaces in their room is anticipated, or if the patient/resident is incontinent, or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing.

- Remove gloves and gown before leaving the patient/resident's room, and wash hands immediately with an antiseptic soap.

- Ensure that after glove and gown removal and hand washing, clothing and hands do not contact environmental surfaces potentially contaminated with the micro-organism (i.e., door knob or curtain) when exiting the room.

- Place contaminated disposable items and linen in appropriately marked barrels. Barrels will be emptied by Housekeeping.

- Disposable Temp-a-Dot thermometers are used for all residents placed on contact precautions. Blood Pressure Cuff and Sphygmomanometer may be used but must be cleansed after use per manufacturer's guidelines in accordance with CDC regulations.

REFERENCES:

Centers for Disease Control and Prevention. Unpublished information: outline for revision of CDC's isolation recommendations, 1994.

Centers for Disease Control and Prevention. Preventing the spread of vancomycin resistance - report from the Hospital Infection Control Practices Advisory Committee. Federal Register 1994;59:25757-25763.

Attachment 4

Niagara Lutheran Health System and Affiliates		Program Application: NLHS NLHRC GHRC √ GC GM NLHF GT
Policy Manual: Infection Control	Prepared by: Director of Nursing	
Latest Revision Date: 03/20	Supersedes:	
Approved By: Executive Management Team	**Approval Date: 03/09/2020**	
Subject: Droplet Precautions	Page 1 of 2	

STANDARD:

The facility will comply with recommendations from the CDC to utilize Standard Precautions to reduce the risks of endemic and epidemic nosocomial infections in residents and health care workers.

POLICY:

It is the responsibility of the Infection Control Nurse or designees to initiate and ensure that droplet precautions are properly implemented. All staff, directly or indirectly, involved in patient/resident care are responsible for following droplet Precautions in conjunction with Standard Precautions.

Droplet Precautions are to be used in conjunction with Standard Precautions for specified patients/residents known or suspected to be infected or colonized with highly infectious or epidemiologically important pathogens. There are three types of recommended transmission-based precautions: airborne, droplet, and contact.

The purpose of Droplet Precautions is to reduce the risk of droplet transmission of infectious agents. Transmission via droplets requires close contact between source and recipient persons and is considered droplet transmission rather than airborne transmission since droplets do not remain suspended in the air and generally travel only short distances (usually 3 feet) through the air.

Droplet transmission involves contact of the conjunctivae, nose, or mouth of a susceptible person with large particle droplets (>5 microns in size) generated from a person who has clinical disease or is a carrier of the microorganisms.

Droplet Precautions apply to any patient/resident known or suspected to have infections transmitted by infectious droplets, including but not limited to diphtheria, meningococcal meningitis, rubella, Coronavirus, and haemophilus.

PROCEDURE:

Droplet Precautions includes the following:

1. Placing the resident in a private room or in a room with patient/resident infected with the same pathogen.
2. Perform hand hygiene when entering and exiting the patient/residents room
3. Wear a mask when within three (3) feet of the patient/resident and at all times when in their room.
4. Ensure the mask covers the mouth and nose entirely, and when removing the mask ensure it is removed using the ear loops to avoid accidental contamination of particles from the front of the mask.

5. Place contaminated disposable items and linen in appropriately marked barrels. Barrels will be emptied by Housekeeping.

REFERENCES:

Centers for Disease Control and Prevention. Unpublished information: outline for revision of CDC's isolation recommendations, 1994.

Centers for Disease Control and Prevention. Preventing the spread of vancomycin resistance - report from the Hospital Infection Control Practices Advisory Committee. Federal Register 1994;59:25757-25763.

Attachment 5

Niagara Lutheran Health System and Affiliates		Program Application: NLHS NLHRC GHRC √ GC GM NLHF GT
Policy Manual: Infection Control	Prepared by: Director of Nursing	
Latest Revision Date: 03/2020	Supersedes: Isolation/Precautions room	
Approved By: Executive Management Team	**Approval Date: 03/09/2020**	
Subject: Precautions Room Procedure	Page 1 of 2	

STANDARD:

Procedural steps must be followed when setting up a precaution/isolation room.

POLICY:

It is the responsibility of the Infection Control Nurse or designee to ensure that all personnel follow the isolation/precaution room procedure as outlined.

PROCEDURE:

Placement of Patient/Resident on Precautions

a. As soon as conditions requiring precautions are identified, the Unit Coordinator/Designee will notify the DON/ADON

b. The Unit Coordinator/Designee will refer to the Infection Control Manual for appropriate precaution techniques to be instituted.

c. The Unit Coordinator/Designee will assure the resident's name is added to the 24 hour report, until 24 hours after precautions are discontinued. Precautions must be addressed on the Interdisciplinary Care Plan.

d. The DON/ADON will consult with the Unit Coordinator and the Social Work Department to determine if room changes are necessary.

Set up of Precaution Rooms

a. The precaution sign will be posted on the door of the resident's room; using only the room and bed number.

b. The appropriate barriers as listed on the precaution signs will be utilized by staff caring for the resident.

c. Gloves, gowns, masks and fluid shield masks when needed, are to be kept in a bedside stand located outside of the resident's room.

Equipment Used for Vital Signs

a. Disposable thermometers are available on each nursing unit.

b. Stethoscopes and sphygmomanometers may be wiped with alcohol sponges and taken from the room after use for patients/residents on precautions.

c. Stethoscopes and sphygmomanometers should be privately used by residents on strict isolation and/or with draining wounds on their arms.

Paper

a. Precaution signs are kept at the Nurses' station.

b. Discontinuation of precautions requires a Nurse's Note and updating of the Interdisciplinary Care Plan.

c. The Medical Record should be marked on the front inside cover of the chart indicating what precautions are indicated.

Instruction of Resident's Family

a. The patient/resident should be informed of the need for precautions by the nurse or provider

b. The nurse or provider will instruct the resident's family and visitors on specific precaution procedures.

REFERENCE:

Attachment 6

Niagara Lutheran Health System and Affiliates		Program Application: NLHS NLHRC GHRC √ GC GM NLHF GT
Policy Manual: Infection Control	Prepared by: Director of Nursing	
Latest Revision Date: 03/20	Supersedes:	
Approved By: Executive Management Team	**Approval Date: 03/09/2020**	
Subject: Hand Washing	Page 1 of 2	

STANDARD:

Hand washing shall be regarded by this facility as the single most important means of preventing the spread of infections.

POLICY:

It is the responsibility of all employees in direct or indirect contact with residents are required to practice frequent hand washing to prevent the spread of infection.

PROCEDURE:

All personnel shall follow our established hand washing procedures, which follow the CDC Guidelines for Hand Hygiene in Health Care Settings, to prevent the spread of infection and disease to other personnel, patients, and visitors. No less than twenty (20) second hand washing shall be performed.

TECHNIQUE:

1. Turn faucets on and adjust water temperature to "warm".
2. Wet hands and wrists thoroughly before adding soap from the dispenser. Dispense at least a dime sized amount of soap into the hands
3. Keep hands lower than elbows to prevent soiled water from running down forearms.
4. Work up lather by vigorously rubbing, washing front and back of hands, between fingers, nail beds and under nails. Friction and lather will emulsify and mechanically remove the microorganisms
5. Rinse thoroughly under running water with hands in the downward position.
6. While water is running, tear off paper towel and dry hands thoroughly and discard
7. Turn off water using a dry paper towel and discard.

Recommended Times - Minimal Standard

a. When coming on duty, and upon completion of duty
b. Whenever hands are obviously soiled
c. Before performing invasive procedures
d. Before preparing or handling medications
e. Before handling clean or soiled dressings, gauze pads, etc.
f. After handling used dressings, contaminated equipment, etc.
g. After contact with blood, body fluids, excretions, secretions, mucous membranes, and any non-intact skin
h. After personal body function (e.g., use of toilet, blowing or wiping the nose, smoking, combing the hair, etc.)
i. After removing gloves
j. Before and after eating

If liquid soap is used, reservoirs must be discarded when empty. If refillable, they must be emptied and cleaned, rinsed and dried, and never topped-off with additional soap.

Alcohol Based Hand Gel

1. Alcohol Based Hand Gel may be used PRN as a substitute for hand washing if hands are not greasy or visibly soiled.
2. Alcohol Based Hand Gel is available through Central Supply
3. A small amount of gel is placed in the palm of the hand. Hands are vigorously rubbed together until the gel is completely absorbed.

Alcohol Based Hand Gel is not effective against C-diff or Covid-19, only soap and water should be used in the case of a patient/resident with the above listed pathogens

REFERENCES:

Boyce MD, J.; Pittet MD, D; [Vol. 51 / RR-16] CDC Morbidity and Mortality Weekly Report; Guideline for Hand Hygiene in Health-Care Settings Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force

Rotter M. Hand washing and hand disinfection [Chapter 87]. In: Mayhall CG, ed. Hospital epidemiology and infection control. 2nd ed. Philadelphia, PA: Lippincott Williams & Wilkins, 1999.

Attachment 7

Niagara Lutheran Health System and Affiliates		Program Application: NLHS NLHRC GHRC √ GC GM NLHF GT
Policy Manual: Infection Control	Prepared by: Director of Nursing	
Latest Revision Date: 03/20	Supersedes:	
Approved By: Executive Management Team	**Approval Date: 03/09/2020**	
Subject: Airborne Precautions	Page 1 of 2	

STANDARD:

Greenfield Health and Rehabilitation Center will comply with recommendations from the CDC and utilize standard precautions to reduce the risks of endemic and epidemic nosocomial infections in residents/patients and health care workers

POLICY:

The purpose of Airborne Precautions is to reduce the risk of airborne transmission of infectious agents. The precautions apply to patients/residents known or suspected to have infections transmitted by the airborne route.

It is the responsibility of the Infection Control Nurse or designee to initiate and assure that airborne precautions are properly implemented. All staff, directly or indirectly involved in resident/patient care are responsible for following Airborne Precautions in conjunction with Standard Precautions.

Airborne Precautions are to be used in conjunction with Standard Precautions for specified residents known or suspected to be infected or colonized with highly infectious or epidemiologically important pathogens. There are three types of recommended transmission based precautions: airborne, droplet, and contact.

Airborne transmissions occurs by dissemination of either airborne droplet nuclei (small particle residue [<5 microns in size] of evaporated droplets that may remain suspended in air for long periods of time) or dust particles containing infectious agents.

Micro-organisms carried in this manner can be widely dispersed by air currents and may become inhaled or deposited on a susceptible host within the same room or over a longer distance from the source resident, depending on environmental factors.

Airborne Precautions apply to residents known or suspected to have infections transmitted by the airborne route, including but not limited to pulmonary tuberculosis, varicella, covid-19 and measles.

PROCEDURE:

Major emphasis includes the following:

1. Placing the resident/patient in a private room and keeping the door closed.
2. Limiting movement and transport of the resident/patient for essential purposes only.

3. Surgical masks for persons who must share air space with infected resident/patient.
4. The resident/patient will be moved to an acute care setting as deemed appropriate. The Greenfield Health and Rehabilitation Center does not have rooms with negative air pressure.

References

Centers for Disease Control and Prevention. Unpublished information: outline for revision of CDC's isolation recommendations, 1994.

Attachment 8

2020 US. Foods Emergency / Disaster Plan

Emergency / Disaster Plan

1. U.S. Foods will keep Emergency/Disaster Plan documents on file for any customer wishing to participate.

2. In the event of an Emergency/Disaster the Customer should contact US Foods to arrange for shipment of their Emergency Order.

3. There are no returns on Emergency/ Disaster orders once the customer has approved shipment of the emergency order.

4. In the event of a local Production System failure, we have 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.

2020 US. Foods Emergency / Disaster Plan

Emergency / Disaster Plan

In the event of an emergency, strike or natural disaster, U.S. Foods will make available to Greenfield Rehab as needed in the event of a natural disaster, emergency, or strike an alternative delivery location will be specified:

- Refrigerated/Freezer Truck (U.S. Foods 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 will use, as needed, our facilities in the East and/or West areas to provide service and delivery to your location.

This plan is a general overview. More specific needs will be determined between U.S. Foods and your facility, as the nature of the emergency becomes evident. U.S. Foods will provide this coverage to CUSTOMR NAME as long as our Prime Vendor relationship exists.

UPSTATE NIAGARA COOPERATIVE, INC.

FARMER OWNED

General Office:
25 Anderson Road
Buffalo, NY 14225

Membership Division:
700 Ellicott Street, Suite 2
Batavia, NY 14020

Information Technology:
90 Anderson Road
Buffalo, NY 14225

Buffalo Fluid Plant:
1730 Dale Road
Buffalo, NY 14225

Rochester Fluid Plant:
45 Fulton Avenue
Rochester, NY 14608

Valley Farms Dairy, LLC:
1860 East Third Street
Williamsport, PA 17701

Cultured Products Plant:
3300 North America Drive
West Seneca, NY 14224

North Country Dairy, LLC:
22 County Route 52
North Lawrence, NY 12967

Upstate Farms Cheese, LLC:
8600 Main Street
Campbell, NY 14821

O-AT-KA Milk Products Cooperative, Inc.:
700 Ellicott Street
Batavia, NY 14020

August 25, 2020

Greenfield Rehab
5949 Broadway Rd
Lancaster, NY 14086

Re: Emergency Water

To Whom it May Concern:

As long as Upstate Niagara Cooperative, Inc. is your milk supplier, we agree to furnish the above institution with an emergency supply of water to cover your needs in the event that your water supply is cut off in any way, providing that our water supply is available.

This water will be supplied to you in gallon containers. A reasonable charge would be assessed to cover our cost of packaging materials and labor.

Sincerely,

Rick Holz

Rick Holz
Directory of DSD Sales

RH/dg

2020 US. Foods Emergency / Disaster Plan

Emergency Customer Communication Form

Facility Name:

1) Primary Authorized Decision Maker

Meghan Schobert

- Daytime Phone
  716-684-3000 x1305
- Night/Weekend Phone
  716-461-5628
- Pager
  N/A
- Cell Phone
  716-461-5628

2) Secondary Authorized Decision Maker

Dina Algeri

- Daytime Phone
  716-684-3000 x1366
- Night/Weekend Phone
  716-317-774-6106
- Pager
- Cell Phone
  317-774-6106

2020 US. Foods Emergency / Disaster Plan

3) Third Authorized Decision Maker

Tim Carney

- Daytime Phone

716-484-3000 x1371

- Night/Weekend Phone

_____

- Pager

_____

- Cell Phone

_____

Authorized Signature: Nyhan Schabert

Date: 9-15-2020

- Please return this form to U.S. Foods or Fax Attention: **Elaine Glatz, Account Coordinator: Fax# (480)629-6410**
- This form will remain confidential and will only be used if an emergency/disaster has occurred.
- No Delivery will be made until an Authorized Decision-Maker has given the approval to send.

2020 US. Foods Emergency / Disaster Plan

Emergency U.S. Foods Contact List

Warehouse	(716) 668-8881 x 8312	Jerry Hagen
	(716) 818-4331	
	(716) 668-8881 x 8233	Tim Quigley
	(716) 997 - 3568	
Transportation	(716) 668-8881 x 8312	Jerry Hagen
	(716) 818-4331	
	(716) 668-8881 x 8280	Dave Hanaka
	(716) 818-1280	
Building is Un-staffed	1-800-333-0828 x 1	Order Hot Line
Healthcare Account Manager	Mobile:	

2020 US. Foods
Emergency / Disaster Plan

Commitment Document

Plan 1 [X] YES [ ] NO

- Upon your request US Foods will duplicate your last order, select and ship the products on the regular scheduled delivery day.

- Deliveries will be routed according to the distance from the distribution facility. Deliveries will be made ONLY if the highways and or roads are passable and open.

Plan 2 [X] YES [ ] NO

- Upon your request your Emergency Order on file will be selected and shipped on the regular scheduled delivery day.
- Deliveries will be routed according to the distance from the distribution facility. Deliveries will be made ONLY if the highways and or roads are passable and open.

- Emergency Ship Orders are NON - RETURNABLE once in progress.

I have read, understand and accept the 2020 Disaster Plan.

Customer Name: Greenfield Health & Rehab

Customer Number:

Authorized Signature: Meghan Schobert

Print Name & Title: Meghan Schobert - Administ

2020 US. Foods Emergency / Disaster Plan

Important
Please Deliver Immediately to:

Tim Carey

Please Read ... Urgent Reply Requested!

Please respond to your Account Coordinator, Elaine Glatz at fax # (480)629-6410 or email Elaine.Glatz@usfoods.com

For questions, contact us at the following numbers:

Phone:	1-800-333-0828
Extension 8285	Elaine Glatz, Account Coordinator
Extension 8354	Julie Langdon, Account Coordinator
Extension 3000	Customer Service Dept
Extension 8355	Maria Donovan, National Sales Manager
Extension 8312	Jerry Hagen, Vice President of Operations

2020 US. Foods Emergency / Disaster Plan

Disaster Order Guide

Customer Name:

Customer Number:

U.S. Foodservice Product #	Label	Pack	Description	Qty Ordered

2020 US. Foods Emergency / Disaster Plan

Disaster Order Guide

Customer Name:

Customer Number:

U.S. Foodservice Product #	Label	Pack	Description	Qty Ordered

2020 US. Foods Emergency / Disaster Plan

Disaster Order Guide

Customer Name: _____

Customer Number: _____

U.S. Foodservice Product #	Label	Pack	Description	Qty Ordered

2020 US. Foods Emergency / Disaster Plan

Disaster Order Guide

Customer Name:

Customer Number:

U.S. Foodservice Product #	Label	Pack	Description	Qty Ordered

Attachment 9

Niagara Lutheran Health System and Affiliates		Program Application:
Section: Administration	Policy #	
Issue Date: 5/1/2020	Revision Date: 5/15/2020	NLHS GHRC √ GC GM NLHF GT
Prepared By: Administrator		
Approved By: Executive Management Team	Approval Date: 5/15/2020	
Policy Subject: **Cohorting of Residents during COVID-19 Pandemic**	Page 1 of 2	

POLICY:

It shall be the policy of the facility to identify protocols for separating residents into cohorts of positive, presumed, and negative, by transferring patients/residents within the facility to maintain Infection Control compliance.

PURPOSE:

To ensure Infection Control compliance is maintained and the safety of all patients/residents and staff are optimized by eliminating exposure to the COVID-19 virus.

PROCEDURE:

1. Patients/residents who are newly admitted and/or re-admitted (defined as unknown) from the hospital or who have gone out to the ER or outside physician visit, will be isolated/monitored for fourteen (14) days in a private room. PPE that shall be worn is a mask (which will be changed after exiting isolation room) and gloves. Red bins for laundry and trash will be placed in each room.
    - The patient/resident will be monitored for any potential symptoms.
    - Therapy shall take place in the patients/residents room during this period.
    - The patient/resident shall remain in room for meals.

2. All long term residents, who reside in a private room may isolate in their room upon return from hospital, ER visit and/or necessary outside physician visit, so long as an assessment has taken place to deem it safe an appropriate that that resident can effectively isolate, and other residents will not violate that residents quarantine.

3. All patients/residents in the facility shall receive a respiratory evaluation every 8 hours. This evaluation will include lung sounds, pulse ox, temperatures and respiratory rate.

4. Patients/residents from any one of the four (4) nursing units who become symptomatic shall be moved to A Unit in a designated room.

5. Nursing Unit A will be designated for positive COVID-19 patients/residents. Rooms A118 through A123 shall be utilized for COVID patients/residents. If necessary the following rooms shall expand to include rooms from A113 through A128 as necessary. New Admissions and re-admissions (defined as unknown) unless determined otherwise as noted in #2 above, shall utilize rooms A113 to A117 and A124 to A128.

6. Dedicated staff who are assigned to one of the four (4) nursing units shall float only as necessary to achieve optimal staffing ratio.
    - Staff assigned on Unit A and B will float between these units only as necessary.
        i. To limit exposure Staff on A Unit assigned to positive COVID-19 and those Isolated Unknown patients/residents will not be assigned to negative and/or non-symptomatic patients/residents on this Unit.
    - Staff assigned on Unit C and D will float between these units only as necessary.

REVISION DATE SUMMARY:
5/15/20

Attachment 10

Niagara Lutheran Health System and Affiliates		Program Application:
Section: Administration	Policy #	NLHS GHRC √ GC GM NLHF GT
Issue Date: 4/2020	Revision Date:	
Prepared By: Administrator		
Approved By: Executive Management Team	Approval Date: 4/2020	
Policy Subject: **Social Distancing of Patients/Residents**	Page 1 of 1	

POLICY:
It shall be the policy of the facility to identify specific guidelines to maintain safe environmental distancing of patients/residents during the COVID-19 Pandemic.

PURPOSE:
To eliminate and/or limit potential exposure of the COVID-19 virus.

PROCEDURE:

1. Activities will be provided in groups of 10 or less residents/patients.
2. Residents/patients travel will be limited to their nursing unit.
3. Meal trays will be provided in the patient/resident rooms where applicable.
4. Those residents requiring assistance and/or supervision with meals will continue to utilize dining rooms at tables arranged to provide distancing.
5. Excess couchs/chairs were removed from common areas on patient/resident units to enable applicable social distancing. Colored tape was placed on carpets in common areas to indicate safe placement of furniture and wheelchairs.
6. Signs are posted on each nursing unit reminding both patients/residents and staff to practice safe distancing.
7. Visitation restricted with the exception of End of Life care and the resident is eminently dying.

REVISION DATE SUMMARY:

Attachment 11

Niagara Lutheran Health System and Affiliates		Program Application:
Section: Housekeeping/Laundry	Policy #	NLHS GHRC √ GC GM NLHF GT
Issue Date: 10/1998	Revision Date: 10/1998, 12/1999, 2/2018	
Prepared By: Director of Housekeeping/Laundry		
Approved By: Quality Assurance Committee	Approval Date: 2/2018	
Policy Subject: **Handling of Regulated Medical Waste**	Page 1 of 2	

POLICY:

It is the policy of the facility to collect all regulated medical waste twice as needed.

EQUIPMENT:

1. Red plastic liners labeled "Regulated Medical Waste"
2. One Sheet
3. Disposable rubber gloves
4. Paper towels
5. Trash hamper cart
6. Identification labels
7. Shipping carton labeled "Regulated Medical Waste"
8. Carton sealing tape
9. Large red plastic liner for shipping carton
10. Key for Regulated Medical Waste storage shed

PROCEDURE:

Protective Equipment Instructions: Tasks performing this procedure may involve exposure to the AIDS and Hepatitis B viruses through contact with blood or body fluids that contain visible blood. Use of barrier proof gown, disposable gloves and face mask are needed. Should you splash blood or body fluids that contain visible blood into your eyes or mouth, or should you spill blood or body fluids that contain visible blood on your skin where there is a cut, wound, chapped skin or a skin rash, wash the area immediately and report the incident to your Supervisor as soon as possible.

1. Transport trash hamper cart to Resident's room to pick up medical waste or soiled utility room.
2. Put on gloves.
3. Remove sheet cover from hamper cart. Tie the red bag and place in cart and recover. Reline can or barrel.
4. Remove gloves. Wash hands.
5. Transport to medical waste room.
6. Unlock door.
7. Put on gloves.
8. Put GHRC stickers on bed.
9. Place in carton lined with red bag.
10. If carton is not already constructed, fold and tape bottom of carton.
11. Place tracking label on carton.
12. Place red bag with GHRC in carton to line it.
13. When carton is full, seal with tape.
14. Remove gloves.
15. Wash hands.
16. Push hamper to cart wash room.
17. Wash out hamper cart.

POINTS TO REMEMBER:

1. Use only red plastic liners in the Regulated Medical Waste containers and the shipping cartons.
2. **DO NOT** use red plastic liners in any other containers or for any other trash.
3. **DO NOT** place any red liners in the dumpster.
4. When closing any of the liners, DO NOT stand so that the air from the bag will blow up into your face.
5. If the Regulated Medical Waste container becomes full and needs to be emptied before the scheduled time, the affected floor will notify the Supervisor who will change it.
6. Be sure that the storage shed is locked when you are finished in there.

REVISION DATE SUMMARY:

10/1998
12/1999
2/2018

Attachment 12

Niagara Lutheran Health System and Affiliates		Program Application: NLHS NLHRC GHRC √ GC GM NLHF GT
Policy Manual: Nursing	Prepared by: Director of Nursing	
Latest Revision Date: 03/20	Supersedes:	
Approved By: Executive Management Team	Approval Date: 5/2020	
Subject: Emergency Med Pass Policy	Page 1 of 2	

STANDARD:

Greenfield Health and Rehabilitation Center will ensure that all essential medications will be provided in a timely manner pursuant to the patient/residents plan of care and best practice guidelines.

POLICY:

During critical staffing levels the nursing supervisor will contact the director of nursing and/or medical director to determine if staffing meets the criteria for essential med pass only. Medications considered non-essential can be held per the guidelines listed below.

This is a list of medicines where timeliness of administration is crucial to minimize harm for patients. Every effort should be made to avoid omitted and delayed doses of essential medicines. Staff must follow facility procedures for obtaining supply and escalating to medical staff should an omission or delay occur.

PROCEDURE:

Non-essential medications are: (Multi)Vitamins, Supplements, Minerals/Electrolytes Over the counter medications, Contraceptives, Antihistamines, Nutrients, Diagnostic Meds, Antiemetics, Antihyperlipidemics, Cough/Cold/Allergy, GI Agents, Gout, Mouth/Throat/ Nasal Agents, Urinary Antispasmodics, Probiotics. PLEASE Mark Meds as HELD in PCC.

Treatments – CNA's may apply the following with instruction for the location and amount: Barrier Creams, Skin Prep, Muscle Rub, Lotions, Antifungal-Powders

Essential Medications: Drug name/class	Examples of medicines / additional information
Anticholinesterases	e.g. pyridostigmine / neostigmine
Anticoagulants	Enoxaparin, Warfarin, Phenindione, Acenocoumarol, Fondaparinux, Apixaban, Rivaroxaban, Dabigatran, Edoxaban
Antiepileptics /Anticonvulsants	Carbamazepine, Clobazam, Clonazepam, Gabapentin, Lamotrigine, Levetiracetam, Midazolam, Phenobarbitone,

	Phenytoin, Pregabalin, Retigabine, Sodium Valproate, Tiagabine, Topiramate, Vigabatrin
Anti-infectives	Co-amoxiclav,Amoxicillin, Trimethorpim, Nitrofurantoin, Cefalexin,Doxycycline
Antiplatelets & thrombolytics for ACS/stroke	Aspirin, Clopidogrel, Ticagrelor, Prasugrel,
Anti - virals	Aciclovir
Bronchodilators	In-halers, nebulizers, Salbutamol, Ipratropium
Cardiac Medications	Anti-hypertensives, Beta-Blockers, Anti-anginals,
Chemotherapy & associated therapies	Antiemetics, steroids and oral chemotherapy agents
Clozapine	A patient must NOT miss more than 48 hours of Clozapine doses. If a treatment break of more than 48 hours has occurred, re-titration with lower doses is required –Seek guidance from GP
Corticosteroids	Prednisolone, Hydrocortisone, Methylprednisolone, Dexamethasone, Fludrocortisone, Budesonide,
Desmopressin (DDAVP)	Risk of profound dehydration and hypernatraemia if doses missed
End of Life Medications	Hadol, Ativitan, Morphine/Roxinol
Immunosuppressants	Azathioprine, Ciclosporin, Mycophenolate, Tacrolimus
Insulin & other hypoglycaemic agents	Metformin, Gliclazide, Pioglitazone, Exenatide, Saxagliptin, Liraglutide, Lixisenatide, Canagliflozin, Dapagliflozin
Neuromuscular agents	Pyridostigmine, Baclofen
Opioid analgesics	Morphine, Oxycodone, Buprenorphine, Fentanyl
Parkinson's Disease medication	Amantadine, Co-beneldopa (Madopar), Co-careldopa (Sinemet), Entacapone, Stalevo/Sastravi/Stanek, Ropinirole, Rotigotine, Apomorphine, Pramipexole,

Attachment 13

Niagara Lutheran Health System and Affiliates		Program Application:
Policy Manual: Nursing	Prepared by: Administrator	NLHS ✓
Latest Revision Date: 03/30/2020	Supersedes:	GHRC ✓
Approved By: Executive Management Team	Approval Date: 03/05/2020	GC ✓
Subject: **COVID-19**	Page 1 of 4	GM ✓
		GT ✓
		NLHF ✓

POLICY:

COVID-19 is the abbreviated name for novel Coronavirus Disease 2019 that first emerged in Wuhan, Hubei Province, China. Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person.

Symptoms may appear as soon as 2 days and as long as 14 days after exposure. Symptoms include fever, dry cough, and shortness of breath. Other symptoms include nasal congestion, runny nose, sore throat or diarrhea. These symptoms are usually mild and begin gradually. Some people who are infected may remain asymptomatic. Up to 80% of infected people recover without any need to seek care, and some will develop severe illness (typically in the second week of illness). Just as with influenza and other viral infections, older adults and patients with comorbid conditions are at increased risk for more severe illness.

Transmission: COVID-19 is spread from person-to-person by respiratory droplets between people 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. At present, COVID-19 is not felt to be spread through airborne transmission such as seen with tuberculosis or measles.

PURPOSE:

To increase awareness to symptoms, progression, treatment and prevention of COVID-19 in the LTC setting. To decrease the spread of viruses through standard, contact, and droplet precautions with eye protection as necessary.

PROCEDURE:

INTERIM RECOMMENDATIONS FOR POST-ACUTE & LONG-TERM CARE FACILITIES
Who Should Be Evaluated As A Suspected Case: Currently, people returning from sites where there is ongoing person-to-person transmission of COVID-19, or who have been in close contact with individuals known to be infected with COVID-19 are at greatest risk for COVID-19. Such individuals have been part of the CDC's case definition used to determine when to evaluate individuals for COVID-19. The CDC also recommends individuals with fever and severe lower respiratory failure requiring hospitalization without an alternative diagnosis to be considered at risk individuals.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.

The CDC may further expand guidance on who to test and under what circumstances.

- Facility will use the CDC definitions to guide whether an individual should be evaluated for COVID-19.
- Facility will regularly monitor the CDC website for updates to the case definition.
- At present, given the rare presence of COVID-19 in the community, healthcare personnel suspecting a case of COVID-19 in the Facility will contact their local and/or state public health department for guidance on management.
- At present and under an abundance of caution, Facility will follow the CDC recommendation that healthcare facilities use **Standard Precautions, Contact Precautions, Droplet Precautions, and Eye Protection.**
- Frequent and thorough hand hygiene should be practiced at all times.
- If an individual meets the CDC case definition of a suspected case, the individual will be discharged to the acute care setting.

Reducing The Risk Of Introducing COVID-19 In Your Post-Acute & Long-Term Care Facility:
Surveillance: Active monitoring and surveillance are important to early detection and recognition of potential outbreaks of all infectious illnesses in long-term care settings. Facility will monitor residents for signs and symptoms of respiratory symptoms, and potential exposure to COVID-19 as described by the CDC.

Employees: Because healthcare personnel reside in the community and work in facilities, they have the potential to introduce infections into the LTC populations. As with all situations, healthcare personnel who are ill are encouraged to stay home and seek healthcare advice through their regular provider. Those with mild symptoms are encouraged to call, rather than going in person, for medical advice. Employees will follow all HIPAA compliance as well as Crisis Communication protocol for all external communication.

Visitors: If there is evidence of community-wide COVID-19 illness, Facility will determine if visitor restrictions should be put in place.

- Signs will be posted requesting that people with acute respiratory illness and/or (regardless of illness presence) known exposure to someone with a COVID-19, or if you have recently traveled to areas with COVID-19 transmission, please refrain from entering the facility.

Facility may:

- Call your State and/or Local Health Department (for testing and guidance).
- Institute social distancing, including suspending group activities including dining and other social events.
- Enforce consistent staff, in which staff are assigned to the same unit or hallway on a consistent basis.
- Monitor temperature and symptom for residents and staff.
- Furlough staff with respiratory symptoms.
- Request HR assist in labor pool if insufficient staff becomes an issue.

Admitting New Residents with COVID-19:

- Facility will accept residents recovering from COVID-19 only after consultation with the local and/or state health department and referring facility, Medical Director and Admissions Coordinator.
- Facility will be familiar with current CDC recommendations regarding cessation of transmission based precautions for individuals with COVID-19 before a decision regarding Admission is made.

Procedural reminders for Patients/Residents with a confirmed or suspected case of Covid-19:

- The patient/residents with confirmed/suspected Covid-19 will be housed on the A-wing new addition rooms.
- They must be placed on both droplet and contact precautions and this is to be maintained for at least 14 days from the onset of symptoms.
- Any staff entering the room should use:
    - an N95 mask with a face shield mask over the top
    - If an N95 is unavailable they should wear a face shield mask over a standard surgical mask.
    - Gloves, Face shield and Gowns must be worn the entire time the staff members are in the patient/residents room.
    - Infection Control Procedures are to be followed regarding hand washing/hygiene and cleansing of shared medical equipment.
- The patient/resident will be placed in a private room or in a semi-private room as the single occupant if no private rooms are available.
- The precautions cart will be maintained outside of the room with all necessary equipment:
    - Gloves, Gowns, Caps, Hand sanitizer, Micro Killz bleach wipes, a disposable stethoscope, blood pressure cuff, and temp-a-dot thermometers.
    - If the vitals items are unavailable and a re-usable item must be used that item must be cleansed with a micro killz bleach wipe upon exiting the room.
- The staff entering that room will be limited to only those that are required for care.
- Medication pass times will be consolidated as much as possible, and attempt to do all needed tasks in one trip (ie: assist with toileting, provide medications, and complete daily assessment in one trip rather than three)
- We will utilize the same therapist for any other suspected/confirmed covid patients- the therapy items needed for those patients will be kept on a separate cart in the wing identified for the patients and will be cleansed with Mircro Killz bleach wipes between each use.
- If the patient/residents needs to leave the room for any reason they need to wear a mask at all times in the common areas and be at least 3 feet away from all other patient/residents
- Housekeeping to utilize all necessary precautions while cleaning the room, at minimum a 10% sodium hypochlorite solution must be utilized in the cleaning of contaminated rooms.

- Laundry may be delivered to the nurse's station and delivered by nursing staff upon their next visit to the room.
- At meal times, those patients will receive their meals on disposable products for the duration of their isolation precautions.

COVID-19 is an evolving situation. Clinicians should use their judgment and consult with public health authorities. Please check websites from the CDC and State/Local Health Departments frequently for updated information.
https://www.cdc.gov/coronavirus/2019-nCoV/index.html

*Long Term Care Respiratory Surveillance Line List (accessed 2/28/20)
https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf

Parent site for the above pdf: https://www.cdc.gov/longtermcare/training.html

**Pandemic Influenza Planning Checklist for Long-Term Care and Other Residential Facilities (accessed 2/28/20)
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwidt6yDt_TnAhVQlnIEHZS5CWAQFjAAegQIAxAB&url=https%3A%2F%2Fwww.cdc.gov%2Fflu%2Fpandemic-resources%2Fpdf%2Flongtermcare.pdf&usg=AOvVaw0p1OLgVLgQVps5lquyRx9K

STAFF WELLNESS/SYMPTOM MONITORING PROCESS

Look at the call-in book each day and if someone calls in with symptoms of COVID, the Safety Manager gives them a call to see what's going on. From there we determine if we need to keep the employee out and have them test, or if they can come back to work.

If suspected positive, or positive, we require a negative test in order for the employee to return to work.

Asymptomatic Employees:

- Asymptomatic employees who have been in contact with a suspected or confirmed positive case will **not** be sent home by the facility.
    - Such employees must note this on the pre-screening questionnaire upon entering the facility.
    - If asymptomatic employees suddenly develop symptoms and have been in contact with a suspected or confirmed positive case, they will be immediately pulled from work, and sent for diagnostic testing. Such employees will be paid under NYS COVID Sick Leave until results are received.
        - Negative results must be received before such employees are permitted to return to work.

Suspected COVID-19 Employees:

- Employees who are a suspected case for COVID-19 due to the sudden onset of symptoms should be tested for COVID-19. Suspected employees should remain out of work until negative test results are received, and will be paid under NYS COVID Sick Leave.

Confirmed COVID-19 Employees:

- Employees who test positive for COVID-19 but remained **asymptomatic** are not eligible to return to work for 14 days from the first positive test date.
    - Such employees will be paid under NYS COVID Sick Leave until negative results are received.
    - If negative results are received after their first 14 days, the facility will use the employee's own benefit time.
    - If positive results are received, the employee will continue to be covered under NYS COVID Sick Leave until negative results are received.
        - Employees are eligible for a total of three, fourteen-day leaves under NYS.
- **Symptomatic** employees may not return to work until 14 days after the onset of symptoms, provided at least 3 days (72 hours) have passed since the resolution of fever without the use of fever-reducing medications, and respiratory symptoms are improving.
    - Such employees will be paid under NYS COVID Sick Leave until negative results are received.
    - If negative results are received after their first 14 days, the facility will use the employee's own benefit time.

- If positive results are received, the employee will continue to be covered under NYS COVID Sick Leave until negative results are received.
    - Employees are eligible for a total of three, fourteen-day leaves under NYS.

Attachment 13

Niagara Lutheran Health System and Affiliates		Program Application:
Section: Housekeeping/Laundry	Policy #	
Issue Date: 10/1998	Revision Date: 10/1998, 12/1999, 11/2016, 5/2019	NLHS GHRC √ GC GM NLHF GT
Prepared By: Director of Housekeeping/Laundry		
Approved By: Quality Assurance Committee	Approval Date: 5/2019	
Policy Subject: **Isolation Room Cleaning (Terminal) Procedures**	Page 1 of 2	

STANDARD:

To provide clean, antiseptic resident room when a resident is discharged, transferred or removed from isolation status.

POLICY:

The Director of Housekeeping and her/his designee are charged with administration of this policy.

PROCEDURE:

Protective Equipment Instructions: *Tasks performing this procedure may involve exposure to the AIDS and Hepatitis B viruses through contact with blood or body fluids that contain visible blood. Use of barrier proof gown, disposable gloves and face mask are needed. Should you splash blood or body fluids that contain visible blood into your eyes or mouth, or should you spill blood or body fluids that contain visible blood on your skin where there is a cut, wound, chapped skin or a skin rash, wash the area immediately and report the incident to your Supervisor as soon as possible.*

A. Materials Required

1. Janitorial cart with supplies
2. Mop bucket with germicidal solution and Wringer
3. Wet mop
4. Pail
5. Gloves
6. Bleach Wipes.

B. Procedure

1. Put on protective clothing - gown, mask.
2. Take down cubicle curtain, place in plastic liner and send to Laundry to be washed.
3. Empty all trash containers and place in Medical Waste Container.
4. Wash and wipe with Bleach Wipes mattresses, pillows and beds.
5. Wash and wipe with Bleach Wipes all surfaces, furniture and fixtures in the room and bathroom.
6. Scrub bathroom floor, fixtures, walls and restock supplies.
7. Wash your hands.

C. Clean Up

1. Clean all cleaning equipment with germicidal solution.
2. Leave room, taking all equipment with you.
3. Remove protective clothing.
4. Deposit trash and linens in proper receptacles.
5. Wash hands.
6. Store equipment properly.

REVISION DATE SUMMARY:

10/1998
12/1999
11/2016
5/2019

Infectious Disease/Pandemic Emergency Checklist

- **Staff education on infectious diseases is an ongoing process in regards to all contagious diseases and how to stop the spread of infection. With the start of the COVID-19, staff was educated on what this virus was, how to stop the spread of this disease, hand washing/hand sanitizing, not cohorting residents (See attached Policy and Procedure on Cohorting of Residents), social distancing (See attached Policy and Procedure) and the proper use of PPE. Attached are multiple educations from March – current. Staff is still being continuously re-educated on proper use of PPE, how to carry laundry, social distancing with themselves as well as the residents. Staff has been educated as to the symptoms of COVID-19 so as to not only detect this in the residents but with them as well. (See attached Policy and Procedure on COVID-19; Coronavirus and Appendixes on Infection Control Inservices). This building has implemented a cleaning policy to be done in the AM and PM on all units. Each department has their own action plan as to what their role is in maintaining a cleaning log to reduce the spread of COVID-19.**

10NYCRR 415.3(i)3(iii)

415.19

Infection Control – According to this section, this facility maintains an infection control program which helps to prevent the development and transmission of disease and infection. It is held by an Infection Control Nurse who is considered to be the Infection Control Preventionist in the building. She/he determines the type of precautions needed for a patient(s) to prevent the spread of disease. The facility, in following infection protocols, maintains sufficient PPE to protect facility personnel for at least a 60 day period.

415.26

Organization and Administration -

42 CFR 483.15(e)

Admission, Transfer and Discharge Rights – Permitting residents to return to facility

42CFR 483.80

Infection Control – This facility electronically reports confirmed and suspected COVID-19 residents and staff daily, total deaths of residents and staff, how much PPE is in the facility, resident beds and census, access to COVID-19 testing and staffing shortages.

This facility calls all family members or has cognitive residents informed when there is a positive COVID-19 case either with a resident or staff member within 24 hours.

This facility keeps current to any new policies and procedures as set out by the Governor of NY and/or the NYSDOH in regards to changes with infection prevention and control of infection and reporting policies. COVID-19 binder has been developed for reference of the most current policies enacted by the NYSDOH.

- This facility maintains the highest standard of infection control through QA meetings that monitor infectious trends in the building on a monthly basis. The infection control nurse monitors daily any infections to assess for a trend or an outbreak in an area of the building. The infection control nurse keeps current with any changes in policies, procedures and reporting guidelines, per the NYSDOH, in order to reduce infection and increase control of infection and makes necessary changes to our infection control policies. Education is provided to staff on any new changes to policies or procedures. QA meetings are established at any time to review policies on infection control or discuss areas of concern regarding infection control that require improvement. Infection outbreaks are surveyed and reported to the NYSDOH immediately. (See attached Policy and Procedure for Classification of Infection/Infection Criteria; Precautions Room Procedure)

- This facility maintains a Surveillance Line Listing for Resident's with Suspected COVID-19 on each unit. This binder includes the date, room number, name of resident, symptoms, interventions, COVID-19 TEST, hospitalized and resolution date. This is a tracking tool that we use to monitor residents who start with any respiratory symptoms to assess their progression and interventions. They are put on a 24 hour report, in which each shift will then follow this resident until they are resolved or COVID is determined to be detected through testing. This Surveillance Line List also allows for us to determine if their starts to become an outbreak in an area within a unit in the building. Residents are tested individually, per physician order, or as an entire building if deemed necessary due to an outbreak in the building. A continuing testing of residents will continue every 3-7 days until all residents test negative for 14 consistent days. By testing our residents every 3-7 days during an outbreak, it allows for an immediate identification of COVID-19 positive residents so that we may isolate them quickly in order to lessen the spread of the COVID-19 virus.

- Staff is monitored daily when they enter the premises with their temperature being taken and monitoring for any other respiratory symptoms that would put both residents and staff at risk. Staff, weekly, receives a throat culture to determine if the presence of COVID is detected. This is conducted by trained nursing staff and starts on a Sunday and ends on a Saturday for one week. KSL, in Amherst, N.Y., currently tests both our staff and our residents for the COVID-19 virus. A courier picks up the tests every night, except on weekends, and usually has results within 3 days of receiving these tests. If a staff member is detected with the COVID-19 virus, then they are immediately taken off of work for 14 days and until they test negative. During a

staffing shortage, it is allowed that they may return in less than 14 days if they have tested negative and they have been asymptomatic for 3 days with no medical interventions.

- **This facility has designated that the Administrator reports the HERDS report daily by 1:00 p.m. on the Health Commerce System and the Director of Nursing reports the NORA report. The Director of Nursing has access and the ability to report on the HERDS in the event the Administrator was unavailable. The Assistant Director of Nursing has the ability to report on the NORA report in the event that the Director of Nursing was unavailable.**