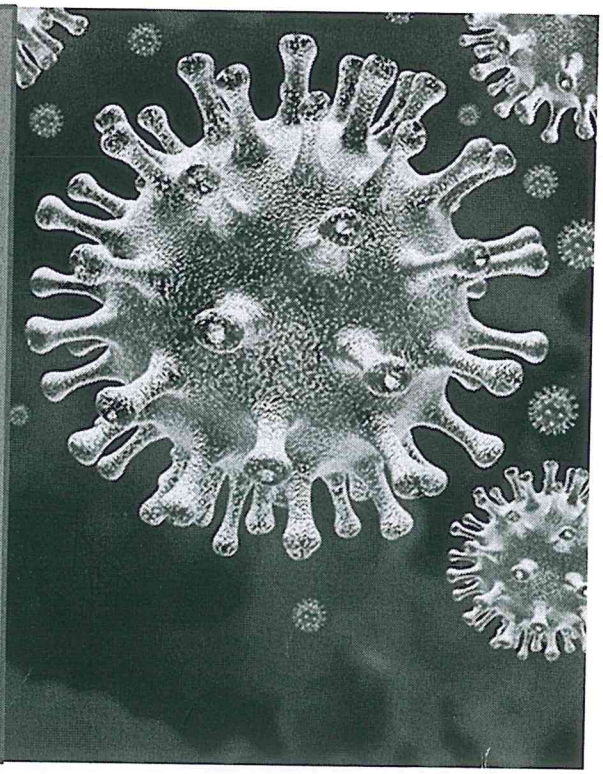
FIDDLER'S Green Manor Pandemic Emergency Plan 2020



FIDDLER'S GREEN MANOR

Comprehensive Emergency Management Plan Template

Part II – Template

2020

Fiddler's Green Manor
168 W Main Street
Springville NY14141

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.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

August 20, 2020

Re: DAL NH 20-09 Required Annual Pandemic Emergency Plan for All Nursing Homes

Dear Nursing Home Operators and Administrators:

On June 17, 2020, Governor Andrew M. Cuomo signed into Law Chapter 114 of the Laws of 2020 creating a new subdivision 12 to section 2803 of the Public Health Law. The new subdivision requires that each residential health care facility, by September 15, 2020, prepare and make available to the public on the facility's website, and immediately upon request, a Pandemic Emergency Plan (PEP).

This DAL explains the requirements for the PEP outlined in the statute and provides additional direction and guidance on how to implement its requirements. The Department will be issuing further guidance on a recommended form for the PEP. Generally, the PEP must include:

1. A communication plan that:
    a. Updates authorized family members and guardians of residents infected with the pandemic infectious disease at least once per day and upon a change in the resident's condition;
    b. Updates all residents and authorized family members and guardians once per week on the number of infections and deaths at the facility;
    c. A plan to provide all residents with daily access to free remote videoconferencing, or similar communication methods, with authorized family members and guardians; and
    d. Required communications must be by electronic means or other method selected by each family member or guardian
2. Infection Protection Plans for staff, residents and families, to include:
    a. A plan for readmission of residents to the facility after hospitalization for the pandemic infectious disease
        i. Such plan must comply with all other applicable State and federal laws and regulations, including but not limited to 10 NYCRR 415.19, 415.3(i)(3)(iii) and 415.26(i); and 42 CFR 483.15(e).
        ii. The facility's plan should also consider how to reduce transmission in the event there are only one or a few residents with the pandemic disease in a facility and corresponding plans for cohorting, including:

1. Use of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, such as at the end of a hallway;
2. Discontinue any sharing of a bathroom with residents outside the cohort;

3. Proper identification of the area for residents with the pandemic infectious disease, including demarcating reminders for healthcare personnel; and
4. Procedures for preventing other residents from entering the area. iii. Additionally, the plan should consider steps for facility administrators and operators to determine cohorting needs and capabilities on a regular basis, including establishing steps to notify regional Department of Health offices and local departments of health if the facility cannot set up cohort areas or can no longer sustain cohorting efforts.

b. Having personal protective equipment (PPE) in a two-month (60 day) supply at the facility or by a contract arrangement[1].
    i. Supply needs are based on facility census, not capacity, and should include considerations of space for storage. To determine supply needs during a pandemic episode, facilities should base such need on DOH existing guidance and regulations; in the absence of such guidance, facilities should consult the Center for Disease Control and Prevention (CDC) PPE burn rate calculator.. ii. Be cognizant of experience with prior pandemic response and adopt protocols outlined in guidance that are specific to the pathogen and illness circulating at the time of the pandemic, and plan to handle worst case scenarios without implementing shortage or other mitigation efforts. iii. This plan should address all personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents, current guidance on various supplies and strategies from the CDC. Supplies to be maintained include, but are not limited to:
        1. N95 respirators
        2. Face shield,
        3. Eye protection
        4. Gowns/isolation gowns,
        5. gloves,
        6. masks, and
        7. Sanitizer and disinfectants in accordance with current EPA Guidance.:

3. Plan for preserving a resident's place at the facility when the resident is hospitalized.

[1] Please also keep in mind that nursing home operators and administrators must also comply with emergency regulations effective July XX, 2020, setting forth PPE stockpile requirements.

a. Such plan must comply with all applicable State and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).

4. Compliance with the PEP
   a. Failure to comply is a violation of § 2803(12), which may subject the facility to penalties pursuant to PHL § 12 and § 12-b and other enforcement remedies.

5. Format for PEP
   a. The Department suggests that in developing the PEP document, the facility follow the format for the Emergency Preparedness plan you developed for the CMS Emergency Preparedness Rule. We suggest that the PEP be included as

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an annex to that plan. A format of an annex will be provided to you. It will be modeled after the templates distributed as part of the 2019 DOH Comprehensive Emergency Management Plan (CEMP)training to nursing homes on developing a PEP. Attached is information for taking an online version of the CEMP training as a refresher; or if you were unable to attend last year's live training sessions.

We will be using the CEMP for purposes of complying with the requirement and a webinar will be scheduled to explain how to incorporate the pandemic emergency plan in the CEMP. Any questions regarding this correspondence should be forwarded to nursinghomeinfo@health.ny.gov.

Thank you for your attention to this important issue affecting residents of nursing homes in New York State.

Sincerely,

Sheila McGarvey

Director
Division of Nursing Homes and ICF/IID Surveillance
Center for Health Care Quality and Surveillance

Calculator | Graphs | Instructions

This spreadsheet is designed to help you track how quickly PPE is being used at your fac

- To start, enter dates into Box A below Day 1, Day 2, Day 3, etc. You can enter the date fc
- Enter the total number of suspected and confirmed COVID-19 patients at the start of ea
A.
- At the start of each day, determine how many full boxes of PPE are remaining from the
- "Type of PPE" refers to the PPE components you have in stock. "Gowns," "gloves," "resp
Use the next column to fill in the size or brand, if applicable. You only need to fill this colu
blank. Examples of sizes/brands have been added for you, but you should modify these ce
can be added in the "Other" Type of PPE section as well.
- Make sure that each box of PPE has the same number of individual units (Example: a bo
"Type of PPE" category in the cells that says "Other".
- Enter the number of full boxes of each Type of PPE starting at Day 1 into the yellow cell
consecutive days of data are needed to calculate a consumption rate (Burn Rate).
- The total number of boxes of PPE used per day will be calculated in Box B. Note: This onl
-The average rate of PPE consumption (burn rate) will be calculated in the pink box (Box 1
the sum of all gowns).
- The average rate of PPE consumption (burn rate) per patient will be calculated in the pir
PPE (such as the sum of all gowns).
- The number of days' worth of remaining PPE will be calculated in Box C based on the ave
- The number of boxes of PPE used per patient per day will be calculated in Box D.
Note: if you receive a resupply of PPE, do not add it into the calculator, as it will disrupt th
Day 1. It is suggested you start a new calculator for the resupplied PPE.
- To skip a day, enter the data from the previous day. For example: If you know the numb
not the start of Day 2, you can insert the value from Day 1 into cell for Day 2 and the tool

Important: Add your data to Box A only. Do not enter data into any other cells.

How the calculator works:
In Box A, your PPE supply from the day prior is subtracted from the current day (Day2 -Da
consumption rate between each two day period is calculated. The total number of consur
the pink section (Box 1). Then the number of boxes of PPE entered in Box A is divided by t
in Box C. The boxes of PPE used per patient (Box D) are calculated by dividing the boxes o

Most cells in this worksheet are locked to prevent users from accidentally changing the fo
fit the needs of your facility, that can be done by unprotecting the worksheet. To unprote
also unprotect the sheet by going to the Review tab > Changes > Unprotect Sheet.

:ility.

)r Day 1 and drag that cell to the right to autopopulate future days.
ch day in the "Suspected and Confirmed COVID-19 Patients" row of Box

day before. Do this for each type of PPE and enter them into Box A.
irators," "surgical masks," and "face shields" have been filled in for you.
ımn in if you have multiple sizes or brands. Otherwise, leave these cells
ells according to your inventory. Note: Additional types or brands of PPE

x of gloves may have 200 individual gloves). If they do not, start a new

s of Box A. Note: You do not need data for all 14 days, but at least 2

ly works if you have entered values for at least Day 1 and Day 2 in Box A.
l) for each individual Type of PPE and by the total type of PPE (such as

ık box (Box 2) for each individual Type of PPE and by the total type of

erage consumption rate.

ıe calculations. Continue following the original supply of PPE entered in

)er of boxes remaining at the start of Day 1 and the start of Day 3, but
will still work.

ıy1) and entered in Box B. As additional data are added in Box A, the
ıption of PPE in Box B is used to calculate the average consumption in
:he consumption rate to calculate the number of days' supply remaining
f PPE used per day by the number of patients per day.

)rmulas. However, if you would like to modify the worksheet to better
:ct the sheet, go to File > Info > Protect > Unprotect Sheet or you can

Calculator | Graphs | Instructions

Box A		Day 1	Day 2	Day 3	Day 4
		XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020
		How Many COVID-19 Patients are Being Treated at Sta			
Number of Suspected and Confirmed COVID-19 Patients		20	20	28	26
Type of PPE	Size/Brand	How Many Full Boxes Are Remaining at Start of the Da			
Gowns	Size 1	500	475	400	350
	Size 2				
	Size 3				
Gloves	small				
	medium				
	large				
	extra large				
Respirators					
Surgical Masks					
Face Shields					
Other	1				
Other	2				
Other	3				
Other	4				
Other	5				

Box B					
			Total Number of Boxes Used per Day (Calculated)		
Type of PPE	Size/Brand		Day 1 -Day 2	Day 2 - Day 3	Day 3 - Day 4
Gowns	Size 1		**25**	**75**	**50**
	Size 2				
	Size 3				
Gloves	small				
	medium				
	large				
	extra large				
Respirators					

Surgical Masks					
Face Shields					
Other	1				
Other	2				
Other	3				
Other	4				
Other	5				

Box C		**Number of Days Supply Remaining (Calculated)**			
Type of PPE	**Size/Brand**	Day 1	Day 2	Day 3	Day 4
Gowns	Size 1	**10.00**	**9.50**	**8.00**	**7.00**
	Size 2				
	Size 3				
Gloves	small				
	medium				
	large				
	extra large				
Respirators					
Surgical Masks					
Face Shields					
Other	1				
Other	2				
Other	3				
Other	4				
Other	5				

Box D		**Boxes of PPE used per patient (Calculated)**			
Type of PPE	**Size/Brand**		Day 1 -Day 2	Day 2 - Day 3	Day 3 - Day 4
Gowns	Size 1		**1.25**	**2.68**	**1.92**
	Size 2				
	Size 3				
Gloves	small				
	medium				

Gloves	large				
	extra large				
Respirators					
Surgical Masks					
Face Shields					
Other	1				
Other	2				
Other	3				
Other	4				
Other	5				

Day 5	Day 6	Day 7	Day 8	Day 9
XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020
ırt of the Day? Enter Below.				
35	36	40	40	
ıy? Enter Below.				

Day 4 - Day 5	Day 5 - Day 6	Day 6 - Day 7	Day 7 - Day 8	Day 8 - Day 9

Day 5	Day 6	Day 7	Day 8	Day 9

Day 4 - Day 5	Day 5 - Day 6	Day 6 - Day 7	Day 7 - Day 8	Day 8 - Day 9

Day 10	Day 11	Day 12	Day 13	Day 14
XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020	XX/XX/2020

Day 9 - Day 10	Day 10 - Day 11	Day 11 - Day 12	Day 12 - Day 13	Day 13 - Day 14

Day 10	Day 11	Day 12	Day 13	Day 14

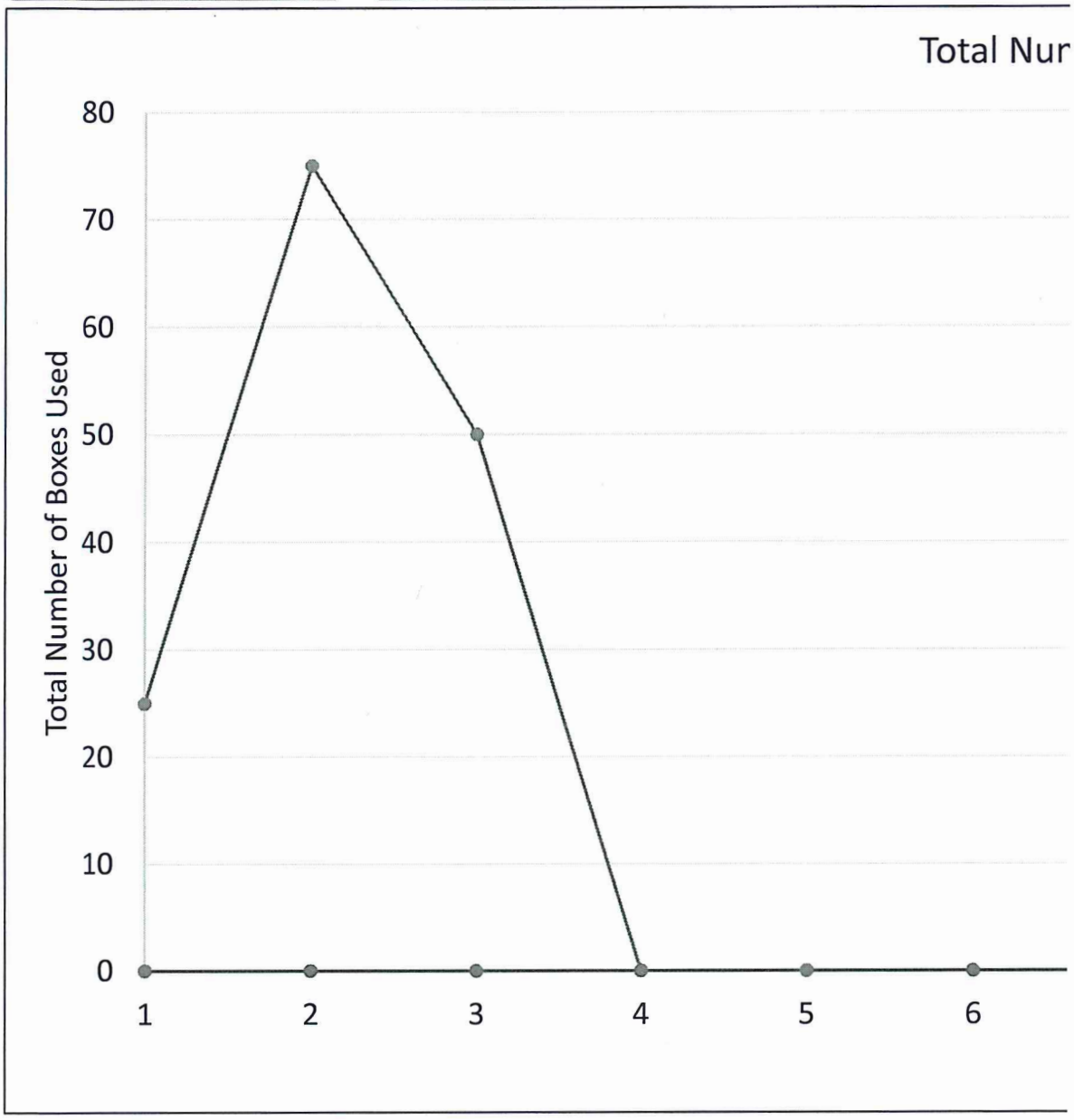
Day 9 - Day 10	Day 10 - Day 11	Day 11 - Day 12	Day 12 - Day 13	Day 13 - Day 14

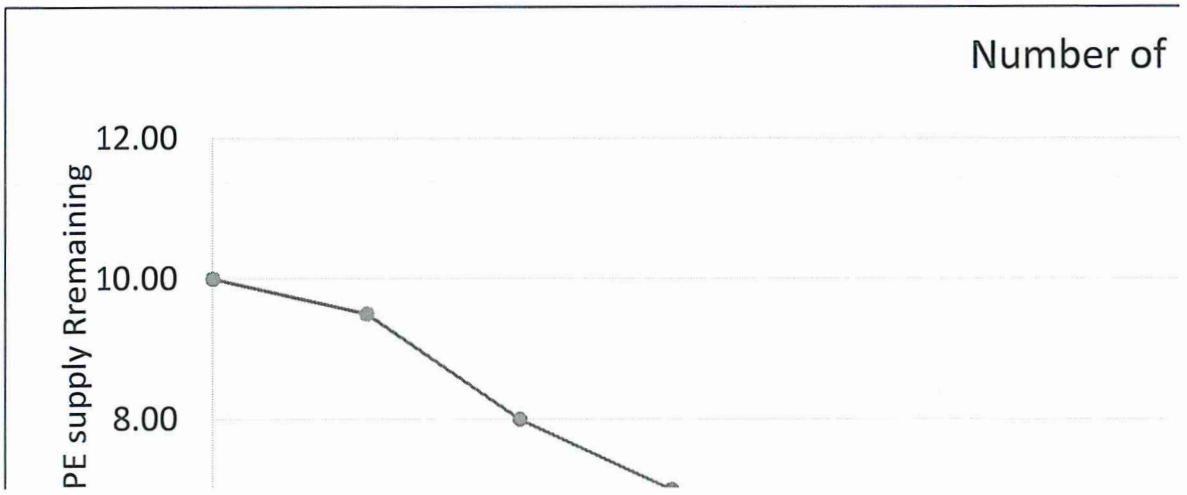
Box 1. Average Consumption of PPE in Boxes (Burn Rate) per Day			
Type of PPE	**Size/Brand**	Burn Rate (boxes/day)	(boxes/day)
Gowns	Size 1	**50.00**	**50.00**
	Size 2		
	Size 3		
Gloves	small		
	medium		
	large		
	extra large		
Respirators			
Surgical Masks			
Face Shields			
Other	1		
Other	2		
Other	3		
Other	4		
Other	5		

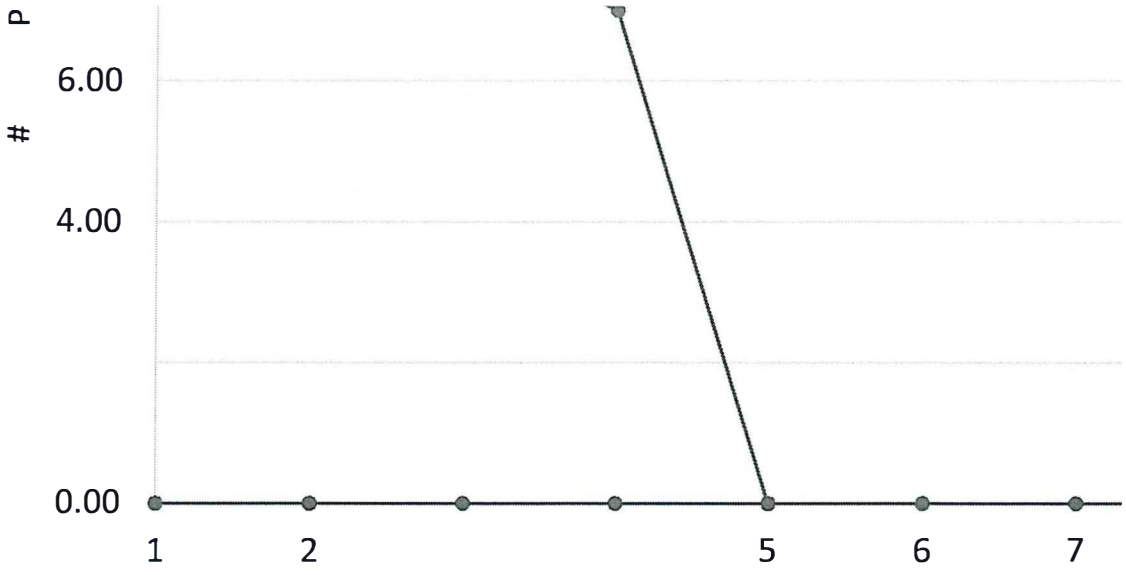
Box 2. Average Consumption of PPE in Boxes (Burn Ra		
Type of PPE	**Size/Brand**	Burn Rate (boxes/day/patient)
Gowns	Size 1	**1.95**
	Size 2	
	Size 3	
Gloves	small	
	medium	
	large	
	extra large	
Respirators		
Surgical Masks		
Face Shields		
Other	1	
Other	2	
Other	3	
Other	4	
Other	5	

te) per Day, per Patient
Burn Rate by Total Type of PPE (boxes/day/patient)
1.95

Calculator | Graphs | Instructions






#
6.00
4.00
0.00
1
2
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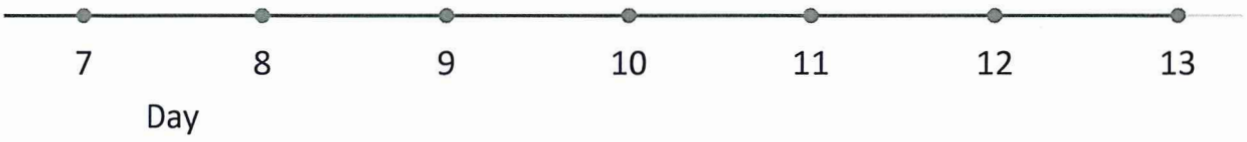
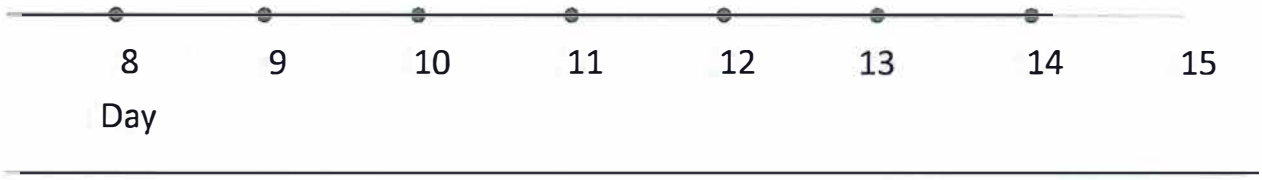
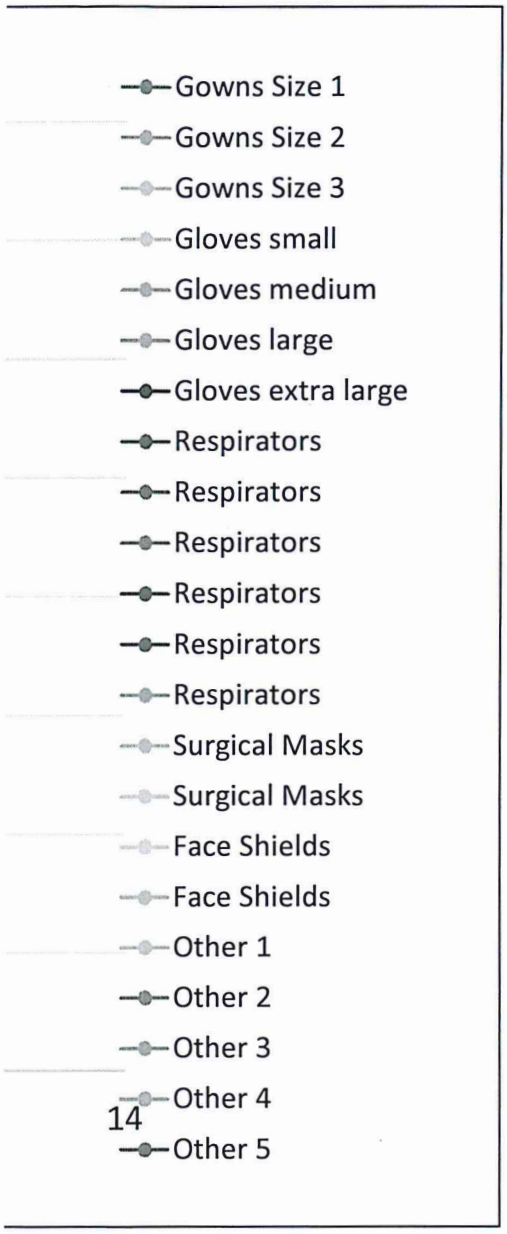
6
7

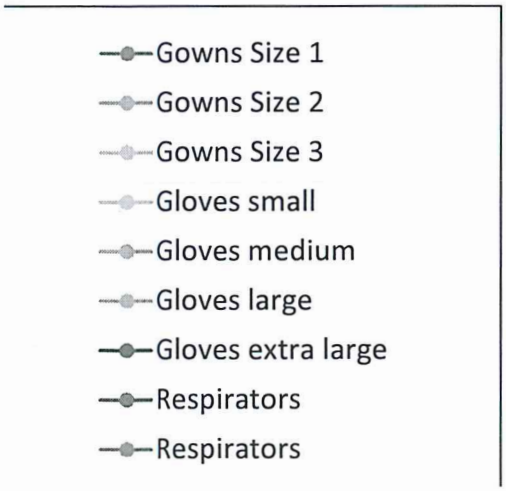
nber of Boxes Used per Day (Calculated)

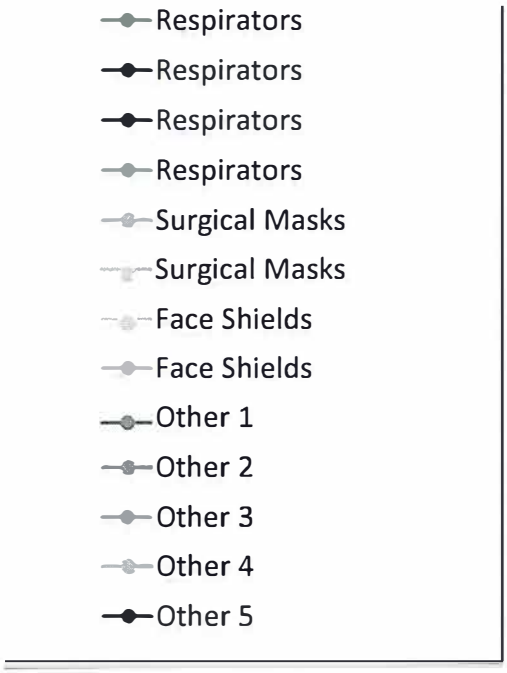


Days of PPE Supply Remaining (Calculated)


8
9
10
11
12
13
14
15
Day


Gowns Size 1
Gowns Size 2
Gowns Size 3
Gloves small
Gloves medium
Gloves large
Gloves extra large
Respirators
Respirators
Respirators
Respirators
Respirators
Respirators
Surgical Masks
Surgical Masks
Face Shields
Face Shields
Other 1
Other 2
Other 3
Other 4
Other 5


Gowns Size 1
Gowns Size 2
Gowns Size 3
Gloves small
Gloves medium
Gloves large
Gloves extra large
Respirators
Respirators


Respirators
Respirators
Respirators
Respirators
Surgical Masks
Surgical Masks
Face Shields
Face Shields
Other 1
Other 2
Other 3
Other 4
Other 5

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	405 W Main St Springville NY 14141 716-592-4487
Local Police Department	65 Franklin Street Springville NY 14141 716-592-3959
Emergency Medical Services	Bertrand Chaffee Hospital 224 E Main Street Springville NY 14141 716-592-2871
Fire Marshal	Fire Chief Mark Gentner 716-807-2219
Local Office of Emergency Management	Erie County OEM 3359 Broadway, Cheektowaga NY 14227 716-681-6070
NYSDOH Regional Office (Business Hours)[2]	Western Region Buffalo Office 584 Deleware Ave, Buffalo NY 14202-1295 716-847-4302
NYSDOH Duty Officer (Business Hours)	866-881-2809
New York State Watch Center (Warning Point) (Non-Business Hours)	518-292-2200

[2] 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:

Heather Morin
Fiddler's Green Manor Administrator

9/14/2020
[Date]

Wendy Egner / Fiddler's Green Director of Nursing

9/14/20
[Date]

Alan Boyd / Maintenance Director

9/14/20
Date

NEW YORK STATE OF OPPORTUNITY. Department of Health

Record of Changes

Table 2: Record of Changes

Version #	Implemented By	Revision Date	Description of Change
1.0	*Jane Doe, Director of Nursing*	*May 1, 2020*	*Updated Section XYZ to reflect legislative changes.*

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

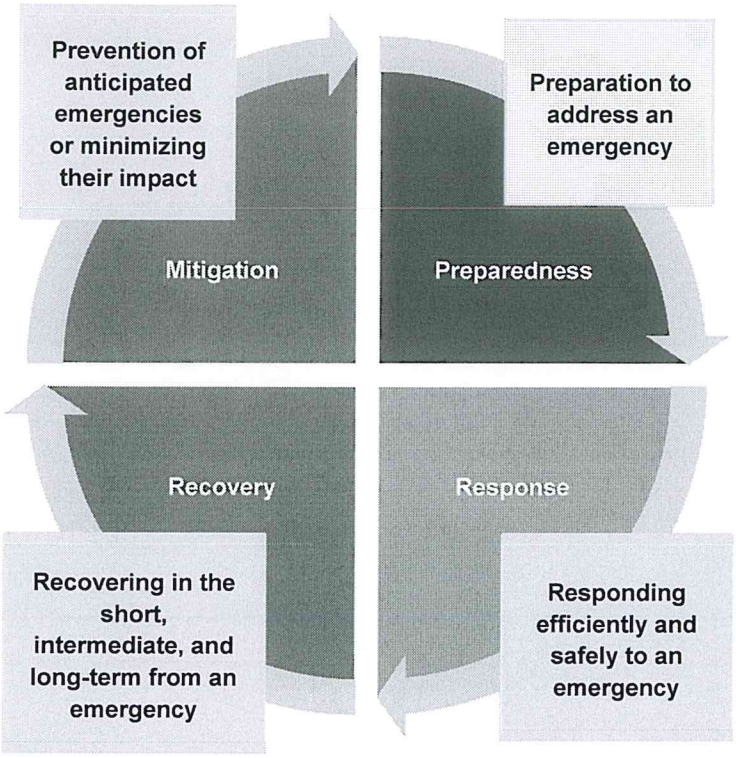
To protect the well-being of residents, staff, and visitors, the following all-hazards Comprehensive Emergency Management Plan (CEMP) has been developed and includes considerations necessary to satisfy the requirements for a Pandemic Emergency Plan (PEP). Appendix K of the CEMP has been adjusted to meet 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 predisaster collaboration with ***Mutual Aid, Fire Chief, Erie County OEM, NYSHFA***.

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.

Fiddler's Green Manor in conjunction with the Emergency Preparedness plan Utilize the Pandemic Emergency Plan.

1.4 Situation

1.4.1 Risk Assessment[3]

[3] 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

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 9/8/2020 and determined the following hazards may affect the facility's ability to maintain operations before, during, and after an incident:

- Fire
- Flood
- Bomb Threat
- Tornado
- Hurricane
- Severe Weather
- Power failure/ utility Disruption
- Work Place Violence / Security Threat
- Missing Resident
- Pandemic Episode
    - Infectious Disease / PEP Annex with specific actions related to that hazard

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

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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.[4]

For more information about the facility's fire prevention efforts (e.g., drills), safety inspections, and equipment testing, please refer to the Fiddler's Emergency Plan Binder / Code: Dr. RED / Fiddler's Green Manor Fire Policy and Procedures.

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.

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

Fire Safety Precautions

Policy Statement

Personnel will follow facility established fire safety precautions in order to provide safety to all concerned.

Policy Interpretation and Implementation

1. All frayed or worn electrical cords must be replaced immediately.
2. Electrical cords may not be run under carpet, rugs, over doors, etc.
3. Only **UL-approved** electrical extension cords shall be used to operate office equipment in administrative office areas.
4. Fuses must be of right amperage or wattage.
5. Circuits should not be overloaded.
6. Gasoline, benzene, etc., shall not be used inside. (Fumes will ignite from any spark.)
7. Paints, thinners, and other flammable liquids must be stored in separate areas away from resident living areas.
8. Flammable liquids must be stored in a locked metal cabinet.
9. Gasoline shall not be stored in the facility.
10. Rags soaked in oil, gasoline, etc., shall be placed in metal containers with self-closing cover devices and stored outside.
11. Chemicals, cleaners, etc., shall be stored as instructed on the containers.
12. All storage rooms shall be kept clean at all times, and only items permitted shall be stored.
13. All storage rooms must be properly ventilated.
14. Do not let trash accumulate.
15. Do not allow accumulation of papers, boxes, cloths, etc., in resident rooms.
16. Do not use open flame devices **during** or **after** a disaster. (Building must be inspected and cleared for possible gas leaks.)
17. Never go back inside a burning or damaged building until an all-clear has been given.
18. Never strike a match in a closed area (closets, etc.).
19. Do not position television sets where they cannot receive proper ventilation (bookshelves, etc.).
20. Attics and crawl spaces may not be used as storage areas.

continues on next page

21. Stay clear of fallen electrical wires.
22. Never touch an electrical appliance when you are wet.
23. Do not use defective equipment.
24. Use the proper equipment for job assignments.
25. Keep filters on heating systems, dryers, etc., free of lint.
26. Make sure heating/cooling system is checked, by authorized persons, before turning on such equipment.
27. All boilers, hot water heaters, etc., must have automatic pressure relief valves.
28. Keep exit ways clear at all times.
29. Do not run in smoke-filled rooms.
30. Keep low when going through smoke.
31. Do not open doors during evacuation until proper procedures are completed.
32. Smoke only in designated areas.
33. Do not put cigarettes in trash cans.
34. Use fire-retardant paints in facility.
35. Make sure fire extinguishers are in designated locations.
36. Make sure proper fire extinguisher is available.
37. Report all hazardous conditions and safety violations.
38. Do not allow smoking around oxygen.
39. "**No Smoking**" signs shall be visible where oxygen is stored or being administered.
40. Smoking, open flames, and spark-producing devices shall be prohibited in oxygen storage areas or in areas where oxygen is being administered. Oxygen cylinders shall not be stored with combustible gases or other flammable materials.
41. Store oxygen in clean, dry locations away from direct sunlight.
42. All oxygen cylinders must be tagged or properly labeled to indicate the contents of the cylinders. (i.e., full, half-full, empty, etc.).
43. Oxygen cylinders must be stored in racks with chains, sturdy portable carts, or approved stands. Oxygen cylinders should never be left free-standing. Oxygen cylinders shall not be stored in any resident room or living area.
44. Use plugs, caps and plastic bags to protect equipment not in use from dust and dirt.
45. Do not allow post valves, regulators, gauges, and fittings to come into contact with oils, greases, organic lubricants, rubber or any other combustible substance.

continues on next page

46. Ensure that any cleaning, repair or filling of oxygen equipment is performed by qualified, properly trained staff.

47. Designate special tools for work on oxygen equipment and label them "For Use with Oxygen Equipment Only." Tools used for oxygen equipment shall be kept free of grease, oil, etc.

48. Ensure that any components added to the regulator (e.g., gauge guards) are installed so that they do not block the regulator vent holes.

49. Oxygen cylinders shall not be dragged or slid across floors.

50. Avoid cross-treading or forcing cylinder regulators.

51. Oxygen cylinders not in use shall have the protective valve caps firmly attached.

52. Turn off oxygen cylinders when not in use.

53. Ensure that staff using oxygen equipment is adequately trained in its operation and in oxygen safety and has knowledge of the manufacturer's instructions for using the equipment.

54. Oxygen cylinders in use shall be on approved carts or stands, and must be attached to the residents' beds.

55. Visually inspect the post valve gasket and regulator inlet prior to installation. If they are not visually clean they should not be used.

56. Momentarily open and close (crack) the post valve to blow out debris prior to installing a regulator.

57. Ensure that the regulator is set with the flow knob in the off position before attaching it to the cylinder.

58. Position the equipment so that the valve is pointed away from the user and any other persons.

59. Open cylinder valve slowly and completely to minimize the heat produced and achieve the desired flow conditions within the equipment.

60. Do not look at the regulator pressure gauge until the cylinder valve is fully opened.

61. "**No Smoking**" signs must be prominently displayed at all times on oxygen cylinders in use.

62. "**No Smoking**" signs must be placed at the resident's bed and on the outside of the room door **before** connecting the oxygen supply.

63. "**No Smoking**" signs must be securely fastened so they do not to fall off and are not accidentally removed during oxygen use.

64. Only licensed nursing personnel may remove "**No Smoking**" signs from areas when oxygen administration has been discontinued.

65. No smoking rules must be strictly enforced while oxygen is in use.

66. Only approved electrical devices, such as telephones, call systems, battery-powered flashlights, radios, etc., shall be used in areas where oxygen is in use.

67. Any plug-in device shall be plugged into outlets located **away** from the site of oxygen administration **before** the oxygen is started.

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68. Oxygen supply must be turned off **before** any plug-in device is unplugged.

69. Lotions, oils, alcohol, or other flammable compounds shall be strictly **prohibited** from use on residents during oxygen use. All such materials must be removed from the area **before** the oxygen is started.

70. Report all violations immediately.

71. The Food and Drug Administration (FDA) has identified several factors that may increase the potential risk for fires from the spontaneous combustion in large quantities of patient examination gloves stored on pallets.

72. FDA recommends the following precautions when storing latex gloves:
    a. Store gloves in a cool and dry place.
    b. Avoid a large inventory of powder-free latex gloves.
    c. Break the stacked cartons on each pallet apart and restack or reconfigure cartons to facilitate cooling ventilation.
    d. Periodically check powder-free gloves for characteristics suggesting deterioration, such as brittleness, tackiness, or an acid chemical odor or stench.
    e. Rotate powder-free latex glove stock using a "first-in, first-out" practice.

73. Further, the FDA warns that if gloves exhibit any characteristics suggesting deterioration, they should not be used because it is doubtful they will provide an adequate protective barrier. If deterioration characteristics should be observed, the FDA also requests that you:
    a. Immediately break apart the stacks to dissipate the heat.
    b. Identify gloves as hazardous and quarantine or remove such gloves.
    c. Contact your local health department or local environmental agency regarding the proper disposal of these gloves as they are considered hazardous materials.

References	
OBRA Regulatory Reference Numbers	§483.70(a) Licensure.; §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards.; §483.70(c) Relationship to Other HHS Regulations.
Survey Tag Numbers	F836
Other References	
Related Documents	
Version	1.0 (H5MAPL1418)

Fire Safety and Prevention

Policy Statement

All personnel must learn methods of fire prevention and must report condition(s) that could result in a potential fire hazard.

Policy Interpretation and Implementation

1. Fire prevention is the responsibility of all personnel, residents, visitors, and the general public.

2. Whoever identifies a fire hazard, or other conditions that could develop into a fire hazard, must report the situation to the department director or Maintenance Director as soon as practical.

3. The following fire safety precautions must be followed in the facility at all times:

Electrical Precautions:

a. Replace all frayed or worn electrical cords immediately.
b. Do not run electrical cords under carpet or rugs, over doors, etc.
c. Use only UL-approved electrical extension cords to operate office equipment in administrative office areas.
d. Use only fuses of correct amperage or wattage.
e. Do not overload circuits.
f. Stay clear of fallen electrical wires.
g. Never touch an electrical appliance when you are wet.
h. Do not use defective equipment.
i. Use the proper equipment for job assignments.

Flammable Items:

a. Smoke only in designated areas.
b. Do not put cigarettes in trash cans.
c. Use fire-retardant paints in facility.
d. Do not use gasoline, benzene, etc., inside. (Fumes will ignite from any spark.)
e. Store paints, thinners, and other flammable liquids in separate areas away from resident living areas.
f. Store flammable liquids in a locked metal cabinet.
g. Do not store gasoline in the facility.
h. Place rags soaked in oil, gasoline, etc., in metal containers with self-closing cover devices and store outside.
i. Store chemicals, cleaners, etc., as instructed on the containers.

Accumulation of Trash:

a. Keep all storage rooms clean at all times, and store only permitted items.
b. Ventilate all storage rooms properly.
c. Do not let trash accumulate.
d. Do not allow accumulation of papers, boxes, cloths, etc., in resident rooms.
e. Do not use attics and crawl spaces as storage areas.

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Open Flames:

a. Do not use open flame devices **during** or **after** a disaster. (Building must be inspected and cleared for possible gas leaks.)
b. Never strike a match in a closed area (closets, etc.).

Overheating:

a. Do not position television sets where they cannot receive proper ventilation (bookshelves, etc.).
b. Keep filters on heating systems, dryers, etc., free of lint.
c. Ensure heating/cooling system is checked, by authorized persons, before turning on such equipment.
d. Ensure all boilers, hot water heaters, etc., have automatic pressure relief valves.

Oxygen Safety:

a. Do not allow smoking around oxygen.
b. Use visible "**No Smoking**" signs where oxygen is stored or being administered.
c. Prohibit smoking, open flames, and spark-producing devices in oxygen storage or administration areas. Do not store oxygen cylinders with combustible gases or other flammable materials.
d. Store oxygen in clean, dry locations away from direct sunlight.
e. Tag or properly label all oxygen cylinders to indicate the contents of the cylinders. (i.e., full, half-full, empty, etc.).
f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area.
g. Use plugs, caps and plastic bags to protect equipment not in use from dust and dirt.
h. Do not allow post valves, regulators, gauges, and fittings to come into contact with oils, greases, organic lubricants, rubber or any other combustible substance.
i. Ensure that any cleaning, repair or filling of oxygen equipment is performed by qualified, properly trained staff.
j. Designate special tools for work on oxygen equipment and label them "For Use with Oxygen Equipment Only." Keep tools used for oxygen equipment free of grease, oil, etc.
k. Ensure that any components added to the regulator (e.g., gauge guards) are installed so that they do not block the regulator vent holes.
l. Do not drag or slide oxygen cylinders across floors.
m. Avoid cross-treading or forcing cylinder regulators.
n. Ensure oxygen cylinders not in use have the protective valve caps firmly attached.
o. Turn off oxygen cylinders when not in use.
p. Ensure that staff using oxygen equipment is adequately trained in its operation and in oxygen safety and has knowledge of the manufacturer's instructions for using the equipment.
q. Ensure oxygen cylinders in use are on approved carts or stands, and are attached to the residents' beds.
r. Visually inspect the post valve gasket and regulator inlet prior to installation. Do not use if they are not visually clean.
s. Momentarily open and close (crack) the post valve to blow out debris prior to installing a regulator.
t. Ensure that the regulator is set with the flow knob in the off position before attaching it to the cylinder.
u. Position the equipment so that the valve is pointed away from the user and any other persons.
v. Open cylinder valve slowly and completely to minimize the heat produced and achieve the desired flow conditions within the equipment.
w. Do not look at the regulator pressure gauge until the cylinder valve is fully opened.
x. Use only approved electrical devices, such as telephones, call systems, battery-powered flashlights, radios, etc., in areas where oxygen is in use.
y. Plug any plug-in device into outlets located **away** from the site of oxygen administration **before** the oxygen is started.
z. Turn off oxygen supply **before** any plug-in device is unplugged.

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aa. **Do not** use lotions, oils, alcohol, or other flammable compounds on residents during oxygen use. Remove all such materials from the area **before** the oxygen is started.

Latex Glove Storage:

a. The Food and Drug Administration (FDA) has identified several factors that may increase the potential risk for fires from the spontaneous combustion in large quantities of patient examination gloves stored on pallets.
b. Store gloves in a cool and dry place.
c. Avoid a large inventory of powder-free latex gloves.
d. Break the stacked cartons on each pallet apart and restack or reconfigure cartons to facilitate cooling ventilation.
e. Periodically check powder-free gloves for characteristics suggesting deterioration, such as brittleness, tackiness, or an acid chemical odor or stench.
f. Rotate powder-free latex glove stock using a "first-in, first-out" practice.
g. Further, the FDA warns that if gloves exhibit any characteristics suggesting deterioration, they should not be used because it is doubtful they will provide an adequate protective barrier. If deterioration characteristics should be observed, the FDA also requests that you:
   (1) Immediately break apart the stacks to dissipate the heat.
   (2) Identify gloves as hazardous and quarantine or remove such gloves.
   (3) Contact your local health department or local environmental agency regarding the proper disposal of these gloves as they are considered hazardous materials.

4. All personnel must report observations of:
   a. Accumulation of trash and rubbish;
   b. Unusual odors or conditions;
   c. Smoking in unauthorized areas;
   d. Frayed or worn electrical cords;
   e. Malfunctioning equipment and supplies;
   f. Any unusual incidents;
   g. Sounding of false alarms; and
   h. Violation of fire safety rules.

5. The Safety Coordinator will be responsible for the prompt investigation of such condition(s). Hazardous conditions must be corrected as soon as practical. Appropriate departments, such as Building Engineers/Maintenance, etc., shall be responsible for the prompt correction of electrical, plumbing or structural hazards.

6. Any hazardous condition requiring more than twenty-four (24) hours to correct must be reported to the Administrator, in writing, outlining what corrections will be made, methods of correction, and when the hazardous condition is expected to be corrected.

7. The Safety Coordinator and Administration will identify and document any hazardous or explosive materials that are stored in locked areas. No one should store any hazardous or explosive materials in locked areas without the prior approval of the Safety Coordinator and management.

8. The facility will train personnel on fire prevention methods.

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References	
OBRA Regulatory Reference Numbers	§483.90(d) Space and Equipment; §483.70(a) Licensure.; §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards.; §483.70(c) Relationship to Other HHS Regulations.
Survey Tag Numbers	F907; F836
Other References	Life Safety Code (2015 Edition)
Related Documents	Alcohol-Based Hand Rub Dispensers, Installation and Use Location of Hazardous Chemicals
Version	1.2 (H5MAPL0325)

Fire Watch

Policy Statement

Fire watch procedures shall be promptly implemented if our facility's sprinkler or fire alarm system is out of service for more than four (4) hours in a twenty-four (24) hour period.

Policy Interpretation and Implementation

1. Our local fire department and state licensing agency will be notified at least twenty-four (24) hours in advance of any situation where it is foreseeable that our fire detection, suppression or protection system(s) will be completely or partially disabled for a period exceeding four or more hours in a twenty-four (24) hour period.
2. Our local fire department and state licensing agency shall be immediately notified when there is an unforeseen disablement (for a period of more than four (4) hours in a twenty-four (24) hour period) of our fire detection, suppression or protection system(s) and that our facility has implemented fire watch procedures.
3. Both the fire department and state licensing agency will be notified when our system(s) is restored and fully operational.
4. Fire watch procedures will not be lifted until the system(s) are fully operational.
5. Fire watch procedures have been developed in conjunction and coordination with our local fire department to ensure that the safety of our residents and personnel is protected.
6. All personnel will undergo training in our fire watch functions prior to being assigned fire watch duties.
7. Inquiries concerning our fire watch procedures should be directed to the Safety Coordinator or to the Administrator.

References	
OBRA Regulatory Reference Numbers	§483.90(d) Space and Equipment
Survey Tag Numbers	F907
Other References	Life Safety Code (2015 Edition)
Related Documents	Emergency Procedure – Fire Watch
Version	1.1 (H5MAPL0327)

THE R.A.C.E. ACRONYM AND FIRE EXTINGUISHER USE

If you are involved in a fire, remember R.A.C.E. to help you respond safely and correctly:

R = **RESCUE** anyone in immediate danger from the fire, if it does not endanger your life

A = **ALARM:** sound the alarm by calling "2600" (on-campus locations only) and activating a pull station alarm box

C = **CONFINE** the fire by closing all doors and windows

E = **EXTINGUISH** the fire with a fire extinguisher, or **EVACUATE** the area if the fire is too large for a fire extinguisher.

PROPER USE OF FIRE EXTINGUISHERS (P.A.S.S.)

To use fire extinguishers correctly, remember the P.A.S.S. acronym:

P = **PULL** the pin on the fire extinguisher

A = **AIM** the extinguisher nozzle at the base of the fire

S = **SQUEEZE** or press the handle

S = **SWEEP** from side to side until the fire appears to be out

10.3
FIRE DRILL POLICY

POLICY:

The facility shall implement a simulated fire drill at least once a month covering all three shifts in a quarter. Attention must be made to ensure that all three shifts are covered per quartr to remain code compliant. The drills shall be initiated by the coded announcement "Dr. RED the movement of residents is not required. The drills must be documented and contained in a three ring binder labeled "Fire Drills." The report shall contain the date, shift, persons assisting, the simulated situation, location, signatures of all persons participating, proper activation of fire doors, magnetic locks, and smoke/fire dampers.

RESPONSIBILITY:

The Administrator shall appoint a qualified employee to perform and train all staff on the Life Safety Concepts as well as Fire Plan. The Administrator's designee shall coordinate the organization, execution and documentation of all aspects of the exercise as well as the annual training and new hire in-service.

PROCEDURE:

1. Refer to 2.2 **Fire Plan**
2. Make the coded announcement to initiate the exercise or activate the alarm (day shift only).
3. Implementthe Fire Plan.
4. Verify and document the proper release of the fire doors, magnetic locks and smoke/fire dampers.
5. Reset the fire panel to reactivate the magnetic locks and door hold open devices (unless coded announcement was used).
6. Document the exercise and file it in the "Fire Drill" binder.

10.4
FIRE DRILL REPORT

Instructions: Check "yes" if conditions are satisfactory and check "no" if unsatisfactory.

Name of Staff Member Reporting: _____

Location of Fire, Drill or Malfunction: _____

Time of Fire Drill: _____

Date of Fire Drill: _____

Yes	No	
		Was the fire alarm heard?
		Was a Fire Alarm Pull, Box# _____Smoke Detector# Sprinkler System Location Activated
		Was there a patient room evacuation drill and patient moved to a safe place? _____
		Were all Fire and Exit doors closed?
		Were proper Fire ExtinQuishers taken to Fire area?
		Were all corridors and passageways leading to exits cleared?
		Were all on duty personnel at assigned stations and teleflhone covered?
		Did all Fire and Smoke Barrier Doors automatically close?

_____

_____

_____

_____

_____

_____

_____

_____

Signature

2.10
Fire Watch Log

Date: _____

	** *Identify facility-specific areas (i.e. front office, kitchen service area, resident care areas, etc.)*					
Time	**	**	**	**	**	**

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- 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.
- Communication Disruption or Loss – use of walkie talkies, wireless radio, and walking to local authorities

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).
- ***Additional Triggers For Fiddler's Green Manor to Activate plan include: External warning, Authority notification, Association Notification, Mutual Aid Alert, Government or Local NYSDOH alert, CDC acknowledgement, Local Fire and Police***

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** provides a comprehensive list of mandatory and recommended external notification recipients based on hazard type.

Table 4: Notification by Hazard Type

Notification Recipient

M = Mandatory
R = Recommended

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 / Pandemic	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	□	□	□	□	□
Local Emergency Management	R	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Local Law Enforcement		□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Local Fire/EMS		□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Local Health Department	R	□	□	□	□	□	□	□	□	□	□	M	□	□	□	□	□
Off Duty Staff		□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Relatives and Responsible Parties		□	□	□	□	□	□	□	□	□	□	M	□	□	□	□	□
Resource Vendors		□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Authority Having Jurisdiction		□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Regional Healthcare Facility Evacuation Center		□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Ownership and Managing Members Specific Jeff Goldstein, Sam Sherman and Mary Swartz																	

[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 **Western region/ Buffalo NY 716-847-4320** 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 518292-2200. 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	Administrator, Director of Nursing, Director of Maintenance, or off shift RN supervisor	Leads the response and activates and manages other Incident Management Team positions.
Public Information Officer	Managing Members, Administrator, Social Services Director	Provides information and updates to visitors, relatives and responsible parties, media, and external organizations.
Safety Officer	Maintenance Director, Emergency Response Coordinator,	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	[Example positions include Infection Control Practitioners, Registered Nurses, Licensed Nurses] **(FGM 9/2020- Wendy Egner DON, Back up-Alex Watson RN unit manager, Richard Cettell RN unit Manager)**	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	[Example positions include Director of Staff Development, Director of Nursing, Assistant Director of Nursing] **(FGM 9/2020- Wendy Egner DON)**	Collects and evaluates information to support decision-making and maintains incident documentation, including staffing plans.
Logistics Section Chief	[Example positions include Assistant Administrator, Admissions Director, Procurement Manager, Transportation Director] **(FGM 9/2020- Administrator- Heather Morin)**	Locates, distributes, and stores resources, arranges transportation, and makes alternate shelter arrangements with receiving facilities.
Finance/Admin Section Chief	[Example positions include Business Office Manager, Human Resource Director] **(FGM -9/2020- Cheryl Gilbert)**	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	[Heather Morin Administrator]	Wendy Egner DON	Alan Boyd Maintenance Director
Public Information Officer	Mary Swartz	Kate Wannemacher	Eric Wozniak Social Services
Safety Officer	Alan.Boyd Maintenance Director	Cheryl Gilbert Human Resources	Brittany Morretta Director of Rehab
Operations Section Chief	Wendy Egner DON	Alex Watson RN	Richard Cettell RN

Planning Section Chief	Wendy Egner DON	Alex Watson RN	Richard Cettell
Logistics Section Chief	Heather Morin Administrator	Wendy Egner DON	Alan Boyd Maintenance Director
Finance/Admin Section Chief	[Cheryl Gilbert Human Resources & BO manager	Kathy Sloand Director of Medical Records	Wendy Stifter

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 FGM Conference room (Basement) and the secondary/back-up location is Administrator's Office (Basement) 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 predisaster physical, mental, social, and economic conditions.

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

Table 7: Pre-Identified Recovery Services

Service	Description of Service	Point(s) of Contact
American Red Cross	Post Disaster Housing Assistance, Emergency Preparedness and Response Training, Blood Drives, Armed Forces Emergency Services, Smoke Alarms, Disaster Relief/Recovery Organizations, Post Disaster Food Services	Western New York Chapter 786 Delaware Avenue Buffalo, NY 14209 Phone: (716) 886-7500 **Fax**: (716) 878-2389 https://www.redcross.org/
Office of Public Health Emergency Preparedness (ERIE COUNTY)	Examples of services provided include: • Observation, assessment and maintenance of Individuals with minor health/medical conditions • Assistance with personal care or activities of daily living • Assistance obtaining , managing and administering	**Office of Public Health Emergency Preparedness** 95 Franklin Street, Room 931 Buffalo, New York 14202 Phone: 716-858-7101 Fax: 716-858-7121 https://www2.erie.gov

	administering medications (prescription and over-the-counter) • Assistance obtaining and utilizing durable medical equipment and medical supplies • Providing PPE	
SALVATION ARMY (ERIE COUNTY/Buffalo NY)	Emergency Feeding services, Emergency Shelter, Clothing, Spritual counseling and grief counseling	Salvation Army 960 Main Street Buffalo NY 14202 Phone: 716-883-9800, & 716-888-6206 Cell: 716-983-0621
FEMA	See FEMA Policy 104-010-04	NYS Region 2 https://www.fema.gov/locations/new-york

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:

FEMA

Coronavirus (COVID-19) Pandemic: Medical Care Costs Eligible for Public Assistance

FEMA Policy FP 104-010-04

BACKGROUND

Under the President's March 13, 2020 COVID-19 emergency declaration[1] and subsequent major disaster declarations for COVID-19, state, local, tribal, and territorial (SLTT) government entities and certain private non-profit (PNP) organizations are eligible to apply for assistance under the FEMA Public Assistance (PA) Program. This policy is applicable to eligible PA Applicants only and is exclusive to emergency and major disaster declarations for the COVID-19 pandemic.

PURPOSE

This policy defines the framework, policy details, and requirements for determining the eligibility of medical care costs under the PA Program to ensure consistent and appropriate implementation across all COVID-19 emergency and major disaster declarations. Except where specifically stated otherwise in this policy, assistance is subject to PA Program requirements as defined in Version 3.1 of the Public Assistance Program and Policy Guide (PAPPG).[2]

PRINCIPLES

A. FEMA will provide assistance for medical care provided under COVID-19 declarations to improve the abilities of communities to effectively respond to the COVID-19 Public Health Emergency.

B. FEMA will implement this policy and any assistance provided in a consistent manner through informed decision making and review of an Applicant's supporting documentation.

C. FEMA will engage with interagency partners, including the U.S. Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC), the Health Resources

[1] www.fema.gov/news-release/2020/03/13/covid-19-emergency-declaration.
[2] The current version of the Public Assistance Program and Policy Guide (PAPPG), Version 3.1, is available on the FEMA website at www.fema.gov/media-library/assets/documents/111781.

and Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS) to ensure this assistance is provided in a coordinated manner without duplicating assistance.

REQUIREMENTS

A. APPLICABILITY

Outcome: To establish the parameters of this policy and ensure it is implemented in a manner consistent with program authorities and appropriate to the needs of the COVID-19 Public Health Emergency.

1. This policy applies to:

    a. All Presidential emergency and major disaster declarations under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), as amended, issued for the COVID-19 Public Health Emergency.

    b. Eligible PA Applicants under the COVID-19 emergency declaration or any subsequent COVID-19 major disaster declaration, including:
        i. SLTT government entities; and
        ii. PNP organizations that own and/or operate medical facilities, as defined in Title 44 of the Code of Federal Regulations (44 C.F.R.) §206.221(e)(5).

    c. This policy does not apply to any other emergency or major disaster declaration.

B. GENERAL ELIGIBILITY CONSIDERATIONS FOR COVID-19 MEDICAL CARE

Outcome: To define the overarching framework for all eligible medical care work related to COVID-19 declarations.

1. All work must be necessary as a direct result of the emergency or major disaster in accordance with 44 C.F.R. §206.223(a)(1).

2. Medical care and associated costs refer to assistance to support the provision of medical care, including eligible facility, equipment, supplies, staffing, and wraparound services (as defined in the **Definitions** section at the end of this document), as well as assistance for clinical care of patients not covered by another funding source as described throughout this policy.

C. ELIGIBLE MEDICAL CARE WORK AND COSTS BY FACILITY TYPE

Outcome: To establish parameters for eligible medical care work and costs for COVID-19 declarations based on the type of facility providing medical care.

1. Primary Medical Care Facility.

    For medical care provided in a primary medical care facility (as defined in the **Definitions** section at the end of this document), work must be directly related to the treatment of

COVID-19 patients. Work may include both emergency and inpatient treatment of COVID-19 patients; this includes both confirmed and suspected cases of COVID-19. Medical care related to treatment of a non-COVID-19 illness or injury in a primary medical care facility is not eligible. The following medical care activities and associated costs are eligible in primary medical care facilities:

a. Emergency and inpatient clinical care for COVID-19 patients, including, but not limited to:
   i. Emergency medical transport related to COVID-19;
   ii. Triage and medically necessary tests and diagnosis related to COVID-19 patients;
   iii. Necessary medical treatment of COVID-19 patients; and
   iv. Prescription costs related to COVID-19 treatment.

b. Purchase, lease, and delivery of specialized medical equipment necessary to respond to COVID-19 (equipment purchases are subject to disposition requirements[3]);

c. Purchase and delivery of PPE, durable medical equipment, and consumable medical supplies necessary to respond to COVID-19 (supply purchases are subject to disposition requirements[4]);
   i. This includes the costs of eligible SLTT government Applicants providing PPE to any public or private medical care facility that treats COVID-19 patients.

d. Medical waste disposal related to COVID-19; and

e. Certain labor costs associated with medical staff providing treatment to COVID-19 patients may be eligible as outlined below. Any labor costs for medical staff that are included in patient billing and/or otherwise covered by another funding source (as described in **Section D.4 Duplication of Benefits** of this policy) are not eligible for PA. Otherwise, the following labor costs may be eligible:
   i. Overtime for budgeted medical staff providing treatment to COVID-19 patients;
   ii. Straight time and overtime for temporary medical staff providing treatment to COVID-19 patients; and
   iii. Straight time, overtime, and other necessary costs for contract medical staff providing treatment to COVID-19 patients. Work and associated costs must be consistent with the scope of the contract and may include costs for travel, lodging, and per diem for contract medical staff from outside the local commuting area.

[3] As described in Chapter 2:V.E. Disposition of Purchased Equipment and Supplies of the PAPPG (V3.1).
[4] Id.

f. For primary medical care facilities, increased operating costs for administrative activities (such as medical billing) are not eligible.[5]

2. Temporary and Expanded Medical Facilities.[6]
FEMA may approve work and costs associated with temporary medical facilities or expanded medical facilities when necessary in response to the COVID-19 Public Health Emergency. These facilities may be used to treat COVID-19 patients, non-COVID-19 patients, or both, as necessary. Medical care activities and associated costs related to treating both COVID-19 and non-COVID-19 patients in a temporary or expanded medical facility may be eligible.

   a. Costs must be reasonable and necessary based on the actual or projected need. The projected needs (i.e., capacity and capability) for a temporary or expanded medical facility must be supported by predictive modeling or other substantiating information used to determine the projected need.

   b. Eligible costs for temporary and expanded medical facilities include:
      i. All eligible items and stipulations included in **Section C.1 Primary Medical Care Facility**, but applicable to both COVID-19 and non-COVID-19 patients;
      ii. Lease, purchase, or construction costs, as reasonable and necessary, of a temporary facility as well as reasonable alterations to a facility necessary to provide medical care services;[7]
      iii. Mobilization and demobilization costs associated with setting up and closing the temporary or expanded medical facility;
      iv. Operating costs including equipment, supplies, staffing, wraparound services (as defined in the **Definitions** section at the end of this document), and clinical care not covered by another funding source; and
      v. Maintenance of a temporary or expanded medical facility in an operationally ready but unused status available for surge capacity for COVID-19 readiness and response when necessary to eliminate or lesson an immediate threat to public health and safety, based on public health guidance, location of areas expected to be impacted, and local/state hospital bed/ICU capacity.

   c. For contract costs related to establishing and/or operating a temporary or expanded medical facility, contracts must include a termination for convenience clause that will be implemented if the site is ultimately not needed, or the needs are less than projected, as determined by the legally responsible entity.
      i. Ongoing and projected needs regarding continuing operations at a temporary or expanded medical facility should be based on regular assessments and the Applicant must document the review process to support its decision making.

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[5] See Chapter 2:VI.B.2. Expenses Related to Operating a Facility or Providing a Service of the PAPPG (V3.1).
[6] Temporary medical facilities may include Alternate Care Sites or Community Based Testing Sites if eligible work and costs related to these facilities are incurred by eligible PA Applicants.
[7] As described in Chapter 2:VI.B.17(e) and (g) of the PAPPG (V3.1).

ii. The assessments should include adjustments to projected needs based on guidance from public health officials, caseload trends, and/or other predictive modeling or methodologies; lead times and associated costs for scaling up or down based on projected needs; and any other supporting information.

iii. The assessments and supporting information are necessary to determine eligibility of claimed costs and should align with PA reasonable cost guidance provided in the PAPPG[8] and the *Public Assistance Reasonable Cost Evaluation Job Aid.*[9]

d. Costs related to expanding a primary medical care facility to effectively respond to COVID-19 must be feasible and cost effective. In most cases, permanent renovations are not eligible unless the Applicant can demonstrate that the work can be completed in time to address COVID-19 capacity needs and is the most cost-effective option. Permanent renovations and other improvements to real property with PA funds are subject to real property disposition requirements.[10]

e. For temporary and expanded medical facilities, and the specific type of temporary medical facilities known as Alternate Care Sites, administrative activities and associated costs necessary for the provision of essential medical services are eligible.

D. GENERAL ELIGIBILITY CONSIDERATIONS FOR COVID-19 COSTS

Outcome: To provide additional information about eligible costs and cost-related considerations.

1. Eligible claimed costs must be necessary in order to respond to the COVID-19 Public Health Emergency and reasonable pursuant to Federal regulations and Federal cost principles.[11] A cost is considered reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. All costs are subject to standard PA program eligibility and other Federal requirements. For COVID-19 declarations, FEMA will use Medicare rates[12] as the basis to determine reasonable costs for eligible clinical care not covered by another funding source. Both patient payments and insurance payments are considered another funding source; clinical care for which providers have received or will receive payments from patients or insurance is not eligible.

2. Cost Share for COVID-19 Declarations. PA funding authorized under COVID-19 declarations is subject to the following cost share provisions:

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[8] As described in Chapter 2:V. Cost Eligibility of the PAPPG (V3.1).

[9] The Public Assistance Reasonable Cost Evaluation Job Aid is available on the FEMA website at www.fema.gov/media-library/assets/documents/90743.

[10] As described in Chapter 2:V.F. Disposition of Real Property of the PAPPG (V3.1).

[11] 2 CFR §200.404.

[12] FEMA will use standard Medicare rates that do not include the 20 percent increase in COVID-19 Medicare DRG rates implemented by the CARES Act.

a. Eligible costs incurred by an eligible Applicant claiming reimbursement through PA are subject to the non-federal cost share established for the respective emergency or major disaster declaration. Pursuant to sections 403(b) and 503(a) of the Stafford Act, the federal share for FEMA PA funding is not less than 75 percent of eligible costs.

b. Direct Federal Assistance provided under Stafford Act authorities is also subject to the cost share established for the respective emergency or major disaster declaration, unless otherwise stipulated.

c. Federal assistance provided by other federal departments and agencies, including instances in which provision of the assistance is facilitated by FEMA, is funded at the cost share of the other federal department or agency, some of which may be provided at 100 percent federal funding.

d. In most cases, federal assistance provided by other federal departments and agencies cannot be used to cover the non-federal cost share. The Applicant can only apply other federal award funds toward the PA non-federal cost share if the other federal award has specific statutory authority allowing it to be utilized to meet cost-share requirements, or is otherwise allowable under the other federal source of funding.

e. The Applicant cannot apply PA funds toward the non-federal cost share of other federal agency funding. For example, States may not use PA funding to meet the State share of Medicaid or the Children's Health Insurance Program (CHIP).[13]

3. Procurement Requirements for COVID-19 Declarations.[14]

a. States and territorial governments are required to follow their own procurement procedures as well as the Federal requirements for procurement of recovered materials and inclusion of required contract provisions per 2 C.F.R. §§ 200.317, 200.322, and 200.326 and Appendix II to 2 CFR Part 200.[15]

b. Tribal governments, local governments, and PNPs must comply with the requirements of 2 C.F.R. §§ 200.318-200.326.

c. In accordance with the March 17, 2020, memorandum from David Bibo, Acting Associate Administrator for the Office of Response and Recovery, and Bridget E. Bean, Assistant Administrator, Grant Programs Directorate, for the duration of the Public Health Emergency, as determined by HHS, local governments, tribal

[13] See 42 C.F.R. § 433.51 and 45 C.F.R. § 75.306.
[14] Additional guidance regarding procurement standards is available at https://www.fema.gov/procurement-disaster-assistance-team.
[15] For additional guidance regarding required contract clauses, see the Procurement Disaster Assistance Team's "FEMA Contract Provisions Template" (2019 ed.), available online at https://www.fema.gov/media-library-data/1569959119092-92358d63e00d17639d5db4de015184c9/PDAT_ContractProvisionsTemplate_9-30-19.pdf.

governments, nonprofits, and other non-state entities may proceed with new and existing non-competitively procured contracts using the exigent/emergency circumstances exception in 2 C.F.R. § 200.320(f)(2). The March 17, 2020 memorandum and other information related to procurement specific to COVID-19 declarations are available on the FEMA website at www.fema.gov/media-library/assets/documents/186350. Additional resources on COVID-19 specific to grants are also available at www.fema.gov/grants under "News and Announcements" and www.fema.gov/coronavirus.

d. SLTT governments may contract with medical providers, including private entities, to carry out any eligible activity described in **Section C. Eligible Medical Care by Facility** of this policy.

e. Contracts must include an actionable termination for convenience clause that will be implemented if any part of the scope of the contract is ultimately not needed, or the needs are less than projected, as determined by the legally responsible entity. Ongoing and projected needs should be based on regular reviews and the Applicant must document the review process to support its decision making. All claimed contract costs must be necessary and reasonable pursuant to applicable Federal regulations and Federal cost principles.

4. Duplication of Benefits.

Pursuant to Section 312 of the Stafford Act, FEMA is prohibited from providing financial assistance where such assistance would duplicate funding available from another program, insurance, or any other source for the same purpose.

a. FEMA cannot duplicate assistance provided by HHS or other federal departments and agencies. This includes, but is not limited to, funding provided by the programs listed below. FEMA is providing this list as a helpful reference, but SLTT government entities and PNPs should consult with the appropriate federal agency and the terms and conditions of each program or source of funding to determine what funding may be considered duplicative.
   i. The Public Health Emergency Preparedness Cooperative Agreement Program;
   ii. The Public Health Crisis Response Cooperative Agreement;
   iii. The Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases;
   iv. The Hospital Preparedness Program Cooperative Agreement;
   v. The Regional Ebola and Other Special Pathogen Treatment Centers Cooperative Agreement;
   vi. The National Emerging Special Pathogens Training and Education Center Cooperative Agreement;
   vii. The Hospital Association COVID-19 Preparedness and Response Activities Cooperative Agreement;
   viii. The Coronavirus Relief Fund and the Provider Relief Fund;

ix. The COVID-19 Uninsured Program; and
x. The Paycheck Protection Program.

b. FEMA cannot provide PA funding for clinical care costs funded by another source, including private insurance, Medicare, Medicaid/CHIP, other public insurance, a pre-existing private payment agreement, or the COVID-19 Uninsured Program for uninsured patients.[16] The Applicant will certify that it has not received and does not anticipate receiving assistance from these sources or any other source for the same work or costs. FEMA will deobligate any PA funding that has been provided in the event that another source provides funds to the Applicant for the same clinical care costs.

c. At no time will FEMA request or accept any Personally Identifiable Information related to the medical care of individual COVID-19 patients.

d. FEMA will reconcile final funding based on any funding provided by another agency or covered by insurance or any other source for the same purpose. FEMA will coordinate with HHS to share information about funding from each agency to assist in preventing duplication of benefits.

5. Time Limitations for the Completion of Work.

a. Costs for eligible medical care for COVID-19 declarations are limited to those incurred within six months of the date of the declaration in accordance with regulatory timeframes for emergency work at 44 C.F.R. §206.204(c) or until the end of the COVID-19 Public Health Emergency, whichever comes first.

b. For all COVID-19 declarations, FEMA may extend the deadline in accordance with 44 C.F.R. §206.204(d) if the duration of the COVID-19 Public Health Emergency extends beyond six months or for work required after the end of the Public Health Emergency, such as demobilization of temporary medical facilities, or to address localized needs as appropriate.

Keith Turi
Assistant Administrator, Recovery Directorate

May 9, 2020
Date

[16] The COVID-19 Uninsured Program reimburses for testing and clinical care costs for the uninsured which is being provided at Medicare rates.

ADDITIONAL INFORMATION

REVIEW CYCLE

This policy will be reviewed periodically during the COVID-19 Public Health Emergency period. The Assistant Administrator for the Recovery Directorate is responsible for authorizing any changes or updates. This policy will sunset with the closure of the national emergency declaration for COVID-19 and any subsequent major disaster declarations for COVID-19.

AUTHORITIES and REFERENCES

Authorities

- Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121-5207, as amended
- Title 44 of the Code of Federal Regulations, Part 206, Subpart H
- Title 2 of the Code of Federal Regulations, Part 200

References

- Public Assistance Program and Policy Guide, Version 3.1

DEFINITIONS

To establish consistent terminology for purposes of implementing this policy, the following definitions are provided below. These definitions are specific to this policy and may differ from definitions prescribed for the same or similar terms in other policies.

1. **Medical Care:** Medical Care refers both to assistance provided to support the provision of medical care and assistance for clinical care. Examples of medical care support include eligible facility, equipment, supplies, and staffing costs.

2. **Clinical Care:** Clinical Care refers to medical treatment of individual patients including testing, diagnosis, treatment, hospitalization, prescriptions, and other costs associated with individual patient treatment typically billed to individual patients, their insurance carriers, Medicare, Medicaid, or other pre-existing payment agreements.

3. **Primary Medical Care Facility:** A primary medical care facility is the facility owned and/or operated by an eligible PA Applicant that provides medical care services. This includes any licensed hospital, outpatient facility, rehabilitation facility, or facility for long-term care.

4. **Temporary Medical Facility:** A temporary medical facility is a facility separate from the primary medical care facility that is used to provide medical care services when the primary medical care facility is overwhelmed by the declared event.

5. **Expanded Medical Facility:** An expanded medical facility is part of the primary medical care facility and refers to an expansion of the primary medical care facility to increase its capacity when the primary medical care facility is overwhelmed by the declared event.

6. **Alternate Care Sites:** Alternate Care Site is a type of Temporary Medical Facility and broadly describes any building or structure of opportunity converted for healthcare use. It provides additional healthcare capacity and capability for an affected community separate from a traditional, established healthcare institution, though healthcare institutions may partner with eligible Applicants operating an Alternate Care Site.

7. **Community-Based Testing Sites:** Community-Based Testing Sites are strategically located sites within a community operated by a SLTT government for the purpose of providing COVID-19 testing to members of the community.

8. **Wraparound Services:** Wraparound services in the context of this policy are the same as those defined in the Alternate Care Site Toolkit. The services will differ at each temporary medical facility. Such services include, but are not limited to, the following: linen and laundry services; food preparation and delivery; biomedical waste removal, including contaminated items such as personal protective equipment; perimeter fencing; contracted security guards; professional cleaning; and other related services. The toolkit and other Alternate Care Site resources are available on the HHS website at https://asprtracie.hhs.gov/technical-resources/111/covid-19-alternate-care-site-resources.

MONITORING AND EVALUATION

FEMA will closely monitor the implementation of this policy through close coordination with regional and field staff, as appropriate, as well as interagency partners and SLTT stakeholders.

QUESTIONS

Applicants should direct questions to their respective FEMA regional office.

- Activation of re-entry/repatriation process if evacuation occurred;[5]
- 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 9 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.	Alan Boyd Maintenance Director in conjunction with Springville Electric(currently provides service) performing activity (e.g., facility department, company]	Curreent Electric Supplier or NYSEG (Independent contractor as needed)
Clean-up of facility grounds (e.g., general housekeeping, removing debris and damaged materials).	Alan Boyd Maintenance Director or Paula Hansen Director of Housekeeping	Landscaping as need (Natures Pride performs current services)
Internal damage assessments (e.g., structural, environmental, operational).	Alan Boyd Maintenace Director	Lamparelli Contruction (716-891-8599) and Serve Pro (716-891-8599) can make assessments (water/smoke damage) provided contruction services in past
Clinical systems and equipment inspection.	Alan Boyd Maintenance Director	In house serviced

Activity	Responsible Entity	Contracts/Agreements

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

Strengthen infrastructure for future disasters (if repair/restoration activities are needed).	Alan Boyd Maintenance Director	Lamparelli Contruction (716-891-8599) and Serve Pro (716-891-8599) can make assessments (water/smoke damage) provided contruction services in past
Communication and transparency of restoration efforts to staff and residents.	Cheryl Gilbert Human Resources	On-shift , phone and mailings
Recurring inspection of restored structures.	Alan Boyd Maintenance Director	In house inspectionand Springville code enforcer as needed (Mike Kaleta 716-592-4936)

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:

- [List facility-specific records and information (e.g., resident data, relative or responsible party information, staff information)]

1. EMR (Electronic Medical Record) transfer of data through E-Finds (including)
    a. Meds & MAR
    b. Resident Profile

[Describe facility's system for maintaining electronic records (e.g., off-site servers, cloud-based systems) and/or protections for paper-based systems (e.g., storage in durable containers in locations designated as least vulnerable)]

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

2. Back up system for PCC (Point Click Care)
3. Emergency Medication Administration Records (can be printed from computer on wheels to printer connected to generator)
4. Resident Profiles Store on each unit and Medical Records second floor
5. Emergency Dietary tickets stored in storage room basement

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.

[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] 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
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")[6] and the Resident Evacuation Critical Information and Tracking Form[7] to track staff.

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 Kronos, Supervisor tracking line list for sign out sheets and tour duty log on each unit. 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 Fiddler's Green Manor Employee Accident and Incident form.

[6] 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.

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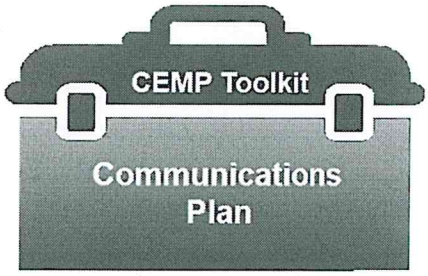
3.3.3 Non-Facility Personnel

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 ethod of M ication Commu	Alternate Method of Communication
Landline telephone	X	
Cell Phone	X	
Voice over Internet Protocol (VOIP)		X

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.

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Cell Phone	X	
Voice over Internet Protocol (VOIP)		X

NEW YORK STATE OF OPPORTUNITY. Department of Health

Text Messages	[ ]	[X]
Email	[X]	[ ]
News Media	[ ]	[X]
Radio Broadcasts	[ ]	[X]
Social Media	[ ]	[X]
Runners	[X]	[ ]
Weather Radio	[ ]	[X]
Emergency Notification Systems[8]	[X]	[ ]
Facility Website	X	
[On-shift]	[X]	[ ]

[8] 12 An emergency notification system is a one-way broadcast, sometimes coordinated by a third-party vendor, and is not required by
NYSDOH.

4.1.1 Communications Review and Approval

[**Describe** the facility-specific approval process for the approval and dissemination of communications materials (e.g., pre-scripted messages)]

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 a Human Resouce Department and Emergency Preparedness Binder list of all staff members, including emergency contact information, at The Human resource department is located in the basement and Emergency Preparedness binder is located in medical director office and Administrator office in Basement . 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

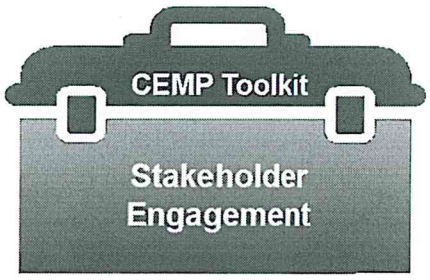
Upon admission, annually, and prior to any recognized threat, the facility will educate residents and responsible parties on the CEMP efforts. Resident communication may include [facilityspecific (e.g., admission documentation, newsletters, Resident Council meetings, resident group meetings, Family Council meetings, etc.).

1. Letters to family and residents
2. Website
3. Resident council Meetings

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 memorycare 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

THIS SECTION 4.3.1 is NOT APPLICABLE to Fiddler's Green Manor

[Remove section if facility is not part of a multi-facility system] The facility will coordinate all messaging with [corporate/parent organization] to ensure external communications are in alignment with corporate policies, procedures, and brand standards. Prior to an incident, the facility will coordinate with [corporate/parent organization] 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 on Electronic Medical Record located on Point Click Care with list of all identified authorized family member's and guardian's (responsible parties') contact information, including phone numbers and email addresses at each unit has computer and paper copies. Such individuals will receive information about the facility's preparedness efforts upon admission.

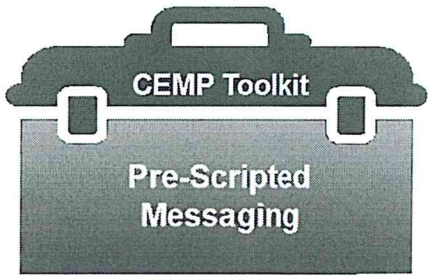
During an incident, the facility will notify responsible parties about the incident, status of the resident, and status of the facility by Designated department heads will provide primary notification via phone. Additional updates may be provided on a regular basis to keep residents relatives/responsible 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
- Location

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; and
- Contact Managing members and provide updates as needed
- 5.2 Finance

5.2.1 Preparedness

[Facility-specific financial functions to account for preparedness-related costs (e.g., purchase of preparedness supplies)]

1. Equipment
2. Transportation
3. Costs related specific to type of incident

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
- Additional facility-specific costs related specific to disaster or pandemic

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.
- Locate and communicate with transfers locations in case of evacuation
- Additional responsibilities as required

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.	Administrator and Maintenance Director	Annually
Review and update contact information for response partners, vendors, and receiving facilities.	Alan Boyd Maintenance Director and Cheryl Gilbert Business office Manager	Annually or as response partners, vendors, and host facilities provide updated information.
Review and update contact information for staff members and residents' emergency contacts.	Cheryl Gilbert Human Resouce Director	Annually or as staff members provide updated information.
Review and update contact information for residents' point(s) of contact (i.e., relatives/responsible parties).	Eric Wozniak Social Services	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.	Alan Boyd Maintenance Director	Annually
Maintain electronic versions of the CEMP in folders/drives that are accessible by others.	Alan Boyd Maintenance Director	Annually
Revise CEMP to address any identified gaps.	Heather Morin 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,	Alan Boyd Maintenance Director, Paula Hansen Housekeeping and Laundry Director, Dietary/Food Service Director	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.
- [Village of Springville Code enforcement Adopted by the Board of Trustees of the Village of Springville 11-5-1979 by L.L. No. 6-1979 (Ch. 90 of the 1979 Code); amended in its entirety 8-25-2014 by L.L. No. 3-2014. Subsequent amendments noted where applicable.

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 (Natural GAS)
- 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
- Rock Salt for ice

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).

☐ Staff to contacted via Onshift , lists maintained of responses and staff are punch into Kronos and utilize tour of duty forms

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-ofscope 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.
- Those cross trained to provide additional services in various departments

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.	Alan Boyd or Cheryl Gilbert	Orientation held first day of employment.
Incorporate into annual educational update training schedule to ensure that all staff are trained on the use of the CEMP, including PEP specific plans, and core preparedness concepts.	Alan Boyd Maintenance department	Annually / Conducts drills
Maintain records of staff completion of training.	Cheryl Gilbert Director of Human Resources	Employee File Located in human resource department
Ensure that residents are aware appropriately of the CEMP, including PEP specific plans, including what to expect of the facility before, during, and after an incident.	Catherine Bullock Director of Activities at Resident Council, Resident Council President to review	Annually or Repeat briefly at time of incident.
Identify specific training requirements for individuals serving in Incident Management Team positions.	1. E-Finds 2. Attending Mutual Aid drills and Disaster preparedness education programs 3. All Management members trained on Disaster plans, emergency preparedness policy and procedure	1. Kathy Sloand - Director of Medical records 2. Alan Boyd Director of Maintenance 3. Annually

4. Infection Preventionist	Kate Wannemacher Managing Member	

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). [9]	Alan Boyd Maintenance Director in coordination with DON and Administrator	Annually
Conduct one discussion-based exercise (e.g., tabletop exercise).	Alan Boyd Maintenance Director in coordination with DON and Administrator	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 Fiddler's Green Attendance records and participation in drills, educational programs.

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.

[9] 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.

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.

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,

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

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

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

Infectious Disease/Pandemic Emergency Checklist	
Preparedness Tasks for <u>all Infectious Disease Events</u>	
☐ Required	Provide staff education on infectious diseases (e.g., reporting requirements (see Annex K of the CEMP toolkit), exposure risks, symptoms, prevention, and infection control, correct use of personal protective equipment, regulations, including 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80), and Federal and State guidance/requirements . Fiddler's Green Manor maintains compliance by providing education to all staff 2x a year or as need to adjust to changes in CDC guidance, NYSDOH regulatory changes, CMS changes or Governor's executive orders.
☐ Required	Develop/Review/Revise and Enforce existing infection prevention, control, and reporting policies. Fiddler's Green Manor has a medical director and staff update and review or revise policies annually, periodically as needed as changes occur or laws change. Fiddler's Green Manor conducts audits and staff re-education as required to meet NYSDOH standards, CDC guidance, Governor's executive orders, and CMS changes. Data is reviewed as needed by QAPI committee.
☐ 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. Refer to Fiddler's Green facility staff/resident testing policies/laboratory services, resources to implement. Facility reports all outbreaks through NORA and to the local NYSDOH department of Epidemiology.
☐ Recommended	Develop/Review/Revise plan for staff testing/laboratory services Staff testing is completed onsite and facility has contract with KSL laboratory for staff testing once a week. Refer to Staff Testing POLICY , policies are developed, reviewed or revised as guidance or laws change.
☐ 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 NYSDOH or HERDS surveys. Fiddler's Green Herds is updated under

	coordinator tools on Health Commerce System. Administrator, Director of Nursing or designee with HERDS access completes NORA or HERDS surveys. NYSDOH/ Epidemiology are apprised of resident and staff conditions via phone. Staff are reviewed and identified as personnel designated to complete required reporting.
☐ Required	Develop/Review/Revise internal policies and procedures, to stock up on medications, environmental cleaning agents, and personal protective equipment as necessary. (Include facility's medical director, Director of Nursing, Infection Control Practitioner, safety officer, human resource director, local and state public health authorities, and others as appropriate in the process) Supplies and Medications and cleaning products are maintained and stored onsite. Policies and procedures are maintained and reviewed annually or as needed for any changes that occur facility /system wide in accordance with laws, regulations, CDC guidance, NYSDOH recommendations, CMS changes. Policy and procedures are located in basement Medical Director office. Staff including Medical Director review and sign off on revised policies for changes and annually to maintain records.
☐ Recommended	Develop/Review/Revise administrative controls (e.g., visitor policies, employee absentee plans, staff wellness/symptoms monitoring, human resource issues for employee leave). [add these controls/policies/plans to Appendix K of Toolkit] Fiddler's Green Manor maintains Policies and procedures in accordance with CDC , Governor's Executive orders and NYSDOH for visitation . Staff are screened and monitored for wellness/symptoms per in accordance with NYSDOH and CDC guidance. Refer to Visitation Policy and Nurse coverage plan. Staffing is determined at the point of incident, identify quantity of staff needed (RN, LPN,C.N.A., other) of staff that may provide clinical care without assistance. However; Additional ancillary staff such as food service, housekeeping and maintenance will probably be required throughout situation. Maintaining resident care and safety throughout the duration of the situation.
☐ Required	Develop/Review/Revise environmental controls (e.g., areas for contaminated waste) Facility is contracted with Steri-cycle to dispose of contaminated waste and Waste management for waste. Environmental controls are maintained in accordance with infection control policy and procedures in accordance with CDC and NYSDOH guidance.

☐ ɟuᴉ	Develop/Review/Revise vendor supply plan for re-supply of food, water, medications, other supplies, and sanitizing agents. Refer to Emergency Preparedness plan Binder located in basement in medical director office. The facility maintains appropriate supplies as required throughout the duration of incident. Periodic review and revision is maintained as needed and contracts or plans revised in accordance to laws, regulations , EPA recommendations, CDC and NYSDOH guidance.
☐ 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 Fiddler's Green Manor has Policies and procedures for Isolation and Cohorting including Green, Yellow and Red

	Zones. Refer to POLICY on Cohorting in accordance with CDC and NYSDOH guidance..
☐ 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 ([describe facility's process, e.g. which non-essential activities to eliminate, changes in dining/other physical space arrangements involving residents/staff] Fiddler's Green Manor has policies and procedures for infections control, visitation, activities and co-horting. Residents are to wear masks in areas of other staff and residents, in accordance with Governor Como's executive Orders visitation is limited as long as facility is COVID free (Indoor and outdoor designated areas available). Dining areas limited with social distancing adhered see policy for communal dinning. Please refer to POLICY on Cohorting.
☐ 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.Re-opening plans are in place for Fiddler's green Manor and reviewed with management team, including review of policy and procedures , visitors/ non-essential personnel per CMS, CDC and NYSDOH guidance. As changes occur, plans will be developed , reviewed and revised accordingly.
☐	
☐	
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 Fiddler's Green Manor has communication policy and procedures for communication residents and family members and during a Pandemic. Refer to Communication POLICY.
☐ 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. Fiddler's Green Manor tests both residents and staff for protection against COVID 19 and the Flu. Visitors are screened prior to visitation in accordance to CDC and NYSDOH guidance. Please refer to visitation policy.
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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: list facility-specific procedures to obtain/maintain/enact guidance The facility is updated with current NYSDOH and CDC guidance, policy and procedure are developed , reviewed and revised as needed in accordance with CDC and NYSDOH , the facility regularly updates signage for example: travel, social distancing, PPE and zone classification as changes or as required or any advisory or specific disease actions. This facility maintains staff testing logs in Human Resource department. Refer to staff and resident testing policy. Staff and all individuals effected by such changes, advisories are notified, educated and or trained accordingly.
☐ 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). Fiddler's Green Manor Director of Nursing, Administrator or designee reports communicable diseases to NYSDOH, CDC or appropriate offices in accordance to laws, regulations, policy and procedures..
☐ Required	The facility will assure it meets all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting Daily Herds reporting is completed by Administrator, Director of Nursing or designee.
☐ 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 Fiddler's Green Manor designates halls and zones using signage and floor demarcation as warranted per policy.
☐ 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: Fiddler's Green Manor assigns staff to work designated isolation areas (green, yellow or red)
☐ 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. **Fiddler's Green Manor utilizes**

	approved cleaning products specific to infectious disease to combat the spread of infection. Staff are trained as needed on cleaning products and policy and procedures for infection control standards in accordance with NYSDOH and CDC
☐ 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 Fiddler's Green Manor provides educational conference calls and updates the Fiddler's Green Manor website. Refer to communication Policy and notification of change policy.
☐ 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 provide information regarding facility-maintained list of external stakeholders to be contacted and mechanisms for sharing this information
☐ 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: Fiddler's Green Manor has a visitation policy with designated areas and appropriate screening and signage. Refer to Visitation , Admission and re-admission Policy and Procedure.
☐	
☐	

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) *Refer to PPE policy and Procedure.*

☐ 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: list facility planned procedures, timeline to post, etc. Facility submits PEP for online posting at required deadline. Facility's PEP is made available for review and located in accessible area.
☐ 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: Refer to change of condition POLICY

☐ 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: Refer to Communication POLICY. This facility has designated staff to ensure all residents and staff are notified.
☐ 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: Video conferencing and equipment are made available, facility cell phone is also made available for use.
☐ 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): *Refer to POLICY for Admission and Readmission*
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following process to preserve a resident's place in a residential health care facility if such resident is hospitalized, in accordance with all applicable laws and regulations including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e): Refer to Infection control Policy
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following planned procedures to maintain or contract to have at least a two-month (60-day) supply of personal protective equipment (including consideration of space for storage) 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)
	PPE is stored in basement storage and Director of Nursing closet, Staffing coordinator orders supplies from Gerimedex, Administrator orders emergency PPE through Erie County Office of Emergency Preparedness.
☐	

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Recovery for <u>all Infectious Disease Events</u>	
☐ Required	The facility will maintain review of, and implement procedures provided in NYSDOH and CDC recovery guidance that is issued at the time of each specific infectious disease or pandemic event, regarding how, when, which activities/procedures/restrictions may be eliminated, restored and the timing of when those changes may be executed.
☐ Required	The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders
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☐	

Fiddlers Green Manor
COVID-19 Employee Testing

Date Initiated: 5/19/2020
Date Revised:

PURPOSE:
To provide guidelines for COVID testing of employees per the NYS

STANDARD

The facility operates to maintain the health and safety of the residents, patients, employees and visitors; in consideration of Department of Health and Centers for Disease Control guidelines whenever possible. The execution of this policy and procedure pursuant to the Governor's Executive Order #202.30 is contingent upon (1) the Facility's physical ability to access the materials, equipment and qualified testers necessary to administer the test twice weekly; (2) the cooperation of all individuals to be tested; (3) clarification with respect to how the huge costs associated with the tests will be paid for, and; (4) any other event or circumstance that may make it impossible to complete this procedure.

POLICY

1. The facility will COVID test all employees* to the extent that test material is available.
2. The facility will contact the Regional Office, New York State Department of Health, to advise of the inability to procure adequate testing supplies and seek guidance as to alternate source(s)
3. Full time employees (those who work 4 or more days in a 7 day period will be tested for COVID, twice weekly to the extent test materials are available.
4. Part-time or "on-call" employees who work less than 4 days per week will be tested on the first scheduled work date of the week (Monday-Tuesday); and again weekly on next scheduled day after 6 days elapse from the last test and the next day worked, provided that test materials are available.
5. Consultant and/or contract staff such as dental, medical, will be tested for COVID, on the first scheduled in-facility engagement of the week, and again during the week if 72 hours (3 days) have elapsed between the first weekly engagement and the subsequent visit within the same week; provided that test materials are available. If they have been tested at another location, proof of testing is required.
6. *Those employees who are found to have or who present verified presence of Covid-19 Antibodies, will not be eliminated from testing. Those employees who have documented history of Covid-19 Diagnosis, will not be eliminated from testing.

PROCEDURE

A.

1. Testing* is done as per policy provided that testing material is available at the facility. The facility administrator (or designee) contacts the New York State Department of Health Regional Office for guidance should adequate testing material not be available.
2. Testing occurs during the individuals scheduled work shift.
3. The tester will be observed to demonstrate documented competency, by a qualified trainer. Competency is demonstrated in the maintenance of strict infection control measures.
4. Testing occurs in a sequestered area of the facility. This area is wiped with a germicidal product in between employee tests.
5. The individual being tested maintains mask protocol including hand hygiene prior to and post specimen collection.
6. The tester remains minimally six feet away from the employee being tested; but dons PPE including face shield for contacts closer than six feet.
7. Employees are scheduled for specimen collection during their work shift so that all direct positions are covered in an organized and scheduled fashion.
8. Records are maintained in a central location regarding the employee name (or number), antibody status, test date, test results.
9. COVID Positive results are communicated immediately upon receipt to the employee; and by close of business on the next day, to the Regional Office of the New York State Department of Health by the facility Administrator.
10. All staff COVID test results will be reported on the HERDS survey the next day as required by NYSDOH.
11. The employees, both current and new, are informed of this policy and the requirements put forth by the Governor's Executive Order which is the genesis of this policy and procedure.

B. Proposed Schedule (predicated on the availability of testing materials)
5/13/2020 Transmission of testing plan to Department of Heath via HERDS.
5/15/2020 Certification of compliance with EO 202.30 to the extent practicable by the administrator and operator
5/20/2020 Swabbing begins and is performed as per policy through June 9, 2020 – the expiration of the EO 202.30

Fiddler's Green Manor

Communal Dining / Activities COVID 19

Date Initiated: 6/3/2020
Date Revised:

PURPOSE:

Based on guidance from the CDC re-opening guidance regarding COVID- 19, Facility Wide Communal Dining and Group Activities will begin. Limited communal dining and activities will follow these procedures.

POLICY

1. Residents should eat in their room if possible.
2. Residents who can safely eat in the dining room and/or attend group activities are:
    a. COVID-19 negative.
    b. Asymptomatic residents only.
    c. Only green zone residents.
3. Maintain 6 feet for social distancing while in the dining room.
4. Separate room into unit specific areas eliminating unit to unit co-mingling for facilities that have only 1 dining/activities room for all units.
5. Label 6 foot distance markers on floors to assure social distancing occurs.
6. Transport only 2 residents at a time in the elevator and residents must wear a mask
7. Encourage frequent hand washing and wearing of facemasks.
8. Limit of 10 residents at a time for group activities in a common area.

Cleaning and Disinfection of Environmental Surfaces COVID 19

Fiddler's Green Manor

Date Initiated: 3/5/2020

Date Revised: 6/3/2020, 7/22/2020

Policy Statement

Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard.

Policy Interpretation and Implementation

1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care and those in the resident's environment:
   a. **Critical items** consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (e.g., urinary catheters) or the vascular system (e.g., intravenous catheters) are considered critical items and must be sterile.
   b. **Semi-critical items** consist of items that may come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (Note: Some items that may come in contact with non-intact skin for a brief period of time (e.g., hydrotherapy tanks, bed side rails) are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.)
   c. **Non-critical items** are those that come in contact with intact skin but not mucous membranes.
      (1) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors.
      (2) Most non-critical items can be decontaminated where they are used (as opposed to being transported to a central processing location).

2. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions.
   a. Most EPA-registered hospital disinfectants have a label contact time of 10 minutes.
   b. By law, all applicable label instructions on EPA-registered products must be followed.

3. **Devices** that are used by staff but not in direct contact with residents (e.g., computer keyboards, PDAs, etc.) shall be cleaned and disinfected regularly daily by the environmental services staff / nursing staff.

   a. **DEVICES used by residents:**

      i. Devices shared between residents in same zones only, i.e. green to green, yellow to yellow etc.

      ii. Only approved disinfecting wipes to be used between use.

      iii. Staff to assist and manage devices between residents to assure proper sanitizing with approved wipes.

4. Intermediate and low-level disinfectants for non-critical items include:
   a. Ethyl or isopropyl alcohol;
   b. Sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions);

c. Phenolic germicidal detergents;
d. Iodophor germicidal detergents; and
e. Quaternary ammonium germicidal detergents (low-level disinfection only).

5. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including:
   a. Recommended use-dilution;
   b. Material compatibility;
   c. Storage;
   d. Shelf-life; and
   e. Safe use and disposal.

6. A one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes will be used in resident care areas where:
   a. uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or
   b. uncertainty exists about the presence of multidrug-resistant organisms on such surfaces.

7. Detergent and water will be used for cleaning surfaces in non resident care areas (e.g., administrative offices).

8. High-level disinfectants/liquid chemical sterilants will not be used for disinfection of non-critical surfaces.

9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.

10. Environmental surfaces will be disinfected (or cleaned) on a regular basis and when surfaces are visibly soiled.

11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.

12. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently (e.g., floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60-minute intervals).

13. Mop heads and cleaning cloths will be decontaminated regularly (e.g., laundered and dried at least daily).

14. Horizontal surfaces will be wet dusted regularly clean cloths moistened with an EPA-registered hospital disinfectant (or detergent). The disinfectant (or detergent) will be prepared as recommended by the manufacturer.

15. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated. Blood-contaminated items will be discarded in compliance with federal regulations (i.e., OSHA Bloodborne Pathogens Standard).

16. The following procedures will be implemented for site decontamination of spills of blood or other potentially infectious materials (OPIM):
   a. Use protective gloves and other PPE (e.g., when sharps are involved use forceps to pick up sharps and discard these items in a puncture-resistant container) appropriate for this task.
   b. Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent, a registered germicide on the EPA Lists D and E (i.e., products with specific label claims for HIV and HBV) or freshly diluted hypochlorite solution.

c. If sodium hypochlorite solutions are selected use a 1:100 dilution to decontaminate nonporous surfaces after a small spill (e.g., <10 mL) of either blood or OPIM.
d. If a spill involves large amounts (e.g., >10 mL) of blood or OPIM, or involves a culture spill in the laboratory, use a 1:10 dilution for the first application of hypochlorite solution before cleaning in order to reduce the risk of infection during the cleaning process in the event of a sharps injury.
e. Follow this decontamination process with a terminal disinfection, using a 1:100 dilution of sodium hypochlorite.

17. If the spill contains large amounts of blood or body fluids, the visible matter will be cleaned with disposable absorbent material, and the contaminated materials discarded in an appropriate, labeled container.

18. Protective gloves and other PPE appropriate for this task will be used.

19. In units with high rates of endemic *Clostridium difficile* infection or in an outbreak setting, dilute solutions of 5.25%–6.15% sodium hypochlorite (e.g., 1:10 dilution of household bleach) will be used for routine environmental disinfection. (Note: Currently, no products are EPA-registered specifically for inactivating *C. difficile* spores.)

20. If chlorine solution is not prepared fresh daily, it will be stored at room temperature for up to 30 days in a capped, opaque plastic bottle. (Note: A 50% reduction in chlorine concentration will occur by day 30.)

21. An EPA-registered sodium hypochlorite product is preferred, but if such products are not available, generic versions of sodium hypochlorite solutions (e.g., household chlorine bleach) may be used.

CORE TACTICS
Healthcare Consulting

INFECTION CONTROL ROUNDS

DATE_____ TIME_____ AUDITOR _____

LOCATION/UNIT_____

	Y	N	Comments:
General: 1. Cough etiquette observed to be performed appropriately			
2. Cleaning of reusable equipment observed to be performed appropriately (i.e. vital signs machines, stethoscopes, etc.)			
3. Corridor handrails, wall hangings, corners and edges clean			
4. Medication/treatment carts clean			
5. Waste receptacles clean and have ample supply of liners			
6. Social distancing of residents is maintained at 6 ft			
7. Staff carry linen away from the clothing			
8. Soiled linen is bagged prior to being removed from room			
Hand Hygiene (HH): 1. Staff observed performing HH prior to and after glove use			
2. Staff observed performing HH after contact with objects/surfaces in the resident's environment			
3. Staff observed performing HH before & after contact with resident's			
4. Staff observed performing HH after removal of PPE			
5. Staff observed performing HH after each resident medication pass			
6. Resident HH observed after toileting			
7. Resident HH observed before & after meals			
8. Staff do not touch rdnt food without gloves on			
9. Hand Sanitizer accessible and sufficient supply in dispenser			
10. Soap dispensers noted to have sufficient supply of soap			

CORE TACTICS
Healthcare Consulting

	Y	N	Comments:
11. Soap & water used if hands are visibly soiled			
12. Sinks are free of clutter and accessible for HH			
13. Are gloves easily accessible and fully stocked			
PPE: 1. Gloves are worn when required (during direct care, potential exposure to blood/body fluids, etc.)			
2. Gloves are removed when required (after direct care, potential exposure to blood/body fluids, etc.)			
3. Is PPE appropriately discarded prior to leaving rdnt room followed by HH (exclusion in cases of extended use recommendations)			
4. Gloves are not worn in hallways			
5. Face masks are worn when within 6 ft of residents			
6. Face masks fully cover nose and mouth			
Interview: Staff know who to contact to obtain additional PPE			
Isolation: 1. Signage located outside of isolation rooms			
2. Isolation bin/supplies located outside doorway			
3. Staff can identify the resident on isolation and the type (Contact, Droplet)			
4. Isolation cart has sufficient PPE for isolation type: Contact: gloves, gown Droplet: gloves, gown, facemask, eye shield (if needed) Airborne: gloves, gown, N95 or higher (facemask if unavailable)			
5. Known/Suspected CoVID-19: Gloves, gown, eye protection, N95 or higher (facemask if unavailable)			
6. Dedicated non-disposable equipment available in residents' room (BP cuff, glucose monitoring machine, stethoscope, oximeter, etc.)			
7. Is there an active care plan for isolation			
Monitoring: 1. Is the resident line list current			
2. Is the staff line list current			
3. Is there a monitoring system to track resident			

CORE TACTICS
Healthcare Consulting

	Y	N	Comments:
respiratory symptoms (i.e. Vital Signs Qshift)			
4. Is there a system to review respiratory symptoms (i.e. Vital Signs) routinely			
Employee/Visitor Entry: 1. Signage posted at entrances for screening/visitor restrictions			
2. Screening of all "approved" visitors/staff conducted upon entrance & documented			
3. Screening staff member wearing appropriate PPE			
4. HH performed prior to exiting screening station			
5. Masks are available & "approved" visitors/staff instruction given on required mask use & appropriate mask changing timeframes			
6. Cleansing process in place for wiping down pens and other equipment at screening station			

Standard Precautions

Policy Statement

Standard Precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents.

Policy Interpretation and Implementation

1. Standard Precautions shall apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases.

2. Staff shall be adequately trained in the various aspects of Standard Precautions to ensure appropriate decision-making in various clinical situations.

3. Residents and family members will be provided with information pertaining to Standard Precautions and the prevention of infection upon the resident's admission to the facility.

Standard precautions include the following practices:

1. Hand hygiene
   a. Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) OR using alcohol-based hand rubs (gels, foams, rinses) that do not require access to water.
   b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom.
   c. In the absence of visible soiling of hands, alcohol-based hand rubs are preferred for hand hygiene.
   d. Wash hands after removing gloves (see below).
   e. Artificial fingernails are discouraged among staff with direct resident contact.

2. Gloves
   a. Wear gloves (clean, non-sterile) when you anticipate direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material.
   b. Wear gloves when in direct contact with a resident who is infected or colonized with organisms that are transmitted by direct contact (VRE, MRSA, VISA-VRSA, etc.).
   c. Wear gloves when handling or touching resident-care equipment that is visibly soiled or potentially contaminated with blood, body fluids, or infectious organisms.
   d. Wear gloves with fit and durability appropriate to the task.
   e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a "clean" one).
   f. Do not reuse gloves.
   g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments.

3. Masks, Eye Protection, Face Shields
   a. Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

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b. Use mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable.

4. Gowns
   a. Wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing.
   b. Wear a gown that is appropriate to the task you are performing.
   c. Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other residents or environments.
   d. Remove gown and perform hand hygiene before leaving the resident's room.
   e. Do not reuse gowns.

5. Resident-Care Equipment
   a. Handle used resident-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of other microorganisms to other residents and environments.
   b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded.

6. Environmental Control
   a. Ensure that environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces are appropriately cleaned.

7. Linen
   a. Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments.

8. Safe Needle Handling
   a. Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles.
   b. Never recap used needles or otherwise manipulate them using both hands, or any other technique that involves directing the point of a needle toward any part of the body.
   c. Do not remove used needles from disposable syringes by hand, and do not bend, break, or otherwise manipulate used needles by hand.
   d. Place used disposable syringes and needles, scalpel blades, and other sharp items in appropriate puncture-resistant containers located as close as practicable to the area in which the items were used. Place reusable syringes and needles in a puncture-resistant container for transport to the reprocessing area.

9. Safe Injection Practices – The following principles are applied to the use of needles, cannulas that replace needles, and intravenous delivery systems:
   a. Always use aseptic technique when handling injection equipment.
   b. Never re-use syringes, even if the needle or cannula on the syringe is changed.
   c. Use IV administration sets for one resident only and dispose of appropriately after use.
   d. Do not use bags of IV solution as a common source for multiple residents.
   e. Use single-dose vials for parenteral medications.
   f. Do not administer medications from single-dose vials to multiple residents.
   g. If multi-dose vials are used, both the cannula and the syringe used to access the vial must be sterile. Discard if the sterility of the vial is compromised.

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10. Respiratory Hygiene/Cough Etiquette – The following measures shall be implemented to contain respiratory secretions in residents, staff and visitors at the point of initial entry into the facility:
    a. Signs posted at entrances in strategic places with instructions to residents, staff, and visitors to cover their mouths and noses when coughing or sneezing; use and dispose of tissues; and perform hand hygiene after hands have been in contact with respiratory secretions.
    b. Availability of tissues and no-touch (e.g., foot-pedal operated) trash receptacles for the disposal of tissues.
    c. Written materials and reminders posted in the facility regarding effective hand hygiene practices.
    d. Availability of conveniently located supplies and equipment for hand hygiene (e.g., sinks, soap, paper towels, and alcohol-based hand rubs).
    e. Availability of masks for residents and visitors who have symptoms of a respiratory infection.

References	
OBRA Regulatory Reference Numbers	483.65(a); 483.75(b).
Survey Tag Numbers	F441; F492
Other References	CDC *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007*
Related Documents	Isolation – Categories of Transmission-Based Precautions
Version	1.2 (H5MAPL0844)

FIDDLER'S GREEN MANOR

ACTIVITY DEPARTMENT COVID PRECAUTION PROTOCOL

All residents and facility staff will participate in activity programs to maintain mental, spiritual and physical wellbeing. It is the responsibility of all caregivers to interact and engage residents under the new coronavirus precautions as outlined by NYSDOH, CDC and CMS guidance.

Procedure:

I. Interdisciplinary Team Approach

A. All departments will ensure residents will maintain a safe distance of 6 feet apart and residents do not congregate in groups.
B. Residents using the elevator will be escorted one at a time as needed.
C. Staff assisting or transporting residents to activities will require wearing a mask when within 6 feet of a resident.

D. The Activity Director or designee will interview each resident for activity preferences and make activity supplies available for residents.

E. All disciplines will observe residents for signs and symptoms of mental status changes or depression for lack of socialization due to possible bed rest or isolation. The care plan will be reviewed and updated accordingly at this time.

F. Resident's, their responsible parties, family and staff are notified of COVID precautions including the restriction of no visitation and the availability of computers for visitation through facetime, Skype or google hangout. All staff can offer or facilitate a virtual visitation or video conferencing. Notification of virtual visitation or video conferencing and documentation in EMR of notification provided by Director of SW , Activity Director and Business Office Manager.

Note: An activity note is required if a change of the care plan is required.

G. Current activities will be discussed, reviewed and modified to accommodate COVID precautions to prevent transmission by the Activity Director and the IDT
H. Activity supplies will have increased sanitization, including surfaces and use in between residents. Disposable or individual activity items assigned as needed.
I. Upon resident admission, readmission, significant change, quarterly, annually and as needed, activity revisions on the plan of care are maintained and updated by Activity Director or designee.

FIDDLER'S GREEN MANOR

ACTIVITY DEPARTMENT COVID PRECAUTION PROTOCOL

J. All residents will have the opportunity to participate in activities
K. All staff will assist residents if assistance is need setting up activities for a resident as care-planned or upon request

Policy Originated By: H. Morin/ LNHA **Date:** 3/20/2020

Reviewed by		**Managing Members**	
Date		**Date**	**By**
3/2020	Act.Director/	3/2020	Mary Swartz /
	SW/		Kate Wannemacher/
	DON/		
	Rehab Director/		

cc: Physical Therapy/ Occupational Therapy
Dietitian/Dict Technician
Assistant Director of Nursing
Housekeeping
Maintenance
Social Services
Business Office
Activities
Nursing
Dietary

Personal Protective Equipment

Policy Statement

Personal protective equipment appropriate to specific task requirements is available at all times.

Policy Interpretation and Implementation

1. Employees required to perform tasks that may involve exposure to blood/body fluids will be provided appropriate protective clothing and equipment.

2. All tasks do not involve the same type or degree of risk, and therefore will not all require the same kind or extent of protection. The type of protective clothing and equipment is based on:
   a. The fluid or tissue to which there is a potential exposure;
   b. The likelihood of exposure;
   c. The potential volume of material;
   d. The probable route of exposure; and
   e. The overall working conditions and job requirements.

3. Protective clothing provided to our employees includes but is not necessarily limited to:
   a. Gowns/aprons/lab coats (disposable, cloth, and/or plastic);
   b. Gloves (sterile, non-sterile, heavy-duty and/or puncture-resistant);
   c. Masks; and
   d. Eyewear (goggles and/or face shields).

4. A supply of protective clothing and equipment is maintained at each nurses' station. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with our facility's personnel policies.

5. Personal protective equipment will be repaired or replaced as needed to maintain its effectiveness at no cost to employees. Staff should inform the Infection Preventionist about protective equipment needing repair or replacement.

References	
OBRA Regulatory Reference Numbers	§483.80(a) Infection prevention and control program.
Survey Tag Numbers	F880
Other References	www.cdc.gov/ncidod/dhqp/ppe.html and www.osha.gov/SLTC/personalprotectiveequipment/index.html.
Related Documents	Standard Precautions
Version	1.3 (H5MAPL0619)

By Signing below you agree to adhere to PPE Policy , CDC , NYSDOH guidance , and confirm receiving a procedural facial Mask

PPE Policy Statement

Personal protective equipment appropriate to specific task requirements is available at all times.

Policy Interpretation and Implementation

Employees required to perform tasks that may involve exposure to blood/body fluids will be provided appropriate protective clothing and equipment.

All tasks do not involve the same type or degree of risk, and therefore will not all require the same kind or extent of protection. The type of protective clothing and equipment is based on:

The fluid or tissue to which there is a potential exposure;
The likelihood of exposure;
The potential volume of material;
The probable route of exposure; and
The overall working conditions and job requirements.

Protective clothing provided to our employees includes but is not necessarily limited to:

Gowns/aprons/lab coats (disposable, cloth, and/or plastic);
Gloves (sterile, non-sterile, heavy-duty and/or puncture-resistant);
Masks; and
Eyewear (goggles and/or face shields).

A supply of protective clothing and equipment is maintained at each nurses' station. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with our facility's personnel policies.

Personal protective equipment will be repaired or replaced as needed to maintain its effectiveness at no cost to employees. Staff should inform the Infection Preventionist about protective equipment needing repair or replacement.

Further CDC and NYSDOH COVID Guidance: Please use PPE properly, adorn and remove properly.

The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.

Face mask must take care not to touch their facemask. If you touch or adjust their facemask you must immediately perform hand hygiene.

A face Mask must be work when within 6 feet of a co-worker or resident and in the community.

Last Name	First Name	Signature & DATE

NURSE COVERAGE PLAN

I. Pursuant to Section 167 of the New York State Labor Law, (Fiddlers Green Manor) (hereinafter referred to as the "Facility") will not mandate over-time for Licensed Practical Nurses or for Registered Nurses except under the following circumstances:

1. Health Care Disaster. The prohibition against mandatory overtime shall not apply in the case of a health care disaster, such as a natural or other type of disaster unexpectedly affecting the county in which the nurse is employed or in a contiguous county that increases the need for health care personnel or requires the maintenance of the existing on-duty personnel to maintain staffing levels necessary to provide adequate health care coverage. A determination that a health care disaster exists shall be made by the health care employer and shall be reasonable under the circumstances. Examples of health care disasters within the meaning of this Part include, but are not limited to, unforeseen events involving multiple serious injuries (e.g. fires, auto accidents, a building collapse), chemical spills or releases, a widespread outbreak of an illness requiring hospitalization for many individuals in the community served by the health care employer, or the occurrence of a riot, disturbance, or other serious event within an institution that increases the level of nursing care needed.
2. Government Declaration of Emergency. The prohibition against mandatory overtime shall not apply in the case of a federal, state or county declaration of emergency in effect pursuant to New York Executive Law Article 2-B or applicable federal law in the county in which the nurse is employed or in a contiguous county.
3. Patient Care Emergency. The prohibition against mandatory overtime shall not apply in the case of a patient care emergency, which shall mean a situation that is unforeseen and could not be prudently planned for and, as determined by the health care employer that requires the continued presence of the nurse to provide safe patient care.

II. The following definitions from Section 167 of the New York State Labor Law will apply to this Nurse Coverage Plan:

a. "Nurse" shall mean a registered professional nurse or a licensed practical nurse as defined by article one hundred thirty-nine of the education law who provides direct patient care, regardless of whether such nurse is employed full-time, part-time, or on a per diem basis. Nurses who provide services to a health care employer through contracts with third party staffing providers such as nurse registries, temporary employment agencies, and the like, or who are engaged to perform services for health care employers as independent contractors shall also be subject to this Part.

b. "On call" shall mean when an employee is required to be ready to perform work functions and required to remain on the employers premises or within a

proximate distance, so close thereto that s/he cannot use the time effectively for his or her own purposes. An employee who is not required to remain on the employer's premises or within a proximate distance thereto but is merely required to leave information, at his or her home or with the health care employer, where he or she may be reached is not working on call.

c. "Overtime" shall mean work hours over and above the nurse's regularly scheduled work hours. **Communicating from shift to shift is considered a part of "regular scheduled hours".**

d. "Regularly scheduled work hours" shall mean the predetermined number of hours a nurse has agreed to work and is normally scheduled to work pursuant to the budgeted hours allocated to the nurse's position by the health care employer.

III. The Facility will ensure that staffing schedules are prepared in advance taking into account holidays, vacations, and other requested time off.

IV. Before mandating over-time for nurses, the Facility will take the following steps:

1. The Facility will maintain a list of nurses who are willing to work over-time on a voluntary basis. Nurses on this list who are in the Facility when the need for over-time arises will be offered the opportunity to work over-time before mandating over-time for nurses.

2. The Facility will maintain an on-call listing of nurses in the event of illness or other unanticipated call in. Nurses on this list will be called before mandating over-time for nurses.

3. The Facility will maintain a listing of telephone numbers of all nurses employed by the facility including full-time, part-time, and per-diem for emergency use. Nurses who are not scheduled to work will be called before nurses are mandated to work over-time.

4. The Facility has signed contract with nurse agencies. The following agencies will be contacted to supply nurses before nurses in the facility are mandated to work over-time.

Name of agency	Telephone number
Floral Agency	718-708-7444
MSN	1-585-241-3010 - (~~Patty~~ Jodie) (585)-241-3010

All efforts to avoid the use of mandatory overtime during a patient care emergency and seek alternative staffing through the methods identified in subdivision IV of this Nurse Coverage Plan shall be documented.

Any nurse in the midst of a procedure or treatment must complete the procedure or treatment unless excused by a Nursing Supervisor.

Emergency/Disaster Job Assignment

Policy Statement

All personnel are pre-assigned specific tasks to perform during emergency situations.

Policy Interpretation and Implementation

1. All personnel are assigned specific tasks to perform during emergency/disaster situations.
2. Department directors are responsible for assigning their respective employees to such positions.
3. All newly hired personnel will be required to attend an orientation class concerning our fire safety and disaster preparedness plans.
4. Periodic in-service training classes will be conducted to keep all personnel informed of changes in our fire safety and disaster preparedness plans as well as any changes in job assignments.
5. In addition to orientation and in-service training classes, periodic drills will be conducted to assist personnel in performing their assigned tasks.

References	
OBRA Regulatory Reference Numbers	§483.73(a)(2) Include strategies for addressing emergency events identified by the risk assessment. §483.73(b)6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.
Survey Tag Numbers	E-0006; E-0024
Other References	

Cohorting/Testing During COVID 19

Date Initiated: 5/3/2020

Date Revised: 6/3/2020, 7/6/2020, 9/2/2020

Policy: It is the policy of the facility to prevent the spread of COVID 19 and to protect and treat all residents affected by the pandemic.

A key component to this will be cohorting of residents. The facility will dedicate space in the facility to care for residents with confirmed COVID-19. This may be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID- 19, residents with negative COVID status and those residents with unknown COVID status.

Definition: Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other patients. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent. Cohorting during COVID 19 will be done in accordance with CDC and NYSDOH guidance to designate space in the Facility to separate residents into cohorts of COVID positive, COVID suspected, negative and unknown status that will include new /readmissions with unknown COVID status. When single patient rooms are not available, patients with **confirmed** COVID-19 may be placed in the same room.

Procedure:

1. The facility will cohort residents with no COVID-19 symptoms (GREEN ZONE), unknown COVID-19 virus (YELLOW ZONE), and confirmed COVID-19 virus (RED ZONE).
2. Newly admitted residents will be placed in the YELLOW zone for a minimum of 14 days on transmission-based precaution. If a newly admitted resident develops fever or respiratory symptoms or other COVID-19 symptoms they will be transferred to a room on a COVID-19 designated unit – Red Zone.
    a. On 5/10/20, Governor Cuomo issued Executive Order requiring testing of all patients being discharged to a nursing home. The Order stated:
        i. "Any article 28 general hospital shall not discharge a patient to a nursing home, without first performing a diagnostic test for COVID-19 and obtaining a negative result."

b. The Order does not indicate when such a test needs to be drawn . Currently we are screening all patients for COVID on admission.

Therefore

i. If a patients admission test is negative and they exhibit no clinical evidence of COVID during the admission they do not need to be retested prior to discharge. The negative test on admission can be used to justify discharge to the Nursing Home.

ii. If a patient is COVID positive on admission or develops COVID positivity in the hospital, they will need **TWO** negative tests at least 24 hours apart in order to discontinue contact/isolation precautions and permit discharge to a Nursing Home

iii. No patient should be discharged to a NURSING Home if there is a COVID test pending

3. All new/readmissions hospital information will be reviewed prior to new/readmission to determine if infection prevention and treatment needs can be met at the facility.
4. All residents will continue to be assessed daily for any symptoms of COVID-19 including fever, respiratory symptoms, or any change in condition. Current data for COVID-19 has demonstrated that nursing home residents may present atypical symptoms including change in mental status.
5. Any resident presenting with signs or symptoms of COVID-19 infection will be assessed by Primary Physician/Nurse Practitioner.
6. Per CMS (8/26/2020) - When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak (as specified below).
7. Identification and early work-up including testing as indicated and treatment will be initiated by clinical staff for all residents with suspected or confirmed COVID-19
8. The facility will continue to promote consistent assignment staffing as below:
    - The staffing coordinator in conjunction with the DON/RNS will make every effort to have Residents that have confirmed COVID-19 to be grouped into one assignment.
    - Every effort will be made to have residents that have suspected COVID-19 to be grouped into one assignment
    - Every effort will be made to have residents that have NO symptoms of COVID-19 or who have had transmission-based precautions discontinued to be grouped into one assignment
9. Residents who are confirmed or suspected of COVID-19 will be placed in appropriate zone have the signage for the zone indicating droplet and contact precautions.

<u>The RED ZONE</u>

- Residents on these units/areas have confirmed cases of COVID-19.
- Residents testing positive for COVID -19 will be roomed in the dedicated red zone.
- Residents identified with COVID-19 symptoms will be identified as Person Under investigation (PUI) and will be placed in a private room if available or cohorted with a

COVID-19 PUI resident. Residents are encouraged to wear a mask if tolerated and educated in respiratory etiquette.

- Caregivers will wear full PPE to include gown, face shields, masks and gloves.
- Residents on these units will continue to be monitored each shift for symptoms and clinical signs indicating a worsening of condition.
- Removal from the Red Zone will be based on the CDC's Symptom Based Strategy:

Per CDC (updated August 10, 2020): Residents that pass the 14-day mark and no longer require droplet and standard precautions will be evaluated by MD/NP to determine. **Symptom-Based Strategy for Discontinuing Transmission-Based Precautions.**

Patients with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: For patients who are **not severely immunocompromised**[1] and who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

The GREEN ZONE

- All Residents in these zones have no symptoms of COVID-19, have had a negative test for COVID-19 or passed the 14-day window and no longer have symptoms including being afebrile x 3 days without antipyretics.
- Caregivers will be required to wear a face mask and follow standard precautions on these units/wings.
- If any resident on one of these units becomes symptomatic or suspect for COVID-19, he/she will be transferred to a room in the RED ZONE and a Physician/NP will assess and order COVID-19 testing and any treatment as indicated.
- Residents on these units will continue to be monitored daily for temperature, and any other symptoms that could be suspect for COVID-19. RN will document in the medical

record when the residents has passed the 14-day mark and have not displayed any symptoms related to COVID-19.

- At the end of the 14 days the resident will receive a nasal pharyngeal swab, and if negative, resident will be transferred to a general unit.

The YELLOW ZONE

- Residents admitted or re-admitted from the hospital will be placed in this designated area for fourteen days on droplet and contacted transmission based precautions to ensure that are not carrying the COVID-19 virus.
- Current resident who attend Dialysis and Methadone clinic appointments multiple days per week will be considered YELLOW ZONE residents and will be maintained in the YELLOW ZONE.
- Transmission based signage for droplet and contact precautions will be posted in the YELLOW ZONE. Caregivers will wear full PPE to include gown, masks and gloves
- Residents on this zone will continue to be monitored daily for signs and symptoms of COVID related illness including vital signs.
- Residents that develops symptoms they will be transferred to RED ZONE. PMD/NP will assess any resident with suspect COVID-19 illness and order testing for COVID 19 as indicated.
- RN will document in the medical record when the residents has passed the 14-day mark and have not displayed any symptoms related to COVID-19.
- At the end of the 14 days the resident will be re-assessed for respiratory symptoms, and temperature and if cleared will be moved into the GREEN ZONE.

Monitoring COVID-19 cases on the Dementia Unit for those living with dementia (IF APPLICABLE TO FACILITY)

- The movement of residents living with Dementia will be reviewed by the IDT and based on a risk benefit analysis a decision will be made if the resident should be moved from room or not. Family members will be consulted and informed.
- If needed, a RED and/or YELLOW zone will be created for COVID-19 cases.
- Residents on these units will continue to be monitored each shift for symptoms and clinical signs indicating a worsening of condition, or the development of symptoms of COVID-19.
- Caregivers will re-direct wandering residents to ensure safe social distancing.

Residents who have signs or symptoms of COVID-19 must be tested. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance. Once test results are obtained, the resident will be placed in the appropriate zone.

THE MOST IMPROTANT ACTIONS TO PROTECT YOUR RESIDENTS AND YOURSELF:

1. Hand hygiene after each resident encounter by all staff in all departments.
2. Proper use of gloves with glove changing between all residents and hand hygiene performed before donning new gloves.
3. Universal masking on all units will continue for all staff in all departments. Avoid touching eyes, nose and mouth with hands.
4. Identify and report immediately any change in resident condition to Charge Nurse and/or RNS.
5. Do not come to work if you are ill. Contact RNS if you become ill while working.
6. If you have a question or need support, please ask. All Team members are valued.

Please Note: To Ensure Residents rights are upheld any room transfers will be discussed with resident/resident representatives and orientation to new room and roommate will be conducted by SW/Designee. All room transfers will be documented in accordance with state and federal regulations

Facility: Fiddler's Green Manor
COVID Visitation Policy

Date Initiated: 7/15/2020
Date Revised:

POLICY: Nursing homes and long term care facilities in New York will be allowed to resume limited visitations for facilities that have been without COVID-19 (staff and/or residents) for at least 28 days, a threshold set by the Centers for Medicare & Medicaid Services.

Current COVID-19 positive residents, residents with COVID-19 signs/symptoms, and residents in a 14-day quarantine or observation period are not eligible for visits.

The facility will submit specific benchmarks and develop a reopening plan via the NY Forward Safety Plan and affirmatively attest that they are following the guidance.

Facility will have a testing plan in place that, at a minimum, ensures all consenting nursing home residents have received a single baseline COVID-19 test. In addition, the NH must have the capability to test or can arrange for testing of all residents upon identification of any individual with symptoms consistent with COVID-19. If a staff member tests positive for the SARS-CoV-2 virus, the NH must have the capacity to continue re-testing all nursing home staff and residents, as applicable

PROCEDURE:

1. Visitation will be limited to outdoor areas, weather permitting. Under certain limited circumstances, as defined by the facility, visitation can be inside, in a well-ventilated space with no more than 10 individuals who are appropriately socially distanced and wearing a facemask or face covering while in the presence of others. This may include residents visiting each other.
2. Visitation is strictly prohibited in resident rooms or care areas with the exception of compassionate visitation. This may change with future NYSDOH/CDC Guidance.
3. Limited visitation will be permitted under the following conditions:
    a. Schedule visitation will occur with Activities personal or designee at half hour increments, with 15 minutes between visits to allow for cleaning of visitation area.
    b. Monitoring of visits will occur by designated staff to assure visitation restrictions are met.
    c. Cleaning and disinfecting areas used for visitation after each visit using an EPA-approved disinfectant.
    d. Maintains signage regarding facemask utilization and hand hygiene and uses applicable floor markings to cue social distancing delineations.
    e. Screen Visitors for signs and symptoms of COVID-19 prior to resident access. Visitation will be refused if the individual(s) exhibits any COVID-19 symptoms or do not pass the screening questions. Screening shall consist of both temperature checks and asking screening questions to assess potential exposure to COVID-19 which shall include questions regarding international travel or

travel to other states designated under the Commissioner's travel advisory. The facility must maintain screening questions asked onsite and make it available upon the Department's request.

f. Maintain documentation both onsite and in an electronic format; to be available upon the Department's request for purposes of inspection and potential contact tracing. Documentation must include the following for each visitor to the nursing home:
    i. Resident visited
    ii. First and last name of the visitor;
    iii. Physical (street) address of the visitor;
    iv. Daytime and evening telephone number;
    v. Date and time of visit;
    vi. Email address, if available
    vii. A notation indicating the individual cleared the screening (both temperature and questions) that does not include any individual temperatures or other individual specific information.

g. Ensure PPE (facemask or face covering) is worn by residents, which covers both the nose and mouth, during visitation, if medically tolerated.

h. The visitors must:
    i. Wear a face mask or face covering which covers both the nose and mouth at all times when on the premises of the NH.
    ii. Maintain social distancing, except when assisting with wheelchair mobility. The nursing home must have adequate supply of masks on hand for visitors and must make them available to visitors who lack an acceptable face covering.

i. Provide alcohol -based hand rub , consisting of at least 60 percent (60%) alcohol, to residents, visitors, and representatives of the long-term care ombudsman visiting residents and those individuals are able demonstrate to appropriate use.

j. Limit visitation to 10 percent (10%) of the residents and only two visitors will be allowed per resident at any one time.

k. Communication of visitation policies in order to comply with this requirement and schedule such visits.

l. Visitors under the age of 18 must be accompanied by an adult 18 years of age or older

m. Current COVID-19 positive residents, residents with COVID-19 signs or symptoms, and residents in a 14-day quarantine or observation period are not eligible for visits.

n. Develop a short, easy -to-read fact sheet outlining visitor expectations including appropriate hand hygiene and face coverings. The fact sheet will be provided upon initial screening to all visitors.

4. If any visitor does not adhere to the DOH/nursing homes' protocol, the visitor will be prohibited from visiting for the duration of the COVID-19 state declared public health emergency.

5. Hours of visitation are: _____. These may be changed as needed to ensure resident and staff safety. If changed, new times will be posted and placed on the visitation fact sheet.

Fiddler's Green Manor
REHABILITATION AND NURSING CENTER

7/14/2020

To Our Residents and Family Members:

We want to thank you for your continued support and patience during this COVID pandemic and we wish to provide you with an update on our status here at Fiddler's Green Manor.

Fiddler's Green Manor remains COVID-19 free. There are no positive cases of both staff and residents. This means we will be permitted to resume visitation on **Monday 7/20/2020** with the following restrictions in place:

1. Visitations will be scheduled one week in advance
2. Limitation of 2 visitors per one resident
3. Visitation is allowed outdoors weather permitting and inside at the front reception.
4. Visits will be limited to 30 minutes, Monday through Friday 9-4PM. Saturday and Sundays visits are limited, special arrangements for times can be made.
5. Distant supervision is required
6. Those residents who reside in the green zone are eligible for visitors is designated areas
7. Visitors will be screened before visitation and required to wear a mask throughout visit
8. Those who are unable to maintain NYSDOH or CDC precautions including 6 feet apart social distancing or wearing a mask will loose visitation privileges.
9. Visitation for comfort care circumstances or at end of life will remain unchanged and will continue.

Please know virtual visitation and video conferencing is still available; please contact Eric Wozniak Director of Social Services or Catherine Bullock Director of Activities to make an appointment for visitation.

Be well and stay safe.

Sincerely,

Heather Morin

Heather A. Morin

Fiddler's Green Manor Administrator

168 W Main Street

Springville NY 14141

716-592-4781

Fiddler's Green Manor
REHABILITATION AND NURSING CENTER

VISITATION FACT SHEET

In accordance with:

- CDC
- NYS DOH
- CMS

The hours of visitation are 9 AM – 4 PM M-F days a week. Weekends can be arranged as needed.

1. ALL visits MUST be scheduled with Eric Wozniak Director of Social Services
2. Visitors under the age of 18 must be accompanied by an adult 18 years of age or older.
3. Only 2 visitors at a time
4. Visitor screen sheet MUST be completed and include the following:
    a. Signs and Symptoms of COVID
    b. Temperature
    c. Screening questions to include potential exposure to COVID and recent travel locations both international in within the US.
5. The visitor MUST complete an information identification form to include:
    a. Resident visited
    b. First and last name of the visitor;
    c. Physical (street) address of the visitor;
    d. Daytime and evening telephone number;
    e. Date and time of visit;
    f. Email address, if available
6. Visitation will be refused if the individual(s) exhibits any COVID-19 symptoms, does not pass the screening questions or does not comply with completion of visitor screen.
7. Current COVID-19 positive residents, residents with COVID-19 signs/symptoms, and residents in a 14-day quarantine or observation period are not eligible for visits.
8. The visitors must:
    a. Wear a face mask or face covering which covers both the nose and mouth at all times when on the premises of the NH.
    b. Maintain social distancing, except when assisting with wheelchair mobility. The nursing home must have adequate supply of masks on hand for visitors and must make them available to visitors who lack an acceptable face covering.
9. If any visitor does not adhere to the DOH/nursing homes' protocol, the visitor will be prohibited from visiting for the duration of the COVID-19 state declared public health emergency.

Thank you for helping us keep our residents happy and healthy.

Fiddler's Green Manor
REHABILITATION AND NURSING CENTER

VISITATION FACT SHEET

In accordance with:

- CDC
- NYS DOH
- CMS

The hours of visitation are 9 AM – 4 PM M-F days a week. Weekends can be arranged as needed.

1. ALL visits MUST be scheduled with _____
2. Visitors under the age of 18 must be accompanied by an adult 18 years of age or older.
3. Only 2 visitors at a time
4. Visitor screen sheet MUST be completed and include the following:
    a. Signs and Symptoms of COVID
    b. Temperature
    c. Screening questions to include potential exposure to COVID and recent travel locations both international in within the US.
5. The visitor MUST complete an information identification form to include:
    a. Resident visited
    b. First and last name of the visitor;
    c. Physical (street) address of the visitor;
    d. Daytime and evening telephone number;
    e. Date and time of visit;
    f. Email address, if available
6. Visitation will be refused if the individual(s) exhibits any COVID-19 symptoms, does not pass the screening questions or does not comply with completion of visitor screen.
7. Current COVID-19 positive residents, residents with COVID-19 signs/symptoms, and residents in a 14-day quarantine or observation period are not eligible for visits.
8. The visitors must:
    a. Wear a face mask or face covering which covers both the nose and mouth at all times when on the premises of the NH.
    b. Maintain social distancing, except when assisting with wheelchair mobility. The nursing home must have adequate supply of masks on hand for visitors and must make them available to visitors who lack an acceptable face covering.
9. If any visitor does not adhere to the DOH/nursing homes' protocol, the visitor will be prohibited from visiting for the duration of the COVID-19 state declared public health emergency.

Thank you for helping us keep our residents happy and healthy.

Visitation Screening Log

Date: ____________

	Address				Phone Number	Email Address (if applicable	Approved By
	Street	City	State	Zip			

Facility: Fiddler's Green Manor

Cleaning & Signage Policy

Part of the 2020 NY Health and Safety Plan

Date Initiated: 7/15/2020
Date Revised:

Policy Purpose

This Policy reflects the Company's Policy on cleaning protocol and signage to adhere to State requirements and to prevent the spread of COVID 19. This Policy shall be in effect until further notice.

1. Company Designee:

The Company Designates Paula Hansen as in charge of overseeing that the Cleaning & Signage Policy is carried out daily.

2. Signage
   - Post signs in the visitation areas reminding residents and visitors of the symptoms of COVID-19, to wear masks when appropriate, and to stay 6 feet away from others when possible.
   - Post social distancing markers where appropriate designating spaces as 6-feet apart.

3. Cleaning Schedule
   - The Designee shall ensure that the Cleaning Schedule below is made available to employees that shall assist with cleaning. The minimum requirement for cleaning all areas is daily.

4. Method of Cleaning
   - Cleaning shall be performed according to CDC requirements and with products approved by the CDC as provided at https://www.cdc.gov/coronavirus/2019-cov/community/disinfectingbuilding-facility.html and as attached hereto.

5. Cleaning Log
   - A Cleaning Log shall be kept by the Designee and those performing cleaning documenting who cleaned which areas, how and when.
   - The Designee shall oversee that completion and safe keeping of the log.

Cleaning and Disinfection of Environmental Surfaces COVID 19

Fiddler's Green Manor

Date Initiated: 3/5/2020

Date Revised: 6/3/2020, 7/22/2020

Policy Statement

Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard.

Policy Interpretation and Implementation

1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care and those in the resident's environment:
   a. **Critical items** consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (e.g., urinary catheters) or the vascular system (e.g., intravenous catheters) are considered critical items and must be sterile.
   b. **Semi-critical items** consist of items that may come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (Note: Some items that may come in contact with non-intact skin for a brief period of time (e.g., hydrotherapy tanks, bed side rails) are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.)
   c. **Non-critical items** are those that come in contact with intact skin but not mucous membranes.
      (1) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors.
      (2) Most non-critical items can be decontaminated where they are used (as opposed to being transported to a central processing location).

2. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions.
   a. Most EPA-registered hospital disinfectants have a label contact time of 10 minutes.
   b. By law, all applicable label instructions on EPA-registered products must be followed.

3. **Devices** that are used by staff but not in direct contact with residents (e.g., computer keyboards, PDAs, etc.) shall be cleaned and disinfected regularly daily by the environmental services staff / nursing staff.

   a. **DEVICES used by residents:**

      i. Devices shared between residents in same zones only, i.e. green to green, yellow to yellow etc.

      ii. Only approved disinfecting wipes to be used between use.

      iii. Staff to assist and manage devices between residents to assure proper sanitizing with approved wipes.

4. Intermediate and low-level disinfectants for non-critical items include:
   a. Ethyl or isopropyl alcohol;
   b. Sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions);

c. Phenolic germicidal detergents;
d. Iodophor germicidal detergents; and
e. Quaternary ammonium germicidal detergents (low-level disinfection only).

5. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including:
   a. Recommended use-dilution;
   b. Material compatibility;
   c. Storage;
   d. Shelf-life; and
   e. Safe use and disposal.

6. A one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes will be used in resident care areas where:
   a. uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or
   b. uncertainty exists about the presence of multidrug-resistant organisms on such surfaces.

7. Detergent and water will be used for cleaning surfaces in non resident care areas (e.g., administrative offices).

8. High-level disinfectants/liquid chemical sterilants will not be used for disinfection of non-critical surfaces.

9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.

10. Environmental surfaces will be disinfected (or cleaned) on a regular basis and when surfaces are visibly soiled.

11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.

12. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently (e.g., floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60-minute intervals).

13. Mop heads and cleaning cloths will be decontaminated regularly (e.g., laundered and dried at least daily).

14. Horizontal surfaces will be wet dusted regularly clean cloths moistened with an EPA-registered hospital disinfectant (or detergent). The disinfectant (or detergent) will be prepared as recommended by the manufacturer.

15. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated. Blood-contaminated items will be discarded in compliance with federal regulations (i.e., OSHA Bloodborne Pathogens Standard).

16. The following procedures will be implemented for site decontamination of spills of blood or other potentially infectious materials (OPIM):
   a. Use protective gloves and other PPE (e.g., when sharps are involved use forceps to pick up sharps and discard these items in a puncture-resistant container) appropriate for this task.
   b. Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent, a registered germicide on the EPA Lists D and E (i.e., products with specific label claims for HIV and HBV) or freshly diluted hypochlorite solution.

c. If sodium hypochlorite solutions are selected use a 1:100 dilution to decontaminate nonporous surfaces after a small spill (e.g., <10 mL) of either blood or OPIM.
d. If a spill involves large amounts (e.g., >10 mL) of blood or OPIM, or involves a culture spill in the laboratory, use a 1:10 dilution for the first application of hypochlorite solution before cleaning in order to reduce the risk of infection during the cleaning process in the event of a sharps injury.
e. Follow this decontamination process with a terminal disinfection, using a 1:100 dilution of sodium hypochlorite.

17. If the spill contains large amounts of blood or body fluids, the visible matter will be cleaned with disposable absorbent material, and the contaminated materials discarded in an appropriate, labeled container.

18. Protective gloves and other PPE appropriate for this task will be used.

19. In units with high rates of endemic *Clostridium difficile* infection or in an outbreak setting, dilute solutions of 5.25%–6.15% sodium hypochlorite (e.g., 1:10 dilution of household bleach) will be used for routine environmental disinfection. (Note: Currently, no products are EPA-registered specifically for inactivating *C. difficile* spores.)

20. If chlorine solution is not prepared fresh daily, it will be stored at room temperature for up to 30 days in a capped, opaque plastic bottle. (Note: A 50% reduction in chlorine concentration will occur by day 30.)

21. An EPA-registered sodium hypochlorite product is preferred, but if such products are not available, generic versions of sodium hypochlorite solutions (e.g., household chlorine bleach) may be used.

Cleaning and Disinfection of Environmental Surfaces COVID 19

Fiddler's Green Manor

Date Initiated: 3/5/2020

Date Revised: 6/3/2020

Policy Statement

Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard.

Policy Interpretation and Implementation

1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care and those in the resident's environment:
   a. **Critical items** consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (e.g., urinary catheters) or the vascular system (e.g., intravenous catheters) are considered critical items and must be sterile.
   b. **Semi-critical items** consist of items that may come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (Note: Some items that may come in contact with non-intact skin for a brief period of time (e.g., hydrotherapy tanks, bed side rails) are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.)
   c. **Non-critical items** are those that come in contact with intact skin but not mucous membranes.
      (1) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors.
      (2) Most non-critical items can be decontaminated where they are used (as opposed to being transported to a central processing location).

2. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions.
   a. Most EPA-registered hospital disinfectants have a label contact time of 10 minutes.
   b. By law, all applicable label instructions on EPA-registered products must be followed.

3. Devices that are used by staff but not in direct contact with residents (e.g., computer keyboards, PDAs, etc.) shall be cleaned and disinfected regularly daily by the environmental services staff / nursing staff.

4. Intermediate and low-level disinfectants for non-critical items include:
   a. Ethyl or isopropyl alcohol;
   b. Sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions);
   c. Phenolic germicidal detergents;
   d. Iodophor germicidal detergents; and
   e. Quaternary ammonium germicidal detergents (low-level disinfection only).

5. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including:
   a. Recommended use-dilution;
   b. Material compatibility;
   c. Storage;
   d. Shelf-life; and

e. Safe use and disposal.

6. A one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes will be used in resident care areas where:
   a. uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or
   b. uncertainty exists about the presence of multidrug-resistant organisms on such surfaces.

7. Detergent and water will be used for cleaning surfaces in non resident care areas (e.g., administrative offices).

8. High-level disinfectants/liquid chemical sterilants will not be used for disinfection of non-critical surfaces.

9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.

10. Environmental surfaces will be disinfected (or cleaned) on a regular basis and when surfaces are visibly soiled.

11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.

12. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently (e.g., floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60-minute intervals).

13. Mop heads and cleaning cloths will be decontaminated regularly (e.g., laundered and dried at least daily).

14. Horizontal surfaces will be wet dusted regularly clean cloths moistened with an EPA-registered hospital disinfectant (or detergent). The disinfectant (or detergent) will be prepared as recommended by the manufacturer.

15. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated. Blood-contaminated items will be discarded in compliance with federal regulations (i.e., OSHA Bloodborne Pathogens Standard).

16. The following procedures will be implemented for site decontamination of spills of blood or other potentially infectious materials (OPIM):
   a. Use protective gloves and other PPE (e.g., when sharps are involved use forceps to pick up sharps and discard these items in a puncture-resistant container) appropriate for this task.
   b. Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent, a registered germicide on the EPA Lists D and E (i.e., products with specific label claims for HIV and HBV) or freshly diluted hypochlorite solution.
   c. If sodium hypochlorite solutions are selected use a 1:100 dilution to decontaminate nonporous surfaces after a small spill (e.g., <10 mL) of either blood or OPIM.
   d. If a spill involves large amounts (e.g., >10 mL) of blood or OPIM, or involves a culture spill in the laboratory, use a 1:10 dilution for the first application of hypochlorite solution before cleaning in order to reduce the risk of infection during the cleaning process in the event of a sharps injury.
   e. Follow this decontamination process with a terminal disinfection, using a 1:100 dilution of sodium hypochlorite.

17. If the spill contains large amounts of blood or body fluids, the visible matter will be cleaned with disposable absorbent material, and the contaminated materials discarded in an appropriate, labeled container.

18. Protective gloves and other PPE appropriate for this task will be used.

19. In units with high rates of endemic *Clostridium difficile* infection or in an outbreak setting, dilute solutions of 5.25%–6.15% sodium hypochlorite (e.g., 1:10 dilution of household bleach) will be used for routine environmental disinfection. (Note: Currently, no products are EPA-registered specifically for inactivating *C. difficile* spores.)

20. If chlorine solution is not prepared fresh daily, it will be stored at room temperature for up to 30 days in a capped, opaque plastic bottle. (Note: A 50% reduction in chlorine concentration will occur by day 30.)

21. An EPA-registered sodium hypochlorite product is preferred, but if such products are not available, generic versions of sodium hypochlorite solutions (e.g., household chlorine bleach) may be used.

Cleaning and Disinfecting Residents' Rooms COVID 19

Fiddler's Green Manor

Date Initiated: 3/5/2020

Date Revised: 6/3/2020

Purpose

The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms during the COVID 19 Pandemic.

General Guidelines

1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.
2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (daily) and when surfaces are visibly soiled.
3. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including:
   a. Recommended use-dilution;
   b. Material compatibility;
   c. Storage;
   d. Shelf-life; and
   e. Safe use and disposal.
4. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.
5. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently.
6. Floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60-minute intervals.
7. Personnel should remain alert for evidence of rodent activity (droppings) and report such findings to the Environmental Services Director.
8. Use heavy-duty gloves (and other PPE as indicated by the ZONES) for housekeeping tasks.
   a. Gloves, protective eyewear and masks may be indicated to reduce exposure levels to disinfectant chemicals as well as to protect employees from exposure to blood and OPIM while cleaning or disinfecting.
   b. Heavy-duty gloves may be reused as long as the integrity of the gloves is intact and they are disinfected regularly.
9. Clean medical waste containers intended for reuse (e.g., bins, pails, cans, etc.) daily or when such receptacles become visibly contaminated with blood, body fluids or other potentially infectious materials.
10. Perform hand hygiene after removing gloves.
11. Intermediate and low-level disinfectants for non-critical items include:
    a. Ethyl or isopropyl alcohol;
    b. Sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions);
    c. Phenolic germicidal detergent;
    d. Iodophor germicidal detergent; and
    e. Quaternary ammonium germicidal detergent (low-level only).
12. The Environmental Services Director and Administrator, in conjunction with the Infection Preventionist, will select appropriate facility disinfectants.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Supplies and equipment appropriate for the task (for example):
   a. Disinfectant solution;
   b. Cleaning cloths;
   c. Mop;
   d. Bucket; and
   e. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

Resident Room Cleaning:

1. Gather supplies as needed.
2. Prepare disinfectant according to manufacturer's recommendations.
3. Discard disinfectant/detergent solutions that become soiled or clouded with dirt and grime and prepare fresh solution.
4. Change mop solution water at least every three (3) rooms, or as necessary.
5. Change cleaning cloths when they become soiled. Wash cleaning cloths daily and allow cloths to dry before reuse.
6. Clean horizontal surfaces (e.g., bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution. Do not use feather dusters.
7. Clean personal use items (e.g., lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly.
8. When cleaning rooms of residents on isolation precautions, use personal protective equipment as indicated.
9. When possible, isolation rooms should be cleaned last and water discarded after cleaning room.
10. Utilize disinfectant solution based on type of precaution.
11. Clean curtains, window blinds, and walls when they are visibly soiled or dusty.
12. Clean spills of blood or body fluids as outlined in the established procedure.

Terminal Room Cleaning:

1. Terminal room cleaning is done when the resident is transferred, discharged, or expires.
2. Gather equipment (e.g., heavy-duty gloves, freshly prepared disinfectant, cleaning cloth, plastic trash bag, mop, and bucket).
3. Prepare disinfectant according to manufacturer's recommendations.
4. Use fresh solutions for terminal and thorough cleaning of all rooms.
5. Discard solution when the procedure has been completed.
6. Clean all high-touch furniture items (e.g., bedside tables, overbed tables, chairs, and beds) with disinfectant solution.
7. Clean all high-touch personal use items (e.g., lights, phones, call bells, bedrails, etc.) with disinfectant solution.
8. Discard personal (e.g., powder, toothpaste, toothbrushes, mouthwash, lotions, and soaps) and single-resident use items (e.g., thermometers).
9. Return items still in their original wrappers to stock if the integrity of the wrapper is not compromised, the outside of the container is visibly clean, and the item is not outdated.

Please visit the CDC website on strategies to optimize the use of N95 Respirators:

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

Optimizing the Use of Personal Protective Equipment (PPE)

Utilization (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/)

LTCF staff *must* be provided with the personal protective equipment (PPE) needed to keep themselves and the residents safe, including gloves, gowns, facemasks, respirators (if available and fit-tested), and eye protection.

According to the CDC, for known or suspected COVID-19 cases, respirators (eg, N95 masks) should be "prioritized for procedures that are likely to generate respiratory aerosols" (such as collecting respiratory specimens) and "facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand."

If respirators are available, facilities should immediately conduct fit testing of healthcare provider staff.

For all residents with undiagnosed respiratory infections, standard, contact, and droplet precautions (including eye protection) should be utilized. It is important to note that the presence of PPE may frighten residents, particularly those who are cognitively impaired. Staff should introduce themselves at the resident's doorway prior to donning PPE and notify the resident that they will be entering the room with their face covered.

Eye protection, gown, and gloves continue to be recommended.

If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP.

Optimizing the use of PPE

(https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html)

Existing CDC guidelines recommend a combination of approaches to conserve supplies while safeguarding health care workers in such circumstances. These existing guidelines recommend that health care institutions:

- Minimize the number of individuals who need to use respiratory protection through the preferential use of engineering and administrative controls;
- Use alternatives to N95 respirators (e.g., other classes of filtering facepiece respirators, elastomeric half-mask and full facepiece air purifying respirators, powered air purifying respirators) where feasible;
- Implement practices allowing extended use and/or limited reuse of N95 respirators, when acceptable; and
- Prioritize the use of N95 respirators for those personnel at the highest risk of contracting or experiencing complications of infection.

Contingency Strategies (during expected shortages)

Use N95 respirators beyond the manufacturer-designated shelf life for training and fit testing.

Extend the use of N95 respirators by wearing the same N95 for repeated close contact encounters with several different residents, without removing the respirator per recommended guidance on implementation of extended use.

Crisis Strategies (during known shortages)

When N95 Supplies are Running Low

Use respirators as identified by CDC as performing adequately for healthcare delivery beyond the manufacturer-designated shelf life.

Use respirators approved under standards used in other countries that are similar to NIOSH-approved respirators.

Implement limited re-use of N95 respirators by one HCP for multiple encounters with different residents, but remove it after each encounter.

Use additional respirators identified by CDC as NOT performing adequately for healthcare delivery beyond the manufacturer-designated shelf life.

Prioritize the use of N95 respirators and facemasks by activity type with and without masking symptomatic resident's.

Respirator Extended Use Recommendations

Extended use is favored over reuse because it is expected to involve less touching of the respirator and therefore less risk of contact transmission.

A key consideration for safe extended use is that the respirator must maintain its fit and function. Workers in other industries routinely use N95 respirators for several hours uninterrupted. Experience in these settings indicates that respirators can function within their design specifications for 8 hours of continuous or intermittent use.

If extended use of N95 respirators is permitted, respiratory protection program administrators should ensure adherence to administrative and engineering controls to limit potential N95 respirator surface contamination (e.g., use of barriers to prevent droplet spray contamination) and consider additional training and reminders (e.g., posters) for staff to reinforce the need to minimize unnecessary contact with the respirator surface, strict adherence to hand hygiene practices, and proper Personal Protective Equipment (PPE) donning and doffing technique.

Healthcare facilities should develop clearly written procedures to advise staff to take the following steps to reduce contact transmission after donning:

- Discard N95 respirators following use during aerosol generating procedures.
- Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids from residents.

- Discard N95 respirators following close contact with, or exit from, the care area of any resident co-infected with an infectious disease requiring contact precautions.
- Consider use of a cleanable face shield (preferred) over an N95 respirator and/or other steps (e.g., masking residents, use of engineering controls) to reduce surface contamination.
- Perform hand hygiene with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit).

Extended use alone is unlikely to degrade respiratory protection. However, healthcare facilities should develop clearly written procedures to advise staff to discard any respirator that is obviously damaged or becomes hard to breathe through.

Respirator Reuse Recommendations

There is no way of determining the maximum possible number of safe reuses for an N95 respirator as a generic number to be applied in all cases. Safe N95 reuse is affected by a number of variables that impact respirator function and contamination over time. However, manufacturers of N95 respirators may have specific guidance regarding reuse of their product. The recommendations below are designed to provide practical advice so that N95 respirators are discarded before they become a significant risk for contact transmission or their functionality is reduced.

If reuse of N95 respirators is permitted, respiratory protection program administrators should ensure adherence to administrative and engineering controls to limit potential N95 respirator surface contamination (e.g., use of barriers to prevent droplet spray contamination) and consider additional training and/or reminders (e.g., posters) for staff to reinforce the need to minimize unnecessary contact with the respirator surface, strict adherence to hand hygiene practices, and proper PPE donning and doffing technique, including physical inspection and performing a user seal check.

Healthcare facilities should develop clearly written procedures to advise staff to take the following steps to reduce contact transmission:

- Discard N95 respirators following use during aerosol generating procedures.
- Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids from residents.
- Discard N95 respirators following close contact with any resident co-infected with an infectious disease requiring contact precautions.
- Consider use of a cleanable face shield (preferred) over an N95 respirator and/or other steps (e.g., masking residents, use of engineering controls), when feasible to reduce surface contamination of the respirator.
- Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly.
- Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit).
- Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene as described above.
- Use a pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check. Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.

When No Respirators Are Left

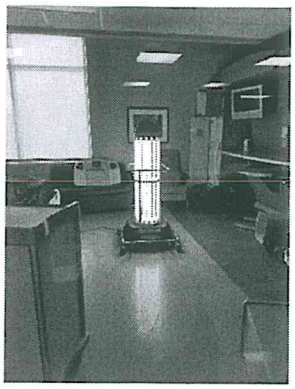
Exclude HCP at higher risk for severe illness from COVID-19 such as those of older age, those with chronic medical conditions, or those who may be pregnant from contact with known or suspected COVID-19 residents

Designate convalescent HCP for provision of care to known or suspected COVID-19 residents (those who have clinically recovered from COVID-19 and may have some protective immunity) to preferentially provide care)

Recommended PPE according to setting, personnel and type of activity

Setting	Personnel	Activity	Type of PPE
Resident Room	Health care workers	Providing direct care to COVID19 residents	Medical mask Gown Gloves Eye protection (goggles or face shield)
		Aerosol-generating procedures performed on COVID-19 residents	Respirator N95 or FFP2 standard, or equivalent. Gown Gloves Eye protection Apron
	Cleaners	Entering the room of COVID-19 residents	Medical mask Gown Heavy duty gloves Eye protection (if risk of splash from organic material or chemicals) Boots or closed work shoes
	Visitors	Entering the room of a COVID19 resident	Medical mask Gown Gloves
Other areas of resident transit (e.g. wards, corridors).	All staff, including health care workers	Any activity that does not involve contact with COVID-19 residents	No PPE required
Administrative areas	All staff, including health care workers.	Administrative tasks that do not involve contact with COVID-19 residents.	No PPE required

Decontamination and Re-use of N-95 using UV Germicidal Irradiation



Ultraviolet germicidal irradiation (UVGI) is a disinfection method that uses short-wavelength **ultraviolet** (**UV**-C) light to kill or inactivate microorganisms by destroying nucleic acids and disrupting their DNA, leaving them unable to perform vital cellular functions.

If your facility utilizes UV Germicidal Irradiation consideration and application to decontaminate N-95 masks may be applicable.

Please visit:
https://www.nebraskamed.com/sites/default/files/documents/covid-19/n-95-decon-process.pdf

Helpful websites:

The Joint Commission: https://www.jointcommission.org/covid-19/?ref=TJCAL20

CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html

CMS: https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus

John Hopkins Center for Health Security: http://www.centerforhealthsecurity.org/

Preventing the Spread of COVID-19	
Fiddler's Green Manor	
DEPARTMENT: Infection Prevention & Control	
DATE APPROVED: 3/10/2020	DATE LAST MODIFIED: 3/10/2020

POLICY

It is the policy of our company to comply with the Center for Disease Control (CDC) and State Department of Health (DOH) guidelines regarding awareness and prevention of the spread of Coronavirus 2019 (COVID-19). The general strategies the CDC recommends to prevent the spread of COVID-19 in care facilities are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza.

All care facilities will take every precaution to identify signs and symptoms of the COVID-19 disease for all contacts including residents, patients, individuals, staff and visitors and anyone else that enters the facility and to implement infection control strategies to avoid any possible spread of this disease.

Care facilities concerned that an individual, resident, visitor or employee may be a COVID-2019 patient under investigation (PUI) should contact their local or state health department immediately for consultation and guidance.

DEFINITIONS

Coronavirus 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.
Visitor: Anyone other than an individual, resident, patient or staff member.

PROCEDURE

1. Infection Prevention and control measures must be enhanced at this time. Close monitoring and surveillance of signs and symptoms of COVID-19 are to be initiated. The signs and symptoms are not unlike other respiratory illness and include: 1) fever; 2) cough; 3) shortness of breath (SOB).
    - It is recommended that a review of all residents', patient or individuals' general health status be discussed at morning meeting/huddle.
    - Hand hygiene is of the utmost importance; the Infection Preventionist (IP)/designee will increase surveillance and training on hand hygiene.
2. Preventing the introduction of respiratory germs INTO the facility will include:
    - Post signs at the entrance instructing visitors not to visit if they have symptoms of respiratory infection.
        - At this time, it is recommended that ANY and ALL visitors and vendors must sign in when they enter the facility. Hand gel should be readily

available at any entrance door with signs posted to cleanse hands upon entrance and often thereafter.

- Direct employees to stay home if they have symptoms of respiratory infection or fever.
    - If an employee is calling in sick, ask the employee what their symptoms are so as to track any symptoms that may be associated with COVID-19. Please advise employees that we will be asking them their symptoms.
- Assess the residents', patients' or individuals' symptoms of respiratory infection upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.

3. Prevent the spread of respiratory germs WITHIN your facility:
    - Keep residents, patients or individuals, families and employees informed.
        - Describe what actions the facility is taking to protect them, including answering their questions and explaining what they can do to protect themselves and their fellow residents.
    - Monitor residents, patients or individuals and employees for fever or respiratory symptoms.
        - Restrict residents, patients or individuals with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
        - In general, for care of residents, patients or individuals with undiagnosed respiratory infections use Standard, Contact and Droplet Precautions with eye protection unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
        - Healthcare personnel should monitor their local and state public health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents, patients or individuals with acute respiratory infection, facilities should also consult with public health authorities for additional guidance.
    - Support hand and respiratory hygiene, as well as cough etiquette by residents, patients or individuals, visitors and employees.
        - Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, patients or individuals, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).
        - Put alcohol-based hand rub in every resident, patient or individuals' room (ideally both inside and outside of the room).
        - Make sure tissues are available and any sink is well-stocked with soap and paper towels for hand washing.
    - Identify dedicated employees to care for COVID-19 patients and provide infection control training.

    - Guidance on implementing recommended infection prevention practices is available in CDC's free online course - The Nursing Home Infection Preventionist Training – which includes resource checklists for facilities and employees to use.
  - Provide the right supplies to ensure easy and correct use of PPE.
    - Post signs on the door or wall outside of the residents, patients or individuals room that clearly describe the type of precautions needed and required PPE.
    - Make PPE, including facemasks, eye protection, gowns and gloves, available immediately outside of the residents, patients or individuals' room.
    - Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.
4. Cleaning and Housekeeping Strategies:
   - It is of the utmost importance that housekeeping staff are aware and competent on the proper cleaning procedures and are following other related policies regarding cleaning resident or individuals' rooms, surfaces and equipment. The IP/designee and department director/administrator will monitor for assurance that cleaning and disinfecting are carried out appropriately.
5. All other infection control policies and measures are to be followed accordingly.
6. Skilled Nursing Facilities (equipped with N95 masks): In the event we suspect a resident is infected with COVID-19, staff will use the N95 masks and eye protection and keep the resident isolated (following proper isolation precautions) while caring for this resident until the resident can be transferred to the hospital setting. A surgical mask will be placed on the resident. The transfer is required to allow for proper treatment (i.e. negative pressure room).
7. All other facilities (not equipped with N95 masks): In the event we suspect an individual is infected with COVID-19, staff will use surgical masks and keep the individual isolated (following proper isolation precautions) while caring for them until they can be transferred to the hospital setting. A surgical mask will be placed on the individual while waiting transfer. The transfer is required to allow for proper treatment (i.e. negative pressure room).

REFERENCE

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

Personal Protective Equipment

Policy Statement

Personal protective equipment appropriate to specific task requirements is available at all times.

Policy Interpretation and Implementation

1. Employees required to perform tasks that may involve exposure to blood/body fluids will be provided appropriate protective clothing and equipment.

2. All tasks do not involve the same type or degree of risk, and therefore will not all require the same kind or extent of protection. The type of protective clothing and equipment is based on:
   a. The fluid or tissue to which there is a potential exposure;
   b. The likelihood of exposure;
   c. The potential volume of material;
   d. The probable route of exposure; and
   e. The overall working conditions and job requirements.

3. Protective clothing provided to our employees includes but is not necessarily limited to:
   a. Gowns/aprons/lab coats (disposable, cloth, and/or plastic);
   b. Gloves (sterile, non-sterile, heavy-duty and/or puncture-resistant);
   c. Masks; and
   d. Eyewear (goggles and/or face shields).

4. A supply of protective clothing and equipment is maintained at each nurses' station. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with our facility's personnel policies.

5. Personal protective equipment will be repaired or replaced as needed to maintain its effectiveness at no cost to employees. Staff should inform the Infection Preventionist about protective equipment needing repair or replacement.

References	
OBRA Regulatory Reference Numbers	§483.80(a) Infection prevention and control program.
Survey Tag Numbers	F880
Other References	www.cdc.gov/ncidod/dhqp/ppe.html and www.osha.gov/SLTC/personalprotectiveequipment/index.html.
Related Documents	Standard Precautions
Version	1.3 (H5MAPL0619)

Communication with Residents and Family Members

Policy Statement

Residents, family members and responsible parties will be notified when there is a disaster or emergency situation at the facility.

Policy Interpretation and Implementation

1. This facility maintains emergency contact numbers in addition to primary telephone numbers for responsible parties and family members.
2. Residents, responsible parties and family members are notified as quickly as possible when there is a disaster/emergency situation at the facility.
3. Staff members are briefed on the following elements to share with residents and family members as assigned:
   a. Type of threat;
   b. Estimated time and severity of impact;
   c. General outlook at the current time;
   d. Expected disruptions to services or routines;
   e. What the facility administration has done and is doing at the time to lessen negative outcomes;
   f. When to expect updated status reports; and
   g. What the residents, responsible parties, and family members can do to help.
4. As part of our overall preparedness planning, family members and responsible parties are given contact information for alternate facilities in the event that the facility must initiate an Immediate Evacuation and residents are moved to an alternate facility.

References	
OBRA Regulatory Reference Numbers	§483.73(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually.

Survey Tag Numbers	E-0029
Other References	
Related Documents	Sample Letter to Family/Responsible Party Regarding Evacuation Instructions
Version	1.0 (PEMAPL0021)

Communication with Residents and Family Members During a Pandemic

Policy Statement

Residents, family members and responsible parties/guardians will be notified weekly, at a minimum, during the pandemic.

Policy Interpretation and Implementation

1. This facility maintains emergency contact numbers in addition to primary telephone numbers for responsible parties and family members.
2. Residents, responsible parties and family members are notified as quickly as possible when there is a pandemic situation at the facility.
3. During a pandemic, the families/responsible parties will be notified at least weekly, or more frequently, to inform them of the number of infections and deaths at the facility related to pandemic infection.
4. The use of written letters, phone calls, mass phone blast messaging, and mass emailing, and/or mass texting will be utilized to reach out to responsible parties/guardians.
5. The use of zoom/video conference call can be used to hold town hall meetings with responsible parties/guardians.
6. Facility websites will be updated as appropriate with visiting information and other publically reported data.
7. Staff members are briefed on the following elements to share with residents and family members as assigned:
    a. Number of residents with new onset of infection;
    b. Number of resident deaths related to pandemic infection;
    c. General outlook at the current time;
    d. Expected disruptions to services or routines;
    e. What the facility administration has done and is doing at the time to lessen negative outcomes;
    f. When to expect updated status reports; and
    g. What the residents, responsible parties, and family members can do to help.

References:

E-0029, §483.73(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually.

Admission / Re-Admission of Residents During a Pandemic

Policy Statement

Admission / Re-Admission to this facility depends upon our ability to provide appropriate medical and nursing care. This includes situations where a resident has a known communicable disease or infection. This is in addition to policy #032

Policy Interpretation and Implementation

1. Prior to or upon admission/re-admission, the Infection Preventionist, or designee, will assess the following infection risks as noted in policy 032 Admission ResCommDisease:
   a. Review of current infection by reviewing history and hospital discharge summaries;
   b. Clinical evidence of a current infection; and treatments provided during hospitalization.

2. The Infection Preventionist or designee will request appropriate information regarding the infectious process from the sending facility prior to the resident's transfer. This information should include the following on the resident's infection status: isolation precautions, signs and symptoms of infection(s), antibiotic usage/treatments, and appropriate lab results, onset of infection and immunization of infection if appropriate.

3. The Infection Preventionist or designee will include these residents on the Infection control log. When considering room assignments the log will be checked to prevent placing residents with MDRO infection, colonization or other infectious isolation precautions with a resident at risk of infection.

4. A resident who is transferred to an acute care facility during a pandemic should be reviewed prior to return for details of the status of any such infection and clarification of any possible infection control risks that the situation presents. Testing will be completed prior to return to facility in order to place resident in the appropriate precautionary rooms.

5. A residents admitted during a pandemic may be placed in a private room, or cohorted with another resident of the same sex who is colonized with a similar organism.

6. Placement of individuals with other potentially infectious conditions (outside the pandemic infection) will be made based on appropriate clinical evaluation by the Attending Physician and/or Medical Director of the status of the infection and risk for its dissemination.

7. Admissions requiring infection control restrictions will be placed on appropriate Isolation Precautions/Zones based on this facility's policies governing Isolation Precautions.

References:
§483.20(a) Admission orders; §483.80(a) Infection prevention and control program, F635; F880

Admissions Policies

Policy Statement

Written policies and procedures governing admissions to the facility will be maintained on a current basis to ensure fair and impartial admission practices.

Policy Interpretation and Implementation

1. The primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility.

2. Our admission policies apply to all residents admitted to the facility without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital or veteran status, and/or payment source.

3. The objectives of our admission policies are to:

   a. Provide uniform guidelines in the admission of residents to the facility;

   b. Admit residents who can be adequately cared for by the facility;

   c. Reduce the fears and anxieties of the resident and family during the admission process;

   d. Review with the resident, and/or his/her representative (sponsor), the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.; and

   e. Assure that appropriate medical and financial records are provided to the facility prior to or upon the resident's admission.

4. It shall be the responsibility of the Administrator, through the admissions department, to assure that the established admission policies, as they may apply, are followed by the facility and resident.

5. Our admission policies and procedures are reviewed for revisions and updates as necessary, but at least annually. Records of such revisions and/or reviews are maintained in the business office.

References	
OBRA Regulatory Reference Numbers	§483.15(b) Equal access to quality care.
Survey Tag Numbers	F621
Other References	
Related Documents	

Version	1.0 (H5MAPL0968)

Change in a Resident's Condition or Status

Policy Statement

Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).

Policy Interpretation and Implementation

1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an):
   a. accident or incident involving the resident;
   b. discovery of injuries of an unknown source;
   c. adverse reaction to medication;
   d. significant change in the resident's physical/emotional/mental condition;
   e. need to alter the resident's medical treatment significantly;
   f. refusal of treatment or medications two (2) or more consecutive times);
   g. need to transfer the resident to a hospital/treatment center;
   h. discharge without proper medical authority; and/or
   i. specific instruction to notify the Physician of changes in the resident's condition.

2. A "significant change" of condition is a major decline or improvement in the resident's status that:
   a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self-limiting");
   b. Impacts more than one area of the resident's health status;
   c. Requires interdisciplinary review and/or revision to the care plan; and
   d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the *Resident Assessment Instrument.*

3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.

4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:
   a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;
   b. There is a significant change in the resident's physical, mental, or psychosocial status;
   c. There is a need to change the resident's room assignment;
   d. A decision has been made to discharge the resident from the facility; and/or
   e. It is necessary to transfer the resident to a hospital/treatment center.

5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

6. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments.

7. In addition to notifying the resident and/or representative, the state mental health agency or state intellectual disability agency will be notified within 24 hours of a significant change in the mental or physical condition of a resident with a mental disorder or intellectual disability.

continues on next page

8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual.

10. The business office manager or designee will verify the address and telephone number of the resident's family or representative (sponsor) on a quarterly basis. Any noted changes will be reported to the Director of Nursing Services to ensure that such information is changed in the resident's medical record.

11. A representative of the business office will notify the resident, his/her family, or representative (sponsor), when:
    a. There is a change in the resident's billing;
    b. There is a change in the resident's level of care status;
    c. There is a change in resident rights under federal or state law or regulations; and/or
    d. There is a change in the rules of the facility that affects the rights or responsibilities of the resident.

References	
OBRA Regulatory Reference Numbers	§483.10(g)(14) Notification of Changes.; §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.; §483.30(a)(1) The medical care of each resident is supervised by a physician;; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable.
Survey Tag Numbers	F580; F637; F710
Other References	
Related Documents	Charting and Documentation Resident Assessment Instrument
Version	2.3 (H5MAPL0118)

Resident Testing COVID 19/Flu

Date Initiated: 5/3/2020
Date Revised: 6/3/2020, 7/6/2020, 9/2/2020

POLICY:

It is the policy of the facility to prevent the spread of COVID 19 and to protect and treat all residents affected by the pandemic. The facility will follow CDC and NYS DOH Guidelines when making decisions on resident testing. Testing may not be readily available to implement the guidelines in all cases. If testing is unavailable, the facility will utilize clinical assessment skills to monitor for symptoms of COVID and take the appropriate isolation precautions. The CDC non-test best strategy will be used when applicable.

Per Section 405.11 Updated 9/1/2020 - Any patient who is known to have been exposed to COVID-19 or influenza or has symptoms consistent with COVID-19 or influenza shall be tested for both such diseases.

SYMPTOMS:

Facility residents may present with the typical symptoms that we associate with COVID-19 or with non-specific symptoms that may easily be missed. Each is described below:

Typical Symptoms:

- Cough
- Fever
- Repeated shaking with chills
- Chills
- Muscle pain
- Shortness of breath
- Headache
- Sore throat
- New loss of taste or smell

Patients with typical symptoms such as those above will be tested for COVID-19 simultaneously with work-up for other causes. For example, CXR, CBC, Flu and RSV testing may be appropriate based on symptoms. Some guidelines suggest waiting for this other workup before proceeding with COVID testing. However, in the interest of early diagnosis and intervention to prevent spread, it is suggested to avoid delays if testing is available.

Non-Specific Symptoms:

- Altered mental status
- Increased lethargy
- Decreased appetite

- Functional decline

While these are common, and will usually be due to other reasons, COVID testing should be considered if COVID is prevalent in the facility or if there is no other explanation for the change in condition.

1. All residents will continue to be assessed daily for any symptoms of COVID-19 including fever, respiratory symptoms, or any change in condition. Current data for COVID-19 has demonstrated that nursing home residents may present atypical symptoms including change in mental status.
2. Any resident presenting with signs or symptoms of COVID-19 infection will be assessed by Primary Physician/Nurse Practitioner.
3. Per CMS (8/26/2020) - When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of COVID-19 first, and then perform testing triggered by an outbreak (as specified below).

Table 1: Testing Summary Testing Trigger	**Staff**	**Residents**
Symptomatic individual identified	Staff with signs and symptoms must be tested	Residents with signs and symptoms must be tested
Outbreak (Any new case arises in facility)	Test all staff that previously tested negative until no new cases are identified*	Test all residents that previously tested negative until no new cases are identified*
Routine testing	According to Table 2 below	Not recommended, unless the resident leaves the facility routinely.

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

MANAGING COVID TEST RESULTS:

Positive results: This will lead to a series of actions including close monitoring, isolation precautions, possible room changes, and required notification to patients/families, and reporting to local authorities. Negative results: A negative test is reassuring but does not rule out COVID. If symptoms persist with no other explanation or despite treatment for other conditions repeat testing should be considered.

NOTE: Testing is always based on clinical judgment and is not limited to the above situations. New information is constantly emerging, so providers are urged to stay current. Any guidelines above and beyond the above by individual states in which we operate in, will be followed.

Residents who have signs or symptoms of COVID-19 must be tested. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance. Once test results are obtained, the resident will be placed in the appropriate zone.

Testing of Residents in Response to an Outbreak

An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak.

In accordance with 42 CFR § 483.50(a)(2)(i), the Medical Director has written a standing order for resident testing.

Upon identification of a single new case of COVID-19 infection in any staff or residents:

- All staff and residents should be tested and results documented.
- All staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.
- For individuals who test positive for COVID-19, repeat testing is not recommended. A symptom-based strategy is intended to replace the need for repeated testing. Facilities should follow the CDC guidance Test-Based Strategy for Discontinuing Transmission-Based Precautions Discontinuing Transmission-Based Precautions for residents and Criteria for Return to Work for Healthcare Personnel with SARS-CoV2 Infection.
- If the 48-hour turn-around time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments.
- Routine testing of asymptomatic residents is not recommended unless prompted by a change in circumstances, such as the identification of a confirmed COVID-19 case in the facility.
- Residents (or resident representatives) may exercise their right to decline COVID-19 testing in accordance with the requirements under 42 CFR § 483.10(c)(6). A resident will be placed in either the Red Zone or the Yellow Zone depending on their level of exposure. This will be documented in the residents medical record

Testing Expired Residents:

- Whenever a person expires while in a nursing home, where in the professional judgment of the nursing home clinician there is a clinical suspicion that COVID-19 or influenza was a cause of death, but no such tests were performed in the 14 days before death, the nursing home shall administer both a COVID-19 and influenza test within 48 hours after death, in accordance with guidance published by the Department. Such tests shall be performed using rapid testing methodologies to the extent available.

- Upon notification to the practitioner of the residents death, the RN supervisor will inform the MD/NP if there were flu or COVID like symptoms and if the resident has been tested for either in the last 14 days.
- If the MD/NP feels the death is due to COVID/influenza, then a rapid COVID/Influenza test must be performed and documented.
- If the MD/NP does not feel the resident's death occurred due to COVID/Influenza, and no test is performed, then this too also needs to be documented.

- The facility shall report the death to the Department immediately after and only upon receipt of both such test results through the Health Emergency Response Data System (HERDS).
- Notwithstanding the foregoing, no test shall be administered if the next of kin objects to such testing. Should the nursing home lack the ability to perform such testing expeditiously, the nursing home should request assistance from the State Department of Health.

BD Veritor Plus Analyzer

I. Policy

The BD Veritor Plus Analyzer is a Point of Care Testing System approved for use to test residents and staff for SARS-CoV-2. In order to maintain quality, it is important that the following procedures be adhered to by all trained persons using the BD Veritor Plus Analyzer. This test system is classified as a CLIA waived test when used according to the manufacturer's instructions.

- The BD Veritor Plus System for rapid detection of SARS-CoV-2 is a chromatographic digital immunoassay intended for the direct and qualitative detection of SARS-C0V-2 nucleocapsid antigens in nasal swabs from residents and staff who are suspected of having COVID-19 and within the first 5 days of symptom onset.
- The BD Veritor Plus System gives health care providers objective, lab-quality immunoassay test results within minutes. This fast and accurate solution streamlines the point of care diagnostic workflow and allows providers to quickly review results and determine the appropriate treatment in a single consultation.
- The gold standard for clinical diagnostic detection of SARS-CoV-2 remains RT-PCR testing. It may be necessary to confirm a rapid antigen test result with a nucleic acid test, especially if the result of the antigen test is inconsistent with the clinical context. When confirming an antigen test result with an RT-PCR test, it is important that the time interval between the 2 sample collections is less than 2 days and there has not been any opportunities for new exposures between the 2 tests. If more than 2 days separate the 2 tests, or there have been opportunities for new exposures between the 2 tests, the nucleic acid test should be considered a separate test – not a confirmatory test.
- A CLIA certified testing site must report rapid antigen diagnostic test results to the local and state health department. Antigen test results that are reported must be clearly distinguished from other COVID-19 tests, such as RT-PCR and antibody tests.
- The rapid antigen tests are currently intended for use in diagnostic testing of symptomatic residents or staff within 5 days of symptom onset. A resident or staff member tested after 5 days of symptoms may drop their viral shedding load below the detection limit of the test. The CDC expands the use of the tests to include use as a screening tool in LTC facilities for staff and residents.

II. Procedure

A. Swab Test Procedure - Nasal Swab Specimen Collection

1. Acceptable specimens for testing with this kit include nasal swab specimens obtained by the dual nares collection method. Specimens obtained early during symptom onset will contain the highest viral titers. Specimens obtained after 5 days of symptoms are more likely to produce negative results when compared to an RT-PCR assay. Inadequate specimen collection, improper specimen handling and/or transport may yield a falsely negative result.
2. Freshly collected specimens should be processed as soon as possible but, no later than 1 hour after specimen collection.
3. The BD Veritor System Kit includes swabs for nasal specimen collection.
4. Insert the swab into 1 nostril of the resident/staff member. The swab tip should be inserted up to 2.5 cm (1 inch) from the edge of the nostril. Roll the swab 5 times along the mucosa inside the nostril to ensure that both mucus and cells are collected.
5. Using the same swab, repeat this process for the other nostril to ensure that an adequate sample is collected from both nasal cavities.
6. Withdraw the swab from the nasal cavity. The sample is now ready for processing using the BD Veritor System SARS-CoV-2 kit.

B. Test Procedure

1. The BD Veritor System assay kit is only intended for nasal swab specimens that are collected and tested directly (i.e. swabs that have NOT been placed in transport media).
2. The kit includes pre-diluted processing reagent in a ready to use "unitized" tube. This kit is NOT intended for testing liquid samples such as wash or aspirate samples or swabs in transport media as results can be compromised by over dilution.

Procedure for Nasal Swab or Control Swabs:

1. Remove 1 extraction reagent tube/tip and 1 BD Veritor System test device from its foil pouch immediately before testing.
2. Label 1 test device and 1 extraction reagent tube for each specimen or control to be tested.
3. Place the labeled extraction reagent tube(s) in a rack in the designated area of the workspace.

Process the Specimen or Control Swab:

1. Remove and discard the cap from the extraction reagent tube.
2. Insert the swab into the tube and plunge the swab up and down in the fluid for a minimum of 15 seconds, taking care not to splash contents out of the tube.
3. Remove the swab while squeezing the sides of the tube to extract the liquid from the swab.
4. Press the attached tip firmly only the extraction reagent tube containing the processed sample (threading or twisting is not required). Mix thoroughly by swirling or flicking the bottom of the tube.
5. DO NOT use tubes or tips from any other product, including other products from BD or other manufacturers.
6. After processing the swab in the extraction reagent, the sample should be analyzed within 30 minutes.

C. Using the BD Veritor Plus Analyzer – Analyze Now Operation

1. Place the BD Veritor Plus Analyzer on a flat, dry, stable surface.
2. Ensure that the Analyzer is not in direct sunlight or exposed to bright light.
3. Check the Analyzer for an inserted device. If a device is present, remove it from the Analyzer.
4. Press the front panel power button. The Analyzer will complete a self-test before it is ready for use. After the self-test completes and any temporary messages are presented, the display window shows "insert test device or double-click button for walk away mode."
5. If an infoscan module is installed:
    a. The display window shows "Scan Config barcode" for 2 seconds after the self-test. This is an optional step, no action is required.
6. When the display window shows "insert test device or double-click button for walk away mode", insert the fully developed test device into the slot on the right side of the Analyzer, aligning the insertion arrow on the test device with the arrow above the slot. Insert the device fully until it stops. A distinctive "click" will be noted when the device is properly aligned in the Analyzer.
7. If an infoscan module is installed:
    a. If the Analyzer has been configured with barcode ID – Enable Operator ID, it will display "scan operator ID". When the message is displayed, after verifying that the Operator ID to be scanned is correct, the operator should scan his/her identification barcode. This message is displayed for up to 30 seconds, after which the test device must be removed and the read process restarted. After a specific operator identification has been recorded, that operator identification will be utilized for all subsequent tests until the Analyzer is powered off. On the next power on cycle, the "scan operator ID" prompt will be repeated during the first test. A test result cannot be generated if an operator ID is not scanned when the operator ID workflow option is enabled.
    b. BD recommends reading operator ID barcodes with the Analyzer positioned at the edge of a flat surface. The barcode should then be moved forward toward the barcode window to be scanned. The scanned barcode value will be shown in the next display window.
    c. If the Analyzer has been configured with barcode ID – Enable Specimen ID, it will display "scan specimen ID". When this message is displayed, after verifying that the specimen ID is correct, the operator should scan the specimen's ID barcode. This message is displayed for up to 30 seconds, after which the test device must be removed and the read process restarted. The specimen ID scan prompt is repeated

for every test. A test result cannot be generated if a specimen ID is not scanned when the specimen ID workflow option is enabled.

d. BD recommends reading the specimen ID barcodes with the Analyzer positioned at the edge of a flat surface. The barcode should then be moved towards the barcode window to be scanned. The scanned barcode value will be shown in the next display window.
e. If the Analyzer has been configured with barcode ID – Enable Kit Lot information, it will display "scan kit lot number". When this message is displayed, the operator should scan the barcode on the exterior of the test kit box. This message is displayed for up to 30 seconds, after which the test device must be removed and the read process restarted. The kit lot number scan prompt is repeated for every test. A test result cannot be generated if the kit lot number is not scanned when the kit information workflow option is enabled.
f. If the test kit box label has 2 barcodes, scan only the upper barcode which starts with 17.
g. BD recommends reading the kit information barcode with the Analyzer positioned at the edge of a flat surface. The barcode should then be moved toward the barcode window to be scanned. The scanned barcode value will be shown in the next display window.

8. After insertion of the test device, the Analyzer will progress through 2 processing steps: a reading step, followed by an analyzing step. The display will show the remaining time for each step as they are performed. Do not touch the Analyzer or remove the test device during this time.
9. When the analysis is complete, the test result will be displayed with the name of the test and a result. If a printer is connected to the unit and powered on, the test result will automatically be sent to the printer.
10. If an infoscan module is installed:
    a. If the Analyzer has been configured with barcode ID – Enable Specimen ID, the specimen identification is also displayed on the screen.
11. Verify that the test type and specimen identification are correct.
12. Once the test type and specimen identification, if appropriate, is verified and the result noted, remove the test device by pulling it out. The display will show "insert test device or double-click button for walk away mode" to indicate the Analyzer is ready to perform another test.
13. If the connect accessory is installed:
    a. The envelope symbol will appear to indicate that results are being transmitted. In the event that the Analyzer cannot transmit the results to BD informatics, it will queue all results to be transmitted and continuously attempt to transmit the results while it is powered on. If the Analyzer is powered off while the envelope symbol is still present, the Analyzer will queue the results and transmit it the next time that it is powered up. The symbol will disappear after the results have been transmitted.
14. To initiate a new test, repeat steps above or turn off the power by depressing the front panel power button for at least half a second and releasing it. If the Analyzer is left unattended for 15 minutes (when operating on the internal battery), or 60 minutes (when operating on the external power adaptor), the Analyzer will automatically shut off and the test result will not be retained on the screen.

D. Using the BD Veritor Plus Analyzer – Walk Away Operation

Note: The AC power adapter must be connected to the Analyzer and plugged into a facility power source to use Walk Away Mode.

Note: If the Analyzer is left unattended for 60 minutes after completion of the test run, the power will automatically shut off and the test result will not be retained on the screen.

1. Place the Analyzer on a flat, dry, stable surface.
2. Ensure that the Analyzer is not in direct sunlight or exposed to bright light.
3. Ensure that the AC power adapter is connected to the Analyzer and plugged into a facility power source.
4. Check the Analyzer for an inserted device. If a device is present, remove it from the Analyzer.

5. Press the front panel power button. The Analyzer will complete a self-test before it is ready for use. After the self-test completes and any temporary messages are presented, the display window shows "insert test device or double-click button for walk away mode."
6. If an infoscan is installed:
    a. The display window shows "scan config barcode" for 2 seconds after the self-test. This is an optional step, no action is required.
7. When the display window shows "insert test device or double-click button for walk away mode", double-click the power button.
8. If an infoscan is installed:
    a. If the Analyzer has been configured with barcode ID- Enable Operator ID, it will display "scan operator ID". When this message is displayed, after verifying that the operator ID to be scanned is correct, the operator should scan his/her identification barcode. This message is displayed for up to 30 seconds, after which the process will restart. After a specific operator identification has been recorded, that operator identification will be utilized for all subsequent tests until the Analyzer is powered off. On the next power cycle, the "scan operator ID" prompt will be repeated during the first test. A test result cannot be generated if the Operator ID is not scanned when the Operator ID workflow option is enabled.
    b. BD recommends reading operator identification barcodes with the Analyzer positioned at the edge of a flat surface. The barcode should then be moved toward the barcode window to be scanned. The scanned barcode value will be shown in the next display window.
    c. If the Analyzer has been configured with barcode ID – Enable Specimen ID, it will display "scan specimen ID." When this message is displayed, after verifying that the specimen ID is correct, the operator should scan the specimen's identification barcode. This message is displayed for up to 30 seconds, after which the process will restart. The specimen ID workflow option is enabled.
    d. BD recommends reading specimen identification barcode with the Analyzer positioned at the edge of a flat surface. The barcode should then be moved toward the barcode window to be scanned. The scanned barcode value will be shown in the next display window.
    e. If the Analyzer has been configured with barcode ID – Enable Kit Lot information, it will display "scan kit lot number." When this message is displayed, the operator should scan the barcode on the exterior of the test kit box. This message is displayed for up to 30 seconds, after which the process restarts. The kit lot number scan prompt is repeated for every test. A test result cannot be generated if the kit lot number is not scanned when the kit information workflow option is enabled.
    f. If the test kit box label has 2 barcodes, scan only the upper barcode which starts with 17.
    g. BD recommends reading the kit information barcode with the Analyzer positioned at the edge of a flat surface. The barcode should then be moved toward the barcode window to be scanned. The scanned barcode vale will be shown in the next display window.
9. The display window will now show "add specimen to test device and insert immediately". This message is displayed for up to 3 minutes, after which the process restarts. Apply the prepared specimen to the test device sample well and immediately insert the test device into the slot on the right side of the Analyzer, aligning the insertion arrow on the test device with the arrow above the slot. Insert the device fully until it stops. A distinctive "click" will be noted when the device is properly aligned in the Analyzer. During this process the test device must remain horizontal to prevent spilling the specimen out of the sample well.
10. The display window will now show "do not disturb test in progress". The incubation time is determined based on the test device barcode. The incubation time remaining is shown on the display. Do not disturb the test device or Analyzer during the incubation period. Do not remove the test device, doing so will cause the test to abort.
11. After the incubation is complete, the Analyzer will progress through 2 processing steps: a reading step, followed by an analyzing step. The display will show the remaining time for each step as they are performed. Do not touch the Analyzer or remove the test device during this time.
12. When the analysis is complete, the test result will be displayed with the name of the test and a result. If a printer is connected to the unit and powered on, the test result will automatically be sent to the printer.

13. If an infoscan is installed:
    a. If the Analyzer has been configured with barcode ID – Enable Specimen ID, the specimen identification is also displayed on screen.
14. Verify that the test type and specimen identification are correct.
15. Once the test type and specimen identification, if appropriate, is verified and the result noted, remove the last device by pulling it out. The display will show "insert test device or double-click button for walk away mode" to indicate the Analyzer is ready to perform another test.
16. If the connect accessory is installed:
    a. The envelope symbol will appear to indicate that results are being transmitted. In the event that the Analyzer cannot transmit the results to BD informatics, it will queue all results to be transmitted and continuously attempt to transmit the results while it is powered on. If the Analyzer is powered off while the envelope symbol is still present, the Analyzer will queue the result and transmit it the next time that it is powered up. This symbol will disappear after the results have been transmitted.
17. To initiate a new test, repeat steps above or turn off the power by depressing the front panel power button for at least half a second and releasing it. If the Analyzer is left unattended for 60 minutes, the Analyzer will automatically shut off and the test result will not be retained on the screen.

E. Interpretation of Results

Display	Interpretation
CoV2 +	Positive Test for SARS CoV-2 (antigen present)
CoV2 -	Presumptive Negative Test for SARS CoV-2 (no antigen detected)
Control Invalid	Test Invalid. *Repeat the test.

F. Quality Control

1. Each Veritor BD System SARS Co-V2 test device contains both positive and negative internal/procedural controls.
    a. The internal positive control line validates the immunological integrity of the device, proper reagent function and assures correct test procedure.
    b. The membrane area surrounding test lines functions as a background check on the assay device.
2. The BD Veritor system instrument evaluates the positive and negative internal procedural controls after insertion of each test device. The BD Veritor Plus Analyzer prompts the operator if a quality issue occurs during assay analysis. Failure of the internal/procedural controls will generate an invalid test result. The internal controls do not assess proper sample collection technique.
3. External Positive and Negative Control swabs are supplied with each unit. These controls provide additional quality control material to assess that the test reagents and the BD Veritor System instrument perform as expected. Prepare kit control swabs and test using the same procedure as used for resident/staff specimens.
4. BD recommends controls to be run once for:
    a. Each new kit lot
    b. Each new operator
    c. As required by facility quality control procedures and in accordance with local, state and federal regulations
5. If the kit controls do not perform as expected, do not report resident/staff results. Contact BD Technical Support at 800-638-8663.

G. Maintenance

1. The BD Veritor Plus Analyzer requires little maintenance from the user to provide reliable performance. Any maintenance or repair not described below should be performed by a BD representative only.
2. A Verification Cartridge is supplied to allow the user to routinely perform functional tests on the Analyzer, following the manufacturer instructions. A verification test counts as one test

towards the Analyzer's maximum allowed number of tests. All BD Veritor System verification cartridges must be obtained from BD or from a BD-authorized distributor. Cartridges from other manufacturers are not compatible with the BD Veritor Plus Analyzer.

H. Cleaning

1. The outer case and display may be wiped with a clean towel lightly moistened with 70% isopropyl alcohol or a 10% bleach solution. Do not introduce the cleaning solution or any other liquids directly into the unit. Do not use a saturated towel which may introduce liquid into the case or display seams. Ensure that the Analyzer is dry and the surface is free of any residual cleaning solution prior to returning to use.
2. The BD Veritor InfoScan module is installed. BD does not recommend cleaning the barcode scanner window with any cleaning agent. Use a clean, soft towel lightly moistened with plain water to clean the window gently. Scratching the window may reduce the scanner's performance.

I. Reporting

1. NYS Regulation requires laboratories (includes facilities performing testing under CLIA waiver) that perform tests for screening, diagnosis, or monitoring of those communicable diseases that require prompt action, as designated by the Commissioner, to report all results, including positive, negative, and indeterminate results, related to such communicable diseases. These results must be reported to the Commissioner through the Electronic Clinical Laboratory Reporting System (ECLRS) on a schedule determined by the Commissioner. Failure to report COVID-19 test results may result in revocation, suspension or limitation of a lab's permit, and both the owner and the director of the lab could be found guilty of a class A misdemeanor.
2. Positive results for COVID-19 must be reported immediately. All other test results related to COVID-19, including the serology antibody testing, must also be submitted to ECLRS.
3. Facilities reporting COVID-19 results should adhere to the following guidance:
    a. Facility must only submit results if they are the site performing the test. Labs may not submit results on referred specimens.
    b. Facilities are required to report test type, specimen source, full patient residential address and phone number, occupation, employer name, work address, employer phone number, sex, race, and ethnicity.
    c. In order to submit data via file transfer (.csv file), a copy of the facility's CLIA waiver shall be provided to the NYSDOH, who will then authorize the site to submit electronically.

III. Reference

1. BD Veritor Plus Analyzer Instructions for Use

New York State Department of Health

PFI: M895 **Limited Service Laboratory Registration** CLIA: 33D0880319

Fiddlers Green Manor Nursing Home

168 West Main St

Springville NY 14141

Director:
Andrew J Landis, M.D.

Owner:
JSSG Healthcare LLC

is hereby authorized to perform the following procedures in accordance with Article 5, Title V, Section 579 of the Public Health Law.

COVID-19 ANTIGEN
Glucose

Amended
Effective Date: September 11, 2020
Expiration Date: February 3, 2021

Single Site
Certification Type: WAIVER
Subject to Revocation
Registration Not Transferable

POST CONSPICUOUSLY

Serial: LIM 37934

Visual PPE Identification During COVID-19

To aid in the protection of our staff and residents the following is to be implemented:

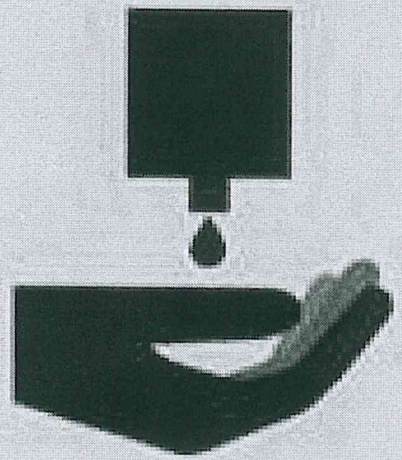
- Placement of a visual identifier (blue tape or a specific sign) is to be utilized to identify an area.
- When this identifier is in place the following PPE is to be worn:
  - Gloves
  - Gown
  - N-95 Mask
  - Eye protection for aerosol treatments
- When leaving designated area please care for your mask so it can be re-used.

N-95 Mask Distribution

To aid in controlling the proper usage of N-95 masks the following needs to be completed:

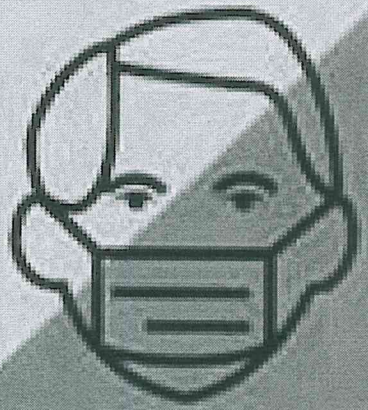
- All N-95 masks will be assigned to each employee.
- Place last name of employee with Sharpie Marker on the edge of the mask.
- Place last name and first initial of employee on paper bag – to be kept in container at a designated location
- Masks will be handed out when temperatures are checked at the beginning of the shift.
- Masks are to be handed in at the end of the shift and placed in the paper bag, by the employee to be kept for the next shift they work.
- Soiled masks will be replaced when soiled or otherwise unusable, but MUST be brought to the nursing supervisor for proof of needing replacement.

PRECAUTIONS



Hand Hygiene

Gown



Surgical Mask

Gloves

On ALL room entries, regardless of anticipated patient contact

Visitors: Report to nurses desk

Transport: Patient must cover with clean sheet

Staff education regarding N-95

- All N-95 masks will be assigned to each employee.
- Place last name of employee with Sharpie Marker on the edge of the mask.
- Place last name and first initial of employee on paper bag – to be kept in container at a designated location
- Masks will be handed out when temperatures are checked at the beginning of the shift.
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EMPLOYEE NAME **DATE**

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- Soiled masks will be replaced when soiled or otherwise unusable, but MUST be brought to the nursing supervisor for proof of needing replacement.

EMPLOYEE NAME **DATE**

Preventing the Spread of COVID-19	
Fiddler's Green Manor	
DEPARTMENT: Infection Prevention & Control	
DATE APPROVED: 3/10/2020	DATE LAST MODIFIED: 3/10/2020

POLICY

It is the policy of our company to comply with the Center for Disease Control (CDC) and State Department of Health (DOH) guidelines regarding awareness and prevention of the spread of Coronavirus 2019 (COVID-19). The general strategies the CDC recommends to prevent the spread of COVID-19 in care facilities are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza.

All care facilities will take every precaution to identify signs and symptoms of the COVID-19 disease for all contacts including residents, patients, individuals, staff and visitors and anyone else that enters the facility and to implement infection control strategies to avoid any possible spread of this disease.

Care facilities concerned that an individual, resident, visitor or employee may be a COVID-2019 patient under investigation (PUI) should contact their local or state health department immediately for consultation and guidance.

DEFINITIONS

Coronavirus 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.
Visitor: Anyone other than an individual, resident, patient or staff member.

PROCEDURE

1. Infection Prevention and control measures must be enhanced at this time. Close monitoring and surveillance of signs and symptoms of COVID-19 are to be initiated. The signs and symptoms are not unlike other respiratory illness and include: 1) fever; 2) cough; 3) shortness of breath (SOB).
    - It is recommended that a review of all residents', patient or individuals' general health status be discussed at morning meeting/huddle.
    - Hand hygiene is of the utmost importance; the Infection Preventionist (IP)/designee will increase surveillance and training on hand hygiene.
2. Preventing the introduction of respiratory germs INTO the facility will include:
    - Post signs at the entrance instructing visitors not to visit if they have symptoms of respiratory infection.
        - At this time, it is recommended that ANY and ALL visitors and vendors must sign in when they enter the facility. Hand gel should be readily

available at any entrance door with signs posted to cleanse hands upon entrance and often thereafter.

- Direct employees to stay home if they have symptoms of respiratory infection or fever.
    - If an employee is calling in sick, ask the employee what their symptoms are so as to track any symptoms that may be associated with COVID-19. Please advise employees that we will be asking them their symptoms.
- Assess the residents', patients' or individuals' symptoms of respiratory infection upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.

3. Prevent the spread of respiratory germs WITHIN your facility:
    - Keep residents, patients or individuals, families and employees informed.
        - Describe what actions the facility is taking to protect them, including answering their questions and explaining what they can do to protect themselves and their fellow residents.
    - Monitor residents, patients or individuals and employees for fever or respiratory symptoms.
        - Restrict residents, patients or individuals with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
        - In general, for care of residents, patients or individuals with undiagnosed respiratory infections use Standard, Contact and Droplet Precautions with eye protection unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
        - Healthcare personnel should monitor their local and state public health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents, patients or individuals with acute respiratory infection, facilities should also consult with public health authorities for additional guidance.
    - Support hand and respiratory hygiene, as well as cough etiquette by residents, patients or individuals, visitors and employees.
        - Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, patients or individuals, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).
        - Put alcohol-based hand rub in every resident, patient or individuals' room (ideally both inside and outside of the room).
        - Make sure tissues are available and any sink is well-stocked with soap and paper towels for hand washing.
    - Identify dedicated employees to care for COVID-19 patients and provide infection control training.

    - Guidance on implementing recommended infection prevention practices is available in CDC's free online course - The Nursing Home Infection Preventionist Training – which includes resource checklists for facilities and employees to use.
  - Provide the right supplies to ensure easy and correct use of PPE.
    - Post signs on the door or wall outside of the residents, patients or individuals room that clearly describe the type of precautions needed and required PPE.
    - Make PPE, including facemasks, eye protection, gowns and gloves, available immediately outside of the residents, patients or individuals' room.
    - Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.
4. Cleaning and Housekeeping Strategies:
   - It is of the utmost importance that housekeeping staff are aware and competent on the proper cleaning procedures and are following other related policies regarding cleaning resident or individuals' rooms, surfaces and equipment. The IP/designee and department director/administrator will monitor for assurance that cleaning and disinfecting are carried out appropriately.
5. All other infection control policies and measures are to be followed accordingly.
6. Skilled Nursing Facilities (equipped with N95 masks): In the event we suspect a resident is infected with COVID-19, staff will use the N95 masks and eye protection and keep the resident isolated (following proper isolation precautions) while caring for this resident until the resident can be transferred to the hospital setting. A surgical mask will be placed on the resident. The transfer is required to allow for proper treatment (i.e. negative pressure room).
7. All other facilities (not equipped with N95 masks): In the event we suspect an individual is infected with COVID-19, staff will use surgical masks and keep the individual isolated (following proper isolation precautions) while caring for them until they can be transferred to the hospital setting. A surgical mask will be placed on the individual while waiting transfer. The transfer is required to allow for proper treatment (i.e. negative pressure room).

REFERENCE

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

Fiddler's Green Manor
Confirmed or Suspected COVID-19

Date Initiated:
Date Revised:

PURPOSE:
To provide guidelines for the prompt detection and effective triage and isolation of potentially infectious patients to prevent unnecessary exposures among residents and healthcare personnel.

Symptoms
For confirmed coronavirus disease 2019 (COVID-19) cases, reported illnesses have ranged from mild symptoms to severe illness and death. Symptoms can include:

- Fever
- Cough
- Shortness of breath

The CDC believes at this time that symptoms of COVID-19 may appear in as few as 2 days or as long as 14 days after exposure.

POLICY:

1. If there are suspected or positive cases of COVID-19 in the facility:

    a. Residents suspected or tested positive of infection with COVID-19 should be given a facemask to wear as tolerated when anyone enters the room.
    b. Notify resident's physician, family and the Medical Director and the Infection Preventionist must be notified. Notify DOH as indicated per guidance.
    c. Initiate Contact/droplet precautions: Place signage on the residents door.
        i. The resident must be placed in their room with the door closed. If the resident has a roommate, close the curtain between the residents and keep the roommate in the room. Cohort suspected or tested positive resident to designated location as soon as possible.
        ii. Implement use that personal protective equipment, place equipment in the storage tote on the residents door.
2. Place dedicated equipment and in the storage tote on the residents doorway
3. All residents on affected units should be placed on droplet/contact precautions, regardless of the presence of symptoms and regardless of COVID-19 status.

4. The facilities will cohort residents and minimize the number of HCP and other staff who enter rooms, avoid floating staff as able.

5. Actively monitor all residents every shift
    i. This monitoring must include a symptom check, vital signs, lung auscultation, and pulse oximetry.

6. Assure that all residents in affected units remain in their rooms. Cancel all group, visitation, activities and communal dining. Offer other activities for residents in their rooms to the extent possible, such as video calls.
    a. Residents must wear facemasks when HCP or other direct care providers enter their rooms, unless such is not tolerable.

7. All residents on affected units should be placed on droplet and contact precautions, regardless of the presence of symptoms and regardless of COVID-19 status.

6. Screen all employees upon start of shift for elevated temperature or suspected exposure. All essential staff need to wear a face mask when within 6 ft of a resident.

References:

https://apps.health.ny.gov/pub/ctrldocs/alrtview/postings/Nursing_Home_Guidance_3_1583593822992_0.6.20_with_signage.pdf

https://commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/COVID19_LTCF_guidance_20200312_1584137320257_0.pdf

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

Department of Health

FIDDLER'S GREEN MANOR

Comprehensive Emergency Management Plan Template

Part III – Toolkit

2020

NEW YORK STATE OF OPPORTUNITY. Department of Health

Fiddler's Green Manor
168 W Main Street

Springville NY 14141

Fiddlersgreenmanor.com

Introduction

This Toolkit Template is meant to supplement the Comprehensive Emergency Management Plan (CEMP) Template to help facilities develop and implement their CEMP. Annex K has been updated to include guidance and format to comply with the new requirements of Chapter 114 of the Laws of 2020 for the development of a Pandemic Emergency Plan (PEP). This document provides a compendium of resources to help empower staff engaged in facility preparedness, response, and recovery operations. Templates and tools should be reviewed and updated on a regular basis.

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

Table of Contents

NEW YORK STATE OF OPPORTUNITY. Department of Health

1. Facility Overview

The facility overview provides an immediate reference sheet about each facility (or individual buildings within a facility's campus) for use when communicating with external parties during an emergency (e.g., law enforcement, fire department, emergency management officials). **Table 1: Facility Overview**

LOCATION AND CONTACT INFORMATION	
Name of Facility	Fiddler's Green Manor
Address	168 W Main Street Springville NY
Cross Streets	Woodard Ave

NEW YORK STATE OF OPPORTUNITY. Department of Health

Telephone	716-592-4781
Fax	Fax: 716-592-2249
Email	Fiddlers Green, All Facility Users <FGMALL@fgmanor.com>
Website	www.fiddlersgreenmanor.com
CONSTRUCTION	
Construction Type	Concrete/cement
Year Building Constructed	1950
Number of Floors (above/below grade)	3
Square Footage	1500

CAPACITY AND STAFFING	
Non-Traditional Surge Space	Rehab Department/ Therapy room, Dinning areas and C.N.A. class room
Number of Facility-Owned Vehicles (including accessible spots/seats)[10]	NONE
UTILITY AND SERVICE PROVIDERS	
Electric Provider	Village of Springville Electric **Monday – Friday 8:00 am- 4:00 pm (716)592-4936 ext. 2** **For after hours emergencies please contact (716) 592-4936 ext. 1221** 5 West Main Street, PO Box 17, Springville, New York 14141
Local Water Provider	Village of Springville Water **Monday – Friday 8:00 am- 4:00 pm (716)592-4936 ext. 2** **For after hours emergencies please contact (716) 592-4936**

[10] This should (if applicable) include number of vehicles, including accessibility level (e.g., number of wheelchair accessible spots, number of seats).

	ext. 1221 5 West Main Street, PO Box 17, Springville, New York 14141
Telephone Provider	Verizon (Land line and supervisor phone) Address: 65 Franklin St # 1400, Buffalo, NY 14202 Phone: (716) 840-8688 and Legacy VOIP (Internet phone system) Website: http://legacysip.com Email: jhayn@legacysip.com Phone: 240-575-6890 'David Werner' <david@aaadataandvoice.com 'David Werner' duvidm@aol.com
Internet Service Provider	Spectrum Services *355 Chicago St* *Buffalo, NY 14204* (888) 406-7063
Generator Services	Penn Power Group 350 Bailey Ave, Buffalo NY 14210 716-823-7242
Propane	Not Applicable
Plumbing	Danny Heineman & Sons 13980 E. Shutt Road Sardinia NY 14134 716-496-5037
Elevator	thyssenkrupp Elevator Buffalo 2745 Broadway #25, Buffalo, NY 14227 (585) 359-9299
HVAC Equipment	Danny Heineman & Sons 13980 E. Shutt Road Sardinia NY 14134 716-496-5037

Fire Equipment/Sprinklers	Davis-Ulmer Fire Protection 1 Commerce Drive Amherst, NY 14228-2395 **Phone:** 716-691-3200 **Fax:** 716-691-1230 https://www.davisulmer.com

2. Hazard Vulnerability Analysis

2.1. HVA Tools

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

Below are example HVA tools that facilities can use to conduct a facility-specific HVA. Facilities can modify the tools to suit their needs.

Table 2: Example HVA Tools

Tool Name	Description
Kaiser Permanente HVA Tool[11]	An excel spreadsheet with incorporated formulas which provide the user with relative risk percentages and summary information.
Children's Hospital Colorado, Community Hazard Vulnerability Assessment Tool	An excel spreadsheet with incorporated formulas which provide the user with relative risk percentages and summary information. The tool includes capabilities throughout the four phases of emergency management (mitigation, preparedness, response, recovery) as a factor in calculating risk.
U.S. Department of Health and Human Services, Healthcare and Public Health Sector Threat/Hazard Assessment Module Automated Tool	An excel spreadsheet that guides facilities through the hazard analysis process through a series of guided questions. After completing all the questions, the tool provides a comprehensive list of risks associated with each hazard.

2.2. HVA Process

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

2.2.1. Convene Staff with Facility-Specific Knowledge

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

- Facility Senior Leader
- Lead Clinical Staff
- Head of Administration/Finance
- Communications Staff

Completing the HVA can be done by a single knowledgeable staff member or as a collaborative process with multiple staff members. For example, multiple staff members can complete an

[11] Kaiser Permanente HVA Tool (2017) is available at https://www.pahospitalpeace.org/sites/main/files/fileattachments/kp_incident_log_hva_template.xlsb.

individual HVA, then they can be compared to validate each assessment and a consensus can be reached using the variety of assessments.

2.2.2. Identify Facility-Specific Hazards

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

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

2.2.3. Assess Hazards

The risk each hazard poses to the facility is determined through a variety of factors. The table below presents each factor and the considerations to make when evaluating them. **Table 3: HVA Considerations**

Hazard Factor	Considerations
Probability	▪ Current local and regional plans ▪ Manufacturer/vendor statistics ▪ Subjective evaluations or best estimate
Human Impact	▪ Potential for staff, resident, or visitor injury or death ▪ Emotional or psychological impact ▪ Local cultural norms
Property Impact	▪ Cost to replace ▪ Cost to set up temporary replacement ▪ Cost to repair ▪ Time to recover
Business Impact	▪ Business interruption ▪ Staff unable to report to work ▪ Violation of contractual agreements, regulatory standards ▪ Interruption of critical supplies ▪ Reputation and public image ▪ Financial impact or burden

Preparedness	▪ Status of current plans ▪ Staff training completion status ▪ Availability of alternate sources for critical resources
Internal Response	▪ Emergency resource levels ▪ Durability/longevity of resources (without replenishment) ▪ Internal resources ability to withstand disasters ▪ Availability of backup systems
External Response	▪ Types of agreements with community agencies ▪ Relationship with local and state agencies ▪ Relationship with local healthcare facilities ▪ Relationship with community volunteers ▪ Vendor pre-incident response plans and contracts

3. Activation Checklist

Any incident large or small can warrant the activation of the CEMP and the processes contained within. This checklist describes the activities that should take place whenever the CEMP is activated and the position that is responsible. Additional facility specific processes can be added into the checklist.

Table 3: Activation Checklist

Task		Completed By
☐	Upon notification of hazard or threat from staff, residents, or visitors, activate the CEMP.	[Facility's Administrator, Senior Leader or designee]
☐	Activate the Communications Plan.	[Facility's Administrator, Senior Leader or designee]
☐	Notify staff of CEMP activation and the hazard or threat through the [facility-specific system (e.g., mass notification system, switchboard operator, overhead paging system)].	[Facility's Administrator, Senior Leader or Public Information Officer]
☐	Assess the potential or actual impact of the incident on residents, staff, and the facility.	[Facility's Administrator, Senior Leader or designee]
☐	Direct Incident Management Team to convene at designated Command Center location.	[Facility's Administrator, Senior Leader or designee]

☐	Based on the hazard and using the "Notification by Hazard Type" table in the CEMP, conduct required notifications.	[Designated Facility Staff]
☐	Set-up the facility's Command Center. *Refer to section below checklist for more information.*	Finance/Administration Section Chief and Logistics Section Chief
☐	Deliver briefing to Incident Management Team, and other staff as appropriate, on the incident including: ▪ Extent or impact of the problem (e.g., hazards, life safety concerns) ▪ Number of residents injured or affected ▪ Status of resident care and ancillary services ▪ Current and projected staffing levels ▪ Status of facility plant, utilities, and environment of care.	Incident Commander

Task		Completed By
☐	Develop an Incident Action Plan to establish goals and objectives to guide incident response throughout the next operational period. Operational period duration will be determined by Incident Commander (e.g., 12 hours, shift change).	Incident Commander
☐	Prepare and distribute position-specific checklists for the Incident Management Team to use during incident response.	Planning Section Chief
☐	Establish a meeting schedule for Incident Management Team to maintain situational awareness of incident and response operations.	Planning Section Chief
☐	Notify residents and their relatives or responsible parties of hazard information and response actions.	Public Information Officer
☐	Task facility staff with completing additional tasks to meet established response goals and objectives.	Incident Management Team
☐	Continue to collect information about incident and its current or projected impacts and perform position duties as assigned.	Incident Management Team

3.1. Command Center

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

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

documentation.

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

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

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

4. Incident Management Team Position Checklists

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

4.1. Incident Commander

INCIDENT COMMANDER	
☐	Activate the CEMP and necessary Incident Management Team positions.
☐	Analyze potential threats or hazards (e.g., weather forecast, law enforcement intelligence) and assess potential or impacts on residents, staff, and the facility.
☐	Brief the Incident Management Team on the nature of the problem, immediate issues, and the initial plan of action.
☐	Evaluate expected or actual facility damage and assign staff to conduct a thorough site assessment.
☐	In accordance with local plans or procedures, notify emergency management, law enforcement, and fire officials of incident conditions for situational awareness and to relay critical needs.

☐	Facilitate regular briefings to review the status of response operations. Request status reports from staff on resident health and safety.
☐	Observe the Incident Management Team for signs of stress and exhaustion and provide rest periods.
☐	Determine the appropriate protective action based on the presence of potential or actual hazards to resident safety and well-being.
☐	Share regular updates with residents and staff to maintain situational updates.
☐	Authorize procurement and distribution of resources.

4.2. Public Information Officer

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

☐	Communicate concerns to the Incident Commander, as needed.

4.3. Safety Officer

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

4.4. Operations Section Chief

OPERATIONS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Assign staff to assess the facility and resident well-being.
☐	Determine how facility services will continue as routinely as possible, including the provision of: ▪ Routine nursing services and documentation ▪ Medication dispersal per resident schedules. ▪ Routine hygienic and nutritional care for residents.
☐	Arrange for the provision of and/or documentation, transfer, and transportation critical medical services, such as dialysis and oxygen therapy, and emergency discharges for atrisk residents.
☐	Maintain resident and staff accountability.
☐	Secure resident records during shelter-in-place operations.
☐	Assess pharmacy supplies and contact pharmacy, as needed, to determine: ▪ Cancellation of deliveries. ▪ Availability of backup pharmacy. ▪ Availability of medical supplies.
☐	Evaluate staffing needs and activate additional staff, as needed.
☐	Direct nursing and rehabilitation staff to: ▪ Tend to physical and emotional needs of residents. ▪ Assist in clearing rooms and hallways, exits, etc. ▪ Support movement of residents during an evacuation.
☐	For receiving facility operations, ensure proper management of arriving residents and their records, including documentation of triage, treatment, and disposition of emergency admits.
☐	Document resident injuries (and action plan to ensure treatment) or deaths.

☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

4.5. Planning Section Chief

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

4.6. Logistics Section Chief

LOGISTICS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Distribute resource request forms to each Incident Management Team member. Document the request, use, return, and condition of resources used to respond.

☐	Ensure the following resources are mobilized, assigned, and tracked: ▪ Staff and Surge Support ▪ Emergency Supplies ▪ Communications Equipment ▪ Food and Water ▪ Transportation
☐	Document volunteer sign-in and sign-out for each operational period (e.g., shift).
☐	Request Incident Commander approval to activate mutual aid and vendor agreements for additional resources.
☐	Communicate concerns to the Incident Commander, as needed.

4.7. Finance/Administration Section Chief

FINANCE/ADMINISTRATION SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Initiate protection of, or move/relocate facility records, as needed.
☐	Maintain incident cost tracking and analysis, including the documentation, retrieval, safeguarding and distribution of cash, credit card, and receipt/invoice processes.
☐	Document and track facility-wide personnel work hours worked relevant to the emergency.
☐	Contact insurance company to notify them of the incident and identify and document requirements for submitting damage/claim reports.
☐	Consult with government officials regarding reimbursement regulations, requirements, and forms.
☐	Approve and submit a financial status report to the Incident Commander summarizing costto-date financial data relative to personnel, supplies, and miscellaneous expenses.

☐	Ensure that required financial and administrative documentation is properly prepared and maintained.
☐	Process invoices received.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

5. Demobilization Checklist

Table 4: Demobilization Checklist

Tasks	
Activate repatriation process.	
☐	Refer to the *NYSDOH Evacuation Plan Template* for further guidance.
☐	Ensure compliance with all local and NYSDOH requirements regarding inspections, remediation actions, and conditions for approval of repatriation.
☐	Receive approval from NYSDOH to reopen the facility.
☐	Initiate repatriation plans and procedures.
Deactivate IMT positions and surge staffing.	
☐	Determine if there is an adequate number of facility personnel to meet remaining incident needs.
☐	Deactivate IMT positions that are no longer needed.
☐	Reduce surge staff (e.g., off-duty personnel, volunteers, contract support) and provide guidance on close-out procedures (e.g., where to submit documentation).
Return or restore emergency resources.	
☐	Estimate current and anticipated resource requirements.
☐	Determine which facility-owned resources need to be returned to storage locations in the facility; or replenished/repaired for future incidents.

☐	Determine processes for transitioning borrowed resources back to sending facility/provider.
☐	Reactivate normal services and operations.
☐	Determine when it is safe to resume normal operations after conferring with the local authority, NYSDOH Regional Office, fire department, law enforcement, public health, and/or any other response authority.

Compile documentation for recordkeeping purposes.	
☐	Collect and manage documentation related to: disaster-related expenses, property damage, direct operating costs, consequential loss, damaged or destroyed equipment, construction-related expenses.
☐	Conduct debriefings with staff and volunteers.
☐	Write an After-Action Report.

6. Stakeholder Engagement

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

6.1. County Office of Emergency Management

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

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

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

Table 5: Office of Emergency Management Engagement

Office of Emergency Management	
☐	Establish point of contact at the County Office of Emergency Management. (Note: A list of county-specific agencies is available at http://www.dhses.ny.gov/oem/contact/map.cfm)
☐	Clarify protocol and mechanisms for accessing information from the County Office of Emergency Management, including: ▪ Resource availability throughout the region ▪ Pre-determined location list ▪ Current available services and utilities ▪ Hazard forecasts ▪ Mass notification systems
☐	Understand jurisdiction's response processes and capabilities, including available resources and response priorities in a large disaster.
☐	Identify available opportunities for training and exercises with the County Office of Emergency Management.
Office of Emergency Management	

☐	Identify critical information that the facility should relay to the County Office of Emergency Management before and during a disaster (e.g., facility status, number of residents needing transport, or infrastructure status).
☐	Seek County Office of Emergency Management input on CEMP development.

6.2. Fire Department and Law Enforcement

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

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

Table 6: Fire Department and Law Enforcement Engagement

Fire Department and Law Enforcement	
☐	Establish point of contact at fire department, emergency medical services, and law enforcement agency.
☐	Identify what critical information should be relayed to fire department, emergency medical services, and law enforcement agencies before, during, and after a disaster.
☐	Identify opportunities for training and exercises with fire department and law enforcement agencies.
☐	Solicit fire department and law enforcement agency input on recommendations to expedite response and recovery actions, including pre-staging equipment/resources, best ingress and egress from facility, and debris removal to restore emergency access.

6.3. Other Stakeholders

6.3.1. Corporate / Parent Organization

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

6.3.2. Community Stakeholders

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

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

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

Table 7: Volunteer Resources

Entity	Description and Skills
ServNY	Administered by the NYSDOH Office of Health Emergency Preparedness, ServNY is an online registration system for licensed healthcare professionals to volunteer when local and regional resources are exhausted. Volunteers are notified of staffing requests via phone or email. ServNY may also be activated by: ▪ County Office of Emergency Management submits a request to the New York State Office of Emergency Management, which sends the request to Emergency Support Function-8 State Health Desk, and then to the NYSDOH Emergency Preparedness; or ▪ Direct order of the NYSDOH Commissioner or designee.
Entity	**Description and Skills**
Community Emergency Response Team (CERT)[12]	Community volunteers that are trained in disaster preparedness and basic disaster response skills. These skills include: ▪ Fire Suppression ▪ Simple Triage and Rapid Treatment – Airway obstruction – Bleeding – Shock – Basic first aid – Establishing a medical treatment area ▪ Light Search and Rescue ▪ Team Organization

[12] Facilities can locate their local CERT program at https://community.fema.gov/Register/Register_Search_Programs

[13] Facilities can locate their local MRC program at https://mrc.hhs.gov/FindMRC

Medical Reserve Corps (MRC)[4]	MRC volunteers are imbedded in ServNY. Volunteers include practicing and retired medical and public health professionals. MRC volunteers can support response capabilities such as: ▪ Disaster medical support ▪ Health screenings ▪ Vaccination clinics ▪ Medical facility surge capacity ▪ Planning, logistical, and administrative support

7. Communications Plan

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

7.1. Objectives

- Ensure communication policies, roles, and activities are clearly defined and well-understood by staff.
- Ensure internal and external communications are accurate, timely, and informative.
- Provide frequent updates to residents, staff, relatives/responsible parties to mitigate concerns and manage expectations.

- Only share known/confirmed information (i.e., do not speculate).
- Utilize one unified voice to avoid confusion or misinformation.

7.2. Implementation

Table 8: Communications Checklist

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

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

7.3. Pre-Scripted Messaging

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

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

7.3.1. Internal Pre-Scripted Messaging

To facilitate timely and effective communications, the following pre-scripted messaging templates have been developed for facilities to tailor for incident-specific messaging. During an incident, the facility will manage or coordinate the development and dissemination of these

messages.

Immediate Messaging

Please note that for incidents that pose an immediate threat to health or safety (e.g., active threat or fire), messaging should be short and direct (i.e., "Enter the nearest room and lock the door," or in the case of fire, "Evacuate the area immediately").

CEMP Activation

The following message should be delivered to on-duty staff members who will assume Incident Management Team positions:

> *[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations have begun in order to manage the incident.*
>
> *You are receiving this message because of your role on the Incident Management Team. Please report to [Location] immediately. Continue to monitor available communications channels for updates. Refrain from sharing this message or subsequent updates with the public.*
>
> *For more information, contact [Name, Title] via phone at [Phone Number] or by email at [Email Address].*

The following message should be delivered to off-duty staff members who will be needed to support incident operations:

> *[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations have begun in order to manage the incident.*
>
> *You are receiving this message because of the need to request additional support for incident operations. Please report to [Location] at [Time]. Continue to monitor available communications channels for updates. Refrain from sharing this message or subsequent updates with the public.*
>
> *Please be prepared to bring [Resources to Support Self-Sufficiency] and [Include IncidentSpecific Safety Information].*
>
> *For more information, contact [Name, Title] via phone at [Phone Number] or by email at [Email Address].*

Pre-Scripted Messaging for Residents

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

appropriate to each resident's level of understanding.

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Please [Directions for residents (e.g., "ready yourself to evacuate"; "remain in your room"; "convene in the cafeteria")].

If you have any questions or need anything, please call [Name, Title] at [Phone Number]. We will provide more information as it becomes available. Your safety is our top priority. Thank you for your patience.

Messaging to Staff about Evacuation to Receiving Facility

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations are being established to manage the incident.

The impacts of [Incident Name] are [Expected to cause or are causing] significant damage to the following areas: [List of Impacted Areas]

For the health, safety, and well-being of residents, [Facility Name] will be evacuating residents to [Receiving Facility]. This facility is located at [Street Address].

Messaging to Residents about Evacuation to Receiving Facility

Please ready yourself for evacuation. Staff will prepare and assist you. We will be aiding those with mobility issues. At the [Receiving Facility], you will receive food, water, shelter, and support services. We are notifying your relatives and responsible parties of the evacuation.

For more information, please call [Name, Title] at [Number].

7.3.2. External Pre-Scripted Messaging

Voicemail Recording Website/Social Media Message

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

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

Tweets, limited to 280 characters, or other short messages can include:

[Facility Name] is experiencing [Incident Name]. Responders are working to resolve the

incident. Resident safety is our top priority. Do not attempt to visit [Facility Name] at this time. For information and updates, please call [Phone Number].

Proactive Messaging to Relatives and Responsible Parties

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

Hello. This is [Name and Position] from [Facility Name]. We are [Calling/Emailing] you to inform you that [Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name].

Emergency operations have been initiated to manage the incident. [Provide high level information on residents' status]. We are doing as much as we can to protect residents. We will provide information as it becomes available. [In the event of evacuation, add] *For resident safety and well-being, residents are being evacuated to [Location].*

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

7.4. Communicating with the Public

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

Key principles of communicating with the media and public are:

- Be knowledgeable. Know the facts before reporting out.
- Be strategic in what information is shared.
- Be credible. Do not try to distort facts to protect the facility. The facility will be held responsible for any misinformation that is provided by the Public Information Officer.
- Be accessible to inquiries; be transparent.
- Be proactive. Control messaging that is released and do not let the media and public distort messaging. Correct any rumors that arise.
- Be flexible. Ensure the audience understands that the situation is unfolding, and information will be shared as it is made available.
- Be calm and collected.
- Be sure to provide contact information where the media and public can direct inquiries.

8. Protective Action Decision Support

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

Table 9: Protective Action Considerations

Protective Action Considerations	
Information and Intelligence	
☐	Have local authorities issued protective action guidance?
☐	Have adjacent counties/municipalities protective action guidance?
☐	What is the status of traffic near the facility?
☐	What is the acuity of the current resident population?
☐	What is the status of receiving facilities?
☐	What is the capacity of receiving facilities to receive residents?
☐	Have send-receive arrangements been put in place and verified?
Anticipated Impacts	
☐	What are the anticipated impacts on the facility?
☐	What is the forecasted external temperature for the next seven days?
☐	What facility infrastructure might be affected?
☐	Are there any anticipated life safety issues?
Resource Levels	
☐	What are staffing levels?

☐	Have surge-staffing options been implemented?
☐	What is the status of medical, pharmaceutical, and resident care supplies?
☐	What is the status of food and water?
	Protective Action Considerations
☐	What is the status of generators and fuel levels?
☐	What is the status of transportation resources?
☐	Have any vendors/service provider agreements been activated?
☐	What are staffing levels?
☐	Have surge staffing options been implemented?

9. After-Action Review Process

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

Table 10: After-Action Review Process

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

10. After-Action Report Template

Table 11: After-Action Report Template

Event	Event Date
[Incident/Exercise Name]	[Date]

Event Description
[Brief description of incident/exercise]

Strengths
▪ [Placeholder] ▪ [Placeholder] ▪ [Placeholder]

Areas for Improvement
▪ [Placeholder] ▪ [Placeholder] ▪ [Placeholder]

Improvement Plan

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

11. Resource Management

11.1. Resource Considerations

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

Generators

- What reporting processes are in place in the event that a generator fails inspection, is not properly maintained, or fails a test?
- What positions are routinely trained on the process of establishing emergency power to the building?
  - Who is responsible for performing this task?
- What procedures are in place to troubleshoot generator system failures?
- How long can emergency power be sustained before having to replenish fuel if tank is full?
- What systems, capabilities, and/or resources will be impacted if power is lost and emergency power is unable to be secured (e.g., food, water, ventilation)?

Fuel

- Is the emergency fuel source municipal fuel or local/on-site fuel?
- What is the current onsite fuel storage capacity?

Potable Water

- Where is potable water stored on site?
- What potential barriers are there to reaching the potable water during an emergency?
- Will potable water storage be safe from contamination by flood waters or severe storms?
- Who manages the potable water storage?

Transportation

- Which types of vehicles are immediately available to the facility?
- Are facility-owned vehicles maintained?
- Where can facility-owned vehicles access fuel?
- How many and which staff can operate facility-owned vehicles?
- Should additional staff be trained pre-disaster as alternatives?
  - Where are copies of operator licenses kept?
- Do staff have identification and primary and alternate routes if normal travel is restricted or roads are closed?

12. Glossary

Table 12: Glossary

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

Hazard	Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

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

Incident Management Team	The Incident Management Team is comprised of pre-designated personnel who are assigned to plan and execute response and recovery operations. Incident Management Team activation is designed to be flexible and scalable depending on the type, scope, and complexity of the incident. As a result, the Incident Commander may decide to activate the entire team or select positions, based on the extent of the emergency.
Lockdown	A security measure taken during an emergency to prevent people from leaving a facility, and to prevent an active threat (one or more persons) from entering a facility.

Term	Definition
Mitigation	Activities providing a critical foundation in the effort to reduce the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster and providing value to the public by creating safer communities. Mitigation seeks to fix the cycle of disaster damage, reconstruction, and repeated damage. These activities or actions, in most cases, will have a long-term sustained effect.
Operational Period	The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually they last 12-24 hours.
Preparedness	A continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response. Preparedness focuses on the following elements: planning; procedures and protocols; training and exercises; personnel qualification and certification; and equipment certification.
Receiving Facility	A facility that has entered into agreement with another facility (nursing home, adult care facility, hospital, etc.), offering to host residents and staff for some part of an emergency response.
Response	Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes.

Recovery	The development, coordination, and execution of service- and siterestoration plans; the reconstitution of government operations and services; individual, private-sector, non-governmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.
Secure Area	An area that has been checked and verified to be clear of fire/danger, with windows and doors closed, equipment shut down, and hallways free of obstacles.
Term	**Definition**
Shelter-in-Place	NYSDOH defines shelter-in-place as the protective action strategy of keeping a small number of residents in their present location when the risks of relocation or evacuation exceed the risks of remaining in current location. Can only be done for coastal storms. Requires pre-approval from NYSDOH prior to each hurricane season and pre-authorization at the time of the incident. Please refer to the 2019 Evacuation Plan.
Situational Awareness	Is the ability to identify, process, and comprehend the essential information about an incident to inform the decision-making process in a continuous and timely cycle and includes the ability to interpret and act upon this information.
Smoke Detector	Smoke detectors are located on ceilings throughout the facility and respond to smoke thereby setting off the alarm.
Threat	Natural or manmade occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property.

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

Hazard Annex A: Active Threat

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

	Preparedness
☐	Conduct a walk-through of the facility to determine vulnerabilities (e.g., publicly accessible entrances), identify emergency escape routes, and determine necessary security measures (e.g., additional locks, cameras).
☐	Train staff on security-related responsibilities and empower staff to report unusual, dangerous, or suspicious activity.
☐	Train staff on the "Run, Hide, Fight" options to enable staff to quickly act during a realworld situation.[13]
☐	Create and implement policies for access control and security: ▪ Require all persons to display an authorized identification badge or pass. ▪ Ensure locked doors remain closed and locked. ▪ Control dissemination of keys and/or keypad code access.
☐	Identify emergency escape routes for each facility office, which may or may not be the same as normal fire evacuation routes.
☐	Identify outside gathering areas within a half mile of the facility and communicate location to staff members for staff, residents, and visitors to convene during an active threat, as appropriate.
☐	Conduct drills with law enforcement officials to familiarize first responders with the facility (e.g., entrances/exits, building layout, notification procedures).

[13] For more information, refer to *Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans* at http://www.phe.gov/Preparedness/planning/Documents/active-shooter-planning-eop2014.pdf

	Response
☐	In response to an active threat, each individual (staff, residents, and visitors) will determine the most appropriate response based on their proximity to the threat and their mobility level. ▪ **RUN:** If it is safe to do so, staff and residents should move as far away from the threat as possible until they are in a safe location. ▪ **HIDE:** If running is not a safe option—or for residents with mobility options—individuals should hide in as safe a place as possible (e.g., thicker walls, fewer windows, lock or barricade doors). ▪ **FIGHT:** If neither running nor hiding is a safe option, as a last resort and when confronted by the assailant, individuals in immediate danger should consider trying to disrupt or incapacitate the assailant by using aggressive force and items in their environment, such as fire extinguishers, chairs, etc.
☐	The Regional Office or Watch Center should not be contacted as the event is in progress. All DOH or Watch Center notifications should be done after law enforcement has deemed the situation safe. The facility will call 9-1-1 if there is a suspected or actual threat to the facility, staff, or residents and will provide as much of the following information as possible: ▪ Facility name and address; ▪ Location and number of attacker(s); ▪ Description of attacker(s), gender, clothing, among other points; ▪ Number and location of any victims. ▪ Type(s) of weapons if known.
☐	After notifying authorities of the emergency, the facility will use its notification methods to warn visitors, off-site staff, and others.
☐	The facility will notify residents, visitors, and staff when law enforcement has determined that the threat has been neutralized.

Hazard Annex B: Blizzard/Ice Storm

A blizzard has a wind speed of 35 mph or higher with blowing snow and extremely limited visibility. An ice storm also reduces visibility and can immobilize ground and air transportation leaving a facility isolated. Ice storms include freezing rain and sleet, both of which cause sheets of ice to form on the ground, which can cause falls. Ice may also build on tree limbs, wires, and awnings. Blizzards and ice storms can cause extreme cold and power outages, and impede travel to and from the facility, impacting delivery of vital services and supplies.

	Preparedness
☐	Procure sufficient rock salt/snow melt to clear primary passageways.
☐	Monitor weather forecasts via radio and television (e.g., National Weather Service).
☐	Begin preparations for a blizzard/ice storm as soon as a watch (storm is 36 – 48 hours out) or warning (storm is occurring or will occur in 24 hours) is issued.
	Response
☐	Ensure all staff and residents remain inside the facility.
☐	Determine which staff will remain on site for up to 72 hours, as shift changes will not be possible during a blizzard due to blocked roads. Develop and disseminate a schedule to ensure all staff have breaks to rest, eat, and sleep.
☐	If the heating system fails, prepare to evacuate, if possible. Contact the NYSDOH Regional Office for guidance on whether to evacuate. If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*

Hazard Annex C: Coastal Storms

Coastal storms may arrive as tropical depressions (maximum sustained winds of 38 mph or less), tropical storms (maximum sustained winds of 39-73 mph), or hurricanes (maximum sustained winds of 74 mph or more, ranging from Category 1-5). Hazards associated with

coastal storms include: flooding; flying debris; extreme winds and tornados; torrential rain; and power outages due to downed trees and power lines.

Preparedness	
☐	Determine which buildings, infrastructure, and essential services would be at risk by flooding.
☐	Assess potential infrastructure impacts from winds and heavy rains: ▪ Assess the ability of facility infrastructure to withstand extreme winds and rain. ▪ Consider infrastructure-hardening measures (e.g., impact-resistant windows).
☐	In the days prior to landfall, review forecast information and intelligence, anticipated impacts, and facility resource levels to determine facility readiness to implement protective actions.
☐	Maintain communication with the County Office of Emergency Management and Health Emergency Preparedness Coalition to receive storm reports for the area.
☐	In the absence of direction from NYSDOH and local authorities (e.g., mandatory evacuation order), determine which protective action to implement.
☐	Implement protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information. If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*
☐	Reassess the situation at regular intervals (e.g., 96 hours, 72 hours, 48 hours, 24 hours) to determine whether additional protective actions are required.
Response	
☐	Evaluate conditions of staff and residents and identify needs and gaps in services.
☐	Assess infrastructure damage and continued threats to staff and residents.
☐	Report status to external partners (e.g., NYSDOH Regional Office, County Office of Emergency Management) and/or relatives and responsible parties, as appropriate.

Hazard Annex D: Dam Failure

The response to a dam failure will depend on the amount of warning time, which will depend on the cause and extent of flooding or primary dam failure. Heavy rains downstream may give a facility time to prepare for a dam failure while intense storms with flash flooding could cause failure within minutes. It is important to respond immediately to any kind of siren/alarm and/or warning coming from dam officials.

Preparedness	
☐	Identify dams near the facility.
☐	Work with County Office of Emergency Management officials to identify the best preparedness actions specific to nearby dams.
☐	Identify which facility buildings, infrastructure, and essential services would be in the path of flood waters as the result of a dam failure.
☐	Consider mitigation activities in areas susceptible to water intrusion.
☐	Develop procedures for relocating resources, vital records, and equipment to assure continuation of services and to prevent damage or loss.
Response	
☐	If the facility suffers structural damage or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	Regularly seek updates on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility's population.
☐	Consider all flood water contaminated. Avoid walking through floodwater and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that have come into contact with floodwater.
☐	Gather critical supplies to take to higher ground (e.g., medications, drinking water, health records, important personal items, communication devices, blankets).
☐	Do not allow electrical devices to come into contact with water.

☐	If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*

Hazard Annex E: Earthquake

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

Preparedness	
☐	Ensure structures are in full compliance with regional building codes.
☐	Implement earthquake protection measures for utilities: ▪ Repair defective electrical wiring. ▪ Repair leaky gas lines. ▪ Install automatic shut off valves triggered by strong vibrations. ▪ Repair or replace inflexible utility connections and fittings.
☐	Protect staff and residents from movable objects: ▪ Secure water heaters, refrigerators, furnaces and/or boilers, washing machines and dryers, and other gas appliances. ▪ Secure top-heavy items. ▪ Store large or heavy items on lower shelves. ▪ Secure cabinets. ▪ Secure overhead lighting.
☐	Stage multiple small fire extinguishers throughout the facility and provide training on fire extinguisher use and associated hazards.[6]
Response	
During Earthquake	

NEW YORK STATE OF OPPORTUNITY. Department of Health

☐	Do not attempt to leave the building during an earthquake.
☐	Instruct residents in wheelchairs to lock their wheels in a safe position and cover their head and neck with their arms if they are able to.

[6] 29 Code of Federal Regulations, 1910.157(g)(1) states that "Where the employer has provided portable fire extinguishers for employee use in the workplace, the employer shall also provide an educational program to familiarize employees with the general principles of fire extinguisher use and the hazards involved with incipient stage fire-fighting." Paragraph (g)(2) states that the "education" required in paragraph (g)(1) "must be provided to employees upon initial employment and at least annually thereafter."

☐	Instruct residents in beds to remain in their beds.
☐	Instruct personnel to take cover under a desk, table, in a doorway. Place hands over your head for protection. Stay away from windows, glass, and exterior doors.
☐	Encourage everyone to remain in place for a few minutes after the initial shock as aftershocks may occur.
After Earthquake	
☐	Survey the facility for injuries, structural damage, fire, ruptured gas or water pipes, etc. If necessary, shut off utility lines and/or panels.
☐	Assign staff to assess residents for any injuries that require immediate attention.
☐	Assess the facility for damage that requires immediate attention (e.g., gas leaks, fires, broken glass, spills).
☐	If there is a fire, follow facility protocol.
☐	If a gas leak is suspected, notify the Plant Manager.
☐	If electrical system damage is suspected, follow facility protocol.
☐	If sewage and water line damage is identified, follow facility protocol.
☐	Comply with public health notices/orders regarding water contamination and utilize emergency potable water resources.
☐	If the facility has suffered structural damage, or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*
☐	Seek updates from staff on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility's population.

Severe Weather Policy

Severe Weather Policy

Policy:

Fiddler Green Manor will prepare and hold equipment necessary to operate during severe weather to include extended snow storms

Responsibility:

Administrator and Management and all assigned staff directed by their respective directors or designee

Procedure:

Fiddlers Green Manor will operate under the guidelines and use the following information to guide them in severe weather.

Environmental Concerns:

1. **Raise temps in building before temps inside drop:** The building can take way too long to catch up by the time temps drop inside.

2. **Make up air/Roof top units:** Check periodically to ensure they are not bringing in cold air. Many roof top units do not work well at tempering the incoming air when the outside temp is under 5 degrees.

3. **Snow plowing and removal:** reach out to your vendor and express your concern regarding lots are to kept clear for staff, resident families, ambulances etc. If you need to salt, do it now, at 0 degrees it's not going to help.

4. **Emergency supplies:** Reach out to your emergency vendors to ensure they understand you may call on them (ensure emergency vendor/contacts are up to date) Water, food etc.

5. **Snow blower:** Extra gas on hand

6. **Batteries:** Ample supply of batteries in case of outage

7. Generator full load run

Effective: March 3, 2016

FIDDLERS GREEN MANOR EMERGENCY PREPERATION CHECKLIST

Area of Concern	Performed by:	COMMENTS:	Signature:
1. Adjust building temps as needed before temps inside drop.			
2. Make up air/roof tops: Shut down when needed. Create log to monitor			
3. Snow removal: Contact snow plow vendor. Salt before under 10 degrees			
4. Emergency Supplies: Contact Vendors			
5. Snow blowing equipment: Ample gas supply			
6. Batteries: Ample supply in case of power outage			
7. Generator full load test:			
8. Review disaster plan:			
9. 02 supply is ample:			

CHAPTERS
SEVERE WEATHER

T:here are two types of response to weather emergencies.

REACTIVE –a response to weather emergencies that are SUDDEN

PREPLANNED -weather emergencies that have advanced warning

Each type is treated differently until it becomes necessary to *evacuate* and then standard procedure for evacuation is followed.

5.1 ***REACTIVE***

1. *Windstorms (includes tornadoes and hurricanes)*

   a) When "alert" is given, keep battery-operated radio/TV tuned for local information/bulletins and while remaining calm, inform the residents.

   b) When "warning" is issued and storm direction is unknown, move residents to corridor area and:

      1) Close all windows
      2) Close window drapes, shades or blinds to prevent injury from flying debris and glass
      3) Move bed-bound residents to the corridors in their beds
      4) Provide all residents with pillows and blankets to protect from flying debris

      Note: Do not place residents in large open areas. The corridors are the safest, strongest place.

   c) If facility is damaged and evacuation is necessary, follow procedures found in "Evacuation."

2. *Flash Floods:*

   a) Keep residents calm
   b) Keep residents in their rooms/beds
   c) Call Fire Department and Police Department for help
   d) Elevate/protect facility records
   e) Maintain potable water supply
   f) If water does not recede rapidly, implement "Evacuation"

Hazard Annex F: Extreme Cold

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

Preparedness	
☐	Conduct regular building maintenance and inspection, including maintenance of heating and air conditioning systems and thermostats.
☐	Test all generators involved in supplying power to areas for resident care and ensure the facility has sufficient fuel on-site to fuel the generator for the period of extreme cold.
☐	Routinely monitor the indoor facility temperature when the outdoor temperature is below 65 degrees Fahrenheit to ensure the indoor temperature in residents' rooms and all common areas is maintained at a minimum of 75 degrees Fahrenheit.[7]
☐	Develop resident assessment protocol, including vital sign checks focusing on core temperature and comfort checks.
☐	Develop procedures for internal relocation of residents to warmer parts of the facility.
☐	Document vendors for additional heating units. Establish agreements and/or contracts with vendors, as possible.

[7] 10 NYCRR 415.5 and 42 CFR 483.15 The regulations contained in 10NYCRR Part 713 require nursing homes to be equipped with a heating system capable of maintaining all resident areas at a minimum temperature of 75 degrees Fahrenheit.

	Response
☐	Conserve heat: ▪ Avoiding unnecessary opening of doors/windows ▪ Close off unoccupied rooms ▪ Cover windows
☐	If the facility experiences heating equipment malfunctions during normal business hours, immediately contact heating equipment service provider and notify the NYSDOH Regional Office. For malfunctions that occur on nights, weekends or holidays, notify the New York State Watch Center (Warning Point) at 518-292-2200.
☐	If heating equipment has failed, regularly monitor individual room temperatures.
☐	Initiate actions to safely increase resident comfort (e.g., provide additional blankets to residents); offer warm liquids (keeping in mind relevant dietary modifications/restrictions).
☐	Assess residents for signs of distress and/or discomfort.
☐	If the internal temperature of the facility remains low and potentially jeopardizes the safety and health of residents, consider internal relocation to a warmer part of the facility (on sunny side; downwind) or evacuation.
☐	If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template.*

Hazard Annex G: Extreme Heat

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

Preparedness	
☐	Regularly inspect the building's HVAC system.
☐	Maintain cooling supplies: ▪ Portable fans and temporary cooling devices ▪ Non-perishable foods and fluids
☐	Develop procedures to monitor the physical environment of the facility (e.g., temperature, humidity, sun screening, ventilation).
☐	Develop procedures for relocation to cooling centers inside the facility. Procedures for the internal relocation of residents to air-conditioned, or cooler areas, of the facility.
☐	Educate staff on risks of extreme heat, including: heat cramp, heat exhaustion, heat stroke, sunburn, and dehydration.
☐	Develop resident assessment protocol, including vital sign checks focusing on core temperature, comfort checks, and checking for resident dehydration.
Response	
☐	Conduct wellness checks and safety precautions: ▪ Check rooms regularly to ensure that air-conditioning is operational. ▪ Keep drapes and windows closed. ▪ Decrease physical activity for residents. ▪ Keep residents inside facility.
☐	Monitor resident exposure and reactions to heat. Follow protocol for transfer to hospital if resident appears to be suffering from heat-related illness such as heat cramps, heat exhaustion, or heat stroke.
☐	Consider re-locating residents to the coolest locations in the facility or creating "cooling centers" where residents can congregate with limited air conditioning, cool cloths, cold beverages, and similar measures.
☐	If the internal temperature of the facility remains high and potentially jeopardizes the safety and health of residents, notify the NYSDOH Regional Office. On nights, weekends or holidays, notify the New York State Watch Center (Warning Point) at 518292-2200.

☐	If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*
☐	Encourage residents to drink fluids to maintain hydration.

Hazard Annex H: Fire

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

	Preparedness
☐	Identify fire and life safety hazards inside the facility: ▪ Missing or broken fire safety equipment ▪ Blocked fire doors and evacuation routes ▪ Accumulated trash ▪ Burned out exit lights
☐	Plant Manager will document and inspect facility's fire and life safety emergency systems, including: ▪ Manual pull alarms ▪ Smoke detectors ▪ Exit doors and stairwells ▪ Sprinklers System ▪ Fire extinguishers ▪ Fire alarm monitoring service ▪ Self-closing fire doors
☐	Test the facility's fire alarm system and record outcomes, as required by NYSDOH regulation.
☐	Train all staff on the type of fire extinguishers in the building, their location, how to access them, and the types of fires they should be used on.
☐	Conduct quarterly fire drills at unexpected times, under varying conditions, and on each shift.
	Response

☐	If the fire alarm system is out of service for more than four hours in a 24-hour period, notify the Authority Having Jurisdiction, evacuate the building, or if approved, implement a fire watch until the fire alarm system has been returned to service.
☐	Rescue those in immediate danger in accordance with the facility's fire rescue procedures.
☐	Pull the fire alarm and then alert residents and staff members.
☐	Contain the fire if possible. ▪ Shut off air flow, as much as possible. ▪ Close all fire doors and shut off fans, ventilation systems, and air conditioning/heating systems. ▪ Use available fire extinguishers if the fire is small and this can be done safely.
☐	Relocate oxygen-dependent residents away from fire since oxygen supply lines (whether portable or central) may lead to combustion in the presence of sparks or fire. If necessary, remove oxygen and reconnect one resident is in a safe area.
☐	If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template*.

Hazard Annex I: Flood

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

Preparedness	
☐	Implement indoor flooding protection measures for buildings: ▪ Repair and replace leaky or broken pipes. ▪ Perform maintenance inspections on water heaters and washing machines. ▪ Identify clogged sewer or drain lines and contact plumbing services, as needed.
☐	Determine which buildings, infrastructure, and essential services may be at risk of flooding.
☐	Consider mitigating risks associated with flooding: ▪ Elevate the furnace, water heater, emergency generator, and electrical panel if susceptible to flooding. ▪ Install sewer backwater valves to prevent sewer backups. ▪ Build barriers to prevent floodwater from entering the facility. ▪ Utilize waterproofing materials to seal walls in basements or identified rooms.
Response	
☐	Maintain contact and communication with the County Office of Emergency Management and Health Emergency Preparedness Coalition to receive flooding reports for the area.
☐	If the facility has suffered structural damage, or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*
☐	If the decision is made to internally relocate, gather critical supplies to take to higher ground (e.g., medications, drinking water, resident records, important personal items, communication devices, blankets).

☐	Regularly seek updates from staff to determine if other protective actions are needed for some or all of the facility's population.
☐	Unplug non-essential appliances, equipment, and computers. Do not allow electrical devices to come into contact with water.
☐	If a gas leak is suspected, notify the Plant Manager.
☐	Check for water line ruptures and sewage contamination and report utility problems to the utility company.
☐	If water lines are disrupted, consider the water supply to be contaminated and utilize the facility's emergency potable water resources.
☐	Comply with public health notices regarding water contamination (e.g., Boil Water, Do Not Drink Water, Do Not Use Water).
☐	Consider all flood water contaminated. Avoid walking through floodwater and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that have come into contact with floodwater.

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

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

	Preparedness
☐	Determine the facility's proximity to potential sources of CBRNE exposure (e.g., transportation corridors, nuclear power plant).
☐	Work with local emergency management, public health, environmental health, and other identified stakeholders to develop a decontamination plan.
☐	Properly dispose of potentially toxic substances like unused chemicals, pharmaceuticals, and other substances.
☐	Conduct trainings on safe handling, transportation, and disposal of hazardous wastes.
	Response
☐	Maintain contact and communication with the County Office of Emergency Management and Health Emergency Preparedness Coalitions to receive updated CBRNE threat information for the area.
☐	Based on the type and location of incident, assess potential impacts of a hazardous materials release.
☐	Review threat information and intelligence, anticipated impacts, and resource levels to determine facility readiness to implement protective actions. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template*.

☐	Assess the need to set up "hot, warm, and cold" zones for which access would be restricted. Secure zones accordingly.
☐	Provide guidance and implement protective measures for food handling, mass feeding, and sanitation.
☐	Preemptive methods to mitigate exposure to hazardous substance outside the facility: ▪ Close all windows, doors, and vents. ▪ Limit the amount of foot traffic in and out of the facility. ▪ Do not allow residents outside, as possible. ▪ If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intake.
☐	Carry out established decontamination procedures, as needed.
☐	Monitor staff and residents for delayed physical responses as a direct result of the incident.
☐	Assess residents for worsened health outcomes as an indirect result of the incident.

Hazard Annex K: Infectious Disease

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

The facility follows effective strategies for preventing infectious diseases. Each county Local Health Department-(LHD) has prevention agenda priorities compiled from community health assessments that can be reviewed and utilized by the facility in fully developing your CEMP Annex E, planning and response checklist for infectious disease and pandemic situations. The information within this Annex includes the identified priorities and focus areas.

Under the Pandemic Emergency Plan (PEP) requirements of Chapter 114 of the Laws of 2020, special focus is required for pandemics. Please use the template's Appendix E and this

Hazard Annex, with prompts for the PEP requirements, to ensure that the plans developed meet all requirements.

Chapter 114 of the Laws of 2020 (full text):

Section 2803 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (a) each residential health care facility shall, no later than Ninety days after the effective date of this subdivision and annually thereafter, or more frequently as may be directed by the commissioner, prepare and make available to the public on the facility's website, and immediately upon request, in a form acceptable to the commissioner, a pandemic emergency plan which shall include but not be limited to:

(i) a communication plan:

(a) to update authorized family members and guardians of infected residents at least once per day and upon a change in a resident's condition and at least once a week to update all residents and authorized families and guardians on the number of infections and deaths at the facility, by electronic or such other means as may be selected by each authorized family member or guardian; and

(b) that includes a method to provide all residents with daily access,

At no cost, to remote videoconference or equivalent communication methods with family members and guardians; and

(ii) protection plans against infection for staff, residents and families, including:

(a) a plan for hospitalized residents to be readmitted to such residential health care facility after treatment, in accordance with all applicable laws and regulations; and

(b) a plan for such residential health care facility to maintain or contract to have at least a two-month supply of personal protective equipment; and

(iii) a plan for preserving a resident's place in a residential healthcare facility if such resident is hospitalized, in accordance with all applicable laws and regulations.

(b) the residential health care facility shall prepare and comply with the pandemic emergency plan. Failure to do so shall be a violation of this subdivision and may be subject to civil penalties pursuant to section twelve and twelve-b of this chapter.

The commissioner shall review each residential healthcare facility for compliance with its plan and the applicable regulations in accordance with paragraphs (a) and (b) of subdivision one of this section.

(c) within thirty days after the residential health care facility's receipt of written notice of noncompliance such residential healthcare facility shall submit a plan of correction in such

form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall ensure each such residential healthcare facility complies with its plan of correction and the applicable regulations.

(d) the commissioner shall promulgate any rules and regulations necessary to implement the provisions of this subdivision.

§ 2. This act shall take effect immediately.

1. Communicable Disease Reporting:

1.1. Importance of Reporting

- NYSDOH is charged with the responsibility of protecting public health and ensuring the safety of health care facilities.
- Reporting is required to detect intra-facility outbreaks, geographic trends, and identify emerging infectious diseases.
- The collection of outbreak data enables the NYSDOH to inform health care facilities of potential risks and preventive actions.
- Reporting facilities can obtain consultation, laboratory support and on-site assistance in outbreak investigations, as needed.

1.2. What must be reported?

NYSDOH Regulated Article 28 nursing homes:

- Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10 NYCRR 2.10), as well as by 10 NYCRR 415.19.[14]
- Any outbreak or significant increase in nosocomial infections above the norm or baseline in nursing home residents or employees must be reported to NYSDOH. This can be done electronically via the Nosocomial Outbreak Reporting Application (NORA). NORA is a NYSDOH Health Commerce System Application. Alternately, facilities may fax an Infection Control Nosocomial Report Form (DOH 4018) on the DOH public website.

[14] A list of diseases and information on properly reporting them can be found below.

- Facilities are expected to conduct surveillance that is adequate to identify background rates and detect significant increases above those rates. Healthcare associated infection outbreaks may also be reported to the LHD.

A single case of a reportable communicable disease or any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) must be reported to the local health department (LHD) where the patient/resident resides. In addition, if the reportable communicable disease is suspected or confirmed to be acquired at the NYSDOH regulated Article 28 nursing home, it must also be reported to the NYSDOH. This can be done electronically via the NORA, or, by faxing an Infection Control Nosocomial Report Form (DOH 4018).

- Reports must be made to the local health department in the county in which the facility is located (as the resident's place of residence) and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately by phone.

- Categories and examples of reportable healthcare-associated infections include:
  - An outbreak or increased incidence of disease due to any infectious agent (e.g. staphylococci, vancomycin resistant enterococci, Pseudomonas, Clostridioides difficile, Klebsiella, Acinetobacter) occurring in residents or in persons working in the facility.
  - Intra-facility outbreaks of influenza, gastroenteritis, pneumonia, or respiratory syncytial virus.
  - Foodborne outbreaks.
  - Infections associated with contaminated medications, replacement fluids, or commercial products.

  - Single cases of healthcare-associated infection due to any of the diseases on the Communicable Disease Reporting list. For example, single cases of nosocomial acquired Legionella, measles virus, invasive group A beta hemolytic Streptococcus.
  - A single case involving Staphylococcus aureus showing reduced susceptibility to vancomycin.
  - Clusters of tuberculin skin test conversions.
  - A single case of active pulmonary or laryngeal tuberculosis in a nursing home resident or employee.
  - Increased or unexpected morbidity or mortality associated with medical devices, practices or procedures resulting in significant infections and/or hospital admissions.
  - Closure of a unit or service due to infections.

- Additional information for making a communicable disease report:
  - Facilities should contact their NYSDOH regional epidemiologist or the NYSDOH Central Office Healthcare Epidemiology and Infection Control Program for general questions and infection control guidance or if additional information is needed about reporting to NORA. Contact information for NYSDOH regional epidemiologists and the Central Office Healthcare Epidemiology and Infection Control Program is located here: https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/regional_epi_staff.htm. For assistance after hours, nights and weekends, call New York State Watch Center (Warning Point) at 518-292-2200.
  - Call your local health department or the New York State Department of Health's Bureau of Communicable Disease Control at (518) 473-4439 or, after hours, at 1 (866) 881-2809; to obtain reporting forms (DOH-389), call (518) 474-0548.
  - For facilities in New York City:
    - Call 1 (866) NYC-DOH1 (1-866-692-3641) for additional information.
    - Use the downloadable Universal Reporting Form (PD-16); those belonging to NYC MED can complete and submit the form online.

2.0. PEP Communication Requirements

As per the requirements of the PEP, a facility must develop external notification procedures directed toward authorized family members and guardians of residents.

To adequately address this requirement, the facility will need to develop a record of all authorized family members and guardians, which should include secondary (back-up) authorized contacts, as applicable.

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

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

3.0 PEP Infection Control Requirements

In addition to communication-related PEP requirements address above, the facility must develop pandemic infection control plans for staff, residents, and families, including plans for (1) developing supply stores and specific plans to maintain, or contract to maintain, at least a twomonth (60 day) supply of personal protective equipment based on facility census, including

consideration of space for storage; and (2) hospitalized residents to be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80. .

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

- Incorporating lessons learned from previous pandemic responses into planning efforts to assist with the development of policies and procedures related to such elements as the management of supplies and PPE, as well as implementation of infection control protocols to assist with proper use and conservation of PPE.
- All personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents. COVID-specific guidance on optimizing PPE and other supply strategies is available on CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Supplies to be maintained include, but are not limited to:
  - N95 respirators;
  - Face shield;
  - Eye protection;
  - Gowns/isolation gowns;
  - gloves;
  - masks; and
  - sanitizers and disinfectants (EPA Guidance for Cleaning and Disinfecting):

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

- Plans for cohorting, including:
  - Use of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, such as at the end of a hallway.

  - Discontinue any sharing of a bathroom with residents outside the cohort
- Proper identification of the area for residents with COVID-19, including demarcating reminders for healthcare personnel; and
- Procedures for preventing other residents from entering the area.

4.0 Other PEP Requirements

PEP further requires that facilities include a plan for preserving a resident's place at the facility when the resident is hospitalized. Such plan must comply with all applicable State and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).

Hazard Annex L: IT/Communications Failure

IT/Communications systems failure can impact the following critical systems: computer network; telephone network; on-site data storage; medical devices; medication replenishment; and HVAC system.

An IT/communications failure incident may hinder standard notification methods. Alternate forms of notification with staff, residents and external agencies include: pagers, hand-held radios, runners, personal cell phones, and social media.

Preparedness	
☐	Utilize cloud-based or off-site servers to store data that also meet resident confidentiality requirements.
☐	Provide staff with training on use of facility computers and potential risks of personal use (e.g., opening attachments from unknown senders).
☐	Ensure redundant communications mechanisms: ▪ Consider procurement of handheld radios or walkie-talkies. ▪ Store paper-based versions of critical forms and documentation, including contact lists.
☐	Identify and protect resident care systems and records, including resident management systems, medical/resident records, resource availability, etc.
☐	Identify and protect clinical support systems including: ▪ Computer desktops, laptops, and tablets at nursing stations, hallways, bedside, laptops, etc. ▪ Electronic and automatic transfer of information between IT systems, dietary, etc.

☐	Identify and protect administrative systems including: ▪ Telephones, fax machines, databases, networks, wireless network, modems, etc. ▪ Fire protection systems, security access, external email, website, etc.

Response	
☐	Implement the facility's business continuity plan, if one exists.
☐	If the disruption is deliberate, contact local law enforcement, the Federal Bureau of Investigation's Cyber Division, and the state cyber terrorism division, as appropriate.
☐	Conduct a risk assessment of affected environmental systems (e.g., utilities) and implement plans to maintain affected systems that support operations. If necessary, consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	Isolate and repair, replace, or remove affected systems from the facility network.
☐	Address social media issues as warranted and use social media for messaging as situation dictates.
☐	Implement manual documentation systems (e.g., paper-based systems).
☐	Implement manual inventory and resupply processes, including medication distribution.
☐	In the event of heating or air conditioning system failure and/or failure of medical devices, it may be necessary to evacuate some or all residents. If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*

Hazard Annex M: Landslide

Landslides occur when masses of rock, earth, or debris move down a slope. Mudslides, also known as debris flows, are a fast-moving landslide. Landslides can occur within mere minutes and can travel several miles. Hazards associated with landslides include:

- **Rapidly moving water and debris that can lead to injury;**
- **Broken electrical, water, gas, and sewage lines that can result in injury or illness; and**
- **Disrupted roadways and railways that can endanger motorists and disrupt transport and access to health care.**

Preparedness	
☐	Evaluate the facility for landslide hazards (e.g., recent wildfires or other incidents that have destroyed ground cover, which mitigates against landslides).
☐	Ensure structures are in full compliance with regional building codes.
☐	Educate staff on landslide warning signs, including: ▪ Springs or saturated ground in areas that are not usually wet. ▪ Bulges in the ground; buckling in the ground. ▪ Increasing space between soil and foundations. ▪ Cracks in foundation.
Response	
☐	If indoors, staff and residents should take cover under desks, tables, or other heavy pieces of furniture. Residents with wheelchairs should be told to lock their wheels. If outdoors, staff and residents should get out of the path of the mudflow and get to high ground.
☐	Monitor surrounding area for flooding.
☐	Direct emergency response personnel to possible victims.

☐	Check building and surrounding area for damage or other safety issues once given the "all clear" by emergency response personnel.
☐	Listen to local radio and TV for emergency information and updates.
☐	Report broken utilities and damaged roadways to local authorities.

Hazard Annex N: Power Outage

Loss of electrical services may be the result of natural disasters, industrial accidents at power generation facilities, or damage to power transmission systems. Natural hazards and weather-related incidents that often cause with power outages include: coastal storms; floods; tornados; and blizzards/ice storms.

Preparedness	
☐	Regularly inspect and test all generators involved in supplying emergency power to areas for resident care and ensure the facility has sufficient fuel on-site to fuel the generator.
☐	See *Hazard Annex L: IT/Communications Failure* for additional preparedness activities.
Response	
☐	Assess the situation. Consult decision support considerations (information and intelligence, anticipated impacts, resources).
☐	Maintain contact and communication with the utility company, County Office of Emergency Management, and Health Emergency Preparedness Coalition to receive utilities restoration reports.
☐	Based on facility decision-making criteria, consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information. If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template.*

TORNADOES

- Step One: Notify Administrator (if possible)
- Step Two: Announce "Dr. Yellow and appropriate level"
- Step Three: Move residents into hallways and safe areas (rooms without windows) such as:

  a) Service hallway
  b) Privacy room
  c) Tub and shower rooms
  d) Housekeeping closets

  Staff members to stay with residents
- Step Four: Have staff open all windows at least six (6) inches, close all doors and pull all drapes.
- Step Five: Remaining staff to go to large storage room.
- Step Six: Once the tornado has passed, evaluate residents/staff for injuries. Initiate triage and hospital movement as necessary.
- Step Seven: Check facility for fire or gas leaks.
- Step Eight: Maintenance will check for structural damage and turn *off* electricity, gas and water as appropriate.
- Step Nine: The Administrator will determine when and how to evacuate residents.

☐	Continually seek updates from staff on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility's population.
☐	The emergency generator will start automatically within 10 seconds of an outage.
☐	If the emergency generator does not start automatically, notify the Plant Manager. If necessary, attempt to start the generator manually by following instructions posted at The generator itself located on west side of building.
☐	Use available flashlights as temporary sources of light. These can be found at Emergency boxes located on each floor
☐	Take all reasonable steps to protect food and water supplies and maintain a safe environment of care for residents and staff.

Hazard Annex O: Tornado

A tornado is a violently rotating column of air touching the ground, usually attached to the base of a thunderstorm. Winds of a tornado may reach 300 miles per hour. Damage paths can be in excess of one mile wide and 50 miles long.

Preparedness	
☐	Develop procedures for quickly moving residents away from spaces with flat, widespan roofs (e.g. cafeterias, auditoriums), which can collapse in the event of a tornado.
☐	Train staff on what **not** to do during a tornado, e.g. move to higher floors or shelter in corners, both of which are dangerous.
☐	Monitor local news and radio outlets for tornado watches or warnings issued by the National Weather Service.
Response	

☐	If a tornado watch is issued: ▪ Ensure all residents and assigned staff are inside the facility and accounted for. ▪ Check outdoors and indoors for any objects that might become projectiles. ▪ Ensure that windows are kept tightly closed. ▪ Move residents, staff, and visitors away from windows, skylights, and exterior walls, as possible.
☐	After tornado impact, assign staff to assess residents for any injuries that require immediate attention. Encourage staff to keep residents as calm as possible.
☐	Survey the facility for injuries, structural damage, fire, ruptured gas or water pipes, etc. If necessary, shut off utility lines and/or panels.
☐	Look for electrical system damage. If there are sparks or broken or frayed wires, or the smell of hot insulation, turn off the electricity at the main fuse box or circuit breaker. If you have to step in water to get to the fuse box or circuit breaker, call an electrician before proceeding. Panel(s) can be found at Basement Boiler Room, Laundry room, Activity Department room, First floor Long hall and Second Floor Long Hall.

Hazard Annex P: Wildfire

Wildfires threatening the facility may emerge with or without warning, however a wildfire evacuation will most likely occur very quickly, as opposed to a coastal storm.

Preparedness	
☐	Implement wildfire protection measures: ▪ Clean roof surfaces and gutters ▪ Use only fire-resistant materials on the exterior of the facility ▪ Consider fire-resistant landscaping
Response	

NEW YORK STATE OF OPPORTUNITY. Department of Health

☐	Maintain contact and communication with County Office of Emergency Management or Health Emergency Preparedness Coalition to receive wildfire-related updates.
☐	Monitor local news for evacuation reports and instructions.
☐	Based on facility decision-making criteria, consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	In case of immediate threat, move residents to a pre-designated staging area for rapid evacuation. If a gas leak is suspected, notify the Plant Manager.
☐	Preemptive methods to mitigate smoke and fire risk: ▪ Close all windows, doors, and vents. ▪ Limit the amount of foot traffic in and out of the facility. ▪ Do not allow residents outside, as possible. ▪ If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intakes.
☐	Regularly seek updates from staff to determine if protective actions are needed for some or all of the facility's population. If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template.*
☐	Monitor residents and staff for complications related to smoke exposure.

☐	Regularly seek updates from staff to determine if other protective actions are needed for some or all of the facility's population.
☐	Unplug non-essential appliances, equipment, and computers. Do not allow electrical devices to come into contact with water.
☐	If a gas leak is suspected, notify the Plant Manager.
☐	Check for water line ruptures and sewage contamination and report utility problems to the utility company.
☐	If water lines are disrupted, consider the water supply to be contaminated and utilize the facility's emergency potable water resources.
☐	Comply with public health notices regarding water contamination (e.g., Boil Water, Do Not Drink Water, Do Not Use Water).
☐	Consider all flood water contaminated. Avoid walking through floodwater and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that have come into contact with floodwater.

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

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

	Preparedness
☐	Determine the facility's proximity to potential sources of CBRNE exposure (e.g., transportation corridors, nuclear power plant).
☐	Work with local emergency management, public health, environmental health, and other identified stakeholders to develop a decontamination plan.
☐	Properly dispose of potentially toxic substances like unused chemicals, pharmaceuticals, and other substances.
☐	Conduct trainings on safe handling, transportation, and disposal of hazardous wastes.
	Response
☐	Maintain contact and communication with the County Office of Emergency Management and Health Emergency Preparedness Coalitions to receive updated CBRNE threat information for the area.
☐	Based on the type and location of incident, assess potential impacts of a hazardous materials release.
☐	Review threat information and intelligence, anticipated impacts, and resource levels to determine facility readiness to implement protective actions. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template*.

☐	Assess the need to set up "hot, warm, and cold" zones for which access would be restricted. Secure zones accordingly.
☐	Provide guidance and implement protective measures for food handling, mass feeding, and sanitation.
☐	Preemptive methods to mitigate exposure to hazardous substance outside the facility: ▪ Close all windows, doors, and vents. ▪ Limit the amount of foot traffic in and out of the facility. ▪ Do not allow residents outside, as possible. ▪ If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intake.
☐	Carry out established decontamination procedures, as needed.
☐	Monitor staff and residents for delayed physical responses as a direct result of the incident.
☐	Assess residents for worsened health outcomes as an indirect result of the incident.

Hazard Annex K: Infectious Disease

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

The facility follows effective strategies for preventing infectious diseases. Each county Local Health Department-(LHD) has prevention agenda priorities compiled from community health assessments that can be reviewed and utilized by the facility in fully developing your CEMP Annex E, planning and response checklist for infectious disease and pandemic situations. The information within this Annex includes the identified priorities and focus areas.

Under the Pandemic Emergency Plan (PEP) requirements of Chapter 114 of the Laws of 2020, special focus is required for pandemics. Please use the template's Appendix E and this

Hazard Annex, with prompts for the PEP requirements, to ensure that the plans developed meet all requirements.

Chapter 114 of the Laws of 2020 (full text):

Section 2803 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (a) each residential health care facility shall, no later than Ninety days after the effective date of this subdivision and annually thereafter, or more frequently as may be directed by the commissioner, prepare and make available to the public on the facility's website, and immediately upon request, in a form acceptable to the commissioner, a pandemic emergency plan which shall include but not be limited to:

(i) a communication plan:

(a) to update authorized family members and guardians of infected residents at least once per day and upon a change in a resident's condition and at least once a week to update all residents and authorized families and guardians on the number of infections and deaths at the facility, by electronic or such other means as may be selected by each authorized family member or guardian; and

(b) that includes a method to provide all residents with daily access,

At no cost, to remote videoconference or equivalent communication methods with family members and guardians; and

(ii) protection plans against infection for staff, residents and families, including:

(a) a plan for hospitalized residents to be readmitted to such residential health care facility after treatment, in accordance with all applicable laws and regulations; and

(b) a plan for such residential health care facility to maintain or contract to have at least a two-month supply of personal protective equipment; and

(iii) a plan for preserving a resident's place in a residential healthcare facility if such resident is hospitalized, in accordance with all applicable laws and regulations.

(b) the residential health care facility shall prepare and comply with the pandemic emergency plan. Failure to do so shall be a violation of this subdivision and may be subject to civil penalties pursuant to section twelve and twelve-b of this chapter.

The commissioner shall review each residential healthcare facility for compliance with its plan and the applicable regulations in accordance with paragraphs (a) and (b) of subdivision one of this section.

(c) within thirty days after the residential health care facility's receipt of written notice of noncompliance such residential healthcare facility shall submit a plan of correction in such

form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall ensure each such residential healthcare facility complies with its plan of correction and the applicable regulations.

(d) the commissioner shall promulgate any rules and regulations necessary to implement the provisions of this subdivision.

§ 2. This act shall take effect immediately.

1. Communicable Disease Reporting:

1.1. Importance of Reporting

- NYSDOH is charged with the responsibility of protecting public health and ensuring the safety of health care facilities.
- Reporting is required to detect intra-facility outbreaks, geographic trends, and identify emerging infectious diseases.
- The collection of outbreak data enables the NYSDOH to inform health care facilities of potential risks and preventive actions.
- Reporting facilities can obtain consultation, laboratory support and on-site assistance in outbreak investigations, as needed.

1.2. What must be reported?

NYSDOH Regulated Article 28 nursing homes:

- Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10 NYCRR 2.10), as well as by 10 NYCRR 415.19.[14]

- Any outbreak or significant increase in nosocomial infections above the norm or baseline in nursing home residents or employees must be reported to NYSDOH. This can be done electronically via the Nosocomial Outbreak Reporting Application (NORA). NORA is a NYSDOH Health Commerce System Application. Alternately, facilities may fax an Infection Control Nosocomial Report Form (DOH 4018) on the DOH public website.

[14] A list of diseases and information on properly reporting them can be found below.

New York State Department of Health

Health Care Facility
Infection Control (Nosocomial) Report

Facility Name: _____ PFI (4-digit facility # required): _____

Street Address: _____ Census: _____

Street Address: _____

City: _____ County: _____

Zip Code: _____ Region: _____

Type: Hospital ☐ LTCF ☐

Contact Person: _____ Phone Number: _____

Title: _____ Fax Number: _____

E-mail: _____

Date of Report: _____

Type of Report: ☐ Outbreak/Increased incidence

☐ Single case nosocomially-acquired reportable communicable disease (*submission of DOH-389 is required*)

☐ Other: _____

Site(s) of infection: ☐ Blood ☐ Eye ☐ Gastrointestinal ☐ Other: _____

(*check all that apply*) ☐ Respiratory ☐ Skin ☐ Urinary

DATE OF ONSET OF SYMPTOMS: (earliest case) _____

PREDOMINATE SYMPTOMS AND DURATION OF ILLNESS: (if fever, include range) _____

_____

_____

NUMBER OF LABORATORY CONFIRMED CASES TO DATE: Patients: _____ Staff: _____

NUMBER OF SUSPECT CASES TO DATE: Patients: _____ Staff: _____

NUMBER TRANSFERRED TO HOSPITAL: Patients: _____ Staff: _____

NUMBER OF CASES RESULTING IN DEATH: Patients: _____ Staff: _____

AFFECTED LOCATION(S) IN FACILITY:

Number of Units: _____ Number of Floors: _____

AFFECTED LOCATION TYPES:

☐ Cardiac ☐ General Medicine ☐ Med/Surg ☐ Surgical

☐ Nursery ☐ OB/GYN ☐ Oncology ☐ Not Applicable

☐ Ortho ☐ Pediatrics ☐ Rehab ☐ Other: _____

AFFECTED ICU TYPES:

☐ Cardiac ☐ General ☐ Medical ☐ Surgical ☐ Other: _____

☐ Neonatal ☐ Neurological ☐ Pediatrics ☐ Not Applicable

AFFECTED TRANSPLANT UNIT TYPES:

☐ Bone Marrow ☐ Cardiac ☐ Not Applicable

☐ Renal Cardiac ☐ Liver ☐ Other

OTHER UNIT TYPE: _____

CAUSATIVE AGENT: _____

SUSPECT/CONFIRMED: ☐ Suspect ☐ Confirmed

HAVE ANY LABORATORY SPECIMENS BEEN COLLECTED:

☐ Yes ☐ No

If yes, what specimens were collected? (check all that apply):

☐ Blood ☐ CSF ☐ Nasal Pharyngeal ☐ Urine

☐ Sputum ☐ Stool ☐ Tracheal Aspirate ☐ Other: _____

If yes, what types of tests were performed? (check all that apply):

☐ Culture ☐ PCR ☐ Rapid Antigen

☐ Serology ☐ Urine Antigen ☐ Other: _____

Name of Laboratory: _____

CONTROL MEASURES TAKEN BY FACILITY (check all that apply):

☐ Antibiotics ☐ Antiviral ☐ Cohort Patients ☐ Cohort Staffing

☐ Education/Inservice ☐ Isolation ☐ Limit/modify patient activities ☐ Minimize floating

☐ Notify Visitors ☐ Reinforce Handwashing ☐ Other: _____

Additional measures not checked above: _____

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No close out form for this case (e.g. Scabies): ☐

Paper Log Number: _____ Level of Investigation: _____

Date Received: _____ Lead Investigator: _____

Received by: _____ Follow-up by: _____

Central Office Contact to Facility: ☐ Yes ☐ No If yes, date: _____

Regional Epidemiology Staff Contact to Facility ☐ Yes ☐ No Date of Initial Contact: _____

Comments: _____

Stat: ☐

- Facilities are expected to conduct surveillance that is adequate to identify background rates and detect significant increases above those rates. Healthcare associated infection outbreaks may also be reported to the LHD.

A single case of a reportable communicable disease or any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) must be reported to the local health department (LHD) where the patient/resident resides. In addition, if the reportable communicable disease is suspected or confirmed to be acquired at the NYSDOH regulated Article 28 nursing home, it must also be reported to the NYSDOH. This can be done electronically via the NORA, or, by faxing an Infection Control Nosocomial Report Form (DOH 4018).

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3.0 PEP Infection Control Requirements

In addition to communication-related PEP requirements address above, the facility must develop pandemic infection control plans for staff, residents, and families, including plans for (1) developing supply stores and specific plans to maintain, or contract to maintain, at least a twomonth (60 day) supply of personal protective equipment based on facility census, including

consideration of space for storage; and (2) hospitalized residents to be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80. .

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

- Incorporating lessons learned from previous pandemic responses into planning efforts to assist with the development of policies and procedures related to such elements as the management of supplies and PPE, as well as implementation of infection control protocols to assist with proper use and conservation of PPE.
- All personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents. COVID-specific guidance on optimizing PPE and other supply strategies is available on CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Supplies to be maintained include, but are not limited to:
  - N95 respirators;
  - Face shield;
  - Eye protection;
  - Gowns/isolation gowns;
  - gloves;
  - masks; and
  - sanitizers and disinfectants (EPA Guidance for Cleaning and Disinfecting):

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

- Plans for cohorting, including:
  - Use of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, such as at the end of a hallway.

  - Discontinue any sharing of a bathroom with residents outside the cohort
- Proper identification of the area for residents with COVID-19, including demarcating reminders for healthcare personnel; and
- Procedures for preventing other residents from entering the area.

4.0 Other PEP Requirements

PEP further requires that facilities include a plan for preserving a resident's place at the facility when the resident is hospitalized. Such plan must comply with all applicable State and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).

Hazard Annex L: IT/Communications Failure

IT/Communications systems failure can impact the following critical systems: computer network; telephone network; on-site data storage; medical devices; medication replenishment; and HVAC system.

An IT/communications failure incident may hinder standard notification methods. Alternate forms of notification with staff, residents and external agencies include: pagers, hand-held radios, runners, personal cell phones, and social media.

Preparedness	
☐	Utilize cloud-based or off-site servers to store data that also meet resident confidentiality requirements.
☐	Provide staff with training on use of facility computers and potential risks of personal use (e.g., opening attachments from unknown senders).
☐	Ensure redundant communications mechanisms: ▪ Consider procurement of handheld radios or walkie-talkies. ▪ Store paper-based versions of critical forms and documentation, including contact lists.
☐	Identify and protect resident care systems and records, including resident management systems, medical/resident records, resource availability, etc.
☐	Identify and protect clinical support systems including: ▪ Computer desktops, laptops, and tablets at nursing stations, hallways, bedside, laptops, etc. ▪ Electronic and automatic transfer of information between IT systems, dietary, etc.

☐	Identify and protect administrative systems including: ▪ Telephones, fax machines, databases, networks, wireless network, modems, etc. ▪ Fire protection systems, security access, external email, website, etc.

Response	
☐	Implement the facility's business continuity plan, if one exists.
☐	If the disruption is deliberate, contact local law enforcement, the Federal Bureau of Investigation's Cyber Division, and the state cyber terrorism division, as appropriate.
☐	Conduct a risk assessment of affected environmental systems (e.g., utilities) and implement plans to maintain affected systems that support operations. If necessary, consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	Isolate and repair, replace, or remove affected systems from the facility network.
☐	Address social media issues as warranted and use social media for messaging as situation dictates.
☐	Implement manual documentation systems (e.g., paper-based systems).
☐	Implement manual inventory and resupply processes, including medication distribution.
☐	In the event of heating or air conditioning system failure and/or failure of medical devices, it may be necessary to evacuate some or all residents. If the decision is made to evacuate, please refer to the *NYSDOH Evacuation Plan Template.*

Hazard Annex M: Landslide

Landslides occur when masses of rock, earth, or debris move down a slope. Mudslides, also known as debris flows, are a fast-moving landslide. Landslides can occur within mere minutes and can travel several miles. Hazards associated with landslides include:

- **Rapidly moving water and debris that can lead to injury;**
- **Broken electrical, water, gas, and sewage lines that can result in injury or illness; and**
- **Disrupted roadways and railways that can endanger motorists and disrupt transport and access to health care.**

Preparedness	
☐	Evaluate the facility for landslide hazards (e.g., recent wildfires or other incidents that have destroyed ground cover, which mitigates against landslides).
☐	Ensure structures are in full compliance with regional building codes.
☐	Educate staff on landslide warning signs, including: ▪ Springs or saturated ground in areas that are not usually wet. ▪ Bulges in the ground; buckling in the ground. ▪ Increasing space between soil and foundations. ▪ Cracks in foundation.
Response	
☐	If indoors, staff and residents should take cover under desks, tables, or other heavy pieces of furniture. Residents with wheelchairs should be told to lock their wheels. If outdoors, staff and residents should get out of the path of the mudflow and get to high ground.
☐	Monitor surrounding area for flooding.
☐	Direct emergency response personnel to possible victims.

☐	Check building and surrounding area for damage or other safety issues once given the "all clear" by emergency response personnel.
☐	Listen to local radio and TV for emergency information and updates.
☐	Report broken utilities and damaged roadways to local authorities.

Hazard Annex N: Power Outage

Loss of electrical services may be the result of natural disasters, industrial accidents at power generation facilities, or damage to power transmission systems. Natural hazards and weather-related incidents that often cause with power outages include: coastal storms; floods; tornados; and blizzards/ice storms.

Preparedness	
☐	Regularly inspect and test all generators involved in supplying emergency power to areas for resident care and ensure the facility has sufficient fuel on-site to fuel the generator.
☐	See *Hazard Annex L: IT/Communications Failure* for additional preparedness activities.
Response	
☐	Assess the situation. Consult decision support considerations (information and intelligence, anticipated impacts, resources).
☐	Maintain contact and communication with the utility company, County Office of Emergency Management, and Health Emergency Preparedness Coalition to receive utilities restoration reports.
☐	Based on facility decision-making criteria, consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information. If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template.*

☐	Continually seek updates from staff on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility's population.
☐	The emergency generator will start automatically within 10 seconds of an outage.
☐	If the emergency generator does not start automatically, notify the Plant Manager. If necessary, attempt to start the generator manually by following instructions posted at The generator itself located on west side of building.
☐	Use available flashlights as temporary sources of light. These can be found at Emergency boxes located on each floor
☐	Take all reasonable steps to protect food and water supplies and maintain a safe environment of care for residents and staff.

Hazard Annex O: Tornado

A tornado is a violently rotating column of air touching the ground, usually attached to the base of a thunderstorm. Winds of a tornado may reach 300 miles per hour. Damage paths can be in excess of one mile wide and 50 miles long.

Preparedness	
☐	Develop procedures for quickly moving residents away from spaces with flat, widespan roofs (e.g. cafeterias, auditoriums), which can collapse in the event of a tornado.
☐	Train staff on what **not** to do during a tornado, e.g. move to higher floors or shelter in corners, both of which are dangerous.
☐	Monitor local news and radio outlets for tornado watches or warnings issued by the National Weather Service.
Response	

☐	If a tornado watch is issued: ▪ Ensure all residents and assigned staff are inside the facility and accounted for. ▪ Check outdoors and indoors for any objects that might become projectiles. ▪ Ensure that windows are kept tightly closed. ▪ Move residents, staff, and visitors away from windows, skylights, and exterior walls, as possible.
☐	After tornado impact, assign staff to assess residents for any injuries that require immediate attention. Encourage staff to keep residents as calm as possible.
☐	Survey the facility for injuries, structural damage, fire, ruptured gas or water pipes, etc. If necessary, shut off utility lines and/or panels.
☐	Look for electrical system damage. If there are sparks or broken or frayed wires, or the smell of hot insulation, turn off the electricity at the main fuse box or circuit breaker. If you have to step in water to get to the fuse box or circuit breaker, call an electrician before proceeding. Panel(s) can be found at Basement Boiler Room, Laundry room, Activity Department room, First floor Long hall and Second Floor Long Hall.

Hazard Annex P: Wildfire

Wildfires threatening the facility may emerge with or without warning, however a wildfire evacuation will most likely occur very quickly, as opposed to a coastal storm.

Preparedness	
☐	Implement wildfire protection measures: ▪ Clean roof surfaces and gutters ▪ Use only fire-resistant materials on the exterior of the facility ▪ Consider fire-resistant landscaping
Response	

☐	Maintain contact and communication with County Office of Emergency Management or Health Emergency Preparedness Coalition to receive wildfire-related updates.
☐	Monitor local news for evacuation reports and instructions.
☐	Based on facility decision-making criteria, consider the implementation of a protective action. Refer to *Annex A: Protective Actions* in the Base Plan for more information.
☐	In case of immediate threat, move residents to a pre-designated staging area for rapid evacuation. If a gas leak is suspected, notify the Plant Manager.
☐	Preemptive methods to mitigate smoke and fire risk: ▪ Close all windows, doors, and vents. ▪ Limit the amount of foot traffic in and out of the facility. ▪ Do not allow residents outside, as possible. ▪ If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intakes.
☐	Regularly seek updates from staff to determine if protective actions are needed for some or all of the facility's population. If the decision is made to evacuate, refer to the *NYSDOH Evacuation Plan Template.*
☐	Monitor residents and staff for complications related to smoke exposure.