Admission / Re-Admission of Residents During a Pandemic

Reviewed/Revised: 12/3/2020

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

Admission of Residents with Communicable Disease

Policy Statement

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.

Policy Interpretation and Implementation

1. Prior to or upon admission, the Infection Preventionist, or designee, will assess the following infection risks for each admission:
   a. *M. tuberculosis* (TB) infection, by purified protein derivative (PPD) test or recent chest x-ray;
   b. Immunization status, by history;
   c. During the period of October 1 through March 31, current status of influenza immunization, by history;
   d. Evidence of continuing active infection or clinically significant colonization by multidrug-resistant organism by history and review of hospital discharge summaries;
   e. Clinical evidence of a current infection; and
   f. Evidence of pediculosis or scabies, by direct observation.

2. The Infection Preventionist or designee will request an Infection Control Transfer Form from the sending facility prior to the resident's transfer. This form should provide information on the resident's infection status, isolation precautions, signs and symptoms of infection(s), antibiotic usage, and influenza/pneumococcal immunization status.

3. The Infection Preventionist or designee will maintain a log of residents with current evidence of infection or colonization due to multidrug-resistant organisms, including methicillin-resistant *staphylococcus aureus*, vancomycin-resistant *enterococci* and *Clostridium difficile* (MRSA/VRE/*C. difficile*). When considering room assignments the log will be checked to prevent placing a resident with MDRO infection or colonization with a resident at risk of infection.

4. A resident who is transferred to an acute care facility with infection due to a multidrug-resistant organism 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.

5. A resident admitted with colonization or infection due to a multidrug-resistant organism may be placed in a private room, or cohorted with another resident of the same sex who is colonized with a similar organism. A colonized resident also may be cohorted or placed with a non-colonized resident who is not immunocompromised, if no other bed is available.

6. Our facility will not deny admission to someone just because they have infection with the human immunodeficiency virus (HIV), or are HIV antibody positive.

7. Placement of individuals with other potentially infectious conditions such as herpes zoster or scabies 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.

8. The facility will not admit individuals with active tuberculosis or acid-fast bacillus (AFB) positive sputum until they have been treated elsewhere for long enough to no longer be considered contagious.

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9. Persons found upon admission evaluation to have a positive PPD reaction or a suspicious chest X-ray will be evaluated promptly to determine whether they might have active TB, in which case they will either not be admitted, will be moved to a section of the facility where appropriate isolation can occur (if available), or will be discharged promptly to a facility where they can be isolated or treated appropriately for active TB.

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

References	
OBRA Regulatory Reference Numbers	§483.20(a) Admission orders; §483.80(a) Infection prevention and control program.
Survey Tag Numbers	F635; F880
Other References	CDC/HICPAC Guidelines for Isolation Precautions at http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html and CDC MRSA information at http://www.cdc.gov/mrsa/index.html
Related Documents	Inter-facility Infection Control Transfer Form Multidrug-Resistant Organisms Tuberculosis, Screening Residents for Vaccination of Residents
Version	2.3 (H5MAPL0039)

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.

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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) Physician Supervision.
Survey Tag Numbers	F580; F637; F710
Other References	
Related Documents	Charting and Documentation Resident Assessment Instrument
Version	2.3 (H5MAPL0118)

BD Veritor Plus Analyzer

Date Initiated: 9/2/2020
Date Revised: 10/25/2020

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

Communal Dining / Activities COVID 19

Date Initiated: 6/3/2020
Date Revised: 4/6/2021

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. Per NYS DOH Visitation Guidelines 3/25/2021

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, except when eating.
8. Nursing homes should consider additional limitations based on status of COVID-19 infections in the facility and the size of the room being used and the ability to socially distance residents (e.g. limit to 10 residents and staff in smaller spaces.

Per CMS – Ref : QSO-20-39-NH REVISED 03/10/2021:
Communal Dining and Activities

- Communal dining and activities may occur while adhering to the core principles of COVID-19 infection prevention. Residents may eat in the same room with social distancing **(e.g., limited number of people at each table and with at least six feet between each person)**. Nursing homes should consider additional limitations based on status of COVID-19 infections in the facility and the size of the room being used and the ability to socially distance residents (e.g. limit to 10 residents and staff in smaller spaces.
- Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering (except while eating). Nursing homes may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.

Cohorting/Zones COVID 19

Date Initiated: 5/3/2020

Date Revised: 6/3/2020, 7/6/2020, 9/2/2020, 11/2/2020, 11/27/20, 1/13/21, 4/19/21, 5/11/2021, 7/15/21, 8/9/21

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/vaccinated (GREEN ZONE), unknown COVID-19 virus (YELLOW ZONE), and confirmed COVID-19 virus (RED ZONE).
2. Residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents are considered low risk per CDC COVID-19 Guidelines and therefore are placed in green zone upon admission.
3. Unvaccinated newly admitted/re-admitted > 24 hours 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 7/2/21 DAL 21-06 states:
        i. The Department of Health strongly encourages hospitals that, as a condition of safe discharge pursuant to existing regulatory obligations under 10 NYCRR 405.9(h)(1), they test patients for COVID-19 prior to discharge to any congregate care setting, including but not limited to nursing homes and adult care facilities and sharing such results with the accepting facility. This will allow the accepting

facility to implement its infection control policies and procedures as appropriate.

ii. Each hospital is responsible for testing and placing potential COVID positive patients in isolation as appropriate.

4. 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.
5. 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.
6. Any resident presenting with signs or symptoms of COVID-19 infection will be assessed by Primary Physician/Nurse Practitioner.
7. 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).
8. 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
9. 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
10. 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.

The RED ZONE

- 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, N-95 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,
  - Passed the 14-day window and no longer have symptoms including being afebrile x 3 days without antipyretics.
  - Fully COVID vaccinated
- 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.

The YELLOW ZONE

- Unvaccinated residents admitted or re-admitted (> 24 hours at hospital) 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.

- Transmission based signage for droplet and contact precautions will be posted in the YELLOW ZONE. Caregivers will wear full PPE to include gown, face shields, 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.

NOTE:

Residents who leave the facility should be reminded to follow all recommended IPC practices including source control, physical distancing, and hand hygiene and to encourage those around them to do the same.

COVID-19 Employee Testing

Date Initiated: 5/19/2020
Date Revised: 7/6/2020, 9/1/2020, 9/17/2020, 11/9/20, 1/4/21, 6/11/21, 7/1/21

PURPOSE:
To provide guidelines for COVID testing of employees per NYS and CDC Guidelines

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 #202.88 is contingent upon (1) the Facility's physical ability to access the materials, equipment and qualified testers necessary to administer the test weekly;

Routine Testing of Staff

Routine testing is based on NYS executive order EO 202.88 (1/4/21 – update 6/10/21 DAL NH-21-01, updated 6/25/21 NH-21-17 *Revised* Nursing Home),

Operators and administrators of all nursing homes are required to test or arrange for the routine testing for COVID-19 of all personnel who have **not been fully vaccinated**, as defined by the Centers for Disease Control and Prevention, including employees, contract staff, medical staff, operators and administrators, **for COVID-19 once per month consistent with county positivity rates and the updated April 27, 2021 CMS guidance (QSO 20-38-NH) which stated "vaccinated staff do not need to be routinely tested."**

Routine Testing of Staff
Routine testing *of unvaccinated staff* should be based on the extent of the virus in the community. *Fully vaccinated staff does not have to be routinely tested. F*acilities should use their county positivity rate in the prior week as the trigger for staff testing frequency. Reports of COVID-19 county-level positivity rates *are* available on the following website (see section titled, "COVID19 Testing"): https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg

Table 2: Routine Testing Intervals Vary by Community COVID-19 Activity Level Community COVID-19 Activity	**County Positivity Rate in the past week**	**Minimum Testing Frequency *of Unvaccinated Staff*+**
Low	**<5%**	**Once a month**
Medium	**5% - 10%**	**Once a week***
High	**>10%**	**Twice a week***

Regardless of the frequency of testing being performed or the facility's COVID-19 status, the facility should continue to screen all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19.

Table 1: Testing Summary Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, *vaccinated and unvaccinated,* with signs and symptoms must be tested	Residents, *vaccinated and unvaccinated,* with signs and symptoms must be tested
Outbreak (Any new case arises in facility)	Test all staff, vaccinated and unvaccinated, that previously tested negative until no new cases are identified*	Test all residents, vaccinated and unvaccinated, 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.

POLICY

1. The facility will COVID test un-vaccinated 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. All un-vaccinated employees who will be tested for COVID, once a month to the extent test materials are available.
4. Consultant and/or contract staff such as dental, medical must provide proof of vaccination status or, for un-vaccinated, proof of COVID testing in the last 30 days.
5. Those un-vaccinated 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.

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

- All staff and residents (regardless of vaccination status) 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.

Symptomatic Response:

Per CDC Website - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html. The following recommendations are based on what is known about currently available COVID-19 vaccines. These recommendations will be updated as additional information, including regarding the ability of currently authorized vaccines to protect against infection with novel variants and the effectiveness of additional authorized vaccines, becomes available. This could result in additional circumstances when work restrictions for fully vaccinated HCP are recommended.

- Fully vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure.
- HCP who have traveled should continue to follow CDC travel recommendations and requirements, including restriction from work, when recommended for any traveler.
- Fully vaccinated inpatients and residents in healthcare settings should continue to quarantine following prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with SARS-CoV-2 infection; outpatients should be cared for using recommended Transmission-Based Precautions.
    - Although not preferred, healthcare facilities could consider waiving quarantine for fully vaccinated patients and residents following prolonged close contact with someone with SARS-CoV-2 infection as a strategy to address critical issues (e.g., lack of space, staff, or PPE to safely care for exposed patients or residents) when other options are unsuccessful or unavailable. These decisions could be made in consultation with public health officials and infection control experts.
- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility if they are fully vaccinated and have **not** had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days.

PROCEDURE

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. The tester will be observed to demonstrate documented competency, by a qualified trainer. Competency is demonstrated in the maintenance of strict infection control measures.
3. Testing occurs in a sequestered area of the facility. This area is wiped with a germicidal product in between employee tests.
4. The individual being tested maintains mask protocol including hand hygiene prior to and post specimen collection.
5. The tester remains minimally six feet away from the employee being tested; but dons PPE including face shield for contacts closer than six feet. Per CDC: For providers collecting specimens or within 6 feet of those to be test for SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens.
6. Testing occurs on scheduled days at the facility. The facility will post days when testing is available.

7. 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 or designee.
8. For those who test negative but have symptoms will be tested through the facility lab and removed from schedule until results received.
9. All staff COVID test results will be reported on the HERDS survey the next day as required by NYSDOH.
10. 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.
11. Testing will be performed with POC or off site testing per supply availability.
12. For POC testing refer to POC testing policy.

Refusal of Testing

When refusal of testing occurs, the staff member will be restricted from the building until the procedures for outbreak testing have been completed or the employee agrees to test per facility and regularity guidelines.

Resident Testing COVID 19/Flu

Date Initiated: 5/3/2020
Date Revised: 6/3/2020, 7/6/2020, 9/2/2020, 11/2/2020

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.

TESTING PROCEDURE:

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. The tester will be observed to demonstrate documented competency, by a qualified trainer. Competency is demonstrated in the maintenance of strict infection control measures.
3. Swabbing occurs in the residents' room. Swab is sent to either the lab for off site testing or processed in-house for POC testing.
4. Residents are encouraged to wear their masks during all staff encounters.
5. Per CDC: For providers collecting specimens or within 6 feet of those to be test for SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens.
6. Testing occurs per NYS and CDC guidelines.
7. COVID Positive results are communicated to the Regional Office of the New York State Department of Health by the facility Administrator or designee. ECLRS Reporting system per guidelines.
8. All resident COVID test results will be reported on the HERDS survey the next day as required by NYSDOH.
9. Families and residents are notified of positive tests per NYS guidelines.

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.

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.