Beechwood Homes

PANDEMIC EMERGENCY PLAN
EMERGING INFECTIOUS DISEASE (EID) RESPONSE PLAN

PURPOSE
The purpose of this Pandemic Emergency/Emerging Infectious Disease Response Plan is to contain an outbreak of disease caused by an infectious agent or biological toxin or respond to other infectious disease emergencies as defined above. This is consistent with the facility's mission to protect the residents and staff from illness and/or death.

Activities that may be implemented during an Infectious Disease Response include:

- Coordination with other healthcare facilities, local, regional, state and federal agencies and other organizations responding to a public health emergency.
- Development and dissemination of information and guidance for the residents, families and staff within your community.
- Containment measures such as infection control, prophylaxis treatment, isolation and quarantine, or restriction and clearance.
- Activities such as surveillance, investigation, and lab testing.

POLICY
This plan will be posted on the facility website and will be updated and submitted for review, by the Commissioner of Health, on an annual basis. The facility will make a copy of this plan available immediately upon request.

During periods of quarantine and/or restricted visitation the facility will implement a method for residents to keep in touch with families or responsible parties, such as providing no-cost access to teleconferencing services, or other means as preferred and identified by residents and their families.

When visitation is restricted the facility will update resident families or responsible parties on a weekly or more regular basis on how they can remotely keep in touch with residents. The facility will assign staff to ensure all residents and families are updated at least weekly on the number of pandemic related infections and deaths at the facility, including residents with pandemic related infection who pass away for reasons other than infection. This responsibility will be assigned at the time of the event.

The facility will assign staff to update families and responsible parties as to the condition of infected residents on a daily basis or upon a change in a resident's condition. This responsibility will be assigned at the time of the event.

Hospitalized residents will be admitted or readmitted 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.
Any current resident 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), shall have their place at the facility preserved.

As required by regulation the facility will maintain, or have access to, a two (2) month (60 day) supply of Personal Protective Equipment (PPE), or any superseding requirements under New York State Executive Orders and/or NYS DOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic. Supply needs are based on facility census as well as existing DOH guidance and regulations, and amount of required PPE can be calculated utilizing the Centers for Disease Control's (CDC) PPE burn rate calculator as needed. This supply of PPE with either be stored onsite or will be readily accessible by the facility.

The PPE supplies to be maintained include, but are not limited to: N95 respirators, Face Shields/Eye Protection (Goggles), Gowns/Isolation Gowns (Disposable and/or linen reusable), Gloves, Facemasks, Hand Sanitizer, and Sanitizers/Disinfectants. Sufficient supply will be stored to address the PPE needs for both residents and staff.

The facility will evaluate their vendor supply plan for re-supply of food, water, medications, environmental cleaning agents, and sanitizing agents as part of their event assessment.

The facility will ensure 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, and reporting requirements of the Health Commerce System, e.g., HERDS survey reporting. This responsibility will be assigned at the time of the event.

NOTE: This plan will work in conjunction with and utilize all existing Beechwood directives, policies, and protocols that are not limited to but include: Infection Control, Disaster Plans, Transmission Based Precautions, Precautions, PPE, Hand Hygiene, COVID-19 Prevention & Treatment, Respiratory Infections-Confirmed or Suspected, Precaution Carts, Precaution Cleaning, Emergency Staffing, Disaster Planning.

SCOPE

An infectious disease emergency occurs when urgent and possibly extensive public health and medical interventions are needed to respond to and contain an infectious disease outbreak that has the potential for significant morbidity and mortality in a given area.

This plan is a functional response guide for the facility Leadership Team and Department Managers.

This plan is to be used in conjunction with the facility's Emergency Operations Plan, Infection Control Plan, and Respiratory Protection Program.

ASSUMPTIONS

The Pandemic Emergency/Emerging Infectious Disease Response Plan integrates the key elements of communicable disease control and prevention with emergency management concepts. The Incident Command System (ICS) organizational structure will be used to scale the response as needed to effectively manage and meet the incident objectives of the infectious disease emergency response.

The Pandemic Emergency/Emerging Infectious Disease Response Plan assumes that individuals occupying leadership positions have completed some ICS training. The Pandemic Emergency/Emerging Infectious Disease Response Plan further acknowledges that there could be a limited number of personnel within the facility with the knowledge and training in infectious diseases, epidemiology, public health, and emergency preparedness.

The Plan assumes each incident will require tailored activation and use of the Pandemic Emergency/Emerging Infectious Disease Response Plan. This plan can be adjusted to address scenarios varying by infectious diseases, size and/or overall severity.

This Pandemic Emergency/Emerging Infectious Disease Response Plan assumes that all confidential data regarding individual cases will not be shared outside of those who need to know, or in order to fulfill legally mandated public health reporting and information sharing.

It is assumed that the facility will form an Emerging Infectious Disease Support Team during pandemic or infectious disease events to include administrative, clinical and support team members to ensure proper response to the infectious disease.

GENERAL ACTIONS APPLICABLE TO ALL STAFF

Healthcare must always be prepared to protect people within our buildings and to protect our residents, families, and staff from harm resulting from exposure to an emerging infectious disease while they are in the facility.

Every disease is different. The local, state, and federal health authorities (NYS DOH, CDC, CMS, ECDOH, WHO, OSHA, etc.) will be the source of the latest information and most up-to-date guidance on prevention, case definition, surveillance, treatment, and clinical response related to a specific disease threat.

Incidents involving an emerging infectious disease, or a suspected case, require the consultation of the facility Medical Director and/or other physicians and Infection Control Practitioners as well as referring to the facility Infection Control Plan and Respiratory Protection Program.

GENERAL PREPAREDNESS FOR EMERGING INFECTIOUS DISEASES (EIDS)

- The facility's Infection Control Plan will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza and should be referenced.
- This plan will:
    - Include administrative controls (screening, isolation, visitor policies, including restrictions as necessary, and employee absentee plans)
    - Address environmental controls (isolation areas/rooms, plastic barriers, sanitation stations, and special areas for contaminated waste)
    - Address human resource issues such as employee leave, staffing, and emergency credentialing
- Assigned clinical leadership will be vigilant and stay informed about EIDs around the world. They will keep administrative leadership briefed on potential risks of new infections in their community and region.
- As part of the Emergency Preparedness Program (EPP), the facility will maintain, or have readily accessible, a two (2) month (60 day) supply of personal protective equipment (PPE), or any superseding requirements under New York State Executive Orders and/or NYS DOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic, including gowns/isolation gowns, face shields/eye protection, masks, assorted sizes of disposable N95 respirators or other appropriate respiratory barrier devices, and gloves, sanitizer, and disinfectants (meeting EPA guidance current at the time of the event).
- The facility will develop plans with their vendors for resupply of food, medications, medical supplies, sanitizing agents, and PPE in the event of a disruption to the normal supply chain including an EID outbreak.
- The facility will provide orientation and in-service training to all staff on the Infection Control Plan and Respiratory Protection Program, including the Pandemic Emergency Plan - Emerging Infectious Diseases response plan (including Reporting Requirements), exposure risks, symptoms, prevention and the use of Personal Protective Equipment, regulations, including 10 NYCRR 415.3(i)(3)(iii), 415.19 and 415.26(i); 42 CFR 483.15€ and 42 CFR § 483.80), and Federal and State guidance/requirements on an annual or as needed basis.
- The facility will follow applicable OSHA requirements, including OSHA's Bloodborne Pathogens (29 CFR 1910.1030), Personal Protective Equipment (29 CFR 1910.132), and Respiratory Protection (29 CFR 1910.134) standards.
- The facility will ensure there is adequate 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) and HERDS surveys).
- The facility will provide initial fit testing for staff that provide resident care prior to the use of N95 respirators, and then annually thereafter.
- The facility will provide education and training on the proper donning and doffing of PPE.
- Department and Clinical managers will monitor staff usage of PPE to ensure it is being properly used (appropriate fit, donning/doffing, appropriate choice of PPE per established procedures, etc.).

DEFINITIONS

- **Emerging Infectious diseases (EIDs)**—Infectious diseases, whose incidence in humans has increased in the past two decades or threatens to increase in the near future, have been defined as "emerging." These diseases, which respect no national boundaries, include:
  - ❖ New infections resulting from changes or evolution of existing organisms
  - ❖ Known infections spreading to new geographic areas or populations
  - ❖ Previously unrecognized infections appearing in areas undergoing ecologic transformation
  - ❖ Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures
  - ❖ For an emerging disease to become established at least two events must occur: (1) the infectious agent has to be introduced into a vulnerable population, and (2) the agent has to be able to spread readily from person-to-person and cause disease. The infection also has to be able to sustain itself within the population; that is, more and more people continue to become infected.
- **Pandemic**—A sudden infectious disease outbreak that becomes very widespread and affects a whole region, continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.
- **Isolation**—Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.
- **Quarantine**—Separation and restriction of the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.
- **Cohorting**—Imposed grouping of two or more residents exposed to, or infected with, the same infectious disease that are separated physically from other residents who have not been exposed to, or infected with, that infectious disease.

PLAN ACTIVATION

Only authorized staff may direct the activation/deactivation of the Pandemic Emergency/Emerging Infectious Disease Response Plan. The activation and notification process should be used in accordance with the Emergency Operations Plan. Staff authorized to initiate activation/deactivation include the:

- Administrator
- Director of Nursing
- Medical Director and/or Infection Control Preventionist
- Other Leadership Team member (as defined by Emergency Operations Plan)

The need to notify department managers/supervisors and external partners of the activation of the Pandemic Emergency/Emerging Infectious Disease Response Plan will be determined by the circumstances of the event including: the suspected disease, the anticipated scope of the response, and the size of the impacted populations.

The Pandemic Emergency/Emerging Infectious Disease Response Plan assumes that all incident communications and requests will follow Incident Command System guidelines. Any communications that changes the scope of the operations, the objectives, or strategies must be approved by the Incident Commander.

ADMINISTRATION / CLINICAL LEADERSHIP CONSIDERATIONS

The leadership team will consider recommendations and requirements from the CDC, OSHA, Center for Medicare and Medicaid (CMS), NYS DOH, ECDOH, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA), and other state or federal laws in determining the disease-specific response actions and precautions it will take to protect its residents, visitors, and staff members.

Once notified by public health authorities at either the federal, state, and/or local level that the EID is likely to, or already has spread to the facility's community, the facility will activate specific surveillance and screening as instructed by the NYS DOH, the Centers for Disease Control, and Prevention (CDC), or ECDOH (the local public health authority).

The facility will consider posting signage for cough etiquette, handwashing, and other hygiene measures in high traffic areas and will provide Alcohol Based Hand Rub and facemasks, if indicated and practical.

Protecting the residents and staff shall be of paramount concern.
The facility may temporarily limit or restrict visitors, subject to superseding NYS Executive Orders and/or NYS DOH guidance in order to reduce exposure risk to residents and staff.

If necessary, and in accordance with applicable NYS Executive Orders and/or NYS DOH guidance, the facility may implement procedures to close the facility to new admissions, limit or restrict visitors when there are confirmed cases in the community, and/or screen all permitted visitors for signs of infection.

The leadership team shall consider:

- The degree of frailty of the residents in the facility.
- The likelihood of the infectious disease being transmitted to the residents and employees.
- The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces).
- The precautions which can be taken to prevent the spread of the infectious disease and other relevant factors.
- The formation and activation of an Emerging Infectious Disease Support Team to include administrative, clinical and support team members.

Once these factors are considered, the leadership team will review the appropriate guidance and determine the extent to which exposed staff, or those showing signs of the infectious disease, must be precluded from contact with residents or other employees.

- Apply whatever action is taken uniformly to all staff in like circumstances.
- Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.
- Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.
- Use accepted scientific procedures and guidance from local public health, NYS DOH and/or CDC, whenever available, to determine the level of risk posed by an employee.
- Utilize appropriate diagnostic testing to confirm level of exposure, if any
- Permit employees to return to work when cleared by a licensed physician; however, additional precautions may be taken to protect the residents as recommended by the local public health, NYS DOH, and/or CDC.

ADMINISTRATOR / INCIDENT COMMANDER

- Assemble key leadership team members. Take into consideration all the following guidance, as applicable to the Infectious Disease the facility or community is managing.
- Consider activating the Command Center to ensure procedures are in place.
- Assess impact on facility operations and resident care.
- Assign a person the responsibility to monitor local, state and federal health websites for updates to existing guidance for long-term care facilities and report to the Command Center team on those updates.
- Assign a person the responsibility of meeting the 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 and reporting requirements of the Health Commerce System, e.g., HERDS survey reporting.
- Develop an action plan with the Command Center team and brief department managers and supervisors.

- Work with Director of Nursing and/or Medical Director to review incident considerations, determine level of service, and need to reschedule or cancel activities.
- During periods of quarantine and/or restricted visitation implement a method for residents to keep in touch with families or responsible parties, such as providing no-cost access to teleconferencing services, or other means as preferred and identified by residents and their families.
- When visitation is restricted assign appropriate staff to update resident families or responsible parties on a weekly or more regular basis on how they can remotely keep in touch with residents. Ensure all residents and families are updated at least weekly on the number of pandemic related infections and deaths at the facility, including residents with pandemic-related infection who pass away for reasons other than infection.
- Assign appropriate staff to update families and responsible parties on the condition of infected residents on a daily basis, or upon a change in a resident's condition
- Approve requests for additional resources (e.g., supplies, equipment, staff, etc.).
- The Incident Commander / Administrator will direct a review and revision, as needed, of internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.
- The Incident Command team will determine a location for the staging and distribution of supplies, equipment, and pharmaceuticals as needed for the incident.
- To ensure that staff and/or new residents are not at risk of spreading the EID into the facility, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work.
- Ensure that appropriate physical and social distancing measures are put into place where indicated. This may include, but is not limited to, cancellation of certain activities and services, changes in resident and staff dining, and other physical space requirements, etc.

Communications

- Provide staff with incident updates on a regular basis, as necessary.
- Appoint a Public Information Officer to prepare media statements, approve as necessary.
- Appoint a Liaison Officer when the incident is multi-jurisdictional or involves several agencies or other healthcare facilities. The Liaison Officer is the main point of contact for other community-based partners involved in response operations (e.g., Red Cross, Fire Department, Emergency Medical Services, Office of Emergency Management, etc.). The Liaison Officer will provide and receive updates and ensure the prompt response to questions, resource requests, and other needs.
- Determine need for the Liaison Officer to contact the following:
    - Local/State Department of Health
    - NYS Department of Health
    - CDC
    - Department of Health and Human Services
    - Healthcare Coalition and/or Mutual Aid partners
- Conduct internal (support team only) conference calls to discuss any new developments, such as state or local policy changes, or ongoing challenges that are arising within long-term care industry and to share any innovative solutions or best practices.
- Develop a communications plan and assign responsibility for communicating to residents and their families. Consider usage of signage and/or resident letters, based on CDC/CMS or health department guidance specific to the EID.
    - Residents and their families will be provided education about the disease and the facility's response strategy at a level appropriate to their interests and need for information by the clinical and social work staff.
- During times when visitation is limited or restricted, implement a method for residents to stay in touch with loved ones (families or responsible parties) such as providing access to teleconferencing services at no cost to the resident.

- Establish dedicated communication methods and contacts for facility staff. The communications should provide updated, evidence-based guidance on outbreak-related topics (e.g., infection control, resident isolation, resident and staff testing), and communication contact will be available 24/7 by members of the EID support team if indicated.
- Convene regular (or as frequently as needed) conference calls, etc. with facility staff to discuss newly released guidance, and to discuss potential strategies for addressing their challenges and concerns.
    - Review federal, state, and local Infection Prevention & Control guidance with facility staff during the regular conference calls.
- Ensure that all documents, messaging, and information developed during the incident are reviewed and approved by the Incident Commander and/or Public Information Officer prior to dissemination.

Assessment

- Develop a screening system to monitor for, and internally review, development of symptoms among residents and healthcare personnel (HCP) in the facility. Information from this monitoring system should be used to implement prevention interventions (e.g., isolation, cohorting).
    - Example: CDC guidance on respiratory surveillance: https://www.cdc. gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf.
- Assign a team member(s) to conduct the following assessments and report back to the Incident Commander:
    - Current resident census and number of open beds
    - Number of affected residents and staff
    - Inventory of PPE types and quantities
        - Input PPE inventory into the PPE Burn Rate Calculator at the onset of the event
- Request an assessment of critical supplies throughout the facility using the *Department Rapid Assessment Form*. Direct departments to conduct assessments of food, water, medical and other supplies.
- Assign a team member to identify resource shortages (medical supplies/equipment, PPE, staffing, etc.).
    - Develop a plan to mitigate resource shortages (e.g.: vendor support, EOC support, staffing agencies, etc.)
    - Determine ability to obtain or borrow resource shortages from other healthcare facilities. Collaborate with the healthcare coalition, mutual aid plan members and/or local/state EOC as necessary.
- Review agreements with vendors and other healthcare facilities. Request vendor support to ensure enough supplies are on hand including:
    - PPE and related supplies for fit testing, if applicable
    - Medications
    - Medical Supplies/Equipment
    - Food/Water
    - Sanitizer and Disinfectants
- Ensure vendor support is available for medical waste disposal.
- Assess the need to order a Building Lockdown via Security.
- Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along with the instruction that anyone who is sick must not enter the building.
- Consider the following restrictions:
    - Professional Visitors: No one allowed in facility without Command Center clearance.
    - Resident Visitors: No one allowed in facility. Relatives and responsible parties will be given appropriate information and location to wait as directed by the Command Center.

Staffing

- Self-screening: Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
    - Reporting any suspected exposure to the EID while off duty to their supervisor and public health.

- Precautionary removal of employees who report an actual or suspected exposure to the EID.
- Self-screening for symptoms prior to reporting to work.
- Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.
- Facility health screening of all staff prior to start of shift and rescreening of staff working extended shifts

- Whenever possible, well and unexposed staff should work in non-infected resident care units. Designated staff "teams" to be assigned to work infected units and not "cross-over" to non-infected units during the same shift/day
- Determine need for further staff education efforts, as necessary, relative to the current threat or infectious disease.
- Review staffing levels and scheduling. Ensure enough staffing resources for sustaining operations for the duration of the event. (i.e. 12-hour shifts versus 8-hour). Develop a plan to address potential staff shortages such as cross training of staff to be feeding assistants, etc.
- Consider contracting staff to supplement current staffing (Agency contract agreements).
- Review and implement disaster credentialing and privileging policies and processes as needed. Adhere to DOH guidance during pandemic for extensions of re-certification/licensure timelines.

Suspected Case within the Facility

- Ensure infected residents are isolated/cohorted and or transferred based on their infection status in accordance with applicable guidance from the CDC, local/state health departments.
    - Follow the guidance of local public and/or state health authorities regarding the transfer of the suspected infectious resident to the appropriate acute facility via emergency medical services if necessary. Residents that are hospitalized will be readmitted to the facility after treatment.
- Place a resident who exhibits symptoms of the EID in an isolation room (single room preferred unless cohorting residents with similar symptoms) and notify local and/or county/state public health authorities.
- As necessary, consider cohorting multiple infected residents using part of a unit (e.g., end of a wing), a dedicated floor or wing, and discontinuing any sharing of bathrooms with residents outside of the cohorting area.
    - Consider posting signage or other means of identifying the area(s) being used for infected residents.
    - At the time of the event determine an effective means to prevent non-infected residents from entering into the cohorting area (e.g., assigned staff members, closure of cross corridor doors, etc.).
- If the suspected infectious resident requires care while awaiting or instead of transfer, follow facility policies for isolation procedures, including all recommended PPE for staff at risk of exposure.
- Keep the number of staff assigned to enter the room of the isolated resident to a minimum.
    - Ideally, only specially trained and prepared staff (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room.
    - Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.
- If feasible, ask the isolated resident to wear a facemask while staff is in the room.
- Provide care at the level necessary to address essential needs of the isolated resident unless it is advised otherwise by public health authorities.
- Conduct control activities such as the management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposed individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.
- Implement the isolation protocol in the facility (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the facility's infection control plan and/or recommended by local, state, or federal public health authorities.
- Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities and in keeping with guidance from the CDC.

DEPARTMENT-SPECIFIC ACTIONS

NURSING STAFF

- Utilize this plan in coordination with the Beechwood Homes Infection Control Directive and Procedure.
- Work with Incident Commander and assigned Public Information Officer to prepare messaging for families of residents and staff.
- Consider the following to address staff concerns:
    - Provide incident specific education, including frank discussions about potential risks and plans for protecting healthcare providers.
    - Establish designated staff assignments to minimize "floating"
    - Establish "Red Zone" only staff who do not cross over to other units
    - Consult with Administrator/Medical Director in regards to need for Emergency Staffing Plan initiation as well as any disaster plan protocols (ie: Suspension of non-essential medication administration (vitamins, etc))
- Participate in lockdown of facility to control people coming into the facility.
- Cancel communal dining and all group activities, such as internal and external group activities, as necessary.
- Explore alternatives to face-to-face visits if visitors are restricted from entering the facility such as teleconferencing services, or other means as preferred and identified by residents and their families. Ensure families and/or responsible parties are updated on a weekly basis how they can remotely keep in touch with residents when visitation is limited or restricted.
- Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes.
- If residents leave their room, determine the need for residents to wear a facemask, perform hand hygiene, limit their movement in the facility, while maintaining physical distancing (staying at least 6 feet away from others), when necessary.
- As assigned provide updates to families and responsible parties on the condition of infected residents on a daily basis or upon a change in a resident's condition.

General Guidelines for Infection Control Practices for Resident Management

- Contact state and local Health Departments, CDC and/or the Department of Health and Human Services for updated information and protocols to follow.
- Any symptomatic staff or residents with suspected or confirmed illnesses should, at a minimum, be managed using Standard Precautions. Additional precautions may be needed to reduce the likelihood for transmission.

Standard and transmission-based precautions to be followed to prevent spread of infections

A facility's infection control practices are important for preventing the transmission of infections. Infection control precautions used by the facility include two primary tiers: "Standard Precautions" and "Transmission-Based Precautions."

Hand Hygiene

Hand hygiene is the single most important practice to reduce the transmission of infectious agents in healthcare settings. This includes hand washing with either plain or antiseptic-containing soap and water for at least 20 seconds, and/or the use of alcohol-based products (gels, rinses, and foams) that do not require the use of water.

The CDC continues to recommend the use of alcohol-based hand rub (ABHR) as the primary method for hand hygiene in most clinical situations. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare personnel after brief interactions with residents or the care environment.

Beechwood Homes

Standard Precautions

Standard precautions represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered.

These evidence-based practices are designed to protect healthcare staff and residents by preventing the spread of infections among residents and ensuring staff does not carry infectious pathogens on their hands or via equipment during resident care.

Standard precautions include hand hygiene, use of PPE (e.g., gloves, gowns, facemasks), respiratory hygiene and cough etiquette, safe injection practices, and safe handling of equipment or items that are likely contaminated with infectious body fluids, as well as cleaning and disinfecting or sterilizing potentially contaminated equipment.

In order to perform hand hygiene appropriately, soap, water, Alcohol-Based Hand Rub (ABHR), and a sink should be readily accessible in appropriate locations, including but not limited to, resident care areas, and food and medication preparation areas. Staff must perform hand hygiene (even if gloves are used):

- Before and after contact with the resident.
- Before performing an aseptic task.
- After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room.
- After removing personal protective equipment (e.g., gloves, gown, facemask).
- After using the restroom.
- Before meals.

If residents need assistance with hand hygiene, staff should assist with washing hands after toileting, before meals, and use of ABHR or soap and water at other times when indicated.
The use of PPE during resident care is determined by the nature of staff interaction and the extent of anticipated blood, body fluid, or pathogen exposure to include contamination of environmental surfaces. Furthermore, appropriate use of PPE includes but is not limited to the following:

- Gloves worn before and removed after contact with blood or body fluid, mucous membranes, or non-intact skin.
- Gloves changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care.
- Gown worn for direct resident contact if the resident has uncontained secretions or excretions or with contaminated or potentially contaminated items.
- Appropriate mouth, nose, and eye protection (e.g., facemasks, face shield) is worn for procedures that are likely to generate splashes or sprays of blood or body fluids.
- PPE appropriately discarded after resident care prior to leaving room followed by hand hygiene.
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms) although, equipment supply carts should not be brought into the resident's room.

Transmission-based Precautions

Transmission-based precautions are used for residents who are known to be, or suspected of being, infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission.

In Long Term Care Facilities, it is appropriate to individualize decisions regarding resident placement (shared or private), balancing infection risks with the need for more than one occupant in a room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident.

It is essential to communicate transmission-based precautions to all healthcare personnel, and for personnel to comply with requirements. Pertinent signage (i.e., isolation precautions) and verbal reporting between staff can enhance compliance with transmission-based precautions to help minimize the transmission of infections within the facility.

It is important to use the standard approaches, as defined by the CDC, for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used.

Communication (e.g., verbal reports, signage) regarding the type of precaution to be used is important. When transmission-based precautions are in place, PPE should be readily available. Proper hand washing remains a key preventive measure, regardless of the type of transmission-based precaution employed.

Transmission-based precautions are maintained for as long as necessary to prevent the transmission of infection. It is appropriate to use the least restrictive approach possible that adequately protects the resident and others. Maintaining isolation longer than necessary may adversely affect psychosocial well-being. The facility should document in the medical record the rationale for the selected transmission-based precautions.

Enhanced Barrier Precautions

Enhanced Barrier Precautions (EBP) are designed to reduce transmission of multidrug resistant organisms (MDROs) in nursing homes. EBP involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those residents at increased risk of MDRO acquisition – i.e.: residents with wounds or indwelling medical devices. Gown and gloves to be used upon entry into resident's room when high-contact care is to be administered and removed prior to leaving the room after care is provided and hand hygiene is performed. Options for resident on EBP include a private room and/or cohorting with another resident on EBP.

Contact Precautions

Contact precautions are intended to prevent transmission of infections that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves upon entering (i.e., before making contact with the resident or resident's environment) the room or cubicle. Prior to leaving the resident's room, the PPE is removed, and hand hygiene is performed. Depending on the situation, options for residents on contact precautions may include the following: a private room, cohorting, or sharing a room with a roommate with limited risk factors (e.g., without indwelling devices, without pressure ulcers and not immunocompromised).

Droplet Precautions

The use of droplet precautions applies when respiratory droplets contain viruses or bacteria particles which may be spread to another susceptible individual. Respiratory viruses can enter the body via the nasal mucosa, conjunctivae, and less frequently, the mouth. Examples of droplet-borne organisms that may cause infections include, but are not limited to, Mycoplasma pneumoniae, influenza, and other respiratory viruses.

Respiratory droplets are generated when an infected person coughs, sneezes, or talks, or during aerosol generating procedures such as nebulizer treatments, suctioning, endotracheal intubation/extubation, cough induction by chest physiotherapy, and cardiopulmonary resuscitation.

The maximum distance for droplet transmission is currently unresolved, but the area of defined risk based on epidemiological findings is at least six (6) feet. In contrast to airborne pathogens, droplet-borne pathogens are generally not transmitted through the air over long distances.

Facemasks are to be used upon entry (i.e., within three feet of a resident) into a resident's room with respiratory droplet precautions. If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face

shield in place of goggles) should be worn. The preference for a resident on droplet precautions would be to place the resident in a private room. If a private room is not available, the resident could be cohorted with a resident with the same infectious agent or share a room with a roommate with limited risk factors. Spatial separation of at least 3 feet and drawing the curtain between resident beds is especially important for residents in multi-bedrooms with infections transmitted by the droplet routes.

Airborne Precautions

Airborne transmission occurs when pathogens are so small that they can be easily dispersed in the air, and because of this, there is a risk of transmitting the disease through inhalation. These small particles containing infectious agents may be dispersed over long distances by air currents and may be inhaled by individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual. Staff caring for residents on airborne precautions should wear a fit-tested N95 or higher-level respirator that is donned prior to room entry.

Precautions to Prevent Transmission of Infectious Agents

It is important that facility staff clearly identify the type of precautions and the appropriate PPE to be used in the care of the resident. The PPE should be readily available near the entrance to the resident's room. Signage can be posted on the resident's door instructing visitors to see the nurse before entering.

It is not always possible to prospectively identify residents needing transmission-based precautions (presumptive precautions). The diagnosis of many infections is based on clinical signs and symptoms but often requires laboratory confirmation. However, since laboratory tests (especially those that depend on culture techniques) may require two or more days to complete, transmission-based precautions may need to be implemented while test results are pending, based on the clinical presentation and the likely category of pathogens.

The use of appropriate transmission-based precautions when a resident develops signs or symptoms of a transmissible infection or arrives at the facility with symptoms of an infection, (pending laboratory confirmation) reduces transmission opportunities. However, once it is confirmed that the resident is no longer a risk for transmitting the infection, removing transmission-based precautions avoids unnecessary social isolation.

Personal Protective Equipment (PPE)

Using personal protective equipment provides a physical barrier between micro-organisms and the wearer. It offers protection by helping to prevent micro-organisms from:

- contaminating hands, eyes, clothing, hair, and shoes
- being transmitted to other residents and staff

Healthcare workers evaluating and interacting with a suspected infectious disease resident must properly wear PPE for standard, contact and droplet precautions. The appropriate PPE must be readily available so that it may be donned immediately when a suspected resident is identified.

It is important to use personal protective equipment effectively, correctly, and always where contact with resident's blood, body fluids, excretions, and secretions may occur.

PPE description, at a minimum:

- Gown (fluid resistant or impermeable)
- Facemask, or necessary respiratory protection (N95)
- Eye protection (goggles or face shield)
- Gloves

Refer to the facility Infection Control Plan for further guidance.

Beechwood Homes

Resident Placement and the Use of Private Rooms for Infection Prevention and Control

The physician and person(s) responsible for infection control should assess individual residents as to the potential for transmitting infectious organisms.

- Room assignments and restriction of activities are determined by this assessment. Although there are many reasons for using private rooms, the major reasons are diseases transmitted in whole or in part by the airborne route or by the resident who extensively soils the environment with body substances.
- Private rooms are generally indicated for residents with uncontrollable excretions (diarrhea), secretions, excessive coughing, heavy wound drainage, or widespread skin disease. Residents should be confined to their rooms while the above conditions exist.
- If the situation is small-scale, follow routine resident placement and established infection control practices.
- If many residents are presenting with similar syndromes, group affected individuals into a designated wing or area of the facility. Before grouping, consult with the local/state Health Department and the facility Infection Control personnel regarding adequate isolation (i.e. ventilation).

Resident Care

Only direct care providers should enter the resident room:

- No person enters room without mandatory training and demonstrated competency.
- Autonomous practice (supported by experts).
- Physical and Occupational Therapy, as necessary.
- Environmental decontamination, as necessary.

The care providers will need to be trained and able to demonstrate competency in the following areas:

- Donning and doffing of PPE.
- Use of the "Buddy System."
- Waste management protocols.
- Decontamination and containment protocols.
- Specimen handling for diagnostic testing.

General Guidelines for Resident Transport within or outside the facility

- Limit movement to that which is to provide proper resident care.
- Mask resident if airborne or droplet organism is suspected, or resident is coughing.

<u>When transporting a resident out of the facility</u> (e.g.: dialysis appointment, evacuation, etc.)

When transporting a known confirmed infectious resident, it is recommended that drivers wear an N95 respirator or facemask and eye protection such as a face shield or goggles as dictated by the contagion transmission type (as long as they do not create a driving hazard).

The resident(s) should wear a facemask or cloth face covering. Occupants of the vehicle should avoid or limit close contact (within 6 feet) with others. The use of larger vehicles such as vans or facility buses is recommended when feasible to allow greater social (physical) distance between vehicle occupants.

Additionally, drivers should practice regular hand hygiene, avoid touching their nose, mouth, or eyes.

The Infection Control Plan provides guidance for cleaning and disinfecting after transport of an infectious resident(s).

General Guidelines for Handling Deceased Residents

- Keep tracking records of all residents.
- Attach a form of identification to the body if there is not an identification wrist band (e.g. toe-tag).
- The decedent should be placed in a body bag or pouch prior to moving the body to any other location or release to a funeral director or coroner/coroner physician/medical examiner.
- Matching identification should always be attached to the outside of the body bag or pouch.

- Personal effects such as eyeglasses, dentures, and hearing aids should be bagged and labeled and placed next to the body.
- Any necessary paperwork for release of the remains should be completed prior to contacting the funeral firm or medical examiner.
- If the facility has a morgue or holding area, the personal effects should remain at the location where the decedent will be signed out and a property form or receipt prepared for either the family or the funeral home.
- Once the decedent is prepared for transport, (i.e. pouched and labeled) the body may be released to the county or other authority as appropriate.

DINING SERVICES

- Assess emergency food, liquids, and supplies and provide information to the Command Center.
- Coordinate meal service with Nursing. Modify menu if deliveries will not be possible. Use disposable plates, cups and utensils as necessary.
- As necessary ensure staff uses necessary PPE if delivering meals or interacting with any residents who may be infectious.
- Establish plan for feeding staff if shift change will not be possible.

HOUSEKEEPING / LAUNDRY / ENVIRONMENTAL HEALTH

Ensure that Environmental Services and Laundry personnel are aware of current guidelines, internal procedures and contacts.

- Review policies and ensure sufficient supplies in the event deliveries cannot be made.
- Environmental cleaning: The facility will follow current CDC and NYS DOH guidelines for environmental cleaning and decontamination specific to the EID in addition to routine cleaning for the duration of the threat.
- Wear appropriate personal protective equipment if cleaning up any contaminate.
- Cleaning, disinfecting and sterilization of equipment and environment:
    - Use principles of Standard Precautions.
    - Germicidal cleaning agents should be available in contaminated and/or isolated resident care areas for cleaning spills of contaminated materials and disinfecting non-critical equipment.
    - Discard single-use resident items appropriately.
    - Contaminated waste should be sorted and discarded in accordance with federal, state, and local regulations.
    - Used resident care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions should be handled in a manner that prevents exposure to skin and mucous membranes, avoids contamination of clothing, and minimizes the likelihood of transfer of microbes to other residents and environments.
    - Rooms and bedside equipment should be cleaned using Standard Precautions, unless the infecting microorganism and the amount of environmental contamination indicates special cleaning.
    - Resident linen should be handled in accordance with Standard Precautions. Although linen may be contaminated, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to other residents, personnel and environments. Facility policy and local/state regulations should determine the methods for handling, transporting and laundering soiled linen.
- Coordinate a linen reduction program, as necessary, with nursing and other appropriate departments.

- Implement environment controls to safely handle, and locate areas, for contaminated waste. Ensure contaminated waste is stored in a safe and secure manner. Use appropriate signage on storage areas. For Example:



MAINTENANCE (or staff assigned security responsibilities)

- Determine ability to isolate sections of the building for contagious residents.
- Assist with implementing the facility's emergency Building Lockdown Plan.
- Assess HVAC capabilities and determine if increased air changes are necessary, as per the CDC recommendations issued at the time of the event.

SECURITY (or staff assigned security responsibilities)

Elevated Threat Alert Procedures

- Facility isolation: In the event there are confirmed cases of the EID in the local community, the facility may consider closing the facility to new admissions and limiting visitors based on the advice of local public health authorities.
- Implement the facility emergency Building Lockdown Plan as directed by the Command Center.
- Determine the need for additional staff to provide security or assist with the building lockdown.
- Control entrances and exits to the building for staff and visitors. Designate an entrance that visitors can use to access the healthcare facility. Reinforce any visitor restrictions.
- Enact special security precautions to safeguard the facility, residents, and staff. Ensure the security of stored emergency supplies such as food, water, PPE, and medical supplies.

SOCIAL SERVICES / SPRITUAL CARE STAFF

- Fear and panic can be expected from both residents and healthcare providers. Psychological responses may include anger, panic, unrealistic concerns about infection, or fear of contagion.
- As assigned by the Command Center, work with families and other responsible parties on behalf of residents.
- Minimize panic by clearly explaining risks to residents.
- Treat anxiety in unexposed persons who are experiencing somatic symptoms with reassurance.
- Fearful or anxious healthcare workers may benefit from their usual sources of social support or by being asked to fulfill a useful role.
- Work with Incident Commander to ensure regular information updates are available to the public.

CENTRAL SUPPLY / RECEIVING AREA

- Assess supplies to determine how long you can continue operations. Take results to Command Center.
- Ensure supplies (medical, PPE, etc.) are securely stored.
- Establish receiving area for additional equipment and supplies. Plan storage and tracking.
- Ensure that there is a sufficient supply of PPE and protocols for obtaining additional PPE supplies.
- Be cognizant of expiration dates of certain PPE, including respirators.
- Collaborate with local/state public health, local/state emergency management, sending and receiving facilities, and other healthcare organizations or systems to address any potential supply chain issues through the Liaison Officer.
- Determine the role of local/state/federal public health authorities in assisting the healthcare sector in prioritizing orders with manufacturers/suppliers.

FINANCE AND HUMAN RESOURCES

- Track hours worked by staff during the response for potential reimbursement during declared public health emergencies.
- Facilitate purchasing of supplies necessary for the emergency response.
- Track and report to the Incident Commander the financial cost of the response including all workmen's comp, property damage, and other claims resulting from the event.

RETURN TO NORMAL OPERATIONS / RECOVERY

Recovery from the spread of an infectious disease will begin when facility officials receive notice from the local Public Health Department or NYS Department of Health based on CDC guidance, that facilities may resume normal operations.

The Incident Commander or designee will determine if staffing, supplies, resources and systems are adequate to manage ongoing activities.

In consultation with Public and/or State Health Department Authorities the facility will recommend specific actions to be taken to return the facility to pre-event status.

The facility will:

- Assess facility, staff, and department operations to determine ability to return back to normal operations.
- Implement sanitization and disinfection procedures.
- Deploy solid waste disposal plans.
- Maintain review of and implement procedures provided in NYS DOH 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.
- Reconsider physical and social distancing restrictions that had been implemented.
- Communicate to residents, families, and other relevant stakeholders any relevant recovery activities regarding a return to normal operations.
- Conduct an After-Action Review to evaluate the response actions taken by the facility as a result of the infectious disease.
- Determine effectiveness of existing plan to respond to similar events in the future.
- Revise existing plan as necessary to address any deficiencies.
- Review processes and incident communication protocols.
- Document / Archive all information of the response
- Assess the economic impact on the facility. Have Finance Section collect cost for reimbursement.
- Have department heads restock supplies.
- Close down Incident Command.