The Bainbridge Nursing and rehabilitation Comprehensive Emergency Plan

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I. COMPREHENSIVE EMERGENCY MANAGEMENT PLAN INTRODUCTION

1. Introductionto Comprehensive Emergency Management Plan (CEMP)

Bainbridge Nursing Rehabilitation and Nursing Centerhas developed and committed to a Comprehensive Emergency Management Planwhich includes considerations necessary to satisfy the requirements for a Pandemic Emergency Plan (PEP) and is designed to provide a safe and expedient response to natural or man-made events which cause major disruption to the environment of care.

TheComprehensive Emergency Management Plan contains policies, procedures and support information needed by its administration, physicians, directors, supervisors and employees to ensure that a high standard of resident safety is maintained and that resident care services can continue to be provided in the event of a major disruption to the environment of care. Bainbridge NursingRehabilitation and Nursing Center has the responsibility to stand prepared at all times in the event of a pandemic emergency situation. The purpose of this plan is to ensure the safety of the residents, staff, volunteers and visitors. This organized response could include additional assistance from companies or government agencies.

2. Purpose of the Comprehensive Emergency Management Plan

The Comprehensive Emergency Management Plan is a program that is designed to include internal resources as well as external resources in a coordinated, organized response to an event that potentially or does disrupt resident care, which may include full or partial evacuation of the facility.If the evacuation plan is implemented, it will be executed using the ICS and announced CODE. The evacuation plan was designed to set forth policy, procedures, and guidelines for mitigation of, preparedness for, response to, and recovery from the relocation or evacuation of residents from the facility.

The Comprehensive Emergency Management Plan incorporates all aspects of evacuation, ranging from relocating residents from a portion of a floor to total evacuation of the facility.The plan is also designed to identify major roles and responsibilities in response to an emergency and to minimize the disruption and provide safe alternatives for residents, staff members and visitors.

The plan is updated at least annually with procedures to be followed for the proper care of residents and personnel and for the reception and treatment of mass casualty, in the event of a pandemic emergency.

3. Scope of the Comprehensive Emergency Management Plan

The scope of this plan extends to any event that disrupts, or has any potential to significantly disrupt, the provision of normal standards of care and/or continuity of operations, regardless of the cause of the incident.

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

4. Risk Assessment

Hazard Vulnerability Analysis (HVA)

Bainbridge NursingRehabilitation and Nursing Center conducts an annual risk assessment to identify which natural and man-made hazards poses the greatest risk to the facility. The facility conducted a facility-specific risk assessment on August 24, 2020 and determined the following hazards may affect the facility's ability to maintain operations before, during and after an incident.

- Severe Thunderstorm
- Snow Fall
- Blizzard
- Ice Storm
- Heat/Humidity
- Flood/External

HVA also identifies the community risks that may result in a multiple healthcare facility evacuation scenario.

destinations. The sequencing of evacuation will also be addressed through communication with the AHJ.

5. Mitigation Measures

The facility takes a variety of preparedness measures to improve readiness in the event of any emergency and/or disaster. Specific measures include, but are not limited to:

- The facility has developed and maintains a Comprehensive Emergency Management Plan
- The facility has developed and maintains a Pre-Disaster Mitigation Plan
- The facility maintains agreements with transportation providers
- The facility maintains agreements with receiving healthcare facilities
- Healthcare facility evacuation agreements are based on the clinical needs of the resident population
- The facility inventories and maintains emergency response/ evacuation equipment
- The facility has pre-identified internal and external holding areas
- The facility has developed training competencies and provides staff training in the Comprehensive Emergency Management Plan

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II. CONCEPT OF OPERATIONS

1. Notification and Activation

Bainbridge NursingRehabilitation and Nursing Center has adopted the Incident Command System to implement the managements of all emergencies. The Incident Command System (ICS) is a standardized on scene, all-hazard incident management concept. ICS has considerable internal flexibility which makes it an efficient management approach for both large and small situations/ emergencies.

In the ICS, Unified Command is a unified team effort which allows all agencies with responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies. This is accomplished without losing or abdicating agency authority, responsibility, or accountability. In the nursing home setting, the facility administration will work in a unified command environment with leadership of public safety response agencies (i.e., Fire, EMS, Police, Local Office of Emergency Management, NYSDOH Regional Office, Local Health Department) to manage an incident or evacuation.

Notifications

Key Notifications

The Incident Commander will ensure proper notifications are made. Specific notifications for staff and regulatory agencies will be detailed under each type of disaster. (Refer to Emergency Management Plan)

Off-Duty Staff Notification

Notify off-duty staff as needed and instruct them to report directly to the labor pool area as they arrive to the facility.

Call List

- All facility managers and supervisors will maintain an up-to-date call list of all personnel. A copy of this will be kept in their department manual and accessible to them at home.
- A copy of each call list will be forwarded to the Administrator and Safety Officer and placed in a binder kept in the IncidentCommandCenter.
- This call list will be reviewed quarterly and revisions will be sent to the Administrator and Safety Officer to be placed in the manual.

External Notifications

Consider the need to make various external notifications including:

- Resident families / emergency contacts
- Resident primary physicians
- Facility Ombudsman
- Media

- Vendors

Designate staff to prepare for and conduct notifications.

Internal Communications

The Incident Commander shall designate a staff member to ensure communications between the CommandCenter and the following:

- All Command Center ICS positions
- Each resident care area / unit
- Holding area(s)
- Loading area(s)
- Labor Pool
- Movement Teams

2. Mobilization

ICS Classifications and Definitions

Every incident response under this plan shall be led by the senior-most leader available in the facility, who shall be known as the **Incident Commander**. However, the senior-most leader may choose to have another staff member serve in the Incident Commander position.

In addition to leading the overall response, the Incident Commander shall be responsible for the functions of **Safety, Liaison, Public Information, Planning and Finance**, until such time as individual functions can be delegated to other participants.

The next qualified senior leader or designee shall be assigned to management of the actual tactical work. This individual is known as the **Operations Section Chief**. The Operations Section Chief supervises for arranging for the staffing, equipment, and transportation assets.

The **IncidentCommandCenter**primary location is the Administrative offices and the Admission Office is the alternate location.

As leadership staff arrive at the CommandCenter, designate the roles of key Incident Command Positions including:

- Operations Section Chief – Director of Nursing
- Liaison Officer – Director of Social Services
- Logistics Section Chief – Director of Environmental Services
- Planning Section Chief – Director of Social Service
- Public Information Officer – Director of Admissions
- Finance Section Chief –Human Resources Director/Designee

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ICS Responsibilities

INCIDENT MANAGEMENT TEAM	DESIGNATED PARTY	MISSION
Incident Commander	Administrator/Designee Avrohom Gross	Overall strategic direction for facility incident management, response and recovery.
Operations Section Chief	Director of Nursing Nora Ruth Eusebio	Organize, assign, supervise Medical Care, Hazardous Materials, Business Continuity resources.
Logistics Section Chief/ Infrastructure Branch Director	Asst. Admin Jacob Goldbrenner & Debi Bruno	Organize & direct operations of physical environment, human resources, materials, services, transportation.
Planning Section Chief	ADNS Shakila Richard	Alternatives for operations, meetings planning, prepare action plans, manage resident tracking.
Public Information Officer	Executive Secretary. Ammani Jabbour	Serve as the conduit for information to staff, visitors, families & news media.
Liaison Officer	Social Service Marion Clutchker	Contact person for representatives from other agencies (i.e. emergency, other SNF).
Charge Nurse/ Department Director	Nursing Supervisor Unit managers	Provide oversight & direction to unit/ department staff.
Labor Pool Unit Leader	Staffing Coordinator Sheree Stuart	Manage labor pool & maintain information on the status, location & availability of on-duty staff & volunteers.
Holding Unit Leader	Director of Building Services Jonathan Amoo	Manage operation of holding area, triage & tracking of residents prior to leaving/ arriving.
Transportation Unit Leader	Director of Rehab Iryn Fontanosa & Tibu Thharken	Oversee & coordinate external & internal transportation equipment.

Labor Pool

The primary Labor Pool location is the first floornursing office and the alternate location is the Frontconference room. The facility will designate a staff member to establish and oversee the Labor Pool (Labor Pool Unit Leader).

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3. Response

To activate any emergency response plan, the individual in-charge of the building at the time will serve as the Incident Commander. This role will change based on staff positions in the building at the time the plan is activated. The Incident Commander position will be filled by staff in the following order:

a. Administrator / Executive Director

b. Assistant Administrator

c. Director of Nursing

d. Assistant Director of Nursing

e. Nursing Supervisor

f. Director of Environmental Services

Response Procedures

- In preparation of the surge, the facility will conduct a Critical Assets Survey to review capacity, special attributes, equipment, communications, pharmaceuticals, staffing and emergency generator.
- As soon as the surge is imminent, the Administrator/ Incident Commander will implement the following plan utilizing the ICS.

Surge Plan

- The facility will increase staffing to 150% when neededand where possible.
- All department heads will adjust working schedules accordingly.
- The facility will acquire resources such as adequate supply of food, medical equipment, PPE's, pharmaceuticals, beds and mattresses, linen etc.
- The facility will plan for adequate ancillary services.
- Assess equipment and supplies.
- Plan for temporary locations of incoming surge.
- The facility has designated specific areas for triage, medical care and living quarters within the building to accommodate potential surge.
- Establish method of privacy for accommodation of patients.
- Establish method to store and secure personal belongings.
- If residents are in an area without call bells, distribute manual bells.
- The facility will take immediate action to contact next of kin or designated representative to apprise of the resident's location and any other information regarding or their condition.
- The facility will maintain ongoing contact with transferring facility.

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4. Recovery

Restoration of Service

- Contact will be made with transferring facility to establish status and determine repatriation timeline. The facility will make every effort to restore normal services as quickly as possible.

Recovery and Repatriation

Recovery Planning

From the moment that an evacuation begins, leadership planning will initiate recovery and re-occupancy planning. Once the cause of an evacuation has been resolved, the facility can apply full focus and energies to a timely re-occupancy.

Repatriation and Re-occupancy

Re-occupying the facility will typically follow the reverse sequence of the evacuation. The major difference will be the pace of events and the associated urgency. The following general sequence will be applied. Resident Evacuation Critical Information and Tracking Forms should be utilized during the repatriation process to ensure tracking is maintained.

Re-occupancy Planning

The Planning Section Chief will oversee the development of an Incident Action Plan (IAP) for re-occupancy. The re-occupancy IAP will include (but not be limited to) the operational periods (time line), re-occupancy objectives, priorities and sequencing, resource allocation and needs projection, safety analysis and mitigation measures, and leadership assignments.

Resident clinical abilities will be reviewed to determine the appropriateness of individual resident return to the facility. Clinical diagnosis such as severe dementia may prohibit resident return do to the emotional stress placed the resident.

Re-occupancy Decision

The Incident Commander will ultimately determine if facility is safe for re-occupancy and the appropriate sequencing for re-occupancy. Such determination will be based on input and recommendations from stakeholders including (as applicable), but not limited to:

- The authority having jurisdiction
- Other agency participants in the Unified Command organization
- State and/or local health department
- Community public safety agencies

- Nursing leadership
- Staff representatives
- Resident representatives
- Community representatives

Communications and Notifications

Notification to all concerned parties shall be carried out.

Resources and Assets

The Incident Commander will mobilize and stage resources as needed, including the pre-stocking/re-stocking of facility assets, as well as arrangements for those resources (including transportation assets) required to effect the repatriation.

Staff Scheduling

A plan will be made for staff redeployment to ensure adequate coverage by position and unit, as well as accompaniment of residents being returned to the facility.

Utilities and Physical Plant

The facility will conduct incident-appropriate physical plant re-activation and system inspections and checks, including fire and emergency alarm systems, security, electrical systems, generators, potable and non-potable water, chillers, elevators, telecommunications, data, and other mechanical and utility systems.

Clinical Systems and Equipment

Incident-appropriate equipment inspection and testing will be conducted.

Housekeeping

Incident-appropriate general housekeeping and facility cleanup will be conducted.

Infection Control

The facility will coordinate environment of care certification and approvals for re-occupancy as needed.

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III INFORMATION MANAGEMENT

1. Critical Facility Records

Collect and prepare the resident's hardcopy chart information including:

Medical Administration Record (MAR)

Physician Orders

Treatment Sheet

Interdisciplinary Care Plan

Advanced Directives and Healthcare Proxy

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

2. Resident Tracking and Information-Sharing

Resident Confidentiality

Maintain resident confidentiality throughout the evacuation process.

The HIPAA Privacy Rule allows resident information to be shared to assist in emergency relief efforts, thus providers and health plans covered by the HIPAA Privacy Rule can share resident information in all the following ways:

Health care providers can share resident information as necessary to provide treatment. Treatment includes:

- Sharing information with other providers (including hospitals and clinics)
- Referring residents for treatment (including linking residents with available providers in areas where the residents have relocated)
- Coordinating resident care with others (such as emergency relief workers or others that can help in finding resident appropriate health services)

Providers can share resident information to the extent necessary to seek payment for these health care services.

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3. Staff Tracking and Accountability

Tracking and Accountability

NYSE-FINDS Resident Tracking System

A Resident Evacuation Critical Information and NYS e-FindsTracking Formwill be available in each resident's chart upon admission. The form will be completed for each resident. This form will track residents throughout the entire evacuation process including:

- Leaving the unit
- Arriving at an internal holding area
- Arriving at an internal loading area
- Departure of the facility
- Arrival and departure at an external holding area (where applicable)
- Arrival at a receiving facility

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IV COMMUNICATIONS

1. Facility Communications

Communications shall take place utilizing the following, as appropriate:

- Standard telephones/ Cell phones
- Runners
- Portable radios
- Text Messages
- Email
- Social Media
- Facility Website

Notification To	Contact Info Location	Responsible Person
Emergency Services	Administration Office	Administrator/Designee
Government Agencies (NYSDOH, Public Health, Office of Emergency Management)	Administration Office	Administrator/Designee
Off duty staff	Nursing Secretary	Sheree
Receiving facilities	Adm. Office	Administrator/Designee
Transportation resources	Transportation and clinic	Marie Clanny
Families / Responsible parties	Admission/ Social Service Office	Directors of Social Services
Media	Administration Office	Debi Bruno
Ombudsman	Administration Office	Administrator/Designee
Primary physicians	Nursing office	DNS
Vendors	Administration	Administrator/Designee

	Office	

2.Internal Communications

The facility maintains a list of names of all staff members, including emergency contact information and the front desk receptionist/security desk. The facility will ensure that all staff are familiar with internal communication equipment, policies and procedures.

The Incident Commander shall designate a staff member to ensure communications between the CommandCenter and the following:

- All Command Center ICS positions
- Each resident care area / unit
- Holding area(s)
- Loading area(s)

- Labor Pool
- Movement Teams

The Logistics Section Chief will:

Distribute communications equipment and ensure communication with Incident Command Chief, Labor Pool Area, Holding Area, Section Chiefs, movement team leaders.

Liaison Officer will:

- Establish communication with other healthcare facilities.
- Request transportation resources
- Notify EMS/ Fire as needed
- Coordinate with the Operations Section Chief and evacuation receiving sites

Public Information Officer will:

- Maintain communication with staff, visitors, families and news media
- Establish a media briefing area

Discharge Transfer Team will:

- Assure proper notification/ communication to families and designated representatives

Labor Pool Leader will:

- Mobilize employees and record information on availability and transportation needs

During and after an incident the IC will establish a location for delivering information to staff and residents.

3. External Communications

Bainbridge Nursingmaintains a list of all residents family members as well as legal representatives which includes phone numbers. Such individuals will receive information and notification of an incident via a robo-call. Additional updates will be provided on a regular basis to keep everyone apprised of the incident and response which may include restrictions on visitation, status of residents and estimated time period of protective actions.

Consider the need to make various external notifications including:

- Resident families / emergency contacts
- Resident primary physicians
- Facility Ombudsman

- Media
- Vendors

V. ADMINISTRATION, FINANCE, LOGISTICS

1. Administration

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

- Identify and develop roles, responsibilities, and delegations of authority for key decisions and actions.
- Ensure key processes are documented
- Annual CEMP review
- Ensure CEMP is in compliance with local, state and federal regulations

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2. Finance

The CFO will account for all direct and indirect incident-related costs from the outset of the response including:

- Personnel
- Resident Care costs due to incident
- Equipment costs/repair
- Vendor services
- Illness/Injury
- Loss of revenue-generating activity

2. Logistics

The Logistics Section Chief will:

- Distribute communications equipment and ensure communication with Incident Command Chief, Labor Pool Area, Holding Area, Section Chiefs, movement team leaders
- Assign Labor Pool Unit Leader and utilize staff call list
- Labor Pool assigns Evacuation Groups and Equipment Turn-around area.
- Set up Loading, Holding and Vehicle Staging Areas
- Appoint Holding Area Unit Leader
- Appoint Transportation Unit Leader to collect and distribute evacuation equipment to affected areas
- Assign Supervisor of Maintenance/ Designee to gather equipment and supplies to be transported to receiving facilities (mattresses, linen, diapers, other supplies)
- Schedule delivery of supplies to receiving facilities to coincide with the arrival of the residents
- Assure that delivery of supplies will occur at the receiving facilities in time or arrange for transport of essential supplies with trucking/ moving company
- Assign necessary staff to set up beds and/or other equipment at receiving facility
- Organize and direct operations of physical environment

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VI INFECTOUS DISEASE/PANDEMIC EMERGENCY

1. Communicable Disease Reporting

Long Term Care facilities have a critical role in the prompt reporting of communicable diseases and can make the difference between disease control and an outbreak. Under the New York State Sanitary Code (10NYCRR 2.10), facilities are to report communicable diseases, including cases, suspected cases and certain carriers, to local health departments thru the Health Commerce System (ie. HERDS).

1.1 Why Report

Timely reporting of communicable diseases by physicians allows public health agencies at the local, state and federal levels to identify newly emerging infections, detect outbreaks, prevent secondary transmission, and evaluate the effectiveness of control measures. For some diseases, every hour can make a difference in preventing illness and death. Because laboratory results may sometimes be negative when disease is present or suspected, the physician's report of suspected/confirmed cases may be the only notification the health department receives. Healthcare facilities have the responsibility for reporting, follow-up, and control of communicable diseases.

1.2 What to Report

Categories and examples of reportable healthcare -associated infections include:

- An outbreak or increased incidence of disease due to any infectious agent occurring in residents or in persons working in the facility.
- Intra-facility outbreaks of influenza, gastroenteritis, pneumonia, or respiratory syncytial virus.
- Infections associated with contaminated medications, or commercial products.
- Single cases of healthcare-associated infection due to any of the diseases on the Communicable Disease Reporting List. For example, single cases of nosocomial acquired Legionella, and measles viruses.
- Clusters of TB skin test conversions.
- A Single case of active pulmonary or laryngeal tuberculosis.

1.3 Communicable Disease Reporting and HIPAA

Reporting of communicable diseases, as required by law, to the local or state health departments is permitted under the Health Insurance Portability and Accountability Act (HIPAA). Providers are not required to obtain patient consent before sending this information to the health departments.

2. PEP Communication Requirements

Long-term care facilities must provide notification to staff members, residents, residents' family, residents' guardians, or representatives when persons working or residing in the long-term care facility are confirmed with a pandemic infection (ie. COVID-19). Such notification shall identify whether the individual was a staff member or resident. The facility shall not, however, reveal personally identifying information about the individual, including name, except as necessary to notify the resident's family or representative and to ensure staff members take sufficient safety precautions.

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The following notifications must be provided within 12 hours after the facility's administration becomes aware of the event, unless sooner notification is required:

1. A verbal communication thru a robo call shall be provided immediately to a resident's family, and a resident's representative whenever a resident receives confirmation of a pandemic infection.
2. A written notification shall be provided within 24 hours to each resident of the facility, resident's family, representative, and to staff members, upon the occurrence of a single confirmed infection, or three or more residents or staff members with new-onset of respiratory symptoms that occur within 72 hours.
3. Updates to residents, their families, their representatives, and staff members shall be provided weekly, or each subsequent time a confirmed infection is identified and/or whenever three or more residents or staff members with new onset of respiratory symptoms occurs within 72 hours. In these updates, facilities will include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered.
4. A verbal communication thru a robo call shall be provided immediately to a resident's family and a resident's representative whenever the long-term care facility receives notice a resident has died from a pandemicinfection.
5. The facility will provide all residents at no cost daily access to remote videoconferencing thru Zoom or Facetime with family members/legal representatives.

3. PEP Infection Control Requirements

1. Bainbridge Nursing will have and maintain personal protective equipment (PPE) in a two-month (60 day) supply at the facility storage area. Supply needs are based on facility census, not capacity, and will include considerations of space for storage. To determine supply needs during a pandemic episode, the facility will consult with the Center for Disease Control and Prevention (CDC) PPE burn rate calculator.

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This plan addresses all personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents, current guidance on various supplies and strategies from the CDC. Supplies to be maintained include, but are not limited to:

1. N95 respirators
2. Face shield,
3. Eye protection
4. Gowns/isolation gowns,
5. gloves,
6. masks, and
7. Sanitizer and disinfectants in accordance with current EPA Guidance.:

2. Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown.

- Depending on the prevalence of COVID-19 in the community, this plan includes placing the resident in a single-person room or in a separate dedicated area so the resident can be monitored for evidence of COVID-19. Staff should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the dedicated area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected.

- **Considerations for new admissions or readmissions to the facility whose COVID-19 is confirmed.**

  Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautionsshould go to the designated COVID-19 care unit.

- Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit.
- New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty.

3. Resident Cohorting

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3.1 Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19

- Determine the location of the COVID-19 care unit and create a staffing plan before residents COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify nursing staff to work on this unit.
- Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19.
- Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms.
- Assign dedicated worker to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (CNAs) and nurses assigned to care for these residents. HCW working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCW working in other areas of the facility.
    - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
    - Assign housekeeping services staff to work only on the unit.
    - Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
    - Ensure HCW practice source control measures and social distancing in the break room and other common areas (i.e., HCW wear a facemask and sit more than 6 feet apart while on break).
- Place signage at the entrance to the COVID-19 care unit that instructs HCW they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- Ensure that HCW have been trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE).
- If PPE shortages exist, implement strategies to optimize PPE supplyon the unit, such as:
    - Bundle care activities to minimize the number of HCW entries into a room.
    - Consider extended use of respirators (or facemasks if respirators are not available), eye protection, and gowns. Limited reuse of PPE may also be considered.
    - Consider prioritizing gown usefor high-contact resident care activities and activities where splash or spray exposures are anticipated.
- Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.

Resident with new-onset suspected or confirmed COVID-19

- Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of SARS-CoV-2 testing.

  - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).
  - If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.
- If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.
- Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).
  - Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections.
  - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
- Counsel all residents to restrict themselves to their room to the extent possible.
- HCW should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.
  - If HCW PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated. Broader testing could be utilized to prioritize PPE supplies (see section on using testing).
- Notify HCW, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning).
  - Promptly (within 24 hours) notify HCW, residents, and families about identification of COVID-19 in the facility:
    - Maintain ongoing, frequent communication with residents, families, and HCW with updates on the situation and facility actions
  - Monitor hand hygiene and PPE use in affected areas
- Maintain all interventions while assessing for new clinical cases (symptomatic residents):
  - Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.
  - If testing is available, asymptomatic residents and HCW who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing
  - The incubation period for COVID-19 can be up to 14 days and the identification of a new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

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4. Other PEP Requirements

Facility will refer to current NYSDOH and Federal behold rules and regulations.