	Personal Protective Equipment (PPE) NY			C IC- 7d
Dept:	Clinical Operations	**New Revised X**	**Last Date Revised:**	12/2020
			Prev. Date Revised:	4/17/2020, 5/6/20, 7/9/2020 9/2020
			Creation Date:	3-24-2020
RELATED FORMS:	CDC/Federal/State/Local Dept of Health Guidelines/Guidance			

Policy:
Personal protective equipment appropriate to specific task/isolation requirements is available at all times.
In lieu of an outbreak (outbreak, epidemic, pandemic) affecting health care workers, the Facility will
follow guidance from the Federal/State/Local Health Departments established for conservation and use of Personal Protective Equipment (PPE).

Procedure:

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

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

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

a. Gowns (disposable, cloth, and/or plastic);
b. Gloves (sterile, non-sterile, heavy-duty and/or puncture-resistant);
c. Masks (surgical, N95) (Universal masking may be implemented based on State/Local DOH) and
d. Eyewear (goggles and/or face shields).

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

4. Employees/HCP should receive job-specific training on PPE and demonstrate competency with selection and proper use (e.g., putting on and removing; donning and doffing without self-contamination).

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

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

7. Contracts with multiple suppliers for PPE will be maintained to ensure adequate supply of PPE flows to each facility as needed and as available while in an active pandemic situation. The Facility will maintain a supply of PPE as required by State or Federal regulation.

8. NYSDOH recommends universal use of eye protection by healthcare personnel for all patient interactions, in addition to face mask; face shield or goggles should be used. Standard eyeglasses are not personal protective equipment and do not constitute sufficient eye protection

9. NYSDOH recognizes that PPE supply shortages might prevent universal use of eye protection in all healthcare encounters. In this situation, the shortage should be documented, and eye protection should be reserved for and considered required for the care of patients and residents with: known COVID-19; symptoms consistent with COVID-19l known exposure to a person with COVID-19; or in settings with a higher prevalence of patients or residents with COVID-19.

COVID -19

1. Universal masking of all persons entering Facility; follow CDC guidance for PPE use and Conservation.

2. As community transmission intensifies within a region, residents should wear facemasks or cloth face covering when leaving their room. Resident may remove face covering when in their room, but should put them back on when others enter room or place a Kleenex covering their mouth. Facemasks should not be placed on anyone who has trouble breathing, unconscious, incapacitated or otherwise unable to remove mask without assistance.

3. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown. Facemasks, if available, should be reserved for HCP. For visitors and residents, a cloth face covering may be appropriate. If a visitor/resident arrives at the facility without a cloth mask, a facemask may be given to them for source control if supplies are available. For staff that are not in direct care contact with residents (administrative staff) a cloth face covering would be acceptable

4. Cloth face coverings can become saturated with respiratory secretions, care should be taken to prevent self-contamination. They should be changed if they become soiled, damp, or hard to breathe through, laundered regularly (e.g., daily and when soiled), and, hand hygiene should be performed immediately before and after any contact with the cloth face covering.

5. Facilities should also provide training about when, how, and where cloth face coverings can be used (e.g., frequency of laundering, guidance on when to replace, circumstances when they can be worn in the facility, importance of hand hygiene to prevent contamination).

6. Confirmed cases of COVID -19, HCP providing direct care should wear full PPE, including N95 masks; follow CDC guidelines for PPE use and conservation.

7. HCP not providing direct care for residents with COVID -19 should wear regular face masks

8. Symptomatic residents (respiratory) should wear a face mask during direct care, if tolerated or unless they meet exceptions identified in policy #2 above.

9. If shared HCP working between wings/units is unavoidable, then HCP should change PPE and perform hand hygiene when moving between affected wings/units and wings/units believed to be unaffected; follow CDC guidance for PPE use and conservation. If HCP is working on

   a unit/wing where both affected and unaffected residents are mixed, then PPE must be changed between affected and unaffected residents. CDC guidance for PPE use and conservation should be followed.

10. Facilities should attempt to maintain a COVID affected unit separate from unaffected residents if possible. Facilities should also attempt, if possible, to designate specific HCP for providing care to those positive with COVID 19.

11. Facilities should designate a unit/wing where admissions and readmissions are placed for monitoring. If unable to designate a separate floor from the COVID 19 residents then residents should be separated within that unit/wing, i. e. front end of hall versus back end of hall.

12. Facilities should follow CDC guidelines for conservation and use of PPE based on conventional, contingency and crisis scenarios.

13. The facility's preferred policy for conservation of PPE in a contingency or crisis scenario is:
    a. Extended use of masks, (surgical and N95 or other respirator masks approved for use).
    b. Protective eyewear/face shields (disposable or reusable) Follow CDC guidelines for conservation and use.
    c. A designated isolation gown is provided for the HCP. If HCP interacts with more than 1 resident known to be infected with the same infectious disease (COVID 19), the HCP can wear the same gown when residents are housed in the same location.
    d. For conservation of isolation gowns, the HCP may wear a cloth gown over the isolation gown. If the cloth gown or isolation gown become visibly soiled during care then they should be disposed of or laundered.
    e. For conservation, in addition to use of a cloth gown over an isolation gown, HCP should wear disposable sleeves over the isolation gown. This protects the sleeves of the isolation gown from becoming contaminated due to the short sleeves on the cloth gown.
    f. Cloth gowns and sleeves should be disposed of or laundered when exiting the resident's room.

	COVID-19 Infection Control- New York			C IC 28d
Dept:	Clinical Operations	**New Revised X**	**Last Date Revised:**	11-7-2020
			Prev. Date Revised:	3-14-20; 3-19-20, 4-6-20; 4-22-20; 5-11-20, 5-14-20, 6-12-20, 7-9-20
			Creation Date:	3-11-20
RELATED FORMS:	CMS/CDC/State/Local DOH Guidance- Employee screening form C IC 28b, Visitation CV 5			

Policy: The facility has established appropriate guidelines pursuant to recommendations from the Local Public Health, State Department of Health, CMS and the Federal Centers for Disease Control (CDC). The policy addresses resident, staff and visitor behavior and responsibilities to try to prevent the transmission of communicable diseases, such as undiagnosed respiratory illness and COVID-19.

The facility has the necessary means to provide adequate care to residents and will not deny an admission or re-admission solely on a resident diagnosed with COVID-19 but will follow CMS/CDC/State/Local DOH guidance.

NY facilities- A resident will not be admitted or re-admitted to the facility until a negative molecular test for SARS-Cov-2 RNA is completed and sent with hospital admission paperwork.

COVID 19 Information

Corona Viruses are a large family of viruses, some causing illness in people and others circulating among animals including camels, cats, and bats and at times evolves and infects people before spreading through human to human contact.

The 2019 novel corona virus (COVID -19) is a new virus that causes respiratory illness in people and can spread from person to person. The virus was first identified during an investigation in Wuhan, China.

Risk:

Risk of infection with COVID -19 is higher for people who are close contacts of someone known to have COVID -19, for example healthcare workers or household members. Others at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.

Symptoms:

Per CDC, prompt detection, triage, and isolation of potential infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel (HCP) and visitors at the facility.

Symptoms may appear in as few as 2 days or as long as 14 days after exposure. Reported illnesses have ranged from people with little to no symptoms to being severely ill and dying.

Common signs and symptoms

***** fever
***** cough
***** Shortness of breath

Less common signs and symptoms

***** confusion or change in mental status. If noted, check pulse oximetry for O2 Sats
* muscle aches, headache
* sore throat, runny nose
* chest pain
* diarrhea, nausea and vomiting
* myalgia
* chills; chills with shaking
* sudden onset of loss of taste/smell

Human corona virus spreads just like the flu or cold:

* through the air by cough/sneezing
* close personal contact such as touching or shaking hands
* touching an object or surface with the virus on it
* occasional fecal contamination
* possible spread thru just speaking, (still not proven fact)

Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible infection with undiagnosed respiratory illness and coronavirus disease 2019 (COVID-19) and therefore have an increased risk of exposure to this virus. HCPs can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control guidelines, including use of recommended personal protective equipment (PPE).

Procedure:

1. The facility, consistent with federal regulations, implements universal, standard infection control practices. This may include information pertaining to:

    * Standard Precautions
    * Transmission Based Precautions
    * Hand hygiene
    * Respiratory hygiene
    * Vaccinations

* Signs and symptoms of common communicable diseases

To prevent the spread of respiratory germs WITHIN the facility, monitor/screen employees for fever or respiratory symptoms. The screener should wear PPE following CMS and DOH recommendations during the screening process. For COVID -19 screening, the facility will monitor employee temperatures prior to starting shift and at end of shift or based on State specific DOH guidance. Refer to employee screening tool C IC 28 for additional screening requirements.

a. Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated). Obtaining a pulse ox on the resident may need completed based on respiratory status. A physician order will be obtained with specific information for completion.

b. In general, for care of residents with undiagnosed respiratory infection and COVID-19 use Standard, Contact, and/or Droplet Precautions with appropriate PPE based on Transmission-based Precautions (gown, gloves, mask/eye protection, N95) unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis). When COVID-19 is identified in the facility, staff wear all recommended PPE (gloves, gown, eye protection, and respirator or face mask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (refer to CDC guidelines for conservation and use of PPE).

c. The facility monitors the Federal CDC website and state and local health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents with acute respiratory infection, the facility shall also consult with local health authorities for additional guidance.

d. Signs should be posted throughout the facility describing ways to prevent the spread of germs. https://www.cdc.gov/coronavirus/2019-ncov/downloads/stop-the-spread-of-germs.pdf

e. Hand and respiratory hygiene as well as cough etiquette by residents, visitors, and employees is imperative. Everyone is encouraged to wash their hands using soap and water or hand sanitizer frequently.

f. Employees are educated and reminded to clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).

g. Put alcohol-based hand rub in common areas, including hallways. Encourage staff, residents and visitors to wash hands with soap and water or to use the hand sanitizer frequently.

h. It is recommended that tissues are available and any sink is well-stocked with soap and paper towels for hand washing.

i. If able, the facility will identify and cohort utilizing separate areas of the facility or a designated wing/unit to provide care for residents with COVID -19. Also, if able, the facility will identify a designated wing/unit to monitor new admissions/readmissions residents that may have been exposed to COVID prior to admission.

j. If able, the facility will identify dedicated employees to care for COVID-19 patients and provide infection control training. A log/assignment sheet will be maintained for those employees providing care.

k. Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.

l. Make PPE, including facemasks, eye protection, gowns, and gloves, available outside of the resident room or close proximity to resident room when it's determined PPE is needed for the resident.

m. Position a trash can near the exit in the resident room to make it easy for employees to discard PPE. Perform hand hygiene upon exiting patient rooms.

n. The Administrator, in conjunction with the Medical Director and Infection Preventionist, has the authority to restrict or ban facility visitation and communal dining, group activities during outbreaks (epidemic, pandemic), whether these originate in the facility or in the community. The Facility will follow guidance recommended by Federal and Government agencies as it relates to restriction of visitors.

o. Visitors are discouraged at all times from visiting when they have potentially contagious infections (for example, upper respiratory infection (URI), influenza, gastroenteritis, or unexplained rashes).

p. Visitors who are symptomatic of communicable diseases, undiagnosed respiratory illness and COVID-19 will be denied visitation at the discretion of the Administrator, DON and/or Charge Nurse and/ or as designated as an emergency proclamation by the State until appropriate evaluation and treatment of the visitor has been established. Signs should be posted at entrance doors and throughout facility reminding visitors of these symptom risks.

q. Visitors/HCP shall be encouraged to wash their hands upon arrival and when leaving the facility, and passively instructed on proper cough etiquette/ respiratory hygiene through signs posted throughout the facility and upon screening.

r. Visitors are expected to adhere to instructions from the Administrator, DON and/or Charge Nurse on duty regarding facility infection control practices and visitation restrictions.

s. The facility reserves the right to remove/restrict all resident independent community access passes during the COVID-19 emergency.

t. All new Admissions or Re-Admissions will be tested for Covid-19 prior to discharge from acute care setting, or any other setting, test results must be NEGATIVE and a part of the discharge paperwork. All Residents sent out to the hospital will return when medically clear and a NEGATIVE COVID-19 test was obtained. If they can't return to their previous room the resident will be placed in a temporary room for 14days then return to their previous room with all their belongings.

u. Resume in-house salon services following guidelines from CMS/NYSDOH to preserve the safety and wellness of all Residents and staff.

    1. The beautician will produce a negative COVID test within the last day (24 hours) prior to services rendered (facility can utilize and follow P&P for POC antigen testing device). Screening by facility staff, washing and sanitizing hands (including prior to services and in between each resident), and utilizing PPE will be adhered to by following current CMS/NYSDOH guidelines.

2. The beautician and Resident must sanitize and/or wash their hands upon entry into the salon and immediately following the appointment when exiting the salon.

3. Screening of Residents per CMS/NYSDOH guidelines must be completed immediately prior to their hair appointment.

4. Removal of all non-essential items from the salon must be completed prior to any services started in the salon i.e. magazines etc. No sharing of any items.

5. The beautician, Resident, and any staff member assisting in services must wear a face mask for the entire salon appointment.

6. The beautician must also wear a face shield along with the face mask at all times while providing services. Wearing of gloves should be used as needed.

7. Capes and Aprons should be used one-time only, regardless if they are disposable or washable.

8. Adequate time must be utilized in-between each resident appointment and end of the day for documented full disinfection of salon (including equipment, workstation, chair, tools, etc.

9. Designate staff to assist in transporting residents to and from salon appointments, allow only one resident in the salon at a time. No waiting area is to be used outside the salon. Keep doors to the salon closed while providing services.

10. Post signage outside of the salon to remind others to adhere to proper hygiene, social distancing rules, appropriate use of PPE, and cleaning and disinfection protocols.

11. The facility will provide the beautician with updated education following CMS/NYSDOH guidelines.

12. The facility will provide the beautician with a logging system to continuously log date of service, each resident's name, and temperature at time of services. The submission of salon services receipts to a designated staff for sign-off must occur for each resident.

13. The facility will monitor and audit the beautician services, and documentation logs and receipts to ensure compliance. The Administrator will notify the beautician of any areas of non-compliance.

2. Steps to promote health and safety:
   a. Stay home when sick.
   b. Avoid touching your eyes, nose and mouth
   c. Cover your cough or sneeze into your elbow, or if unable, then use a tissue, then throw the tissue in the trash.
   d. Clean and disinfect frequently touched objects and surfaces using an approved/ recommended cleaning product.
   e. Wash your hands often with soap and water for at least 20 seconds or utilize hand sanitizer.
   f. Avoid close contact with people who are sick
   g. **Follow public health advice** regarding school closures, avoiding crowds and other social distancing measures.
   h. **Stay informed.** CDC's COVID-19 Situation Summary will be updated regularly as information becomes available.

3. Visitor restriction will be followed based on Federal and State guidance. Visitor guidance could be recommended as "Restricting", "Limiting", and "Discouraging"; refer to CMS guidance related to definitions of each recommendation. Examples of "limiting" visitors are noted below:

   a. Those visiting a person with dementia (e.g., to lend support, ease anxiety, help the person feel safe/secure/grounded if staff are not able to comfort resident).
   b. Those visiting a hospice patient or end of life resident.
   c. Those visiting who are able to lend a patient "psychosocial support."

4. Facilities who are notified of a resident in the facility or recently transferred to the hospital and notified by the hospital that a resident tested positive for COVID 19, need to follow guidance for care of that resident/residents based on CDC and Local and State Health Departments. These agencies are to be notified of a presumptive positive or confirmed positive resident for further guidance of care. CEO/COO/Regional Clinical Nurse/VP Buildings & Grounds should be notified of any Suspicious, Presumptive Positive or Positive resident.

5. Violations of these policies shall be reported to the Administrator. The Administrator has the right to remove, restrict or ban visitors as indicated.

6. If the facility is unable to provide adequate care to a Resident at any time during the resident's stay, the facility must call their respective regional office of the Department of Health to provide necessary information and assist with any relocation needs if needed, including but not limited to assistance with arranging transportation to an alternate facility that can provide adequate care for the resident.

Discontinuation of Transmission-Based Precautions for Residents with COVID-19

Transmission-based precautions are used by healthcare facilities to care for patients with confirmed or probable COVID-19, or in response to known or suspected exposure to COVID-19. These guidelines apply to healthcare facilities where transmission-based precautions are used.

The decision to discontinue Transmission-Based Precautions for patients with confirmed COVID-19 should be made using either a test-based strategy or a symptom-based (i.e., time-since-illness onset and time-since-recovery strategy) or time-based strategy as described below. **Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.**

Symptomatic residents with COVID-19 should remain in Transmission- Based Precautions Until Either:

Test-based strategy

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive swab specimens collected ≥24 hours apart (total of two negative specimens)

Symptom-based strategy

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 10 days have passed *since symptoms first appeared*

Residents with laboratory confirmed COVID 19 who have not had any symptoms should remain in Transmission-based Precautions until either:

Test-based strategy

o Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive specimens collected ≥24 hour's apart (total of two negative specimens).

o Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Time-based strategy

* 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

o Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Discontinuation of Empiric Transmission Based precautions for residents suspected of having COVID-19

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 patient can be made based upon having negative results from at least one FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARSCoV-2 RNA.

- If a higher level of clinical suspicion for COVID-19 exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.
- If a patient suspected of having COVID-19 is never tested, the decision to discontinue Transmission-Based Precautions can be made based upon using the *symptom-based strategy* described above.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Discharge of residents with COVID-19 from a healthcare facility:

Patients should be discharged from the healthcare facility whenever clinically indicated

If discharged to home: Facility will provide discharge instructions at time of discharge

- Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions.

- The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations.

- Guidance on implementing home care of persons who do not require hospitalization and the discontinuation of home isolation for persons with COVID-19 is available.

If discharged to a skilled-nursing facility or other long-term care facility (e.g., personal care home, assisted living facility) AND

- **Transmission-Based Precautions *are still required***, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.

- **Transmission-Based Precautions *have been discontinued***, but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room ideally with a dedicated bathroom, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline. Note that these restrictions may already be in place for the entire facility; however, as the COVID-19 response in the Commonwealth evolves, this may not be the case. In that event, these restrictions would apply as described here for the individual resident.

- **Transmission-Based Precautions *have been discontinued*** and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

For skilled nursing facilities and other long-term care facilities: Discontinuing "exposed" or : "affected" status for a unit or facility

To declare a unit or facility that has housed COVID-19-positive residents unaffected by COVID-19, **all** of the following conditions must apply:

- All residents on the unit who were confirmed or probable cases of COVID-19 must have met the criteria for discontinuation of transmission-based precautions
- A minimum of 14 days have passed since the date of symptom onset for the last clinical case
- A minimum of 14 days have passed since the implementation of transmission-based precautions for COVID-19 and other infection prevention and control interventions for COVID19
- All residents who were not confirmed or probable cases of COVID-19 remain asymptomatic
- All staff remain asymptomatic or have met return-to-work criteria
- No additional or ongoing exposures have occurred (e.g. through exposure infectious healthcare workers)

Emergency Preparedness COVID 19/ Pandemic Program and Plans

Policy: Emergency Preparedness Program Pandemic (COVID 19)	
Date:	E Tag – E-001

Objective:

The primary objective of this manual is to provide a means for safeguarding the residents, staff and visitors related to a Pandemic Outbreak.

This Pandemic/COVID-19 Emergency Preparedness Procedure Guide is provided to coordinate activities within Premier Genesee Center for Nursing and Rehabilitation during the Pandemic national and state emergencies.

A copy of this plan is available to be viewed either at the Facility or on the Facility's website.

Facility Approvals

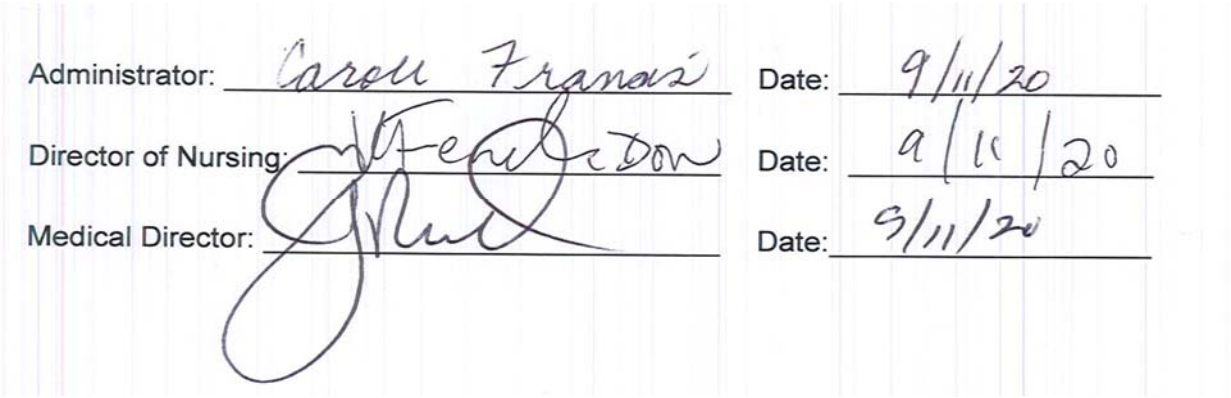


TABLE OF CONTENTS

Appendices

Section 1

Incident Management Team & COMMUNICATION

Policy: Pandemic (COVID 19) Communications	
Date:	E Tag – E-0029

Objective:

The primary objective is to provide a means for safeguarding the residents; protect the employees and safeguard the facility; and to establish procedures for receiving and handling disasters.

Policy:

Every facility is expected to have an Incident Management Team which is the predetermined group of individuals who may serve the incident command functions. Typically, the Incident Commander will determine the size and composition of the IMT, including who is available; the demands created by the incident; etc.

Incident Management Team for Premier Genesee is as follows:

1. **Carole Francis, Administrator**
2. **Kristina Ferrando, Director of Nursing**
3. **Wendy Holt, Director of Environmental Services**
4. **Steve Leffel, Director of Maintenance**

EXTERNAL CRITICAL CONTACTS

TYPE	**TEL #/**	**CONTACT NAME**
POLICE	**585-345-6350** **585-344-6200**	**BATAVIA POLICE** **NYS POLICE**
FIRE	**911 or 585-343-3311**	**BATAVIA FIRE DEPT**
STATE SURVEY AGENCY DAYTIME #	**716-847-4320**	**NYS DEPT OF HEALTH**
STATE SURVEY AGENCY 24 HOUR #	**866-882-2809**	**NYS DEPT OF HEALTH**
LOCAL PUBLIC HEALTH AGENCY	**585-344-2580**	**GENESEE COUNTY DEPT OF HEALTH**
LOCAL EMERGENCY MANAGEMENT AGENCY	**585-344-0078**	**GENESEE COUNTY EMERGENCY MGMT**
AMBULANCE COMPANY	**585-343-6200**	**MERCY EMS**
PARATRANSIT OR OTHER TRANSPORTATION #1	**585-343-3079**	**RTS**
PARATRANSIT OR OTHER TRANSPORTATION #2	**716-371-0960**	**CAMERON**
NATURAL GAS SUPPLIER	**800-365-3234**	**NATIONAL FUEL**
ELECTRIC UTILITY	**800-642-4272**	**NATIONAL GRID**

TELEPHONE COMPANY	**800-343-5554**	**MERIDIAN**
WATER AND SEWER	**585-345-6325**	**CITY OF BATAVIA**
GENERATOR FUEL OIL	**585-343-4453**	**REISDORF BROTHERS**
FIRE ALARM SYSTEM	**716-632-0920**	**GENERAL SECURITY**
EMERGENCY WATER SUPPLY	**716-892-3434**	**UPSTATE MILK**
EMERGENCY FOOD SUPPLY	**800-333-0828**	**US FOODS**

Internal Communications

Premier Genesee
Department Head List

Title	*Name*	*Phone*	*Extension*
Administrator	Carole Francis	585-344-0584	2101
Nursing			
Director of Nursing	Kristina Ferrando, RN	"	2230
Assistant Director of Nursing	Kevin Fortuna, RN	"	2130
Rehab Unit Manager	Chelsea Bishop RN	"	2140
Unit 3 Manager	Jason Genova, LPN	"	2133
Unit 4 Manager	Beth Maczo, LPN	"	2134
Unit 5 Manager	Renee Wapniewski,LPN	"	2135
RN Supervisor	Todd Warren, RN	"	2131
Social Work			
Director of Social Services	Barbara Jovic	"	2127
Social Work Assistant	Tanya Adams	"	2125
Other Departments			
Activities Director	Rhonda Kunker	"	2139
Admissions Coordinator	Donna Sullivan	"	2290
Admissions Liaison	Melissa Tuso	"	2279
Business Office Manager	Kim Harlach	"	2115
Dietician	Amy Zemla	"	2123

Dining Services Director	Heather Mandeville	“	2121
In-service Coordinator/Infection Control	Shari Mazerbo	“	2147
Director of Maintenance	Steve Leffel	“	2146
Director of Environmental Services	Wendy Holt	“	2119
Human Resources	Kari Green	“	2214
MDS Coordinator	Racheal Hall	“	2109
Medical Director	Dr. Ju Joh	“	page
Rehab Director	Joe Molea	“	2278
Scheduling	Michelle Battaglia	“	2138

Communication Plan – Residents/Family Members/Guardians

Premier Genesee has developed as part of the Pandemic Emergency Plan a plan to communicate with Residents/Family Members/ Guardians.

- The Facility will update authorized family members and guardians of residents infected with the pandemic disease within 24 hours of the disease being identified and at least daily thereafter and upon a change of condition.
- All residents and authorized family members and guardians will be updated at least weekly on the number of infections and deaths related to the pandemic illness.
- Residents will be provided access to free remote video conferencing or similar communication as needed in order for them to communicate with family members or guardians.
- The communication to authorized family members will be in electronic form unless another method is selected by the family member or guardian. Samples methods of electronic communication are Cell phone, land line telephone, text messages and email.
- The facility will modify the frequency or method of the communication based on any Regulatory Agency guidance.

Section 2

Infectious Disease Policies

Policy: Infectious Diseases	
Date:	E Tag – E-0013/E-0015

Policy

To protect our residents, families, and staff from harm resulting from exposure to an emergent infectious disease while they are in our facility.

General Preparedness for Infectious Diseases

Premier Genesee's emergency program includes a response plan for a community-wide infectious disease outbreak such as COVID-19, SARS, influenza and alike. This plan includes:

1. Build on the workplace practices described in the Infection Prevention and Control Program (IPCP)
2. The annual review of the IPCP policies and practices
3. Include administrative controls (screening, isolation, visitor policies and employee absentee plans).
4. Review of the surveillance and antibiotic stewardship programs.
5. Review influenza/pneumococcal immunization of residents.
6. Address environmental controls (isolation rooms, plastic barriers, sanitation stations, and special areas for contaminated wastes).
7. Address human resource issues such as employee leave following all Regulatory requirements.
8. Be compatible with the facility's business continuity plan.
9. Incident Commander or individual(s) will monitor and evaluate the emerging situation and inform staff and others as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.
10. As part of the emergency operations plan, the facility will maintain a supply of appropriate personal protective equipment (PPE). Premier Genesee will maintain a supply of PPE as required by DOH requirements.
11. Premier Genesee and its purchasing department will develop plans with their vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including an infectious disease outbreak/pandemic.
12. The facility will inform staff and provide training for employees and practice the infectious disease response plan through drills, competencies, and exercises as part of the facility's emergency preparedness training.
13. The Facility will comply with all reporting requirements issued by the CDC, CMS, State and Local Departments of Health

Threat

1. Once notified by the public health authorities at either the federal, state and/or local level that the infectious disease is likely to or already has spread to the facility's community, the facility will activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), The Centers of Medicare and Medicaid (CMS) and/or the State/local public health authorities.
2. The facility's Incident Commander along with individuals appointed by the Incident Commander to work with the facility's medical director, pharmacy provider and others to best understand the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing facilities as provided by the CDC, CMS and other relevant local, state and federal public health agencies.
3. Working with advice from the facility's medical director or clinical consultant, safety officer, human resource director, local and state public health authorities, and others as appropriate and will review and revise internal policies and procedures, stock up on medications, environmental cleaning agents, and PPE as indicated by the specific disease threat.
4. Staff will be educated on the exposure risks, symptoms, and prevention of the infectious disease. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.
5. Provide residents and families with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information.
6. Brief contractors, vendors and other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents.
7. 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 will the instruction that anyone who is sick must not enter the building.
8. To ensure that staff, and/or new residents are not at risk of spreading the infectious disease into the facility, screening for exposure risks, signs and symptoms will be done PRIOR to admission of a new resident and at least prior to the employee starting their work shift.
9. Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of local public health authorities and may include:
    1. *Self-isolation* - in the event there are confirmed cases of the infectious disease in the local community, the facility may consider closing the facility to new admissions, and limiting visitors based on the advice of the local CDC, CMS or public health authorities.
    2. *Environmental cleaning* - the facility will follow current CDC guidelines for environmental cleaning specific to the infectious disease in addition to routine cleaning for the duration of the threat.
10. Place a resident who exhibits symptoms of the infectious disease in a room with the door closed until further assessment is completed.
11. If an employee exhibits symptoms of the infectious disease during the screening process, place them in a separate room, notify the Infection Preventionist/DON and proceed per screening guidelines. If an employee exhibits symptoms of the infectious disease during their work shift, immediately remove them from the work area into a separate room. Notify the Infection Preventionist/DON for further guidance and recommendations.
12. Under the guidance of public health authorities, encourage follow up with the employee's physician for testing and or treatment or arrange a transfer of the suspected infectious

person to the appropriate acute facility via emergency medical services if employee is acutely ill and requiring emergency services as soon as possible.
13. If the suspected infectious person requires care while awaiting transfer, follow facility policies for isolation procedures, including all recommended PPE for staff at risk of exposure.
14. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (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 infectious disease, and the use of the appropriate PPE.
15. If feasible, ask the isolated person to wear a facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless advised otherwise by public health authorities.
16. Conduct control activities such as 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.
17. Implement the isolation protocol in the facility (isolation rooms, cancelation of group activities and social dining) as described in the facility’s infection prevention and control plan and/or recommended by local, state, or federal public health authorities.

Employer Considerations

Facility management will consider its requirements under CMS and state licensure, and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and other employees shall be of paramount concern. Management shall take into account:

1. The degree of frailty of the residents in the facility.
2. The likelihood of the infectious disease being transmitted to the residents and employees.
3. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces).
4. The precautions which can be taken to prevent the spread of the infectious disease and other relevant factors.
5. Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.
6. Apply whatever action is taken uniformly to all staff in like circumstances.
7. 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.
8. Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.
9. Generally accepted scientific procedures, whenever available, will be used to determine the level of risk posed by an employee.
10. Permit employees to use sick leave, vacation time, and FMLA where appropriate while they are out of work.
11. Permit employees to return to work when cleared by a licensed physician, however, additional precautions may be taken to protect the residents.

12. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline.

Definitions

Infectious disease - whose incidence in humans has increased in the past two decades or threatens to increase in the near future. These diseases, which respect no national boundaries, include:

1. New infections resulting from changes or evolution of existing organisms
2. Known infections spreading to new geographic areas or populations
3. Previously unrecognized infections appearing in areas undergoing ecologic transformation
4. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

Pandemic - A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a 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 of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

Infection Control Policies:

<table>
<tr><td></td><td colspan="2">Pandemic (COVID-19) Infection Control- New York</td><td></td><td>C IC 28d</td></tr>
<tr><td rowspan="3">Dept:</td><td rowspan="3">Clinical Operations</td><td rowspan="3">New
Revised X</td><td>Last Date Reviewed/Revised:</td><td>7/9/2020</td></tr>
<tr><td>Prev. Date Reviewed/Revised:</td><td>3-14-20; 3-19-20, 4-6-20; 4-22-20; 5-11-20, 5-14-20, 6/12/20</td></tr>
<tr><td>Creation Date:</td><td>3-11-20</td></tr>
<tr><td colspan="2">RELATED FORMS:</td><td colspan="3">CMS/CDC/State/Local DOH Guidance- Employee screening form C IC 28b, Visitation CV 5</td></tr>
</table>

Policy: The facility has established appropriate guidelines pursuant to recommendations from the Local Public Health, State Department of Health, CMS and the Federal Centers for Disease Control (CDC). The

policy addresses resident, staff and visitor behavior and responsibilities to try to prevent the transmission of communicable diseases, such as undiagnosed respiratory illness and COVID-19.
The facility has the necessary means to provide adequate care to residents and will not deny an admission or re-admission solely on a resident diagnosed with Pandemic illness but will follow CMS/CDC/State/Local DOH guidance.
NY facilities- A resident will not be admitted or re-admitted to the facility until a negative molecular test for SARS-Cov-2 RNA is completed and sent with hospital admission paperwork.

COVID 19 Information

Corona Viruses are a large family of viruses, some causing illness in people and others circulating among animals including camels, cats, and bats and at times evolves and infects people before spreading through human to human contact.
The 2019 novel corona virus (COVID -19) is a new virus that causes respiratory illness in people and can spread from person to person. The virus was first identified during an investigation in Wuhan, China.

Risk:

Risk of infection with COVID -19 is higher for people who are close contacts of someone known to have COVID -19, for example healthcare workers or household members. Others at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.

Symptoms:

Per CDC, prompt detection, triage, and isolation of potential infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel (HCP) and visitors at the facility.

Symptoms may appear in as few as 2 days or as long as 14 days after exposure. Reported illnesses have ranged from people with little to no symptoms to being severely ill and dying.

Common signs and symptoms

***** fever
***** cough
***** Shortness of breath

Less common signs and symptoms

***** confusion or change in mental status. If noted, check pulse oximetry for O2 Sats
* muscle aches, headache
* sore throat, runny nose
* chest pain
* diarrhea, nausea and vomiting
* myalgia
* chills; chills with shaking
* sudden onset of loss of taste/smell

Human corona virus spreads just like the flu or cold:

* through the air by cough/sneezing
* close personal contact such as touching or shaking hands
* touching an object or surface with the virus on it

* occasional fecal contamination
* possible spread thru just speaking, (still not proven fact)

Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible infection with undiagnosed respiratory illness and coronavirus disease 2019 (COVID-19) and therefore have an increased risk of exposure to this virus. HCPs can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control guidelines, including use of recommended personal protective equipment (PPE).

Procedure:

1. The facility, consistent with federal regulations, implements universal, standard infection control practices. This may include information pertaining to:

    * Standard Precautions
    * Transmission Based Precautions
    * Hand hygiene
    * Respiratory hygiene
    * Vaccinations
    * Signs and symptoms of common communicable diseases

To prevent the spread of respiratory germs WITHIN the facility, monitor/screen employees for fever or respiratory symptoms. The screener should wear PPE following CMS and DOH recommendations during the screening process. For COVID -19 screening, the facility will monitor employee temperatures prior to starting shift and at end of shift or based on State specific DOH guidance. Refer to employee screening tool C IC 28 for additional screening requirements.

a. Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated). Obtaining a pulse ox on the resident may need completed based on respiratory status. A physician order will be obtained with specific information for completion.

b. In general, for care of residents with undiagnosed respiratory infection and COVID-19 use Standard, Contact, and/or Droplet Precautions with appropriate PPE based on Transmission-based Precautions (gown, gloves, mask/eye protection, N95) unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis). When COVID-19 is identified in the facility, staff wear all recommended PPE (gloves, gown, eye protection,

and respirator or face mask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (refer to CDC guidelines for conservation and use of PPE).

c. The facility monitors the Federal CDC website and state and local health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents with acute respiratory infection, the facility shall also consult with local health authorities for additional guidance.

d. Signs should be posted throughout the facility describing ways to prevent the spread of germs. https://www.cdc.gov/coronavirus/2019-ncov/downloads/stop-the-spread-of-germs.pdf

e. Hand and respiratory hygiene as well as cough etiquette by residents, visitors, and employees is imperative. Everyone is encouraged to wash their hands using soap and water or hand sanitizer frequently.

f. Employees are educated and reminded to clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).

g. Put alcohol-based hand rub in common areas, including hallways. Encourage staff, residents and visitors to wash hands with soap and water or to use the hand sanitizer frequently.

h. It is recommended that tissues are available and any sink is well-stocked with soap and paper towels for hand washing.

i. If able, the facility will identify and cohort utilizing separate areas of the facility or a designated wing/unit to provide care for residents with COVID -19. Also, if able, the facility will identify a designated wing/unit to monitor new admissions/readmissions residents that may have been exposed to COVID prior to admission.

j. If able, the facility will identify dedicated employees to care for COVID-19 patients and provide infection control training. A log/assignment sheet will be maintained for those employees providing care.

k. Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.

l. Make PPE, including facemasks, eye protection, gowns, and gloves, available outside of the resident room or close proximity to resident room when it's determined PPE is needed for the resident.

m. Position a trash can near the exit in the resident room to make it easy for employees to discard PPE. Perform hand hygiene upon exiting patient rooms.

n. The Administrator, in conjunction with the Medical Director and Infection Preventionist, has the authority to restrict or ban facility visitation and communal dining, group activities during outbreaks (epidemic, pandemic), whether these originate in the facility or in the community. The Facility will follow guidance recommended by Federal and Government agencies as it relates to restriction of visitors.

o. Visitors are discouraged at all times from visiting when they have potentially contagious infections (for example, upper respiratory infection (URI), influenza, gastroenteritis, or unexplained rashes).

p. Visitors who are symptomatic of communicable diseases, undiagnosed respiratory illness and COVID-19 will be denied visitation at the discretion of the Administrator, DON and/or Charge Nurse and/ or as designated as an emergency proclamation by the State until appropriate evaluation and treatment of the visitor has been established. Signs should be posted at entrance doors and throughout facility reminding visitors of these symptom risks.

q. Visitors/HCP shall be encouraged to wash their hands upon arrival and when leaving the facility, and passively instructed on proper cough etiquette/ respiratory hygiene through signs posted throughout the facility and upon screening.

r. Visitors are expected to adhere to instructions from the Administrator, DON and/or Charge Nurse on duty regarding facility infection control practices and visitation restrictions.

s. The facility reserves the right to remove/restrict all resident independent community access passes during the COVID-19 emergency.

t. All new Admissions or Re-Admissions will be tested for Covid-19 prior to discharge from acute care setting, or any other setting, test results must be NEGATIVE and a part of the discharge paperwork. All Residents sent out to the hospital will return when medically clear and a NEGATIVE COVID-19 test was obtained. If they can't return to their previous room the resident will be placed in a temporary room for 14days then return to their previous room with all their belongings.

2. Steps to promote health and safety:
   a. Stay home when sick.
   b. Avoid touching your eyes, nose and mouth

c. Cover your cough or sneeze into your elbow, or if unable, then use a tissue, then throw the tissue in the trash.
d. Clean and disinfect frequently touched objects and surfaces using an approved/ recommended cleaning product.
e. Wash your hands often with soap and water for at least 20 seconds or utilize hand sanitizer.
f. Avoid close contact with people who are sick
g. **Follow public health advice** regarding school closures, avoiding crowds and other social distancing measures.
h. **Stay informed.** CDC's COVID-19 Situation Summary will be updated regularly as information becomes available.

3. Visitor restriction will be followed based on Federal and State guidance. Visitor guidance could be recommended as "Restricting", "Limiting", and "Discouraging"; refer to CMS guidance related to definitions of each recommendation. Examples of "limiting" visitors are noted below:

a. Those visiting a person with dementia (e.g., to lend support, ease anxiety, help the person feel safe/secure/grounded if staff are not able to comfort resident).
b. Those visiting a hospice patient or end of life resident.
c. Those visiting who are able to lend a patient "psychosocial support."

4. Facilities who are notified of a resident in the facility or recently transferred to the hospital and notified by the hospital that a resident tested positive for COVID 19, need to follow guidance for care of that resident/residents based on CDC and Local and State Health Departments. These agencies are to be notified of a presumptive positive or confirmed positive resident for further guidance of care. CEO/COO/Regional Clinical Nurse/VP Buildings & Grounds should be notified of any Suspicious, Presumptive Positive or Positive resident.

5. Violations of these policies shall be reported to the Administrator. The Administrator has the right to remove, restrict or ban visitors as indicated.

6. If the facility is unable to provide adequate care to a Resident at any time during the resident's stay, the facility must call their respective regional office of the Department of Health to provide necessary information and assist with any relocation needs if needed, including but not limited to assistance with arranging transportation to an alternate facility that can provide adequate care for the resident.

Discontinuation of Transmission-Based Precautions for Residents with COVID-19

Transmission-based precautions are used by healthcare facilities to care for patients with confirmed or probable COVID-19, or in response to known or suspected exposure to COVID-19. These guidelines apply to healthcare facilities where transmission-based precautions are used.

The decision to discontinue Transmission-Based Precautions for patients with confirmed COVID-19 should be made using either a test-based strategy or a symptom-based (i.e., time-since-illness onset and time-since-recovery strategy) or time-based strategy as described below. **Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.**

Symptomatic residents with COVID-19 should remain in Transmission- Based Precautions Until Either:

Test-based strategy

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive swab specimens collected ≥24 hours apart (total of two negative specimens)

Symptom-based strategy

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and**

* Improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
* At least 10 days have passed *since symptoms first appeared*

Residents with laboratory confirmed COVID 19 who have not had any symptoms should remain in Transmission-based Precautions until either:

Test-based strategy

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive specimens collected ≥24 hours apart (total of two negative specimens).
- Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Time-based strategy

* 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

- Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Discontinuation of Empiric Transmission Based precautions for residents suspected of having COVID-19

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 patient can be made based upon having negative results from at least one FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARSCoV-2 RNA.

- If a higher level of clinical suspicion for COVID-19 exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.
- If a patient suspected of having COVID-19 is never tested, the decision to discontinue Transmission-Based Precautions can be made based upon using the *symptom-based strategy* described above.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Discharge of residents with COVID-19 from a healthcare facility:

Patients should be discharged from the healthcare facility whenever clinically indicated

If discharged to home: Facility will provide discharge instructions at time of discharge

- Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions.

- The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations.
- Guidance on implementing home care of persons who do not require hospitalization and the discontinuation of home isolation for persons with COVID-19 is available.

If discharged to a skilled-nursing facility or other long-term care facility (e.g., personal care home, assisted living facility) AND

- **Transmission-Based Precautions *are still required***, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.

- **Transmission-Based Precautions *have been discontinued***, but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room ideally with a dedicated bathroom, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline. Note that these restrictions may already be in place for the entire facility; however, as the COVID-19 response in the Commonwealth evolves, this may not be the case. In that event, these restrictions would apply as described here for the individual resident.

- **Transmission-Based Precautions *have been discontinued*** and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

For skilled nursing facilities and other long-term care facilities: Discontinuing "exposed" or: "affected" status for a unit or facility

To declare a unit or facility that has housed COVID-19-positive residents unaffected by COVID-19, **all** of the following conditions must apply:

- All residents on the unit who were confirmed or probable cases of COVID-19 must have met the criteria for discontinuation of transmission-based precautions
- A minimum of 14 days has passed since the date of symptom onset for the last clinical case
- A minimum of 14 days has passed since the implementation of transmission-based precautions for COVID-19 and other infection prevention and control interventions for COVID19
- All residents who were not confirmed or probable cases of COVID-19 remain asymptomatic
- All staff remain asymptomatic or have met return-to-work criteria
- No additional or ongoing exposures have occurred (e.g. through exposure infectious healthcare workers)

	Personal Protective Equipment (PPE) NY			C IC- 7d
Dept:	Clinical Operations	**New Revised X**	**Last Date Revised:**	7/9/2020
			Prev. Date Revised:	4/17/2020, 5/6/20
			Creation Date:	3-24-2020
RELATED FORMS:	CDC/Federal/State/Local Dept of Health Guidelines/Guidance			

Policy:
Personal protective equipment appropriate to specific task/isolation requirements is available at all times. In lieu of an outbreak (outbreak, epidemic, pandemic) affecting health care workers, the Facility will follow guidance from the Federal/State/Local Health Departments established for conservation and use of Personal Protective Equipment (PPE).

Procedure:

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

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

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

a. Gowns (disposable, cloth, and/or plastic);
b. Gloves (sterile, non-sterile, heavy-duty and/or puncture-resistant);
c. Masks (surgical, N95) (Universal masking may be implemented based on State/Local DOH) and
d. Eyewear (goggles and/or face shields).

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

4. Employees/HCP should receive job-specific training on PPE and demonstrate competency with selection and proper use (e.g., putting on and removing; donning and doffing without self-contamination).

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

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

7. Contracts with multiple suppliers for PPE will be maintained to ensure adequate supply of PPE flows to each facility as needed and as available while in an active pandemic situation. The Facility will maintain a supply of PPE as required by State or Federal regulation.

COVID -19

1. Universal masking of all persons entering Facility; follow CDC guidance for PPE use and Conservation.

2. As community transmission intensifies within a region, residents should wear facemasks or cloth face covering when leaving their room. Resident may remove face covering when in their room, but should put them back on when others enter room or place a Kleenex covering their mouth. Facemasks should not be placed on anyone who has trouble breathing, unconscious, incapacitated or otherwise unable to remove mask without assistance.

3. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown. Facemasks, if available, should be reserved for HCP. For visitors and residents, a cloth face covering may be appropriate. If a visitor/resident arrives at the facility without a cloth mask, a facemask may be given to them for source control if supplies are available. For staff that are not in direct care contact with residents (administrative staff) a cloth face covering would be acceptable

4. Cloth face coverings can become saturated with respiratory secretions, care should be taken to prevent self-contamination. They should be changed if they become soiled, damp, or hard to breathe through, laundered regularly (e.g., daily and when soiled), and, hand hygiene should be performed immediately before and after any contact with the cloth face covering.

5. Facilities should also provide training about when, how, and where cloth face coverings can be used

(e.g., frequency of laundering, guidance on when to replace, circumstances when they can be worn in the facility, importance of hand hygiene to prevent contamination).

6. Confirmed cases of COVID -19, HCP providing direct care should wear full PPE, including N95 masks; follow CDC guidelines for PPE use and conservation.

7. HCP not providing direct care for residents with COVID -19 should wear regular face masks

8. Symptomatic residents (respiratory) should wear a face mask during direct care, if tolerated or unless they meet exceptions identified in policy #2 above.

9. If shared HCP working between wings/units is unavoidable, then HCP should change PPE and perform hand hygiene when moving between affected wings/units and wings/units believed to be unaffected; follow CDC guidance for PPE use and conservation. If HCP is working on

   a unit/wing where both affected and unaffected residents are mixed, then PPE must be changed between affected and unaffected residents. CDC guidance for PPE use and conservation should be followed.

10. Facilities should attempt to maintain a COVID affected unit separate from unaffected residents if possible. Facilities should also attempt, if possible, to designate specific HCP for providing care to those positive with COVID 19.

11. Facilities should designate a unit/wing where admissions and readmissions are placed for monitoring. If unable to designate a separate floor from the COVID 19 residents then residents should be separated within that unit/wing, i. e. front end of hall versus back end of hall.

12. Facilities should follow CDC guidelines for conservation and use of PPE based on conventional, contingency and crisis scenarios.

13. The facility's preferred policy for conservation of PPE in a contingency or crisis scenario is:
    a. Extended use of masks, (surgical and N95 or other respirator masks approved for use).
    b. Protective eyewear/face shields (disposable or reusable) Follow CDC guidelines for conservation and use.
    c. A designated isolation gown is provided for the HCP. If HCP interacts with more than 1 resident known to be infected with the same infectious disease (COVID 19), the HCP can wear the same gown when residents are housed in the same location.
    d. For conservation of isolation gowns, the HCP may wear a cloth gown over the isolation gown. If the cloth gown or isolation gown become visibly soiled during care then they should be disposed of or laundered.
    e. For conservation, in addition to use of a cloth gown over an isolation gown, HCP should wear disposable sleeves over the isolation gown. This protects the sleeves of the isolation gown from becoming contaminated due to the short sleeves on the cloth gown.
    f. Cloth gowns and sleeves should be disposed of or laundered when exiting the resident's room.

Section 3

QUARANTINE/ COHORTING RESIDENTS (RED, YELLOW GREEN ZONES)

Staffing

Identify the initial and potential minimum staffing necessary if/when worst case scenario occurs.

Try to establish dedicated staff even if it is only one person out of several. This will allow for better continuity of care and services through the outbreak (like an Incident Commander for the unit)

Train, train and then train again on the use of PPE that is expected when in the unit. Below is the minimum expectation of CMS:

- For a resident with known or suspected COVID-19: staff must wear gloves, gown, eye protection and an N95 or higher-level respirator, if available. A facemask is an acceptable alternative if a respirator is not available. Additionally, if there are COVID-19 cases in the facility or sustained community transmission, staff must implement universal use of facemasks while in the facility (based on availability). When COVID-19 is identified in the facility, staff must wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).

Minimize staff permitted to work on the Exposed/Red Zone area if facility is able to do so.

When possible, and prior to unit establishment, move any resident to an area of the facility which does not have virus concerns. (Green Zone)

Residents who are virus free but are being monitored for the virus (i.e. new admissions) will be housed in a separate area of the facility if possible. (Yellow zone)

Encourage resident activities such as telephone, Face time, social media and “window sessions’ to sustain engagement. If able to do “window sessions”, add room numbers to the outside windows so the room can be located for such visits.

Communicate updates with your staff and families.

Resident Care Equipment

Dedicate or obtain Medication and Treatment carts which will remain in the Red Zone Units.

Dedicate or obtain devices such as lifts, transfer equipment, laundry carts, linen storage cart, trash barrels, housekeeping cart, etc. All of these items will remain on or within the unit.

Consider dedicated therapy and activities items for the unit

Check List for the Separation-Quarantine Zone

Vestibule - Quarantine Zone

- ☐ Table/cart for supplies
- ☐ 60% or greater alcohol-based hand sanitizer
- ☐ Masks, clothing protectors, eye protection, gloves of multiple sizes
- ☐ shoe covers, surgical caps if available and necessary
- ☐ Log for signing into the COVID-19 designated area with pen
- ☐ Anti-viral Wipes
- ☐ Sign with reminders of proper PPE usage

Within the Zone:

- ☐ Covered can for trash
- ☐ Covered can for linen
- ☐ Table/cart for supplies
- ☐ Covered container for equipment that needs to be cleaned for reuse
- ☐ Wipes for equipment and staff shoes
- ☐ Disinfecting spray
- ☐ 60% or greater alcohol-based hand sanitizer
- ☐ Extra trash bags
- ☐ Med/treatment cart OR tackle box with a lock
- ☐ Vital sign machine if available
- ☐ Crash cart – kept near the outside of the zone
- ☐ Housekeeping cart with mop, broom, dustpan
- ☐ Office supplies – pens, highlighters, paper
- ☐ Clean Linen cart
- ☐ Clean supply area/cart
- ☐ Cooler for Ice and water
- ☐ Clothes line and close pins or other means of hanging PPE

Policy: Pandemic (COVID 19) Red Zone/Exposed Zone	
Date:	E Tag – E-007

A specific wing/unit/floor may be designated if able to maintain precautions. A room should be designated to don and doff PPE and disinfect as soon as possible when leaving the designated area.

ESTABLISHING

- Dedicated staff, when possible, will be assigned to the Red Zone.
- Staff will limit personal items taken into the zone. Limit jewelry, pens, stethoscopes, personal food or drinks, etc.
- 60% or greater alcohol-based hand sanitizer should be available at the entry/exit
- Signs to be clearly posted regarding
    - PPE
- Limited access to necessary staff only
- Needed supplies should be gathered and taken with staff into the Zone area
- Hands should be cleaned before entering; wash with soap and water or 60% or greater alcohol-based hand sanitizer
- PPE should be applied appropriately: clothing covers, mask, eye protectant, gloves
- All equipment should be hung on clothes lines with clothes pins to air out or other methods to hang items. If an item is soiled or damaged it should be discarded appropriately.
- Gloves and clothing coverings are to be removed and placed in proper receptacles
- N95 masks will remain on the individual wearing and not removed until leaving the unit
- Wash hands with soap and water or use 60% alcohol-based hand sanitizer
- After passing through the Red Zone, hands will be sanitized again

RESTOCKING

- A list of needed supplies will be communicated to the IC. The IC will designate an area that supplies can be gathered near the entrance of the Red Zone area for restocking
- PPE supplies are to be checked every shift for availability and replenished as needed
- Staging room to be checked every shift and dirty linen and trash will be removed and new bags placed
- Staging room bin of equipment that needs to be cleaned for reuse will be removed at end of shift and cleaned. Cleaned items will be placed in clean supply area to be used.
- The nurse will compile a list of items needed prior to end of shift and communicate to designee to gather supplies for next shift.
- Clean linen will be delivered to the staging room in plastic bags for restocking of the cart outside the Red Zone area.

PROCESS FOR FOOD/WATER DELIVERY

- Dietary will deliver meal/s to the area on a dietary cart and notify nursing staff that meals have arrived. Ensure appropriate condiments are on the trays.
- Each meal tray is to be passed through the Red Zone by staff with the cart remaining on the outside to a cart that is inside the zone. Care will be taken to not touch the plastic walls or the other staff member. Delivery staff member should then perform hand hygiene before leaving the area. Residents will be served on disposable paper products. All disposable paper products will be disposed of on the unit.
- The reverse process will be used after the meal and trays are collected.
- The dietary cart will be returned to the kitchen and dishes cleaned as normally done.
- Cart will be cleaned and disinfected in kitchen.
- A separate Ice Chest may be brought into the unit. Ice will be brought to the unit and transferred to the dedicated ice chest to ensure residents will receive ice water each shift or more frequently as requested.

LINEN AND TRASH

- All dirty linen will be placed in a plastic bag. Roll the bag edges to create an opening.
  - Roll dirty linen, outside to inside, being careful to not shake linen, and place inside the bag. Unroll the bag and tie closed.
  - Bag of linen will be removed from rooms to be placed in a covered, no-touch dirty linen container in the dirty room.
  - When the linen container is full but not overflowing, the bag will be tied closed, removed from the container, and placed into a covered dirty linen container to be taken to laundry for processing.
  - Trash will be removed from rooms in tied bags and placed in the covered, no-touch trash container in the dirty room.
  - When the trash container is full but not overflowing, the bag will be tied closed, removed from the container, placed into a covered dirty trash container to be taken out to the dumpster. All trash and dirty linens will be removed from the unit and taken to the dumpster or the laundry room.

Section 4

Screening Conduct

Policy: Security and Safety – Lockdown	
Date:	E Tag – E-0013, E-0015

Premier Genesee emergency management plans include security strategies. The Incident Commander will assign, as necessary, a security manager who will be responsible for maintaining facility security during an emergency event. Staff may be able to help in watching over facility resources and security. This may be as simple as assisting in making rounds, alerting Incident Management team to areas of concern, and reporting unknown persons on the premises. Reinforce security protocols with staff to ensure that only authorized people are in the nursing home.

Security measures will help protect the facility and its residents and staff during a disaster when, due to emergency generator support requirements, the facility is probably one of few buildings with light, food, water and medical supplies. It is important to coordinate security needs during a disaster with local law enforcement agencies and at time the facility may hire additional security staff by appropriate agencies.

Upon activation of the facility's' emergency management plan, security staff may be initiated and often assigned as appropriate to all unlocked entrances and exits, as necessary. Ideally, have a central reception center where everyone arriving at the facility checks in. The entrance to the facility should be restricted to personnel bearing staff identification cards, staff from affiliated facilities, family members of staff as indicated in the plan, approved volunteers, state authorities, and to residents. Where feasible, use photo identifications or other means to assure positive identification. Family members may want to check on their loved ones with a personal visit; make sure they are signed in, wear a badge, and do not disrupt disaster management activities.

Policy

The incident commander will determine with the IMT when it would be necessary to have a facility LOCKDOWN. The incident commander will initiate the lockdown procedures with Security/ Safety Officer and identifying which doors will be locked down and which will remain in use. The security officer will see to it that each exit door which is to be locked down is completed. At no time will locking of any door impede the egress OUT of the facility. Lockdown refers to ENTERING the facility. The Incident Commander will normally establish a single entrance for the facility and only allow authorized individuals to enter the facility. The Incident Commander will make a facility announcement regarding the lockdown and any direction necessary for all individuals.

COVID-19 Screening procedures

- Staff will be screened upon arriving at work. A screener will complete the screen questions and take employee temperatures prior to start of shift and at the end of the work shift, if an employee works more than 12 hours they will be rescreened again at that point.
- If the employee has a temperature of 100.0 degrees or higher, they are not permitted to work. The employee will speak to the IC immediately who will give directions to the employee on further actions.
- If the employee answers yes to any of the signs and symptoms at the top of the screening tool or having been in the presence of an individual suspected or confirmed positive for COVID-19 or other infectious diseases they will be required to wear a mask and speak to the IC immediately who will give directions to the employee on further actions.
- Facility's single entrance and screening station will include screening log, pens, thermometer, 60% or greater alcohol-based hand sanitizer and additional PPE as necessary. Screens must be collected for all staff and visitors when they enter the facility and maintained for up to 12 months.
- Thermometers will be disinfected with alcohol wipes between users.
- Signage present at door will remind all to cover cough, hand wash, no visitors and stop for screening
- Hand sanitizer will be available upon entry
- At any time during a shift and if an employee feels ill, they should immediately notify their supervisor and/or the IC who will take the employee temperature. The IC will follow the procedure outlined above.

This guidance is based on available information and subject to change as additional information becomes available.

Policy: COVID-19 Employee/Visitor Screening	
Date:	E Tag – E-0015

Employee Screening Tool (Sample - Subject to Change)

Date of Screening_____ Time of Screening _____
Name: _____ Position_____ Agency Name_____

Have you traveled by plane or cruise ship within and/or outside the United States in the last 14 days?	If YES, please indicate details: Level 3 travel areas are restricted.
Have you traveled to any of the States in USA where Governor Cuomo has ordered 14-day quarantine upon return? **STAFF- must notify your supervisor immediately.** If YES, where & when _____. Immediate testing required upon return to work, if screen positive, no entry to facility. Date/time testing completed _____ Direct care Staff will wear full PPE with N95 mask, Non direct care staff will wear N95 mask until test results received	☐ **Alabama** ☐ **Alaska** ☐ **Florida** ☐ **Mississippi** ☐ **Puerto Rico** ☐ **Montana** ☐ **Indiana** ☐ **Minnesota** ☐ **Arkansas** ☐ **Georgia** ☐ **Nevada** ☐ **Kentucky** ☐ **Iowa** ☐ **North Carolina** ☐ **Illinois** ☐ **California** ☐ **Louisiana** ☐ **South Carolina** ☐ **Tennessee** ☐ **Texas** ☐ **Utah** ☐ **Missouri** ☐ **Oklahoma** ☐ **Idaho** ☐ **Kansas** ☐ **Hawaii** ☐ **Nebraska** ☐ **South Dakota** ☐ **Wisconsin** ☐ **North Dakota** ☐ **Virginia** ☐ **U.S. Virgin Islands** ☐ **Guam**
Fever (>100F) or history of fever in the last 14 days? ☐	Please indicate temperature and/or history: Shift Sign in_____ 12-hour shift sign in _____
Sore throat Cough Shortness of breath/difficulty breathing Chills Chills with repeated shaking Muscle pain Headache New loss of taste or smell Malaise Diarrhea	☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO**
Contact with a person with confirmed or under investigation of coronavirus (COVID-19) within the last 14 days?	IF YES PLEASE INDICATE DETAILS AND RESTRICT FROM ENTERING UNTIL AFTER INVESTIGATION OF DETAILS.
Have you worked in another facility where there are/were residents identified with COVID 19?	IF YES PROVIDE DETAILS AND RESTRICT FROM ENTERING UNTIL AFTER INVESTIGATION OF DETAILS.
Education and /or Materials provided regarding facemask or cloth face covering. Hand hygiene education in reference to adjusting or touching facemasks and cloth face covering.	HAND HYGIENE OBSERVED, individual needs to wash their hands or use alcohol-based hand rub on entry, was this done _____

Visitor Screening Tool (Sample - Subject to Change)

Date of Screening__/___/2020 Time of Screening: _____
Visitor full name: _____ Physical Address of Visitor _____ Contact Phone Number: _____ Email Address of Visitor if available: _____

Have you traveled by plane or cruise ship within and/or outside the United States in the last 14 days?	If YES, please indicate details: Level 3 travel areas are restricted.
Have you traveled to any of the States in USA where Governor Cuomo has ordered 14-day quarantine upon return? If YES, where _____. When did you return, _____ After your 14-day self-quarantine you will be able to set up a scheduled visit if your screening is without concerns	☐ **Alabama** ☐ **Alaska** ☐ **Florida** ☐ **Mississippi** ☐ **Illinois** ☐ **Arkansas** ☐ **Georgia** ☐ **Nevada** ☐ **Wisconsin** ☐ **Iowa** ☐ **North Carolina** ☐ **Indiana** ☐ **California** ☐ **Louisiana** ☐ **South Carolina** ☐ **Missouri** ☐ **Puerto Rico** ☐ **Tennessee** ☐ **Texas** ☐ **Utah** ☐ **Nebraska** ☐ **Kentucky** ☐ **Montana** ☐ **Oklahoma** ☐ **Idaho** ☐ **North Dakota** ☐ **Virginia** ☐ **Kansas** ☐ **Hawaii** ☐ **South Dakota** ☐ **U.S. Virgin Islands** ☐ **Minnesota** ☐ **Guam**
Fever (>100F) or history of fever in the last 14 days?	Please indicate temperature and/or history: **Temperature prior to visit**: _____
Sore throat Cough Shortness of breath Chills Chills with repeated shaking Muscle pain Headache New loss of taste or smell Malaise (illness) Diarrhea	☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO**
Contact with a person with confirmed or under investigation of coronavirus (COVID-19) within the last 14 days?	IF YES PLEASE INDICATE DETAILS AND RESTRICT FROM ENTERING UNTIL AFTER INVESTIGATION OF DETAILS.
Have you been in a community or family setting where there are/were individuals identified with COVID 19?	IF YES PROVIDE DETAILS AND RESTRICT FROM ENTERING UNTIL AFTER INVESTIGATION OF DETAILS.
Education and /or Materials provided regarding facemask or cloth face covering. Hand hygiene education in reference to adjusting or touching facemasks and cloth face covering.	**HAND HYGIENE OBSERVED, individual needs to wash their hands o use alcohol-based hand rub on entry, was this done** **_____**

This individual (Visitor) has cleared the screening process for Temperature and questions for Covid-19 screening
Employee signature: _____

Pandemic additional policies- Return to Work Guidelines

	Pandemic (COVID 19) Quarantine/Return to Work for HCP			C IC 28a
Dept:	CLINCIAL AND ADMINISTRATIVE 4 pages	**New Revised X**	**Last Date Revised:**	5-11-2020
			Prev. Date Revised:	4-22-2020
			Creation Date:	3-19-2020

This guidance is based on available information about COVID-19 and subject to change as additional information becomes available.

Policy

The facility will follow guidance released by the CDC or State Department of Health for return to work for healthcare personnel with confirmed or suspected COVID-19 or infectious disease symptomatic and asymptomatic.

A healthcare personnel (HCP) is defined as anyone who has direct and/or in-direct contact.

Process:

Decisions about return to work for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom–based (time since illness onset and time since recovery strategy), a test-based strategy or a time-based strategy for persons who did not develop symptoms.

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19

Symptomatic HCP With Suspected or Confirmed COVID-19

Test-based strategy, Exclude From Work Until:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) [1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).
- All test results should be final before isolation is ended. Testing guidance is based upon Limited information and is subject to changes as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract (nasopharyngeal swab) Specimens.

Symptom-based Strategy, Exclude From Work Until:

- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath, **and**
- At least 14 days have passed since symptoms first appeared.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms: Either strategy is acceptable depending on local circumstances:

Time Based Strategy, Exclude From Work Until:

- 14 days have passed since the date of their first positive COVID-19 diagnostic test assuming they Have not subsequently developed symptoms since their positive test.
- If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used.
- Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after Their first positive test.

Test- based Strategy, Exclude From Work Until:

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours Apart (total of two negative specimens).
- Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in The course of their illness. There have been reports of prolonged detection of RNA without direct Correlation to viral culture.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.
If HCP had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the healthcare facility
    - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
    - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen
- Ensure that recovered HCW wear all indicated PPE according to facility policy. The immunity of recovered persons to COVID-19 infection is not known, and a lack of proper PPE could expose HCP to other communicable diseases.

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. As the COVID-19 pandemic progresses, staffing shortages occur due to HCP exposures, illness, and need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above.

If there are no longer enough staff to provide safe patient care, and other contingency capacity strategies have been exhausted (see CDC strategies), healthcare facilities and employers may need to implement crisis capacity strategies to continue to provide patient care.

Under **crisis capacity strategies**, HCP who have recovered from COVID-19, and are well enough to work, are permitted to return to work before meeting above criteria. Such HCP should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:

1. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
2. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
3. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
4. As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients ***without*** suspected or confirmed COVID-19.

If HCP are permitted to return to work before meeting all return to work criteria, they should still adhere to all Return to Work Practices and Work Restrictions recommendations described above. Feeling well enough to work is a decision that can only be made by the HCP, understanding that their regular duties are likely to be physically demanding. If agreeable to all parties, consider shortened shifts or extra breaks for HCP who feel well enough to work, but have not fully recovered from illness.

Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for more information.

Footnotes

[1]All test results should be final before isolation is ended. Testing guidance is based upon limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract (nasopharyngeal swab) specimens.

Definitions

Cloth face covering: Textile (cloth) cover that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE and it is uncertain whether cloth face coverings protect the wearer.** Guidance on design, use, and maintenance of cloth face coverings is available.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

Resident Screening/Referrals

- Admissions Liaison to request the hospital's completed COVID-19 screen be sent with each resident
- All screens must receive a negative test prior to admission
- Facility to complete the resident screen:
    - With all new admissions
    - With all readmissions,
    - With all LOAs (dialysis, appointments, home visits, ANY time resident leaves and returns to the building)
    - Daily, providing no suspected cases are in the facility
- Educate Resident to notify staff with any new onset symptoms or changes if able
- All screens need to have the residents name and date and be kept in the facility for 12 months in a secure area
- During the pandemic, residents may be asked to remain in rooms, masks should be worn whenever they must leave the room
- Any resident leaving the facility, excluding discharges home, will have a mask placed prior to leaving facility. Examples: dialysis, ED, appointments, etc.

When COVID-19 is suspected at the facility, complete the following:

- Apply a mask to the resident
- Move the resident to the facility's designated COVID-19 Exposed/Red Zone
- Begin COVID-19 precautions per the residents' attending physician and or medical director
- Follow COVID-19 precautions for the roommate for 14 days.
- Notify physician and get an order for COVID-19 precautions and treatment
- Notify family/responsible party within 24 hours of the test result
- Notify Key Management Personnel
- If a resident in the facility is suspected of COVID-19 due to meeting the criteria on the screen, symptom monitoring and vital signs should be completed at least q shift.
- Utilize consistent staff as able to limit exposure
- Continue COVID-19 precautions based on CDC/CMS guidance for discontinuing transmission-based precautions...
- Update COVID-19 Care Plan and care card as needed

Policy: COVID-19 Resident Confirmed Positive	
Date:	E-0015

The testing of COVID-19 for nursing facilities is completed by various labs. When notified of a positive test the facility should, if not completed previously:

The IC will be in contact with the local Health Department and State Health Department to report positive findings as required by CDC/CMS guidance.

- Immediately apply mask to affected resident
- Move resident to facility designated COVID-19 Red Zone area.
- Initiate COVID-19 precautions, ex: mask, gowns, eye protection and gloves when within 6' and providing care and services.
- Notify physician and/or Medical Directors for any additional orders for COVID-19
- Notify family/responsible party within 24 hours of the test
- The Nursing Supervisor will notify the Incident Commander (Administrator) and DON.
- IC will notify key management personnel
- Utilize designated staff as practicable
- Continue COVID-19 precautions until resident meets guidelines from CDC/CMS for discontinuation of transmission-based precautions.
- Notify all Residents and Responsible parties of the additional positive case by the end of the following day.

Policy: COVID-19 Transfer to Hospital	
Date:	E Tag – E-007

Policy
The facility policy is to abide by all individual code statuses. The facility's goal is to shelter and treat in place, provided facility is able to administer the level of care needed.

Procedure
Ensure that all residents' code statuses are current and documented in the resident's medical record.

If resident has COVID-19 signs and symptoms, increasing in severity and requires a higher level of care than that the facility can provide, the MD/CNP will be contacted for further orders.

- Notify physician and get an order for COVID-19 precautions and treatment
- Contact accepting hospital and notify of signs and symptoms of suspected or confirmed COVID-19 and provide current status of resident
- Contact EMS and notify of signs and symptoms of suspected or confirmed COVID-19 and provide current status of resident
- Screen EMS staff upon arrival
- Resident to be masked, isolated in room with door closed until EMS arrival
- Send all required transfer forms and communications with resident
- Notify family/responsible party
- Notify Key Management Personnel

Policy: COVID-19 Inter-facility Transfer for Suspected or Positive test	
Date:	E Tag – E-007

Procedure
Coordinate transfer with members of the Regional support team or local health department if needed.

If permitted:

- Obtain order from Physician or Nurse Practitioner for transfer
- Contact accepting center and notify of diagnosis and current status
- Contact EMS/Transportation Company, notify of current status
- Screen EMS/Transportation staff or family upon arrival
- Resident isolation to be maintained until transported
- Resident to be masked prior to leaving the room
- Send all required transfer forms and communications with resident

Policy: COVID-19 Visitors- Vendors - Others	
Date:	E-0015

Policy

We must ensure to provide a clean and safe living environment for each resident and staff member in our care. As a result, we will continue to update our Facility's COVID-19 (Coronavirus) policies with the most current recommendations shared by the New York Department of Health, the Centers for Medicare & Medicaid Services (CMS) and the Center for Disease Control (CDC).

Procedure

CMS has updated the QSO notice 20-14-NH and all facilities will cease allowing visitors (except in end-of life circumstances) and non-essential staff/vendors from entering the facility.

Any individual entering facility including ALL staff, visitors, vendors, contractors etc., including X-ray techs, lab staff, hospice care staff, therapists, dietitians, ambulance staff, etc., who are at the facility based on the resident's plan of care are permitted to enter facility providing the following screening is completed:

- Have you been experiencing any signs and symptoms of COVID-19 including, fever greater than 100.0 degrees, cough, shortness of breath, and/or aches and pains?
- Have been exposed to anyone positive for COVID-19?
- Have temperature taken and recorded.
- Ensure that individual is offered alcohol-based hand sanitizer.

Anyone entering the facility is required to wear a mask and, as appropriate, additional PPE. Encourage visitors to practice social distancing without touching, hugging or kissing resident.

Deliveries:

- Delivery personnel requiring entry into the building must be screened, according to guidelines set above. Deliveries should be completed quickly, and facility staff should limit interaction with delivery personnel. Where possible, deliveries could be left outdoors for facility staff to retrieve.
- Vendors are to leave deliveries at the door unless otherwise directed by facility.
- Vendors that deliver to the back door must also be screened

Section 5

Staffing

Policy: Pandemic (COVID 19) Staffing	
Date:	E Tag – E-0013, E-0015

In emergencies, staffing is normally critical. Premier Genesee will normally use its staff in emergencies and may at time need to use alternate staffing arrangements in the event that normal shift changes becomes a challenge to maintain.

The Incident Management Team members will meet and report their current and forecasted staffing needs. Team members will assemble and review their department staff responsibilities and identify within each department the individual responsible for transmitting information to the department staff and how the Incident Commander and/or the Planning Officer may assist in providing situational reports to other members of the Command Team.

Information to be transmitted to staff over the course of the emergency event:

- Status of facility's condition in terms of structural integrity
- Status and location of resources staff needs to do their job (food, water, linen, medications, etc.)
- Position-specific instructions
- Evacuation vs. sheltering-in-place
- What administration is doing to achieve normalcy in operations
- What extra tasks staff can be doing to help like checking on fellow staff members

The Logistics Section Chief or, if assigned, the Staffing/Scheduling Unit Leader will provide an updated employee contact roster and will work across departments to initiate call-back procedures. The call-back procedure is how staff is informed of pending threats and the return-to-work requirements.

Include any special notifications or instructions:

- Notification provided to staff to return to duty
- Status and nature of emergency event
- Who to report to during your shift
- Assignment upon return
- Special instructions
- Bringing an extra change of clothes
- Food and snacks
- Identify a person within their department who will function as a liaison with or is a member of the Command Team and how that translates to the dissemination of information and rumor control

Staff Augmentation

Under some situations, regular staff may be unable to return to work when called back, especially when illness or injury is involved, roads are flooded, or there is no access to fuel. As a planning assumption, the nursing home will need to be prepared to locate additional qualified temporary personnel to fill gaps in staff coverage.

Personnel may be obtained from:

- Sister facilities in the same state (preferred)
- Sister facilities from out of state (seek regulatory approval)
- Temporary staffing agency (select a familiar organization with criminal history screening standards)
- Emergency nursing staffing programs (contact the appropriate oversight agency for guidance and assistance in accessing volunteers from out of state)

Pandemic Update for Staffing Plan

Department	Plan	Implementation notes
Nursing	- Remove tasks from nursing staff that can be done by non-licensed staff such as answering call lights, water pitcher pass, etc. - Pull all certified and licensed staff to the floor if in crisis mode. This includes nurse management, MDS, staffing, wound nurse, etc. - Posted a sign-up sheet asking for volunteers to work in Pandemic isolation wing. - Offer on-site housing, meals and hazard pay. - Continue to interview and hire. These could be done remotely or by telephone.	
Housekeeping and Laundry	- As necessary, focus on linens and less on personal laundry - It is critical to be cleaning the facility top to bottom. Increase staffing to accomplish this task. - Central supply clerk must monitor cleaning supply usage and ordering	
Dining Services	- Focus on easily prepared foods such as soups, sandwiches, premade items	
Therapy	- Focus on assistance with care rather than rehabilitation in crisis mode	

	- Therapist may be asked to work as aide if and when caseload dwindles	
Administration	- Administrator must serve as Incident Commander. - IC will review work assignments and if practicable rotate staff in-out and allow to work from home such as HR, BOM, Dietitian, etc. - IC must monitor resident care – resident temperature and sign/symptoms log. - IC works closely with the Medical Director and if/when Pandemic tests/ positives with County Health Department Officials. - IC must instill urgency but calmness in crisis and remember it's all hands on deck. No one is too good and 'not my job' will not be tolerated. IC will oversee all Pandemic operations while the Operations Chief (director of nursing) will staff the facility. - IC will assign crisis tasks as necessary and remember to discontinue non-life sustaining tasks and focus on resident care and staff support. - IC will frequently in-service and be transparent and report updates - IC will prepare to feed staff - IC will issue essential worker letters	
All	- With no cases all staff must wear surgical masks - With cases all staff at all times are only permitted to wear N95 masks on the designated unit or room. - All residents should remain in their rooms - Therapy and activities will be in the resident rooms - Screening staff prior to shift has taken place since the week of _____. - Visitors such as hospice and family of residents actively dying must be screened and provided PPE	

Section 6

COVID-19 Additional Policies and Procedures

Policy: COVID-19 Interim Infection Prevention and Control PPE Use and Conservation	
Date:	E Tag – E-0015

Policy
This guidance has been updated based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering face piece respirators (FFRs) (commonly known as N95 respirators), and gowns. (CDC, March 27, 2020).

Procedures
Measures recommended by the Centers for Disease Control (CDC) have been implemented in each facility to limit the spread and transmission of COVID-19 and to protect the workers within each facility before implementation of “surge capacity” measures.

This policy provides guidelines based upon CDC recommendations for interim conservation and reuse of Personal Protective Equipment (PPE), standard infection control and transmission-based protocols to prevent and limit the spread of infectious disease.

Controlling exposures to occupational hazards is a fundamental way to protect personnel. Conventionally, a hierarchy has been used to achieve feasible and effective controls. Multiple control strategies can be implemented concurrently and or sequentially. This hierarchy can be represented as follows:

- Elimination
- Substitution
- Engineering controls
- Administrative controls
- Personal Protective Equipment (PPE)

The following strategies will be implemented to optimize the supply of PPE if supplies are low or additional supplies are unavailable and the facility has reached “surge capacity”. This refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of N95 respirators during the COVID-19 response.

Implement extended use of eye protection.

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
    - If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below.

Reuse of Eye Protection:

- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- Health care provider (HCP) should take care not to touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.
- HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.
- While wearing gloves, carefully wipe the *inside, followed by the outside* of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe.
- Carefully wipe the *outside* of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
- Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
- Fully dry (air dry or use clean absorbent towels).
- Remove gloves and perform hand hygiene.

Strategies for Optimizing the Supply of Isolation Gowns

Extended use of isolation gowns
Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as Clostridioides difficile) among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practice.

Re-use of cloth isolation gowns
Disposable gowns are not typically amenable to being doffed and re-used because the ties and fasteners typically break during doffing. Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between.

In a situation where the gown is being used as part of standard precautions to protect HCP from a splash, the risk of re-using a non-visibly soiled cloth isolation gown may be lower. However, for care of patients with suspected or confirmed COVID-19, HCP risk from re-use of cloth isolation gowns without laundering among (1) single HCP caring for multiple patients using one gown or (2) among multiple HCP sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCP and not necessarily prevent transmission between patients. Any gown that becomes visibly soiled during patient care should be disposed of and cleaned.

Prioritize gowns
Gowns should be prioritized for the following activities:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:
    - Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

Surgical gowns should be prioritized for surgical and other sterile procedures. Facilities may consider suspending use of gowns for endemic multidrug resistant organisms (e.g., MRSA, VRE, ESBL-producing organisms).

Strategies for Optimizing the Supply of Facemasks

Implement limited re-use of facemasks

Limited re-use of facemasks is the practice of using the same facemask by one HCP for multiple encounters with different patients but removing it after each encounter. As it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, care should be taken to ensure that HCP do not touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- Not all facemasks can be re-used.
    - Facemasks that fasten to the provider via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.
    - Facemasks with elastic ear hooks may be more suitable for re-use.
- HCP should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

Prioritize facemasks for selected activities such as:

- For provision of essential surgeries and procedures
- During care activities where splashes and sprays are anticipated
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable
- For performing aerosol generating procedures, if respirators are no longer available

HCP use of homemade masks:
In settings where facemasks are not available, HCP might use homemade masks (e.g., bandana, scarf, handmade) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.

Use of N-95 Mask/respirators
Personal Protective Equipment and Respiratory Protection should be used as part of a suite of strategies to protect personnel, complementing the use of engineering and administrative controls as needed.

Use surgical N95 respirators only for HCP who need protection from both airborne and fluid hazards (e.g., splashes, sprays). If needed but unavailable, use face shield over standard N95 respirator. Use alternatives to N95 respirators where feasible e.g., other disposable filtering face piece respirators, elastomeric respirators with appropriate filters or cartridges, powered air purifying respirators

When N95 Supplies are Running Low
Use respirators approved under standards used in other countries that are similar to NIOSH-approved N95 respirators but that may not necessarily be NIOSH-approved. Implement limited re-use of N95 respirators for patients with COVID-19.

Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several patients, without removing the respirator between patient encounters. Extended use may be implemented when multiple patients are infected with the same respiratory pathogen and patients are placed together in dedicated waiting rooms or hospital wards. Extended use has been recommended as an option for conserving respirators during previous respiratory pathogen outbreaks and pandemics.

Reuse refers to the practice of using the same N95 respirator for multiple encounters with patients but removing it ('doffing') after each encounter. The respirator is stored in between encounters to be put on again ('donned') prior to the next encounter with a patient. For pathogens in which contact transmission (e.g., fomites) is not a concern, non-emergency reuse has been practiced for decades. Even when N95 respirator reuse is practiced or recommended, restrictions are in place which limit the number of times the same FFR is re-used. Thus, N95 respirator reuse is often referred to as "limited reuse". Limited reuse has been recommended and widely used as an option for conserving respirators during previous respiratory pathogen outbreaks and pandemics.

Policy: Staff – Activities – Pandemic (COVID 19)	
Date:	E Tag – E-0013, E-0015

Policy
It is the objective of the facility to maintain resident engagement and activities during the Pandemic outbreak.

Procedures
All individuals are recommended to maintain a 'social distance' of 6 feet from others. The facility encourages this behavior and will implement as possible.
The activity department will limit 'group' activities to no more than 6 individuals provided they can maintain the suggested 6 feet of social distancing.
There will be no external volunteers such as artists, pastors, musicians, etc.

- There will be a focus on individual activities which will including visitation, conversation and assistance with communications with family/friends
    - Skype & Face Time
    - Social Media
    - Telephone
    - Mailings
    - Email

- Circulate an activities cart to offer residents alternative activity supplies
- Activities staff are expected to clean activity supplies and materials as possible between resident uses.
- Activity staff are expected to follow proper hand hygiene when making physical contact with residents by washing with soap and water for 20 seconds or more or using 60% or greater alcohol-based hand sanitizer
- Activity staff should disinfect identified activity areas between each resident event as possible.
- Update Care Plan and care card as needed
- Meet with Resident Council President as much as possible
- No food or drink shall be provided during the 'group 'activity

Policy: Pandemic (COVID 19) Dietary	
Date:	E Tag – E-001

- Dietitian can in most cases complete their assessment remotely or by reviewing the documentation in the resident's electronic and paper chart.

- Registered Dietitian to discuss with Interdisciplinary Team prior to entering Pandemic area to complete dietary assessment

- Registered Dietitian must be screened and wear appropriate PPE while in the facility. If required, the Registered Dietitian must limit any time on the Separation-Quarantine Zone and don appropriate PPE. The visit must be time limited to what is necessary.

- Dietary will deliver meal/s to the Exposed/Red Zone on a cart and notify nursing staff that meals have arrived. Ensure appropriate condiments are on the trays.

- Each meal tray is to be passed through the Red Zone vestibule by staff with a cart remaining in the unit and the kitchen tray cart remaining on the outside. Care will be taken to not touch the plastic walls or the other staff members. Disposable paper products will be used. All paper will be disposed of on the unit.

- Dietary staff will return to unit to retrieve cart and transport back to kitchen.

- Cart will be cleaned and disinfected in kitchen.

Policy: Pandemic (COVID 19) Crisis Use of Gowns	
Date:	E Tag – E-0015

Procedures

Use of alternative clothing coverings for health care workers will be utilized during crisis times. This can include lab coats, resident gowns, aprons with sleeves, coveralls.

- Educate staff on proper don/doff procedures of gowns
- Do not touch outer surfaces of the gown during care. If touched, wash hands with soap and water or use 60% alcohol-based hand sanitizer
- Extend use of gowns:
    - Use of the same gown by the same healthcare worker is permitted while interacting with multiple residents with the same known infectious disease
    - Cloth gowns can be untied and retied for reuse without laundering in-between, if not visibly soiled
    - Facility should install Clothes Lines with plastic clothes pins to allow for the hanging for all PPE which will allow it to air out and extend its life.
    - Gowns should be discarded is visibility soiled or damaged
- Prioritize gowns:
    - Utilize with any activities where splashes and sprays are anticipated- aerosols, etc.
    - Utilize with high contact resident care activities- bathing, linen changing, toileting assist, etc.

Policy: Pandemic (COVID 19) Crisis Strategies Face Mask Quick Guide per CDC Guidelines	
Date:	E Tag – E-007

Procedure

When there are no suspected cases of Pandemic illness in the facility, all staff should wear a surgical mask. Surgical masks should only be worn for a few days and then discarded. These are not designed to extended use. Homemade normally can be washed and reused. When there is a test for and/ or positive case of Pandemic illness, the staff will always be required to wear a N95 or greater mask. N95 masks may be used of quite a while if they are not damaged or soiled. When the N95 mask is soiled or dirty it can be sanitized by Battelle – www.battelle.com and follow the instructions for sanitization.

The IC should also do the following:

- Educate Staff on proper don/doff procedures of face masks
- Provide one face mask to each employee providing care within facility
- Remove if soiled, damaged or difficult to breathe through the mask and dispose of the mask.
- Do not touch outer surfaces of the mask during care. If touched, wash hands with soap and water or use 60% alcohol-based hand sanitizer
- When removing face mask, carefully fold so that the outer surfaces are touching to reduce contact with the storage container
- Face masks should be stored in a paper bag or breathable container labeled with staff name and stored in non-resident area
- Check the mask for tears, holes, and strap integrity before repeat use
- Mask removal and replacement must be done in a deliberate manner to reduce the risk of contamination. Wash hands with soap and water or use 60% alcohol-based hand sanitizer.

Policy: Pandemic (COVID 19) Use of Graduate Nurses	
Date:	E Tag – E-0015

- Verify the Department of Health's position on using individuals who have completed nursing school, but have yet to be tested as licensed nurses.
- These graduate nurses may perform duties of a nurse including medication pass, delegation of tasks to others as appropriate, assessments as appropriate, reporting to doctors and Nurse Practitioners and writing orders received during COVID-19 crisis.
- The individual nurse should receive a letter from their nursing school confirming their completion of education which must be provide to the facility's Human Resources Supervisor. Have the prospective nurse provide the facility with a copy of the letter from the nursing school where they completed nurses training.
- The Director of Nursing should interview and perform nursing competencies to confirm to ensure resident safety
- Verify how long these individuals are permitted to service in the Graduate Nursing capacity. All these individuals must take and pass the Nursing Licensure exam to continue serving as a nurse.

Policy: Pandemic (COVID 19) Delegation of Duties Physical, Occupational and Speech Therapy	
Date:	E Tag – E-0015

- Each facility utilizes the services of occupational, physical and speech therapist who at times may be asked to perform nursing assistant-type duties.
- Therapist may perform nursing assistant duties as permitted by law
- Therapist may perform nursing assistant duties for which they have been trained such as restorative and functional ADL and mobility maintenance services
- No therapist will be asked to perform any duty they are not competent to perform
- Perform and document routine vital signs, orthostatic BPs, etc.
- Assist in feeding moderate risk residents (history of some choking issues)
- Any other basic support duties that could also be performed by non-direct-care staff.

Policy: Pandemic (COVID 19) Therapy Services	
Date:	E Tag – E-0015

During a pandemic, therapy services are expected to continue according to the resident's plan of care. The following is expected to be implemented as applicable:

- Therapy services of concurrent and group are permitted, if the residents and therapist maintain the social distancing expectations. If these are conducted in the therapy gym, there will be no additional residents present.
- Therapy services which can be done in the resident's room are strongly encouraged. If/when there is a positive case of Pandemic illness all therapy services will be performed in the resident's room.
- No therapy services will be performed in the corridors
- In all facilities, all staff and residents are required to be wearing the appropriate face mask based on the facility's Pandemic risk factor

Section 7

Nursing Home Incident Command System

Policy: Communications: Nursing Home Incident Command	
Date:	E Tag – E-0029

The facility's response plan recognizes and adopts the Nursing Home Incident Command System. A system is an effective communication and resource management response.

INTRODUCTION

Nursing homes provide essential services that must always be protected, including those extraordinary occasions we call emergencies or disasters. Yet it is difficult to predict when an incident may occur that threatens the ability of a nursing home to safely care for its residents, staff and visitors; or conduct normal operations that maintain the facility's business viability (continuity of operations).

In 2016, the Centers for Medicare and Medicaid Services (CMS) expanded the emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers. In so doing, CMS defines an emergency or disaster as: "An event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional or national level by an authorized public official such as a Governor, the Secretary of HHS, or the President of the United States. It also includes events that can affect the facility internally."

All nursing homes should be prepared for and exhibit resiliency when faced with any type of incident, ranging from an internal emergency that affects only one facility to a large, regional disaster that simultaneously affects many healthcare facilities and the community. The Incident Command System (ICS) provides a practical, proven approach to disaster management that is an integral part of the National Incident Management System (NIMS). ICS is utilized for incident management throughout the public and private sectors.

ICS can be used by anyone who understands the basic functional requirements necessary for establishing goals and objectives to meet the operational needs of an incident. ICS become so universally adopted. The answer is because it is the most successful approach to managing emergencies/disasters (incidents) that require a coordinated response beyond typical day-to-day challenges. For some public safety agencies, ICS is routinely used daily.

In the healthcare environment nursing homes have adapted ICS to fit their specific needs, leading to the Nursing Home Incident Command System (NHICS). The adoption of these systems allows healthcare facilities to effectively integrate into the emergency management structure, and by so doing, maximize positive outcomes.

To simplify for a moment, let's consider a "disaster" to be a big problem that you didn't expect. Examples: your facility lost power and the backup generators failed; a tornado ripped away part of your building; there is an active shooter in your facility. With these situations, a number of problems are created and response priorities must be identified (as an example, it would be a priority to safely evacuate residents from a structurally damaged building). ICS enables you to create an organizational structure and road map to optimally manage the incident relative to the situational circumstances.

Why isn't the normal, day-to-day organizational system used by each nursing home sufficient to manage a disaster? The answer is that disasters are not "business as usual"; they are, by definition, extraordinary events that place highly unusual stresses on the facility, including the management team and staff that work at the facility. Effectively responding to a disaster requires additional skills that must be acquired before the disaster occurs. If this document conveys only one important point, it is that each facility should commit to preparing in advance for such an event.

ICS, like all well established and tested systems, utilizes a standardized organizational structure and terminology (we recommend sticking with the structure and terminology for reasons we'll discuss in more detail later). While ICS's fundamental principles are carved in stone, there is great flexibility in how ICS is applied in a specific setting, including nursing homes, for any given incident. NHICS provides a road map for essential tasks in an emergency. NHICS provides standardization that can markedly improve the ability of an organization to successfully respond to a disaster.

ESSENTIAL RESPONSIBILITIES NHICS FUNCTIONS

For small incidents, the activities of all NHICS sections may be managed effectively by one person, the Incident Commander. For larger incidents, more people are almost certainly needed. NHICS is very specific on how the NHICS organizational structure grows as incidents become larger and more complex.

The **Incident Commander** is responsible for the following:

- Establishes the use of NHICS to manage the incident
- Establishes the initial objectives for managing the incident
- Identifies the supporting NHICS staff necessary to respond to the incident
- Recruits assistance as needed
- Keeps senior administration informed
- Coordinates with other response partners as necessary, e.g., EMS, fire, law enforcement, public health

There are three additional members of the Command Staff that report to the Incident Commander. These functions must always be addressed; although in a small incident, the Incident Commander may be able to handle these responsibilities.

The **Safety Officer** is responsible for the overall safety of the response actions, including modifying or suspending operations if conditions are unsafe to continue. For example, a nursing home may be forced to evacuate all or part of the facility due to an earthquake. The Safety Officer should evaluate the site to which residents are relocated to ensure the location is free of hazards or risk.

The **Liaison/Public Information** Officer serves as the communication link between the nursing home and external partners. This position provides information to external response agencies such as public health authorities, emergency management officials, law enforcement and other agencies that have been identified by the facility as key community partners that may be involved in response. This position also communicates with the media.

The **Medical Specialist** is the person with specific expertise in clinical areas such as infectious disease, trauma management, and medical ethics who may be asked to provide the Command staff with needed advice and coordination assistance. This role may be filled by persons outside of the facility but ideally will be filled by the facility's Medical Director/Specialist who has familiarity with the resident population and the disaster plan for the facility. The Medical Director/Specialist reports to the Incident Commander; however, in actual event, this specialist may work directly with operations personnel providing advice or guidance in the response activities.

Operations (Doers)

The Operations Section coordinates all tactical activities. Under the direction of an Operations Section Chief, these people implement actions that are consistent with the objectives initially identified by the Incident Commander and further identified in the Incident Action Plan (IAP). The oversight of the Operations Section is provided by an Operations Section Chief. Additional positions, if necessary, may include a Resident Services Branch Director and an Infrastructure Branch Director.

Logistics (Getters)

Logistics ensures the preservation of essential services including communications and information technology. Logistics organizes and maintains the facility's supplies, equipment, transportation and labor pool in support of the residents, staff, and staff dependents in accordance with facility policy. It must account for those resources used and requested for operations.

Pre-incident planning should identify critical items that may be needed for various responses based on annual completion of a Hazard Vulnerability Analysis. The on-hand inventory documentation should be kept current and readily available for use when needed.

Planning (Planners)

The Planning Section is responsible for collecting and analyzing relevant situational information, creating plans that support the success of the NHICS process, and maintaining documents or displays that show the current status of relevant resources (e.g., what resources such as staff, heaters, generators, etc.) are assigned where. The Planning Section provides up-to-date and accurate information regarding residents, staff, supplies and equipment and projects the ability to sustain operations. An important duty assigned to the Planning Section is the development of the Incident Action Plan (IAP); the Planning Section also keeps careful track of personnel who report to the IMT (this process is called “Check In”).
The Planning Section will take the lead in coordinating documentation efforts by working with other members of the IMT to document the incident, typically using NHICS Forms. This section is also responsible for archiving the documents created during the response.

Finance (Supporters)

The Finance Section is responsible for all purchasing related to the management of the incident; in addition to tracking and reporting all financial and administrative information, including records management, payroll, and the overall incident budget. Finance oversees the costs and expenditures incurred by the response actions, including the purchasing of supplies and equipment. The Finance must also account for lost revenue associated with the response and recovery and ensure thorough investigation and documentation of incident-related claims.

Incident Management Team (IMT)

The IMT is the predetermined group of individuals who may serve the incident command functions. Typically, the Incident Commander will determine the size and composition of the IMT, including who is available; the demands created by the incident; etc.

If an incident occurs without notice, the highest-ranking individual at the facility will assume the Incident Commander role and respond by initiating the facility’s disaster plan has pre-established who the immediate on-site Incident Commander should be. This person should continue in the role of Incident Commander until relieved by another person designated the disaster plan. As previously stated, the one IMT position always activated is the Incident Commander. If this person can handle all five of the essential functions of incident response – Command, Operations, Planning, Logistics, and Finance and Administration – then the IMT may be exactly one person. As soon as the Incident Commander recognizes that there is a need to expand the IMT to successfully manage these five essential functions, then the IMT should expand at that point as necessary.

The person in the role of Incident Commander should be a knowledgeable and steady hand, not easily prone to being rattled by a pressured and possibly chaotic situation, and trusted by management. The ability of an Incident Commander to “size up” the incident and plan to add the appropriate IMT members is essential to effective leadership. Proper “size up” of an incident requires a quick understanding of current needs coupled with the ability to project needs in the near term. It is very difficult to manage an emergency if the response organization is constantly playing “catch up”.

As soon as the Incident Commander recognizes the need for additional IMT members to successfully manage the five NHICS functions throughout the duration of the incident, he or she should expand the organization in a standardized fashion. This means that it is built from the “top down”, i.e., the Incident Commander may recognize the need to activate other members of the Command Staff (Liaison/Public Information Officer, Safety Officer or Medical Director/Specialist) and/or one or more Section Chief(s), as needed for the incident. This expansion continues until all five functions are successfully managed; similarly, positions may be de-activated as the incident needs diminish. Every decision to expand or contract the size of the IMT should reflect the basic needs of the incident, keeping in mind the concept of “span-of-control”, i.e., no individual should manage more than 3 to 5 individuals.

If expansion of the IMT is needed, it expands in a standardized fashion. Position titles within the IMT define the role and tasks assigned to that role. Titles identify the hierarchy within the chain of command, which is an important component of the NHICS management system.

In any emergency response, it is critical that clear lines of authority (chain of command) exist within the facility to make sure there is timely and efficient decision-making. It is important that you define this chain of command and the authority and decision-making ability of the facility’s incident commander and identify who is designated to fill this role. This is an important aspect of your disaster plan.

Support for your disaster planning needs to start at the top of the facility. Bring the leaders of your facility into the planning process from the very beginning to identify and agree upon the best course of action for your facility, its residents and staff. It is important to discuss the financial and clinical implications of the various proposed response strategies. This may include items such as closing to new admissions or agreeing to be a “surge” or overflow setting for the local hospital. Medical and administrative priorities need to match, and your facility’s leadership team needs to be clear about its role and authority.

Nursing Home Incident Command Systems (NHICS) can be used at facility both large and small — it can even be used by just one person! If you have a small facility, the same person may fill multiple spots on the NHICS facility chart. Just be sure through practice and exercise that one designated person is not disproportionately overburdened with her or his roles in an emergency.

The Nursing Home Incident Command System (NHICS) is a framework for response that NHICS is based on incident command principles that are utilize across the nation by hospitals, clinics, fire fighters, law enforcement, emergency medical authorities and other response partners in accordance with concepts promoted by the National Incident Management System (NIMS). These principles include: Command Structure (activated with whomever is in the facility when the incident occurs), Common Terminology, Modular, Span of Control, Modular Organization (that can expand and contract depending on resources and needs), and Systems for Resource and Information Management.

Basic NHICS Job Action Overview

- **Incident Commander**: Leads the response, appoints section leaders, approves plans and key actions (CEO, administrator, Director of Nursing (DON), nursing supervisor.)

- **Operations Section**: Handles key actions including first aid, search and rescue, fire suppression, securing the site (DON, Department supervisors, nursing supervisor, direct care staff.)

- **Planning Section**: Gathers information, thinks ahead, makes and revises action plans and keeps all team members informed and communicating. (Safety committee, Continuity of operations planning team, etc.)

- **Logistics Section**: Finds, distributes and stores all necessary resources (maintenance supervisor, purchasing, human resources director)

- **Finance Section:** Tracks all expenses, claims, activities and personnel time and is the record keeper for the incident (controller, accounts dept., payroll.)

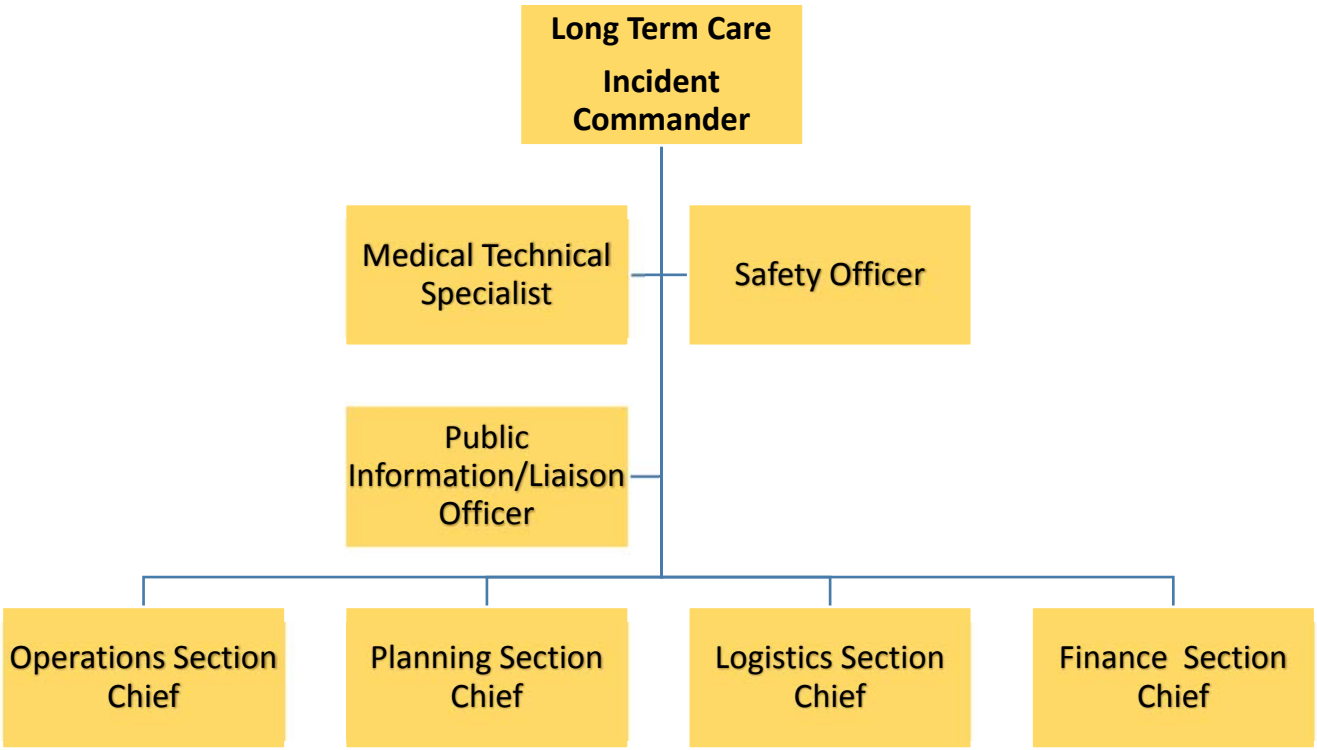
- **Safety Officer**: Ensure safety of staff, residents and visitors; monitor and correct hazardous conditions. Has authority to halt any operation that poses immediate threat to life and health.

- **Public Information/ Liaison Officer**: Serves as the primary point of contact for supporting agencies, media, staff, visitors and families, and concerned others as approved by the Incident Commander.

- **Medical Tech Specialist**: Serves as the primary oversight. triage, first aid (as necessary) and medical care to residents. Provides support to the Operation Chief

Specific personnel placed in the various roles are determinant on the skills and position with the facility. The Job Action Sheets are found in Appendix A.

Incident Command Organization Chart



Depending on the size of the facility, one person may occupy multiple positions **within the section.** You do not need to activate all positions – only activate what you need for the incident. This is your basic Incident Command, if part of a larger system i.e.: health facility, you will need to know where your ICS fits within that facility's structure

Incident Management Team (IMT)

The Incident Management Team (IMT) is established to response and manage incidents. The IMT is a total of 8 positions which are the most commonly established. Because of staffing limitations and the need to prioritize resident care, the more expansive organizational structures seen in ICS and HICS have been "rolled up" in NHICS. List of individuals or positions that maybe utilized to man the incident command system for the facility includes:

- Incident Commander: Administrator, DON, Director of Facilities, RN Supervisor

- Operations Section Chief: DON, ADON, Social Services Director, Human Resources

- Planning Section Chief: Marketing/Admissions Director Social Services Director, Human Resources

- Logistic Section Chief: Social Services Director, Human Resources, Maintenance Supervisor

- Finance Section Chief: Human Resources, Office Manager

- Medical Technical Specialist: Medical Director

- Public Information/ Liaison Officer: Marketing/Admissions Director Social Services Director, Human Resources

Notification

The Incident Commander shall be responsible for notifying the appropriate departments. Also, the Health Department shall be immediately notified in the nursing facility are temporarily disrupted due to any disaster, such as fire, storm, flood, or any other interruption of services which would affect the health and safety of the residents. The State and Local offices of the Department of Medicaid shall be notified by of any unusual incidents involving the health, safety, and wellbeing of residents in the Personal Care facilities

Appendix A

Federal Regulations - QSO Notice 20-20-NF

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16 Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

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DATE: TO: FROM:

SUBJECT:

March 23, 2020
State Survey Agency Directors

Director
Quality, Safety & Oversight Group

Prioritization of Survey Activities

Ref: QSO-20-20-All

Memorandum Summary

• ***TheCentersforMedicare&MedicaidServices(CMS)iscommitted***totakingcriticalsteps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19).

- On Friday, March 13, 2020, the President declared a national emergency, which triggers the Secretary's ability to authorize waivers or modifications of certain requirements pursuant to section 1135 of the Social Security Act (the Act). Under section 1135(b)(5) of the Act, CMS is prioritizing surveys by authorizing modification of timetables and deadlines for the performance of certain required activities, delaying revisit surveys, and generally exercising enforcement discretion for three weeks.
- During this three-week timeframe, **only** the following types of surveys will be prioritized and conducted:

• Complaint/facility-reportedincidentsurveys: Statesurveyagencies (SSAs) will conduct surveys related to complaints and facility-reported incidents (FRIs) that are triaged at the

Immediate Jeopardy (IJ) level. A streamlined Infection Control review tool will also be utilized during these surveys, regardless of the Immediate Jeopardy allegation.

- Targeted Infection Control Surveys: Federal CMS and State surveyors will conduct targeted Infection Control surveys of providers identified through collaboration with the Centers for Disease Control and Prevention (CDC) and the HHS Assistant Secretary for Preparedness and Response (ASPR). They will use a streamlined review checklist to minimize the impact on provider activities, while ensuring providers are implementing actions to protect the health and safety of individuals to respond to the COVID-19 pandemic.
- Self-assessments: The Infection Control checklist referenced above will also be shared with all providers and suppliers to allow for voluntary self-assessment of their Infection Control plan and protections.

Memorandum Summary Continued

- During the prioritization period, the following surveys will not be authorized: Standard surveys for long term care facilities (nursing homes), hospitals, home health agencies (HHAs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and hospices. This includes the life safety code and Emergency Preparedness elements of those standard surveys; and revisits that are not associated with IJ.
- Furthermore, for Clinical Laboratory Improvement Amendments (CLIA), we intend to prioritize immediate jeopardy situations over recertification surveys, and generally intend to use enforcement discretion, unless immediate jeopardy situations arise.
- Finally, initial certification surveys will continue to be authorized in accordance within current guidance and prioritization.

Background

CMS is committed to taking critical steps to ensure America's health care facilities, providers, and clinical laboratories are prepared to respond to the threat of COVID-19 and other respiratory illness. Specifically, under section 1135(b)(5) of the Act, CMS is prioritizing and suspending certain federal and SSA surveys, and delaying revisit surveys, pursuant to federal requirements for the next three weeks, beginning March 20, 2020, for all certified provider and supplier types. Also, for Clinical Laboratory Improvement Amendments (CLIA), we intend to prioritize immediate jeopardy situations over recertification surveys, and generally intend to use enforcement discretion, unless immediate jeopardy situations arise. During this three-week timeframe, SSAs and CMS surveyors will prioritize and conduct surveys (including revisit surveys) related to complaints and facility- reported incidents (FRIs) that are triaged at the Immediate Jeopardy (IJ) level, for all allegations, in addition to a review with a Focused Infection Control survey. Federal surveyors will perform targeted Infection Control surveys of facilities in those areas most in need of additional oversight, as identified through collaboration with the CDC and ASPR.

If state or federal surveyors are unable to meet the Personal Protective Equipment (PPE) expectations outlined by the latest CDC guidance to safely perform an onsite survey due to

lack of appropriate PPE supplies, they are instructed to refrain from entering the /provider, and obtain information necessary remotely, to the extent possible. Surveyors should continue the survey once they have the necessary PPE to do so safely.

The Focused Infection Control Survey is available to every provider in the country to make them aware of Infection Control priorities during this time of crisis, and providers and suppliers may perform a voluntary self-assessment of their ability to meet these priorities.

This shift in approach will allow health care providers time to implement the most recent infection control guidance from both CMS and the Centers for Disease Control and Prevention (CDC). At the same time, we are doing our duty to protect patients from harm, and ensuring providers are implementing actions to prevent the spread of COVID-19.

Therefore, during the prioritization period, the following surveys will **not** be authorized: • Standardsurveysforlongtermcarefacilities (nursinghomes), hospitals, home

Health agencies (HHAs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and hospices. This includes the life safety code and Emergency Preparedness elements of those standard surveys;

- Revisits that are not associated with IJ. As a result, the following enforcement actions will be suspended, until revisits are again authorized:
    - For nursing homes – Imposition of Denial of Payment for New Admissions (DPNA), including situations where facilities that are not in substantial compliance at 3 months, will be lifted to allow for new admissions during this time;
    - For HHAs – Imposition of suspension of payments for new admissions (SPNA) following the last day of the survey when termination is imposed will be lifted to allow for new admissions during this time;
    - For nursing homes and HHAs – Suspend per day civil money penalty (CMP) accumulation, and imposition of termination for facilities that are not in substantial compliance at 6 months.
- For CLIA, we intend to prioritize immediate jeopardy situations over recertification surveys.

  This announcement follows previous action to focus survey activity on infection control. On March 4, 2020, CMS announced a suspension of inspections for federal and state inspectors (https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/suspension-survey-activities). This earlier announcement focused on immediate jeopardy complaints, complaints alleging infection control concerns – especially COVID-19 – statutorily required surveys, revisit surveys to resolve enforcement actions, initial certifications, inspections for facilities with histories of infection control deficiencies in the last three years, and inspections of facilities with histories of infection control deficiencies at low levels of severity. This action supersedes the March 4th announcement, and prioritizes surveys related to complaints and FRIs triaged at the IJ level, while suspending the other types of surveys.

Prioritization of Surveys

When conducting surveys related to complaints and facility-reported incidents (FRIs) that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys necessary to verify removal of IJ which has been previously cited, surveyors and CMS Regional Offices should adhere to the following guidelines:

1. SSAs follow their normal process for triaging complaints and FRIs:
a. If a complaint or FRI is triaged at the IJ level, the state should follow the

normal policies and procedures for surveying the provider. For example, a survey of a long term care facility (LTC) would be conducted within two business days of receipt of the allegation (State Operations Manual (SOM), Chapter 5, Section 5075.9).

2. If a complaint or FRI is triaged at the non- IJ level, the state would enter the allegation into the ASPEN Complaints/Incidents Tracking System (ACTS) per the instructions in the SOM Chapter 5. An onsite survey will not be conducted during the prioritization period. CMS will issue guidance related to these non- IJ complaints or FRIs in the next few weeks.
3. This normal complaint triaging process also applies to CLIA complaints.

2. For facilities that have been cited for IJ-level deficiencies and that surveyors have not

verified that the IJ has been removed, surveyors would proceed as normal, and conduct a revisit survey to verify the IJ is removed.

1. If the revisit survey determines there is continuing noncompliance, but not at the IJ level, surveyors would not conduct another onsite revisit survey. The provider may submit a plan of correction (POC), but an onsite revisit survey will not be conducted during the prioritization period, and these cases will be held. The provider may delay submission of a plan of correction until this prioritization period is over.
2. If a survey is conducted because a complaint or FRI was triaged at the IJ level, and the provider is cited for noncompliance, but not at the IJ level (e.g., Level 3 – actual harm), surveyors would not conduct a revisit survey. The provider may submit a plan of correction (POC), but an onsite revisit survey will not be conducted during the prioritization period, and these cases will be held. The provider may delay submission of a plan of correction until this prioritization period is over.
3. For level-3 (LTC) or condition level (Non-LTC) citations (for which an onsite revisit survey would normally be conducted), the provider may submit a plan of correction (POC), but an onsite revisit survey will not be conducted during the prioritization period, and these cases will be held. The provider may delay submission of a plan of correction until this prioritization period is over. CMS will issue guidance on how to verify compliance with these citations in the next few weeks.

4. For level-2 (LTC) or standard level (non-LTC) citations, the provider may submit a POC, and providers and survey agencies could verify compliance through normal procedures through a desk review. The provider may delay submission of a plan of correction until this prioritization period is over.
5. For clinical laboratories, surveyors will conduct a revisit survey to verify removal of IJ once a credible allegation of compliance has been received.

3. *Federal CMS and State Surveyors will conduct focused Infection Control surveys in areas deemed necessary through collaboration with CDC and ASPR. Please note this workload for SSAs is contingent on their ability to perform surveys based on PPE availability and fulfillment of other State Emergency Response responsibilities (such as staffing medical shelters or testing stations).*
    1. *Revisit surveys: Surveyors will follow the same guidance for revisit surveys explained in section 2 above.*
    2. *Enforcement actions will also follow the guidance for all other surveys during the prioritization period explained in section 4 below.*
4. Enforcement Actions:

a. For pending enforcement cycles during the prioritization period where the

Provider is currently not in substantial compliance or has not had a revisit

Survey to verify substantial compliance, and a per day civil money penalty (CMP), or DPNA (for nursing homes) or SPNA (for HHAs) was imposed for noncompliance that occurred prior to the prioritization date of surveys: These remedies will be suspended (stopped) as of the start of the survey prioritization date. In other words, the CMP will stop accruing and the DPNA/SPNA will end as of the suspension date. Additionally, CMS will not impose any new remedies to address noncompliance that occurred prior to the start of the survey prioritization period. NOTE: This does not apply to unremoved IJs. Enforcement actions will proceed as usual per the SOM for unremoved IJ deficiencies. CMS will issue guidance on how to reconcile these actions in the next few weeks.

2. For pending enforcement cycles during the prioritization period where the provider is currently not in substantial compliance or has not had a revisit survey to verify substantial compliance, and for pending enforcement cycles with new noncompliance cited after the issuance of this memo, and a per day CMP, or DPNA (for nursing homes) or SPNA (for HHAs) was imposed for IJ level noncompliance (where the IJ has not been removed): Surveyors will follow normal policies and procedures for removing the IJ. CMS will also follow normal policies and procedures for imposing enforcement remedies for remediating the noncompliance. For example, for noncompliance cited at the IJ level, that has not been removed at the time of the survey exit, the CMS Office will impose an enforcement remedy (e.g., CMP, 23-day termination), and the state surveyors will conduct a revisit survey. On the revisit survey, surveyors will either verify substantial compliance, or cite noncompliance at a lower level if warranted.
    i. If the IJ noncompliance is reduced and cited at level 3 (LTC) or condition level (non-LTC), an onsite revisit survey will not be conducted during the prioritization

period, and these cases will be held. CMS will issue guidance on how to impose enforcement and verify compliance with these in the next few weeks (see 2.c.).

ii. If the IJ noncompliance is reduced and cited at level 2 (LTC) or standard level (non-LTC), facilities and survey agencies would verify compliance through normal procedures through a desk review (see 2.d.). However, CMS should not impose remedies during the prioritization period for any noncompliance that was identified before or after the start of the survey prioritization period, unless the noncompliance is an unremoved IJ.

3. The three-month mandatory DPNA and six-month mandatory termination (nursing homes) for not being in substantial compliance (for nursing homes and HHAs) will not take place, and be deferred for an evaluation at a later date. However, enforcement actions related to IJ remain and continue under normal procedures.
4. If CMS has previously imposed an alternative sanction (e.g., SPNA, CMP) on a HHA for noncompliance identified prior to the suspension, the six-month mandatory termination will not take place, and be deferred for an evaluation at a later date.

e. For existing CLIA enforcement cases where a civil money penalty (CMP) per day of non-compliance was imposed, accrual of CMP will stop as of the survey COVID-19 suspension date. CMS will issue guidance on how to reconcile these actions in the next few weeks. Other CLIA enforcement actions that have been initiated will be handled on a case-by-case basis with consultation DCLIQ managers and staff.

5. If during an IJ complaint or FRI survey, the surveyor identifies that there is an active COVID-19 case in the facility:

If the COVID-19 case is, or is not, related to the IJ, surveyors should report the case and facility to their agency, the state health department (to coordinate with the Centers for Disease Control and Prevention (CDC)), and the CMS Regional Office. These agencies should coordinate and decide on any further actions that should be taken. The Infection Control focused survey process can be used to investigate noncompliance and ensure the provider takes steps to minimize transmission.

For onsite surveys that were started prior to the prioritization period and don't fall under this guidance, survey teams should end the survey and exit the facility.

Lastly, any initial certification surveys remain authorized to increase the health care capacity of the country.

Note: While CMS' directive applies to the CMS' federal surveyors and state agency surveyors, CMS also urges other surveyors, including accrediting organizations (AOs), to follow suit. Additionally, CMS' survey prioritization applies to surveys for compliance with federal regulations, not state surveys pursuant to state licensure.

Additional Instructions for Nursing Homes

We are disseminating the Infection Control survey developed by CMS and CDC so facilities can educate themselves on the latest practices and expectations. We expect facilities to use this new process, in conjunction with the latest guidance from CDC, to perform a voluntary self-assessment of their ability to prevent the transmission of COVID-19. This document may be requested by surveyors, if an onsite investigation takes place. We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program. Contact information for each state's health departments is identified on the Centers for Disease Control & Prevention's (CDC's) website at: https://www.cdc.gov/HAI/state-based/index.html.

Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and to whom possible incidents of communicable disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii)). CDC recommends that nursing homes notify their health department about residents with severe respiratory infection, or a cluster of respiratory illness (e.g., > or = 3 residents or HCP with new-onset respiratory symptoms within 72 hours). Local and state reporting guidelines or requirements may vary. Monitor the CDC website for information and resources to help prevent the introduction and spread of COVID-19 in nursing homes (CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019- ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html). We urge providers to review the tools and implement actions to protect the health and safety of individuals to respond to the COVID-19 pandemic.

Additional Instructions for Other (Non-Long-Term Care) Provider Types

Education and Signage

Where the patient/resident is sleeping at the health care facility, signage on the patient's room is important to ensuring that all staff are aware of the necessary infection control steps. https://www.cdc.gov/infectioncontrol/pdf/droplet-precautions-sign-P.pdf

In the home setting, health care staff may have little control over the home environment, but must 1) educate staff, patients and family members regarding infection control procedures and how to avoid transmission of COVID-19, and 2) maintain clean equipment and supplies and follow appropriate infection control procedures during home visits and transport of reusable patient care items. For further information refer to CDC's interim guidance for home care of people not requiring hospitalization for COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home- care.html).

Limitations on Visitors

To mitigate the spread of the COVID-19 virus, CMS is providing guidance to restrict visitation in health care facilities such as hospitals, critical access hospitals, psychiatric hospitals, inpatient hospice units, and intermediate care facilities for individuals with developmental disabilities. For

CMS restrictions on visitation in nursing homes, see QSO-20-14
https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf.

CMS is providing the following expanded guidance to prevent the spread of COVID-19:

a) Visitors should receive the same screening as patients, including whether they have had:
• Fever or symptoms of a respiratory infection, such as a cough and sore throat.
• International travel within the last 14 days to CDC Level 3 risk countries. For updated information on restricted countries visit:
https://www.cdc.gov/coronavirus/2019ncov/travelers/index.html

• Contact with someone with known or suspected COVID-19.

b) Health care facilities should set limitations on visitation. For example, limitations may include restricting the number of visitors per patient, or limiting visitors to only those that provide

assistance to the patient, or limiting visitors under a certain age.
c) Health care facilities should provide signage at entrances for screening individuals, provide temperature checks/ ask about fever, and encourage frequent hand washing and use of hand sanitizer before entering the facility and before and after entering patient rooms

d) If visiting and not seeking medical treatment themselves, individuals with fevers, cough, sore throat, body aches or runny nose or not following infection control guidance should be restricted from entry.

e) Facilities should screen and limit visitors for any recent trips (within the last 30 days) on cruise ships as well as close contact with a suspect or laboratory-confirmed COVID-19 patient within the last 14 days, or overseas travel from certain countries.

https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html,
https://wwwnc.cdc.gov/travel/page/covid-19-cruise-ship
Facilities should instruct visitors to limit their movement within the facility (e.g., reduce walking the halls, trips to cafeteria, etc.)

Facilities should establish limited entry points for all visitors and/or establish alternative sites for screening prior to entry. Facilities can implement measures to:
Increase communication with families (phone, face-time, skype, etc.).

Potentially offer a hotline for with a recording that is updated at set times so families can get an update on the facility's general status. If appropriate, consider offering telephonic screening of recent travel and wellness prior to coming in for scheduled appointments. This may help limit the amount of visitor movement throughout the organization and congestion at entry points.

Consider closing common visiting areas and encouraging patients to visit with loved ones in their patient rooms.

In home and community-based settings, health care providers should advise patients with COVID- 19 of the CDC guidance to mitigate transmission of the virus. This includes isolating at home during illness, restricting activities except for medical care, using a separate bathroom and bedroom if possible, and prohibiting visitors who do not have an essential need to be in the home. The certified Medicare/Medicaid provider is expected to share this information with patients with the COVID-19 virus and his/her caregiver. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance- prevent-spread.html

Some states have chosen to establish more restrictive criteria than described above. Health care providers to follow the more restrictive criteria when present.

Access for Healthcare Staff

CMS is aware that some providers (nursing homes, assisted living facilities, etc.) have significantly restricted entry for staff from other Medicare/Medicaid certified providers who are providing direct care to patients. In general, if the staff is appropriately wearing PPE, and do not meet criteria for restricted access, they should be allowed to enter and provide services to the patient (interdisciplinary hospice care, dialysis, organ procurement, home health, etc.).

For hospitals, this would also apply to organ procurement coordinators. Ensuring that individuals have continued access to life-saving organs is critical. We understand that hospitals are preparing for a potential surge in COVID-19 patients however, we would ask that donor hospitals continue with operations in regards to allowing organ procurement coordinators into hospitals to discuss organ donation with families. Hospital and OPO leadership should communicate on risk assessments in their communities and any potential impacts for organ recovery operations.

CMS will continue to evaluate the survey prioritization in light of the situation on the ground in areas with large numbers of COVID-19 cases, to determine if CMS needs to continue this past the initial three weeks.

Section 3087 of the 21st Century Cures Act, signed into law in December 2016, added subsection (f) to section 319 of the Public Health Service Act. This new subsection gives the HHS Secretary the authority to waive Paperwork Reduction Act (PRA) (44 USC 3501 et seq.) requirements with respect to voluntary collection of information during a public health emergency (PHE), as declared by the Secretary, or when a disease or disorder is significantly likely to become a public health emergency (SLPHE). Under this new authority, the HHS Secretary may waive PRA requirements for the voluntary collection of information if the Secretary determines that: (1) a PHE exists according to section 319(a) of the PHS Act or determines that a disease or disorder, including a novel and emerging public health threat, is a SLPHE under section 319(f) of the PHS Act; and (2) the PHE/SLPHE, including the specific preparation for and response to it, necessitates a waiver of the PRA requirements. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been designated as the office that will coordinate the process for the Secretary to approve or reject each request.
The information collection requirements contained in this information collection request have been submitted and approved under a PRA Waiver granted by the Secretary of Health and Human Services. The waiver can be viewed at https://aspe.hhs.gov/public-health-emergency-declaration-pra-waivers.

Contact: Questions about this document should be addressed to QSOG_EmergencyPrep@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

COVID-19 Focused Survey for Nursing Homes

Infection Control

This survey tool must be used to investigate compliance at F880 and determine whether the facility is implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections. Entry and screening procedures as well as resident care guidance has varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS requirements and surveyors will use guidance that is in effect at the time of the survey. Refer to QSO memos released at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to- States-and-Regions.

This survey tool provides a focused review of the critical elements associated with the transmission of COVID-19, will help surveyors to prioritize survey activities while onsite, and identify those survey activities which can be accomplished offsite. These efficiencies will decrease the potential for transmission of COVID-19, as well as lessen disruptions to the facility and minimize exposure of the surveyor. Surveyors should be mindful to ensure their activities do not interfere with the active treatment or prevention of transmission of COVID-19.

If citing for noncompliance related to COVID-19, the surveyor(s) must include the following language at the beginning of the Deficient Practice Statement or other place determined appropriate on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to [properly prevent and/or contain – or other appropriate statement] **COVID-19**."

If surveyors see concerns related to compliance with other requirements, they should investigate them in accordance with the existing guidance in Appendix PP of the State Operations Manual and related survey instructions. Surveyors may also need to consider investigating concerns related to Emergency Preparedness in accordance with the guidance in Appendix Z of the State Operations Manual (e.g., for emergency staffing).

For the purpose of this survey tool, "staff" includes employees, consultants, contractors, volunteers, and others who provide care and services to residents on behalf of the facility. The Infection Prevention and Control Program (IPCP) must be facility-wide and include all departments and contracted services.

Surveyor(s) reviews for:

- The overall effectiveness of the Infection Prevention and Control Program (IPCP) including IPCP policies and procedures;
- Standard and Transmission-Based Precautions;
- Quality of resident care practices, including those with COVID-19 (laboratory-positive case), if applicable;
- The surveillance plan;
- Visitor entry and facility screening practices;
- Education, monitoring, and screening practices of staff; and

- Facility policies and procedures to address staffing issues during emergencies, such as transmission of COVID-19

1. Standard and Transmission-Based Precautions (TBPs)

CMS is aware that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact their healthcare coalition for assistance (https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx), follow national and/or local guidelines for optimizing their current supply or identify the next best option to care for residents. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC guidance for healthcare professionals is located at: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html and healthcare facilities is located at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html. Guidance on strategies for optimizing PPE supply is located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the State Agency should contact the CMS Regional Location.

General Standard Precautions

Are staff performing the following appropriately:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant

  Manufacturer's instructions for use)?

  Hand Hygiene

  Are staff performing hand hygiene when indicated?
  If alcohol-based hand rub (ABHR) is available, is it readily accessible and preferentially used by staff for hand hygiene?

If there are shortages of ABHR, are staff performing hand hygiene using soap and water instead?
Are staff washing hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids)?

Do staff perform hand hygiene (even if gloves are used) in the following situations?

- Before and after contact with the resident;
- After contact with blood, body fluids, or visibly contaminated surfaces;
- After contact with objects and surfaces in the resident's environment;
- After removing personal protective equipment (e.g., gloves, gown, facemask); and
- Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a

Central venous catheter, and/or dressing care)?
When being assisted by staff, is resident hand hygiene performed after toileting and before meals?

Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.

Personal Protective Equipment (PPE)

Determine if staff appropriately use PPE including, but not limited to, the following:

- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
- Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
- Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;

And

- An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions.

Is PPE appropriately removed and discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national/local recommendations), followed by hand hygiene?
If PPE use is extended/reused, is it done according to national and/or local guidelines? If it is reused, is it cleaned/decontaminated/maintained

After and/or between uses?
Interview appropriate staff to determine if PPE is available, accessible and used by staff.

- Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what procedures is the facility taking to address this issue?
- Do staff know how to obtain PPE supplies before providing care?
- Do they know who to contact for replacement supplies?

Transmission-Based Precautions (Note: PPE use is based on availability and latest CDC guidance. See note on Pages 1-2)

Determine if appropriate Transmission-Based Precautions are implemented:

- For a resident on Contact Precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;
- For a resident on Droplet Precautions: staff don a facemask within six feet of a resident;
- For a resident on Airborne Precautions: staff don an N95 or higher-level respirator prior to room entry of a resident;
- For a resident with an undiagnosed respiratory infection: staff follow Standard, Contact, and Droplet Precautions (i.e., facemask, gloves,

  Isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis);

- For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator

  If available. A facemask is an acceptable alternative if a respirator is not available. Additionally, if there are COVID-19 cases in the facility or sustained community transmission, staff implement universal use of facemasks while in the facility (based on availability). When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).

COVID-19 Focused Survey for Nursing Homes

Some procedures performed on residents with known or suspected COVID-19 could generate infectious aerosols (i.e., aerosol- generating procedures (AGPs)). In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:

Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and an isolation gown.

- The number of staff present during the procedure should be limited to only those essential for resident care and procedure support.

- AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed.
- Clean and disinfect the room surfaces promptly and with appropriate disinfectant. Use disinfectants on List N of the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-COV-2 or other national recommendations;

- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare setting prior to use on another resident;
- Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare setting (effective against the organism identified if known) at least daily and when visibly soiled; and
- Is signage on the use of specific PPE (for staff) posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide)?

  Interview appropriate staff to determine if they are aware of processes/protocols for Transmission-Based Precautions and how staff is monitored for compliance.

  If concerns are identified, expand the sample to include more residents on Transmission-Based Precautions.

  2. Resident Care

  If there is sustained community transmission or case(s) of COVID-19 in the facility, is the facility restricting residents (to the extent possible) to their rooms except for medically necessary purposes? If there is a case in the facility, and residents have to leave their room, are they wearing a facemask, performing hand hygiene, limiting their movement in the facility, and performing social distancing (efforts are made to keep them at least 6 feet away from others). If PPE shortage is an issue, facemasks should be limited to residents diagnosed with or having signs/symptoms of respiratory illness or COVID-19.

  Has the facility cancelled group outings, group activities, and communal dining?

1. Did staff implement appropriate Standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and Transmission-Based Precautions (if applicable)? Yes **No F880**

Has the facility isolated residents with known or suspected COVID-19 in a private room (if available), or taken other actions based on national (e.g., CDC), state, or local public health authority recommendations?

For the resident who develops severe symptoms of illness and requires transfer to a hospital for a higher level of care, did the facility alert emergency medical services and the receiving facility of the resident's diagnosis (suspected or confirmed COVID-19) and precautions to be taken by transferring and receiving staff as well as place a facemask on the resident during transfer (as supply allows)?

For residents who need to leave the facility for care (e.g. dialysis, etc.), did the facility notify the transportation and receiving health care team of the resident's suspected or confirmed COVID-19 status?

Does the facility have residents who must leave the facility regularly for medically necessary purposes (e.g., residents receiving hemodialysis and chemotherapy) wear a facemask (if available) whenever they leave their room, including for procedures outside of the facility?

2. Did staff provide appropriate resident care?

3. IPCP Standards, Policies and Procedures

Did the facility establish a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19?

Does the facility's policies or procedures include when to notify local/state public health officials if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected?

Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

4. Infection Surveillance

How many residents and staff in the facility have fever, respiratory signs/symptoms, or other signs/symptoms related to COVID-19?
How many residents and staff have been diagnosed with COVID-19 and when was the first case confirmed?
How many residents and staff have been tested for COVID-19? What is the protocol for determining when residents and staff should be tested?

Has the facility established/implemented a surveillance plan, based on a facility assessment, for identifying (i.e., screening), tracking, monitoring and/or reporting of fever (at a minimum, vital signs are taken per shift), respiratory illness, and/or other signs/symptoms of COVID-19 and immediately isolate anyone who is symptomatic?

Does the plan include early detection, management of a potentially infectious, symptomatic resident that may require laboratory testing and/or Transmission-Based Precautions/PPE (the plan may include tracking this information in an infectious disease log)?

3. Does the facility have a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19? Yes **No F880**

Does the facility have a process for communicating the diagnosis, treatment, and laboratory test results when transferring a resident to an acute care hospital or other healthcare provider; and obtaining pertinent notes such as discharge summary, lab results, current diagnoses, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals?

Can appropriate staff (e.g., nursing and unit managers) identify/describe the communication protocol with local/state public health officials? Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

5. Visitor Entry

Review for compliance of:
• Screening processes and criteria (i.e., screening questions and assessment of illness);
• Restriction criteria; and
• Signage posted at facility entrances for screening and restrictions as well as a communication plan to alert visitors of new

Procedures/restrictions.
For those permitted entry, are they instructed to frequently perform hand hygiene; limit their interactions with others in the facility and surfaces

Touched; restrict their visit to the resident's room or other location designated by the facility; and offered PPE (e.g., facemask) as supply allows? What is the facility's process for communicating this information?

For those permitted entry, are they advised to monitor for signs and symptoms of COVID-19 and appropriate actions to take if signs and/or symptoms occur?

4. Did the facility provide appropriate infection surveillance?

5. Did the facility perform appropriate screening, restriction, and education of visitors?

6. Education, Monitoring, and Screening of Staff

Is there evidence the facility has provided education to staff on COVID-19 (e.g., symptoms, how it is transmitted, screening criteria, work exclusions)?

How does the facility convey updates on COVID-19 to all staff?
Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their

Temperature and documenting absence of illness (or signs/symptoms of COVID-19 as more information becomes available)? If staff develop symptoms at work (as stated above), does the facility:

Place them in a facemask and have them return home;
Inform the facility's infection Preventionist and include information on individuals, equipment, and locations the person came in contact with; and

• Follow current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019- ncov/healthcare-facilities/hcp-return-work.html).

6. Did the facility provide appropriate education, monitoring, and screening of staff?	Yes	**No F880**

7. Emergency Preparedness - Staffing in Emergencies

Policy development: Does the facility have a policy and procedure for ensuring staffing to meet the needs of the residents when needed during an emergency, such as a COVID-19 outbreak?

Policy implementation: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the residents? (N/A if an emergency staff was not needed)

Section 3087 of the 21st Century Cures Act, signed into law in December 2016, added subsection (f) to section 319 of the Public Health Service Act. This new subsection gives the HHS Secretary the authority to waive Paperwork Reduction Act (PRA) (44 USC 3501 et seq.) requirements with respect to voluntary collection of information during a public health emergency (PHE), as declared by the Secretary, or when a disease or disorder is significantly likely to become a public health emergency (SLPHE). Under this new authority, the HHS Secretary may waive PRA requirements for the voluntary collection of information if the Secretary determines that: (1) a PHE exists according to section 319(a) of the PHS Act or determines that a disease or disorder, including a novel and emerging public health threat, is a SLPHE under section 319(f) of the PHS Act; and (2) the PHE/SLPHE, including the specific preparation for and response to it, necessitates a waiver of the PRA requirements. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been designated as the office that will coordinate the process for the Secretary to approve or reject each request.

The information collection requirements contained in this information collection request have been submitted and approved under a PRA Waiver granted by the Secretary of Health and Human Services. The waiver can be viewed at https://aspe.hhs.gov/public-health-emergency-declaration- pre-waivers.

7. Did the facility develop and implement policies and procedures for staffing strategies during an emergency? Yes No E0024

Summary of the COVID-19 Focused Survey for Nursing Homes

This is a summary of the COVID-19 Focused Survey for Nursing Homes and the Survey Protocol. Surveyors should review the Survey Protocol for more detailed information as well as the Focused Survey. Facilities can review the Focused Survey to determine CMS's expectations for an infection prevention and control program during the COVID-19 pandemic.

Offsite Survey Activity	Onsite Survey Activity	Facility Self-Assessment
• For facilities with an active COVID-19 case, the survey team should contact their State Survey Agency (SSA), the state health department, and CMS Regional Location to coordinate activities for these facilities. • Ensure surveyors are medically cleared, and have personal protective equipment (PPE) that could be required onsite. • Conduct offsite planning to limit interruptions to care while onsite. Obtain information on: ○ Facility-reported information; ○ CDC, state/local public health reports; ○ Available hospital information regarding patients transferred to the hospital; and/or ○ Complaint allegations. • Identify survey activities that will be conducted offsite, such as: ○ Medical record review ○ Telephonic interviews, such as: ♣ Surveillance policies ♣ First onset of symptoms ♣ Communication to facility leaders and health officials ○ Policy/Procedure Review	• Limit the onsite team to one to two surveyors. • Identify onsite assignments for activities, such as: Resident Care Observations: ○ Hand hygiene practices ○ Proper use/ discarding of PPE ○ Cleansing medical equipment ○ Effective Transmission-Based Precautions Environmental observations: ○ Signage at entrances and resident rooms ○ Screening (staff at shift change, entrances, limiting nonessential staff) ○ Hand hygiene stations Interviews: ○ Policy/Procedure knowledge ○ Surveillance for sign/symptoms ○ Notifying local health officials • Adhere to all CDC guidance for infection prevention and control related to COVID-19. • Provide the facility with the COVID-19 Entrance Conference worksheet and utilize this to request necessary information.	Facilities should utilize the COVID-19 Focused Survey for Nursing Homes as a self- assessment tool. Priority areas for self-assessment include all of the following: 1. Standard Precautions; a. Hand hygiene b. Use of PPE c. Transmission-Based Precautions 2. Resident care (including resident placement); 3. Infection prevention and control standards, policies and procedures; 4. Infection surveillance; 5. Visitor entry (i.e., screening, restriction, and education); 6. Education, monitoring, and

♣ Infect. Control/Prev. Plan ♣ Emerg. Prep. Plan, including contingency strategies (e.g., staffing) • Conduct survey exit discussion telephonically and draft the CMS-2567 offsite.	• Identify and arrange for interviews that can be done telephonically. • Be alert of other immediate jeopardy (IJ) situations that may be present, and investigate appropriately.	screening of staff; and 7. Emergency preparedness – staffing in emergencies

Summary of the COVID-19 Focused Survey for Nursing Homes

Section 3087 of the 21st Century Cures Act, signed into law in December 2016, added subsection (f) to section 319 of the Public Health Service Act. This new subsection gives the HHS Secretary the authority to waive Paperwork Reduction Act (PRA) (44 USC 3501 et seq.) requirements with respect to voluntary collection of information during a public health emergency (PHE), as declared by the Secretary, or when a disease or disorder is significantly likely to become a public health emergency (SLPHE). Under this new authority, the HHS Secretary may waive PRA requirements for the voluntary collection of information if the Secretary determines that: (1) a PHE exists according to section 319(a) of the PHS Act or determines that a disease or disorder, including a novel and emerging public health threat, is a SLPHE under section 319(f) of the PHS Act; and (2) the PHE/SLPHE, including the specific preparation for and response to it, necessitates a waiver of the PRA requirements. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been designated as the office that will coordinate the process for the Secretary to approve or reject each request.

The information collection requirements contained in this information collection request have been submitted and approved under a PRA Waiver granted by the Secretary of Health and Human Services. The waiver can be viewed at https://aspe.hhs.gov/public-health- emergency-declaration-pre-waivers.

COVID-19 Focused Infection Control Survey: Acute and Continuing Care

Surveyors to prioritize survey activities while onsite, and identify those survey activities which can be accomplished offsite. These efficiencies will decrease the potential for transmission of COVID-19, as well as lessen disruptions to the facility and minimize exposure of the surveyor. Surveyors should be mindful to ensure their activities do not interfere with the active treatment or prevention of transmission of COVID-19.
Entry and screening procedures as well as patient care guidance has varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS guidance that is in effect at the time of the survey. Refer to QSO memos released at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.

Content within this tool may be generally applied to any setting. However, CMS recognizes that not all acute and continuing care providers have the same acuity or capacity and therefore, depending upon the setting, not all information will be applicable on every survey (e.g.; aerosol generating procedures section). If citing for noncompliance related to COVID-19, the surveyor(s) must include the following language at the beginning of the Deficient Practice Statement or other place determined appropriate on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to [properly prevent and/or contain – or other appropriate statement] **COVID-19**."

If surveyors see concerns related to compliance with other requirements, they should investigate them in accordance with guidance in the appropriate provider/supplier appendix of the State Operations Manual and related survey instructions. Surveyors may also need to consider investigating concerns related to Emergency Preparedness in accordance with the guidance in Appendix Z of the State Operations Manual (e.g., for emergency staffing).

For purposes of this document, "staff" includes employees, consultants, contractors, volunteers, and others who provide care and services to patients on behalf of the facility. Additionally, the general term "facility" means inpatient, congregate settings, hospitals, intermediate care facilities for individuals with intellectual disabilities, dialysis facilities, and clinics, and "home" refers to settings such as hospice and home health where care is provided in the home.

General guidance: This survey tool provides a focused review of the critical elements associated with the transmission of COVID-19, will help

Entering the Facility/Triage/Registration/Visitor Handling

Prior to entering the facility:

- Is signage posted at facility entrances with visitation restrictions and screening procedures?
- Are signs posted at entrances with instructions to individuals seeking medical care with symptoms of respiratory infection to immediately

  Put on a mask and keep it on during their assessment, cover their mouth/nose when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after contact with respiratory secretions?

  Upon entering the facility:

- Are staff trained on appropriate processes (e.g., questions to ask and actions to take) to rapidly identify and isolate suspect COVID-19

  Cases?

- Is there a process that occurs after a suspected case is identified to include immediate notification of facility leadership/infection control?

Visitation

- Facilities should limit visitation.
- Are facilities actively screening visitors (CDC currently recommends staff are checking for fever and signs and/or symptoms of respiratory

  Infection, and other criteria such as travel or exposure to COVID-19)?

- What is your current screening criteria?
- For permitted visitors are they instructed to frequently perform hand hygiene; limit their interactions with others in the facility; restrict

  Their visit to the patient's room or other location designated by the facility; and offered personal protective equipment (PPE) as supply allows?

  Standard and Transmission-Based Precautions (TBPs)

  CMS is aware that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control. However, CMS does expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact their healthcare coalition for assistance (https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx), follow national and/or local guidelines for optimizing their current supply or identify the next best option to care for patients. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC guidance for healthcare professionals is located at: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html and healthcare facilities is located at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html. Guidance on strategies for optimizing PPE supply is located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the State Agency should contact the CMS Regional Location.

  General Standard Precautions

  Are staff performing the following appropriately:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable patient medical equipment (i.e., cleaning and disinfection per device and disinfectant manufacturer's instructions for use)?

Did the facility perform appropriate screening of visitors?	Yes	**No (see appropriate IPC tags for the provider/supplier type)**

Hand Hygiene

Are staff performing hand hygiene when indicated?

If alcohol-based hand rub (ABHR) is available, is it readily accessible and preferentially used by staff for hand hygiene?

Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), If there are shortages of ABHR, hand hygiene using soap and water is used instead?

Do staff perform hand hygiene (even if gloves are used) in the following situations?

- Before and after contact with patients;
- After contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the care environment;
- After removing personal protective equipment (e.g., gloves, gown, facemask); and
- Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a

  Central venous catheter, medication preparation, and/or dressing care).
  Interview appropriate staff to determine if hand hygiene supplies are readily available and who they contact for replacement supplies.

  Personal Protective Equipment (PPE)

  Determine if staff appropriately use PPE including, but not limited to, the following:

  - Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
  - Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
  - Gloves are changed and hand hygiene is performed before moving from a contaminated site to a clean site during care (body, equipment, etc.);
  - An isolation gown is worn for direct patient contact if the patient has uncontained secretions or excretions;

- A facemask, gloves, isolation gown, and eye protection are worn when caring for a patient with new acute cough or symptoms of an

  Undiagnosed respiratory infection unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis)
  If PPE use is extended/reused, is it done according to national and/or local guidelines? If it is reused, is it cleaned/decontaminated/maintained

  After and/or between uses?
  Interview appropriate staff to determine if PPE is available, accessible and used by staff.

- Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what procedures is the facility taking to address this issue?
- Do staff know how to obtain PPE supplies before providing care?
- Do they know who to contact for replacement supplies?

Did staff implement appropriate hand hygiene?

Aerosol – Generating Procedures

- Appropriate mouth, nose, clothing, gloves, and eye protection (e.g., N95 or higher-level respirator, if available; face shield, gowns) is worn for performing aerosol-generating and/or procedures that are likely to generate splashes or sprays of blood or body fluids and COVID-19 is suspected;
- Some procedures performed on patient with known or suspected COVID-19 could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:

  o Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown.
  o The number of staff present during the procedure should be limited to only those essential for care and procedure support.
  o AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is

  Medically necessary, then it should take place in a private room with the door closed.
  o Clean and disinfect procedure room surfaces promptly as and with appropriate disinfectant. Use disinfectants on List N of the EPA

  website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS- COV-2 or other national recommendations;

Transmission-Based Precautions

Determine if appropriate transmission-based precautions are implemented, including but not limited to:

- Signage on the patient's room regarding need for transmission-based precautions.
- PPE use by staff (i.e., don gloves and gowns before contact with the patient and their care environment while on contact precautions; don

  Facemask within three feet of a patient on droplet precautions; for facilities that use/have N-95 masks - don a fit-tested N95 or higher level

  Respirator prior to room entry of a patient on airborne precautions);

- Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) are used, or if not

  Available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant prior to

  Use on another patient or before being returned to a common clean storage area;

- When transport or movement is medically-necessary outside of the patient room, does the patient wear a facemask?
- Contaminated surfaces, objects and environmental surfaces that are touched frequently and in close proximity to the patient (e.g., bed rails,

  Over-bed table, bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare use (effective against the organism identified if known) at least daily and when visibly soiled.

  Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.

  For providers of care in the home, has the provider, educated patients and family members regarding transmission of infectious diseases and specifically mitigating transmission of COVID-19.

Did staff implement appropriate use of PPE?

Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.

If concerns are identified, expand the sample to include more patients with transmission-based precautions.

Standards, Policies and Procedures

Did the facility establish a facility-wide IPCP including written standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19?

Does the facility's policies or procedures include when to notify local/state public health officials if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected?

Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

Infection Surveillance

Does the facility know how many patients in the facility have been diagnosed with COVID-19 (suspected and confirmed)?

The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of fever, respiratory illness, or other signs/symptoms of COVID-19.

The plan includes early detection, management of a potentially infectious, symptomatic patient and the implementation of appropriate transmission-based precautions/PPE.

The facility has a process for communicating the diagnosis, treatment, and laboratory test results when transferring patients to an acute care hospital or other healthcare provider.

Can appropriate staff (e.g., nursing and leadership) identify/describe the communication protocol with local/state public health officials? Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

Education, Monitoring, and Screening of Staff

• Is there evidence the provider has educated staff on COVID-19 (e.g., symptoms, how it is transmitted, screening criteria, work exclusions)? Page 5

Did the staff implement appropriate transmission-based precautions? Yes **No (see appropriate IPC tags for the provider/supplier type)**

Did the facility develop and implement an overall IPCP including policies and procedures for undiagnosed respiratory illness and COVID-19? Yes No (see appropriate IPC tags for the provider/supplier type)

Did the facility provide appropriate infection surveillance?

COVID-19 Focused Infection Control Survey: Acute and Continuing Care

- How does the provider convey updates on COVID-19 to all staff?
- Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their temperature and documenting absence of illness (or signs/symptoms of COVID-19 as more information becomes available)?

• If staff develop symptoms at work (as stated above), does the facility:

o has a process for staff to report their illness or developing symptoms;
o place them in a facemask and have them return home for appropriate medical evaluation;
o informs the facility's infection Preventionist and include information on individuals, equipment, and locations the person came in

contact with; and
o Follow current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019-

ncov/healthcare-facilities/hcp-return-work.html).

Emergency Preparedness - Staffing in Emergencies

Policy development: Does the facility have a policy and procedure for ensuring staffing to meet the needs of the patients when needed during an emergency, such as a COVID-19 outbreak?

Policy implementation: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the patient? (N/A if an emergency staff was not needed)

Yes No (see appropriate Emergency Preparedness tag for the provider/supplier type)

The following sections are specific nuances to consider and assess when on survey.

Did the facility provide appropriate education, monitoring, and screening of staff? Yes **No (see appropriate IPC tags for the provider/supplier type)**

Did the facility develop and implement policies and procedures for staffing strategies during an emergency?

Considerations Specifically for Surveys of Hospitals and Critical Access Hospitals

Patient Care

• Is the facility restricting patients (to the extent possible) to their rooms except for medically necessary purposes? If patients have to leave their room, are they wearing a facemask, performing hand hygiene, limiting their movement in the facility, and performing social distancing (stay at least 6 feet away from others). If PPE shortage is an issue, facemasks should be limited to patients diagnosed with COVID-19 or has signs/symptoms of respiratory illness or COVID-19.

• Has the facility isolated residents with known or suspected COVID-19 in a private room (if available), or taken other actions based on national (e.g., CDC), state, or local public health authority recommendations?

Did staff provide appropriate care for patients with known or suspected COVID-19? Yes No (Hospital Tag A-0747, CAH Tag C-0278)

Environmental Cleaning

- During environmental cleaning procedures, personnel wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection)?
- Environmental surfaces in patient care areas are cleaned and disinfected, using an EPA-registered disinfectant on a regular basis (e.g., daily), when spills occur and when surfaces are visibly contaminated? Use disinfectants on List N of the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-COV-2 or other national recommendations;
- Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).
- The hospital decontaminates spills of blood or other body fluids according to its policies and procedures, using appropriate EPA-registered hospital disinfectants?

Did staff provide appropriate environmental cleaning for facilities with known or suspected COVID-19? Yes No (Hospital Tag A-0747, CAH Tag C-0278)

Additional Considerations Specifically for Dialysis Facility Surveys

Hand Hygiene Considerations

- Perform handwashing with soap and water at dedicated handwashing sinks if hands are visibly soiled (see § 494.30(a)(1)(i))
- Remove gloves and perform hand hygiene between each patient or dialysis station

Cleaning and Disinfection Considerations

- Items taken to the dialysis station must be either disposed of, dedicated for use on a single patient or cleaned and disinfected before being taken to a common clean area or used on another patient
- Use proper aseptic technique during vascular access care, medication preparation and administration
- Proper cleaning and disinfection of the dialysis station including the dialysis machine, chair, prime waste receptacle, reusable acid and bicarbonate containers after the previous patient fully vacates the station.

• Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. • Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled.
• Proper disposal of bio-hazard waste

Isolation Considerations
• Ensure dedicated machines, equipment, instruments, supplies, and medications that will not be used to care for non-isolation patients.

Did staff implement appropriate hand hygiene, cleaning/disinfection and isolation considerations? Yes **No (see Condition 42 CFR 494.30 and Tags V110-V148)**

Section 3087 of the 21st Century Cures Act, signed into law in December 2016, added subsection (f) to section 319 of the Public Health Service Act. This new subsection gives the HHS Secretary the authority to waive Paperwork Reduction Act (PRA) (44 USC 3501 et seq.) requirements with respect to voluntary collection of information during a public health emergency (PHE), as declared by the Secretary, or when a disease or disorder is significantly likely to become a public health emergency (SLPHE). Under this new authority, the HHS Secretary may waive PRA requirements for the voluntary collection of information if the Secretary determines that: (1) a PHE exists according to section 319(a) of the PHS Act or determines that a disease or disorder, including a novel and emerging public health threat, is a SLPHE under section 319(f) of the PHS Act; and (2) the PHE/SLPHE, including the specific preparation for and response to it, necessitates a waiver of the PRA requirements. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been designated as the office that will coordinate the process for the Secretary to approve or reject each request.

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Human Services. The waiver can be viewed at https://aspe.hhs.gov/public-health-emergency-declaration- pre-waivers.

This is a summary of the COVID-19 Focused Survey for acute and continuing care providers (Non-Long-term care facilities). Surveyors should review the Focused Infection Control Survey tool in light of the established State Operations Manual Survey Protocol for more detailed information. Facilities can review the Focused Survey to determine CMS's expectations for an infection prevention and control program during the COVID-19 pandemic.

Offsite Survey Activity	**Onsite Survey Activity**	**Facility Self-Assessment**
• If the survey team plans to enter a facility with an active COVID-19 case, the survey team should contact their State Survey Agency (SA), the state health department, and CMS Regional Location to coordinate activities for these facilities. • SAs should ensure surveyors are medically cleared, trained in the appropriate use of and have needed personal protective equipment (PPE) that could be required onsite. • Conduct offsite planning to limit interruptions to care while onsite. Obtain information on: ○ Facility-reported information; ○ CDC, state/local public health reports; ○ Complaint allegations. • Identify survey activities that will be conducted offsite, such as: ○ Medical record review ○ Telephonic interviews ○ Facility Policy/Procedure review • Conduct any survey exit discussion with the facility by	• If the survey team identifies an active COVID-19 case after entering a facility, the survey team should contact their SA, the state health department, and CMS Regional Location to coordinate activities for the facility. • Limit the onsite team to one to two surveyors. • Identify onsite assignments for activities, such as: Observations: ○ Hand hygiene practices ○ Proper use/discarding of PPE ○ Cleansing medical equipment ○ Effective Transmission-Based Precautions Interviews: ○ Policy/Procedure knowledge ○ Surveillance for sign/symptoms ○ Notifying local health officials • Adhere to all CDC guidance for infection prevention and control related to COVID-19. • Identify and arrange for interviews that can be done telephonically.	Facilities should utilize the COVID-19 Focused Survey as a self-assessment tool. Priority areas for self-assessment include all of the following: 1. Standard Precautions; a. Hand hygiene b. Use of PPE c. Transmission-Based Precautions 2. Patient care (including patient placement); 3. Infection prevention and control standards, policies and procedures (hand hygiene, PPE, cleaning and disinfection, surveillance); 4. Visitor entry (i.e., screening, restriction, and education);

telephone and draft the CMS-2567 offsite.	• Be alert of other immediate jeopardy (IJ) situations that may be present, and investigate appropriately.	5. Education, monitoring, and screening of staff; and 6. Emergency preparedness – staffing in emergencies

Section 3087 of the 21st Century Cures Act, signed into law in December 2016, added subsection (f) to section 319 of the Public Health Service Act. This new subsection gives the HHS Secretary the authority to waive Paperwork Reduction Act (PRA) (44 USC 3501 et seq.) requirements with respect to voluntary collection of information during a public health emergency (PHE), as declared by the Secretary, or when a disease or disorder is significantly likely to become a public health emergency (SLPHE). Under this new authority, the HHS Secretary may waive PRA requirements for the voluntary collection of information if the Secretary determines that: (1) a PHE exists according to section 319(a) of the PHS Act or determines that a disease or disorder, including a novel and emerging public health threat, is a SLPHE under section 319(f) of the PHS Act; and (2) the PHE/SLPHE, including the specific preparation for and response to it, necessitates a waiver of the PRA requirements. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been designated as the office that will coordinate the process for the Secretary to approve or reject each request.

The information collection requirements contained in this information collection request have been submitted and approved under a PRA Waiver granted by the Secretary of Health and Human Services. The waiver can be viewed at https://aspe.hhs.gov/public-health-emergency- declaration-pre-waivers.

Appendix B

NHICS Job Action Sheets

INCIDENT COMMANDER

Mission: Organize and direct the Nursing Home Command Center (NHCC). Give overall strategic direction for incident management and support activities, including emergency response and recovery. Authorize total facility evacuation if warranted.

Date: _____ Start: _____ End: _____	Name of Person Assigned to Position: _____
Phone: _____ Signature: _____	Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment *(role may be filled by the Nursing Home Administrator or designee)* • Assume the position of Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		

Assess the operational situation
• Activate the emergency operations plan and initiate internal notifications as appropriate
• Determine need for and appropriately appoint Command Staff and Section Chiefs, or Branch Directors, and Medical/Technical Specialists as needed
• Initiate the Incident Briefing of all appointed staff. Include the following:
  ○ Nature of the problem (incident type, victim count, injury/illness type, etc.)
  ○ Safety of staff, residents, and visitors
  ○ Risks to personnel and need for protective equipment
  ○ Risks to the physical plant
  ○ Estimated duration of incident
  ○ Need for modifying daily operations
  ○ Probability of need for shelter-in-place, partial or total evacuation
  ○ Verification of transportation plans
  ○ IMT positions required to manage the incident		

Immediate Response (0-2 hours)	Time	Initial
○ Need to notify state licensing agency ○ Overall community response actions being taken ○ Status of local, county, and state Emergency Operations Centers (EOC)		
• Distribute corresponding Job Action Sheets and position identification (see NHICS 207) • Designate time for the next Briefing or Incident Action Planning meeting		
Determine the incident objectives, tactics, and assignments • Receive verbal status reports from Command Staff to determine response and recovery levels and incident objectives • Identify the operational period and NHCC shift change (e.g. every 12 hours) • Receive initial facility damage survey report from Infrastructure Branch Chief and evaluate the need for evacuation • Obtain resident census and status from Planning Section Chief, and request a facility-wide projection report for 4, 8, 12, 24, and 48 hours from time of incident onset. Adjust projections as necessary		
Activities • Consider the use of an alternative staff time tracking method. Delegate to Finance Administration Section Chief if activated: ○ Distribute time sheets to staff and Medical Director/Specialist assigned to Command, and ensure time is recorded appropriately ○ Determine the frequency that staff should submit these time sheets to the Finance/Administration Section Chief (e.g. at the completion of a shift or at the end of each operational period) • Seek information from Section Chiefs regarding current "on-hand" resources of medical equipment, supplies, medications, food, and water as indicated by the incident and authorize as needed. Delegate to Logistics Section Chief if activated • Ensure that appropriate contact with outside agencies has been established and that facility status/resource information is provided to appropriate agencies through the Liaison/Public Information Officer (PIO) • Work with Liaison/PIO to draft initial message for notification to family members, responsible parties, and/or other "need to know" parties regarding the resident and facility status • As appropriate to the incident, authorize a resident prioritization assessment for the purposes of designating appropriate transfer or discharge (e.g. ventilator and /or dialysis residents may need to be		

Immediate Response (0-2 hours)	Time	Initial
discharged to higher level of care or ambulatory residents may need to go first) • Assess current or projected generator load and fuel supply		
Resources • Assign one or more clerical personnel from current staffing to function as the NHCC Scribe/Runner at IMT Briefings or other meetings as appropriate • Delegate tasks as the demand and workload increase		
Communication • Utilize available communications technology or a runner to alert staff regarding the incident • Initiate emergency notification to residents, families and external partners • Notify nursing home Chief Executive Officer, Board of Directors, state survey agency, and other appropriate internal and external officials of situation status		
Safety and security • Review security and facility surge capacity and capability plans as appropriate		

Intermediate Response (2-12 hours)	Time	Initial
Activities • Continue to authorize resources as needed or requested by Command Staff/Section Chiefs • Designate regular briefings with Command Staff/Section Chiefs to identify and plan for: o Update of current situation/response and status of other area long-term care facilities, hospitals, emergency management/local emergency operation centers, and public health officials and other community response agencies o Facility operational support issues o Risk communication and situation updates to staff and families o Implementation of facility surge capacity procedures o Ensuring resident tracking system is established and linked with appropriate outside agencies and/or local Emergency Operations Center o Appropriate use and activation of safety practices and procedures o Enhanced staff protection measures as appropriate o Media relations and briefings		

Intermediate Response (2-12 hours)	Time	Initial
○ Staff and family support • As needed, conduct Incident Action Planning meetings or collect information from Section Chiefs and Command Staff to determine appropriate response to changing conditions and recovery levels • Oversee and approve revision of the IAP developed by the Planning Section Chief • Update overall objectives, tactics, and assignments • Initiate planning for transfer of command as appropriate • Approve media releases submitted by the Liaison/PIO • Ensure that the approved IAP is communicated to all Command Staff and Section Chiefs • Communicate facility and incident status and the IAP to CEO or designee, or to other executives on a need-to-know basis		
Resources • Authorize resources as needed or requested by Command Staff and Section Chiefs		
Communication • Communicate with other health care facilities to determine their ability to accept residents if transferred • Continue coordination with the Liaison/PIO for internal and external messaging and briefings		
Safety and security • Ensure that resident and personnel safety measures and risk reduction actions are followed		

Extended Response (greater than 12 hours)	Time	Initial
Activities • Ensure that briefings of staff, residents and the medical community are regularly conducted • Evaluate overall operational status, and ensure critical issues are addressed • Review /revise the IAP with the Planning Section Chief for each operational period and report on plan at shift change/briefings • Upon transfer of command, brief your replacement on the status of all ongoing operations, critical issues, relevant incident information, and IAP for the next operational period • Ensure continued communications with local, regional, and state response coordination centers, families, and other Nursing Home Incident Command Centers (NHCCs) through the Liaison/PIO and others		

Extended Response (greater than 12 hours)	Time	Initial
Resources • Authorize resources as needed or requested by Command Staff and Section Chiefs		
Communication • Continue to update for staff, residents, families and external partners • Continue coordination with the Liaison/PIO for internal and external messaging and briefings • Update the nursing home CEO, Board of Directors, state survey agency, and other appropriate internal and external officials of situation status		
Safety and security • Ensure your physical readiness, and that of all Staff and volunteers, through proper nutrition, water intake, rest periods and relief, and stress management techniques		

Demobilization/System Recovery	Time	Initial
Activities • Assess the plan developed by Planning and Operations for the gradual demobilization of the NHCC and emergency operations according to the progression of the incident and facility status • Demobilize positions in the NHCC and return personnel to their normal jobs as appropriate until the incident is resolved and there is a return to normal operations • Brief staff, administration, and other executives • Approve announcement of “ALL CLEAR” when the incident no longer poses a critical safety threat or can be managed using normal facility operations • Ensure outside agencies and families are aware of status change • Ensure demobilization of the facility and restocking of supplies, as appropriate including: o Return of borrowed equipment to appropriate location o Replacement of broken or lost items o Clean up facility, command center and environment, as warranted. o Restock of NHCC supplies and equipment • Ensure that after-action activities are coordinated and completed including: o Collection of all NHCC documentation by the Planning Section Chief		

Demobilization/System Recovery	Time	Initial
○ Coordination and submission of response and recovery costs, and reimbursement documentation by the Finance/Administration and Planning Section Chiefs ○ Conducting staff debriefings to identify accomplishments, and response and improvement issues ○ Identification of needed revisions to the emergency operations plan, Job Action Sheets, operational procedures, records, and/or other related items ○ Writing the facility After Action Report and Improvement Plan ○ Post-incident media briefings and facility status updates ○ Post-incident education and information for residents, staff, and families		
Communication • Communicate final nursing home status and termination of the incident to local EOC, area nursing homes, officials, and state survey agency		

Documents and Tools
☐ Communication plan
☐ Business Continuity Plan
☐ Facility emergency operations plan and other plans as cited in the Job Action Sheets
☐ Facility organizational chart
☐ Facility telephone directory

LIAISON/PUBLIC INFORMATION OFFICER (PIO)

Mission: Function as the incident contact person in the facility for representatives from other agencies such as local emergency management, law enforcement, licensing agencies and serve as the conduit for information to internal and external stakeholders, including residents, staff, visitors and families, and the news media, as approved by the Incident Commander.

Date: _____ Start: _____ End: _____ Name of Person Assigned to Position: _____

Phone: _____ Signature: _____ Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment • Receive appointment from the Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		
Activities • Activate the facility communication plan • Obtain initial status and information from the Planning Section Chief to provide as appropriate to external stakeholders, and local and/or county Emergency Operations Center, upon request: o Resident Care Capacity: Current census and the number of residents that can be accommodated within the nursing home o Nursing Home's Overall Status: Current condition of nursing home structure, security, staffing and utilities o Any current or anticipated shortage of critical resources including personnel, equipment, supplies, medications, etc. o Number of residents and mode of transportation for residents requiring transfer to hospitals or receiving facilities, if applicable o Any resources that are requested by other facilities (e.g., personnel, equipment, supplies, medications, etc.) • Report current nursing home status; communicate changes, critical issues and unmet resource needs to assisting and cooperating organizations (e.g., other facilities, local EOCs, public health and/or regulatory agencies) • Establish a designated media staging and briefing area located away from the Nursing Home Command Center (NHCC) and resident services activity areas. Inform on-site media of the physical areas to which they have access and those that are restricted. Coordinate designation of such areas with the Infrastructure Branch Director • Contact external PIOs from community and governmental agencies to collaborate on public information and media messages being developed by those entities. Ensure consistent and collaborative messages from all entities • Assess the need to activate a staff and/or family member "hotline" for live or recorded information concerning the incident and the facility status. Establish if needed • Develop public information and media messages to be reviewed and approved by the Incident Commander before release to families, the news media and the public.		

Immediate Response (0-2 hours)	Time	Initial
• Attend all Command briefings and incident action planning meetings to gather and share incident and facility information		
Resources • Conduct or assign personnel to monitor, and report to you, incident and response information from sources such as the internet, radio, television, and newspapers		
Communication • Use available communications technology or a runner to alert staff regarding the incident, as directed by the Incident Commander • Initiate emergency notification to residents, family/guardians and external partners		

Intermediate Response (2-12 hours)	Time	Initial
Activities • Continue to attend all Command briefings and incident action planning meetings to gather and share incident and facility information. Contribute media and public information activities and goals to the Incident Action Plan (IAP) • Request and offer assistance and information as needed through the emergency communication network or from the local and/or regional Emergency Operations Center • Respond to requests and issues from IMT members regarding inter-organization (e.g., other nursing homes, hospitals, governmental entities, response partners) problems • Review the facility's emergency admit/resident tracking status (see NHICS 254 and 255). Report to appropriate authorities the following minimum data: o Casualty Data; type, number and seriousness of injuries to residents, staff, and visitors o Current resident census o Number of new residents admitted and level of care needs o Number of residents transferred to hospitals, discharged home, or transferred to other facilities		

Intermediate Response (2-12 hours)	Time	Initial
• Continue contact and dialogue with external PIOs, from community and governmental agencies to ascertain public information and media messages being developed by those entities. Coordinate translation of critical communications into multiple languages as needed for resident and families • Continue to develop and revise public information and media messages to be reviewed and approved by the Incident Commander before release to the news media and the public. Issue regular and timely incident information reports to the news media in collaboration with of the Planning Section Chief • Utilize internal nursing home communications systems (e.g., email, intranet, internal TV, written report postings) to disseminate current information and status update messages to staff • Assess the need to activate a "hotline" for recorded information concerning the incident and facility status, and establish the "hotline" if needed • Review the need for updates of critical information through directional signage for staff, visitors, and media. Assist in the development and dissemination of signage		
Communication • Continue updates for staff, residents, families and external partners, including resident condition and evacuation staff, if applicable • Continue coordination with the Incident Commander for internal and external messaging and briefings		

Extended Response (greater than 12 hours)	Time	Initial
Activities • Continue to receive regular progress reports from the Incident Commander, Section Chiefs and others, as appropriate • Coordinate with the Logistics Section Chief to determine requests for assistance to be released to the public via the media • Communicate with Logistics Section Chief on status of supplies, equipment and other resources that could be mobilized to other facilities, if needed or requested • With approval from Incident Commander conduct ongoing news conferences, providing updates on resident information and operational status. Facilitate staff and resident interviews as appropriate • Ensure ongoing information coordination with other agencies, hospitals, local Emergency Operations Center and the Joint Information Center • Prepare and maintain records and reports as indicated or requested		

Extended Response (greater than 12 hours)	Time	Initial
• Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information		
Communication • Continue updates for staff, residents, families and external partners, including return to normal operations • Continue coordination with the Incident Commander for internal and external messaging and briefings		

Demobilization/System Recovery	Time	Initial

Activities
• Coordinate release of final media briefings and reports
• Ensure return/retrieval of equipment and supplies, and return all assigned incident command equipment
• Upon deactivation of your position, brief the Incident Commander on current problems, outstanding issues, and follow-up requirements
• Participate in after-action debriefings and document observations and recommendations for improvements for possible inclusion in the After-Action Report. Topics include:
  ○ Accomplishments and issues
  ○ Review of pertinent position descriptions and operational checklists
  ○ Recommendations for procedure changes
• Participate in after-action meetings and debriefings as required		

Documents and Tools
☐ Communication plan ☐ Facility emergency situational plan ☐ Facility organizational chart ☐ Facility telephone directory ☐ cell/internet phone ☐ Community and governmental PIO and Joint Information Center contact information ☐ Local media contact information

MEDICAL DIRECTOR/SPECIALIST

Mission: Consult with the Incident Commander and/or Operations Section Chief on the medical, biological/infectious, and/or hazmat implications related to the event as indicated by incident needs and scope of practice. Oversee medical services and assist with diagnosis, treatment and medical management of residents and injured staff.

Date: _____ Start: _____ End: _____	Name of Person Assigned to Position: _____
Phone: _____ Signature: _____	Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment • Receive appointment from the Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		
Assess the operational situation • Obtain initial status briefing and information from the Incident Commander, Operations and/or Planning Section Chiefs and identify priority actions which could include: o Triage of injured residents, employees and non-employees on the premises o Resident acuity determinations related to admissions, transfers and/or evacuation o Types of biological, environmental, radiological, chemical and/or infectious hazards involved o Current guidance on the prevention, precautions and treatment of medical problems associated with the identified hazards		
Activities • Participate in Incident Action Plan (IAP) preparation, briefings, and meetings with the Incident Commander as needed • Assist in the identification of medically-related resource requirements as appropriate		

Immediate Response (0-2 hours)	Time	Initial
• Maintain communications with the Operations Section Chief to identify critical resident issues and resource needs • Work with the Safety Officer, the Infrastructure Branch Director and others to determine safety risks of the incident to personnel, the physical plant, and the environment. Advise the Incident Commander and Section Chiefs of any unsafe condition and corrective recommendations • If the incident involves biological or infectious disease recommend and maintain appropriate isolation precautions and staff protection		
Communication • Communicate with the Operations Section Chief information regarding specific decontamination and treatment procedures • Reach out to the local health department and emergency management to advise the Incident Commander if the external area is safe for discontinuation of shelter-in-place (i.e. plume incident) • In conjunction with the Incident Commander determine the threat (if any) to the nursing home and the need for shelter-in-place or facility evacuation (i.e., hazardous materials incident)		

Intermediate Response (2-12 hours)	Time	Initial
Activities • Continue to attend briefings and Incident Action Planning meetings as needed to gather and share critical incident and resident status information. Contribute information as needed for incorporation into the goals to the IAP • Continue to consult with Resident Services Branch Director on issues related to resident care and monitor the delivery and quality of nursing care in resident areas as needed • Evaluate and consult on key ethical issues related to the incident such as standards of care and use of limited resources. Develop recommendations for addressing these issues • Respond to requests and issues from Incident Management Team (IMT) members regarding medical issues • Attend command briefings and Incident Action Planning meetings as needed to gather and share critical incident and resident status information. Contribute information as needed for incorporation • Oversee the communication with attending, receiving, and/or referring physicians, and emergency medical personnel and intervene as needed to facilitate the coordination of resident care		

Intermediate Response (2-12 hours)	Time	Initial
• Maintain communication with the Public Health Department to obtain current information on status, precautions, and treatment of illness and injuries related to the incident and provide required reports		
Communication • Maintain communications with the Operations Section Chief information regarding specific decontamination and treatment procedures • Continue reaching out to the local health department and emergency management to advise the Incident Commander if the external area is safe for discontinuation of shelter-in-place		

Extended Response (greater than 12 hours)	Time	Initial
Activities • Continue to attend briefings and Incident Action Planning meetings as needed to gather and share critical medical advice and resident status information • Continue to oversee communication with attending physicians and the Public Health Department as needed related to the incident and to provide required reports		
Communication • Maintain communications with the Operations Section Chief information regarding specific decontamination and treatment procedures • Continue reaching out to the local health department and emergency management to advise the Incident Commander if the external area is safe for discontinuation of shelter-in-place (i.e. plume incident)		

Documents and Tools
☐ Facility emergency operations plan ☐ Facility organizational chart ☐ Facility telephone directory

SAFETY OFFICER

Mission: Ensure safety of staff, residents, and visitors; monitor and correct hazardous conditions. Have authority to halt any operation that poses immediate threat to life and health.

Date: _____ Start: _____ End: _____	Name of Person Assigned to Position: _____
Phone: _____ Signature: _____	Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment • Receive appointment from the Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		
Assess the operational situation • Identify risks to the facility • Assess safety of staff, residents and visitors • Initiate environmental monitoring as indicated by the incident or hazardous condition		
Determine the incident objectives, tactics, and assignments • Establish contact with local public safety agencies as well as other facilities, as appropriate to access any pertinent safety information • Provide information to the Incident Commander including safety-related capabilities and limitations		
Activities • Attend all briefings and Planning meetings to gather and share incident and facility safety requirements. Contribute safety issues, activities, and goals to the Incident Action Plan (IAP) • Work with the Medical Director/Specialist, the Infrastructure Branch Director and others to determine safety risks of the incident to personnel, the physical plant, and the environment. Advise the Incident Commander		

Immediate Response (0-2 hours)	Time	Initial

and Section Chiefs of any unsafe condition and corrective recommendations
• Work with Incident Command staff in designating restricted access areas and providing signage.
  ○ Identify and secure all facility pedestrian and traffic points of entry, as appropriate
• Coordinate all of the activities related to facility security such as access control, crowd and traffic control, and law enforcement interface
• Evaluate building and/or incident hazards and identify vulnerabilities using the Facility System Status Report (see NHICS 251)
• Consider need for the following, and report findings to the Operations Section Chief:
  ○ Emergency lockdown
  ○ Security/bomb sweep of designated areas
  ○ Providing urgent security-related information to all personnel
  ○ Need for security personnel to use personal protective equipment
  ○ Removing unauthorized persons from restricted areas
  ○ Security of the facility, common areas, resident care, morgue, and other sensitive or strategic areas from unauthorized access
  ○ Rerouting of vehicle entry and exit as needed for safety
  ○ Security posts in any operational decontamination area
  ○ Patrol of parking and shipping areas for suspicious activity
  ○ Traffic school
• Specify type and level of Personal Protective Equipment (PPE) to be utilized by staff to ensure their protection, based upon the incident or hazardous condition (with medical consultation if possible)
• Monitor operational safety of resident services and/or decontamination operations if applicable
• Identify and report all hazards and unsafe conditions to the Incident Commander
• Initiate environmental monitoring as indicated by the incident or hazardous condition
• Assess nursing home operations and practices of staff, and terminate and report any unsafe operation or practice, recommending corrective actions to ensure safe service delivery		

Resources • Obtain non-entry signage around unsafe or restricted areas, as needed • Request a Scribe/Runner as needed from the Logistics Section Chief, if activated, to perform documentation and tracking		
Communication		

Immediate Response (0-2 hours)	Time	Initial
• Immediately notify the Incident Commander and Operations Section Chief of any internal or external areas that are unsafe for occupancy or use • Work with Liaison/PIO to obtain contact information for police with local jurisdiction. Depending on the nature of the event, make initial contact to open communication channels		
Safety and security • Address immediate security personnel needs using current staff, surrounding resources (police, sheriff, or other security forces), and communicate need for additional external resources through Operations Section		

Intermediate Response (2-12 hours)	Time	Initial
Activities • Attend all Command briefings and incident action planning meetings to gather and share incident and facility information. Contribute safety issues, activities, and goals to the IAP • Coordinate translation of critical communications into languages for residents and/or staff as necessary to safety • In conjunction with the Infrastructure Branch Director, continue to assess safety risks of the incident to personnel, the facility, and the environment; advise the Incident Commander and Section Chiefs of any unsafe conditions and corrective recommendations • Ensure proper equipment needs are met and equipment is operational prior to each operational period • Communicate the need and take actions to secure unsafe areas; post non-entry signs • Ensure associated staff identify and report all hazards and unsafe conditions • Ensure vehicular and pedestrian traffic control measures are working effectively • Continue to observe all staff and volunteers for signs of stress and at risk behavior		
Communication • Coordinate activities with local, state, and federal law enforcement, as appropriate with the Liaison/PIO • Report staff injury and illness for follow up by Finance/ Administration Section Chief		

Intermediate Response (2-12 hours)	Time	Initial
Safety and security • Ensure continued implementation of all safety practices and procedures in the facility		

Extended Response (greater than 12 hours)	Time	Initial
Activities • Continue to reassess the safety risks of the extended incident to personnel, the facility, and the environment, and report appropriately; advise the Incident Commander and Section Chiefs of any unsafe condition and corrective recommendations • Continue to attend Command briefings and incident action planning meetings to share incident and nursing home information. Contribute safety issues, activities and goals to the IAP • Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques • Continue to observe all staff and volunteers for signs of stress and at risk behavior • Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information		
Communication • Continue coordination activities with local, state, and federal law enforcement, as appropriate with the Liaison/PIO • Follow up on and continuing reporting staff injury and illness for follow up by Finance/ Administration Section Chief		
Safety and security • Ensure continued implementation of all safety practices and procedures in the facility		

Demobilization/System Recovery	Time	Initial
Activities • Ensure facility and any impacted areas are ready for safe return of residents and staff • Ensure return/retrieval of equipment and supplies, and return all assigned incident command equipment • Upon deactivation of your position, brief the Incident Commander on current problems, outstanding issues, and follow-up requirements		

Demobilization/System Recovery	Time	Initial

• Participate in after-action debriefings and document observations and recommendations for improvements for possible inclusion in the After-Action Report. Topics include:
  ○ Accomplishments and issues
  ○ Review of pertinent position descriptions and operational checklists
  ○ Recommendations for procedure changes
• Participate in after-action meetings and debriefings as required
• Complete documentation and follow up for personnel injuries as appropriate		

Documents and Tools
☐ Facility emergency operations plan ☐ Communication plan ☐ Facility organizational chart ☐ Facility telephone directory

OPERATIONS SECTION CHIEF

Mission: Develop and implement strategy and operations to carry out the objectives established in the Incident Action Plan (IAP). Oversee the direct implementation of nursing home's resident care and services, and infrastructure operations.

Date: _____ Start: _____ End: _____ Name of Person Assigned to Position: _____

Phone: _____ Signature: _____ Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment • Receive appointment from the Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		
Assess the operational situation • Obtain information and status from Operations Branch Directors, if assigned • Provide initial information to the Incident Commander on the operational situation including capabilities and limitations		
Activities • Establish an Operations Section area (preferably in close proximity to IC) to support section briefings, meetings and the updating of assignments • Participate in briefings and Incident Action Plan preparation/meetings with Incident Commander: o Gather and share critical incident and resident status information o Discuss section-level objectives, assignments, strategies/tactics, and resources needed. • Identify projected resident care needs with the Medical Director/Specialist and Resident Services Branch Director. • Serve as primary contact with the Medical Director/Specialist		

Immediate Response (0-2 hours)	Time	Initial
• Brief the Incident Commander on facility's internal factors that may impact the decision to evacuate or shelter in place (e.g. Resident acuity, physical plant damage, etc.)		
Resources • Maintain communications with Resident Services Branch Director and Logistics Section Chief to ensure the accurate movement and tracking of residents, personnel and resources to appropriate areas • Maintain communications with the Infrastructure Branch Director to ensure repair and cleanup (plant operations)		
Communication • Communicate Branch-level activities and concerns to the Incident Commander		
Safety and Security • Ensure Operations Section personnel comply with safety policies and procedures • Determine if a communicable disease risk exists; implement appropriate response procedures collaborating with the appropriate Medical-Technical Specialist, if activated • Ensure personal protective equipment (PPE) is available and utilized appropriately in coordination with the Safety Officer		

Intermediate Response (2-12 hours)	Time	Initial
• Meet regularly with the Incident Commander; Command Staff, and other Section Chiefs to update them the status of the Operations Section and obtain important info to relay to Resident and Infrastructure Branches • Implement evacuation procedures at the direction of the Incident Commander and with the assistance of the Resident Services Branch Director and other Section Chiefs • Ensure the following are being addressed: o Section Staff health and safety o Resident tracking on appropriate NHICS forms *(see **Appendix for tracking tools)*** o Resident care o Bed availability o Inter-facility transfers (into and from facility) o Information sharing with local Emergency Operations Center, local hospitals, public health, and law enforcement in coordination with the Incident Commander and Liaison • Resident-related resource movement through (area of refuge) Documentation		

Intermediate Response (2-12 hours)	Time	Initial
• Schedule planning meetings with Branch Directors to update the Section objectives, strategies, tactics and resources • Coordinate resident care treatment standards and case definitions of infectious diseases with public health officials, as appropriate • Ensure that the Operations Section is adequately staffed and supplied • Coordinate personnel, supply, and equipment needs with Logistics, projections and needs with the Planning Section, and financial matters with the Finance/Administration Section		
Resources • Maintain communications with Resident Services Branch Director and Logistics Section Chief to ensure the accurate movement and tracking of residents, personnel and resources to appropriate areas • Maintain communications with the Infrastructure Branch Director to ensure repair and cleanup (plant operations)		

Extended Response (greater than 12 hours)	Time	Initial
• Continue to monitor Operations Section personnel's ability to meet workload demands, staff health and safety, resource needs and documentation practices • Conduct regular situation briefings with Operations Section Branch Directors ***Resident Care*** • Address the following issues: o Bed availability o Resident transfers o Resident tracking o Resident health and safety o Mental/Behavioral health for residents, staff, and dependents sheltering at the facility o Staffing needs o Staff prophylaxis o Medications o Medical equipment and supplies o Resident-related resource movement through (area of refuge) o Linkages with the medical community, area facilities, and other healthcare facilities		
Infrastructure • Assess capacity to deliver: o Nutrition/hydration Facility heating and air conditioning		

Extended Response (greater than 12 hours)	Time	Initial
○ Power ○ Telecommunications ○ Potable and non-potable water ○ Medical gas delivery ○ Sanitation ○ Road clearance ○ Damage assessment and repair ○ Facility cleanliness ○ Vertical transport/airlift ○ Facility access • Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information		
Resources • Continue to maintain communications with: ○ Resident Services Branch Director and Logistics Section Chief to ensure the accurate movement and tracking of residents, personnel and resources to appropriate areas ○ Infrastructure Branch Director to ensure repair and cleanup (plant operations)		
Communication • Continue communicating Branch-level activities and concerns to the Incident Commander		

Demobilization/System Recovery	Time	Initial
• As needs decrease, return Operations Section staff to their usual jobs and combine or deactivate positions in a phased manner, in coordination with the Planning Chief • Coordinate resident care restoration to normal services • Coordinate final reporting of resident information with external agencies through Incident Commander • Work with Planning and Finance/Administration Sections to complete cost data information • Debrief staff on lessons learned and procedural/equipment changes needed • Upon deactivation of your position, brief the Incident Commander on current problems, outstanding issues, and follow-up requirements • Submit comments to the Incident Commander for discussion and possible inclusion in an after-action report; topics include: ○ Review of pertinent position descriptions and operational checklists		

Demobilization/System Recovery	Time	Initial
○ Recommendations for procedure changes ○ Section accomplishments and issues • Participate in after-action meetings and debriefings as required • Provide behavioral health support to staff if needed or requested		

Documents and Tools
☐ Facility emergency operations plan ☐ Communication plan ☐ Facility organizational chart ☐ Facility telephone directory

LOGISTICS SECTION CHIEF

Mission: Organize and direct those operations associated with maintenance of the physical environment of the facility and the NHCC. This includes adequate levels of personnel, food, equipment, information technology/systems and all supplies to support incident activities. Arrange and coordinate transportation and transport needs for all ambulatory and non-ambulatory residents, personnel and material resources.

Date: _____ Start: _____ End: _____	Name of Person Assigned to Position: _____
Phone: _____ Signature: _____	Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment • Receive appointment from the Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		
Assess the operational situation • Obtain information from the Operations Section Chief and Branch Directors to assess critical issues and resource needs • Provide information to the Incident Commander on the Logistics Section operational situation including capabilities and limitations		

Activities
• Participate in briefings and Incident Action Plan (IAP) preparation/meetings with Incident Commander:
  ○ Gather and share critical incident logistics information
  ○ Discuss section-level objectives, assignments, strategies/tactics, and resources needed.
• Assist in damage assessment, strategic planning, work assignments, and the identification of resource requirements
• Identify, mobilize, dispatch and track all resources used during the incident
• Maintain communications with Operations Section Chief and Branch Directors to identify critical issues and resource needs. Including:		

Immediate Response (0-2 hours)	Time	Initial
○ Identification of the number of non-staff (e.g. staff dependents, visitors) requiring shelter in the facility, ○ Type of supply needs and project duration of need for non-staff, ○ On-hand inventory of general equipment and supplies needed for the next 6 days, based on the type of event, ○ Transportation requirements and needs for residents, personnel, and materials • Determine location of (area of refuge) and prepare for the receipt and distribution of personnel, supplies, equipment, pharmaceuticals and/or the movement of residents and vehicles in event that emergency admits, or evacuation is required • Coordinate with the Resident Services Branch Director to set up (area of refuge) for resident evacuation, if needed • For movement of residents within the facility or to a (area of refuge), use staff from across departments to assist in the gathering and placement of transport equipment. Work with Resident Services Branch Director to monitor status of resident movement • Ensure resource ordering procedures are communicated to appropriate Sections and requests are timely and accurately processed • Inventory available in house and out of facility transportation resources: ○ Available facility transportation resources (vans, buses, staff cars) ○ Available outside of facility transportation resources (vans, buses, shuttles, ambulances) ○ Coordinate with Operations Chief, Resident Care Services to identify the total number of residents requiring transport, and what kind of transport they can utilize (e.g. car, van, bus, and ambulance) and transport equipment (e.g. gurneys, litters, wheelchairs and stretchers) ○ Coordinate requests for private sector transportation with vendor(s) per existing response plans and agreements, or, as a last resort, with the Liaison Officer through the local Emergency Operations Center (EOC) for public sector support ***Facility-specific*** • Contribute to the Facility System Status Report (NHICS 251) and obtain completed form from the Infrastructure Branch Director to learn what supplies/services may need to be ordered to effect repairs. Determine what functions of the facility are: ○ Fully functional 100% operable with no limitations ○ Partially functional, operable or somewhat operable with limitations ○ Non-functional, out of commission		

Immediate Response (0-2 hours)	Time	Initial

• Document location, reason, and time/resource estimates for necessary repair of any system that is not fully operational
• For Facility support coordinate with the Infrastructure Branch Director (Operations Section) to determine on hand inventory of the following:
  o Gasoline and other fuels
  o Oxygen
  o Power generators
  o Water (non-drinkable)
  o Extension cords
  o Flashlights
  o Batteries
  o Fans
  o Garbage bags
  o Duct and masking tape
• For Resident and Staff Support, determine on hand inventory of the following, based on the type of event but not limited to:
  o Medications
  o Medical Supplies:
  ▪ Biohazard management
  ▪ Medication cups and straws
  ▪ Disposable briefs and washcloths
  ▪ Plastic draw sheets
  ▪ Sterile soaps
  ▪ Catheter kits
  ▪ Nasogastric tubes and Gastrostomy tubes
  ▪ Tube feedings and pumps
  ▪ Lancets for blood sugar
  ▪ Dressings/bandages
  ▪ Oxygen, administration masks, ventilators and suction devices
  o Linens
  o Plastic bags
• Ensure proper cleaning and disinfection of the nursing home environment
• Acquire, inventory, and provide medical and non-medical care equipment and supplies
Information Technology		

Immediate Response (0-2 hours)	Time	Initial
• Inventory and assess status of other on-site communications equipment, including two-way pagers, internal and external telephone/fax, satellite phones, public address systems, data message boards; initiate repairs per standard operating procedures • Set up and maintain communication equipment and provide ongoing support for the facility's Incident Command Center location • Activate recorded emergency message on facility phone if indicated, informing callers of alternative number or website to check for status information • Inventory and assess IT systems, hardware and software • As time and the emergency event allows, take immediate steps to protect the facility's hard drives, monitors, cords, etc. from damage • Identify potential needs and obtain equipment, supplies, and outside vendors as needed to assist in the recovery, preservation, and/relocation of critical data • Acquire access to all essential business records (resident records, purchasing contracts, billing and insurance data) ***Staffing*** • Inventory the number and classify staff presently available • In an evacuation scenario, work with Resident Services Branch Director, and Section Chiefs as needed to assign and verify personnel going to all receiving facilities • Determine from all section's levels of personnel and additional resources needed for next operational period and place emergency orders as needed		
Resources • Work with the Finance/Administration Chief on the preparation of additional service and equipment contracts and record any expenses related to the emergency event • Keep Planning Section Chief updated with status and utilization of resources		
Communication • Reach out to the Resident Services Branch Director and Infrastructure Branch Director to ensure staff, resident and facility supply needs are being met • Establish and maintain contact with vendors		

Immediate Response (0-2 hours)	Time	Initial
• Work closely with the Finance/Administration Section Chief to verify the screening process and/or credentialing of newly recruited and/or volunteer staff		

Intermediate Response (2-12 hours)	Time	Initial

Activities
• Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response
• Continue to report information gathered to the Incident Commander of any internal factors which may influence the decision to evacuate or shelter in place including:
  • Transportation
  • Status of receiving facilities
  • Supplies
  • Staff availability
• Obtain needed material and fulfill resource requests with the assistance of the Finance/ Administration Section Chief and Liaison Officer
• Initiate the Resource Accounting Record (see NHICS 257) to track resources include staff, resident care supplies, communication hardware and food/water
• Continue to ensure the following are being addressed:
  • Maintenance and resupply of critical inventories (e.g. food, water, medical supplies)
  • Staff dependent care
  • Provision of supplies
  • Transportation services and equipment
• Provide mechanisms to alert the Operations Section Chief and Safety Officer to respond to internal resident and/or physical emergencies (e.g., cardiac arrest, fire, etc.), if primary communications systems fail
• Coordinate the use of external resources to assist with service delivery and utilize (area of refuge)
• In coordination with Safety Officer, monitor the area continuously for safety and dependent needs (e.g., medical needs, including medications, medical care and nutrition)
• Continue coordination of transportation resources/shipments into and out of the facility with the vendor by phone or local EOC
Facility-specific
• Closely monitor building system status, equipment and supply usage		

Intermediate Response (2-12 hours)	Time	Initial
• Re-stock facility management and support areas, supply closets, and carts per request and at least every 8 hours ***Information Technology*** • Assess immediate and future impact of the incident on IT systems and establish priorities for use of available IT/IS systems, including computer hardware, software and infrastructure support to staff • Maintain communications systems (both internal and external connectivity) and network capability • Ensure maintenance, restoration and back up of critical clinical and business data including resident medical records, billing, and business/financial records		
Resources • Ensure equipment, supplies, and personal protective equipment (PPE) are replaced as needed, coordinating with Operations Section Chief		
Communication • Continue to reach out to the Resident Services Branch Director and Infrastructure Branch Director to ensure staff, resident and facility supply needs are being met • Continue to work closely with the Finance/Administration Section Chief to verify the screening process and/or credentialing of newly recruited and/or volunteer staff. Resolve any issues that arise		

Extended Response (greater than 12 hours)	Time	Initial
Activities o Continue to attend regular briefings and meetings o Maintain the Resource Accounting Record (see NHICS 257) to track equipment used during the response o Receive and archive all documentation related to internal and external facility communication systems o Report unexpected problems and unresolved issues immediately ***Staffing*** o Anticipate increased staff needs created by increased numbers of residents, longer working hours, and concerns about family welfare o Coordinate referrals to in-house Resident Services Branch to treat staff needing psychological support o Expand dependent-care capacity as situation warrants and resources allow		

Extended Response (greater than 12 hours)	Time	Initial
○ Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information		
Resources • Monitor levels of all supplies and equipment, and collaborate as needed		
Communication • Continue to reach out to the Resident Services Branch Director and Infrastructure Branch Director to ensure staff, resident and facility supply needs are being met		

Demobilization/System Recovery	Time	Initial
Activities ○ Coordinate return of all assigned equipment to appropriate locations and restock NHCC supplies ○ Ensure return/retrieval of equipment and supplies and return of all assigned incident command equipment. Coordinate replacement of broken or misplaced items ○ Work with Planning and Finance/Administration Section Chief to complete cost data information ○ Upon deactivation of your position, brief the Incident Commander on current problems, outstanding issues, and follow-up requirements ○ Submit comments to the Incident Commander for discussion and possible inclusion in an after-action report; topics include: • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues ○ Participate in after-action meetings and debriefings as required		

Documents and Tools
☐ Facility emergency operations plan ☐ Facility organizational chart ☐ Facility telephone directory ☐ Facility maps and ancillary services schematics ☐ Vendor support and repair directory ☐ Master inventory control lists

FINANCE/ADMINISTRATION SECTION CHIEF

Mission: Monitor the utilization of financial assets and the accounting for financial expenditures. Supervise the documentation of expenditures and cost reimbursement activities. Ensure thorough investigation and documentation of incident-related claims, and the screening of volunteers. Contribute to the Incident Action Plan (IAP).

Date: _____ Start: _____ End: _____ Name of Person Assigned to Position: _____

Phone: _____ Signature: _____ Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment • Receive appointment from the Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		

Activities
• Participate in briefings and Incident Action Plan (IAP) preparation/meetings with the Incident Commander:
  ○ Gather and share critical incident and resident status information
  ○ Discuss section-level objectives, assignments, strategies/tactics, and resources needed
• Brief Command and General staff on use of alternative staff time tracking method if used
• Document facility-wide personnel hours worked as related to the emergency. If alternative staff time tracking method is utilized, distribute the Time Sheet (see NHICS 252) to IMT personnel and ensure time is recorded
• Ensure there are adequate forms for documentation of personnel hours worked and volunteer hours worked in all areas for 14-day run if needed		

Immediate Response (0-2 hours)	Time	Initial
• Collect Time Sheets at the completion of a shift or at the end of each operational period as determined by Incident Commander • Determine if any special contractual arrangements/agreements are needed. Interpret and initiate contracts/agreements to minimize costs (when possible) and resolve disputes • Maintain communications with Operations and Logistics Section Chiefs to ensure that procurement, costs, and business continuity actions are identified and tracked appropriately • Maintain communications with Safety Officer to immediately identify employee and non-employee claims issued against the facility. Initiate investigation and documentation of claims as possible • Establish cost reporting procedures, including proper coding • Implement third-party billing procedures • Implement procedures for receiving and depositing funds • Establish and document emergency agreements for the sharing, transfer of materials, equipment, and supplies, etc., to other entities • Assess the need to obtain cash reserves due to the emergency • Provide cost implications of incident objectives • Assist the Logistics Section Chief in accounting for facility staff and in the screening and/or credentialing of newly recruited and/or volunteer staff		
Resources o Ensure equipment, supplies, and personal protective equipment (PPE) are replaced as needed, coordinating with Operations and Logistics Section Chiefs		
Communication o Communicate with Command and General staff regarding procurement and time sheet recording and submission as necessary o Initiate the process for screening and tracking of incoming volunteers and/or new personnel. Communicate the process to volunteer assigned to in-take personnel		

Intermediate Response (2-12 hours)	Time	Initial
Activities o Meet regularly with the Incident Commander; Command staff, other Section Chiefs on the status of the response o Initiate documentation for purchases made during the response		

Intermediate Response (2-12 hours)	Time	Initial
○ Identify and document insurance company requirements for submitting damage/claim reports. Take photos and videos as appropriate ○ Document claims on facility risk/loss forms. Coordinate with facility Risk Manager ○ Ensure that records required by insurers, government and other agencies for loss recovery are accurately compiled, maintained and available ○ Create a "cost-to-date" incident financial status report as directed by the IC summarizing financial data relative to personnel, supplies and other expenditures and expenses ○ Work with the Logistics Section Chief to assist with preservation/recovery of business and financial records ○ Work with the Incident Commander and other Section Chiefs to identify short-term and long-term issues with financial implications; establish needed policies and procedures ○ Collect all Section Personnel Time Sheets (see NHICS Form 252) from each work area for recording and tabulation		
Resources ○ Ensure equipment, supplies, and personal protective equipment (PPE) are replaced as needed, coordinating with Operations and Logistics Section Chiefs		
Communication ○ Check in routinely with Section Chiefs to discuss procurement issues ○ In close coordination with the Safety Officer, handle any claims that arise from the incident		

Extended Response (greater than 12 hours)	Time	Initial
Activities ○ Continue to attend regular briefings and meetings ○ Ensure that required financial and administrative documentation are properly prepared. Collate and process invoices received ○ Continue to track all costs and collect invoices and other records as needed to reconcile financial records and document reimbursement claims ○ Present financial updates to the Incident Commander and Command Staff as requested by the IC ○ Ensure that routine, non-incident related administrative oversight of nursing home financial operations is maintained ○ Coordinate emergency procurement requests with Logistics Section		

Extended Response (greater than 12 hours)	Time	Initial
○ Maintain cash reserves on hand ○ Consult with local, state, and federal officials regarding reimbursement regulations and requirements; ensure required documentation is prepared according to guidance received ○ Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information		
Resources ○ Monitor levels of all supplies and equipment, and collaborate on needs with the Logistics Section Chief		
Communication ○ Contact insurance carriers to initiate reimbursement and claims procedures ○ Coordinate with Risk Management for additional insurance and documentation needs, including photographs of damage, etc.		

Demobilization/System Recovery	Time	Initial
Activities • Collect and analyze all financial related data • Ensure processing and payment of invoiced costs • Submit required reimbursement paperwork and track payments • Work with Planning Section to ensure cost data information is documented • Upon deactivation of your position, brief the Incident Commander on current problems, outstanding issues, and follow-up requirements • Participate in after-action meetings and debriefings as required		

Documents and Tools
☐ Facility emergency operations plan ☐ Facility organizational chart ☐ Facility telephone directory ☐ Facility inventory ☐ Facility financial data forms

PLANNING SECTION CHIEF

Mission: Oversee all incident-related data gathering, situational information and analysis regarding incident operations and assigned resources. Collect, process and maintain accurate and complete incident files, including a record of the Nursing Home's response and recovery activities, decisions and key communications. Develop projections to inform long range planning, prepare situation summaries and maps, conduct planning meetings, and prepare the Incident Action Plan (IAP). Disseminate the new IAP to all assigned NHCC staff at the beginning of each Operational Period.

Date: _____ Start: _____ End: _____ Name of Person Assigned to Position: _____

Phone: _____ Signature: _____ Initial: _____

Immediate Response (0-2 hours)	Time	Initial
Receive appointment • Receive appointment from the Incident Commander • Read this entire Job Action Sheet • Notify your usual supervisor that you have been assigned to the Incident Management Team (IMT) • Report to the Incident Commander until demobilized		
Assess the operational situation • Obtain information and status from the Operations and Logistics Section Chiefs to ensure the accurate tracking of personnel and resources • Provide information to the Incident Commander on the operational situation including capabilities and limitations		
Activities • In conjunction with the Liaison/PIO collect situational awareness information (i.e., weather, roads, evacuation routes/sites) • In consultation with the Incident Commander, establish the incident objectives and operational period. Initiate the Incident briefing so that the Incident Commander has the Form to brief incoming IMT staff • Coordinate preparation and documentation of the NHICS 200: IAP Quick Start and distribute copies to the Incident Commander and all Section Chiefs		

Immediate Response (0-2 hours)	Time	Initial

• Facilitate and conduct IAP preparation/meetings with Command Staff, Section Chiefs and other key positions to plan for the next operational period:
  ○ Gather and share critical incident and resident status information
  ○ Discuss section-level objectives, assignments, strategies/tactics, and resources needed (*optionally document on a NHICS 204: Assignments List*)
• Prepare a system to receive documentation and completed forms from all Sections over the course of the NHCC activation. Include the following:
  ○ Duplicates of forms and reports to authorized NHCC requestors if copy service available, otherwise note request and provide summary of key information
  ○ File, maintain, and store incident files for legal, analytical, and historical purposes
• Coordinate with Logistics Section Chief to ensure access to IT systems with e-mail/intranet communication to increase communication and document sharing with all sections (if available)		

Resources • Maintain communications with Logistics Section Chief and Infrastructure Branch Director to ensure the accurate tracking of personnel and resources • Request a scribe/runner to support documentation activities, if needed • Make requests for external assistance, as needed, in coordination with the Liaison/PIO		
Communication • Communicate with Command Staff and Section Chiefs (informally and formally - via planning meetings) to obtain and document overall status		

Intermediate Response (2-12 hours)	Time	Initial
Activities • Participate in all briefings and meetings in support of the IC as requested • Meet regularly with the Incident Commander to brief on the section status and the IAP • Continue to monitor changing incident conditions • Continue to conduct regular Incident Action Planning meetings with Command Staff, Section Chiefs, and the Incident Commander for continued update and development of the IAP		

Intermediate Response (2-12 hours)	Time	Initial
• Ensure that personnel and equipment are being tracked and reported • Check the accuracy and completeness of documentation, forms, and records submitted. Correct errors or omissions by contacting the appropriate NHCC Section staff • Ensure backup and protection of existing data for main and support computer systems, in coordination with the Logistics Section Chief		
Resources • As work load increases request a scribe/runner to support documentation activities, if needed		
Communication • Continue communications with Command Staff and Section Chiefs (informally and formally - via planning meetings) to obtain and document overall status		

Extended Response (greater than 12 hours)	Time	Initial
• Continue to receive projected activity reports from Section Chiefs at designated intervals to prepare NHCC status reports and update the IAP • Assess ability to deactivate positions, as appropriate, in collaboration with Section Chiefs and demobilization of activated Sections • Continue checking the accuracy and completeness of records submitted. Correct errors or omissions by contacting the appropriate NHCC Section staff • Continue to ensure backup and protection of existing data for main and support computer systems, in coordination with the Logistics Section Chief • Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information		
Communication • Continue discussions (formal and informal) with Command Staff and Section Chiefs to obtain and document overall status		

Demobilization/System Recovery	Time	Initial

Activities
○ Continue to meet with Command Staff, Section Chiefs and Branch Directors to evaluate facility and personnel, review the plan for demobilization and update the IAP
○ Assist Section Chiefs in restoring Nursing home to normal operations
○ Work with Finance/Administration Sections to complete cost data information
○ Begin development of the Incident After-Action Report and Improvement Plan and assign staff to complete portions/sections of the report
○ Debrief staff on lessons learned and procedural/equipment changes need
○ Upon deactivation, brief the Incident Commander on current problems, outstanding issues, and follow-up requirements
○ Submit comments to the Incident Commander for discussion and possible inclusion in an after-action report; topics include:
  ○ Review of pertinent position descriptions and operational checklists
  ○ Recommendations for procedure changes
  ○ Section accomplishments and issues
○ Participate in after-action meetings and debriefings as required
○ Coordinate the final reporting of resident information with external agencies through the Liaison/PIO		

Documents and Tools
☐ Facility Emergency Operations Plan ☐ Facility organizational chart ☐ Facility telephone directory

Appendix C

Other

	Fire Drills During a Pandemic (COVID 19)			
Dept:	Clinical Operations	**New X Revised**	**Last Date Revised:**	
			Prev. Date Revised:	
			Creation Date:	4-21-2020
RELATED FORMS:	Documentation in Tels system			

Policy: Fire Drills During a Pandemic to prevent the spread of infectious disease by reducing staff and resident interaction.

Procedure:

1. Still continue to perform fire drill 1x per month as required, this can however be done during normal working hours, the 1st,2nd, and 3rd shift will not matter at this time as we will not be performing a standard drill.
2. When performing the fire drill follow these guidelines
    a. Call monitoring company and put system on test
    b. Announce to the building you will be performing a test of the fire alarm system, staff do not need to respond
    c. Pull the fire alarm and immediately silence the alarm
    d. Verify that all Fire/Smoke doors close as designed
    e. Verify that all strobes work as designed
    f. Return fire alarm panel to normal operation
    g. Call the monitoring company and take the fire alarm system off of test
    h. Post a different fire drill "reminder" each month near the time clocks, this can be PASS, RACE, etc.
    i. Put a copy of the education posted near the time clocks with your fire drill documentation in leu of having a sign in sheet.
3. Items not to do during a fire drill
    a. Have staff respond to a given area of the building
        i. Under normal conditions staff from all over the building respond to the drill, we do not want to bring this type of group together
    b. Do not move residents from the smoke compartment where the drill is being performed to another
        i. Under normal conditions staff will move residents from the smoke compartment where the drill is being performed to an adjacent smoke compartment, we do not want to be moving residents at this time in this manner.