



***NYC HEALTH + HOSPITALS
COLER REHABILITATION & NURSING CARE CENTER***

ANNUAL PANDEMIC EMERGENCY PLAN

Table of Review and Approval

Date Reviewed	Date Approved
9/1/20	9/9/20
2/8/2022	2/24/2022

The Annual Pandemic Emergency Plan (APEP) was originally written and approved on 9/9/20; reviewed and approved on February 24, 2022.

As of September 15, 2020, it is required by the New York State Department of Health (NYSDOH) that the Annual Pandemic Emergency Plan must be reviewed annually. It should also be reviewed and updated when an event or law indicates that some or all of the APEP should be changed/updated.

The Annual Pandemic Emergency Plan has been posted on the facility's website.

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FACILITY INFORMATION

Facility: NYC H+H/Coler Rehabilitation and Nursing Care Center

Address: 900 Main Street

City: Roosevelt Island State: NY ZIP Code: 10044

Phone Number: 212-848-6300

Contact Person: Stephen J. Catullo, CEO/Administrator

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New York, New York 10013

I. INTRODUCTION TO THE PLAN

In order to provide for changes in demographics, technology and other emerging issues, this plan will be reviewed and updated annually and/or after incidence of a pandemic. This Annual Pandemic Emergency Plan (APEP) is developed to be consistent with the New York State Department of Health requirement of an APEP, effective September 15, 2020.

Purpose: To describe the actions to be taken in a pandemic to make sure that the residents, staff and visitors of this facility are kept safe from harm. The safety and well-being of the residents, staff, and visitors take first priority over all other considerations.

Demographics:

- A. This facility is located at 900 Main Street, Roosevelt Island, New York 10044.
- B. The facility is an 815-bed residential health care facility (RHCF), which provides short-term post-acute rehabilitation care and skilled nursing services, including specialized dementia care.
- C. This facility has on-site hemodialysis services to provide chronic renal dialysis care to residents of the RHCF.

II. EMERGENCY PLAN

Readiness and Hazard Assessment/Pandemic Influenza/Illness Planning

- A. This facility maintains a comprehensive emergency management plan (CEMP) to prepare for, respond to, and recover from natural and man-made disasters. The facility follows an “all hazards” approach in developing the CEMP, with a pandemic identified as one (1) of those hazards.
- B. This facility performs an annual readiness assessment of the facility’s preparedness for responding to pandemic influenza/illness (see Pandemic Influenza/Illness Planning Checklist Annual Update **Exhibit 1**). This APEP is written and updated based on the readiness assessment. Changes or additions to the APEP will be made based on the annual readiness assessment, gaps identified during exercises or real events or guidance issued by the Centers for Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH). A copy of the annual updated Pandemic Influenza/Illness Planning Checklist will be kept with the APEP.
- C. A copy of the APEP is attached to the facility’s CEMP as an Annex document. In addition, a hard copy of the APEP will be kept in the facility and the plan will be posted on the facility’s website.

Structure for Planning and Decision-making

- A. The facility shall have a multidisciplinary planning committee to specifically address pandemic preparedness and response.
- B. The Multidisciplinary Pandemic Planning Team consists of the following individuals:

Name	Title
Stephen Catullo	CEO/Administrator
Yves-Rose Pascal	Director of Nursing
Rani Rao, M.D.	Chief Medical Officer
Monsy Martinez	Director of Quality Management/Regulatory Affairs
Verna Mitchell	Deputy Director of Nursing
Edouard Hazel, M.D.	Chief of Infection Control
Carmentina Silvestre-Tan	Infection Preventionist
Denise Thompson	Infection Preventionist
Ravindra Amin, M.D.	Chief of Psychiatry
Cheryl Dury	Director of Social Work
Alfonso Pistone	Associate Executive Director of Administration
Abraham Shapiro	Director of Materials Management
Jose Rodriguez	Director of Emergency Management and Hospital Police
Daniel Berry	Risk Manager
Gina Velez	Personnel Director

- C. The Pandemic Response Coordinator, who is the person responsible for coordinating preparedness planning is: Stephen J. Catullo, CEO/Administrator.

- D. Other Facility Programs (i.e., on-site dialysis through Dialyze Direct that need to be addressed as part of this APEP: Hemodialysis services)

Coordination

- A. Local and state health departments and provider/trade associations points of contact have been identified for information on pandemic planning resources, as follows:

<u>Name of Agency/Organization</u>	<u>Phone Number</u>
New York City Department of Health and Mental Hygiene	212-346-7572
New York State Department of Health	518-473-4436
Mayor’s Office of Emergency Management	646-692-3641
New York State Office of Emergency Management (NYSOEM)	518-292- 2200

- B. Local, regional or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact, have been identified, as follows:

<u>Name of Agency/Organization</u>	<u>Phone Number</u>
NYC H+H Emergency Management	212-788-3525
New York City Office of Emergency Management (NYCEM)	212-639-9675
Greater New York Hospital Association	212-246-7100

- C. Area hospitals points of contact have been identified in the event that facility residents require hospitalization or facility beds are needed for hospital patients being discharged in order to free up needed hospital beds, as follows:

<u>Name of Hospital</u>	<u>Phone Number</u>
Mount Sinai Hospital - Mount Sinai Queens	718-932-1000
NYC H+H/Bellevue	212-562-4141
NYC H+H/Harlem	212-939-1000
NYC H+H/Metropolitan	212-423-6262
NYC H+H/Jacobi	718-918-5000
NYC H+H/North Central Bronx	718-519-5000
NYC H+H/Coney Island	718-372-0275
NYC H+H/Kings County	718-245-3131
NYC H+H/Woodhull	718-963-8000
NYC H+H/Elmhurst	718-334-4000
NYC H+H/Queens	718-883-3000
NYC H+H/Lincoln	718-579-5000

III. INFECTION CONTROL PROTECTION PLAN

Description of Surveillance and Monitoring Activities

The facility monitors public health advisories (federal, state, and local) and updates are provided to the Pandemic Response Coordinator and other members of the Multidisciplinary Pandemic Planning Team when pandemic influenza/illness has been reported in the United States and is nearing the New York City Metropolitan Area.

The facility conducts surveillance activities for residents, staff, family and visitors on an ongoing basis. Signage and hand hygiene stations are posted at all entrances, instructing families, visitors and contractors to:

- Perform hand hygiene
- Use source control measures i.e. proper use of facemask and physical distancing
- Health screening for Febrile and Respiratory Illness (FRI) symptoms
- No entry if any individuals have fever or respiratory symptoms
- No entry if not cleared from quarantine, had recent significant exposure to communicable diseases or recently confirmed positive i.e. COVID-19.
- Current CMS or NYSDOH visitation and testing guidelines among residents, staff and visitors are followed.
- All healthcare employees must have completed required COVID-19 vaccination.

The facility asks family and visitors to undergo health screening for FRI prior to visits, practice core principles in the infection prevention and control of communicable diseases such as frequent performance of hand hygiene, use of proper source control, physical distancing of at least 6 feet and they are to disclose if they have respiratory symptoms, positive viral test, or high risk exposures to positive communicable disease. If ill, they are discouraged from visiting the facility. During a pandemic illness outbreak, the facility will follow CDC/CMS and New York State Department of Health guidelines to limit or restrict entry to the building.

The current Infection Control Program at the facility provides for continuous facility-wide surveillance activities to establish baseline levels of infection on an annual basis. Infection rates above the baseline may be indicative of an influenza/illness outbreak or the arrival of a pandemic illness at the facility. The facility will maintain an ongoing surveillance program to be enhanced during a reported pandemic influenza/illness outbreak in the community (see Table 1 below).

Table 1: Surveillance Objectives by Pandemic Phase (For COVID-19, see COVID-19 annual plan)

Phase 1 (Interpandemic Period)
Objectives and Actions:
<ul style="list-style-type: none"> • To assess for seasonal influenza. • To detect cluster cases of Febrile Respiratory Illness (FRI)/ Influenza-Like Illness (ILI). • To provide for annual education and provide seasonal flu vaccine including COVID-19 vaccines to residents, staff and volunteers and to maintain immunization statistics and adverse effects information. • To promote source control measures, physical distancing, respiratory or cough etiquette and hand hygiene to residents, families, visitors, and staff including volunteers and contractor/vendors. • To notify NYC H+H of suspected outbreak activity as defined by CDC and NYSDOH guidance and initiate other notifications, as required, to the local and/or state health departments. • To communicate updates to residents, families, visitors, and staff including volunteers, contractors/vendors. • Active Febrile Respiratory Screening measures for the residents, families, visitors, and staff including volunteers, and contractors/vendors. • Ensure supplies are readily available or accessible (PPE, hand sanitizers, cleaning and disinfecting products, etc.)
Phase 2 (Pandemic Alert Period - Low)
Objectives and Actions:
<ul style="list-style-type: none"> • To implement active surveillance measures for FRI/ILI screening for residents, families, visitors, and staff including volunteers and vendors/contractors. • To notify the Infection Control Practitioner or designee of reported or identified FRI/ILL. They will alert, as appropriate, the local and state health department of cluster of FRI. • Infection Control will actively monitor residents closely for signs and symptoms by: <ul style="list-style-type: none"> ○ Conducting unit rounds. ○ Reviewing shift reports. ○ Auditing and reviewing physician and nurse progress notes. ○ Routine reviewing of the pharmacy antibiotic utilization reports. ○ Reviewing laboratory reports. ○ Communication with the staff about their clinical observations and during huddle endorsements. ○ Communication with the OHS and department heads about employees with communicable disease. ○ Review of sick call log i.e. Nursing Department. ○ Review of census activity log for admissions and discharges. • To implement management of respiratory outbreak as required for outbreak activity as defined by CDC and NYSDOH guidance and initiate outbreak reports to local and state health department, as required.
Phase 3 (Pandemic Alert Phase – High)
Objectives and Actions
<ul style="list-style-type: none"> • To activate the Pandemic Emergency Plan and Emergency Plan (as needed). • To maintain active surveillance for monitoring of FRI/ILI in residents and staff. • To finalize plans for pandemic vaccine storage and security (as applicable). • To establish clinic sites for residents, staff and volunteers. • To develop plans for antiviral storage, security and administration, including staff prophylactic treatment. • To follow guidelines for avian/pandemic flu/illness, as issued by CDC and NYSDOH, and provide education and training to staff for personal preparedness, resident care and pandemic influenza/illness management. • To ensure that availability of staffing, equipment and supplies, as required, for the facility. • To provide educational material and in-services; i.e., Annual Pandemic Emergency Plan; cross training; hand hygiene
Phase 4 (Pandemic Period)
Objectives and Actions
<ul style="list-style-type: none"> • To implement measures for suspected and confirmed pandemic strain in the facility.

<ul style="list-style-type: none"> • To implement mandatory active screening of staff, visitors, contractors/vendors and family members (see Sample Surveillance Screening Tool Exhibit 2).
<ul style="list-style-type: none"> • To implement heightened surveillance of residents and staff illnesses for symptoms of the pandemic influenza/illness.
<ul style="list-style-type: none"> • To implement control and support measures for residents, staff, visitors and families.
<ul style="list-style-type: none"> • To implement access restrictions for staff, visitors, families, volunteers and vendors.
<ul style="list-style-type: none"> • To implement protocols for isolation of residents with confirmed or suspected illness.
<ul style="list-style-type: none"> • To implement protocols for cohorting residents with confirmed or suspected illness.
<ul style="list-style-type: none"> • To direct staff to cohort to their assigned units as much as possible.

The facility has processes in place to prevent the occurrence of an outbreak and surveillance programs to quickly identify and implement control measures to contain it. The facility also prepares to respond to large-scale epidemics as part of its emergency preparedness plan. The facility’s infection prevention and control program staff monitor and maintain a data communication with relevant agencies through the NYSDOH Health Alert Network (HAN) for events happening in the local, national and global community. The facility record and report occupational injuries and illness to identify work-related cases.

Active Surveillance for Respiratory Infection or other Pandemic Illness

When there is influenza or pandemic illness activity in the local community, active surveillance for the influenza/illness is conducted among all new and current residents, healthcare personnel and visitors of the facility until the end of the influenza season and/or pandemic. Daily monitoring will occur once a single laboratory-confirmed case of the influenza/illness has been identified in a resident, as it is likely there are other cases among exposed persons. Daily active surveillance occurs until at least one (1) week after the last laboratory-confirmed influenza/illness case was identified or until further recommendation by NYSDOH regional officer or public health authority (PHA).

When it is not influenza season, influenza testing shall occur when any resident has signs and symptoms of influenza-like illness. If there is one (1) laboratory-confirmed influenza positive case along with other cases of respiratory infection in a unit of the facility, an influenza outbreak might be occurring. In the event that an influenza outbreak is identified in this scenario, daily monitoring will occur until at least one (1) week after the last laboratory confirmed influenza case occurred until further recommendation by NYSDOH regional officer or public health authority (PHA).

Once an outbreak has been identified, outbreak prevention and control measures will be implemented immediately. Testing for influenza/illness will occur for the following:

- All new onset ill persons in affected unit and unaffected units in the facility; and
- Persons who develop acute respiratory illness symptoms more than 72 hours after beginning antiviral chemoprophylaxis.

It should be noted that elderly persons and other long-term care residents, including those who are medically fragile and those with neurological and neurocognitive conditions, may manifest atypical signs and symptoms with influenza/illness virus infection, and may not have fever.

Identification and Management of Residents with Symptoms

Identification of residents with symptoms will occur through the monitoring and active surveillance activities described above. The facility will implement standard and droplet precautions for all residents with suspected or confirmed influenza/illness. Standard precautions will be applied into the care of all residents, regardless of the suspected or confirmed presence of the influenza/illness.

It is the policy of this facility to protect residents, staff and others who may be in our facility from harm during a pandemic outbreak. To accomplish this, the facility has developed protocols for testing residents and the ongoing surveillance testing of the resident population (see Table 2).

Table 2: Procedures to Test Residents

<ul style="list-style-type: none"> • Facility will test any symptomatic resident in accordance with guidance and direction of the CDC, local and state health department.
<ul style="list-style-type: none"> • If the facility has no symptomatic residents, facility will consult with local and state health department and determine testing strategy, if applicable and needed.
<ul style="list-style-type: none"> • Testing will be done through a testing lab that can provide test results in a timely manner.
<ul style="list-style-type: none"> • If no testing capacity can be located that meets the timeframe goal for timely turnaround of tests, the facility will document all attempts to obtain testing and keep documents of those efforts for review.
<ul style="list-style-type: none"> • If an alternative test is approved that could help meet the timely turn-around goals and is approved by the local and state health department, the facility will incorporate those procedures in support of the facility’s overarching objective to receive test results in a timely manner.
<ul style="list-style-type: none"> • For residents with suspected or confirmed influenza-like illness, the facility will implement protocols for transmission-based precautions/ isolation precautions and/or cohorting residents per facility policy.
<ul style="list-style-type: none"> • Positive residents will be removed from transmission-based precautions/ isolation precautions and/or cohorting following latest guidance issued by CDC, local and state health departments for discontinuation of transmission-based precautions/ isolation precautions.
<ul style="list-style-type: none"> • The facility will report any positive tests in accordance with local and state health department requirements for the reporting of healthcare associated infections (HAI).

The facility has also developed procedures for the isolation and/or cohorting for residents during a pandemic outbreak by designating spaces within the facility into three (3) zones, which is based on the residents’ testing status, as follows:

Positive (i.e., COVID) – Space designated to be used and occupied by confirmed positive residents and staff assigned to their care. Newly admitted and readmitted residents with confirmed positive results who have not met the criteria for discontinuation of transmission-based precautions and are allowed to be admitted/readmitted to the facility based on CDC and NYSDOH guidance will be admitted to this space.

Unknown (i.e., COVID) – Space designated to be used and occupied by asymptomatic residents with exposure and/or residents who have an unknown testing status and staff assigned to their care.

Negative – Space designated to be used and occupied by confirmed negative residents and staff assigned to their care.

These zones are meant to provide safe care and treatment of residents during the pandemic outbreak (see Table 3). Resident isolation and/or cohorting procedures and locations (zones) will be reevaluated by clinical staff frequently as demand dictates.

Table 3: Procedures to Isolate and/or Cohort Residents

Positive Zone
<ul style="list-style-type: none"> Residents testing positive will be placed in a single room, if available, or cohorted within a zone designated by the facility as a positive zone.
<ul style="list-style-type: none"> Residents testing positive will only be cohorted with other confirmed positive cases.
<ul style="list-style-type: none"> If a resident tests positive in a room with roommates who are asymptomatic and negative, the positive resident will be moved to a positive zone.
<ul style="list-style-type: none"> Residents in a positive zone designated for confirmed cases will be treated by staff with contact and droplet precautions (N95 respirator use) + eye protection until they have a negative test result or deemed recovered as per CDC and or NYSDOH guidelines.
<ul style="list-style-type: none"> If no movement is possible, the facility will isolate the residents to the extent possible within the same unit per CDC and or NYSDOH guidelines.
<ul style="list-style-type: none"> Residents in a positive zone will be assessed every shift to document respiratory rate, temperature and oxygen saturation.
<ul style="list-style-type: none"> The facility will monitor guidance from CDC and or NYSDOH and adjust procedures for cohorting accordingly.
<ul style="list-style-type: none"> The facility will assign staff to work the positive zones exclusively to the extent possible.
<ul style="list-style-type: none"> If staff will be shared across the various zones in any way, the staff will fully doff all PPE and leave all dirty PPE in designated receptacles, perform hand hygiene, and don new PPE in accordance with CDC guidance for the area they are entering.
Unknown Zone
<ul style="list-style-type: none"> Asymptomatic residents who are exposed to a confirmed case will be cohorted in observation until their test results are known.
<ul style="list-style-type: none"> Symptomatic residents with unknown status will be placed in a single room until their test results are known.
<ul style="list-style-type: none"> Residents in an unknown zone will be treated by staff with contact and droplet precautions + eye protection until a negative test result can be achieved or the resident meets the time criteria to return to a negative zone based on current, applicable guidance from CDC and NYSDOH.
<ul style="list-style-type: none"> If staff will be shared across the various zones in any way, the staff will fully doff all PPE and leave all dirty PPE in designated receptacles, perform hand hygiene, and don new PPE in accordance with CDC guidance for the area they are entering.
<ul style="list-style-type: none"> All residents in an unknown zone will be screened for symptoms of the viral illness and have their vital signs monitored, including oxygen saturation and temperature checks at a minimum of two (2) times per day and documented in the clinical record.
Negative Zone
<ul style="list-style-type: none"> Residents in the negative zone will consist of confirmed negative residents or those who have fully recovered from the viral illness.
<ul style="list-style-type: none"> Residents will be cohorted with other confirmed negative or recovered residents.
<ul style="list-style-type: none"> Residents will be moved to the negative zone only after they have received a negative test or they have met the criteria for the discontinuation of transmission-based precautions per current CDC and or NYSDOH guidance.
<ul style="list-style-type: none"> The facility will change room designations in response to testing results and may need to add or remove unit designations depending on space available/needed.

In cases where the facility may get large amounts of positive cases interspersed within the facility, the facility will designate who is on what precautions for each resident and clearly communicate the

procedures to minimize the risk of spreading with the eventual goal of having clearly designated spaces with the building set on the zone groupings outlined above.

The facility, at a minimum, follows the CDC-recommended standard precautions in providing care to residents, regardless of suspected or confirmed infection status (see Table 4). These practices are designed to both protect and prevent health care providers from spreading infections among residents and staff. The use of PPE, and the type of PPE used, under standard precautions is based on the nature of the clinical interaction with the resident and the potential exposure to blood, body fluids and/or infectious materials. All facility health care providers receive ongoing training on and must demonstrate an understanding of:

- When to use PPE;
- What PPE is necessary;
- How to properly don, use and doff PPE in a manner to prevent cross contamination;
- How to properly dispose of or disinfect and maintain PPE; and
- The limitations or optimizing use of PPE.

CDC recommends transmission-based precautions (i.e., contact, droplet and/or airborne precautions- if available) be implemented for residents with documented or suspected diagnoses where contact with the resident, their body fluids or their environment presents a substantial transmission risk despite adherence to standard precautions. During a pandemic outbreak, PPE will be worn by staff at all times during care of residents who are placed in the designated zones for confirmed cases, (positive) and asymptomatic residents with exposure and/or residents with no known status (unknown) of the facility.

Table 4 – Standard Precautions and Transmission-based Precautions

Standard Precautions	
Hand Hygiene	<ul style="list-style-type: none"> • Use an alcohol-based hand rub or wash hands with soap and water for the following clinical indications: <ul style="list-style-type: none"> - Immediately before touching a resident. - Before performing an aseptic task or handling invasive medical device. - Before moving from work on a soiled body site to a clean body site on the same patient. - After touching a resident or the resident’s immediate environment - After contact with blood, body fluids or contaminated surfaces - Immediately after glove removal • Perform hand hygiene with soap and water when hands are visibly soiled and when caring for residents with enteric infections.
Environmental Cleaning and Disinfection	<ul style="list-style-type: none"> • Routine and targeted cleaning of environmental surfaces as indicated by the level of resident contact and degree of soiling. <ul style="list-style-type: none"> - Clean and disinfect surfaces in close proximity to the resident and frequently touched surfaces in the resident care environment on a more frequent schedule compared to other surfaces. - Promptly clean and decontaminate spills of blood and other potentially infectious materials.

	<ul style="list-style-type: none"> • Use only of facility approved EPA-registered List N disinfectants that have microbiocidal activity against the pathogens i.e. COVID-19 or tuberculocidal most likely to contaminate the-resident care environment. • Follow manufacturer’s instructions for proper use of cleaning and disinfecting products (i.e., dilution, contact time, material compatibility, storage, shelf-life, safe use and disposal).
Injection and Medication Safety	<ul style="list-style-type: none"> • Use aseptic technique when preparing and administering medications. • Disinfect the access diaphragms of medication vials before inserting device into the vial. • Use needles and syringes for one resident only (this includes manufactured prefilled syringes and cartridge devices such as insulin pens). • Enter medication containers with a new needle and a new syringe, even when obtaining additional doses for the same resident. • Ensure single-dose or single use vials, ampules and bags or bottles of parenteral solution are used for one resident only. • Use fluid infusion or administration sets (e.g., intravenous tubing) for one resident only. • Dedicate multidose vials to a single resident whenever possible. If multidose vials are used for more than one resident, restrict the medication vials to a centralized medication area and do not bring them into the immediate resident treatment area (i.e. resident room).
Appropriate Use of Personal Protective Equipment	<ul style="list-style-type: none"> • Ensure proper selection and use of personal protective equipment (PPE) based on the nature of the resident interaction and potential exposure to blood, body fluids and/or infectious materials. <ul style="list-style-type: none"> - Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-contact skin, potentially contaminated skin or contaminated equipment could occur. - Wear a gown that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions or excretions. - Use protective eyewear and a mask, or a face shield, to protect the mucous membranes of the eye, nose and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields and combinations of each according to the need anticipated by the task performed. Staff to follow extended use of these PPE if applicable. - Remove and discard PPE, other than respirators, upon completing a task before leaving the resident room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the resident room or care area and closing the door ensuring safety is not compromised. - Do not use the same gown or pair of gloves for care of more than one resident. Remove and discard disposable gloves upon completion of a task or when soiled during the process of care.
Minimizing Potential Exposures	<ul style="list-style-type: none"> • Use respiratory hygiene and cough etiquette to reduce the transmission of respiratory infections within the facility. • Prompt residents and visitors with symptoms of respiratory infection to contain their respiratory secretions and perform hand hygiene after contact with respiratory secretions by providing tissues, masks, hand hygiene supplies and instructional signage and/or handouts at points of entry and throughout the facility. • When space permits, separate residents with respiratory symptoms from others as soon as possible. Suspicion of highly transmissible respiratory infections like COVID-19 or influenza is entertained. Immediate and appropriate implementation

	of infection control measures such as transmission-based precautions or cohorting are to be in place.
Reprocessing of Reusable Medical Equipment	<ul style="list-style-type: none"> • Routine cleaning and reprocessing (disinfect or sterilize) reusable medical equipment (e.g., blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) in between uses is done. Immediate cleaning and disinfection are done when non-critical resident care equipment is visibly soiled with blood or body fluids. <ul style="list-style-type: none"> - Consult and adhere to manufacturer’s instructions. • Maintain separation between clean and dirty/soiled equipment to prevent cross contamination. • Clear designation of clean versus dirty items is in place.

Plan for Preserving Resident’s Place if a Resident is Hospitalized and How Hospitalized Residents are Readmitted to the Facility After Hospital Treatment

As required under Section 415.3 of Title 10 of the New York State Codes, Rules and Regulations (10 NYCRR), the facility has an established bed-hold and readmission policy in place to preserve a resident’s right to a bed reservation (or bed-hold) while a resident is absent from the facility for a hospitalization and the duration and conditions of the bed-hold policy during which the resident is permitted to return and resume residence to the facility. The policy outlines the conditions under which the resident is returned to their previous room or to an available bed. The resident and their family and/or legal guardian are given this information in writing upon admission to the facility and at their time of transfer to a hospital.

During a pandemic, and if the resident’s status is unknown upon readmission to the facility, the resident may need to be placed on a different unit, pending a negative test and/or they have met the criteria for the removal of transmission-based precautions based on CDC guidance or if the resident’s previous room is now located in a designated area for positive and symptomatic suspected cases.

Notification to State and Local Health Departments

As required under Sections 2.1 and 2.2 of 10 NYCRR, nosocomial infections are to be reported within 24 hours of recognition. The facility is required to notify the state and local health department as follows:

- New York State Department of Health: Reported via the Nosocomial Reporting Application (NORA) electronic system.
- New York City Department of Health and Mental Hygiene: Reported by phone.

The facility will meet any additional notification requirements that may be put in place by NYSDOH during a pandemic situation, including submission of information and reports through the Health Commerce System web-based system.

Criteria to Limit or Restrict Visitors, Volunteers and Non-essential Staff

Residents with multiple conditions are at highest risk of infection and complications, so the facility must use every tool at its disposal to reduce the risk of exposure to and spread of influenza-like or other pandemic illness within the facility. Temporary restricting of visitors and non-essential workers is one method to reduce the risk of virus spread in nursing homes, keeping residents safe. The facility will follow CDC guidelines to limit or restrict entry to the building and any guidance/regulation that may be put in place by the New York State Department of Health regarding visitors to nursing homes, which may include:

- Visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or currently meet the criteria for quarantine should not enter the facility *until they meet the criteria used for residents to discontinue transmission-based precautions (quarantine)*.
- Visitors who are unable to adhere to the core principles of infection prevention should not be permitted to visit or should be asked to leave.
- Visitation is allowed for all residents at all times ensuring visitors adhere to the core principles of COVID-19 infection prevention at all times (face covering, physical distancing, hand hygiene).
- Outdoor visitation is preferred when the resident and/or visitor are *not up-to-date with all recommended COVID-19 vaccine doses*.
- Compassionate care visits are allowed at all times.
- Visitors, residents, or their representative should be made aware of the potential risk of visiting and necessary precautions related to COVID-19 in order to visit the resident.

The facility understands the vital importance of keeping residents connected with their loved ones. When visitation is restricted during a pandemic situation, the facility will facilitate increased virtual communication between residents and families and will also keep residents' families informed about their care. Please refer to **Section IV Communication Plan** below for additional information.

The facility will have signage posted at all entrances instructing all visitors, residents, staff, volunteers and contractors about:

- Any identified risks of virus spread in the facility;
- Any screening procedures in effect, including temperature checks and symptom screening;
- Any restrictions in place (e.g., limitations on who can enter); and
- Any infection protection plan practices required (i.e., face covering, hand hygiene, etc.).

Considerations for Specialty Units/Other Facility Programs

The facility has an on-site hemodialysis (dialysis den) program to provide chronic renal dialysis care to residents. During an identified outbreak or when level of COVID-19 community transmission is substantial to high, universal use of eye protection (i.e. face shield or goggles) and N95 respirator (after passing fit test) among caregivers in the hemodialysis unit will be implemented regardless of the pandemic illness status (i.e., negative, positive, suspected) of the resident. Consideration will be given

to creating a “late shift” for hemodialysis for those identified as positive resident to allow for additional disinfecting prior to the next day’s dialysis sessions. In addition, a staffing and dialysis capacity plan has been developed by Dialyze Direct, the contractor that provides the on-site hemodialysis services to residents (see **Staffing and Dialysis Capacity Plan Exhibit 3**)

Resources and Supplies to Adhere to Infection Control Policies

During a pandemic, health care settings will need large quantities of equipment and supplies to provide care and to protect health care workers. It is anticipated that the demand will be high and traditional supply chains may break down. In preparation for a pandemic, the following measures will be instituted by the facility:

1. The facility will maintain a 60-day (2 months) supply of personal protective equipment (PPE). PPE supplies include N95 masks, surgical masks, face shields or goggles, medical gowns and medical gloves. The amount of PPE need for a 60-day supply will be based on the PPE burn rate/average consumption rate and will be adjusted accordingly if the burn rate/average consumption rate increases or decreases.
2. A 30-day stockpile of essential supplies needed to adhere to infection control policies. Essential supplies include environment cleaning and disinfection supplies, disposable masks, disposable gloves, tissues, hand soap, paper towels and alcohol-based hand sanitizers.
3. All supplies will be checked for expiration dates and rotated on a regular basis to prevent stock expiration. The facility Administrator will determine the frequency of the stock rotation.

Environmental Infection Control

The facility has policies and procedures in place for cleaning and disinfection of the Coler environment and resident care equipment. Facility approved EPA-registered, hospital-grade disinfectants are used for cleaning high-touch surfaces and shared resident care equipment. During a pandemic, the facility will follow CDC guidelines for any increased environmental cleaning and/or frequency of cleaning. Environmental services personnel who clean and disinfect rooms will be equipped with appropriate PPE for cleaning within the spaces of each zone used for the cohorting of residents as recommended by CDC and NYSDOH guidelines. While alcohol-based hand sanitizer (ABHS) is the preferred method of hand hygiene, sinks throughout the facility will be stocked with soap and paper towels to encourage hand hygiene with the use of soap and water.

Management of laundry, food service utensils and medical waste will be performed in accordance with routine procedures and supplemented with additional processing, based on recommendation and/or requirement of CDC guidelines and/or any guidance or requirements issued by NYSDOH.

Tissues and facemasks will be available for residents and visitors and placed near entrances and in common areas of the facility along with no-touch receptacles for disposal. Necessary PPE for health care provider use will be available outside of resident rooms and in other areas where resident care is provided. No-touch receptacles for disposal of used/soiled PPE are placed outside of resident rooms

and in other areas where resident care is provided for the safe doffing of PPE. These receptacles are “designated” for the disposal of used/soiled PPE.

IV. COMMUNICATION PLAN

The facility has in place a communication plan as part of its emergency preparedness plan. This communication plan can be enhanced and supplemented with additional elements and information to ensure that all parties are provided with updated information on the status of the facility’s situations and the status of residents during a pandemic outbreak. The communication plan provides a framework to manage and coordinate the wide variety of communications that take place during a pandemic. It covers who will receive communications, how the communications will be delivered, what information will be communicated, who communicates and the frequency of the communications.

Internal Communication

Target audiences for internal communications include:

- Nursing Staff to ensure continuity of resident care;
- Physicians to ensure continuity of resident care;
- All other clinical staff to assist nursing staff on the units; and
- All non-clinical staff to ensure that essential services continue.

The key communication messages delivered to internal target audiences include topics such as trainings and in-services for the pandemic response, testing of employees, availability of transportation for late night staff, and hotel accommodations (see Table 5). The messages can be made over the public address system, blast emails and/or calls to units and department heads.

Table 5 – Communication Message Contents

Message Topics	Message Content to be Delivered	Delivery Methods
Pandemic Illness Training and In-services for: <ol style="list-style-type: none"> 1. Explanation of the pandemic illness 2. PPE requirements and proper use, donning and doffing 3. Cohorting of units 	<ul style="list-style-type: none"> • Training for new agency staff, clinical and non-clinical and all facility staff • On-going schedule of in class training with PowerPoint presentations and/or online training 	<ul style="list-style-type: none"> • Blast emails • Scheduling through departments • PA announcements • Everbridge (Mass Notification System)
Donations Received by Facility for Staff	Types of donations received for all shifts: <ul style="list-style-type: none"> • Meals – breakfast, lunch, dinner • Groceries/Snacks • Toiletries 	<ul style="list-style-type: none"> • PA announcements • Calls to units and department heads

Employee Testing	On-site testing available on all shifts by medical staff and/or contractors: <ul style="list-style-type: none"> • Location • Times • Frequency of testing 	<ul style="list-style-type: none"> • Blast emails • PA announcements • Everbridge (Mass Notification System)
Transportation	Taxi service for late night staff	<ul style="list-style-type: none"> • Blast emails • Everbridge (Mass Notification System)
Hotels	Arrangements for those who chose to: <ul style="list-style-type: none"> • Stay close to the facility • Self-quarantine 	<ul style="list-style-type: none"> • Blast emails • Everbridge (Mass Notification System)

External Communications

External communications with community stakeholders, elected officials and the press are coordinated with the NYC Health + Hospitals Communications Office.

Communications with Residents, Families and Visitors

The facility has developed a plan to maintain routine communication with residents, families and visitors during a pandemic outbreak. Communication methods include signage, letters, emails, in-person communication, video conferencing and updates on the facility’s social media accounts. The messages delivered through these communication methods include:

- Current precautions being taken in the facility to prevent and/or contain infection;
- Actions residents, families and visitors can take to protect themselves;
- Reinforcing adherence to standard infection control precautions, including hand hygiene, respiratory hygiene and cough etiquette;
- Reminding families and visitors not to visit when ill or if they have a known exposure to the pandemic illness; and
- Any limitation and/or restrictions on visitors that are in place.

The facility has a procedure in place to maintain up-to-date contact information on family members and/or legal representatives of residents. This contact information is obtained upon admission to the facility and confirmed or updated through the quarterly comprehensive care plan meeting process and upon a significant change in the resident’s medical condition. In addition, contact information is updated upon notification from staff or family that information has changed.

The following table (Table 6) outlines the targeted audiences, the key communication messages to be delivered, the method for delivery of the information and the frequency of communication.

Table 6 – Communication with Residents, Families and Legal Representatives

Audience	Message	Delivery Method	Frequency
Residents	<ul style="list-style-type: none"> • Updates on visitation • Updates on status of pandemic outbreak 	<ul style="list-style-type: none"> • Resident Council meeting • Town Hall/Unit meetings • Mass notification system 	<ul style="list-style-type: none"> • Monthly • As needed/weekly
Authorized Family Members and Legal Representatives	<ul style="list-style-type: none"> • Updates on visitation • Updates on status of pandemic outbreak or any other related updates • Status of infected and non-infected residents, as well as any expirations of residents with pandemic-related infection • Provision of alternate means of communicating with residents 	<ul style="list-style-type: none"> • Virtual town hall meetings • Telephone hotline for families • Mass notification system • Letters • Emails • Calls • Video conferencing (i.e., Facetime, Skype, Zoom) 	<ul style="list-style-type: none"> • As needed • Daily for infected residents and more frequently if the condition changes • Weekly for non-infected residents • Upon request by families <p>Note: During pandemic outbreak, daily access will be provided if requested.</p>

Communication with Other Healthcare Providers

The facility will consult and collaborate with NYC Health + Hospitals, NYC Emergency Management, local and state health departments, network institutions with NYC Health + Hospitals and affiliates with mutual support (EMS) relationships to ensure that coordinated, system-wide consistent efforts are implemented to minimize the impact of any service disruptions while acting to reduce the risk of disease transmission. Key contact information for all of the above entities has been identified and is maintained by the facility as part of this plan and the facility’s emergency preparedness plan.

V. OCCUPATIONAL HEALTH

Monitoring of Staff for Symptoms of Respiratory Illness/Pandemic Illness

To protect residents, staff and others who may be in the facility from harm during a pandemic outbreak, the facility has developed procedures for monitoring staff for symptoms of influenza-type or other pandemic illness, testing staff members who present with symptoms and the ongoing testing of staff, as needed and may be required by NYSDOH (see Table 7).

Table 7 Procedures to Monitor and Test Staff

<ul style="list-style-type: none"> • Facility will test staff in accordance with guidance and direction of the CMS/CDC, local and state health department.
<ul style="list-style-type: none"> • Testing will be done through a testing lab that can provide test results in a timely manner.

<ul style="list-style-type: none"> • If no testing capacity can be located that meets the timeframe goal for timely turnaround of tests, the facility will document all attempts to obtain testing and keep documents of those efforts for review.
<ul style="list-style-type: none"> • If an alternative test is approved that could help meet the timely turn-around goals and is approved by the local and state health department, the facility will incorporate those procedures in support of the facility's overarching objective to receive test results in a timely manner.
<ul style="list-style-type: none"> • The facility will rely on the staff to self-identify their illness status and departmental head report of ill staff.
<ul style="list-style-type: none"> • The facility will follow CDC, local and state health department guidance for sending directly exposed staff home for the incubation period of the novel agent (if known).
<ul style="list-style-type: none"> • The facility will follow CDC, local and state health department guidance for the return-to-work criteria for staff testing positive.
<ul style="list-style-type: none"> • The facility will report any positive tests in accordance with local and state health department requirements for the reporting of nosocomial/ healthcare associated infections.
<ul style="list-style-type: none"> • Staff who refuse to be tested shall be prohibited from providing care or services to the facility until testing is performed.

As referenced above under **Section III Infection Control Protection Plan**, staff will be monitored for influenza-like or other pandemic illness through self-monitoring/self-reporting pre-pandemic and through mandatory screening upon staff arrival for work (see Sample Screening Tool **Exhibit 2**).

Work Restrictions for Ill/Exposed Staff

The facility will follow CDC, local and state health department guidance and requirements as to the use of ill/exposed staff and any work restrictions placed on staff to work while ill/exposed.

NYC Health + Hospitals has implemented a policy to outline the criteria for healthcare personnel to return to work from suspected, confirmed or exposure to COVID-19 (see **Exhibit 4 - Return to Work Criteria for HCP with Suspected, Confirmed or Exposure to COVID-19**). This policy will be updated/revised based on any guidance and/or restrictions put in place by NYSDOH.

Sick Leave Policies/Leave Policies

The facility follows the leave policies issued by NYC Health + Hospitals. These policies are non-punitive, flexible and consistent with public health policies that allow ill health care providers and facility staff to stay home.

Respiratory Protection Plan for Healthcare Providers and Other Facility Staff

The facility has a respiratory protection plan in place for healthcare providers and other facility staff. This plan identifies work areas, processes or tasks that require respiratory protection for infection control purposes during normal work operations and during non-routine or emergency situations, like a pandemic outbreak. This program is limited to the use of disposable particulate respirators (minimum N95). The types of work activities, which require facility staff to wear disposable N95 respirators, are:

Table 8 – Work Activities that Require N95 Respirators

Work Activity to be Performed	Where, When, Other Factors
Having any resident contact	When entering room of resident on airborne precautions
Providing direct resident care and/or having close resident contact	In patient resident care areas when either CDC or NYSDOH recommend the use of N95 precautions.
Working in areas designated for COVID observation or treatment	C Building 5 th Floor
Conducting staff testing and health assessments (i.e., COVID 19 testing, respirator fit testing, annual physicals, etc.)	OHS or alternate location
Responding to RRTs (resident or staff) with potential of exposure to COVID 19.	Facility wide

Routine infection control and isolation for typical care situations are well known and tend to remain consistent over time. However, during an outbreak of a new virus type or pandemic flu, infection control guidance may change as the situation unfolds, based on epidemiological data. In these situations, the facility will keep current with CDC/NYSDOH recommendation and the program will be adjusted and employees kept informed as changes occur.

Only respirators approved by the National Institute for Occupational Safety and Health (NIOSH) are used by the facility. Staff assigned to tasks that require respiratory protection are provided a medical evaluation to determine the employee’s ability to use a respirator before the employee is fit tested or required to use the respirator in the workplace. All staff using N95 respirators must have been fit tested prior to using them and fit testing is conducted at least annually after initial fit testing to ensure proper fit.

Staff use their respirators under the conditions specified in Table 8 above and in accordance with the training they receive on the use of the respirator issued. The respirator is not used in a manner for which it is not certified by NIOSH or by its manufacturer. Staff is trained upon initial assignment to job tasks where a respirator has been determined necessary and at least annually thereafter.

As mentioned above, the facility keeps current on CDC/NYSDOH recommendations that could affect respirator use. In those instances, the Respiratory Protection Plan is updated as needed to implement any changes needed in the respiratory protection program. Staff that use N95 respirators are informed of the changes and in-services are scheduled, as needed, to train staff as to the changes/updates to the respiratory protection program and use of N95 respirators.

VI. EDUCATION AND TRAINING PLAN

The facility has a policy and procedures in place for the education on the prevention and control of infections with the facility. Education on the basic principles of infection prevention and control within the facility is provided to all healthcare providers, other facility staff, volunteers, residents, family members and guardians of residents. For facility staff, infection control prevention and control

education occurs upon hire, annually thereafter and when there is a need to provide more in-depth education when surveillance findings identify a need for a focused in-service; for residents, family and visitors, education occurs upon admission, when there is a change in the resident's condition and when surveillance findings identify a need for a focused in-service.

As discussed under **Section III Infection Control Plan** above, the facility will provide training/in-services as part of its ongoing surveillance program. Education and training efforts will be enhanced and expanded during a reported pandemic outbreak in the community as follows:

Facility Staff

Before the pandemic: Staff will be educated and trained about the facility's containment plan before it needs to be implemented. Examples of containment measures that will be discussed include, but are not limited to, the following:

- Screening procedures the facility expects to implement;
- Importance of self-assessing and reporting influenza or other pandemic illness symptoms before coming to work;
- Information about cohorting of residents and assigning staff;
- How residents' movement may be limited (e.g., temporarily closing the dining room and serving meals on units, canceling social and recreational activities, etc.); and
- How visitation by family and others may be restricted/limited and communication alternatives that will be put in place (i.e., video conferencing) in the event that visitation is not allowed.

In addition, leave policies, sick time, PPE and any other policies and procedures that may be implemented during the pandemic will be reviewed with staff. Staff will also be educated about the roles they will play during the pandemic phase. As part of the preparation for the pandemic, staff will be in-serviced on transmission-based precautions, and the requirements for use and correct usage of PPE.

During the pandemic: Staff will receive training and education to update them on pandemic-specific information and any guidance issued by CDC and/or NYSDOH on containment of the pandemic illness or treatment of residents during the pandemic. In addition, staff will be updated and educated on any change in policies or additional containment measures that may be put in place.

Education and training will be provided through department staff meetings and scheduled employee meetings as well as through assigned on-line training modules.

Residents

Before the pandemic: Residents will receive focused training regarding the actions the facility is taking to protect them and why they are important. Training topics to be reviewed with residents include, but are not limited to, the following:

- Importance of source control (proper use of facemask), physical or social distancing, hand hygiene, respiratory hygiene and cough etiquette, vaccination;
- Screening procedures for residents the facility expects to implement;
- Information about the potential cohorting of residents;
- Information on the required testing protocol;
- Information on the required health screening process;
- How residents' movement may be limited (e.g., temporarily closing the dining room and serving meals on units, canceling social and recreational activities, etc.); and
- How visitation by family and others may be restricted/limited and communication alternatives that will be put in place (i.e., video conferencing) in the event that visitation is not allowed.

During the pandemic: The facility will continue to provide focused education and training to update residents on the pandemic status of the facility as well as any updated information regarding the necessary restrictions on movement within the facility and any restriction/limitation on visitors to the facility.

Education materials and information will be adapted to the language needs and cognitive levels of the residents and will include, but not be limited to, signage, posters, pamphlets, letters, and one on one or small group discussion/presentation.

Visitors, Family Members and Guardians of Residents

Before the pandemic: Visitors, family members and guardians of residents will receive focused training regarding the actions the facility is taking to protect residents and anyone who enters the facility and why they are important. Training topics to be reviewed include, but are not limited to, the following:

- Importance of source control (proper use of facemask), physical or social distancing, hand hygiene, respiratory hygiene and cough etiquette, vaccination;
- Screening procedures for residents the facility expects to implement;
- Information about the potential cohorting of residents;
- Information on the required testing protocol;
- Information on the required health screening process;
- How residents' movement may be limited (e.g., temporarily closing the dining room and serving meals on units, canceling social and recreational activities, etc.); and
- How visitation by family and others may be restricted/limited and communication alternatives that will be put in place (i.e., video conferencing) in the event that visitation is not allowed.

During the pandemic: The facility will continue to provide focused education and training to update visitors, family members and guardians of residents on the pandemic status of the facility as well as

any updated information regarding the necessary restrictions on movement within the facility and any restriction/limitation on visitors to the facility.

Education materials and information will be adapted to the language needs and cognitive levels of the visitors and family members and will include, but not be limited to, signage, posters, pamphlets, and letters.

VII. VACCINE AND ANTIVIRAL USE PLAN

Influenza transmission and illness can be dramatically reduced when a vaccine is available and vaccine guidelines are carefully followed. As part of the facility's COVID-19 vaccination and seasonal influenza plan, the COVID-19 vaccine and seasonal flu vaccine are offered to residents and staff of the facility. Prior to the start of a new pandemic, and for some time into it, no vaccine will be available for that particular pandemic-causing strain of pathogens i.e. SARS-CoV-2 or influenza. When a vaccine becomes available, it will be in very limited supply and not available to the whole population. The facility will distribute and administer vaccine and antiviral medications (if available) according to CDC and NYSDOH directives and following the governmental/public health mandated order of priorities for giving the vaccine and antiviral medications.

Obtaining Most Current Recommendations and Guidance for Use, Availability, Access and Distribution of Vaccines and Antiviral Medications

The facility monitors public health advisories (federal and state) and guidance issued by CDC and NYSDOH as it relates to influenza outbreaks and the use, availability, access and distribution of influenza vaccines and antiviral medications. As mentioned above, the facility will follow the governmental/public health mandated order of priorities for giving the vaccine when the vaccine for that particular pandemic-causing strain of influenza becomes available. CDC guidance will be followed for the use of antiviral medication, with the final decision on whether or not to treat with antivirals resting with the treating physician.

Estimating the Number of Staff and Residents Who Would Be Targeted As First and Second Priority for Receipt of Influenza & Other Vaccines or Antiviral Prophylaxis

The criteria for determining the number of staff and residents who would be targeted as first and second priority for receipt of the pandemic-influenza vaccine or antiviral prophylaxis will be based on CDC and NYSDOH guidance and will most likely be tailored to fit the need of the population for that particular strain of influenza causing pandemic.

Receipt of Pandemic Influenza Vaccine: It is expected that healthcare personnel and first responders will be among those with first priority to receive the vaccine when it becomes available. First priority will be given to pregnant employees, staff involved with direct resident care and staff identified as having health conditions associated with higher risk of medical complications resulting from the pandemic influenza. Second priority will be given to the remainder of the facility staff. Priority for

the vaccine among residents will be determined by guidance issued by CDC and NYSDOH and the availability of the vaccine. The most important strategy is to keep the pandemic virus out the facility through vaccination of the staff.

Receipt of Antiviral Prophylaxis: As mentioned above, the final decision on whether or not to treat a specific resident with antivirals rests with the treating physician and will be based on the review of the resident's medical history and existing condition. Notwithstanding the treating physician's decision, the following resident categories will be given higher priority in receiving antivirals:

- Residents with more severe illness with suspected or confirmed influenza; and
- Residents with suspected or confirmed influenza who are a high risk for complications due to chronic medical or immunosuppressive conditions.

In addition, residents presenting with suspected COVID-19 or influenza who have symptoms of lower respiratory tract illness or clinical deterioration should also receive prompt empiric antiviral therapy, regardless of previous health or age. It should be noted that in a pandemic situation it may be quite difficult to take antivirals prophylactically due to the large amount required to be ingested in order for the drug to be effective, as well as the likelihood that exposure to the virus may be ongoing and therefore making a single prophylaxis regimen ineffective. Antiviral medications when given during the early onset of the highly transmissible viral infections such as COVID-19 or influenza, they can shorten the duration of illness symptoms and reduce the risk of thereby possibly limiting the spread of the virus in the facility.

Plan to Expedite Delivery of Influenza Vaccine or Antiviral Prophylaxis to Residents and Staff

The facility will remain alert for any changes of the CDC's guidance and recommendations on the use of COVID-19, influenza vaccine and antiviral medications in a nursing home setting. Based on this guidance, the facility will work to obtain vaccines and/or antivirals through its purchase arrangements for pharmaceuticals. In addition, during the pandemic phase, vaccines and antivirals may be made available through the local health department and/or NYSDOH. This will depend on the availability of, and rank on, the federal vaccine priority list and the federal antiviral priority list with relation to other groups requesting vaccines and/or antivirals. In the event that vaccines and/or antivirals are made available to the facility, the facility will work to expedite delivery of the vaccine and/or antiviral prophylaxis for use with residents and staff.

VIII. ISSUES RELATED TO SURGE CAPACITY DURING A PANDEMIC

Contingency Staffing Plan/Planning for Staff Shortages

It is the policy of the facility to maximize its staff availability to ensure the provision of safe resident care during a health care disaster. As described above, the facility has developed a procedure for the safe care and treatment of residents during a pandemic outbreak by designating spaces within the facility into three (3) zones, which is based on the residents' testing status, as follows:

Positive (i.e., COVID) – Space designated to be used and occupied by confirmed positive residents and staff assigned to their care. Newly admitted and readmitted residents with confirmed positive results who have not met the criteria for discontinuation of transmission-based precautions and are allowed to be admitted/readmitted to the facility based on CDC and NYSDOH guidance will be admitted to this space.

Unknown (i.e., COVID) – Space designated to be used and occupied by asymptomatic residents with exposure and/or residents who have an unknown testing status and staff assigned to their care.

Negative – Space designated to be used and occupied by confirmed negative residents and staff assigned to their care.

Staff assigned to work in positive zones will not be assigned to work in either unknown or negative zones. The facility can assign staff to work in unknown or negative zones but that staff will not be assigned to work in a positive zone. Implementing the zone system, which is meant to manage resident flow, and assigning dedicated staff to the zones should help to minimize the number of staff exposed to those with suspected or confirmed pandemic influenza/illness.

It is the expectation that all staff will continue to report to their normal duties unless specific directions are given otherwise. All staff will be mobilized to assist with essential job duties to provide care to the residents and to maintain the facility. During a pandemic outbreak, the facility will implement the following, considering the absenteeism due to illness and other factors, to deal with immediate staffing needs safely:

- Mandatory overtime;
- Calling on per-diem staff;
- Use of agency staff;
- Requesting an additional day of work from off-duty employees;
- Seeking voluntary overtime;
- Alternate work assignments as deemed necessary to maintain essential services; and
- Use of volunteers in the event of extreme staffing shortages.

The facility will consider the following essential elements when utilizing temporary staff (i.e., agency staff, volunteers, etc.) in an emergency staffing shortage in providing care safely:

- Staff/personnel receives training;
- Staff is oriented/familiarized with equipment and supplies;
- Staff is oriented/familiarized with the facility structure, space and set-up; and
- Staff is oriented to policy and procedures of the facility.

Identification of Essential Materials and Equipment/Plan to Address Likely Supply Shortages

During a pandemic, health care settings will need large quantities of equipment and supplies to provide care and to protect health care workers. It is anticipated that the demand will be high and that traditional supply chains may break down. In preparation for a pandemic, the following measures will be instituted:

1. The facility will maintain a 60-day supply of PPE, which will be based on the PPE burn rate/average consumption rate and will be adjusted accordingly if the burn rate/average consumption rate increases or decreases.
2. A 30-day supply of essential supplies (i.e., tissues, hand sanitizer, etc.) needed to adhere to infection control policies will be maintained.
3. The normal restocking/reordering of other supplies will remain in place unless a new need for a supply item, delay in receiving or a shortage is anticipated.

All stockpiled supplies, which are kept secured in the central storeroom and, when needed, in an additional secure location, are checked for expiration dates and rotated on a regular basis to prevent stock expiration. The facility administrator will determine the frequency of the stock rotation.

Working collaboratively with the NYC Health + Hospitals centralized materials management office and using NYC Health + Hospitals' supply chain tracking/monitoring software package, the facility's Manager of Materials Management can place orders routinely or on a stat basis to obtain the necessary supply or equipment item. During a pandemic, PPE availability is reported on a daily basis to the New York City Health + Hospitals centralized materials management office and the New York State Department of Health through the Health Electronic Reporting Data System (HERDS) so that anticipated shortages can be identified and the shortage addressed through either ordering of additional supplies or identifying the availability of PPE from other health care facilities.

Alternative Care Plans for Residents Who Need Acute Care

During a pandemic surge, mildly to moderately symptomatic confirmed positive and suspected positive residents may need acute care (hospital) services. The non-availability of hospital beds may require alternate care plans for these residents to include:

- Providing the low-level or mid-level care for mild to moderately symptomatic residents within the facility, which may include the provision of oxygen, if needed. The level of alternate care shall not exceed Level 3 (medical-surgical care).
- Transferring the resident to an established alternate care site (i.e., mobile field medical unit) where the resident can remain and receive low-level and mid-level medical care, including the provision of oxygen, if needed, for the duration of the isolation period. The level of alternate care shall not exceed Level 3 (medical-surgical care).

Where possible, the facility will strive to meet the clinical needs of a mild to moderately symptomatic confirmed positive or suspected positive resident in order to keep the resident at the facility. If the

facility cannot meet the clinical needs of the resident, the facility will request to transfer the resident to another alternate care site/provider as required by NYSDOH directives to do so.

Higher acuity care residents requiring significant ventilator support, including intensive monitoring on a ventilator (care corresponding to Level 2 (step-down care) and Level 1 (intensive care unit care), will be transferred to an acute care hospital for care.

It is the policy of the facility to notify the emergency contact/next of kin in the event of a significant change in the resident's medical condition and/or the transfer of the resident to another facility, in this case either to a hospital or an established alternate care site. Please refer to **Section IV Communication Plan** above, for additional information on communication with authorized family members and legal representatives.

Surge Capacity Plan to Help Increase Hospital Bed Capacity

NYC Health + Hospitals has a centralized admission function to assist in the nursing home placement of resident being discharged from one (1) of the 11 NYC Health + Hospitals acute care hospitals. In addition, the facility reports the number of available beds to NYSDOH on a weekly basis through the Health Commerce System and through the HERDS system during an emergency situation to assist other acute care hospitals with information as to the availability of beds for resident needing placement in order to help increase hospital bed capacity during a pandemic. The facility will follow NYSDOH directives regarding the transfer and acceptance of resident from hospitals during a pandemic, including any directives that may be issued on not accepting resident with confirmed positive status of the pandemic illness.

The facility works collaboratively with discharge planners from hospitals to obtain the necessary documentation to facilitate the clinical review for appropriate placement of discharged hospital resident in an available bed. During a pandemic, placement in an available bed at the facility will be determined by the resident's testing status and/or health status as a result of the pandemic, which may result in the declination of placement by the facility if a bed is not available in the correct designated cohorting spaces established by the facility.

During a pandemic, the facility will assess residents admitted to the facility for short-term rehabilitative services to determine if they can safely be discharged home in order to free up beds that may be needed to address placement of discharged hospital resident in need of low level medical/surgical care at the facility.

Increased Need for Post Mortem Care/Disposition of Deceased Residents

At the present time, there is limited morgue capacity at the facility. During a pandemic, there could be an increased need for surge morgue capacity. In the case of surge morgue capacity need, the facility may establish a Body Collection Point (BCP) with the NYC Office of Chief Medical Examiner (OCME). A BCP is a temporary refrigeration unit used to store decedents until transport is arranged. It allows the facility to store deceased residents until they can be released to funeral homes or until

OCME takes possession if a body is not claimed. The purpose of the BCP is to decompress the facility's morgue to give funeral homes the time to get to the facility to make the removal and follow the wishes of the family.

A BCP is obtained by submitting a request for one (1) to NYC Emergency Management (NYCEM). The management of the BCP is the responsibility of the facility and is an extension of the facility's morgue space. As such, the facility is responsible for the following:

- Case Transport: Movement of the deceased from resident care areas to the BCP for temporary storage;
- Family Management: Communicating with families to make notification of death and enable arrangement for final disposition;
- Release Cases: Release of cases to funeral homes on demand and in accordance with normal procedures;
- Temperature Monitoring: Remains should be stored between 37-44°F. The facility will monitor the ambient temperature inside the BCP to ensure the temperature range is maintained;
- Fuel Management: The facility is responsible for monitoring fuel levels. NYCEM has facilitated refueling operations;
- Case Management/Tracking: The facility maintains a morgue census for all cases stored in the BCP. A daily morgue census of the facility's fixed morgue and the BCP is provided to OCME to assist in monitoring case storage capabilities and manage transport resources Citywide.
- Security: The facility ensures that the unit is secure 24 hours a day. Depending on the placement of the unit, this may include taking measures to ensure privacy, deploying lighting elements or cameras, deploying tents or covered walkways, etc.; and
- Personal Effects: The facility is responsible for the management of personal effects and for maintaining a chain of custody and document form for when the items are collected after death to their release to family members.

EXHIBIT 1

Pandemic Influenza/Illness Planning Checklist – Annual Update

1. Structure for planning and decision-making.

Reviewed	No Update Needed	Updated	
			<p>Pandemic influenza/illness has been incorporated into emergency planning and exercises for the facility.</p> <p>A multidisciplinary planning committee or team has been created to specifically address pandemic influenza/illness preparedness planning. Committee's name: <u>Multidisciplinary Pandemic Planning Team</u></p> <p>A person has been assigned responsibility for coordinating preparedness planning, hereafter referred to as the pandemic influenza/illness response coordinator: <u>Stephen Catullo CEO</u></p> <p>Members of the planning committee include (as applicable to each setting) the following:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Facility Administration : <u>Stephen Catullo; Alfonso Pistone</u> <input checked="" type="checkbox"/> Medical Director: <u>Rani Rao, M.D.</u> <input checked="" type="checkbox"/> Nursing Administration: <u>Yves-Rose Pascal; Verna Mitchell</u> <input checked="" type="checkbox"/> Risk Management: <u>Daniel Berry</u> <input checked="" type="checkbox"/> Infection Prevention and Control: <u>Edouard Hazel, M.D.; Carmentina Silvestre-Tan; Denise Thompson</u> <input type="checkbox"/> Occupational Health: <input type="checkbox"/> Staff Training and Orientation: <input type="checkbox"/> Engineering/Maintenance services: <input checked="" type="checkbox"/> Emergency Management Coordinator: <u>Jose Rodriguez</u> <input type="checkbox"/> Environmental services: <input type="checkbox"/> Dietary services: <input type="checkbox"/> Pharmacy services: <input type="checkbox"/> Rehabilitation services: <input type="checkbox"/> Transportation services: <input checked="" type="checkbox"/> Purchasing Agent: <u>Abraham Shapiro</u> <input checked="" type="checkbox"/> Other: <ul style="list-style-type: none"> ✓ Quality Management/Regulatory Affairs: <u>Monsy Nieves-Martinez</u> ✓ Social Work: <u>Cheryl Dury</u> ✓ Psychiatry: <u>Ravindra Amin, M.D.</u> ✓ Human Resources: <u>Gina Velez</u>

1. Structure for planning and decision-making (continued)

Reviewed	No Update Needed	Updated	
			<p>Local and state health departments and provider/trade association points of contact have been identified for information on pandemic influenza/illness planning resources.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Local health department contact: <u>212-346-7572</u> <input type="checkbox"/> State health department contact: <u>518-473-4436</u> <input type="checkbox"/> New York City Emergency Management: <u>646-692-3641</u> <input type="checkbox"/> NYS Office of Emergency Management: <u>518-292-2200</u> <input type="checkbox"/> Greater New York Hospital Association: <u>212-246-7100</u> <p>Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified:</p> <ul style="list-style-type: none"> <input type="checkbox"/> City: <u>NYCHHC Management; New York City Emergency Management (NYCEM)</u> <input type="checkbox"/> County: N/A <input type="checkbox"/> State: <u>NYS Office of Emergency Management</u> <p>Area hospitals points of contact have been identified in the event that facility residents require hospitalization or facility beds are needed for hospital residents being discharged in order to free up needed hospital beds:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mount Sinai Queens 718-932-1000 <input type="checkbox"/> NYC H+H/Bellevue 212-562-4141 <input type="checkbox"/> NYC H+H/Harlem 212-939-4000 <input type="checkbox"/> NYC H+H/Metropolitan 212-423-6262 <input type="checkbox"/> NYC H+H/Jacobi 718-918-5000 <input type="checkbox"/> NYC H+H/North Central Bronx 718-519-5000 <input type="checkbox"/> NYC H+H/Coney Island 718-372-0275 - <input type="checkbox"/> NYC H+H/Kings County 718-245-3131 <input type="checkbox"/> NYC H+H/Woodhull 718-963-8000 <input type="checkbox"/> NYC H+H/Elmhurst 718-334-4000 <input type="checkbox"/> NYC H+H/Queens 718-883-3000 <input type="checkbox"/> NYC H+H/Lincoln 718-579-5000

2. Development of a written pandemic plan.

Reviewed	No Update Needed	Updated	
			Copies have been obtained of relevant sections of the HHS Pandemic Influenza/Illness Plan (available at www.hhs.gov/pandemic-flu/plan) and available state, regional, or local plans are reviewed for incorporation into the facility's plan.
			The facility plan includes the elements listed in #3 below.
			The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

3. Elements of a pandemic plan

Reviewed	No Update Needed	Updated	
			<p>A plan is in place for surveillance and detection of the presence of pandemic influenza/illness in residents and staff.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A person has been assigned responsibility for monitoring public health advisories (federal and state), and updating the pandemic response coordinator and members of the pandemic influenza/illness planning committee when pandemic influenza/illness has been reported in the United States and is nearing the geographic area. For more information, see www.cdc.gov/flu/weekly/fluactivity.htm; https://covid.cdc.gov/covid-data-tracker/#datatracker-home Insert name, title and contact information of person responsible) <i>Jose Rodriguez (Safety Officer) and Carmentina Silvestre-Tan (Infection Preventionist)</i>
			<ul style="list-style-type: none"> <input type="checkbox"/> A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. For more information, see www.cdc.gov/flu/professionals/diagnosis/. (Having a system for tracking illness trends during seasonal influenza will ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.) <input type="checkbox"/> A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza/illness. <input type="checkbox"/> Assessment for seasonal influenza is included in the evaluation of incoming residents. There is an admission policy or protocol to determine the appropriate placement and isolation of resident with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza/illness.) <input type="checkbox"/> A system is in place to monitor for, and internally review transmission of, influenza among residents and staff in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting). (This system will be necessary for assessing pandemic influenza transmission.)
			<p>A facility communication plan has been developed. For more information, see www.hhs.gov/pandemicflu/plan/sup10.htm.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Key public health points of contact during a pandemic have been identified. <input type="checkbox"/> Local health department contact: <u>212-346-7572</u> <input type="checkbox"/> State health department contact: <u>518-473-4436</u> <input type="checkbox"/> A person has been assigned responsibility for communications with public health authorities during a pandemic: <u>Stephen Catullo</u>

3. Elements of a pandemic plan (continued)

Reviewed	No Update Needed	Updated	
			<ul style="list-style-type: none"> <input type="checkbox"/> A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of pandemic influenza/illness in the facility. (Having one voice that speaks for the facility during a pandemic will help ensure the delivery of timely and accurate information). <input type="checkbox"/> Contact information for family members or guardians of facility residents is up-to-date. <input type="checkbox"/> Communication plans include how signs, phone trees, and other methods of communications will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., sales and delivery people) about the status of pandemic influenza/illness in the facility. <input type="checkbox"/> A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals' emergency medical services, relevant community organizations (including those involved with disaster preparedness) with whom it will be necessary to maintain communication during a pandemic. <input type="checkbox"/> A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during a pandemic.
			<p>A plan is in place to provide education and training to ensure that all personnel, residents, and family members of residents understand the implications of, and basic prevention and control measures for, pandemic influenza/ illness.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A person has been designated with responsibility for coordinating education and training on pandemic influenza/illness (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance): _____ <input type="checkbox"/> Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital-sponsored) programs have been identified. See www.cdc.gov/flu/professionals/training/. <input type="checkbox"/> Language and reading-level appropriate materials have been identified to supplement and support education and training programs (e.g., available through state and federal public health agencies such as www.cdc.gov/flu/groups.htm. and through professional organizations), and a plan is in place for obtaining these materials. <input type="checkbox"/> Education and training includes information on infection control measures to prevent the spread of pandemic influenza/illness. <input type="checkbox"/> The facility has a plan for expediting the credentialing and training of non-facility staff brought in from other locations to provide resident care when the facility reaches a staffing crisis. <input type="checkbox"/> Informational material (e.g., brochures, posters) on pandemic influenza/illness and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the pandemic.

3. Elements of a pandemic plan (continued)

Reviewed	No Update Needed	Updated	
			<p>An infection control plan is in place for managing residents and visitors with pandemic COVID-19 or influenza/illness that includes the following: (For information infection control recommendations for pandemic influenza/illness, see Pandemic Influenza HHS.gov Pandemic Influenza Pandemic Influenza (Flu) CDC; AND Global COVID-19 CDC)</p> <p>An infection control policy that requires direct care staff to use Standard (www.cdc.gov/ncidod/dhqp/g1_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/g1_isolation_droplet.html) with symptomatic residents.</p> <p>A plan for implementing Respiratory Hygiene/Cough Etiquette throughout the facility. (See www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm.)</p> <p>A plan for cohorting symptomatic residents or groups using one or more of the following strategies:</p> <ol style="list-style-type: none"> 1) Confining symptomatic resident and their exposed roommates to their room, 2) Placing symptomatic residents together in one area of the facility, or 3) Closing units where symptomatic and asymptomatic residents reside (i.e., restricting all residents to an affected unit, regardless of symptoms). <p>The plan includes a stipulation that, where possible, staff who are assigned to work on affected units will not work on other units.</p> <p>Criteria and protocols for closing units or the entire facility to new admissions when pandemic influenza/illness is in the facility have been developed.</p> <p>Criteria and protocols for enforcing visitor limitations have been developed</p>
			<p>An occupational health plan for addressing staff absences and other related occupational issues has been developed that includes the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A liberal/non-punitive sick leave policy that addresses the needs of symptomatic personnel and facility staffing needs. The policy considers: <ul style="list-style-type: none"> <input type="radio"/> The handling of personnel who develop symptoms while at work. <input type="radio"/> When personnel may return to work after having pandemic influenza/illness.

3. Elements of a pandemic plan (continued)

Reviewed	No Update Needed	Updated	
			<ul style="list-style-type: none"> ○ When personnel who are symptomatic but well enough to work, will be permitted to continue working. ○ Personnel who need to care for family members who become ill. ○ A plan to educate staff to self-assess and report symptoms of pandemic influenza before reporting for duty. ○ A list of mental health and faith-based resources that will be available to provide counseling to personnel during a pandemic. ○ A system to monitor influenza vaccination of personnel. ○ A plan for managing personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised workers) by placing them on administrative leave or altering their work location.
			<p>A vaccine and antiviral use plan has been developed.</p> <ul style="list-style-type: none"> <input type="checkbox"/> CDC and state health department websites have been identified for obtaining the most current recommendations and guidance for the use, availability, access, and distribution of vaccines and antiviral medications during a pandemic. For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html. <input type="checkbox"/> HHS guidance has been used to estimate the number of personnel and residents who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html. <input type="checkbox"/> A plan is in place for expediting delivery of influenza vaccine or antiviral prophylaxis to residents and staff as recommended by the state health department.
			<p>Issues related to surge capacity during a pandemic have been addressed.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations. <input type="checkbox"/> A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza/illness pandemic: _____ <input type="checkbox"/> Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law.

3. Elements of a pandemic plan (continued)

Reviewed	No Update Needed	Updated	
			<ul style="list-style-type: none"> <li data-bbox="735 394 1430 512">❑ The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis. <li data-bbox="735 552 1414 701">❑ Estimates have been made of the quantities of essential materials and equipment (e.g., masks, gloves, hand hygiene products, intravenous pumps) that would be needed during a six-week pandemic. <u>Note: NYSDOH requires 2 months' supply of PPE</u> <li data-bbox="735 741 1382 827">❑ A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources. <li data-bbox="735 867 1398 953">❑ Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable. <li data-bbox="735 993 1409 1047">❑ Surge capacity plans include strategies to help increase hospital bed capacity in the community. <li data-bbox="735 1087 1430 1205">❑ Signed agreements have been established with area hospitals for admission to the long-term care facility of non-influenza resident to facilitate utilization of acute care resources for more seriously ill resident. <li data-bbox="735 1245 1409 1331">❑ Facility space has been identified that could be adapted for use as expanded in resident beds and information provided to local and regional planning contacts. <li data-bbox="735 1371 1425 1457">❑ A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents. <li data-bbox="735 1497 1409 1551">❑ An area in the facility that could be used as a temporary morgue has been identified. <li data-bbox="735 1591 1398 1646">❑ Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.

Adapted from the Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC)'s **Long –Term Care and Other Residential Facilities Pandemic Influenza Checklist**

EXHIBIT 2

Sample Surveillance Screening Tool

Respiratory Infection Screening Tool	
Date:	Health Care Worker Instructions
Unit:	
Section A: Respiratory Symptoms	
Are you experiencing any of the following symptoms: <ul style="list-style-type: none">○ New/Worse Cough OR○ New/Worse shortness of breath (worse than what is normal for you)	If YES, Continue to Section B. If NO, stop here.
Section B: Temperature	
Are you feeling feverish, with shakes or chills in the last 24 hours? Or is the temperature above 99.7 °F? Record Temperature: _____	If YES, mask the resident immediately and initiate Contact + Droplet Precautions (N95 respirator) with Eye Protection
Section C: Additional Screening for Influenza-like Illness	
If resident fails Section A and B, proceed with additional screening for influenza-like illness: <ul style="list-style-type: none"><input type="checkbox"/> Sore throat<input type="checkbox"/> Arthralgia – joint pain<input type="checkbox"/> Myalgia – muscle pain<input type="checkbox"/> Prostration – extreme physical weakness/exhaustion<input type="checkbox"/> Diarrhea	

EXHIBIT 3



Memorandum
Via Email

To: New York City Health + Hospitals
From: Dialyze Direct Clinical Services
Subject: COVID-19 Resurgence – Staffing and Dialysis Capacity Plan
Date: August 20, 2020

The following serves as Dialyze Direct’s Staffing and Dialysis Capacity Plan in the event of a COVID-19 resurgence within the New York state region. In the event of dialysis caregiver staffing shortages, Dialyze Direct will deploy the following strategies to ensure the reduction in risk of dialysis care delay:

- 1) Patient Schedule Augmentation – Dialyze Direct will augment patient schedules (under the guidance and approval of the patient’s nephrologist and Dialyze Direct’s medical director) to maximize clinical staff flexibility. The augmented schedules will create greater availability among Dialyze Direct existing staff and reduce staffing shortages.
- 2) Source Existing Dialyze Direct Staff from External Regions – Dialyze Direct maintains staff in 11 other states within the country. In the event of a dialysis staffing shortage, Dialyze Direct has the capability of sourcing staff from external regions that are unaffected by the pandemic for purposes of providing temporary relief to a region experiencing a spike in prevalence.

Dialyze Direct will accept all medically stable dialysis residents into its home dialysis program (pursuant to physician orders). In the event that Dialyze Direct reaches max capacity of dialysis residents at the nursing facility, Dialyze Direct will:

- 1) Provide daily alerts to nursing facility staff that Dialyze Direct has reached max capacity, and make recommendations that hospitals should place holds on further admissions until vacancy clears.
- 2) Pursue alternative dialysis availability within the nursing facility such as makeshift dens, bedside cohorts, etc.

Lastly, Dialyze Direct maintains an ample inventory of equipment and supplies, and has strong supply chain relationships. We continually replenish and maintain a base level inventory of equipment and supplies that are intended to last for six months.

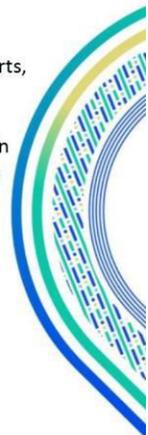


EXHIBIT 4

Return to Work Criteria for Health Care Personnel with Suspected or Confirmed Exposure to COVID-19

DOC ID HHCMPA162020v12

Effective Date: February 11, 2022

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SUMMARY OF UPDATES:

The following sections have been updated as of 2/11/2022

1. Boosted HCP do not require testing after high risk exposure
2. Isolation criteria for staff, regardless of vaccination status, is 5 days with/without negative test, if asymptomatic or mild-moderate illness with improving symptoms
3. Acceptable COVID-19 testing for unboosted staff return to work after high risk exposure now includes choice of either a lab-performed COVID-19 antigen test or PCR with testing on days specified below.
4. Revised definition of boosted person.

Purpose	To provide guidance on return to work criteria after COVID-19 infection or exposure.		
Scope	All New York City Health + Hospitals Personnel		
Process	HCP Isolation Guidance		
	Symptom Status	Vaccination Status	Return to Work Criteria
	Symptomatic	<ul style="list-style-type: none"> • Any 	<ul style="list-style-type: none"> • At least 5 days have passed since date of symptom onset, with date of onset considered day 0. No testing is required to return to work. • Not have a fever for at least 72 hours without fever-reducing medication • Have resolution of symptoms or, if still with residual symptoms, then all are improving • Not have rhinorrhea (runny nose) • Have no more than minimal, non-productive cough (i.e., not disruptive to work and does not stop the person from wearing their mask continuously, not coughing up phlegm) • HCP must consistently and correctly wear a N95 respirator or equivalent or a well-fitting face mask (such as a surgical mask) • HCP practice social distancing from coworkers at all times except when job duties do not permit such distancing. • If HCP must remove their respirator or well-fitting facemask, for example, in

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		<ul style="list-style-type: none"> order to eat or drink, HCP should separate themselves from others. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen
Asymptomatic	<ul style="list-style-type: none"> Any 	<ul style="list-style-type: none"> At least 5 days have passed since the date of first positive viral test, with date of collection considered day 0. No testing is required to return to work. HCP must consistently and correctly wear a N95 respirator or equivalent or a well-fitting face mask (such as a surgical mask) HCP practice social distancing from coworkers at all times except when job duties do not permit such distancing. If HCP must remove their respirator or well-fitting facemask, for example, in order to eat or drink, HCP should separate themselves from others. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen
HCP with severe to critical illness or who are moderately to severely immunocompromised		<ul style="list-style-type: none"> At least 10 days and up to 20 days have passed since symptoms first appeared, and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved. <p>Consultation with infectious disease specialist is required because moderately</p>

to severely immunocompromised HCPs may produce replication-competent virus beyond 20 days after symptom onset or for those who were asymptomatic throughout their infection, the date of their first positive viral test.

HCP Exposure Guidance

Lower-Risk Exposures of HCP Exposed to Individuals with Confirmed COVID-19 Infection

- In general, asymptomatic HCP who have had a lower-risk exposure do not require work restriction regardless of vaccination status and do not develop symptoms or test positive for SARS-CoV-2.
- If HCP becomes symptomatic, they must isolate, not report to work and notify facility OHS, and get tested

Higher-Risk Exposures of HCP Exposed to Individuals with Confirmed COVID-19 Infection

Vaccination Status	Guidance
Up-to-date with Vaccination: <ul style="list-style-type: none"> ○ Fully vaccinated and boosted OR ○ Fully vaccinated but not eligible for booster dose 	<ul style="list-style-type: none"> ○ Does not require work restriction or testing requirements if they do not develop symptoms or test positive for SARS-CoV-2
Not up-to-date with Vaccination: <ul style="list-style-type: none"> ○ Fully vaccinated and eligible for booster but <i>not boosted</i> OR ○ Not fully vaccinated 	<ul style="list-style-type: none"> ○ Does not require work restriction if they do not develop symptoms or test positive for SARS-CoV-2 ○ MUST get tested with negative PCR or lab-performed antigen tests on days 1, 2, 3, and 5-7 but can continue to work (total of 6 serial tests) ○ If HCP test positive or becomes symptomatic, the HCP must isolate,

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		not report to work and notify facility OHS
		<p>Note: The specific factors associated with these exposures should be evaluated on a case by case basis; interventions, including restriction from work, can be applied if the risk for transmission is deemed substantial or are otherwise directed to do so by the DOH.</p> <p>Testing must still occur for asymptomatic HCPs (regardless of vaccinations status) even if HCP has recovered from COVID-19 in the prior 90 days.</p>
	HCP Working in Nursing Homes	Fully vaccinated asymptomatic HCP with exposure do not need to quarantine but are required to continue to receive COVID-19 testing twice weekly at their facility or based on most recent NYSDOH Executive Order.
	HCP Travel Guidance	<p>HCP Travel Requirements for New York State (General): As of June 25, 2021, the New York State Travel Advisory is no longer in effect. As such, travelers arriving in New York are no longer required to submit traveler health forms.</p> <p>All travelers, domestic and international, should continue to follow all CDC travel requirements.</p> <p>Asymptomatic HCP Returning from Domestic Travel: Asymptomatic HCP returning from domestic travel no longer have to test or quarantine. Self-monitor for COVID-19 symptoms; isolate and get tested if you develop symptoms.</p> <p>HCP Returning from International Travel: HCPs returning from international travel should continue to follow CDC guidance which recommends getting tested for COVID-19 with a viral test 3-5 days after travel. Self-monitor for COVID-19 symptoms; isolate and get tested if you develop symptoms.</p>
	Paid Sick Leave	HCP and COVID-19 Paid Sick Leave: Employees who engage in domestic or international travel, not related to work, will need to use their personal leave

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		time, from the time of return to New York until the end of any required period of quarantine or isolation.
	HCPs Working Remotely	<p>Guidelines for HCPs Working Remotely Exposed to COVID-19:</p> <p>HCPs working remotely who are exposed to COVID-19 should adhere to their local Health Department regulations or notifications regarding quarantine and should use their personal leave time for any absences.</p>
Definitions	Healthcare Personnel (HCP)	HCP refers to all clinical and non-clinical, paid or unpaid persons, including Contact Tracers or Community Care Workers working in healthcare settings or in the community; including facility offices and central office locations who have the potential for direct or indirect exposure to patients, staff or infectious materials, including bodily substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.
	Severely Immunocompromised	<p>Severely immunocompromised:</p> <ul style="list-style-type: none"> • Receiving chemotherapy for hematopoietic malignancies • Receiving chemotherapy or radiation for solid-organ malignancies • immunosuppressed following solid-organ transplant, or during conditioning and 72 months following hematopoietic stem cell transplant • Taking biologic therapy (e.g. rituximab, IL-L7,IL-6, or TNF inhibitors or others) • Receiving at least 20 mg or 2 mg/kg body weight of prednisone (or equivalent) per day for 14 or more days immunosuppressed because of severe inherited or acquired immunodeficiencies (e.g., agammaglobulinemia or HIV infection with CD4 count less than 200 or others)
	Mild illness	Individuals who have any of the various signs and symptoms of COVID-19 (e.g. fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, chest pain or abnormal chest imaging.
	Moderate illness	Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO ₂) ≥94% on room air at sea level and various signs and

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		symptoms of COVID-19 (e.g. fever, cough, sore throat, malaise, headache, muscle pain) with shortness of breath, dyspnea, chest pain or abnormal chest imaging.
	Severe Illness	Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50% on chest imaging.
	Critical Illness	Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
	Exposure	HCP: Prolonged ("prolonged" refers to a cumulative time period of 10 or more minutes during a 24-hour period) close (within 6 feet) contact with a patient, visitor or HCP with confirmed COVID-19. In addition, HCP was not wearing a respirator or face mask or HCP was not wearing protective eyewear if the person with COVID-19 was not wearing a facemask or HCP not wearing all recommended PPE during an aerosol generating procedure with a patient with confirmed COVID-19 or HCP was deemed to have had an exposure (including proximate contact) by a local health department.
	High Risk Exposure	High risk exposures generally involve the HCP's eyes, nose and mouth to material containing COVID-19 virus. Particularly if the HCP is in a room during an aerosol generating procedure
	Low Risk Exposure	Low risk exposures include having body contact with the patient (e.g., rolling the patient) <i>without gown or gloves</i> particularly if hand hygiene is not performed and the HCP touches their mouth, nose or eyes.
	Close Contact	Anyone who has prolonged close contact (within 6 feet for a cumulative total of 15 minutes over 24 hours) to someone with COVID-19 infection who is not using PPE correctly, not wearing a well-fitting mask whether the HCP and/or the individual with COVID-19 infection are fully vaccinated.
	Fully Vaccinated	≥2 weeks after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna or a WHO approved vaccine) or ≥2 weeks after they have received a single-dose vaccine (Johnson and Johnson (J&J)/Janssen).
	Partially Vaccinated	Received 1 dose of a 2-dose series (Pfizer-BioNTech or Moderna or a WHO approved vaccine).

Return to Work Criteria for Health Care Personnel with Suspected or Confirmed Exposure to COVID-19



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	<p>Up to date with COVID-19 Vaccination</p> <p>A person is considered up to date when all recommended COVID-19 vaccines doses have been received, including any booster dose(s) when eligible. Many people who are immunocompromised may need an additional dose as part of their primary vaccine series</p>
	<p>Boosted</p> <p>A person is considered “boosted” and up to date right after getting their booster dose.</p>
References	<p>CDC: Potential Exposure at Work: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html</p> <p>Interim Advisory on Return-to-Work Protocols for Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 in Healthcare Settings. January 4, 2022</p> <p>Updated Advisory on Return-to-Work Protocols for Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, February 4, 2022 DOH Advisory RTW 2022 Feb4.pdf (qnyha.org)</p>

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