

NYC HEALTH + HOSPITALS

Dr. Susan Smith McKinney Nursing and Rehabilitation Center

ANNUAL PANDEMIC EMERGENCY PLAN 2025

Table of Review and Approval

Date Reviewed	Date Approved
9/10/20	9/14/2020
12/9/2021	12/17/2021
12/14/2022	1/11/2023
1/25/2024	1/29/2024
4/1/2025	4/1/2025

The Annual Pandemic Emergency Plan (APEP) was originally written and approved on 9/14/20 and reviewed 4/1/2025.

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 dated 4/1/2025 has been posted on the facility's website.

TABLE OF CONTENTS

FACILITY INFORMATION

I. INTRODUCTION TO PLAN

- PURPOSE
- DEMOGRAPHICS

II. EMERGENCY PLAN

- READINESS ASSESSMENT/PANDEMIC INFLUENZA/ILLNESS PLANNING
- STRUCTURE FOR PLANNING AND DECISION-MAKING
- COORDINATION WITH OUTSIDE AGENCIES/ORGANIZATIONS

III. INFECTION CONTROL PROTECTION PLAN

- DESCRIPTION OF SURVEILLANCE AND MONITORING ACTIVITIES
- ACTIVE SURVEILLANCE FOR RESPIRATORY INFECTION OR OTHER PANDEMIC ILLNESS
- IDENTIFICATION AND MANAGEMENT OF RESIDENTS WITH SYMPTOMS
- NOTIFICATION TO STATE AND LOCAL HEALTH DEPARTMENTS
- CRITERIA TO LIMIT OR RESTRICT VISITORS, VOLUNTEERS AND NON-ESSENTIAL STAFF
- RESOURCES AND SUPPLIES TO ADHERE TO INFECTION CONTROL PRACTICES

IV. COMMUNICATION PLAN

- INTERNAL COMMUNICATION
- EXTERNAL COMMUNICATION
- COMMUNICATION WITH RESIDENTS, FAMILIES AND VISITORS
- COMMUNICATION WITH OTHER HEALTHCARE PROVIDERS

V. OCCUPATIONAL HEALTH

- MONITORING OF STAFF FOR SYMPTOMS OF RESPIRATORY ILLNESS/PANDEMIC ILLNESS
- WORK RESTRICTIONS FOR ILL/EXPOSED STAFF
- SICK LEAVE POLICIES
- RESPIRATORY PROTECTION PLAN FOR HEALTHCARE PROVIDERS AND OTHER FACILITY STAFF

EDUCATION AND TRAINING PLAN

- FACILITY STAFF
- RESIDENTS
- VISITORS, FAMILY MEMBERS AND GUARDIANS OF RESIDENTS

VI. VACCINE AND ANTIVIRAL USE PLAN

- OBTAINING MOST CURRENT RECOMMENDATIONS AND GUIDANCE FOR USE, AVAILABILITY, ACCESS AND DISTRIBUTION OF VACCINES AND ANTIVIRAL MEDICATIONS
- ESTIMATING THE NUMBER OF STAFF AND RESIDENTS WHO WOULD BE TARGETED AS FIRST AND SECOND PRIORITY FOR RECEIPT OF INFLUENZA VACCINE OR ANTIVIRAL PROPHYLAXIS
- PLAN TO EXPEDITE DELIVERY OF INFLUENZA VACCINE OR ANTIVIRAL PROPHYLAXIS TO RESIDENTS AND STAFF

VII. ISSUES RELATED TO SURGE CAPACITY DURING A PANDEMIC

- CONTINGENCY STAFFING PLAN/PLANNING FOR STAFF SHORTAGES
- IDENTIFICATION OF ESSENTIAL MATERIALS AND EQUIPMENT/PLAN TO ADDRESS LIKELY SUPPLY SHORTAGES
- ALTERNATIVE CARE PLANS FOR RESIDENTS WHO NEED ACUTE CARE
- SURGE CAPACITY PLAN TO HELP INCREASE HOSPITAL BED CAPACITY
- INCREASED NEED FOR POST MORTEM CARE/DISPOSITION OF DECEASED RESIDENTS

EXHIBITS

- 1. Pandemic Influenza/Illness Planning Checklist**
- 2. Sample Surveillance Screening Tool**
- 3. NYC Health + Hospitals Policy – Return to Work Criteria for HCP with Suspected, Confirmed or Exposure to COVID-19**

FACILITY INFORMATION

Facility: NYC H+H/Dr. Susan Smith McKinney Nursing & Rehabilitation Center

Address: 594 Albany Avenue

City: Brooklyn **State:** NY **ZIP Code:** 11203

Phone Number: 718-245-7000

Contact Person: Lucan Rodrigues, M.D., Chief Medical Officer

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New York, New York 10004

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 during a pandemic to ensure that the patients, staff, and visitors of this facility are kept safe from harm. The safety and well-being of the patients, staff, and visitors take priority over all other considerations.

Demographics:

- A. This facility is located at 594 Albany Avenue, Brooklyn, New York 11203.
- B. The facility is a 320-bed residential health care facility (RHCF), which provides short-term post-acute rehabilitation care and skilled nursing services, including specialized care for serious injuries and medically complex services.

II. EMERGENCY PLAN

Readiness Assessment/Pandemic Influenza/Illness Planning

- A. This facility maintains a comprehensive Emergency Operations Plan (EOP) to prepare for, respond to, and recover from natural and man-made disasters. The facility utilizes an all-hazards approach to emergency preparedness planning, concentrating on the essential capacities and capabilities needed to prepare for a wide range of emergencies or disasters, including pandemics and emerging infectious diseases (EIDs).
- B. This facility conducts an annual readiness assessment to evaluate its preparedness for responding to pandemic influenza/illness (see Pandemic Influenza/Illness Planning Checklist Annual Update, Exhibit 1). The APEP is written and updated based on this 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 annually updated Pandemic Influenza/Illness Planning Checklist will be kept with the APEP.
- C. A copy of the APEP is attached to the facility's EOP 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 establish a multidisciplinary planning committee specifically to address pandemic preparedness and response.

B. The Multidisciplinary Pandemic Planning Team consists of the following individuals:

Name	Title
Daveth Forbes	CEO/Administrator
Stephen Piazza	Director, Maintenance and Engineering
(Vacant)	Deputy Executive Director
Doreen Windross	Nurse Educator
Anthony Williams	Director, Food and Nutrition Services
Angela Cooper	Director, Public Relations
Vanessa Jackson	Director of Quality Management
Sara Freizer	Director, Social Services
Christopher Sinclair	Director, Human Resources
Roy Chester	Director, Environmental Services
Lucan Rodrigues, M.D.	Chief Medical Officer
April Ann James	Director, Rehabilitation Services
Donna Findlay	Infection Preventionist
Saskia Huey	Infection Preventionist
Janet Larghi	Director, Therapeutic Recreation
Gail Nurse	Director, Central Stores
Onique Julien	Director, Laundry and Linen Services
Ann Whyte-Akinyooye, RN	Director of Nursing/Chief Nursing Officer
Sadia Nahar	Director of Emergency Management

C. The Pandemic Response Coordinator, who is the person responsible for coordinating preparedness planning is: Lucan Rodrigues, M.D., Chief Medical Officer.

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	212-639-9675
New York State Department of Health	212-417-4200
New York City Emergency Management	718-422-8700
New York State Emergency Management	845-454-0430

- 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>
NYC H+H Emergency Management
New York City of Emergency Management
New York State Emergency Management

- 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 hospital beds, as follows:

<u>Name of Hospital</u>	<u>Phone Number</u>
Kingsbrook Jewish Medical Center	718-604-5000
SUNY Downstate Medical Center University Hospital	718-270-1000
NYC H+H/Bellevue	212-562-4132
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/South Brooklyn	844-692-4692
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 and state) and provides updates 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 approaching the New York City Metropolitan Area.

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

- Perform hand hygiene
- Undergo passive screening
- Not enter if they have respiratory symptoms

The facility requests that families and visitors sign in and out of the facility and encourages them to perform hand hygiene before and after visits. If they are ill, they are discouraged from visiting the facility. During a pandemic illness outbreak, the facility will follow CDC 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 continuous, facility-wide surveillance activities to establish baseline levels of infection on an annual basis. Infection rates above the baseline may indicate an influenza/illness outbreak or the arrival of a pandemic illness at the facility. The facility will maintain an ongoing surveillance program, which will be enhanced during a reported pandemic influenza/illness outbreak in the community (see Table 1 below).

Table 1: Surveillance Objectives by Pandemic Phase

Phase 1 (Interpandemic Period)
Objectives and Actions:
<ul style="list-style-type: none"> Assess for seasonal influenza. Detect cluster cases of Febrile Respiratory Illness (FRI)/ Influenza-Like Illness (ILI). Provide for annual education and provide seasonal flu vaccine to residents, staff, and volunteers and maintain immunization statistics and adverse effects information. To promote respiratory (cough etiquette) and hand hygiene to residents, families, visitors, volunteers, and contractor/vendors. Notify NYC H+H of suspected outbreak activity as defined by the CDC and NYSDOH guidelines and initiate other notifications, as required, to the local and/or state health departments. Communicate updates to residents, families, volunteers, contractors/vendors, and staff as appropriate Implement passive Febrile Respiratory Screening measures for visitors, contractors/vendors, visitors and families.
Phase 2 (Pandemic Alert Period - Low)
Objectives and Actions:
<ul style="list-style-type: none"> Implement active surveillance measures for FRI/ILI screening for visitors, vendors/contractors, and family members. 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 a cluster of FRI in staff. 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 Reviewing the monthly pharmacy antibiotic utilization reports Reviewing lab reports Communication with the staff about their clinical observations Implement management of respiratory outbreaks as required, based on outbreak activity as defined by the CDC and NYSDOH guidelines. 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"> Activate the Pandemic Emergency Plan and Emergency Operations Plan (as needed). Maintain active surveillance for monitoring of FRI/ILI in residents and staff. Finalize plans for pandemic vaccine storage and security (as applicable). Establish clinic sites for residents, staff, and volunteers. Develop plans for antiviral storage, security, and administration, including staff prophylactic treatment. Follow guidelines for avian/pandemic flu/illness, as issued by the CDC and NYSDOH, and provide education and training to staff for personal preparedness, resident care, and pandemic influenza/illness management. Ensure that availability of equipment and supplies, as required for the facility. Provide educational material and in-services (e.g., Annual Pandemic Emergency Plan; cross training; hand hygiene).
Phase 4 (Pandemic Period)
Objectives and Actions
<ul style="list-style-type: none"> Implement measures for suspected and confirmed pandemic strains in the facility.

<ul style="list-style-type: none"> • 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"> • Heighted surveillance of residents and staff illnesses for symptoms of the pandemic influenza/illness.
<ul style="list-style-type: none"> • Implement control and support measures for residents, staff, visitors, and families.
<ul style="list-style-type: none"> • Implement access restrictions for staff, visitors, families, volunteers, and vendors.
<ul style="list-style-type: none"> • Implement protocols for isolation of residents with confirmed or suspected illness.
<ul style="list-style-type: none"> • Implement protocols for cohorting residents with confirmed or suspected illness.
<ul style="list-style-type: none"> • Direct staff to cohort to their assigned units as much as possible.

The facility has processes in place to prevent outbreaks and surveillance programs to quickly identify and implement control measures to contain them. 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 communication with relevant agencies through the NYSDOH Health Alert Network (HAN) for events happening in the local, national, and global community.

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.

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.

Once an outbreak has been identified, outbreak prevention and control measures will be implemented immediately. As mentioned above, daily active surveillance will be conducted until at least one (1) week after the last confirmed influenza/illness case occurred. Testing for influenza/illness will occur for the following:

- Ill persons who are in an affected unit as well as ill persons in previously 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

• Facility will test any symptomatic resident in accordance with guidance and direction of the CDC, local and state health department.
• If the facility has no symptomatic residents, facility will consult with local and state health department and determine testing strategy, if applicable and needed.
• Testing will be done through a testing lab that can provide test results in a timely manner.
• 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.
• 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.
• For residents with suspected or confirmed influenza-like illness, the facility will implement protocols for isolation and/or cohorting residents per facility policy.
• Positive residents will be removed from isolation after 10 days with day of test being day zero and afebrile for 48 hours, or as directed by guidance issued by CDC, local and state health departments for removal of transmission-based precautions.
• The facility will report any positive tests in accordance with local and state health department requirements for the reporting of nosocomial infections.

The facility has also developed procedures for the isolation and/or cohorting for residents during a pandemic outbreak by assigning residents within the facility into two (2) groups, which is based on the residents' identified influenza/pandemic illness status, as follows:

- *Confirmed Positive Residents* – Space designated to be used and occupied by confirmed positive residents and staff assigned to their care. Newly admitted or 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.
- *Confirmed Negative or Recovered Residents* – Space designated to be used and occupied by confirmed negative or recovered patients and staff assigned to their care.

These group assignments 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 will be reevaluated by clinical staff frequently as demand dictates. All residents are tested based on current regulatory guidance and providers recommendations for the pandemic illness during the pandemic event.

Table 3: Procedures to Isolate and/or Cohort Residents

Confirmed Cases
<ul style="list-style-type: none"> Confirmed positive residents will cohort in the facility's designated area(s)/units.
<ul style="list-style-type: none"> All confirmed positive residents are placed on contact and droplet precautions.
<ul style="list-style-type: none"> If no beds are available in the designated area/unit, confirmed positive residents are restricted to their rooms and will wear surgical masks when caregivers enter the room, unless a facemask is not tolerated.
<ul style="list-style-type: none"> Confirmed positive residents that are restricted to their rooms will have signs posted on the door, indicating specific PPE needed to enter the room.
<ul style="list-style-type: none"> Confirmed positive residents will be treated with contact and droplet precautions for 10 days with day of test being day zero and afebrile for 48 hours or as directed by guidance issued by CDC, local and state health departments for removal of transmission-based precautions.
<ul style="list-style-type: none"> Curtains are used as barriers between the beds. The facility will maintain the minimum distance between beds, with curtain pulled, per CDC guidance.
<ul style="list-style-type: none"> Confirmed positive residents 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 adjust procedures for cohorting accordingly.
<ul style="list-style-type: none"> To the extent possible, employees are consistently assigned to the same resident in order to limit the number of individuals interacting with the resident.
<ul style="list-style-type: none"> To the extent possible, employee assignments across units are limited. If staff will be shared across the various groups in any way, the staff will fully doff 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.
Confirmed Negative or Recovered Residents
<ul style="list-style-type: none"> Confirmed negative or recovered residents will be offered a surgical mask on a daily basis, particularly those who leave their rooms.
<ul style="list-style-type: none"> The wearing of surgical masks by residents (except when eating) will be reinforced.
<ul style="list-style-type: none"> Residents are assessed each shift for fever, symptoms of respiratory infection or Influenza-like illness and decreased oxygen saturation.
<ul style="list-style-type: none"> To the extent possible, all residents admitted or readmitted from the hospital, who are not known to have the influenza/pandemic illness, will be closely monitored for signs and symptoms for 7 days after admission.

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 group assignments 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. 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 self-contamination;
- How to properly dispose of or disinfect and maintain PPE; and
- The limitations of PPE.

CDC recommends transmission-based precautions (i.e., contact, droplet and/or airborne precautions) be implemented for patients with documented or suspected diagnoses where contact with the patient, 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 within the confirmed positive.

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 patient. - 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 patient or the patient'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.
Environmental Cleaning and Disinfection	<ul style="list-style-type: none"> • Routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling. <ul style="list-style-type: none"> - Clean and disinfect surfaces in close proximity to the patient and frequently touched surfaces in the patient care environment on a more frequent schedule compared to other surfaces. - Promptly clean and decontaminate spills of blood and other potentially infectious materials. • Use of EPA-registered disinfectants that have microbiocidal activity against the pathogens most likely to contaminate the patient-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 patient 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 patient. • Ensure single-dose or single use vials, ampules and bags or bottles of parenteral solution are used for one patient only. • Use fluid infusion or administration sets (e.g., intravenous tubing) for one patient only. • Dedicate multidose vials to a single patient whenever possible. If multidose vials are used for more than one patient, restrict the medication vials to a centralized medication area and do not bring them into the immediate patient treatment area (i.e., patient 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 patient 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. - Remove and discard PPE, other than respirators, upon completing a task before leaving the patient's room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door.

	<ul style="list-style-type: none"> - Do not use the same gown or pair of gloves for care of more than one patient. Remove and discard disposable gloves upon completion of a task or when soiled during the process of care. - Refer to “Use and Rescue of N95 Respirators” for guidance on extended and limited use of NIOSH-certified N95 respirators.
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 patients with respiratory symptoms from others as soon as possible.
Reprocessing of Reusable Medical Equipment	<ul style="list-style-type: none"> • Clean and reprocess (disinfect or sterilize) reusable medical equipment (e.g., blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) prior to use on another patient when soiled. <ul style="list-style-type: none"> - Consult and adhere to manufacturer’s instructions. • Maintain separation between clean and soiled equipment to prevent cross contamination.

Source: Centers for Diseases Control and Prevention

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 patient 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.

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:

- Restricting visitors, volunteers and non-essential staff who are identified as symptomatic or asymptomatic based on screening done at time of entry into the building.
- Restricting all visitors with exceptions for compassionate care, such as end-of-life situations.
- Restricting visitors to the resident's room or other location designated by the facility.
- Restricting the number of visitors allowed per resident (i.e., two (2) visitors at a time).
- Restricting the number of residents who may receive visitors at the same time (i.e., 10% of residents may receive visitors at the same time).
- Restricting all volunteers and nonessential health care personnel and other personnel (i.e., barbers).
- Requiring the wearing of a face covering when in the building.

When the facility implements restriction of all visitors with exceptions for compassionate care, such as end-of-life situations, visitors who enter the facility under this exception will be equipped with personal protective equipment (PPE) like masks, and the visit will be limited to a specific room only.

When the facility limits the number of residents who may receive visitors at the same time, families may be required to schedule their visit in advance instead of just walking in. In addition, the facility may limit the time length of the visit to allow other residents to have visitors.

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.).

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 stockpile of essential supplies needed to adhere to infection control policies. Essential supplies include environment cleaning and disinfection supplies, 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 building and medical equipment. 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.

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.

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 patient and resident care;
- Physicians to ensure continuity of patient and 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
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 	<ul style="list-style-type: none"> • Blast emails • PA announcements

	<ul style="list-style-type: none"> • Frequency of testing 	
Transportation	Taxi service for late night staff	<ul style="list-style-type: none"> • Blast emails
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

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 	<ul style="list-style-type: none"> • Monthly • As needed
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 due to pandemic illness • Provision of alternate means of communicating residents 	<ul style="list-style-type: none"> • Virtual town hall meetings • Telephone hotline for families • 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 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. Testing is also available on-site.
<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.

<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"> • If a staff member tests positive and they are not symptomatic and willing to work, and CDC, local and state health department guidance allow, they will only be assigned to areas designated for positive residents in the “positive” zone (as described above) and will minimize time spent in any of the other non-positive zones of the building.
<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 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. As reflected in Table 7 above, if a staff member tests positive, is not symptomatic, is willing to work and the CDC and NYSDOH guidance/regulations allow, they will only be assigned to areas designated for positive residents in the “positive” zone for cohorting confirmed positive and symptomatic residents.

NYC Health + Hospitals has implemented a policy to outline the criteria for healthcare personnel to return to work from confirmed or exposure to COVID-19 (see **Exhibit 3 - 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 patient contact	When entering room of patient(s) on airborne precautions
Providing direct patient care and/or having close patient contact	In patient care areas when either CDC or NYSDOH recommend the use of N95 precautions.

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 social distancing, hand hygiene, respiratory hygiene and cough etiquette;
- Screening procedures for residents the facility expects to implement;
- Information about the potential cohorting of residents;

- 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 social distancing, hand hygiene, respiratory hygiene and cough etiquette;
- Screening procedures for residents the facility expects to implement;
- Information about the potential cohorting of residents;
- 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 seasonal influenza plan, the seasonal flu vaccine is 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 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 Vaccine 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 patient 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 patient 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 patient 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 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 medication may help lessen the effect of influenza when given to residents who already have the disease, thereby lessening the severity and duration of symptoms, and 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 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 assigning residents within the facility into three (3) groups, which is based on the residents' identified influenza/pandemic illness status, as follows:

- Confirmed Positive Residents – Space designated to be used and occupied by confirmed positive residents and staff assigned to their care. Newly admitted or 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.
- Confirmed Negative or Recovered Residents – Space designated to be used and occupied by confirmed negative or recovered patients and staff assigned to their care.

To the extent possible, staff is consistently assigned to the same resident in order to limit the number of individuals interacting with a resident. Staff assignments across units are limited as well. Assigning dedicated staff to take care of residents, being mindful of the groupings of residents based on their identified influenza/pandemic illness status, 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 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 patients 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 patients 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 patients 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 patients 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 patients from hospitals during a pandemic, including any directives that may be issued on not accepting patients 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 patients in an available bed. During a pandemic, placement in an available bed at the facility will be determined by the patient'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 patients 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 will 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 patient 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>Lucan Rodrigues, M.D.</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>David Weinstein, Daveth Forbes</u> <input checked="" type="checkbox"/> Medical Director: <u>Lucan Rodrigues, M.D.</u> <input checked="" type="checkbox"/> Nursing administration: <u>Ann Whyte-Akinyooye, R.N.</u> <input checked="" type="checkbox"/> Risk Management: <u>Elizabeth Sicard</u> <input checked="" type="checkbox"/> Infection Prevention and Control: <u>Donna Findlay, R.N.</u> <input checked="" type="checkbox"/> Occupational Health: <u>Theresa Thompson, R.N.</u> <input checked="" type="checkbox"/> Staff Training and orientation: <u>Doreen Windross</u> <input checked="" type="checkbox"/> Engineering/maintenance services: <u>Stephen Piazza</u> <input checked="" type="checkbox"/> Environmental services: <u>Roy Chester</u> <input checked="" type="checkbox"/> Dietary services: <u>Anthony Williams</u> <input checked="" type="checkbox"/> Pharmacy services: <u>Cindy Schechter/Pharmscripts</u> <input checked="" type="checkbox"/> Rehabilitation services: <u>April Ann James</u> <input checked="" type="checkbox"/> Transportation services: <u>N/A</u> <input checked="" type="checkbox"/> Purchasing Agent: <u>Gail Nurse</u> <input checked="" type="checkbox"/> Other: <ul style="list-style-type: none"> ✓ Quality Assurance: <u>Vanessa Jackson</u> ✓ Laundry & Linen Services: <u>Onique Julien</u> ✓ Social Services: <u>Sara Freizer</u> ✓ Therapeutic Recreation: <u>Janet Larghi</u> ✓ Public Relations: <u>Angela Cooper</u> ✓ Human Resources: <u>Chris Sinclair</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> <p><input type="checkbox"/> Local health department contact: <u>212-639-9675</u></p> <p><input type="checkbox"/> State health department contact: <u>212-417-4200</u></p> <p><input type="checkbox"/> New York City Emergency Management: <u>845-454-0430</u></p> <p><input type="checkbox"/> NYS Emergency Management: <u>718-422-8700</u></p> <p>Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified:</p> <p><input type="checkbox"/> City: <u>NYCHHC Emergency Management; New York City Emergency Management</u></p> <p><input type="checkbox"/> County: N/A</p> <p><input type="checkbox"/> State: <u>NYS Emergency Management</u></p> <p>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:</p> <p><input type="checkbox"/> <u>Kingsbrook Jewish Medical Center: 718-604-5000</u></p> <p><input type="checkbox"/> <u>SUNY Downstate Medical Center University Hospital: 718-279-1000</u></p> <p><input type="checkbox"/> <u>NYC H+H/Bellevue: 212-562-4132</u></p> <p><input type="checkbox"/> <u>NYC H+H/Harlem: 212-939-1000</u></p> <p><input type="checkbox"/> <u>NYC H+H/Metropolitan: 212-423-6262</u></p> <p><input type="checkbox"/> <u>NYC H+H/Jacobi: 718-918-5000</u></p> <p><input type="checkbox"/> <u>NYC H+H/North Central Bronx: 718-519-5000</u></p> <p><input type="checkbox"/> <u>NYC H+H/South Brooklyn: 844-692-4692</u></p> <p><input type="checkbox"/> <u>NYC H+H/Kings County: 718-245-3131</u></p> <p><input type="checkbox"/> <u>NYC H+H/Woodhull: 718-963-8000</u></p> <p><input type="checkbox"/> <u>NYC H+H/Elmhurst: 718-334-4000</u></p> <p><input type="checkbox"/> <u>NYC H+H/Queens: 718-883-3000</u></p> <p><input type="checkbox"/> <u>NYC H+H/Lincoln: 718-579-5000</u></p>

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/pandemicflu/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.
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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> <p><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 has been reported in the United States and is nearing the geographic area. For more information, see www.cdc.gov/flu/weekly/fluactivity.htm. Insert name, title and contact information of person responsible)</p>
			<p><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.)</p> <p><input type="checkbox"/> A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza/illness.</p> <p><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 patients with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza/illness.)</p> <p><input type="checkbox"/> A system is in place to monitor for, and internally review transmission of, influenza among patients 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>
			<p>A facility communication plan has been developed. For more information, see www.hhs.gov/pandemicflu/plan/sup10.htm.</p> <p><input type="checkbox"/> Key public health points of contact during a pandemic have been identified.</p> <p><input type="checkbox"/> Local health department contact: <u>212-447-2676</u></p> <p><input type="checkbox"/> State health department contact: <u>518-473-4436</u></p> <p><input type="checkbox"/> A person has been assigned responsibility for communications with public health authorities during a pandemic: _____</p>

3. Elements of a pandemic plan (continued)			
Reviewed	No Update Needed	Updated	
			<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.</p> <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 patient 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 influenza/illness that includes the following: (For information infection control recommendations for pandemic influenza/illness, see www.hhs.gov/pandemicflu/plan/sup4html. And www.cdc.gov/fluprofessionals/infectioncontrol/longermcare.htm.</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>

			<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"> ○ The handling of personnel who develop symptoms while at work. ○ When personnel may return to work after having pandemic influenza/illness.
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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, immuno-compromised 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

			<p>services based on residents' health status, functional limitations, disabilities, and essential facility operations.</p> <p><input type="checkbox"/> A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza/illness pandemic: _____</p> <p><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.</p>
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3. Elements of a pandemic plan (continued)

Reviewed	No Update Needed	Updated	
			<p><input type="checkbox"/> The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.</p> <p><input type="checkbox"/> 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></p> <p><input type="checkbox"/> A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources.</p> <p><input type="checkbox"/> Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable.</p> <p><input type="checkbox"/> Surge capacity plans include strategies to help increase hospital bed capacity in the community.</p> <p><input type="checkbox"/> Signed agreements have been established with area hospitals for admission to the long-term care facility of non-influenza patients to facilitate utilization of acute care resources for more seriously ill patients.</p> <p><input type="checkbox"/> Facility space has been identified that could be adapted for use as expanded inpatient beds and information provided to local and regional planning contacts.</p> <p><input type="checkbox"/> A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents.</p>

			<input type="checkbox"/> An area in the facility that could be used as a temporary morgue has been identified. <input type="checkbox"/> Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.
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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

NYC

First Name *

First Name

Last Name *

Last Name

Company Name

Company Name

Phone *

XXX-XXX-XXXX

Alternate Phone (Mobile or Home)

XXX-XXX-XXXX

Email

Email Address

Location Entering *

Please select ...


Meeting With or Visiting With *

▼ Name the person you are meeting

Reason For Visit

Please select ...

Location Check In Date and Time *

▼ 01/17/2023 9:58 AM 

Symptoms

Do you currently have a fever, headache, cough, shortness of breath, rash, sore throat, diarrhea, chills, new loss of taste and smell or other viral illness signs and symptoms?

No

Yes

COVID-19 PCR Test

Have you had a positive COVID-19 test in the past 10 days?

No

Yes

Exposure

Have you had close contact with someone that has symptoms of COVID-19 or has tested positive for COVID-19 in the last 10 days?

No

Yes

All visitors, including ambulatory care patients and their companions, must adhere to the infection prevention and control guidances.


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EXHIBIT 3

Return to Work Criteria for Health Care Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2			
DOC ID HHCMPA162020v13	Effective Date: June 12, 2023	Page 1 of 10	

SUMMARY OF UPDATES:

The following sections comply with NYSDOH and CDC guidance

1. All staff are required to report all suspected and confirmed SARS-CoV-2 infections to OHS.
2. In most circumstances, asymptomatic HCP with higher-risk exposures **do not** require work restriction regardless of vaccination status.
3. HCP with higher risk exposure must have a series of 3 viral tests: 1st test not earlier than 24 hours after the exposure and, if negative again 48 hours after the first negative test and, if negative again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 and no work restrictions.
4. HCP has COVID-19 -like symptoms; prioritize testing, if negative test HCP most likely does not have COVID-19.
5. HCP has SARS-CoV-2 infection; is asymptomatic and not immunocompromised, then Isolate for 7 days, viral test negative 48 hours prior to returning to work.
6. HCP has SARS-CoV-2 infection; mild to moderate illness and moderate to severe immunosuppression, then Isolate for 7 days, viral test negative 48 hours prior to returning to work, fever free at least 24 hours prior to returning and symptoms have improved.
7. HCP has SARS-CoV-2 infection; severe to critical illness and **not** moderate to severe immunosuppression, then Isolate for at least 10 days and up to 20 days, viral test negative 48 hours prior to returning to work, fever free at least 24 hours prior to returning and symptoms have improved.
8. HCP has SARS-CoV-2 infection; severe to critical illness and moderate to severe immunosuppression, then Isolate for at least 10 days and up to 20 days, viral test negative 48 hours prior to returning to work, fever free at least 24 hours prior to returning and symptoms have improved. Use test-based strategy to determine work restriction and consult an infectious diseases specialist or other expert.
9. Due to challenges in interpreting the results, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those HCP who have recovered from SARS-CoV-2 in the prior 31-90 days; however, an antigen test instead of NAAT (PCR) is recommended.
10. Guidance addressing recommended infection Prevention and Control Practices including use of source control by HCP is available in Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).
11. Effective 5/12/2023, 2 doses monovalent Pfizer and Moderna Vaccines are being replaced by 1 dose of bivalent Pfizer and Moderna. This constitutes fully vaccinated status for the HCP.

Return to Work Criteria for Health Care Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2

DOC ID HHCMPA162020v13

Effective Date: June 12, 2023

Page 2 of 10



Purpose	To provide guidance on return to work criteria after COVID-19 infection or exposure.		
Scope	All New York City Health + Hospitals Personnel		
Process	Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 (COVID-19) Infection		
	Symptom Status	Vaccination Status	Return to Work Criteria
	Mild symptoms	ANY	<ul style="list-style-type: none"> • Prioritize viral testing with nucleic acid or antigen detection assays • When testing a person with COVID-19 like symptoms, negative results from at least one viral test indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.
	<p>Return to Work Criteria for HCP with SARS-CoV-2 Infection</p> <ul style="list-style-type: none"> • The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by symptom severity and presence of immunocompromising conditions. • After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from OHS if symptoms worsen. • If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., Use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified. • Either a NAAT/PCR (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later (day 7) * • The exact Criteria that determine which HCP will shed replication-competent virus for longer periods are not known. 		

Return to Work Criteria for Health Care Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2

DOC ID HHCMPA162020v13

Effective Date: June 12, 2023

Page 3 of 10



Process	Symptom Status	Immunocompromising Conditions	Return to Work Criteria
	Asymptomatic	Not Moderate to Severe	<ul style="list-style-type: none"> At least 7 days have passed since the date of their first positive if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7)
	Mild to moderate Illness	Moderate to Severe	<ul style="list-style-type: none"> At least 7 days have passed since symptoms first appeared in a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and Symptoms have improved (e.g., cough, shortness of breath)
	Severe to critical Illness	Not Moderate to Severe	<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 the fever without the use of fever-reducing medications, and Symptoms have improved (e.g., cough, shortness of breath) The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction

Return to Work Criteria for Health Care Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2

DOC ID HHCMPA162020v13

Effective Date: June 12, 2023

Page 4 of 10



Process

Test-based strategy for use with HCP that are moderately to severely immunocompromised

- Moderately to severely immunocompromised HCP 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
- Use of the test-based strategy (as described) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work
- **HCP who are symptomatic could return to work after the following criteria are met:**
 - Resolution of fever without the use of fever-reducing medications, **and**
 - Improvement in symptoms (e.g., cough, shortness of breath, **and**
 - Results are negative from at least 2 consecutive respiratory specimens collected 48 hours apart (total of two negative specimens') tested using antigen test or NAAT(PCR).
- **HCP who are asymptomatic could return to work after the following criteria are met:**
 - Results are negative from at **2 consecutive respiratory specimens** collected 48 hours apart (**total of two negative specimens**) tested using an antigen test or NAAT (PCR).

Return to Work Criteria for HCP Who Were Exposed to Individuals with Confirmed SARS-CoV-2 Infection

Higher-risk exposures are classified as HCP who had prolonged, close contact, with a patient, visitor, or HCP with confirmed SARS+CoV-2 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask for facemask)
- HCP was not wearing eye protection if the person with SAR-CoV-2 infections was not wearing aa cloth mask of facemask
- HCP was not wearing all recommended PPE (i.e., Gown, Gloves, Eye protection, Respirator) while present in the room for an aerosol-generating procedure.

Return to Work Criteria for Health Care Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2

DOC ID HHCMPA162020v13

Effective Date: June 12, 2023

Page 5 of 10



Process

Following a higher-risk exposure, the HCP must:


- Have a series of 3 viral test for SARS-CoV-2 infection.
 - Testing is recommended immediately but not earlier than 24 hours after the exposure and, if negative, again 48 hours after the first negative test and, if negative again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
 - Due to challenges in interpreting the result, testing is generally not recommended for **asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days**. Testing should be considered for those HCP who have recovered from SARS-CoV-2 in the prior 31-90 days; however, an antigen test instead of NAAT (PCR) is recommended. This is because some people may remain NAAT positive but not infectious during this period.
- Follow all recommended infection prevention and control practices, including wearing a well-fitting source control, monitoring themselves for fever, or symptoms consistent with COVID-19 and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their OHS department for further instructions.

Work restriction is **not required** for most asymptomatic HCP following a higher risk exposure, regardless of vaccination status. Examples of when work restriction should be considered include:

- HCP is unable to be tested or wear source control as recommended for 10 days following their exposure;
- HCP is moderately to severely immunocompromised;
- HCP cares for or works on a unit with patients who are moderately to severely immunocompromised;
- HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

If work restriction is recommended, HCP can return to work after either of the following time periods:

- HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following higher-risk exposure is negative.
- If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

Return to Work Criteria for Health Care Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2			
DOC ID HHCMPA162020v13	Effective Date: June 12, 2023	Page 6 of 10	

Process	<ul style="list-style-type: none"> Follow all recommended infection prevention and control practices, including wearing a well-fitting source control, monitoring themselves for fever, or symptoms consistent with COVID-19 and not reporting to work when ill or if testing positive for SARS-CoV-2 infection. Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their OHS department for further instructions.
	<p>Determining the time period when the patient, visitor or HCP with confirmed SARS-CoV-2 infection could have been infectious;</p> <ul style="list-style-type: none"> For HCP with confirmed SARS-CoV-2 infection who develop symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions. For HCP with confirmed SARS-CoV-2 infection who are asymptomatic, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic hcp with SARS-CoV-2 infection may have been exposed could help inform the period when they are infectious. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the HCP meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
	HCP with Travel or Community Exposures
	<ul style="list-style-type: none"> HCP must contact their OHS department for guidance on work restrictions. In general, HCPs who have had prolonged, close contact with someone in the community with SARS-CoV-2 (example, household contacts) should be managed as described for higher-risk occupational exposures above. 100% remote symptomatic workers should contact their OHS department for guidance on work restrictions.

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

DOC ID HHCMPA162020v13

Effective Date: June 12, 2023

Page 7 of 10



Definitions	Healthcare Personnel (HCP)	HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.
	Immunocompromised	<p>For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the Interim Clinical Considerations for Use of COVID-19 Vaccines.</p> <ul style="list-style-type: none"> • Other factors, such as end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about need for work restriction if the HCP had close contact with someone with SARS-CoV-2 infection. However, people in this category should still consider continuing to practice physical distancing and use of source control while in a healthcare facility, even if they have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC. • Ultimately, the degree of immunocompromise for the HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.
	SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)	<p>Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.</p> <p>Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) $\geq 94\%$ on room air at sea level.</p>

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


DOC ID HHCMPA162020v13

Effective Date: June 12, 2023

Page 8 of 10



		<p>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%.</p> <p>Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.</p> <p>Fever: For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0°F (37.8°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs]).</p> <p>Facemask: OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as medical procedure masks. Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.</p> <p>Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.</p> <p>Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. Guidance on design, use, and maintenance of cloth masks is available.</p>
	Exposure	<p>HCP: Prolonged (“prolonged” refers to a cumulative time period of 15 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</p>

Return to Work Criteria for Health Care Personnel with Suspected or Confirmed Exposure to COVID-19			
DOC ID HHCMPA162020v13	Effective Date: June 12, 2023	Page 9 of 10	

		exposure (including proximate contact) by a local health department.
	Higher-risk exposures	High risk exposures generally involve the HCP's eyes, nose and mouth to material containing SARS-CoV-2, particularly if the HCP were present in the room for an aerosol-generating procedure. HCP has had prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infections
	Other exposures	Exposures not classified as high risk 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 eyes, mouth or nose. When classifying potential exposures specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source Control) should be evaluated on a case by case basis. These factors might raise or lower the level of risk; interventions, including restrictions from work, can be adjusted based on the estimated risk for transmission.
	Prolonged close contact	HCP who has prolonged close contact (within 6 feet for a cumulative total of 15 minutes over 24 hours) to someone with SARS-CoV-2 infection who is not using PPE correctly, not wearing a well-fitting mask whether the HCP and/or the individual with SARS-CoV-2 infection are fully vaccinated or any duration should be considered prolonged if the exposure occurred during the performance an aerosol-generating procedure.
	Fully vaccinated	≥2 weeks after they have received the second dose in a Monovalent 2- dose series (Pfizer-BioNTech or Moderna or a WHO approved vaccine) or ≥2 weeks after they have received a 1-dose of Johnson and Johnson (J&J)/Janssen or 1-dose of Bivalent Pfizer or Moderna vaccine.
	Partially vaccinated	Received 1 dose of a 2-dose series (Pfizer-BioNTech or Moderna or a WHO approved vaccine).
References	<p>CDC: Potential Exposure at Work: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html</p> <p>Interim Guidance for Managing Healthcare personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, September 23,2022.</p> <p>Healthcare worker vaccine mandate guidance, NYSDOH, May 24, 2023.</p>	

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

DOC ID HHCMPA162020v13

Effective Date: June 12, 2023

Page 10 of 10

**NYC
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HOSPITALS**

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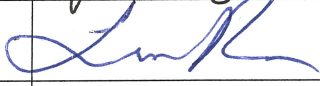

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