

APPENDIX H TO ANNEX D

***NYC HEALTH + HOSPITALS
NEW GOUVERNEUR HOSPITAL
SKILLED NURSING FACILITY 1606***

ANNUAL PANDEMIC EMERGENCY PLAN

Table of Review and Approval

Date Reviewed	Date Approved
9/1/2020	9/10/2020
11/8/2021	11/8/2021
2/17/2022	2/17/2022
1/5/2023	1/5/2023
1/5/2024	1/5/2024
6/3/2024	6/3/2024
3/4/2025	3/4/2025
3/16/2026	3/16/2026

The Annual Pandemic Emergency Plan (APEP) was originally written and approved on 9/1/2020.

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 3/16/2026 has been posted on the facility's website.

Approved: Susan Sales, CEO

Signature:  Date: 3/16/26

Approved: Sherry Humphrey MD, Medical Director

Signature:  Date: 4/7/26

Approved: Charleen Clark, RN, Director of Nursing

Signature:  Date: 4/7/26

Reviewed: Sunni Silver, Deputy Executive Director


Signature:  Date: 4/7/26

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FACILITY INFORMATION

Facility: NYC H+H/New Gouverneur Hospital Skilled Nursing Facility

Address: 227 Madison Street

City: New York **State:** NY

ZIP Code: 10002

Phone Number: 212-441-5000

Contact Person: Susan Sales, FACHE, CEO/Administrator

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125 Worth Street

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I. INTRODUCTION TO THE PLAN

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

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

Demographics:

- A. This facility is located at 227 Madison Street, New York 10002.
- B. The facility is a 295-bed residential health care facility (RHCF), which provides short-term post-acute rehabilitation care and skilled nursing services.

II. EMERGENCY PLAN

Readiness Assessment/Pandemic Influenza/Illness Planning

- A. This facility maintains a comprehensive emergency management plan (CEMP) to prepare for, respond to, and recover from natural and man-made disasters. The facility follows an “all hazards” approach in developing the CEMP, with a pandemic identified as one (1) of those hazards.

- B. This facility performs an annual readiness assessment of the facility’s preparedness for responding to pandemic influenza/illness (see Pandemic Influenza/Illness Planning Checklist Annual Update **Exhibit 1**). This APEP is written and updated based on the readiness assessment. Changes or additions to the APEP will be made based on the annual readiness assessment, gaps identified during exercises or real events or guidance issued by the Centers for Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH). A copy of the annual updated Pandemic Influenza/Illness Planning Checklist will be kept with the APEP.

- C. A copy of the APEP is attached to the facility’s CEMP as an APPENDIX H to Annex D “Pandemic and Highly Infectious Disease”. 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 maintains a multidisciplinary planning committee to specifically address pandemic preparedness and response.

- B. The Multidisciplinary Pandemic Planning Team consists of the following individuals (by title):

Title
CEO/Administrator
Deputy Executive Director
Director of Nursing/Chief Nursing Officer
Chief of Hospital Police
Chief Medical Officer
Associate and Deputy Director(s) of Nursing
Assistant Director of Nursing/Infection Control Practitioner
Nurse Educator(s)
Director of Social Work
Director of Therapeutic Recreation
Director of Rehabilitation Services
Director of Quality Management
Director of Environmental Services

- C. The Pandemic Response Coordinator, who is the person responsible for coordinating preparedness planning is: Sherry Humphrey, 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	212-447-2676
New York State Department of Health	518-473-4436
New York City Emergency Management	646-692-3641
New York State Emergency Management	518-292-2301

- 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 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 needed hospital beds, as follows:

<u>Name of Hospital</u>	<u>Phone Number</u>
New York Presbyterian/Lower Manhattan Hospital	212-312-5175
NYC H+H/Bellevue	212-562-4132
NYC H+H/Harlem	212-939-1000
NYC H+H/Metropolitan	212-423-8893
NYC H+H/Jacobi	718-918-5000
NYC H+H/North Central Bronx	718-519-3500
NYC H+H/Coney Island	718-616-3000
NYC H+H/Kings County	718-245-3901
NYC H+H/Woodhull	718-963-8101
NYC H+H/Elmhurst	718-334-4000
NYC H+H/Queens	718-883-2350
NYC H+H/Lincoln	718-579-5700

III. INFECTION CONTROL PROTECTION PLAN

Description of Surveillance and Monitoring Activities

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

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

- Perform hand hygiene
- Self-screen for Febrile Respiratory Illness (FRI) symptoms
- Not enter if they have respiratory symptoms

The facility asks family and visitors to sign in and out of the facility, self-screen for FRI prior to visits, perform hand hygiene before and after visits and they are directed to contact their personal physician if they have respiratory symptoms. If 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 for continuous facility-wide surveillance activities to establish baseline levels of infection on an annual basis. Infection rates above the baseline may be indicative of an influenza/illness outbreak or the arrival of a pandemic illness at the facility. The facility will maintain an ongoing surveillance program to be enhanced during a reported pandemic influenza/illness outbreak in the community (see Table 1 below).

Table 1: Surveillance Objectives by Pandemic Phase

Phase 1 (Interpandemic Period)
Objectives and Actions:
<ul style="list-style-type: none"> • To assess for seasonal influenza.
<ul style="list-style-type: none"> • To detect cluster cases of Febrile Respiratory Illness (FRI)/ Influenza-Like Illness (ILI).
<ul style="list-style-type: none"> • To provide for annual education and provide seasonal flu vaccine to residents, staff and volunteers and to maintain immunization statistics and adverse effects information.
<ul style="list-style-type: none"> • To promote respiratory (cough etiquette) and hand hygiene to residents, families, visitors, volunteers and contractors/vendors.
<ul style="list-style-type: none"> • To notify NYC H+H of suspected outbreak activity as defined by CDC and NYSDOH guidelines and initiate other notifications, as required, to the local and/or state health departments.
<ul style="list-style-type: none"> • To communicate updates to residents, families, volunteers, contractors/vendors and staff.
<ul style="list-style-type: none"> • 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"> • To implement active surveillance measures for FRI/ILI screening for visitors, vendors/contractors and family members.
<ul style="list-style-type: none"> • To notify the Infection Control Practitioner or designee of reported or identified FRI/ILL. They will alert, as appropriate, the local and state health department of cluster of FRI in staff.
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • To implement management of respiratory outbreak as required for outbreak activity as defined by CDC and NYSDOH guidelines and initiate outbreak reports to local and state health department, as required.

Phase 3 (Pandemic Alert Phase – High)
Objectives and Actions
<ul style="list-style-type: none"> • To activate the Pandemic Emergency Plan and Emergency Plan (as needed).
<ul style="list-style-type: none"> • To maintain active surveillance for monitoring of FRI/ILI in residents and staff.
<ul style="list-style-type: none"> • To finalize plans for pandemic vaccine storage and security (as applicable).
<ul style="list-style-type: none"> • To establish clinic sites for residents, staff and volunteers.

<ul style="list-style-type: none"> • To develop plans for antiviral storage, security and administration, including staff prophylactic treatment.
<ul style="list-style-type: none"> • To follow guidelines for avian/pandemic flu/illness, as issued by CDC and NYSDOH, and provide education and training to staff for personal preparedness, resident care and pandemic influenza/illness management.
<ul style="list-style-type: none"> • To ensure that availability of equipment and supplies, as required, for the facility.
<ul style="list-style-type: none"> • To provide educational material and in-services; i.e., Annual Pandemic Emergency Plan; cross training; hand hygiene

Phase 4 (Pandemic Period)
Objectives and Actions
<ul style="list-style-type: none"> • To implement measures for suspected and confirmed pandemic strain in the facility.
<ul style="list-style-type: none"> • To implement mandatory active screening of staff, visitors, contractors/vendors and family members (see Sample Surveillance Screening Tool Exhibit 2).
<ul style="list-style-type: none"> • To implement heightened surveillance of residents and staff illnesses for symptoms of the pandemic influenza/illness.
<ul style="list-style-type: none"> • To implement control and support measures for residents, staff, visitors and families.
<ul style="list-style-type: none"> • To implement access restrictions for staff, visitors, families, volunteers and vendors.
<ul style="list-style-type: none"> • To implement protocols for isolation of residents with confirmed or suspected illness.
<ul style="list-style-type: none"> • To implement protocols for cohorting residents with confirmed or suspected illness.
<ul style="list-style-type: none"> • To direct staff to cohort to their assigned units as much as possible.

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

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

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

<ul style="list-style-type: none"> • Positive residents will be removed from isolation and/or cohorting as per current NYS / DOH and CDC guidelines
<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.

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 three (3) groups, which is based on the residents’ identified influenza/pandemic illness status, as follows:

- Positive – 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 based on CDC and NYSDOH guidance, will be admitted to this space.
- Unknown – Space designated to be used and occupied by asymptomatic residents with exposure and/or residents who have an unknown testing status and staff assigned to their care.
- Negative – Space designated to be used and occupied by confirmed negative residents and staff assigned to their care.

These 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 on a weekly basis for the pandemic illness during the pandemic event.

Table 3: Procedures to Isolate and/or Cohort Residents

Positive
<ul style="list-style-type: none"> • All confirmed positive residents are placed on contact and droplet precautions.
<ul style="list-style-type: none"> • 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 until the resident meets the time criteria to discontinue isolation based on current CDC guidance on discontinuation of isolation
<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.

Unknown
<ul style="list-style-type: none"> Persons under investigation/suspected 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"> Persons under investigation/suspected positive residents will be moved to a single room, if possible, and not housed with an unexposed resident. The resident will be paired with another potentially exposed resident if no single rooms are available.
<ul style="list-style-type: none"> Persons under investigation/suspected positive patients will be treated with contact and droplet precautions until a negative test result can be achieved or the resident meets the time criteria to return to a confirmed negative/recovered group assignment based on current CDC guidance for the removal of transmission-based precautions.
<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 all PPE and leave all dirty PPE in designated receptacles, perform hand hygiene, and don new PPE in accordance with CDC guidance for the area they are entering.
<ul style="list-style-type: none"> Persons under investigation/suspected positive patients will be screened for symptoms of the influenza-like illness and have their vital signs monitored, including oxygen saturation and temperature checks at a minimum of once per shift and documented in the clinical record.

Negative
<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 per CDC and NYSDOH guidance.

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 and NYC Health+Hospitals proscribed 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 unknown groupings as required by NYC Health+Hospitals.

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).

<p>Appropriate Use of Personal Protective Equipment</p>	<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. - 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. - 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.
<p>Minimizing Potential Exposures</p>	<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 at points of entry and throughout the facility. • When space permits, separate patients with respiratory symptoms from others as soon as possible.
<p>Reprocessing of Reusable Medical Equipment</p>	<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. - Consult and adhere to manufacturer's instructions. • Maintain separation between clean and soiled equipment to prevent cross contamination.

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 State Department of Health: Reported via Daily HERDS Survey in Health Commerce System (HCS)
- New York City Department of Health and Mental Hygiene: Reported by phone, as required.

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.

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 maintains 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, and will be managed via the NYC Health+Hospitals centralized materials management system(s).
2. A 30-day stockpile of essential supplies needed to adhere to infection control policies. Essential supplies include environment cleaning and disinfection supplies, disposable masks, disposable gloves, tissues, hand soap, paper towels and alcohol-based hand sanitizers.
3. All supplies will be checked for expiration dates and rotated on a regular basis to prevent stock expiration. The NYC Health+Hospitals centralized materials management team will direct stock rotation, replacement, and replenishment.

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 and/or NYC Health+Hospitals.

Facemasks and hand sanitizer 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 in areas where resident care is provided. No-touch receptacles for disposal of used/soiled PPE are placed in 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
<p>Pandemic Illness Training and In-services for:</p> <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
<p>Donations Received by Facility for Staff</p>	<p>Types of donations received for all shifts:</p> <ul style="list-style-type: none"> • Meals – breakfast, lunch, dinner • Groceries/Snacks • Toiletries 	<ul style="list-style-type: none"> • Calls to units and department heads
<p>Employee Testing</p>	<p>On-site testing available on all shifts by medical staff and/or contractors:</p> <ul style="list-style-type: none"> • Location • Times • Frequency of testing 	<ul style="list-style-type: none"> • Blast emails • Posted signage
<p>Transportation</p>	<p>Taxi or bus service may be provided by NYC Health+Hospitals for certain staff.</p>	<ul style="list-style-type: none"> • Blast emails
<p>Hotels</p>	<p>As provided by NYC Health+Hospitals, arrangements for those who chose to stay close to the facility or Self-quarantine.</p>	<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 Central Office Communications & Marketing.

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/Newsletters • 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 Note: During pandemic outbreak, daily access will be provided if requested.

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 any staff in accordance with guidance and direction of the CDC, local and state health department, and NYC Health+Hospitals, as appropriate.
<ul style="list-style-type: none">• Testing will be done through a testing lab that can provide test results in a timely manner.
<ul style="list-style-type: none">• If no testing capacity can be located that meets the timeframe goal for timely turnaround of tests, the facility will document all attempts to obtain testing and keep documents of those efforts for review.
<ul style="list-style-type: none">• If an alternative test is approved that could help meet the timely turn-around goals and is approved by the local and state health department, and NYC Health+Hospitals, as appropriate; 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 and NYC Health+Hospitals guidelines, as appropriate for return-to-work criteria for staff testing positive.
<ul style="list-style-type: none">• The facility will report any positive tests in accordance with local and state health department requirements for the reporting of nosocomial 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, and NYC Health+Hospitals guidance and requirements as to the use of ill/exposed staff and any work restrictions placed on staff to work while ill/exposed.

NYC Health + Hospitals has implemented a policy to outline the criteria for healthcare personnel to return to work from suspected, confirmed or exposure to COVID-19 (see **Exhibit 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 and fit tested 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.

II. VACCINE AND ANTIVIRAL USE PLAN

Influenza-like 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. 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.

NOTE: the facility participates in the New York City DOHMH Auxiliary Distribution program for vaccines and related pharmaceuticals.

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:

- Positive – 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 based on CDC and NYSDOH guidance, will be admitted to this space.
- Unknown – Space designated to be used and occupied by asymptomatic residents with exposure and/or residents who have an unknown testing status and staff assigned to their care.
- Negative – Space designated to be used and occupied by confirmed negative residents and staff assigned to their care.

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 may implement the following, considering the absenteeism due to illness and other factors, to deal with immediate staffing needs safely:

- Calling on per-diem staff;
- Use of agency staff;

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

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

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

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

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

1. The facility will maintain a 60-day supply of PPE, which will be based on the PPE burn rate/average consumption rate and will be adjusted accordingly if the burn rate/average consumption rate increases or decreases.
2. A 30-day supply of essential supplies (i.e., hand sanitizer, other cleaning supplies 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 NYC Health+Hospitals centralized materials management team will direct stock rotation, replacement and replenishment.

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 NYC 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 what the facility can effectively provide.
- 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.

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, 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. The acceptance of an admission will be based on NYSDOH directives regarding the transfer and acceptance of patients during a pandemic.

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 may establish a Body Collection Point (BCP) with the NYC Office of Chief Medical Examiner (OCME). A BCP is a temporary refrigeration unit used to store decedents until transport is arranged. It allows the facility to store deceased residents until they can be released to funeral homes or until OCME takes possession if a body is not claimed. The purpose of the BCP is to decompress the facility's morgue to give funeral homes the time to get to the facility to make the removal and follow the wishes of the family.

Mass fatality management plan is detailed in Annex F to the Comprehensive Emergency Management Plan.

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EXHIBIT 1

Pandemic Influenza/Illness Planning Checklist – Annual Update 3/2026

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>Charleen Clark, R.N., MSN</u></p> <p>Members of the planning committee include (as applicable to each setting) the following:</p> <p>Facility Administration: <u>Susan Sales, FACHE</u> Medical Director: <u>Sherry Humphrey, M.D.</u> Nursing administration: <u>Charleen Clark, R.N., MSN;</u> <u>Marcia Styles, RN</u> Quality Management: <u>Emalyn Bravo</u> Infection Prev. and Control: <u>Bryan Daulo, R.N.</u> Occupational Health: <u>Marie Pesola PA</u> Staff Training and orientation: <u>Edwine Joseph, R.N.</u> Engineering/maintenance services: <u>John Muniz</u> Emergency Management: <u>Sunni Silver and Anthony Schembri</u> Environmental services: <u>Paola Melendez</u> Dietary services: <u>Rusana Borocho RD</u> Pharmacy services: <u>Pharmscript</u> Rehabilitation services: <u>Danny Wong</u> Purchasing Agent: <central office> Social Services: <u>Marianne Kane</u> Therapeutic Recreation: <u>Carolyn Franklin</u></p>

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>Local health department contact: <u>212-447-2676</u> State health department contact: <u>518-473-4436</u> New York City Emergency Management: <u>646-692-3641</u> NYS Emergency Management: <u>518-292-2301</u></p> <p>Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified: City: <u>NYCHHC Emergency Management; New York City Emergency Management</u> 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 (see listing in Annex J to the CEMP (Communications Resources))</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/pandemic flu/plan) and available state, regional, or local plans are reviewed for incorporation into the facility's plan.
	✓		The facility plan includes the elements listed in #3 below.
	✓		The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

3. Elements of a pandemic plan

Reviewed	No Update Needed	Updated	
	✓		<p>A plan is in place for surveillance and detection of the presence of pandemic influenza/illness in residents and staff. 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.</p> <p>Insert name, title and contact information of person responsible): <u>Bryan Daulo, R.N.</u></p>
	✓		<p>A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. (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>A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza/illness.</p> <p>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>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>

3. Elements of a pandemic plan (continued)			
Reviewed	No Update Needed	Updated	
	✓		<p>A facility communication plan has been developed.</p> <p>Key public health points of contact during a pandemic have been identified.</p> <p>Local health department contact: <u>212-447-2676</u> State health department contact: <u>518-473-4436</u></p> <p>A person has been assigned responsibility for communications with public health authorities during a pandemic.</p>
	✓		<p>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).</p> <p>Contact information for family members or guardians of facility residents is up-to-date.</p> <p>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.</p> <p>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 beds (see listing in Annex J to the CEMP (Communications Resources)</p>

3. Elements of a pandemic plan (continued)

Reviewed	No Update Needed	Updated	
	✓		<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> <p>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):</p> <p>Current and potential opportunities for long-distance (e.g., web- based) and local (e.g., health department or hospital-sponsored) programs have been identified.</p> <p>Language and reading-level appropriate materials have been identified to supplement and support education and training programs and a plan is in place for obtaining these materials.</p> <p>Education and training includes information on infection control measures to prevent the spread of pandemic influenza/illness.</p> <p>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.</p> <p>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.</p>

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:</p> <p>An infection control policy that requires direct care staff to use Standard and Droplet Precautions (i.e., mask for close contact) with symptomatic residents.</p> <p>A plan for implementing Respiratory Hygiene/Cough Etiquette throughout the facility</p> <p>A plan for cohorting symptomatic residents or groups using one or more of the following strategies: Confining symptomatic resident and their exposed roommates to their room, Placing symptomatic residents together in one area of the facility, or Closing units where symptomatic and asymptomatic residents reside (i.e., restricting all residents to an affected unit, regardless of symptoms).</p> <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> <p>A liberal/non-punitive sick leave policy that addresses the needs of symptomatic personnel and facility staffing needs. The policy considers:</p> <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.

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> <p>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.</p> <p>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.</p>
			<p>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>

3. Elements of a pandemic plan (continued)			
Reviewed	No Update Needed	Updated	
	✓		<p>Issues related to surge capacity during a pandemic have been addressed.</p> <p>A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.</p> <p>A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza/illness pandemic.</p> <p>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> <p>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>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. <i>Note: NYSDOH requires 60-day supply of PPE</i></p> <p>A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources.</p> <p>Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable.</p> <p>Surge capacity plans include strategies to help increase hospital bed capacity in the community.</p>

3. Elements of a pandemic plan (continued)			
Reviewed	No Update Needed	Updated	
	✓		<p>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>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>A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents. An area in the facility that could be used as a temporary morgue has been identified. Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.</p>

EXHIBIT 2

Sample Surveillance Screening Tool

Respiratory Infection Screening Tool	
Date:	Health Care Worker Instructions
Unit:	
Section A: Respiratory Symptoms	
Are you experiencing any of the following symptoms: <ul style="list-style-type: none"> ○ New/Worse Cough OR ○ New/Worse shortness of breath (worse than what is normal for you) 	If YES, Continue to Section B. If NO, stop here.
Section B: Temperature	
Are you feeling feverish, had shakes or chills in the last 24 hours? Or is the temperature above 99.7 °F? Record Temperature: _____	If YES, mask the patient immediately and initiate Droplet Precautions
Section C: Additional Screening for Influenza-like Illness	
If patient fails Section A and B, proceed with additional screening for influenza-like illness: <ul style="list-style-type: none"> 1 Sore throat 1 Arthraigia – joint pain 1 Myalagia – muscle pain 1 Prostration – extreme physical weakness/exhaustion 1 Diarrhea 	

Facility Point of Entry Screening Tool	
Section A: Temperature	
Automatically monitored upon entry by mounted thermal imaging system	See PoE Screening Policy IC-C-17 for flowchart
Section B: Screening Questions	
As defined by On-line PoE Screening Tool	See PoE Screening Policy IC-C-17 for flowchart

INSERT IC-C-16, 17

SKILLED NURSING FACILITY
MANAGEMENT OF COVID-19

Policy #: IC C-16	Date: March 2020
Last Reviewed: March 23, 2026	

POLICY:

It is the policy of NYC Health + Hospitals / Gouverneur to immediately identify key strategies to prevent the spread of COVID-19 into the facility to protect residents, families, and staff from serious illness, complications, and death.

***NOTE:** If guidance changes or updated after this policy has been approved, Gouverneur should follow the most current guidelines issued by the governing body by which the facility is required to follow i.e. Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), New York State Department of Health (NYS DOH), and NYC Health + Hospitals.*

PURPOSE:

To provide immediate response and action to protect and maintain the health and safety of our residents, families, and healthcare personnel (HCP) from severe infections, hospitalizations and death during the ongoing novel coronavirus (COVID-19) outbreak

SCOPE:

Gouverneur Skilled Nursing Facility

PROCEDURE/GUIDELINE:
I. VISITATION GUIDELINES

- Facility shall comply with current NYS DOH visitation guidelines.
- All visitors are required to comply with facilities core infection control practices which includes but not limited to:
 - Hand hygiene
 - Patient, family, and caregiver education
 - Standard precautions and/or Transmission-based precautions
 - Appropriate use of personal protective equipment
 - (Use of facemask when COVID-19 or other respiratory virus cases in the community are high)
 - Minimizing potential exposures
- A posted signage is available at all points of entry and all visitors are instructed to self-screen and report:
 - Any symptoms compatible with COVID-19
 - Positive COVID-19 test result within past 10 days
 - Close contact with someone with COVID-19 within past 10 days

Any visitors answering yes to the above will be asked to inform staff and are asked to defer non-urgent, in-person visitation until they meet Centers for Disease Control and Prevention (CDC) criteria for healthcare settings to end isolation.

The most up-to-date set of visitation guidelines are attached to this policy as Appendix A.

II. STAFF EDUCATION

- Provide ongoing staff education and training about COVID-19 (e.g., symptoms, how it is transmitted). Resources are available at <https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html>.
- Sick leave policies and the importance of self-quarantine when experiencing symptoms, i.e. fever, coughing, weakness. (See return to work policy available via facility intranet for all employees <http://hhcinsider.nychhc.org/sites/COVID-19/Pages/Index.aspx>)
- Reinforcing the importance of up-to-date COVID-19 vaccination.
- Importance of adherence to hand hygiene and proper use of personal protective equipment, including any updates to recommendations based on PPE availability. Resources are available at https://www.cdc.gov/handhygiene/campaign/promotional.html#anchor_1555101687 and <https://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf>.

III. SCREENING AND SURVEILLANCE

- A. **Screening and Surveillance of Employees, Contractors, and Vendors entering facility**
- All employees, contractors, and vendors entering Gouverneur Skilled Nursing Facility will self-screen for viral respiratory illness, including but, not limited to, RSV, influenza, and COVID-19, using a standardized signage at the point of entry into the facility.
 - Screening Questionnaire Signage includes:
 - a. Fever, shortness of breath, cough, sore throat, nasal congestion or other COVID-19 symptoms
 - b. Close contact with someone with COVID-19 in the past 10 days
 - a. A positive COVID-19 test within the past 10 days
 - Any employee/contractor/vendor who has one or more of the above must report to Occupational Health Services (OHS).
 - Facility shall take every effort to limit floating of staff between units and or assignment.
- B. **Screening and Surveillance of Residents**
- All residents shall be continuously assessed for any change in condition and will be reported to covering physician immediately.
 - Facility shall abide by the current SARS-CoV-2 (COVID-19) testing guidelines issued local and or federal health care authorities.

IV. PERSONAL PROTECTIVE EQUIPMENT (PPE) AND OTHER SUPPLIES

- Central Supply staff shall perform daily Inventory of current available PPE, hand hygiene/sanitizer, EPA approved disinfectants in stock daily. PPE supplies inventory will be reported to HERDS survey monthly.

- Central Supply shall be responsible for procurement, storage and distribution of PPEs and other supplies deemed essential to care of the residents and maintenance of a safe and clean environment.
- In the event that facility is unable to procure essential items mentioned above through regular channels, facility shall notify NYC Health+Hospitals Central Office Emergency Management (COEM) to assist in procurement of essential items. (*please refer to Emergency Operation Plan section II “Resource Management”*)

V. **HAND HYGIENE AND ENVIRONMENTAL DISINFECTION**

All staff are required to perform hand hygiene following hand hygiene procedure (see hand hygiene competency) as per policy especially on following occasions but not limited to:

1. Before start of the shift;
2. Before and after resident care;
3. Before and after meals;
4. After using the bathroom;
5. After contact with any contaminants;
6. When hands are visibly soiled;
7. After the end of shift.

Environmental Disinfection

Care and maintenance of environment in providing a clean and safe environment for its residents, families, visitors, and staff, and an integral component if a successful infection control program, as such, Gouverneur shall establish following guidelines for staff in maintaining and disinfecting the facility.

Environmental services shall:

- be responsible for overall sanitation and disinfection of facility premises;
- use EPA registered and hospital grade disinfectant as per Environmental Services Protocol;
- be responsible for stocking individual bathrooms with sufficient supply of soap and paper towel;
- ensure all hand sanitizer stands are adequately stocked;
- be responsible for terminal cleaning of rooms as scheduled and once room has been vacated;
- be responsible for cleaning and disinfecting wheelchairs regularly as scheduled;
- Ensure that areas with high volume of traffic and high contact surfaces are frequently cleaned; and sanitized such as foyer, elevators, elevator foyers, door handles, tables etc.

Nursing shall

- be responsible in sanitizing and disinfecting medical equipment and other items used for resident care before and after each resident use

VI. **MASK USE AND SOURCE CONTROL**

- Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person’s mouth and nose to prevent spread of respiratory secretions when they

are breathing, talking, sneezing, or coughing. Masks and respirators also offer varying levels of protection to the wearer.

- If community transmission level is high, all staff entering facility, regardless of vaccination status or past history of laboratory-confirmed COVID-19, RSV or seasonal influenza are required to wear a well-fitting mask (note: cloth masks are not allowed) that covers their mouth and nose at all times (except when eating or drinking) while in a shared indoor workspace, public setting, elevators, etc.
- Source control is optional for staff throughout all facilities during low community transmission. However, source control is mandatory for staff working on a unit or area of the facility experiencing a COVID-19 outbreak, or other respiratory infection.
- Masks are optional for visitors and residents unless the unit or area of the facility is experiencing a COVID-19 outbreak, or other respiratory infection.
- All new admissions are advised to wear source control for the 10 days following their admission.
- The facility is expected to provide masks to all visitors and staff. In addition, unit staff should actively distribute facial masks to all visitors enter their unit, as needed.
- All residents and visitors who are able to wear masks, should wear face coverings or masks when the facility's county COVID-19 community transmission level is high and during large gatherings.

VII. RESIDENT EDUCATION AND MONITORING

- Facility provides education to resident about COVID-19, how to keep themselves safe, and that the facility is doing to keep them safe. Resources are available at: <https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html> <https://coronavirus.health.ny.gov/home>.
- Nursing staff shall assess all residents for fever, symptoms of respiratory infection, oxygen saturation if pulse oximeter is available. Long-term care residents with COVID-19 may not show typical symptoms, such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, altered mental status, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- In communities and nursing homes in NY with a high burden of COVID-19, treat any resident with any influenza-like illness (ILI), pneumonia diagnosis, or unexplained change in status as possible COVID-19, place them in appropriate transmission-based precautions, and follow additional guidance.

VIII. ADMISSIONS

- Empiric use of Transmission-Based Precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings) unless new admissions meet CDC criteria.

IX. CARE OF RESIDENTS WITH COVID-19

A. Confirmed or Suspected COVID-19

- Resident presenting with symptoms related to COVID-19, will be tested for COVID-19 and be placed on enhanced droplet and contact isolation until result becomes available and COVID-19 status has been determined. A respiratory viral panel will be performed to rule out co-infection with other viruses.

- Residents confirmed to have SARS-CoV-2 infection should be placed in a single room, if available, or housed with other residents with only SARS-CoV-2 infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation). In general, it is recommended that the door to the room remain closed to reduce transmission of COVID-19. However, in some circumstances (e.g., cognitively impaired resident), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway i.e. use of HEPA filter.
- Post signs on the residents' doors indicating specific PPE needed to enter the room. Examples include contact and droplet precautions OR the facility **STOP sign** for precautions.
- Use standard plus contact and enhanced droplet precautions for care of residents with possible, suspect, or confirmed COVID-19; Wear gowns, gloves, eye protection (goggles or face shield), N95 respirator mask.
- Residents with confirmed or suspected COVID-19 must wear a face mask when staff enter their room, unless a facemask is not tolerated.
- Outbreak testing will be performed on Unit / Units where a positive case has been identified (staff or resident). Testing is done 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.
- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
- If cohorting, only residents with the same respiratory pathogen should be housed in the same room. MDRO colonization states and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
- Gouverneur will consider designating a unit within the facility, with dedicated healthcare personnel (HCP), to care for residents with COVID-19 infection when the number of residents with COVID-19 infection is high. Dedicated healthcare personnel are assigned to only care of these residents during their shifts.
- If ill residents need to be transferred, communicate with EMS and receiving hospital about patient's possible COVID-19 status.

B. Communal Dining and Activities

- While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. The safest approach is for everyone, particularly those at high risk for severe illness, to wear a face covering or mask while in communal areas of the facility. Communal dining and activities are guided by community level of COVID-19 transmission, individual resident recent history of exposure or diagnosis of COVID infection and the identification of an outbreak in a resident unit or in neighboring resident care areas.
- Residents may participate in all activities unless under individual restrictions applicable to their risk of acquiring or transmitting certain infections (residents on contact, transmission-based precautions, symptomatic). They could leave the facility as they

choose. They and any individual accompanying them on a pass or outside activities, should be reminded to follow all recommended infection prevention and control practices, especially for those at high risk for severe illness. This education process is to be conducted and documented in the resident's EMR.

- Upon the resident's return, nursing homes should screen residents upon return for signs or symptoms of COVID-19:
 - If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, refer to CDC's guidance for residents who have had close contact for next steps regarding testing and quarantine.
 - If the resident develops signs or symptoms of COVID-19 after the outing, see the CDC's guidance for residents with symptoms of COVID-19.

X. DEDICATED SPACE FOR COVID-19

Strict implementation of infection prevention and control measures, waste removal and maintenance of the environment and proper cohorting of staff providing care, treatment and services to residents infected with SARS-CoV-2.

1. While social distancing should be observed in the nursing unit where the clerical and ancillary staff works, all attempts should be made to isolate this space from resident care areas. Residents should not have access to the space and staff should remove their PPE and perform hand hygiene after any interaction with a positive case.
2. The spaces should preferably be well-ventilated and contained. HEPA filtration is preferable if available, and doors should be kept closed (if there are no safety issues) as to prevent transmission of SARS-CoV-2. Visual alerts are posted at the lobby entrance and in other strategic places (e.g. high traffic flow areas, elevators, resident units) to provide instructions about hand hygiene, respiratory hygiene, cough etiquette and PPE requirements. Necessary PPE, hand hygiene supplies, and disinfecting wipes are made available for use. A trash can is available to discard doffed (removed) PPE.
3. Ideally, environmental services (EVS) staff should be dedicated to this unit, but to the extent possible, EVS staff should avoid working on both the COVID-19 care unit and other units during the same shift.
4. Staff will use facility/ Environmental Protection Agency (EPA) approved List N cleaning and disinfecting wipes proven effective against SARS-CoV-2 virus especially to those most frequently touched areas in the immediate environment of care routinely, after interaction with the resident, and as needed basis.
5. Dedicated medical equipment should be used when caring for a resident with suspected or confirmed SARS-CoV-2 infection.
6. All non-dedicated, non-disposable medical equipment used for that resident should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another resident.
7. All care/service providers should appropriately wear full PPE such as gloves, gown, eye protection (face shield or goggles), and NIOSH-approved N95 respirator. Facility will follow NYSDOH recommended PPE stockpile guidelines.
8. Management of laundry, food service utensils, and medical waste are performed in accordance with routine procedures.
9. Enhance cleaning schedule using facility approved EPA-registered disinfectant effective against COVID-19 (e.g., PDI Sani wipes) from List N and perform terminal cleaning subsequent to the resident transfer, room relocation or discharge.

10. Residents will receive services deemed essential to their care in their rooms so as to prevent complications from their primary conditions and for the effective treatment of COVID-19 infection. Limit resident movement outside his/her/their room unless deemed essential.
11. The residents must wear a surgical or procedural mask unless not tolerable during interactions with staff and when receiving care treatment or services. They should be provided new mask if it becomes soiled or damaged. Residents who are non-compliance to wear mask, an education process will be provided and documented on the importance of masking.
12. When ill residents need to be transferred, EMS and receiving hospital or facility will be made aware of resident's COVID-19 diagnosis and clinical condition through verbal and in writing using the Inter-facility Infection Control Transfer Form.
13. For residents who must be transported for essential services, resident will be encouraged to wear facemask, if tolerated and able to remove by themselves. The resident should preferably be brought outside of their room by the unit care team and transferred to a clean bed or wheelchair in order to avoid transport personnel from having to enter the room and to avoid cross contamination i.e. moving a contaminated bed or wheelchair.
14. Transport personnel and the receiving facility or departments should be notified about the suspected/confirmed diagnosis prior to transfer verbally and through use of Inter-Facility Infection Control Transfer Form.
15. Criteria for discontinuing Transmission-Based Precautions and transferring a positive resident out of the COVID-19 unit follow CMS-CDC, NYSDOH guidance.

XI. STAFFING

The facility recognizes the need during increase cases of COVID-19 to exercise all efforts to maintain adequate staffing as to ensure residents safety. For the containment of large COVID-19 outbreaks, the facility will sequentially implement relevant CDC recommendations on staffing, cohorting during increasing demand in care, treatment or services and rapidly decreasing number of staff due to the furlough of employees who develop the infection.

They include:

- Conventional Strategies
- Contingency Capacity Strategies
- Crisis Capacity Strategies

A. CONVENTIONAL STRATEGIES

1. All staff are encouraged to take the most up-to-date COVID-19 vaccine and be watchful of contacts who display signs and symptoms of a respiratory illness
2. COVID-19 Testing Kits are made available at OHS and the Nursing Office to staff for self-testing after exposure to contacts with respiratory illness or if they develop respiratory symptoms themselves.
3. The facility observes masking policy appropriate for the level of community transmission or after the identification of positive case among residents and/or staff.
4. All departments design staffing formulas that ensure uninterrupted delivery of services taken into consideration not only emergency or sick leaves but also natural disasters or surge in infectious cases.
5. Communicate with NYC Health + Hospitals PAC leadership, local healthcare coalitions,

federal, state, and local public health partners.

6. Employees assigned to the care of residents with COVID-19 infection who developed a positive test, should be restricted from caring for residents who are COVID-19 free. They should be tested frequently and quarantine if they developed COVID-19 infection.
7. The facility will follow current NYC Health + Hospitals' guidance on Return to Work Criteria for Health Care Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.

B. CONTINGENCY STRATEGIES

Contingency Capacity Strategies are put in place to mitigate staffing shortages. When shortages are anticipated, either because of rapidly increasing community transmission, or the documentation of high level of transmission in the facility among residents and HCP, the facility administration in collaboration with human resources and occupational health services, will utilize contingency capacity strategies to plan and prepare for mitigating staffing shortage. They include:

1. Adjust staff schedules, activate additional staffing from sister facilities or staffing agencies, rotate staff to positions that support resident care activities, consider shortening the return to work policy for staff who recently tested positive for the virus. Considerations for determining which HCP should be prioritized for this option include:
 - The types of symptoms they are experiencing (e.g., persistent fever, cough).
 - Their degree of interaction with residents and other HCP in the facility.
2. When allowing HCP with SARS-CoV-2 infection who are well enough and willing to work to return to work, the following are required:
 - The infected staff is asymptomatic throughout his infection or had mild to moderate illness and is not moderately or severely immunocompromised.
 - At least 5 days had passed since symptoms first appeared (day 0), and symptoms (e.g., cough, shortness of breath) have improved.
 - The facility will follow current NYC Health + Hospitals' guidance on Return to Work Criteria for Health Care Personnel with SARS-CoV-2 infection.
 - If HCP are requested to return to work before meeting all conventional Return to Work Criteria:
 - They should self-monitor for symptoms and seek re-evaluation from occupational health service if symptoms recur or worsen.
 - Until they meet the conventional return to work criteria, they should wear a respirator or well-fitting facemask at all times, even when they are in non-resident care areas such as breakrooms.
 - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should physically distant at least 6 ft. from others.
 - Residents to wear facemask (if tolerable and able to remove by themselves) while interacting with these HCP.

C. CRISIS CAPACITY STRATEGIES

When staffing shortages occur, the facility might consider crisis capacity strategy in collaboration with human resources and occupational health services, which might include but not limited to:

1. The transfer of stable residents to designated healthcare facilities, or alternate care sites with adequate staffing.

2. If shortages continue despite other mitigation strategies, as a last resort, consideration to allow HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, will be discussed with NYC H + H Post-Acute Care (PAC) Leadership.
3. Such considerations for determining which HCP could return to work when infected include:
 - Type of HCP shortages that need to be addressed.
 - Where individual HCP are in the course of their illness
 - The types of symptoms they are experiencing (e.g., persistent fever, cough).
 - Their degree of interaction with residents and other HCP in the facility
 - Type of residents they care for (i.e. consider resident care only with residents known or suspected to have SARS-CoV-2 infection rather than residents who are immunocompromised).
4. If HCP are requested to work before meeting all criteria, they should be restricted from contact with residents who are moderately to severely immunocompromised (e.g., transplant, hematology-oncology) and the facility will consider prioritizing their duties in the following order:
 - a. Allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., residents or other HCP), such as in telemedicine/remote work services.
 - b. Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for residents with confirmed SARS-CoV-2 infection, preferably in a cohort setting.
 - c. Strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential.
5. If HCP are requested to return to work before meeting all conventional Return to Work Criteria:
 - They should self-monitor for symptoms and seek re-evaluation from occupational health service if symptoms recur or worsen.
 - Until they meet the conventional return to work criteria, they should wear a respirator or well-fitting facemask at all times, even when they are in non-resident care areas such as breakrooms.
 - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should physically distant at least 6 feet from others.
 - Residents to wear facemask (if tolerable and able to remove by themselves) while interacting with these HCP.

XII. COVID-19 TESTING

- Viral tests, including Nucleic Acid Amplification Tests (NAATs, such as Reverse Transcription – Polymerase Chain Reaction) and SARS-CoV-2 Antigen tests are used as diagnostic tests to detect current infection with COVID-19. Both tests are available at the facility.
- Testing is conducted by a licensed nurse or a trained patient care associate, and based on current CDC, CMS, and NYS DOH guidance.
- For SARS-CoV-2 antigen tests, the tester should follow the manufacturer’s instructions for use.

- Routine screening testing of asymptomatic employees are no longer recommended based on current guidelines from Centers for Medicare and Medicaid Services (CMS) and NYS Department of Health (NYS DOH).
- Testing, regardless of vaccination status, is required for employees with symptoms; employees with higher risk exposures; and in outbreak settings.
- Employees who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and an employee refuses testing, the employee should be restricted from the building until the procedures for outbreak testing have been completed. The facility will follow its Occupational Health and HR policies with respect to any employee who refuses testing.
- 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 who have recovered in the prior 31-90 days; however, an Antigen test instead of a nucleic acid amplification test (NAAT) is recommended.

XIII. COVID-19 VACCINATION

- Pursuant to DAL #21-04: COVID-19 Vaccine Regulation dated April 19, 2021, Gouverneur shall be responsible to arrange for ongoing vaccination of both residents and staff.
- Gouverneur shall adhere to most current vaccination requirements for health care providers (HCP) issued by governing bodies such as, and Centers for Medicare and Medicaid Services (CMS).

Gouverneur Administration

- Gouverneur shall post conspicuous signage throughout the facility, including at points of entry and exit and each residential hallway, reminding personnel and residents that the facility offers COVID-19 vaccination.
- Gouverneur shall provide all personnel and residents who decline to be vaccinated a written affirmation for their signature, which indicates that they were offered the opportunity for a COVID-19 vaccination but declined. The affirmation must state that the signatory is aware that, if they later decide to get vaccinated for COVID-19, it is their responsibility to request vaccination from the facility.
- Gouverneur shall maintain signed affirmations on file at the facility.

Residents

- Gouverneur shall offer all consenting residents, unvaccinated against COVID-19, an opportunity to receive their first or any required dose of the COVID-19 vaccine within 7 days of admission or re admission.
- Residents who are cognitively impaired and unable to make decisions by themselves, listed responsible party will be contacted to obtain consent and will be documented on resident's chart.
- Residents who are cognitively impaired and unable to make decisions by themselves, who do not have a responsible party, 2 physician signatures will be obtained to sign on behalf of resident's consent.

- Gouverneur shall educate and provide information to all resident and their family members on the risks and benefits of COVID-19 vaccine.
- Resident's electronic medical record (EMR) will be updated to reflect resident's vaccination status

Staff (new, existing, and contractual)

- Gouverneur shall offer all consenting staff (both new, existing, and contractual), unvaccinated against COVID-19, an opportunity to receive their first or any required dose of the COVID-19 vaccine within 7 days of hire.
- Gouverneur shall educate and provide information to all staff members on the risks and benefits of COVID-19 vaccine.
- Gouverneur shall obtain signed consents form, for staff consenting to receive the COVID-19 vaccine, and declination form for staff declining COVID-19 vaccine.

XIV. FAMILY EDUCATION AND ONGOING NOTIFICATION

- Facility will maintain ongoing communication with the Gouverneur community, designated representatives/NOK's related to changes with COVID-19.
- The facility shall provide updated information to families/next-of-kin about COVID-19 situation in Gouverneur regularly, through electronic messaging system, resident and family virtual council meetings and newsletters.
- Gouverneur staff will continue to make every effort to obtain the family members/NOK's email addresses to:
 - Communicate general updates related to COVID-19
 - Provide emotional support to families/NOK's during this challenging time
- Facility will provide alternative methods for /communication/visitation (e.g., video conferencing).

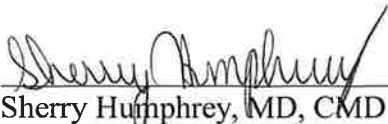
In accordance with NYS Governor's revised Executive Order, Gouverneur has initiated the COVID-19 call-in number. This will ensure that families/NOKs can obtain information related to new confirmed cases of COVID-19 and or COVID-19 related deaths. This recorded message is updated daily and can be updated remotely/offsite should additional changes need to communicated.

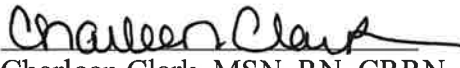
REFERENCES

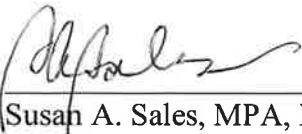
1. Centers for Disease Control and Prevention. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
2. Centers for Disease Control and Prevention. Healthcare Infection Prevention and Control FAQs for COVID-19 found at website:
<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>
3. Standard, Droplet and Contact precautions. Guidance is available on the CDC website at:
<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>
4. PPE donning/doffing procedures is available at:
<https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf>
<http://hhcinsider.nychhc.org/sites/COVID-19/Pages/Index.aspx>
5. CMS QSO-20-38-NH – Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements
<https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf>
6. CMS QSO-20-29-NH - Nursing Home Visitation - COVID-19 (REVISED)
<https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf>
7. NYSDOH DAL NH 20-04 COVID-19 Guidance for Nursing Homes REVISED March 11, 2020
9. NYSDOH Nursing Home COVID-19 Preparedness Self-Assessment Checklist Version 4/10/2020.
9. Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF):
<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-carefacilities.Html>
10. PPE conservation guidelines, available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>
11. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007. Healthcare Infection Control Practices Advisory Committee
12. CDC: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#new-admissions>

APPENDIX A – VISITATION GUIDELINES

Approved:



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NYC Health + Hospitals/Gouverneur

Visitation Guidelines

Effective Immediately

Please see below for the most up-to-date information on our in-person visitation guidelines. These guidelines are subject to change based on COVID status of both residents and staff and on direction provided by the New York State Department of Health.

- Visitation is recommended in patient/resident room during the preferred visiting hours of 8:00 am - 9:00 pm.
- Visitors under the age of 16 must be accompanied by an adult.
- Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet current criteria to end isolation.
- For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact.
- Masking for all visitors above the age of 2 is encouraged when in the facility.
- When a patient/resident has a respiratory illness, the visit should ideally occur in the resident's room, the resident and their visitors should wear a mask (if tolerated and physically distance (if possible) during the visit.
- If any visitor fails to adhere to the protocol, he/she/they will not be permitted to visit and asked to leave.

Families can call our COVID-19 Hotline for information on COVID-19 cases and visitation changes at 646-615-1701.

We strongly encourage visitors to be vaccinated against COVID-19.

Effective 1/12/24



POINT OF ENTRY SCREENING POLICY

Policy #: IC C17	Date: October 1, 2021
Last Reviewed: March 23, 2026	

POLICY:

It is the policy of NYC Health + Hospitals / Gouverneur to employ screening strategies to prevent the spread of COVID-19 in the facility to protect residents, families and staff from serious illness and life-threatening complications.

NOTE: This guidance is subject to change/s and update/s to comply with most current guidelines issued by NYS Department of Health (NYSDOH, Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), and NYC Health + Hospitals.

PURPOSE:

To provide guidance for Gouverneur Skilled Nursing Facility on Point-of-Entry screening for COVID-19 and other respiratory viral illness for all individuals entering the facility including but not limited to employees, visitors, contractors/vendors

SCOPE:

All employees, contractors / vendors, family members / visitors

PROCEDURE/GUIDELINE:

I. EMPLOYEES, CONTRACTORS AND VENDORS

1. All employees, contractors, and vendors entering Gouverneur Skilled Nursing Facility will self-screen for viral respiratory illness, including but, not limited to, RSV, influenza, and COVID-19, using a standardized signage at the point of entry into the facility.
2. Screening Questionnaire Signage includes:
 - a. Fever, shortness of breath, cough, sore throat, nasal congestion or other COVID-19 symptoms
 - b. Close contact with someone with COVID-19 in the past 10 days
 - c. A positive COVID-19 test within the past 10 days
3. Any employee/contractor/vendor who has one or more of the above must report to Occupational Health Services (OHS).

II. FAMILY MEMBERS / VISITORS:

1. All family members and visitors entering Gouverneur Skilled Nursing Facility will self-

screen for viral respiratory illness, including but, not limited to, RSV, influenza, and COVID-19, using a standardized signage at the point of entry into the facility.

2. Screening Questionnaire Signage includes:
 - a. Fever, shortness of breath, cough, sore throat, nasal congestion or other COVID-19 symptoms
 - b. Close contact with someone with COVID-19 in the past 10 days
 - c. A positive COVID-19 test within the past 10 days
3. Any family member / visitor who answers “yes” to any of the above screening questions are to inform staff and may be allowed entry to the facility if approved by appropriate clinical leadership at their intended destination within the facility.
4. Generally, family members / visitors who have tested positive for COVID-19 within the past 10 days or have compatible symptoms should defer non-urgent in-person visitation until they have completed their 10-day isolation period (note this time period is longer than what is recommended in the community)
5. Urgent in-person visitation can include:
 - a. End-of-life
 - b. Intellectual, developmental, or other cognitive disability
 - c. Any additional patient care areas or circumstances at the discretion of facility leadership based on resident’s status, condition, circumstances, OR facility policy.
6. For visitors who have had close contact with someone with COVID-19 in past 10 days, as long as the visitor can wear a facemask throughout time at facility, may enter the facility but should be encouraged to also defer non-urgent in-person visitation until 10 days after their close contact.
7. Visitors are not required to be tested or vaccinated (or show proof of such) as a condition of visitation.

III. INFECTION PREVENTION AND CONTROL:

1. All visitors must adhere to the following polices and practices by the facility:
 - a. Counseling residents and their visitor(s) about the risks of an in-person visit (as needed).
 - b. Visitors must wear a surgical mask or other well-fitting mask at all times during high transmission levels of any respiratory virus in the community, regardless of visitor or resident vaccination status for COVID-19. Surgical masks will be provided to the visitor, as needed.
 - c. The facility is expected to provide masks to all visitors and staff. In addition, unit staff should actively distribute facial masks to all visitors enter their unit, as needed.

- d. Visitors may be provided with and asked to wear additional personal protective equipment (PPE), as appropriate to the resident's condition or diagnosis(es) as recommended by the facility policy.
- e. Visitors must be advised regarding how to perform appropriate and effective hand hygiene and limiting surfaces touched in resident's room as well as the proper donning, doffing, and disposal of PPE and must adhere to such procedures.
- f. Visitors who fail to wear a surgical mask and other PPE as requested by the facility will be asked to leave the facility.
- g. Once in the facility, visitors must remain in the resident's room throughout the visit, except when directed to leave by staff during aerosol-generating procedures or other procedures or circumstances for which visitors are usually asked to leave, or to use the restroom, and must maintain appropriate distance from any other residents or staff.

IV. EXEMPTIONS:

1. The following are exempt from the testing requirements of this Advisory:
 - a) As stated in previous Department and CMS guidance at 42 CFR § 483.10(f)(4)(i)(C) requires that a Medicare and Medicaid-certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. If an ombudsman is planning to visit a resident who is on transmission-based precautions or in quarantine, or an unvaccinated resident in a nursing home in a county where the level of community transmission is substantial or high in the past 7 days, the resident and ombudsman should be made aware of the potential risk of visiting, and the visit should take place in the resident's room. Representatives of the Office of the Ombudsman should adhere to the core principles of COVID- 19 infection prevention as described above.
 - b) Compassionate caregiving visitors, within the meaning of Public Health Law §2801-h, who are visiting in anticipation of the end of a resident's life or in the instance of a significant mental, physical, or social decline or crisis of a resident. In any case where such an exception is made, the visitor must wear any additional personal protective equipment (PPE) that facility personnel deem appropriate to the situation.
 - c) Emergency medical services (EMS) personnel are not subject to self-screening requirements.

REFERENCES:

NYS-DOH DAL: Guidance for use of Face Masks and Face Coverings in Healthcare Facilities - February 10, 2023

NYS-DOH Health Advisory: Nursing Home Visitor Testing and Screening for COVID-19 - March 17, 2023

NYS-DOH Health Advisory: COVID Infection Prevention and Control Nursing Home FAQs - November 18, 2022

CMS QSO-20-39-NH: Nursing Home Visitation - COVID-19 – September 23, 2022

CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic – September 27, 2022

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