NEW YORK STATE OF OPPORTUNITY. Department of Health

GOOD SAMARITAN NURSING AND REHABILITATION CARE CENTER

Comprehensive Emergency Management Plan

2021

Good Samaritan Nursing and Rehabilitation Care Center
101 Elm St. Sayville, New York 11782
Goodsamaritannursinghome.chsli.org

Instructions

The NYSDOH Comprehensive Emergency Management (CEMP) Template is a tool to help facilities develop and maintain facility-specific CEMPs. For 2020, Appendix K has been updated to include guidance and formatted to provide a form to comply with the new requirements of Chapter 114 of the Laws of 2020 for the development of a Pandemic Emergency Plan (PEP).The plan template is designed to help facilities easily identify the information needed to effectively plan for, respond to, and recover from natural and man-made disasters. All content in this template should be reviewed and tailored to meet the needs of each facility.

Refer to *Part 1 – Instructions* for additional information about completion of this template.

Refer to *Part 3 – Toolkit* for supplementary tools and templates to inform CEMP development and implementation.

Emergency Contacts

The following table lists contact information for public safety and public health representatives for quick reference during an emergency.

Table 1: Emergency Contact Information

Organization	Phone Number(s)
Local Fire Department	631-589-0189
Local Police Department	631-854-8500 Fifth Pct.
Emergency Medical Services	Hunter 631-777-5600 Fire Department 911
Fire Marshal	631-852-4855 Eves and WE 631-852-4815 Sayville 631-224-5477
Local Office of Emergency Management	631-852-4900
NYSDOH Regional Office (Business Hours)[1]	631-851-3611
NYSDOH Duty Officer (Business Hours)	866-881-2809
New York State Watch Center (Warning Point) (Non-Business Hours)	518-292-2200

[1] During normal business hours (non-holiday weekdays from 8:00 am – 5:00 pm), contact the NYSDOH Regional Office for your region or the NYSDOH Duty Officer. Outside of normal business hours (e.g., evenings, weekends, or holidays), contact the New York State Watch Center (Warning Point).

Approval and Implementation

This Comprehensive Emergency Management Plan (CEMP) has been approved for implementation by:

Joseph Costa ,CAO _____ _____***9/10/21***___
Joseph Costa, CAO
Administrator Good Samaritan Nursing and Rehabilitation

Chris Cardinal, RN _____ _____***9/10/21***___
Chris Cardinal, RN
Director of Performance Improvement

Michael Lambert_____ _____**9/10/21**_____
Michael Lambert
CHS Continuing Care Division
CHS Board of Directors

Record of Changes

Table 2: Record of Changes

Version #	Implemented By	Revision Date	Description of Change
1.0	Chris Cardinal, RN Director of Performance Improvement	09/15/20	Implementation and completion of CEMP Template and Annex E
2.0	Chris Cardinal, RN Director of Performance Improvement	9/10/21	Review and update

Record of External Distribution

Table 3: Record of External Distribution

Date	Recipient Name	Recipient Organization	Format	Number of Copies
9/15/20		Suffolk County Office of Emergency Management	Email	*1*
9/15/20		NYSDOH Regional Office	Email	1
9/15/20		Sayville Fire Department	Email	1
9/15/20		Suffolk County Police Dept.	Email	1
9/15/20		Catholic Health Services	Email	1
9/15/20		Facility Website	Attachment	1

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1 Background

1.1 Introduction

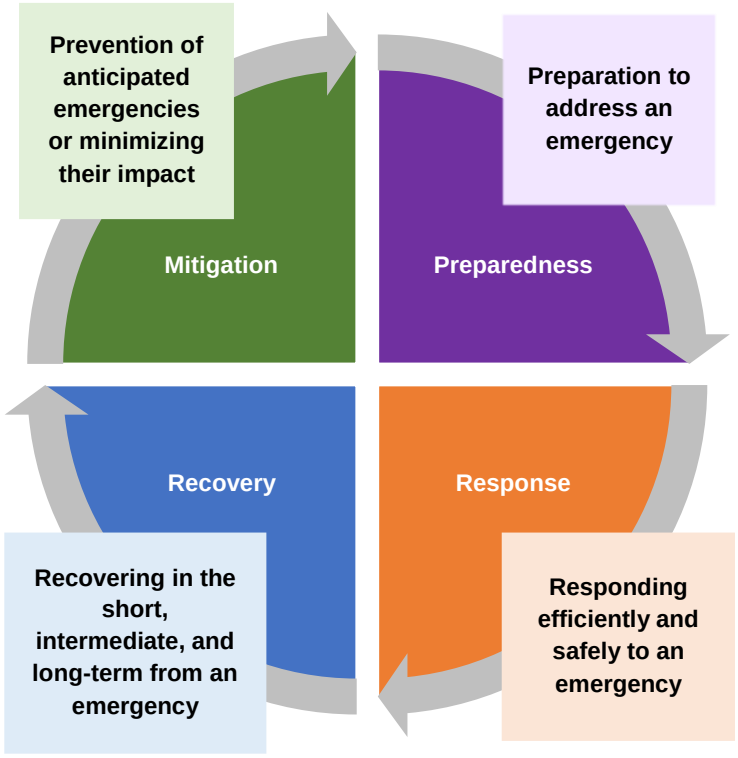
To protect the well-being of residents, staff, and visitors, the following all-hazards Comprehensive Emergency Management Plan (CEMP) has been developed and includes considerations necessary to satisfy the requirements for a Pandemic Emergency Plan (PEP). Appendix K of the CEMP has been adjusted to meet the needs of the PEP and will also provide facilities a form to post for the public on the facility's website, and to provide immediately upon request. The CEMP is informed by the conduct of facility-based and community-based risk assessments and pre-disaster collaboration with New York State Department of Health, Local Office of Emergency Management, Local Fire and Police Departments, and Catholic Health Services.

This CEMP is a living document that will be reviewed annually, at a minimum, in accordance with *Section 7: Plan Development and Maintenance*.

1.2 Purpose

The purpose of this plan is to describe the facility's approach to mitigating the effects of, preparing for, responding to, and recovering from natural disasters, man-made incidents, and/or facility emergencies.

Figure 1: Four Phases of Emergency Management



1.3 Scope

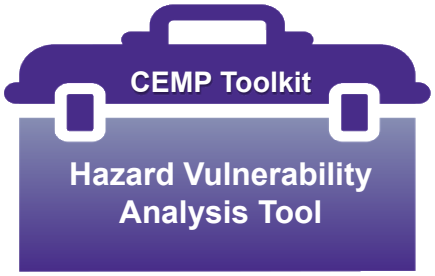
The scope of this plan extends to any event that disrupts, or has the potential to significantly disrupt, the provision of normal standards of care and/or continuity of operations, regardless of the cause of the incident (i.e., man-made or natural disaster).

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

The facility complies with NYSDOH and Joint Commission regulations and guidelines in regard to Emergency Management. The facility completes a Hazard Vulnerability Analysis annually to assist in the identification of all potential hazards and conditions. The facility formulates Emergency Management Plans and policies to provide guidance and policy for the management of all potential risks to the facility, these are also reviewed and revised as indicated annually

1.4 Situation

1.4.1 Risk Assessment[2]



The facility conducts an annual risk assessment to identify which natural and man-made hazards pose the greatest risk to the facility (i.e., human and economic losses based on the vulnerability of people, buildings, and infrastructure).

The facility conducted a facility-specific risk assessment on 9/10/20 and determined the following hazards may affect the facility's ability to maintain operations before, during, and after an incident:

- Based on the most recent Hazard Vulnerability Analysis, the facility's top 10 risks are :
    - Infectious Disease Outbreak
    - Hurricane
    - Inclement Weather
    - Pandemic
    - Sewer Failure
    - Active Shooter
    - External Flood
    - Hostage Situation
    - Acts of Intent
    - Bomb Threat

The facility has reviewed their high risk areas and has policies and plans for the management of each type of incident. Staff is also educated regarding Emergency Management and specific incident management

This risk information serves as the foundation for the plan—including associated policies, procedures, and preparedness activities.

[2] The Hazard Vulnerability Analysis (HVA) is the industry standard for assessing risk to healthcare facilities. Facilities may rely on a community-based risk assessment developed by public health agencies, emergency management agencies, and Health Emergency Preparedness Coalition or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment.

1.4.2 Mitigation Overview

The primary focus of the facility's pre-disaster mitigation efforts is to identify the facility's level of vulnerability to various hazards and mitigate those vulnerabilities to ensure continuity of service delivery and business operations despite potential or actual hazardous conditions.

To minimize impacts to service delivery and business operations during an emergency, the facility has completed the following mitigation activities:

- Development and maintenance of a CEMP;
- Procurement of emergency supplies and resources;
- Establishment and maintenance of mutual aid and vendor agreements to provide supplementary emergency assistance;
- Regular instruction to staff on plans, policies, and procedures; and
- Validation of plans, policies, and procedures through exercises.[3]

For more information about the facility's fire prevention efforts (e.g., drills), safety inspections, and equipment testing, please refer to the Fire Prevention Plan

1.5 Planning Assumptions

This plan is guided by the following planning assumptions:

- Emergencies and disasters can occur without notice, any day, and on any shift.
- Emergencies and disasters may be facility-specific, local, regional, or state-wide.
- Local and/or state authorities may declare an emergency.
- The facility may receive requests from other facilities for resource support (supplies, equipment, staffing, or to serve as a receiving facility).
- Facility security may be compromised during an emergency.
- The emergency may exceed the facility's capabilities and external emergency resources may be unavailable. The facility is expected to be able to function without an influx of outside supplies or assistance for 96 hours.
- Power systems (including emergency generators) could fail.
- During an emergency, it may be difficult for some staff to get to the facility, or alternately, they may need to stay in the facility for a prolonged period of time.

[3] Refer to the "Training and Exercises" section of this plan for additional information about pre-incident trainings and exercises.

2 Concept of Operations

2.1 Notification and Activation

2.1.1 Hazard Identification

The facility may receive advance warning about an impending natural disaster (e.g., hurricane forecast) or man-made threat (e.g., law enforcement report), which will be used to determine initial response activities and the movement of personnel, equipment, and supplies. For no-notice incidents (e.g., active shooter, tornado), facilities will not receive advance warning about the disaster, and will need to determine response activities based on the impact of the disaster.

The Incident Commander may designate a staff member to monitor evolving conditions, typically through television news, reports from government authorities, and weather forecasts.

All staff have a responsibility to report potential or actual hazards or threats to their direct supervisor.

2.1.2 Activation

Upon notification of hazard or threat—from staff, residents, or external organizations—the senior-most on-site facility official will determine whether to activate the plan based on one or more of the triggers below:

- The provision of normal standards of care and/or continuity of operations is threatened and could potentially cause harm.
- The facility has determined to implement a protective action.
- The facility is serving as a receiving facility.
- The facility is testing the plan during internal and external exercises (e.g., fire drills).

If one or more activation criteria are met and the plan is activated, the senior-most on-site facility official—or the most appropriate official based on the incident—will assume the role of “Incident Commander” and operations proceed as outlined in this document.

2.1.3 Staff Notification

Once a hazard or threat report has been made, an initial notification message will be disseminated to staff in accordance with the facility's communication plan.

Department Managers or their designees will contact on-duty personnel to provide additional instructions and solicit relevant incident information from personnel (e.g., status of residents, status of equipment).

Once on-duty personnel have been notified, Department Managers will notify off-duty personnel if necessary and provide additional guidance/instruction (e.g., request to report to facility).

Department personnel are to follow instructions from Department Managers, keep lines of communication open, and provide status updates in a timely manner.

2.1.4 External Notification

Depending on the type and severity of the incident, the facility may also notify external parties (e.g., local office of emergency management, resource vendors, relatives and responsible parties) utilizing local notification procedures to request assistance (e.g., guidance, information, resources) or to provide situational awareness.

The NYSDOH Regional Office is a mandatory notification recipient regardless of hazard type, while other notifications may be hazard-specific. Table 4: Notification by Hazard Type~~Table 4~~ provides a comprehensive list of mandatory and recommended external notification recipients based on hazard type.

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Table 4: Notification by Hazard Type

M = Mandatory
R = Recommended

Notification Recipient	Example Hazard	Active Threat[4]	Blizzard/Ice Storm	Coastal Storm	Dam Failure	Water Disruption	Earthquake	Extreme Cold	Extreme Heat	Fire	Flood	CBRNE[5]	Infectious Disease / Pandemic	Landslide	IT/Comms Failure	Power Outage	Tornado	Wildfire
NYSDOH Regional Office[6]	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Facility Senior Leader	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Local Emergency Management	R		R	M	M		M	R	R		R	M	R	R			M	M
Local Law Enforcement		M																
Local Fire/EMS		M								M		M						M
Local Health Department	R	R		R	R	R	R			R	R	R	M	R		R	R	R
Off Duty Staff			R	R	R		R			R	R	R	R	R			R	R
Relatives and Responsible Parties		R	R	R	R		R	R	R	R	R	R	M	R			R	R
Resource Vendors			R	R	R	R	R				R	R	M	R			R	R
Authority Having Jurisdiction																		
Regional Healthcare Facility Evacuation Center			R	R	R		R				R			R			R	R
CatholicHealth Services		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M

[4] "Active threat" is defined as an individual or group of individuals actively engaged in killing or attempting to kill people in a populated area. Example attack methods may include bombs, firearms, and fire as a weapon.

[5] "CBRNE" refers to "Chemical, Biological, Radiological, Nuclear, or Explosive"

[6] To notify NYSDOH of an emergency during business hours (non-holiday weekdays from 8:00 am – 5:00 pm), the Incident Commander will contact the NYSDOH Regional Office 631-851-3611 Outside of normal business hours (e.g., evenings, weekends, or holidays), the Incident Commander will contact the New York State Watch Center (Warning Point) at 518-292-2200. The Watch Command will return the call and will ask for the type of emergency and the type of facility (e.g. hospital, nursing home, adult home) involved. The Watch Command will then route the call to the Administrator on Duty, who will assist the facility with response to the situation.

2.2 Mobilization

2.2.1 Incident Management Team

Upon plan activation, the Incident Commander will activate some or all positions of the Incident Management Team, which is comprised of pre-designated personnel who are trained and assigned to plan and execute response and recovery operations.

Incident Management Team activation is designed to be flexible and scalable depending on the type, scope, and complexity of the incident. As a result, the Incident Commander will decide to activate the entire team or select positions based on the extent of the emergency.

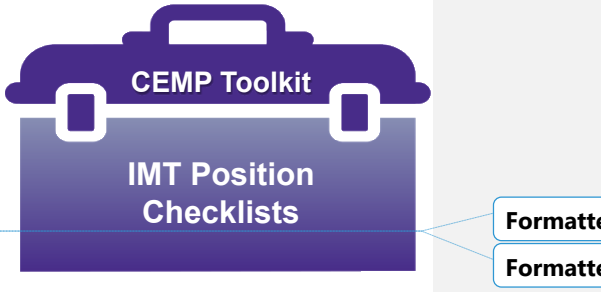

Table 5~~Table 5~~ outlines suggested facility positions to fill each of the Incident Management Team positions. The most appropriate individual given the event/incident may fill different roles as needed.

Table 5: Incident Management Team - Facility Position Crosswalk

Incident Position	Facility Position Title	Description
Incident Commander	Administrator Director of Nursing Services Nursing Supervisor	Leads the response and activates and manages other Incident Management Team positions.
Public Information Officer	CHS V.P. Public Information and External Affairs Public Relations and Brand Reputation Manager	Provides information and updates to visitors, relatives and responsible parties, media, and external organizations.
Safety Officer	Senior Facility Manager In-service Coordinator Nursing Supervisor	Ensures safety of staff, residents, and visitors; monitors and addresses hazardous conditions; empowered to halt any activity that poses an immediate threat to health and safety.
Operations Section Chief	Administrator Director of Nursing Services Nursing Supervisor	Manages tactical operations executed by staff (e.g., continuity of resident services, administration of first aid).

Incident Position	Facility Position Title	Description
Planning Section Chief	Director of Nursing Services MDS Coordinator Nursing Supervisor	Collects and evaluates information to support decision-making and maintains incident documentation, including staffing plans.
Logistics Section Chief	Senior Facility Manager Medical Records Coordinator Nursing Supervisor	Locates, distributes, and stores resources, arranges transportation, and makes alternate shelter arrangements with receiving facilities.
Finance/Admin Section Chief	V.P. Finance SNF	Monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

If the primary designee for an Incident Management Team position is unavailable, Table 6~~Table 6~~ identifies primary, secondary, and tertiary facility personnel that will staff Incident Management Team positions.

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While assignments are dependent upon the requirements of the incident, available resources, and available personnel, this table provides initial options for succession planning, including shift changes.

Table 6: Orders of Succession

Incident Position	Primary	Successor 1	Successor 2
Incident Commander	Administrator	Director of Nursing Services	Nursing Supervisor
Public Information Officer	V.P. Public Information/External Affairs	Public Relations and Brand Reputation Manager 1	Public Relations and Brand Reputation Manager 2
Safety Officer	Senior Facility Manager	In-service Coordinator	Nursing Supervisor
Operations Section Chief	Administrator	Director of Nursing Services	Nursing Supervisor
Planning Section Chief	Director of Nursing Services	MDS Coordinator	Nursing Supervisor
Logistics Section Chief	Senior Facility Manager	Medical Record Coordinator	Nursing Supervisor
Finance/Admin Section Chief	V.P. Finance SNFs		

2.2.2 Command Center

The Incident Commander will designate a space, e.g., facility conference room or other large gathering space, on the facility premises to serve as the centralized location for incident management and coordination activities, also known as the "Command Center."

The designated location for the Command Center is Administrative Boardroom and the secondary/back-up location is the second floor classroom, unless circumstances of the emergency dictate the specification of a different location upon activation of the CEMP, in which case staff will be notified of the change at time of activation.

2.3 Response

2.3.1 Assessment

The Incident Commander will convene activated Incident Management Team members in the Command Center and assign staff to assess designated areas of the facility to account for residents and identify potential or actual risks, including the following:

- Number of residents injured or affected;
- Status of resident care and support services;
- Extent or impact of the problem (e.g., hazards, life safety concerns);
- Current and projected staffing levels (clinical, support, and supervisory/managerial);
- Status of facility plant, utilities, and environment of care;
- Projected impact on normal facility operations;
- Facility resident occupancy and bed availability;
- Need for protective action; and
- Resource needs.

2.3.2 Protective Actions

Refer to **Annex A: Protective Actions** for more information.

2.3.3 Staffing

Based on the outcomes of the assessment, the Planning Section Chief will develop a staffing plan for the operational period (e.g., remainder of shift). The Operation Section Chief will execute the staffing plan by overseeing staff execution of response activities. The Finance/Administration Section Chief will manage the storage and processing of timekeeping and related documentation to track staff hours.

2.4 Recovery

2.4.1 Recovery Services

Recovery services focus on the needs of residents and staff and help to restore the facility's pre-disaster physical, mental, social, and economic conditions.

Recovery services may include coordination with government, non-profit, and private sector organizations to identify community resources and services (e.g., employee assistance programs, state and federal disaster assistance programs, if eligible). Pre-existing facility- and community-based services and pre-established points of contact are provided in Table 7~~Table 8~~.

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Table 7~~8~~: Pre-Identified Recovery Services

Service	Description of Service	Point(s) of Contact
Catholic Health Services	Parent Organization	CEO, COO, and CMO

Ongoing recovery activities, limited staff resources, as well as the incident's physical and mental health impact on staff members may delay facility staff from returning to normal job duties, responsibilities, and scheduling.

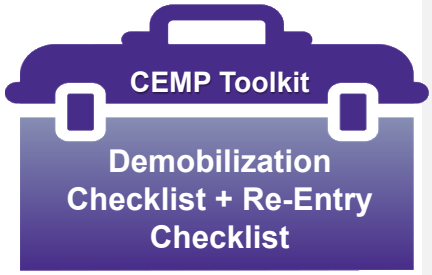
Resuming pre-incident staff scheduling will require a planned transition of staff resources, accounting for the following considerations:

- Priority staffing of critical functions and services (e.g., resident care services, maintenance, dining services).
- Personal staff needs (e.g., restore private residence, care for relatives, attend memorial services, mental/behavioral health services).
- Continued use or release of surge staffing, if activated during incident.

2.4.2 Demobilization

As the incident evolves, the Incident Commander will begin to develop a demobilization plan that includes the following elements:

- Activation of re-entry/repatriation process if evacuation occurred;[7]
- Deactivation of surge staffing;
- Replenishment of emergency resources;
- Reactivation of normal services and operations; and
- Compilation of documentation for recordkeeping purposes.



2.4.3 Infrastructure Restoration

Once the Incident Commander has directed the transition from incident response operations to demobilization, the facility will focus on restoring normal services and operations to provide continuity of care and preserve the safety and security of residents.

Table 8~~Table 9~~ outlines entities responsible for performing infrastructure restoration activities and related contracts/agreements.

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Table 8~~9~~: Infrastructure Restoration Activities

Activity	Responsible Entity	Contracts/Agreements
Internal assessment of electrical power.	PSEG JPG Electric GSNH Maintenance Dept.	
Clean-up of facility grounds (e.g., general housekeeping, removing debris and damaged materials).	GSNH Maintenance Dept. Witcomb Landscaping	
Internal damage assessments (e.g., structural, environmental, operational).	Catholic Health Services	Parent Organization
Clinical systems and equipment inspection.	Catholic Health Services IT Matrixcare GDC Mechanical	Parent Organization Clinical EMR

[7] Refer to the *NYSDOH Evacuation Plan Template* for more information about repatriation.

Activity	Responsible Entity	Contracts/Agreements
Strengthen infrastructure for future disasters (if repair/restoration activities are needed).	Catholic Health Services Charel Contracting Liro Group	Parent Organization
Communication and transparency of restoration efforts to staff and residents.	Administrator	
Recurring inspection of restored structures.	Catholic Health Services GSNR Maintenance Charel Contracting Liro Group	Parent Organization

2.4.4 Resumption of Full Services

Department Managers will conduct an internal assessment of the status of resident care services and advise the Incident Commander and/or facility leadership on the prioritization and timeline of recovery activities.

Special consideration will be given to services that may require extensive inspection due to safety concerns surrounding equipment/supplies and interruption of utilities support and resident care services that directly impact the resumption of services (e.g., food service, laundry).

Staff, residents, and relatives/responsible parties will be notified of any services or resident care services that are not available, and as possible, provided updates on timeframes for resumption. The Planning Section Chief will develop a phased plan for resumption of pre-incident staff scheduling to help transition the facility from surge staffing back to regular staffing levels.

2.4.5 Resource Inventory and Accountability

Full resumption of services involves a timely detailed inventory assessment and inspection of all equipment, devices, and supplies to determine the state of resources post-disaster and identify those that need repair or replacement.

All resources, especially resident care equipment, devices, and supplies, will be assessed for health and safety risks. Questions on resource damage or potential health and safety risks will be directed to the original manufacturer for additional guidance.

3 Information Management

3.1 Critical Facility Records

Critical facility records that require protection and/or transfer during an incident include:

- Facility paper records maintained for current residents prior to institution of electronic medical record
- Facility paper records not included in current electronic medical record

The facility currently has an electronic medical record, Matrixcare, which is maintained by the vendor and Catholic Health Services IT Department. Information is backed up daily. Access to the EMR is generator supported.

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

3.2 Resident Tracking and Information-Sharing

3.2.1 Tracking Evacuated Residents

The facility will use the New York State Evacuation of Facilities in Disasters System ("eFINDS")[8] and the Resident Evacuation Critical Information and Tracking Form[9] to track evacuated residents and ensure resident care is maintained.

Resident Confidentiality

The facility will ensure resident confidentiality throughout the evacuation process in accordance with the Health Insurance Portability and Accountability Act Privacy Rule (Privacy Rule), as well as with any other applicable privacy laws. Under the Privacy Rule, covered health care providers are permitted to disclose protected health information to public health authorities authorized by law to collect protected health information to control disease, injury, or disability, as well as to public or private entities authorized by law or charter to assist in disaster relief efforts. The Privacy Rule also permits disclosure

[8] eFINDS is a secure, confidential system intended to provide authorized users with real-time access to the location of residents evacuated during an emergency event. The system is to be used to log and track residents during an urgent or non-emergent evacuation. See Appendix K of the *NYSDOH Evacuation Plan Template* for further information and procedures on eFINDS.

[9][9] The Resident Evacuation Critical Information and Tracking Form is a standardized form utilized to provide pertinent individual resident information to receiving facilities and provide redundant tracking during the evacuation process, including repatriation. See Appendix L of the *NYSDOH Evacuation Plan Template* for the complete form.

10 see HIPAA privacy rule information in CEMP toolkit, Annex K) or: https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/hipaa-privacy-emergency-situations.pdf

of protected health information in other circumstances. Private counsel should be consulted where there are specific questions about resident confidentiality.

3.3 Staff Tracking and Accountability

3.3.1 Tracking Facility Personnel

The facility currently tracks staff through electronic and paper listing of each staff member and their contact information. Location and individual staff member assignments are currently tracked on a paper schedule

3.3.2 Staff Accountability

Staff accountability enhances site safety by allowing the facility to track staff locations and assignments during an emergency. Staff accountability procedures will be implemented as soon as the plan is activated.

The facility will utilize paper based sign in/sign out sheets when at alternate location, time clock will be utilized for facility based attendance to track the arrival and departure times of staff. During every operational period (e.g., shift change), Department Managers or designees will conduct an accountability check to ensure all on-site staff are accounted for.

If an individual becomes injured or incapacitated during response operations, Department Managers or designees will notify the Incident Commander to ensure the staff member's status change is reflected in staffing assignments, sign in/sign out sheets

3.3.3 Non-Facility Personnel

The Incident Commander—or Logistics Section Chief, if activated—will ensure that appropriate credentialing and verification processes are followed. Throughout the response, the Incident Commander—or Planning Section Chief, if activated—will track non-facility personnel providing surge support along with their respective duties and the number of hours worked.

4 Communications

4.1 Facility Communications

As part of CEMP development, the facility conducted a communications assessment to identify existing facility communications systems, tools, and resources that can be leveraged during an incident and to determine where additional resources or policies may be needed.

Primary (the best and intended option) and alternate (secondary back-up option) methods of communication are outlined in Table 9~~Table 9~~.

Table 9~~10~~: Methods of Communication

Mechanism	Primary Method of Communication	Alternate Method of Communication
Landline telephone	X	☐
Cell Phone	X	☐
Voice over Internet Protocol (VOIP)	☐	☐
Text Messages	X	☐
Email	**X**	☐
News Media	☐	X
Radio Broadcasts	☐	X
Social Media	☐	X
Runners	X	☐
Weather Radio	☐	☐
Emergency Notification Systems[10]	☐	X
Facility Website		X
Two-way radios	X	☐

[10] An emergency notification system is a one-way broadcast, sometimes coordinated by a third-party vendor, and is not required by NYSDOH.

4.1.1 Communications Review and Approval

4.1.2 *Pre-scripted messages will be formulated and approved by the facility administrator and CHS VP Public Information/External Affairs prior to communicating with the public*

Upon plan activation, the Incident Commander may designate a staff member as the Public Information Officer to serve as the single point of contact for the development, refinement, and dissemination of internal and external communications.

Key Public Information Officer functions include:

- Develops and establishes mechanisms to rapidly receive and transmit information to local emergency management;
- Develops situational reports/updates for internal audiences (staff and residents) and external audiences;
- Develops coordinated, timely, consistent, and reliable messaging and/or tailor pre-scripted messaging;
- Conducts direct resident and relative/responsible party outreach, as appropriate; and
- Addresses rumors and misinformation.

4.2 Internal Communications

4.2.1 Staff Communication

The facility maintains an electronic and paper list of all staff members, including emergency contact information, at the facility and at CHS Human Resources. To prepare for impacts to communication systems, the facility also maintains redundant forms of communication with on-site and off-site staff. The facility will ensure that all staff are familiar with internal communication equipment, policies, and procedures.

4.2.2 Staff Reception Area

Depending on the nature of the incident, the facility may choose to establish a staff reception area (e.g., in a break room or near the time clock) to coordinate and check-in staff members as they arrive to the facility to support incident operations.

The staff reception area also provides a central location where staff can receive job assignments, checklists, situational updates, and briefings each time they report for their shift. Implementing a sign-in/sign-out system at the staff reception area will ensure full staff accountability. The staff reception area also provides the Incident Commander with a central location for staffing updates and inquiries.

4.2.3 Resident Communication

Upon admission, annually, and prior to any recognized threat, the facility will educate residents and responsible parties on the CEMP efforts. Resident communication may include educational information in the admissions packet, discussion at Resident Council meetings, and to residents during an event.

During and after an incident, the Incident Commander—or Public Information Officer, if activated—will establish a regular location and frequency for delivering information to staff, residents, and on-site responsible parties (e.g., set times throughout the day), recognizing that message accuracy is a key component influencing resident trust in the facility and in perceptions of the response and recovery efforts.

Communication will be adapted, as needed, to meet population-specific needs, including memory-care residents, individuals with vision and/or hearing impairments, and individuals with other access and functional needs.

4.3 External Communications

Under no circumstances will protected health information be released over publicly-accessible communications or media outlets. All communications with external entities shall be in plain language, without the use of codes or ambiguous language.

4.3.1 Corporate/Parent Organization

The facility will coordinate all messaging with Catholic Health Services to ensure external communications are in alignment with corporate policies, procedures, and brand standards. Prior to an incident, the facility will coordinate with Catholic Health Services to ensure an on-site facility staff member(s) has authorization and approval to disseminate messages.

4.3.2 Authorized Family and Guardians

The facility maintains a list (Designated Representative's Listing) of all identified authorized family member's and guardian's (responsible parties') contact information, including phone numbers and email addresses at the facility and they are also located on each resident's face sheet in the electronic medical record. Such individuals will receive information about the facility's preparedness efforts upon admission.

During an incident, the facility will notify responsible parties about the incident, status of the resident, and status of the facility by phone or email. Additional updates may be provided on a

regular basis to keep residents relatives/responsible parties apprised of the incident and the response.

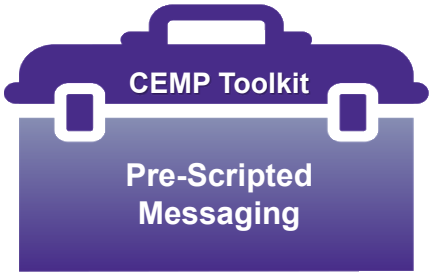
The initial notification message to residents' primary point of contact (e.g., relative) will include the following information:

- Nature of the incident;
- Status of resident;
- Restrictions on visitation; and
- Estimated duration of protective actions
- Any other information pertinent to the presenting incident

When incident conditions do not allow the facility to contact residents' relatives/responsible parties in a timely manner, or if primary methods of communication are unavailable, the facility will utilize local or state health officials, the facility website, and/or a recorded outgoing message on voicemail, among other methods, to provide information to families on the status and location of residents.

4.3.3 Media and General Public

During an emergency, the facility will utilize traditional media (e.g., television, newspaper, radio) and social media (e.g., Facebook, Twitter) to keep relatives and responsible parties aware of the situation and the facility's response posture.



The Incident Commander—or Public Information Officer, if activated—may assign a staff member to monitor the facility's social media pages and email account to respond to inquiries and address any misinformation.

5 Administration, Finance, Logistics

5.1 Administration

5.1.1 Preparedness

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

- Identify and develop roles, responsibilities, and delegations of authority for key decisions and actions including the approval of the CEMP;
- Ensure key processes are documented in the CEMP;
- Coordinate annual CEMP review, including the *Annexes for all hazards*;
- Ensure CEMP is in compliance with local, state, and federal regulations; and
- Review and revise the Hazard Vulnerability Analysis for potential hazards at least annually

5.2 Finance

5.2.1 Preparedness

The facility's corporate/parent organization, Catholic Health Services will assist the facility with any financial needs during any incident

5.2.2 Incident Response

Financial functions during an incident include tracking of personnel time and related costs, initiating contracts, arranging for personnel-related payments and Workers' Compensation, tracking of response and recovery costs, and payment of invoices.

The Finance/Administration Section Chief or designee will account for all direct and indirect incident-related costs from the outset of the response, including:

- Personnel (especially overtime and supplementary staffing)
- Event-related resident care and clinical support activities
- Incident-related resources
- Equipment repair and replacement
- Costs for event-related facility operations
- Vendor services
- Personnel illness, injury, or property damage claims
- Loss of revenue-generating activities
- Cleanup, repair, replacement, and/or rebuild expenses

5.3 Logistics

5.3.1 Preparedness

Logistics functions prior to an incident include identifying and monitoring emergency resource levels, and executing mutual aid agreements, resource service contracts, and memorandums of understanding. These functions will be carried out pre-incident by the Administrator or their designee.

5.3.2 Incident Response

To assess the facility's logistical needs during an incident, the Logistics Section Chief or designee will complete the following:

- Regularly monitor supply levels and anticipate resource needs during an incident;
- Identify multiple providers of services and resources to have alternate options in case of resource or service shortages; and
- Coordinate with the Finance Section Chief to ensure all resource and service costs are being tracked.
- Restock supplies to pre-incident preparedness levels,
- Coordinate distribution of supplies to service areas.

6 Plan Development and Maintenance

To ensure plans, policies, and procedures reflect facility-specific needs and capabilities, the facility will conduct the following activities:

Table 1011: Plans, Policies, and Procedures

Activity	Led By	Frequency
Review and update the facility's risk assessment.	Administrator Director of PI Management team	Annually
Review and update contact information for response partners, vendors, and receiving facilities.	Administrator Department Directors CHS Supply Chain	Annually or as response partners, vendors, and host facilities provide updated information.
Review and update contact information for staff members and residents' emergency contacts.	CHS Human Resources GSNR Payroll Coordinator Director of Social Services	Annually or as staff members provide updated information.
Review and update contact information for residents' point(s) of contact (i.e., relatives/responsible parties).	Admissions Coordinator Director of Social Services	At admission/readmission, at each Care Plan Meeting, and as residents, relatives, and responsible parties provide updated information.
Post clear and visible facility maps outlining emergency resources at all nurses' stations, staff areas, hallways, and at the front desk.	GSNR Maintenance	Annually
Maintain electronic versions of the CEMP in folders/drives that are accessible by others.	Administrator Director of PI	Annually
Revise CEMP to address any identified gaps.	Administrator Director of PI	Upon completion of an exercise or real-world incident.
Inventory emergency supplies (e.g., potable water, food, resident care supplies, communication devices, batteries, flashlights,	Senior Facility Manager Director of Nutritional Services	Quarterly

7 Authorities and References

This plan may be informed by the following authorities and references:

- Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288, as amended, 42 U.S.C. 5121-5207)
- Title 44 of the Code of Federal Regulations, Emergency Management and Assistance
- Homeland Security Act (Public Law 107-296, as amended, 6 U.S.C. §§ 101 et seq.)
- Homeland Security Presidential Directive 5, 2003
- Post-Katrina Emergency Management Reform Act of 2006, 2006
- National Response Framework, January 2016
- National Disaster Recovery Framework, Second Edition, 2016
- National Incident Management System, 2017
- Presidential Policy Directive 8: National Preparedness, 2011
- CFR Title 42, Chapter IV, Subchapter G, Part 483, Subpart B, Section 483.73, 2016
- Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006
- March 2018 DRAFT Nursing Home Emergency Operations Plan – Evacuation
- NYSDOH Healthcare Facility Evacuation Center Manual
- Nursing Home Incident Command System (NHICS) Guidebook, 2017
- Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule
- NYSDOH Healthcare Facility Evacuation Center Metropolitan Area Regional Office Region Facility Guidance Document for the 2017 Coastal Storm Season
- NFPA 99 – Health Care Facilities Code, 2012 edition and Tentative Interim Amendments 12-2, 12-3, 12-5, and 12-6
- NFPA 101 – Life Safety Code, 2012 edition and Tentative Interim Amendments 12-1, 12-2, 12-3, and 12-4
- NFPA 110 – Standard for Emergency and Standby Power Systems, 2010 edition and Tentative Interim Amendments to Chapter 7
- 10 NYCRR Parts 400 and 415
- NYS Exec. Law, Article 2-B
- Public Health Service Act (codified at 42 USC §§ 243, 247d, 247d-6b, 300hh-10(c)(3)(b), 311, 319)
- Cybersecurity Information Sharing Act of 2015 (Pub. L. No. 114-113, codified at 6 U.S.C. §§ 1501 et seq.)
- Chapter 114 of the Laws of New York 2020.

Annexes

Annex A: Protective Actions

The Incident Commander may decide to implement protective actions for an entire facility or specific populations within a facility. A brief overview of protective action options is outlined in Table ~~*11*~~ Table 11. For more information, refer to the *NYSDOH Evacuation Plan Template*, *NYSDOH Healthcare Facility Evacuation Center Metropolitan Area Regional Office Region Facility Guidance Document for the 2018 Coastal Storm Season*, and the *NYSDOH Healthcare Facility Evacuation Center Manual*.

Table 11~~12~~: Protective Actions

Protective Action		Potential Triggers	Authorization
Defend-in-Place	**Defend-in-Place** is the ability of a facility to safely retain all residents during an incident-related hazard (e.g., flood, severe weather, wildfire).	▪ Unforeseen disaster impacts cause facility to shelter residents in order to achieve protection.	▪ May be initiated by the Incident Commander **ONLY** in the absence of a mandatory evacuation order. ▪ Does not required NYSDOH approval.
Shelter-in-Place	**Shelter-in-Place** is keeping a small number of residents in their present location when the risks of relocation or evacuation exceed the risks of remaining in current location.	▪ Disaster forecast predicts low impact on facility. ▪ Facility is structurally sound to withstand current conditions. ▪ Interruptions to clinical services would cause significant risk to resident health and safety.	▪ Can only be done for coastal storms. ▪ Requires pre-approval from NYSDOH prior to each hurricane season and re-authorization at time of the incident.

Protective Action		Potential Triggers	Authorization
Internal Relocation	**Internal Relocation** is the movement of residents away from threat within a facility.	▪ Need to consolidate staffing resources. ▪ Consolidation of mass care operations (e.g., clinical services, dining). ▪ Minor flooding. ▪ Structural damage. ▪ Internal emergency (e.g., fire). ▪ Temperature presents life safety issue.	▪ Determined by facility based on safety factors. ▪ If this protective action is selected, the NYSDOH Regional Office must be notified.
Evacuation	**Evacuation** is the movement of residents to an external location (e.g., a receiving facility) due to actual or anticipated unsafe conditions.	▪ Mandatory or advised order from authorities. ▪ Predicted hazard impact threatens facility capacity to provide safe and secure shelter conditions. ▪ Structural damage. ▪ Emergency and standby power systems failure resulting in facility inability to maintain suitable temperature.	▪ Refer to the *NYSDOH Evacuation Plan Template.*
Lockdown	**Lockdown** is a temporary sheltering technique used to limit exposure of building occupants to an imminent hazard or threat. When "locking down," building occupants will shelter inside a room and prevent access from the outside.	▪ Presence of an active threat (e.g., active shooter, bomb threat, suspicious package). ▪ Direction from law enforcement.	▪ Determined by facility based on the notification of an active threat on or near the facility premises.

Annex B: Resource Management

1. Preparedness

Additionally, the facility maintains an inventory of emergency resources and corresponding suppliers/vendors, for supplies that would be needed under all hazards, including:

- Generators
- Fuel for generators and vehicles
- Propane tanks
- Food and water for a minimum of 96 hours for staff and residents
- Disposable dining supplies and food preparation equipment and supplies
- Medical and over-the-counter pharmaceutical supplies
- Personal protective equipment (PPE), as determined by the specific needs for each hazard
- Emergency lighting, cooling, heating, and communications equipment
- Resident movement equipment (e.g., stair chairs, bed sleds, lifts)
- Durable medical equipment (e.g., walkers, wheelchairs, oxygen, beds)
- Linens, gowns, privacy plans
- Housekeeping supplies, disinfectants, detergents
- Resident specific supplies (e.g., identification, medical risk information, medical records, physician orders, Medication Administration Records, Treatment Administration Records, Contact Information Sheet, last 72 hours of labs, x-rays, nurses' notes, psychiatric notes, doctor's progress notes, Activities of Daily Living (ADL) notes, most recent History and Physical (H&P), clothing, footwear, and hygiene supplies)
- Administrative supplies

The facility's resource inventory will be updated annually to ensure that adequate resource levels are maintained, and supplier/vendor contact information is current.

2. Resource Distribution and Replenishment

During an incident, the Incident Commander—or Logistics Section Chief, if activated—will release emergency resources to support operations. The Incident Commander—or Operations Section Chief, if activated—will ensure the provision of subsistence needs.

The Incident Commander—or Planning Section Chief, if activated—will track the status of resources used during the incident. When defined resource replenishment thresholds are met, the Planning Section Chief will coordinate with appropriate staff to replenish resources, including:

- Procurement from alternate or nontraditional vendors
- Procurement from communities outside the affected region

- Resource substitution
- Resource sharing arrangements with mutual aid partners
- Request for external stockpile support from healthcare associations, local emergency management.

3. Resource Sharing

In the event of a large-scale or regional emergency, the facility may need to share resources with mutual aid partners or healthcare facilities in the community, contiguous geographic area, or across a larger region of the state and contiguous states as indicated.

4. Emergency Staffing

4.1. Off-Duty Personnel

If off-duty personnel are needed to support incident operations, the facility will conduct the following activities in accordance with facility-specific employee agreements:

Table 1213: Off-Duty Personnel Mobilization Checklist

Off-Duty Personnel Mobilization Checklist	
☐	The senior most on-site facility official will confirm that mobilization of off-duty personnel is permissible (e.g., overtime pay).
☐	Once approved, Department Managers will be notified of the need to mobilize off-duty personnel.
☐	Off-duty personnel will be notified of the request and provided with instructions including: ▪ Time and location to report ▪ Assigned duties ▪ Safety information ▪ Resources to support self-sufficiency (e.g., water, flashlight)
☐	Once mobilized, off-duty staff will report for duty as directed.
☐	If staff are not needed immediately, staff will be requested to remain available by phone.
☐	To mobilize additional off-duty staff, the facility may need to provide additional staff support services (e.g., childcare, respite care, pet care). These services help to incentivize staff to remain on site during the incident, but also need to be carefully managed (e.g., reduce liability, manage expectations).

☐	

4.2. Other Job Functions

In accordance with employment contracts, collective bargaining agreements, etc., an employee may be called upon to aid with work outside of job-prescribed duties, work in departments or carry out functions other than those normally assigned, and/or work hours in excess of (or different from) their normal schedule. Unless temporarily permitted by an Executive Order issued by the Governor under section 29-a of Executive Law, employees may not be asked to function out-of-scope of certified or licensed job responsibilities.

The Incident Management Team will request periodic updates on staffing levels (available and assigned). In addition to deploying clinical staff as needed for resident care activities, non-medical assignments from the labor pool may include:

- Security augmentation
- Runners / messengers
- Switchboard support
- Clerical or ancillary support
- Transportation
- Resident information, monitoring, and one-on-ones, as needed
- Preparing and/or serving meals, snacks, and hydration for residents, staff, visitors, and volunteers
- Cleaning and disinfecting areas, as needed
- Laundry services
- Recreational or entertainment activities
- Providing information, escorts, assistance, or other services to relatives and visitors
- Other tasks or assignments as needed within their skill set, training, and licensure/certification.

In accordance with employment contracts, collective bargaining agreements, etc., and at the determination of the Incident Commander, all or some staff members may be changed to 12-hour emergency shifts to maximize staffing. These shifts may be scheduled as around regular work hours, in six or 12-hour shifts, or as needed to meet facility emergency objectives.

4.3. Surge Staffing

If surge staffing is required—for example, staff has become overwhelmed—it may be necessary to implement surge staffing (e.g., staffing agencies).

The facility may coordinate with pre-established credentialed volunteers included in the facility roster or credentialed volunteers associated with programs such as Community Emergency Response Team (CERT), Medical Reserve Corps (MRC), and ServNY.

The facility will utilize emergency staffing as needed and as identified and allowed under executive orders issued during a given hazard/emergency.

Annex C: Emergency Power Systems

1. Capabilities

In the event of an electrical power disruption causing partial or complete loss of the facility's primary power source, the facility is responsible for providing alternate sources of energy for staff and residents (e.g., generator).

In accordance with the facility's plans, policies, and procedures,[11] the facility will ensure provision of the following subsistence needs through the activation, operation, and maintenance of permanently attached onsite generators:

- Maintain temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;
- Emergency lighting;
- Fire detection and extinguishing, and alarm systems; and
- Sewage and waste disposal.

2. Resilience and Vulnerabilities

Onsite generators and associated equipment and supplies are located, installed, inspected, tested, and maintained in accordance with the National Fire Protection Association's (NFPA) codes and standards.

In extreme circumstances, incident-related damages may limit generator and fuel source accessibility, operability, or render them completely inoperable. In these instances, an urgent or planned evacuation will be considered if a replacement generator cannot be obtained in a timely manner.

[11] CMS requires healthcare facilities to accommodate any additional electrical loads the facility determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies, and procedures. It is up to each facility to make emergency power system decisions based on its risk assessment and emergency plan.

Annex D: Training and Exercises

1. Training

To empower facility personnel and external stakeholders (e.g., emergency personnel) to implement plans, policies, and procedures during an incident, the facility will conduct the following training activities:

Table 1314: Training

Activity	Led By	Frequency
Conduct comprehensive orientation to familiarize new staff members with the CEMP, including PEP specific plans, the facility layout, and emergency resources.	In-service Coordinator	Orientation held within 10 days of employment.
Incorporate into annual educational update training schedule to ensure that all staff are trained on the use of the CEMP, including PEP specific plans, and core preparedness concepts.	In-service Coordinator	Annually
Maintain records of staff completion of training.	In-service Coordinator	Ongoing
Ensure that residents are aware appropriately of the CEMP, including PEP specific plans, including what to expect of the facility before, during, and after an incident.	Administrator Director Social Services	Repeat briefly at time of incident.
Identify specific training requirements for individuals serving in Incident Management Team positions.	Administrator	Annually and as needed

2. Exercises

To validate plans, policies, procedures, and trainings, the facility will conduct the following exercise activities:

Table 1415: Exercises

Activity	Led By	Frequency
Conduct one operations-based exercise (e.g., full-scale or functional exercise). [12]	Senior Facility Manager	Annually
Conduct one discussion-based exercise (e.g., tabletop exercise).	Senior Facility Manager	Annually

3. Documentation

3.1. Participation Records

In alignment with industry best practices for emergency preparedness, the facility will maintain documentation and evidence of course completion through sign in sheets or LMS electronic tracking.

3.2. After Action Reports

The facility will develop After Action Reports to document lessons learned from tabletop and full-scale exercises and real-world emergencies and to demonstrate that the facility has incorporated any necessary improvements or corrective actions.

After Action Reports will document what was supposed to happen; what occurred; what went well; what the facility can do differently or improve upon; and corrective action/improvement plan and associated timelines.

[12] If a facility activates its CEMP due to a disaster, the facility is exempt from the operational exercise for the year ending November 15. A facility is only exempt if the event is fully documented, a post-incident after action review is conducted and documented, and the response strengths, areas for improvement, and corrective actions are documented and maintained for three (3) years. However, the secondary requirement for a tabletop exercise still applies.

Annex E: Infectious Disease/Pandemic Emergency

The circumstances of infectious disease emergencies, including ones that rise to the level of a pandemic, vary due to multiple factors, including type of biological agent, scale of exposure, mode of transmission and intentionality. Infectious disease emergencies can include outbreaks, epidemics and pandemics. The facility must plan effective strategies for responding to all types of infectious diseases, including those that rise to the higher level of pandemic.

The following Infectious Disease/Pandemic Emergency Checklist outlines the hazard-specific preparedness, response, and recovery activities the facility should plan for that are unique to an incident involving infectious disease as well as those incidents that rise to the occasion of a pandemic emergency. The facility should indicate for each checklist item, how they plan to address that task.

The Local Health Department (LHD) of each New York State county, maintains prevention agenda priorities compiled from community health assessments. The checklist items noted in this Annex include the identified LHD priorities and focus areas. Nursing homes should use this information in conjunction with an internal risk assessment to create their plan and to set priorities, policies and procedures.

This checklist also includes all elements required for inclusion in the facility's Pandemic Emergency Plan (PEP), as specified within the new subsection 12 of Section 2803, Chapter 114 of the Laws of 2020, for infectious disease events that rise to the level of a pandemic.

To assure an effective, comprehensive and compliant plan, the facility should refer to information in Annex K of the CEMP Toolkit, to fully understand elements in the checklist including the detailed requirements for the PEP.

A summary of the key components of the PEP requirements for pandemic situations is as follows:

- development of a Communication Plan,

- development of protection plans against infection for staff, residents, and families, including the maintenance of a 2-month (60 day) supply of infection control personal protective equipment and supplies (including consideration of space for storage), and

- A plan for preserving a resident's place in and/or being readmitted to a residential health care facility or alternate care site if such resident is hospitalized, in accordance with all applicable laws and regulations.

Finally, any appendices and documents, such as regulations, executive orders, guidance, lists, contracts, etc. that the facility creates that pertain to the tasks in this Annex, and/or refers to in this Annex, should be attached to the corresponding Annex K of the CEMP Toolkit rather than attached here, so that this Annex remains a succinct plan of action.

Infectious Disease/Pandemic Emergency Checklist	
Preparedness Tasks for <u>all Infectious Disease Events</u>	
☐ Required	Provide staff education on infectious diseases (e.g., reporting requirements (see Annex K of the CEMP toolkit), exposure risks, symptoms, prevention, and infection control, correct use of personal protective equipment, regulations, including 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80), and Federal and State guidance/requirements The facility provides education to all staff regarding Infection Control and Management during the orientation process, annually and upon identification of new infectious process, outbreak or pandemic. These include but are not limited to: • General Infection Control Practices including Universal/Standard Precautions • General and specific precautions for infectious processes including monitoring and screening, if applicable • Hand Hygiene • Respiratory Etiquette • Information on Common Infectious Processes and any New Infectious Processes including prevention and management • Personal Protective Equipment-donning and doffing, when required, and appropriate disposal • Cleaning of resident areas and equipment between each resident use • Pandemic Policy and Plan • Outbreak Policy and Plan • Surge Policy and Plan • Emergency Management including Incident Command Center
☐ Required	Develop/Review/Revise and Enforce existing infection prevention, control, and reporting policies. All Infection Prevention and Control policies are reviewed at least annually and upon receipt of new information or regulations from the New York State Department of Health (NYSDOH) and/or Center for Disease Control (CDC). Policies are updated by the Infection Preventionist and reviewed and approved by administration personnel. Staff are educated on any changes or revisions to current policies The facility maintains compliance with reporting of infectious processes, outbreaks, pandemic/epidemic as per NYSDOH regulations (NORA, HERDS, NHSN)

☐ Recommended	Conduct routine/ongoing, infectious disease surveillance that is adequate to identify background rates of infectious diseases and detect significant increases above those rates. This will allow for immediate identification when rates increase above these usual baseline levels. The facility monitors all incidence of infection daily • New infections are reported through 24 hour report and discussed at morning huddle • Infection Preventionist is responsible for tracking incidence of infection and infection rates, including laboratory result monitoring • The facility maintains a contract with local hospital based laboratory that is also part of the Catholic Health Services System (CHS) and manages the laboratory service needs of the facility for residents and staff. • Infection Preventionist maintains a record of infections and historical infection rates • Any incidence of infection, increase in infections or symptoms are immediately reported to the Infection Preventionist (IP), Administrator (Adm), Director of Nursing (DNS), and the Medical Director for review, investigation, management, and reporting • Upon identification of signs/symptoms of an infectious process, monitoring and tracking are enhanced (line list, resident and employee tracking, screening and monitoring) • Residents may require isolation and/or specific precautions depending on the type of infectious process • If a potential outbreak or pandemic is suspected or identified, units may be closed, residents and staff may require cohorting. Visitation, group dining or group activities may be suspended. Resources will be reviewed and acquired as indicated to manage the presenting situation • Infection incidence will be reported as per NYSDOH regulations
☐ Recommended	Develop/Review/Revise plan for staff testing/laboratory services The facility is contracted with a local hospital based laboratory that is also part of the Catholic Health Service System (CHS) and manages the laboratory service needs of the facility for residents and staff. • Lab service technicians from the contracted laboratory collect required and ordered laboratory specimens from residents of the facility and transport them back to the laboratory for testing • Trained personnel (physicians, nurse practitioners, registered nurses) may collect specimens from residents and staff which are then transported to the laboratory for testing. • Results of testing are reported to the facility upon completion. Ordered and required testing is tracked to ensure completion and receipt of results • A copy of all resident testing results are provided to the Infection Preventionist, the

	unit where the resident resides for review by the attending physician or nurse practitioner, and registered nurse staffing and become part of the resident's permanent medical record. • A copy of all staff testing results are provided to the Infection Preventionist, Human Resources for review by the medical director and are part of the employees permanent health file • Based on the type of infectious process identified, daily screening and monitoring of residents and staff may be required and will be performed by registered nurse personnel of the facility as indicated by the NYSDOH and/or CDC. • Staff are directed not to report for work if ill and must report specified symptoms or confirmed diagnosis for tracking and prevention purposes • Staff may not return to work unless testing is negative or is cleared by a physician ~~or~~ medical director or employee health in accordance with NYSDOH regulations
☐ Required	Review and assure that there is, adequate facility staff access to communicable disease reporting tools and other outbreak specific reporting requirements on the Health Commerce System (e.g., Nosocomial Outbreak Reporting Application (NORA), HERDS surveys Administration staff and the Infection Preventionist have access to the Health Commerce System and required reporting formats, access is reviewed at least annually or upon replacement of staff. NORA and HERDS Surveys are completed in accordance with NYSDOH regulations or upon notification from the Health Commerce System Reportable events are outlined by regulation: • Outbreak or increased incidence of infectious process ○ Staphylococci ○ Vancomycin resistant enterococci ○ Pseudomonas ○ Clostridium difficile ○ Klebsiella ○ Acinteobacter • Inter-facility outbreaks ○ Influenza ○ Gastroenteritis ○ Pneumonia ○ Respiratory Syncytial Virus (RSV) ○ Covid-19 • Foodborne outbreaks

	• Infections associated with contaminated medicines, replacement fluids, or commercial products
	• Single cases of healthcare associated infections due to any diseases on the Communicable Disease Reporting list.
	  ○ Legionella
	  ○ Measles virus
	  ○ Invasive Group A streptococcus
	  ○ Staph aureus with reduced susceptibility to vancomycin
	• Clusters of TB (tuberculosis) test conversions
	• Single case of pulmonary or laryngeal tuberculosis
	• Increased or unexpected morbidity or mortality associated with medical devices, practices or procedures resulting in significant infections and/or hospital admissions
	• Closure of a unit or service due to infections

☐
Required
	Develop/Review/Revise internal policies and procedures, to stock up on medications, environmental cleaning agents, and personal protective equipment as necessary. (Include facility's medical director, Director of Nursing, Infection Control Practitioner, safety officer, human resource director, local and state public health authorities, and others as appropriate in the process)
	The facility maintains a sufficient number of supplies within the facility to maintain operations for at least 96 hours. Supplies are reviewed at least quarterly and are reviewed daily during increased incidence of usage.
	• Medications
	  ○ Maintains 5 day supply for current residents
	  ○ Emergency Omni Medication System supply of medications
	  ○ Emergency IV equipment supply
	  ○ Pharmacy vendor supply/Local pharmacy emergency supply
	• Personal Protective Equipment Emergency supply based on usage during the pandemic
	  ○ Additional 30 day supply acquired by August 31, 2020
	  ○ Additional 60 day supply will be acquired by September 30, 2020
	  ○ Emergency supply will be stocked at CHS storage area in close proximity to the facility to ensure access (CHS Deer Park Storage area)
	• Environmental Cleaning Supplies
	  ○ Facility based storage for at least 96 hours
	  ○ Additional supplies available through vendors agreements and contracts

	The facility is part of a Healthcare System-Catholic Health Services which assists the facility in obtaining any required supplies, works with all contracted agencies and vendors to ensure emergency availability of resources Each department will maintain a list of contracted agencies and vendors utilized as well as any emergency preparedness agreements

☐
Recommended
	Develop/Review/Revise administrative controls (e.g., visitor policies, employee absentee plans, staff wellness/symptoms monitoring, human resource issues for employee leave).
	
	These policies have been reviewed and revised in accordance with recent pandemic regulations and directives from the NYSDOH and the CDC
	
	• Visitation:
	  ○ Remains restricted in accordance with NYSDOH regulations. Designated Representatives, Residents, and Staff have been kept appraised of any changes to our visitation policies and NYSDOH directives
	• Employee Absentee Plans
	  ○ Monitoring/Screening of employees for current infectious process
	  ○ Directing staff not to report to work if ill
	  ○ Communicating symptoms and/or diagnosis of illness to facility, report to Infection Preventionist and Human Resources
	• Emergency staffing plan to ensure sufficient staff availability during increased absenteeism
	  ○ Daily staffing patterns are based on census and need of each unit
	  ○ Discontinue vacations and personal time off
	  ○ Elicit part-time and perdiem staff to work additional hours
	  ○ Paid overtime
	  ○ Clinical staff (RN, LPN, C.N.A.) fulfilling non-essential positions may be utilized for resident care
	  ○ Additional pay may be authorized for overtime hours during heightened needs such as pandemic/outbreak with administrative and CHS authorization
	  ○ CHS Human Resources will assist facilities with additional staffing needs
	  ○ In extreme circumstances voluntary medical personnel may be utilized as per policy and NYSDOH regulations
	
	• Staff Wellness/Symptoms Monitoring
	  ○ Daily monitoring/screening of staff upon arrival to facility as directed by the NYSDOH
	  ○ Directives to staff not to report to work if ill

	○ Staff to report symptoms and diagnosis during periods of absenteeism ○ Staff must be cleared by physician and medical director prior to return to work ○ Infection Preventionist and Human Resources to be kept appraised of all staff absenteeism and reported symptoms and/or diagnosis • Employee Leaves of Absence ○ Any employee requiring a leave of absence must contact CHS Human Resources for assistance
☐ Required	Develop/Review/Revise environmental controls (e.g., areas for contaminated waste) The facility has policies in effect related to Daily Cleaning, Terminal Cleaning, Management of Contaminated Waste In the event of an outbreak or pandemic, additional cleaning precautions are initiated • EPA hospital approved disinfectants are utilized with reference and compliance with contact time (kill time) as per manufacturers direction • Disinfectant wipes are utilized on all equipment between resident usages which are EPA hospital approved disinfectants. These are also utilized in compliance with manufacturers direction regarding contact time (kill time) • Common areas (lobby, dayrooms, care areas, public restrooms, cafeteria, lounges, conference rooms) and all major high-touch areas are cleaned multiple times per day, • Unit based common areas (nursing station, nutrition areas, staff restrooms, locker rooms) are cleaned multiple times daily, • Resident rooms are cleaned in accordance with isolation room cleaning standards, cleaning these rooms last, using a new mop head/floor cloth with each room. Separate dusting/cleaning cloths are utilized between each room or area. • Upon discharge or transfer of any resident, the room shall be cleaned in accordance with the Terminal Cleaning Policy
☐ Required	Develop/Review/Revise vendor supply plan for re-supply of food, water, medications, other supplies, and sanitizing agents. As previously indicated, the facility shall maintain a 96 hour supply of required resources to continue operations including but not limited to food, water, medications, cleaning and sanitizing agents, PPE, fuel, and any other required supplies based on the current emergency situation. Each department will maintain a list of contracted/vendor resources and will review emergency management plans and availability with them. The facility is part of a system, Catholic Health Services (CHS) who will also assist the

	facility in obtaining and maintaining a sufficient resource of supplies to maintain operations
☐ Required	Develop/Review/Revise facility plan to ensure that residents are isolated/cohorted and or transferred based on their infection status in accordance with applicable NYSDOH and Centers for Disease Control and Prevention (CDC) guidance Upon identification or notification, the facility will comply with NYSDOH and/or CDC guidance and directives in the event of any outbreak, epidemic or pandemic infectious disease process The facility will take the following steps to ensure proper isolation and cohorting to effectively manage and minimize transmission of the infectious process: • Specific units and/or unit areas will be designated to manage residents that are positive for the infection, and those that are suspected of the infection. • The facility will only accept residents who can be properly cared for and deemed negative via testing prior to admission/readmission unless otherwise directed by the NYSDOH • New admissions/readmissions will be isolated and monitored for 14 days (at a minimum) until it is confirmed they do not have the infectious process • All residents will be monitored daily for potential signs and symptoms of the infection • Residents who have tested positive will be transferred to the unit designated for the management of positive residents and will be placed in a single room or cohorted with another positive resident • Residents presenting with symptoms of the infection will continue to be monitored and tested and will be transferred to the designated unit for the management of suspected residents • Based on the census of positive residents, and suspected residents, a full unit may not be required but an isolated portion of the unit may be utilized to cohort these residents. The area of the unit will be separated by a divider with appropriate signage regarding entrance to the area, and signage regarding isolation/quarantine. • Residents who have symptoms that progress beyond the capability of the facility will be transferred to a local hospital for additional treatment as indicated by the attending physician, nurse practitioner or medical director. The accepting facility will receive information regarding the resident's current status, medical history, lab results, advanced directives. The transporting service and the hospital will be made aware verbally and in writing of the resident's current infectious status prior to transport to ensure proper management and preventative interventions. • Precautions to be taken for each resident in the cohort will be posted outside each residents room with PPE directives • Signage indicating the area is for isolation/quarantine shall be posted outside the area with directions regarding who may enter the area and precautions to be taken including PPE directives

	• PPE, hand hygiene and disinfectant supplies will be available in close proximity to the area and resident rooms
	• Trash cans will be available in each resident bathroom and throughout the area/unit to properly discard PPE
	• Residents may be removed from the isolation/quarantined area in accordance with NYDOH guidelines and returned to their regular room or a room that is not a designated cohort area.
	  ○ Positive residents who have completed their treatment and have tested negative
	  ○ Residents who had suspected symptoms, tested negative, and have completed the isolation/quarantine period
	• Negative residents shall not be permitted inside any cohort designated area
	• Residents in a cohort designated area may not leave the area for any reason unless directed to do so by clinical personnel and may not share any equipment, items, bathrooms with those in a non-cohorted area

☐ Recommended	Develop plans for cohorting, including using of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, and discontinuing any sharing of a bathroom with residents outside the cohort. As stated above, the facility will designate units or part of a unit for residents who are positive for the infection, and those who are suspected of having the infection Utilization of a full unit or part of a unit will be dependent on the census of positive and negative residents. If a portion of a unit is to be utilized it will be divided from the rest of the unit with a barrier or divider with appropriate signage indicating the area is isolated/quarantined. The facility will utilize the following areas for isolation, quarantine: • Unit: South Unit

☐ Recommended	Develop/Review/Revise a plan to ensure social distancing measures can be put into place where indicated
	Upon notification of an outbreak, epidemic, or pandemic, the facility will comply with guidance from the NYSDOH and/or CDC on appropriate actions to take which may include the following:
	• Restriction of visitation
	  ○ Visitation may be substituted with video conferencing with family members, phone calls, window visits as permitted by regulation
	• Restriction of community dining
	  ○ In place of community dining, residents will still indicate their meal preferences but will have food delivered to their designated rooms

	• Restriction of group/community activities ○ These will be replaced with activities within residents rooms such as individualized activity resources (games, puzzles), activities through television programs (mass), televised movies • Dayrooms will no longer be utilized or other communal areas, residents will be restricted to their rooms • Employee break/meal areas may have indicators of 6 feet social distancing and tables will be placed 6 feet apart.
☐ Recommended	Develop/Review/Revise a plan to recover/return to normal operations when, and as specified by, State and CDC guidance at the time of each specific infectious disease or pandemic event e.g., regarding how, when, which activities /procedures /restrictions may be eliminated, restored and the timing of when those changes may be executed. Upon advisement of the NYSDOH and CDC to return to normal operations, the facility administrator will meet with all department directors and establish a plan to return to normal operations The following areas will be reviewed: • Visitation • Dining • Communal Activity • Beauty Parlor Services • Volunteers • Church Services Precautions regarding the return of the infectious process, pandemic will also be discussed in accordance with NYSDOH and CDC regulations and directives
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Additional Preparedness Planning Tasks for <u>Pandemic Events</u>	
☐ Required	***In accordance with PEP requirements,*** Develop/Review/Revise a Pandemic Communication Plan that includes all required elements of the PEP The facility communication plan will assist the facility in maintaining situational awareness throughout the duration of an event. The facility will incorporate the following in its Communication Plan: • Maintain an up to date contact information listing of all resident designated

	representatives
	• Maintain an up to date contact information listing for all staff members
	• Designate and train personnel to serve as Public Information Officers prior to any incident
	  ○ FEMA IS-29 Public Information Officer
	  ○ FEMA IS-42 Social Media
	• Develop pre-scripted messages that have administrative approval prior to initiating any communication
	• Ensure multiple personnel have access to training, facility's website, social media and voice mail systems
	• Keep the Incident Management Team appraised of any new communications or directions from the NYSDOH, CDC or other agency prior to and during the event
	• Always inform internal personnel prior to external communications
	• Provide guidance to office personnel where to direct inquiries (media, personnel, relatives, designated representatives, vendors
	• Maintain a log of incoming calls with contact information and reason for inquiry
	• Update facility voicemail to provide alternative contact information in the event the facility is evacuated or to field incoming inquiries.
	• In the event of an emergent issue at the facility that requires restrictions or changes to normal operations, residents and staff will be informed, and designated representatives will be notifies by email or by phone depending on the event
	• In the event of a pandemic, the facility will notify the designated representatives of residents who have been affected by the infection of the residents status on a daily basis via phone communication. All designated representatives will receive weekly updates on the pandemic, and the status of the facility on a weekly basis via email. Those without access to email will be called with an update

☐ Required	***In accordance with PEP requirements,*** Development/Review/Revise plans for protection of staff, residents and families against infection that includes all required elements of the PEP. The facility will take measures to protect residents, staff and families against infection during any outbreak or pandemic: • Establish Incident Command Center and Incident Management Team for the event • Restrict communal events such as visitation, communal dining, communal activities, volunteers, and non-essential staff and activities as indicated through NYSDOH and CDC guidelines and regulations • Notify all staff, residents and designated representatives of the event and actions

	required to be taken • Provide education to staff, residents, and designated representatives regarding the infectious process, prevention, and management interventions • Establish screening/monitoring processes In accordance with NYSDOH and CDC guidelines • Initiate cohorting, isolation/quarantine policies in accordance with NYSDOH and CDC guidelines • Ensure adequate signage and indication of all restricted areas within the facility • Ensure Precaution signs on entrance to resident rooms for those affected by the infection • Review all pertinent policies and procedures for revision based on current event
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Response Tasks for <u>all Infectious Disease Events</u>:	
☐ Recommended	The facility will implement the following procedures to obtain and maintain current guidance, signage, advisories from the NYSDOH and the U.S. Centers for Disease Control and Prevention (CDC) on disease-specific response actions, e.g., including management of residents and staff suspected or confirmed to have disease: The facility will maintain communication with the NYSDOH, CDC, and Health Commerce System to ensure regular updates on the current event. Contact information regarding administrative personnel to be notified by each agency will be kept updated Facility Administration personnel will review websites daily for any changes or updates
☐ Required	The facility will assure it meets all reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYCRR 2.10 Part 2), as well as by 10 NYCRR 415.19. (see Annex K of the CEMP toolkit for reporting requirements). Administration staff and the Infection Preventionist have access to the Health Commerce System and required reporting formats, access is reviewed at least annually or upon replacement of staff. NORA and HERDS Surveys are completed in accordance with NYSDOH regulations or upon notification from the Health Commerce System Reportable events are outlined by regulation: • Outbreak or increased incidence of infectious process ○ Staphylococci

	○ Vancomycin resistant enterococci ○ Pseudomonas ○ Clostridium difficile ○ Klebsiella ○ Acinteobacter • Inter-facility outbreaks ○ Influenza ○ Gastroenteritis ○ Pneumonia ○ Respiratory Syncytial Virus (RSV) ○ Covid-19 • Foodborne outbreaks • Infections associated with contaminated medicines, replacement fluids, or commercial products • Single cases of healthcare associated infections due to any diseases on the Communicable Disease Reporting list. ○ Legionella ○ Measles virus ○ Invasive Group A streptococcus ○ Staph aureus with reduced susceptibility to vancomycin • Clusters of TB (tuberculosis) test conversions • Single case of pulmonary or laryngeal tuberculosis • Increased or unexpected morbidity or mortality associated with medical devices, practices or procedures resulting in significant infections and/or hospital admissions • Closure of a unit or service due to infections
☐ Required	The facility will assure it meets all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting Administration staff and the Infection Preventionist have access to the Health Commerce System and required reporting formats, access is reviewed at least annually or upon replacement of staff. NORA and HERDS Surveys are completed in accordance with NYSDOH regulations or upon notification from the Health Commerce System

☐ Recommended	The Infection Control Practitioner will clearly post signs for cough etiquette, hand washing, and other hygiene measures in high visibility areas. Consider providing hand sanitizer and face/nose masks, if practical. The facility's Infection Control Preventionist will ensure that appropriate signage will be placed within the facility, at entrance to the facility, outside restricted areas, and outside affected resident rooms in accordance with NYSDOH and CDC regulations and guidance for the presenting event Masks and other required PPE will be provided to staff on a daily basis Hand Sanitizer will be readily available in all resident care areas Staff are educated during orientation, annually and upon identification of need regarding hand hygiene, PPE, and infection control measures
☐ Recommended	The facility will implement the following procedures to limit exposure between infected and non-infected persons and consider segregation of ill persons, in accordance with any applicable NYSDOH and CDC guidance, as well as with facility infection control and prevention program policies Upon identification or notification, the facility will comply with NYSDOH and/or CDC guidance and directives in the event of any outbreak, epidemic or pandemic infectious disease process The facility will take the following steps to ensure proper isolation and cohorting to effectively manage and minimize transmission of the infectious process: • Specific units and/or unit areas will be designated to manage residents that are positive for the infection, those that are suspected of the infection, and those that are newly admitted or readmitted. • The facility will only accept residents who can be properly cared for and deemed negative via testing prior to admission/readmission unless otherwise directed by the NYSDOH • New admissions/readmissions will be isolated and monitored for 14 days (at a minimum) until it is confirmed they do not have the infectious process • All residents will be monitored daily for potential signs and symptoms of the infection • Residents who have tested positive will be transferred to the unit designated for the management of positive residents and will be placed in a single room or cohorted with another positive resident • Residents presenting with symptoms of the infection will continue to be monitored and tested and will be transferred to the designated unit for the management of suspected residents • Based on the census of positive residents, and suspected residents' full unit may not be required but an isolated portion of the unit may be utilized to cohort these residents. The area of the unit will be separated by a divider with appropriate signage regarding entrance to the area, and signage regarding

	isolation/quarantine.
	• Residents who have symptoms that progress beyond the capability of the facility will be transferred to a local hospital for additional treatment as indicated by the attending physician, nurse practitioner or medical director. The accepting facility will receive information regarding the resident's current status, medical history, lab results, advanced directives. The transporting service and the hospital will be made aware verbally and in writing of the resident's current infectious status prior to transport to ensure proper management and preventative interventions.
	• Precautions to be taken for each resident in the cohort will be posted outside each residents room with PPE directives
	• Signage indicating the area is for isolation/quarantine shall be posted outside the area with directions regarding who may enter the area and precautions to be taken including PPE directives
	• PPE, hand hygiene and disinfectant supplies will be available in close proximity to the area and resident rooms
	• Trash cans will be available in each resident's bathroom and throughout the area/unit to properly discard PPE
	• Residents may be removed from the isolation/quarantined area in accordance with NYDOH guidelines and returned to their regular room or a room that is not a designated cohort area
	  ○ Positive residents who have completed their treatment and have tested negative
	  ○ Residents who had suspected symptoms, tested negative, and have completed the isolation/quarantine period
	• Negative residents shall not be permitted inside any cohort designated area
	• Residents in a cohort designated area may not leave the area for any reason unless directed to do so by clinical personnel and may not share any equipment, items, bathrooms with those in a non-cohorted area

☐ Recommended	The facility will implement the following procedures to ensure that as much as is possible, separate staffing is provided to care for each infection status cohort, including surge staffing strategies: The facility, to the extent possible, will cohort staff to the designated areas of residents who are positive for the infection, residents who are suspected of having the infection and residents that are newly admitted/readmitted to the facility. In the event of increased absenteeism, additional staff may have to be assigned to those areas and remain assigned to the same areas Staffing will be adjusted according to census on the designated units In the event the facility has to provide care to additional residents (greater than usual census), the facility's Surge Policy will be instituted which includes the addition of staff to

	treat and care for increased census. Staff will be cohorted to these areas as well, to the extent possible.
☐ Recommended	The facility will conduct cleaning/decontamination in response to the infectious disease in accordance with any applicable NYSDOH, EPA and CDC guidance, as well as with facility policy for cleaning and disinfecting of isolation rooms. The facility has policies in effect related to Daily Cleaning, Terminal Cleaning, Management of Contaminated Waste In the event of an outbreak or pandemic, additional cleaning precautions are initiated • EPA hospital approved disinfectants are utilized with reference and compliance with contact time (kill time) as per manufacturers direction • Disinfectant wipes are utilized on all equipment between resident usages which are EPA hospital approved disinfectants. These are also utilized in compliance with manufacturers direction regarding contact time (kill time) • Common areas (lobby, dayrooms, care areas, public restrooms, cafeteria, lounges, conference rooms) and all major high-touch areas are cleaned multiple times per day, • Unit based common areas (nursing station, nutrition areas, staff restrooms, locker rooms) are cleaned multiple times daily, • Resident rooms are cleaned in accordance with isolation room cleaning standards, cleaning these rooms last, using a new mop head/floor cloth with each room. Separate dusting/cleaning cloths are utilized between each room or area. • Upon discharge or transfer of any resident, the room shall be cleaned in accordance with the Terminal Cleaning Policy
☐ Required	The facility will implement the following procedures to provide residents, relatives, and friends with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information The facility will maintain a listing of each residents designated representative and contact information Upon notification of an event disrupting normal operations, the facility shall notify all residents of the event, infectious disease and the signs, symptoms and preventative measures required • Residents shall be educated on the unit where they reside by clinical personnel • Designated representatives will be notified via email of the event. If email is not an option, the designated representative will be notified by phone or mail • In the event of an outbreak or pandemic, the designated representatives will be notified via phone call if their family member/resident has been affected and will receive daily updates via phone call until resolved. All other designated representatives will receive a weekly update regarding the event on a weekly

	basis.
☐ Recommended	The facility will contact all staff, vendors, other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents As part of a system, Catholic Health Services, the President and CEO as well as the Chief Medical Officer will be kept appraised of the facility's status, and any new changes or updates. Each department will maintain a list of current vendors/contracts and will notify them of any event affecting facility operations and interventions instituted to manage the current situation including but not limited to restricted access to the facility or resident care areas, screening/monitoring activities, required PPE Other stakeholders such as emergency management, fire and police departments, NYSDOH will be notified of emergency management policies as indicated
☐ Required	Subject to any superseding New York State Executive Orders and/or NYSDOH guidance that may otherwise temporarily prohibit visitors, the facility will advise visitors to limit visits to reduce exposure risk to residents and staff. If necessary, and in accordance with applicable New York State Executive Orders and/or NYSDOH guidance, the facility will implement the following procedures to close the facility to new admissions, limit visitors when there are confirmed cases in the community and/or to screen all permitted visitors for signs of infection: The facility will comply with NYS Executive Orders and/or NYSDOH guidance in the event of a pandemic or other infectious process that may require limitation of visitation for the protection of residents, staff and family members. Residents and designated representatives will be notified of any changes to visitation policies. If limited visitation is permitted by regulation and guidance such as end-of-life visits, designated representatives will be screened for the infectious process and be provided with any necessary PPE to ensure protection. The facility will close to new admissions only upon the direction of the NYSDOH.
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Additional Response Tasks for <u>Pandemic Events</u>:	
☐ Recommended	Ensure staff are using PPE properly (appropriate fit, don/doff, appropriate choice of PPE per procedures) Staff are educated and practice use of PPE including donning and doffing of PPE during orientation, annually and upon identification of an infectious process requiring PPE

	Staff are educated on all types of precautionary measures that may occur at any time at the facility during orientation, annually and upon identification of an infectious process Residents requiring specific PPE will have signage indicated outside their door for review by staff prior to entry Designated staff are seal tested for N-95 masks
☐ Required	***In accordance with PEP requirements,*** the facility will follow the following procedures to post a copy of the facility's PEP, in a form acceptable to the commissioner, on the facility's public website, and make available immediately upon request: The facility's Pandemic Emergency Plan upon completion and approval will be posted on the facility's website utilizing the NYSDOH CEMP Template and Annex E with reference to Annex K in the toolkit The facility will post the plan by September 15, 2020 Any updates will be posted within 15 days of the change The facility will maintain an electronic copy of the plan and a printed copy of the plan that is immediately available upon request
☐ Required	**In accordance with PEP requirements,** the facility will utilize the following methods to update authorized family members and guardians of infected residents (i.e., those infected with a pandemic-related infection) at least once per day and upon a change in a resident's condition: The facility will notify the designated representatives of those affected by the pandemic upon diagnosis via phone communication by the attending physician or registered nurse assigned to that resident. The designated representative will receive daily updates of the resident's condition and will be notified of any changes in condition at least daily via phone communication.
☐ Required	***In accordance with PEP requirements***, the facility will implement the following procedures/methods to ensure that all residents and authorized families and guardians are updated at least once a week on the number of pandemic-related infections and deaths at the facility, including residents with a pandemic-related infection who pass away for reasons other than such infection: The facility will maintain an updated list of all resident designated representatives, contact information will be reviewed during quarterly Comprehensive Care Plan meetings Designated representatives will receive a weekly email designed to update them on the pandemic and the facility's status related to the pandemic including but not limited to: • Advisory updates from the NYSDOH • New Pandemic related infections (residents and staff) • Total number of Pandemic related Infections (residents and staff)

	• Number of deaths within the facility • Number of Pandemic related deaths within the facility (residents and staff)
☐ Required	***In accordance with PEP requirements***, the facility will implement the following mechanisms to provide all residents with no cost daily access to remote videoconference or equivalent communication methods with family members and guardians: Each resident has access to phone communication with designated representatives and family members. The phone number for each resident is provided to the designated representative Videoconferencing (i.e. Facetime) is available and can be arranged through the Recreation Department. The department will arrange an appointment upon request from the resident or designated representative. The department will also ensure all residents are aware of videoconferencing and will ask them if they wish to make an appointment. Some residents also have some of their own devices, cell phones, Ipads, etc, the staff will assist them with videoconferencing on these devices as requested
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following process/procedures to assure hospitalized residents will be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); and 42 CFR 483.15(e): As per the facility's Bed hold Policy and NYSDOH regulations, the facility shall hold a bed within the facility for the residents return. Whenever possible, the facility will attempt to hold the resident's assigned room prior to transfer.
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following process to preserve a resident's place in a residential health care facility if such resident is hospitalized, in accordance with all applicable laws and regulations including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e): As per the facility's Bed hold Policy and NYSDOH regulations, the facility shall hold a bed within the facility for the residents return. Whenever possible, the facility will attempt to hold the resident's assigned room prior to transfer.
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following planned procedures to maintain or contract to have at least a two-month (60-day) supply of personal protective equipment (including consideration of space for storage) or any superseding requirements under New York State Executive Orders and/or NYSDOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic. As a minimum, all types of PPE found to be necessary in the COVID pandemic should be included in the 60-day stockpile. This includes, but is not limited to: – N95 respirators

	– Face shield – Eye protection – Gowns/isolation gowns – Gloves – Masks – Sanitizer and disinfectants (meeting EPA Guidance current at the time of the pandemic) The facility maintains a sufficient number of supplies within the facility to maintain operations for at least 96 hours. Supplies are reviewed at least quarterly and are reviewed daily during increased incidence of usage. • Medications ○ Maintains 5 day supply for current residents ○ Emergency Omni Medication System supply of medications ○ Emergency IV equipment supply ○ Pharmacy vendor supply/Local pharmacy emergency supply • Personal Protective Equipment Emergency supply based on usage during the pandemic ○ Additional 30 day supply acquired by August 31, 2020 ○ Additional 60 day supply will be acquired by September 30, 2020 ○ Emergency supply will be stocked at CHS storage area in close proximity to the facility to ensure access (CHS Deer Park Storage area) • Environmental Cleaning Supplies ○ Facility based storage for at least 96 hours ○ Additional supplies available through vendors agreements and contracts The facility is part of a Healthcare System-Catholic Health Services which assists the facility in obtaining any required supplies, works with all contracted agencies and vendors to ensure emergency availability of resources Each department will maintain a list of contracted agencies and vendors utilized as well as any emergency preparedness agreements
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Recovery for <u>all Infectious Disease Events</u>	
☐ Required	The facility will maintain review of, and implement procedures provided in NYSDOH and CDC recovery guidance that is issued at the time of each specific infectious disease or pandemic event, regarding how, when, which activities/procedures/restrictions may be eliminated, restored and the timing of when those changes may be executed.

	The facility will maintain a copy of NYSDOH and CDC guidance and regulation regarding recovery from a pandemic event Upon advisement of the NYSDOH and CDC to return to normal operations, the facility administrator will meet with all department directors and establish a plan to return to normal operations The following areas will be reviewed: • Visitation • Dining • Communal Activity • Beauty Parlor Services • Volunteers • Church Services Precautions regarding the return of the infectious process, pandemic will also be discussed in accordance with NYSDOH and CDC regulations and directives
☐ Required	The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders The facility will keep residents, staff, and designated representatives appraised of any updates or changes provided by the NYSDOH and CDC • Residents will be notified by the clinical staff on their units • Staff will be updated by Administration and/or Incident Management Team • Designated representatives will be notified by email or by alternate method of choice
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