

## Annex B.7- Emerging Infectious Disease/Pandemic Emergency Plan

### Definitions:

#### Emerging Infectious diseases (EIDs)

Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:

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

#### Pandemic

A sudden infectious disease outbreak that becomes very widespread and affects a whole region, continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

#### Isolation

Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.

#### Quarantine

Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been exposed to prevent the spread of the disease.

### General Preparedness for Emerging Infectious Diseases (EIDs)/Pandemic

- a. Develop/review/revise and enforce existing infection prevention, control and reporting policies. The facility's Infection Prevention and Control Policy will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza, coronavirus (COVID-19).
- b. Medical Director/Clinical leadership/Infection Preventionist will be vigilant and stay informed about EIDs around the world. They will keep administrative leadership briefed as needed on potential risks of new infections in their community and region.
- c. The facility will maintain at a least a two-month stockpile supply of personal protective equipment (PPE) including surgical mask, N-95 respirators, face shield/eye protection, gowns/isolation gowns, gloves, sanitizer and disinfectants.
- d. The facility will develop/review/revise plans with Finger Lakes Health emergency management, materials management, and/or vendors for re-supply of food, medications, sanitizing and environmental cleaning agents, and PPE in the event of a disruption to normal business including an EID outbreak or Pandemic.
- e. The facility will develop/review/revise environmental controls (e.g., areas for contaminated waste) in conjunction with FLH Facilities Director and Housekeeping Manager.
- f. The facility will provide annual education on infectious diseases, exposure risk, symptoms, prevention, and infection control, correct use of personal protective equipment, regulations and Federal and State guidance/requirements. The facility will provide education/training, and test staff knowledge and competency utilizing computer based learning (Netlearning), read and signs, in-person education/competency and/or various exercises/drills.
- g. 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. The facility's administrator, director of nursing, infection preventionist and other personnel deem necessary will have access to HCS and HERDS reporting. The facility administrator grants permission to access HCS and assigns reporting responsibilities.
- h. This plan will:
  - i. include administrative controls (screening, isolation, visitor policies and employee absentee plans, human resource issues for employee leave).

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- ii. address environmental controls (isolation areas/rooms, plastic barriers, sanitation stations, and special areas for contaminated waste)
  - iii. communication plan
  - iv. protection plans against infection for staff, residents and families.
  - v. ensure residents are isolated/cohorted and/or transferred based on their infection status in accordance with applicable NYSDOH and CDC guidance.
- i. The facility will follow the following procedures to post a copy of this plan, in a form acceptable to the commissioner, on the facility's public website, and make available immediately upon request:
- a. This plan will be prepared within 90 days of the effective date of the bill and annually thereafter.
  - b. The emergency management committee will review this plan, and revise if necessary, at least annually.
  - c. Once approved, FLH Community Services will post this plan to the facility's website.
  - d. This plan will be readily available upon request via hard copy in emergency plan binders, and electronic copy via LTC desktop emergency folder and DocuShare.

## GENERAL ACTIONS APPLICABLE TO ALL STAFF

Healthcare must always be prepared to protect people within our buildings and to protect our residents, families, and staff from harm resulting from exposure to an emerging infectious disease or pandemic while they are in the facility.

Every disease is different. The local, state, and federal health authorities will be the source of the latest information and most up-to-date guidance on prevention, case definition, surveillance, treatment, and skilled nursing response related to a specific disease threat.

The procedures outlined are designed to help protect our residents, families, and staff from harm resulting from exposure to an emerging infectious disease or pandemic.

Incidents involving an emerging infectious disease, or suspected case, require the consultation of the facility Medical Director and/or other physician in addition to referring to the facility's Infection Control and Prevention Plan.

### Hand Hygiene

Hand hygiene is the single most important practice to reduce the transmission of infectious agents in healthcare settings. This includes hand washing with either plain or antiseptic-containing soap and water, or the use of alcohol-based products (gels, rinses, and foams) that do not require the use of water. (Refer to FLH Hand Hygiene Policy)

### Standard Precautions

The basic principle is that all residents may be colonized with a resistant organism or blood borne pathogen; therefore, the healthcare worker needs to apply this principle in the care of all residents during each interaction. (Refer to LTC Infection Control Practices Policy)

### Contact Precautions

For residents with known or suspected epidemiologically important infections or colonization with resistant organisms transmitted by direct or indirect contact with residents or the environment (e.g., wound infections, colonization with MRSA, VRE, resistant gram-negative bacilli, RSV infection, skin infections (herpes zoster), C. difficile infection or other types of infectious diarrhea), excessive wound drainage and fecal incontinence. (Refer to LTC Contact Precautions Policy)

### Droplet Precautions

Prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain airborne over long distances, special air handling and ventilation are not required. Infectious agents for which droplet precautions are indicated include Bordetella pertussis, influenza virus, coronavirus, adenovirus, rhinovirus, Neisseria meningitides, and group A Streptococcus (for the first 24 hours of antimicrobial therapy). (Refer to LTC Droplet Precautions Policy)

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## **Airborne Isolation**

Residents known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance. (LTC sites do not have negative pressure rooms available; resident should be transferred to acute and FLH Airborne Isolation Policy will be followed as necessary.)

## **ADMINISTRATION / CLINICAL LEADERSHIP “CONSIDERATIONS” TO PROTECT RESIDENT, FAMILIES AND EMPLOYEES.**

The leadership team will consider its requirements under OSHA, Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state or federal laws in determining the precautions it will take to protect its residents, families and employees. Protecting the residents, families and employees shall be of paramount concern. The leadership team shall take into account:

- The degree of frailty of the residents in the facility.
- The likelihood of the infectious disease being transmitted to the residents, employees and families/visitors.
- The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces).
- The precautions which can be taken to prevent the spread of the infectious disease and other relevant factors.
- Once these factors are considered, the leadership team in conjunction with Employee Health will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.
- Apply whatever action is taken uniformly to all staff in like circumstances.
- Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.
- Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this as directed by Human Resources.
- Permit employees to use sick leave, vacation time, and FMLA where appropriate while they are out of work as directed by Human Resources.
- Permit employees to return to work when cleared by Employee Health; however, additional precautions may be taken to protect the residents.
- Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline.

## **INCIDENT COMMANDER/ ADMINISTRATOR**

- Assess impact on facility operations and resident care. Develop an action plan and determine need to activate Incident Command to manage the incident.
- Work with Director of Nursing/ Medical Director and/or designee to review incident considerations, determine level of service and rescheduling necessities.
- Consider activating the Command Center to ensure procedures are in place.

### **Communications**

- Provide staff with incident updates, as necessary.
- Prepare media statements, as necessary. Community services will review and approve prior to release.
- Ensure appropriate external and internal notifications have taken place.
- Determine need to contact the following:
  - Local/State Department of Health
  - CDC
  - Department of Health and Human Services
- Implement communication plan for residents and their families.
  - Director of Nursing/Nurse Manager/Designee will update authorized families and guardians of infected residents (i.e. those infected with a pandemic- related infection) at least once per day on resident’s condition and upon a change in resident’s condition.

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- The facility will implement the following 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:
  - Announce status notifications of confirmed cases and pandemic-related deaths in the facility on the facility's website, information line, and/or email notifications to resident's point of contact, if applicable.
  - Social work/designee may notify in-house residents by verbal communication, resident council meetings or memos.
- Videoconferencing (FaceTime, Skype, etc.) will be available to all residents daily with no cost for resident and family/guardian communication. The facility will maintain and utilize designated communication devices (tablets and cell phones). Social worker/designee will be responsible for arranging and scheduling videoconference visits.
- Develop a communications plan to interact with other external entities (local responders, other healthcare facilities, etc.) during a regional incident.

## Reporting

- Assure all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting. Incident Commander/Administrator will:
  - determine personnel to gather required data
  - review HCS assigned roles and contact information
  - assign personnel responsibilities for reporting
- Assure all reporting requirement 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.
  - Employee Health is responsible for reporting staff suspected or confirmed cases
  - Infection Preventionist/designee is responsible for reporting resident suspected or confirmed cases.

## Assessment

- Assess visitation or need to order building lockdown.
  - 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 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:
    - Admission mandatory 14-day precautionary measure, or suspend new admissions.
    - Facility building lockdown
    - Professional Visitors: No one allowed in facility without Command Center clearance and meet appropriate screening (temperature, signs & symptoms, and exposure) criteria determined by Command Center.
    - Resident Visitors: No one allowed in facility. Relatives and responsible parties will be given appropriate information and location for updates/notifications as directed by the Command Center. Command center will determine exception to end-of-life or compassionate care visits, and screening criteria.
- Request an assessment of critical supplies throughout the facility.
  - Direct departments to conduct assessments of food, water, medical and other supplies.
  - Review agreements with vendors, in conjunction with materials management. Request vendor support to ensure sufficient supplies are on hand including: PPE, medications, medical supplies/equipment, food/water and environmental cleaning agents.
  - 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.

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As a minimum, all types of PPE found to be necessary in a 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)

- FLH Materials Management will assist the facility in procuring, maintaining and storing at least a two month (60-days) supply of PPE based on the facility's burn rate as determined through region benchmarks and NYSDOH.
- The facility will assess the supply needs and daily burn rate based on facility census, not capacity. In the event that the burn rate should change, the incident commander/administrator will notify Materials Management who will assist in obtaining more supplies.
- The stockpile will be maintained in a central location and available upon demand.

## **Staffing**

- Determine need for further staff education efforts, as necessary, relative to the current threat or infectious disease.
- Review staffing levels and scheduling. Ensure sufficient staffing resources for sustaining operations for the duration of the event.
- Consider activating Labor Pool to assign staff to supplement current staffing.
- Determine if shift changes will be possible. If not, make provisions for adequate scheduling of on-duty staff, including eating and sleeping arrangements.
- Develop/Review/Revise plan for staff testing and laboratory service in conjunction with Employee Health and Hospital Laboratory.

## **Local Threat Procedures**

- Once notified by the public health authorities at either the federal, state and/or local level that the EID/Pandemic is likely to or already has spread to the facility's community, the facility will activate specific surveillance and screening as instructed by the Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities.
- The facility's Infection Control Practitioner will research the specific signs, symptoms, incubation period, route of infection, the risks of exposure, and the recommendations for skilled nursing facilities as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state, and federal public health agencies.
- Working with advice from the facility's Medical Director or clinical consultant, local and state public health authorities, and others as appropriate. The Infection Control Practitioner will review and revise internal policies and procedures, and communicate with related department to ensure stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.
- Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.
- If EID is spreading through an airborne route, then the facility will transfer suspected or infected resident to acute facility for airborne isolation and treatment. If non-critical resident must be managed in the facility due to surge, Infection Control and Employee Health personnel will initiate a respiratory protection plan to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.
- 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. This information may be provided via website, information line, or email.
- Brief contractors and other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents.

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- Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along with the instruction that anyone who is sick must not enter the building.
- To ensure that staff, and/or new residents are not at risk of spreading the EID into the facility, screening for exposure risk and signs and symptoms, and testing if available, may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work. Follow admission precautionary measure protocols as necessary.
- Self-screening: Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
  - Reporting any suspected exposure to the EID while off duty to their supervisor and public health.
  - Precautionary removal of employees who report an actual or suspected exposure to the EID.
  - Self-screening for symptoms prior to reporting to work.
  - Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and/or Employee Health, and in compliance with appropriate labor laws.
- Self-isolation: In the event there are confirmed cases of the EID in the local community, the facility may consider closing the facility to new admissions and limiting visitors based on the advice of local public health authorities.
- Environmental cleaning: The facility will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
- Engineering controls: The facility will use appropriate physical plant alterations as available such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

### **Suspected Case within the Facility**

- Place a resident who exhibits symptoms of the EID in a private room, if available, or maintain the resident in their room (If the resident is in a semi-private room with another resident, the roommate will be treated as suspect as well) and notify medical provider and local and/or county/state public health authorities.
- On-duty staff who exhibits symptoms of the EID will be sent home immediately for self-isolation and notify Employee Health. Staff will contact primary care physician and/or local and/or county/state public health authorities.
- Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute facility via emergency medical services as soon as possible.
- If the suspected infectious person requires care while awaiting transfer, follow facility policies for isolation procedures, including all recommended PPE for staff at risk of exposure.
- Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.
- If feasible, ask the isolated person to wear a facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless it is advised otherwise by public health authorities.
- Conduct control activities such as the management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.
- Implement the isolation protocol in the facility (private rooms, cohorting, cancellation of group activities and social/communal dining) as described in the facility's infection prevention and control plan and/or recommended by local, state, or federal public health authorities.
- Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

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## DEPARTMENT-SPECIFIC ACTIONS

### DIRECTOR OF NURSING/ INFECTION CONTROL PERSONNEL

- Coordinate with nurse manager/designee to update authorized families and guardians of infected residents once per day on resident's condition or more frequently if the condition changes.
- Coordinate with social workers to provide all residents with daily access to videoconferencing (FaceTime, Skype, etc.) for resident and family communication.
- Consider the following to address staff concerns:
  - Provide education, including frank discussions about potential risks and plans for protecting healthcare providers.
- Participate in lockdown of facility to control people coming into the facility.

### General Guidelines for Infection Control Practices for Resident Management

- The facility Infection Control personnel will contact state and local Health Departments, CDC and/or the Department of Health and Human Services for updated information and protocols to follow.
- Any symptomatic staff or residents with suspected or confirmed illnesses should, at a minimum, be managed using Standard Precautions for certain diseases or syndromes (e.g. smallpox and pneumonic plague). Additional precautions may be needed to reduce the likelihood for transmission.

### General Guidelines for Unknown Exposure and Contaminated Resident Placement

- The facility will implement the following procedures to preserve a resident's place in the facility and assure hospitalized residents will be admitted or readmitted after treatment:
  - Medical staff will determine if immediate transfer to the acute hospital is necessary. If the resident is still eligible for and require the services of our facility when deemed medically cleared by the acute hospital, and there is an appropriate bed available to meet the resident's medical needs, the resident will be readmitted upon the first availability of a gender appropriate bed in a semi-private room.

#### **Resident Placement:**

- Prior to admission, identify on the preadmission screen if resident is exhibiting symptoms of EID to determine appropriate placement within the facility. Residents may be required to be screened for EID though testing, if available, prior to admission.
- All new admissions will be admitted to a designated location within the facility and placed on isolation for 14 days. This area should be as separated as possible from the rest of the in house residents.
  - Admit residents to private rooms
  - If private rooms are not available, semi-private rooms should be utilized as private rooms
  - If two admissions are coming from the same hospital and the same room, it may be permissible to cohort these two admissions together
- In the absence of a designated area, every effort should be made to place resident in private or semi-private rooms without a roommate. If this is not possible, the curtain in the semi-private room must be closed at all times for 14 days post admission and all other infection control protocols utilized.
- Residents who leave the facility (ER, appointments, etc.) will be screened for potential infectious disease exposure and may return to room/unit if residing in a private room or a private room is available on unit if necessary; otherwise the resident will be re-admitted to designated unit. Resident will be monitored and placed on precautionary measures for 14 days.
- Residents can be transferred out of observation area to other areas in the facility if they remain afebrile and without symptoms for 14 days after admission. Testing at the end of this period could be considered to increase certainty that the resident is not infected.

#### **Care and Treatment of Residents with unknown exposure to infectious disease:**

The following precautionary measures will be implemented for a period of no less than 14 days:

- Residents will remain in their room as much as possible.

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- Limit socialization and activities out of the room
  - No dining out of room
- All services should be provided in the resident's room when possible, in lieu of having the resident leave the room
- Resident will need to wear a facemask when others are in the room for provision of care and services.
- Resident must wear mask if they need to leave the room for any reason (examples include showering, being weighed, ambulating in the hallway or going to the therapy gym for specific equipment use only available there) and follow social distancing protocol. If resident cannot tolerate a facemask or cloth face covering or one is not available, they should use tissues to cover their mouth and nose while out of their room.
- Limit transport and movement of the resident outside of the room to medically essential purposes.
- Consistent staff from all departments should be assigned to this designated area for resident(s) on precautionary measures, including:
  - Nursing
  - Environmental Services – may need to complete the cleaning of this area at the end of the day as opposed to the beginning of the day
  - Facilities/Maintenance – should identify the same maintenance person to handle any issues in this designated area
  - Social Work
  - Rehab Services
- Required PPE for precautionary measure:
  - All staff must wear a facemask in resident's room;
  - For high contact patient activities, staff will don a facemask, gloves and gown. Encourage resident to wear mask if possible during cares. Examples include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care.
  - Put on a clean isolation gown upon entry into the resident room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
  - In situation of severely limited or no available gowns, the following pieces of clothing can be considered as a last resort for care of residents on precautionary measures as single use. However, none of these options can be considered PPE, since their capability to protect HCP is unknown. Preferable features include long sleeves and closures (snaps, buttons) that can be fastened and secured.
    - Disposable laboratory coats
    - Reusable (washable) patient gowns
    - Reusable (washable) laboratory coats
    - Disposable aprons
    - Combinations of clothing: Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available:
      - Long sleeve aprons in combination with long sleeve patient gowns or laboratory coats
      - Open back gowns with long sleeve patient gowns or laboratory coats
      - Sleeve covers in combination with aprons and long sleeve patient gowns or laboratory coats
  - Staff must follow appropriate donning and doffing procedures to prevent spread of infection.
- Resident care equipment will be cleaned/sanitized appropriately after each use. Supplies brought into the room should be limited to those necessary at that time. Unused supplies cannot be returned to general circulation.
- Residents will be monitored daily for any symptoms of infectious disease, including temperature and other vital signs as necessary (respirations, lung auscultation, and pulse oximetry).

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## **General Guidelines for Resident Transport**

- Limit movement to that which is to provide proper resident care.
- Only the resident and transporter should be in an elevator.
- Mask resident if airborne or droplet organism is suspected, or resident is coughing.

## **General Guidelines for Discharge Management**

- Refrain from discharge until resident is deemed non-infectious, if possible.
- Ensure those discharged have education and follow-up material.

## **General Guidelines for Post-Mortem Care**

- Keep tracking records of all residents.

## **Psychological**

Fear and panic can be expected from both residents and healthcare providers. Psychological responses may include anger, panic, unrealistic concerns about infection, or fear of contagion.

To address resident and general public fears:

- Minimize panic by clearly explaining risks, offering careful but rapid medical evaluation/treatment, and avoiding unnecessary isolation or quarantine.
- Treat anxiety in unexposed persons who are experiencing somatic symptoms as order by Medical Provider.
- Fearful or anxious healthcare workers may benefit from their usual sources of social support or by being asked to fulfill a useful role.

## **Resident Care**

Only direct care providers in the resident room:

- No person enters room without mandatory training and demonstrated competency
- Autonomous practice (supported by experts)
- Physical and Occupational Therapy
- Environmental decontamination

The care team train and validate competency in the following areas:

- Donning and doffing of PPE
- Waste management protocols
- Decontamination and containment protocols per CDC and Department of Health.
- Specimen handling for diagnostic testing per CDC and Department of Health.

## **NUTRITIONAL SERVICES**

- Conduct an assessment of emergency food, liquids and supplies and provide information to the Command Center.
- Coordinate meal service with Nursing. Modify menu if deliveries will not be possible.
- As necessary ensure staff utilize necessary PPE if delivering meals or interacting with any residents who may be infectious.
- Establish plan for feeding staff if shift change will not be possible.

## **HOUSEKEEPING / LAUNDRY**

- Review policies and ensure sufficient supplies in the event deliveries cannot be made.
- Wear appropriate personal protective equipment if cleaning up any contaminate.
- Cleaning, disinfecting and sterilization of equipment and environment:
  - Utilize principles of Standard Universal Precautions.
  - Germicidal cleaning agents should be available in contaminated and/or isolated resident care areas for cleaning spills of contaminated materials and disinfecting non-critical equipment.
  - Discard single-use resident items appropriately.

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- Contaminated waste should be sorted and discarded in accordance with federal, state and local regulations.
- Used resident care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions should be handled in a manner that prevents exposure to skin and mucous membranes, avoids contamination of clothing and minimizes the likelihood of transfer of microbes to other residents and environments.
- Rooms and bedside equipment should be cleaned utilizing Standard Universal Precautions, unless the infecting microorganism and the amount of environmental contamination indicates special cleaning.
- Resident linen should be handled in accordance with Standard Universal Precautions. Although linen may be contaminated, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to other residents, personnel and environments. Facility policy and local/state regulations should determine the methods for handling, transporting and laundering soiled linen.
- Coordinate a linen reduction program, as necessary, with nursing and other appropriate departments.

## **FACILITIES/MAINTENANCE**

- Determine ability to isolate sections of the building for contagious residents.
- Assist with implementing the facility's emergency lockdown policy including control of elevators and stairs.

## **STAFF ASSIGNED SECURITY RESPONSIBILITIES**

### **Elevated Threat Alert Procedures**

- Implement the facility emergency lockdown policy including control of elevators and stairs as directed by the Command Center.
- Determine the need for additional staff to provide security or assist with the building lockdown.
- Control entrances and exits to the building for staff and visitors.
- Reinforce any visitor restrictions.

## **SOCIAL WORK**

- As assigned by the Command Center, work with families and other responsible parties on behalf of residents.
- Arrange and schedule remote videoconferencing visits for resident and family communication.
- Minimize panic by clearly explaining risks to residents.
- Treat anxiety in unexposed persons who are experiencing somatic symptoms with reassurance.

## **SUPPLY / RECEIVING AREA**

### **Elevated Threat Alert Procedures**

- Administrator/Director of Nursing will assess supplies to determine how long you can continue operations. Take results to Command Center.
- Establish receiving area for additional equipment and supplies. Plan storage and tracking.

## **RETURN TO NORMAL OPERATIONS / RECOVERY**

- Internal / External Contamination Eliminated
  - Get clearance from Public and/or Health Department Authorities for an All Clear.
  - Assess facility, staff and department operations to determine ability to return back to normal operations.
  - Communicate to the public that the facility is open for business.
  - Have Finance Section collect cost for reimbursement.
  - Have department heads re-stock supplies.
  - Develop a full report for critique.
  - Close down Incident Command.
  - Critique reports and make necessary updates.