



ANDREW M. CUOMO
Governor

Department of Health

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

August 20, 2020

Re: DAL NH 20-09 Required
Annual Pandemic
Emergency Plan for All
Nursing Homes

Dear Nursing Home Operators and Administrators:

On June 17, 2020, Governor Andrew M. Cuomo signed into Law Chapter 114 of the Laws of 2020 creating a new subdivision 12 to section 2803 of the Public Health Law. The new subdivision requires that each residential health care facility, by September 15, 2020, prepare and make available to the public on the facility's website, and immediately upon request, a Pandemic Emergency Plan (PEP).

This DAL explains the requirements for the PEP outlined in the statute and provides additional direction and guidance on how to implement its requirements. The Department will be issuing further guidance on a recommended form for the PEP. Generally, the PEP must include:

- 1 A communication plan that:
 - 1.a Updates authorized family members and guardians of residents infected with the pandemic infectious disease at least once per day and upon a change in the resident's condition;
 - 1.b Updates all residents and authorized family members and guardians once per week on the number of infections and deaths at the facility;
 - 1.c A plan to provide all residents with daily access to free remote videoconferencing, or similar communication methods, with authorized family members and guardians; and
 - 1.d Required communications must be by electronic means or other method selected by each family member or guardian
- 2 Infection Protection Plans for staff, residents and families, to include:



2.a A plan for readmission of residents to the facility after hospitalization for the pandemic infectious disease

- a.i Such plan must comply with all other applicable State and federal laws and regulations, including but not limited to 10 NYCRR 415.19, 415.3(i)(3)(iii) and 415.26(i); and 42 CFR 483.15(e).
 - a.ii The facility's plan should also consider how to reduce transmission in the event there are only one or a few residents with the pandemic disease in a facility and corresponding plans for cohorting, including:
 - ii.1 Use of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, such as at the end of a hallway;
 - ii.2 Discontinue any sharing of a bathroom with residents outside the cohort;
-

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- ii.3 Proper identification of the area for residents with the pandemic infectious disease, including demarcating reminders for healthcare personnel; and
 - ii.4 Procedures for preventing other residents from entering the area. iii. Additionally, the plan should consider steps for facility administrators and operators to determine cohorting needs and capabilities on a regular basis, including establishing steps to notify regional Department of Health offices and local departments of health if the facility cannot set up cohort areas or can no longer sustain cohorting efforts.
- 2.b Having personal protective equipment (PPE) in a two-month (60 day) supply at the facility or by a contract arrangement¹.
- b.i Supply needs are based on facility census, not capacity, and should include considerations of space for storage. To determine supply needs during a pandemic episode, facilities should base such need on DOH existing guidance and regulations; in the absence of such

¹ Please also keep in mind that nursing home operators and administrators must also comply with emergency regulations effective July XX, 2020, setting forth PPE stockpile requirements.

guidance, facilities should consult the [Center for Disease Control and Prevention \(CDC\) PPE burn rate calculator](#)..

- ii. Be cognizant of experience with prior pandemic response and adopt protocols outlined in guidance that are specific to the pathogen and illness circulating at the time of the pandemic, and plan to handle worst case scenarios without implementing shortage or other mitigation efforts.
- iii. This plan should address all personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents, current guidance on various supplies and strategies from the CDC. Supplies to be maintained include, but are not limited to:
 - i.1 N95 respirators
 - i.2 Face shield,
 - i.3 Eye protection
 - i.4 Gowns/isolation gowns,
 - i.5 gloves,
 - i.6 masks, and
 - i.7 Sanitizer and disinfectants in accordance with current EPA Guidance.:

- 3 Plan for preserving a resident's place at the facility when the resident is hospitalized.
 - 3.a Such plan must comply with all applicable State and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).
- 4 Compliance with the PEP
 - 4.a Failure to comply is a violation of § 2803(12), which may subject the facility to penalties pursuant to PHL § 12 and § 12-b and other enforcement remedies.
- 5 Format for PEP
 - 5.a The Department suggests that in developing the PEP document, the facility follow the format for the Emergency Preparedness plan you developed for the CMS Emergency Preparedness Rule. We suggest that the PEP be included as

an annex to that plan. A format of an annex will be provided to you. It will be modeled after the templates distributed as part of

the 2019 DOH Comprehensive Emergency Management Plan (CEMP) training to nursing homes on developing a PEP.

Attached is information for taking an online version of the CEMP training as a refresher; or if you were unable to attend last year's live training sessions.

We will be using the CEMP for purposes of complying with the requirement and a webinar will be scheduled to explain how to incorporate the pandemic emergency plan in the CEMP. Any questions regarding this correspondence should be forwarded to nursinghomeinfo@health.ny.gov.

Thank you for your attention to this important issue affecting residents of nursing homes in New York State.

Sincerely,

Sheila McGarvey

Director

Division of Nursing Homes and
ICF/IID

Surveillance

Center for Health Care Quality
and Surveillance

Attachments (3) as follows:

OHEP.CEMPONLINE

CEMP and PEP Template

PEP Tool Kit Annex K – Infectious Disease

AGENDA

Webinar:

New York State Required, Pandemic Emergency Plan (PEP) for Residential Health Care Facilities.

Friday August 21, 2020 11:00am to 1:00pm

Introductory Remarks:	Valerie Deetz, Deputy Director, Center of Provider Services and Oversight Office of Primary Care/Health Systems Management (OPCHSM), New York State Department of Health (NYSDOH)
PEP Requirements and Plan Development Review: • Planning templates; • Consistency with CMS Emergency Preparedness Program requirements	Debra Sottolano, PhD Lead for Emergency Preparedness for OPCHSM and Liaison to NYSDOH Office of Health Emergency Preparedness (OHEP)
Q&A session with Attendees	Operated Assisted: Additional NYSDOH Representatives from Divisions of Legal Affairs and Epidemiology



Comprehensive Emergency Management Plan Training Online Training Module

Background

The purpose of the New York State Department of Health (NYSDOH) Comprehensive Emergency Management Plan (CEMP) Training is to provide personnel at adult care facilities across the State of New York with the information and tools to develop a CEMP to prepare for, respond to, and recover from natural and man-made disasters.

Training Objectives

- 1 Facilitate staff familiarity with CEMP purpose, use, development, and implementation.
- 2 Empower facilities to be self-sufficient for 72 hours after an incident.
- 3 Enable facilities' timely determination and implementation of protective actions.
- 4 Foster collaboration and coordination with facility emergency response partners
- 5 Build the foundation for a risk-based CEMP and emergency preparedness program.
- 6 Empower facilities to use the Incident Command System to respond to emergencies.
- 7 Empower Facilities to identify critical information to protect and disseminate during an incident.

Target Audience

Nursing Home or Adult care facility personnel that will be involved in facility level emergency planning (strongly recommended for Administrators and Safety / Security / Plant Managers).

Prior completion of [FEMA ICS-100.C](#) strongly encouraged.

Training produced by Hagerty Consulting, Inc.

Training Module

Training delivered though an interactive online module that can be found using the registration information below or by clicking here:

[OHEP-CEMPONLINE](#)

Questions Regarding NYSDOH Learning Management System (LMS)

Direct questions to edlearn@health.ny.gov or 518474-2893.

Questions Regarding Training

Direct questions to prepedap@health.ny.gov or 518-474-2893.

Registration

To enroll in the training, please go to www.NYLearnsPH.com and either register or login to the LMS. Search Course Catalog for: **OHEPCEMPONLINE** OR click this shortcut to the course enrollment page on the [LMS](#).

NOTE - PLEASE READ - Please verify your contact information in your LMS profile when registering. All required course materials will be sent using the e-mail address listed in the LMS.



COMPREHENSIVE EMERGENCY MANAGEMENT PLAN

Humboldt House

64 Hager Street

Buffalo, New York 14208

71-886-4377

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	716-856-5111
Local Police Department	716-851-4415
Emergency Medical Services	911 central dispatch
Fire Marshal	716-856-5111
Local Office of Emergency Management	Erie County OEM 3369 Broadway Cheektowaga, NY 14227 716-681-6070
NYSDOH Regional Office (Business Hours)²	Western Region-Buffalo Office 584 Delaware Ave, Buffalo, NY 14202 (716) 847-4320
NYSDOH Duty Officer (Business Hours)	866-881-2809
New York State Watch Center (Warning Point) (Non-Business Hours)	518-292-2200

² 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:

Martin Mackenzie

Administrator

07/17/2026

Karen Capuano Director of Nursing

07/17/2026

Jimme Green, Director of Environmental Services

07/17/2026

Record of Changes

Table 2: Record of Changes

Version #	Implemented By	Revision Date	Description of Change
	<i>Jerome Krull</i>	<i>3/24/2022</i>	<i>Updated new staff</i>
	Peter Fadeley	2/16/2024	Updating New team
	Martin Mackenzie	7/17/2026	Updating New Team

Record of External Distribution

Table 3: Record of External Distribution

Date	Recipient Name	Recipient Organization	Format	Number of Copies
<i>May 1, 2020</i>	<i>Jim Doe</i>	<i>Local Office of Emergency Management</i>	<i>Digital (Email)</i>	<i>1</i>
3/25/2022	Website	Website Update for Families	Email	1
3/25/2022	Mary Swartz	Regional Director	Email	1
3/25/2022	Emmanual White	Union Representative	Email	1
3/25/2022	Staff	Staff	Posted	1
2/16/2024	Staff	Staff	Posted	1
2/16/2024	Mary Swartz	Website Update	Posted	1

7/17/2024	Mary Swartz	Website Update	Posted	1

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1 Background

1.1 Introduction

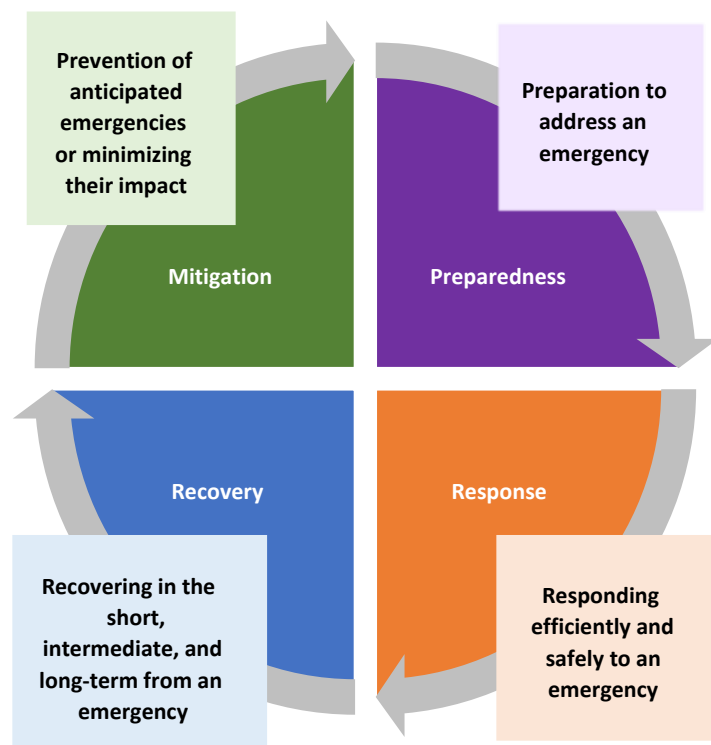
To protect the well-being of residents, staff, and visitors, the following all-hazards Comprehensive Emergency Management Plan (CEMP) has been developed and includes considerations necessary to satisfy the requirements for a Pandemic Emergency Plan (PEP). Appendix K of the CEMP has been adjusted to meet 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 predisaster collaboration with NYS Mutual Aid Partners and local management agencies.

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 PEP, EPP and Facility Assessment will offer clear instruction so that our facility is prepared to respond effectively and safely to an emergency.

1.4 Situation

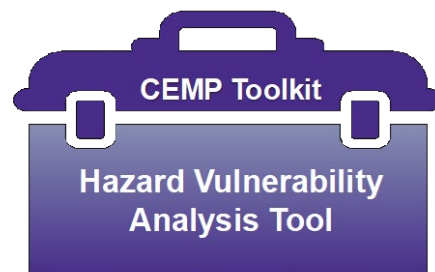
1.4.1 Risk Assessment³

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 3/08/22 and determined the following hazards may affect the facility's ability to maintain operations before, during, and after an incident:

- Epidemic / Infectious Disease
- Blizzard
- Civil Unrest

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



³ 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.⁴

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

⁴ Refer to the "Training and Exercises" section of this plan for additional information about pre-incident trainings and exercises.

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 72 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.
- Other circumstances that may arise beyond facilities control such as gun violence and other geographic threats.

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). Additional steps are outlined in the facility EPP Manual.



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).

The facility will use electronic method of communication with staff, families and responsible parties through use of ONSHIFT, REPTICITY applications.

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** provides a comprehensive list of mandatory and recommended external notification recipients based on hazard type.

Table 4: Notification by Hazard Type

		4									Fire	ES						
M = Mandatory R = Recommended																		
NYSDOH Regional Office⁶	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	M	☐	☐	☐	☐	☐	☐	☐	M	☐	M	☐	☐	☐	☐	M	☐
Local Law Enforcement		M	☐	☐	☐	☐	☐	☐	☐	M	☐	M	☐	☐	☐	☐	M	☐
Local Fire/EMS		☐	☐	☐	☐	☐	☐	☐	☐	☐	M	☐	☐	M	☐	M	☐	☐
Local Health Department	R	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	M	M	☐	☐	R	☐	☐
Off Duty Staff		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relatives and Responsible Parties		☐	☐	☐	☐	☐	☐	☐	☐	R	☐	R	M	☐	R	R	☐	☐
Resource Vendors		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Authority Having Jurisdiction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Regional Healthcare Facility Evacuation Center		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 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 Maintenance Director	Leads the response and activates and manages other Incident Management Team positions.
Public Information Officer	Managing Members Administrator Assistant Administrator	Provides information and updates to visitors, relatives and responsible parties, media, and external organizations.
Safety Officer	Assistant Administrator/Maintenance Team	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	Director of Nursing	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	DON	Collects and evaluates information to support decision-making and maintains incident documentation, including staffing plans.
Logistics Section Chief	Martin Mackenzie, Administrator	Locates, distributes, and stores resources, arranges transportation, and makes alternate shelter arrangements with receiving facilities.
Finance/Admin Section Chief	Business Office Manager	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** identifies primary, secondary, and tertiary facility personnel that will staff Incident Management Team positions.

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	Martin Mackenzie Administrator	Karen Capuano, Director of Nursing	Tania Safi Assistant Administrator
Public Information Officer	Mary Swartz	Kate Wannemacher	Sierra Richards Social Work
Safety Officer	Roger Evans/Geovanni Otero Maintenance	Tania Safi, Asst admin	Jimmie Green Director of Environmental Services
Operations Section Chief	Martin Mackenzie Administrator	Karen Capuano DON	1. Tania Safi
Planning Section Chief	Karen Capuano DON	Renee Dolinar	Tania Safi

Logistics Section Chief	Martin Mackenzie Administrator	Tania Safi, Assistant Administrator	Roger Evans Maintenance Supervisor
Finance/Admin Section Chief	Sophia Winters Business Office	Wendy Stifter	

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 Conference Room and the secondary/back-up location is 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 predisaster 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 8**.

Table 7: Pre-Identified Recovery Services

Service	Description of Service	Point(s) of Contact
American Red Cross	Post Disaster Housing Assistance, Emergency Preparedness, Response Training, Blood drives, Smoke Alarms, Disaster Relief/Recovery, Post disaster food services.	Western New York Chapter 786 Delaware Avenue Buffalo, NY 14209 716-886-7500
WNY Mutual Aid Plan	Consortium of Facilities in WNY designed to assist staff residents and families obtain services available in community as well as for facility	[www.mutualaidplan.org] 716-810-7000 716-220-5817 Cell
Office of Public Health Emergency Preparedness- Erie County	Assistance with personal care, activities of daily living, managing/administering medication, obtaining PPE, obtaining durable medical equipment.	Office of Public Health Emergency Preparedness 95 Franklin Street, Room 931 Buffalo, NY 14202 716-858-7101
Salvation Army	Emergency meals, emergency shelter, clothing, spiritual counseling, grief counseling	960 Main Street Buffalo, NY 14202 716-888-6206 716-983-0621
FEMA		https://www.fema.gov/locations/newyork

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.

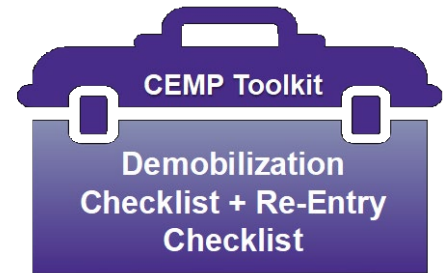
Resuming pre-incident staff scheduling will require a planned transition of staff resources, accounting for the following considerations:

- 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;⁵
- 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 9 outlines entities responsible for performing infrastructure restoration activities and related contracts/agreements.

Table 8: Infrastructure Restoration Activities

Activity	Responsible Entity	Contracts/Agreements
Internal assessment of electrical power.	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor)	Current Supplier -NYSEG]
Clean-up of facility grounds (e.g., general housekeeping, removing debris and damaged materials).	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor) Jimmie Green Environmental Services Director	Landscaping – KD Landscaping and Snowplowing
Internal damage assessments (e.g., structural, environmental, operational).	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor)	Lamparelli Construction- 716-891-8599 Serv Pro- 716-891-8599
Clinical systems and equipment inspection.	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor)	In house serviced

⁵ 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).	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor)	Lamparelli Construction- 716-891-8599 Serv Pro- 716-891-8599
Communication and transparency of restoration efforts to staff and residents.	Tania Safi Assistant Administrator	On-shift, calls, mailings
Recurring inspection of restored structures.	Maintenance Team Roger Evans and Geovanni Otero	“Not Applicable”

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:

- Point Click Care Electronic Medical Record Documents stored Electronically

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 Form⁹ 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 of protected health information in other circumstances.

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 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>

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 will use the New York State Evacuation of Facilities in Disasters System (“eFINDS”)⁶ and the Resident Evacuation Critical Information and Tracking Form⁷ to track staff.

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 Kronos, Supervisor tracking line list and tour of duty log on each unit 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 sign-in/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.



⁶ 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.

⁷ 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.

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: Methods of Communication

Mechanism	Primary Method of Communication	Alternate Method of Communication
Landline telephone	☒	☐
Cell Phone	☐	☒
Voice over Internet Protocol (VOIP)	☐	☒
Text Messages	☒	☐
Email	☒	☐
News Media	☒	☐
Radio Broadcasts	☐	☐

	☐	☒
Social Media	☐	☒
Runners	☒	☐
Weather Radio	☐	☒
Emergency Notification Systems⁸	☒	☐
Facility Website		
ONSHIFT for Staff Communication		
REPTICITY for family communication	☒	☐

4.1.1 Communications Review and Approval

Messages approved by communications officer or Administrator

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;

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

- 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 a master list of all staff members, including emergency contact information, at WWW.ONSIFT.COM. 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 documented on admission, newsletters, Resident Council meetings, resident group meetings, Family Council meetings..

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 Avante Management to ensure external communications are aligned with corporate policies, procedures and brand standards. Prior to an incident the facility will coordinate with Avante Management to ensure an onsite facility staff members has authorization and approval to disseminate messages.

4.3.2 Authorized Family and Guardians

The facility maintains a list [Point Click Care resource list of all identified authorized family member's and guardian's (responsible parties') contact information, including phone numbers and email addresses at Humboldt House uses Repticity to update and notify family members.. 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 using Repticity to communicate with family members. Additional updates may be provided on a regular basis to keep residents relatives/responsible parties apprised of the incident and the response.

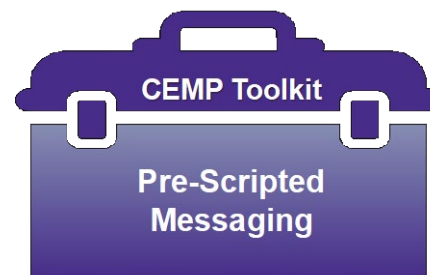
The initial notification message to residents' primary point of contact (e.g., relative) will include the following information:

- Nature of the incident;
- Status of resident;
- Restrictions on visitation; and
- Estimated duration of protective actions
-

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 ▪

5.2 Finance

5.2.1 Preparedness

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.
- Update HPN Daily during Pandemic with daily supply mgt of Personal Protective Equipment (PPE) if requested.

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 10: Plans, Policies, and Procedures

Activity	Led By	Frequency
Review and update the facility's risk assessment.	Administrator, QAPI Committee	Annually
Review and update contact information for response partners, vendors, and receiving facilities.	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor)	Annually or as response partners, vendors, and host facilities provide updated information.
Review and update contact information for staff members and residents' emergency contacts.	Desirea McCloud HR	Annually or as staff members provide updated information.
Review and update contact information for residents' point(s) of contact (i.e., relatives/responsible parties).	Sierra Richard, 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.	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor)	Annually
Maintain electronic versions of the CEMP in folders/drives that are accessible by others.	Martin Mackenzie, Administrator	Annually
Revise CEMP to address any identified gaps.	Safety Committee Martin Mackenzie, Administrator	Upon completion of an exercise or real-world incident.
Inventory emergency supplies (e.g., potable water, food, resident care supplies, communication devices, batteries, flashlights,	Geovanni Otero Maintenance Director/ Roger Evans (Maint Supervisor) Jimmie Green Housekeeping/Laundry Dawn Degnan , FSD	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

The background of the page is a blurred, high-angle photograph of a clinical or laboratory environment. Several individuals wearing white lab coats are visible, some standing and others moving. The floor is light-colored, and there are some pieces of equipment or furniture in the background. The overall tone is professional and clean.

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**. 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*.

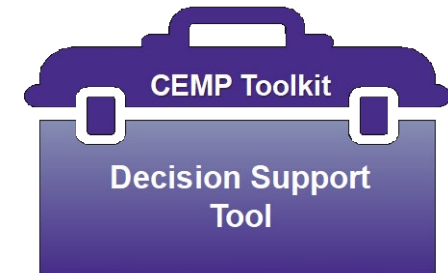


Table 11: Protective Actions

Protective Action	Potential Triggers	Authorization
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 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 <u>pre-approval</u> from NYSDOH prior to each hurricane season and <u>re-authorization</u> at time of the incident.

Protective Action	Potential Triggers	Authorization
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 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 <i>NYSDOH Evacuation Plan Template</i>.
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
- Food and water for a minimum of 72 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 12: 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).
☐	See Staffing Plan

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,¹³ 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;
- 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.

¹³ 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 13: 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.	DON, Maintenance	Orientation held on first day 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.	DON	Monthly / Annually with Anniversary Date Conducts drills
Maintain records of staff completion of training.	HR	On going
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.	Director of Activities at Resident Council, Resident Council President to review.	Monthly , PRN Repeat briefly at time of incident.
Identify specific training requirements for individuals serving in Incident Management Team positions.	Safety Committee eFinds Mutual Aid Drills	Quarterly



2. Exercises

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

Table 14: Exercises

Activity	Led By	Frequency
Conduct one operations-based exercise (e.g., full-scale or functional exercise). ⁹	Safety Committee	Bi-Annually
Conduct one discussion-based exercise (e.g., tabletop exercise).	Safety Committee	Every 6 months

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 Fiddlers Green attendance record, participation in drills and education.

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



⁹ 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.

do differently or improve upon; and corrective action/improvement plan and associated timelines.

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:

- o 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 all Infectious Disease Events

☐ 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 <u>The facility Infection Preventionist (IP) in conjunction with QA Director/designee will provide education on Infection Prevention and management upon the hiring of new staff as well as ongoing education on an annual basis or as needed should a facility experience an outbreak of an infectious disease.</u> <u>The IP or designee will conduct an annual competency based education on hand hygiene and donning/doffing of PPE for all staff.</u> <u>The IP and or the QA Director/Designee will provide in-servicing for all staff on infection prevention policies and procedures as needed.</u> <u>Refer to Policy and Procedure : Infection Prevention and training</u>
☐ Required	Develop/Review/Revise and Enforce existing infection prevention, control, and reporting policies. <u>The facility will continue to review/revise and enforce existing infection prevention control and reporting policies.</u> <u>The IP will update the Infection Control Manual annually or as needed due to or during an event.</u>

	<u>The IP will as needed consult with local Epidemiologist to ensure that any new regulations and/or areas of concern related to Infection Prevention and Control are incorporated into the Facilities Infection Control Prevention Plan.</u>
☐ 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. [REDACTED] <u>The QAPI committee will review all resident infections as well as usage of antibiotics on a monthly basis to identify any trends and areas for improvement</u>
☐ Recommended	Develop/Review/Revise plan for staff testing/laboratory services <u>The facility will continue to review/revise and enforce existing infection prevention control and reporting policies.</u> <u>The IP will as needed consult with local Epidemiologist to ensure that any new regulations and/or areas of concern related to Infection Prevention and Control are incorporated into the Facilities Infection Control Prevention Plan.</u>
☐ 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 <u>The facility has access to HPN, all roles are assigned and updated as needed for reporting to NYSDOH.</u> <u>The following staff members have access to HERDS: Administrator, Asst Admin, ADON, DON</u>
☐ 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) <u>The IDT Disciplinary Team (IDT) in conjunction with the Medical Director and pharmacy will review policies for stocking needed supplies.</u>



	<u>The facility is contracted with pharmacy vendor to arrange for supply of residents medications to be delivered should there be a Pandemic Emergency.</u> <u>The facility has established par levels for approved PPE equipment and supplies to include approved environmental cleaning agents based on pandemic usage.</u> Refer to the following policies: PPE Environmental Cleaning Agents Vendor List (Mutual Aid)
☐ Recommended	Develop/Review/Revise administrative controls (e.g., visitor policies, employee absentee plans, staff wellness/symptoms monitoring, human resource issues for employee leave). <u>All sick calls will be monitored by department heads to identify any staff pattern or cluster of symptoms associated with infectious agent. The HR manager in conjunction the IP will keep a line of sick calls and reported during morning meetings.</u> <u>Visitors will be informed of any visiting restriction related to an infection Pandemic and visitation restrictions will be enforced.</u> <u>A contingency staffing plan is in place that identifies the staffing needs and prioritizes critical and non-essential services, based on resident needs and essential facility operations.</u> Refer to the following policies: <u>Visitation guidelines during pandemic</u> <u>Staff Screening and monitoring during pandemic</u> <u>Staffing Plan</u>
☐ Required	Develop/Review/Revise environmental controls (e.g., areas for contaminated waste) <u>Areas of contaminated waste are clearly identified as per NYSDOH guidelines.</u> <u>The Director of Plant Operations or designee shall follow all rules for handling contaminated waste. The onsite storage of waste shall be labeled and in accordance with all regulations.</u> <u>The facility will amend the Policy and Procedure on Bio hazardous waste as needed.</u> <u>Refer to Policy and Procedure on Handling of Biohazardous Waste Material</u>

	<u>communicated to provider and transporter and clearly documented on the transfer paper work.</u> <u>All attempts will be made to have dedicated caregivers assigned to each Cohort group and to minimize the number of different caregivers assigned.</u> <u>Refer to the following Policy and Procedure:</u> <u>Cohorting Guidelines during a Pandemic</u> <u>Transferring Residents with Infection Diseases</u>
☐ Recommended	Develop/Review/Revise a plan to ensure social distancing measures can be put into place where indicated <u>The facility will review/revise the Policy on Communal Dining Guidelines and Recreational Activities during a Pandemic to ensure that Social Distancing is adhered to in accordance with State and CDC guidance.</u> <u>The facility will review/revise the Policy on Recreational Activities during a Pandemic to ensure that Social Distancing is adhered to in accordance with State and CDC guidelines.</u> <u>The facility will ensure that staff break rooms allow for social distancing of staff.</u> <u>All staff will be re-educated on these updates as needed.</u> <u>Refer to the following Policy and Procedure:</u> <u>Communal Dining</u> <u>Recreation Needs during a Pandemic</u>
☐ 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 <u>The facility will adhere to directives 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.</u> <u>The facility will maintain communication with the local NYS DOH and CMS and follow guidelines for returning to normal operations. The decision for outside vendors/consults will be made on a case to case basis.</u> <u>During the recovery period, residents and staff will continue to be monitored daily in order to identify any symptoms that could be related to the infectious agent.</u> <u>Refer to the following Policy and Procedure:</u> <u>Staff Monitoring during a Pandemic Emergency</u> <u>Resident Monitoring during the Recovery phase of a Pandemic Emergency</u>

☐	
☐	
Additional Preparedness Planning Tasks for <u>Pandemic Events</u>	
☐ Required	<i>In accordance with PEP requirements,</i> Develop/Review/Revise a Pandemic Communication Plan that includes all required elements of the PEP The Administrator in conjunction with the Social Service Director and Medical Records Director will ensure that there is an accurate list of each resident's Representative, and preference for type of communication. Communication of a pandemic includes utilizing established Staff Contact List to notify all staff members in all departments The facility will update website on the identification of any infectious disease outbreak. <i>Refer to Policy and Procedure:</i> • <i>Communication with Residents and Families During Pandemic</i> • <i>Resident Representative/Contact information</i> <i>Refer to Staff Contact List located in EPP</i>
☐ Required	<i>In accordance with PEP requirements,</i> Development/Review/Revise plans for protection of staff, residents and families against infection that includes all required elements of the PEP. <u>Education of staff, residents, and representatives</u> <u>Screening of residents</u> <u>Screening of staff</u> <u>Visitor Restriction as indicated and in accordance with NYSDOH and CDC</u> <u>Proper use of PPE</u> <u>Cohorting of Residents and Staff</u> <i>Refer to Prevention and Control Policy and Procedures</i>
☐	
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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:

	<u>The IP/Designee will ensure that appropriate signage is visible in designated areas.</u> <u>The IP/Designee will ensure that clearly posted signs for cough etiquette, hand washing, and other measures in high visibility areas.</u> <i>Refer to CDC website for Signage download</i>
☐ 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)

☐ Required	The facility will assure it meets all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting <u>The DON will report communicable diseases via the NORA reporting system on the HCS</u> <u>The DON will report communicable diseases via the NORA reporting systems on the HCS</u> <u>The facility will contact the NYSDOH regional epidemiologist or the NYSDOH Central Office Healthcare Epidemiology and Infection Control Program for general questions and guidance</u>
☐ 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. <i>Refer to Guidance, Signage, Advisories</i>
☐ 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 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: • <u>Cohort residents according to their infection status</u> • <u>Monitor residents to identify symptoms associated with infectious agent</u> • <u>Units will be quarantined in accordance with NYSDOH and CDC guidance and every effort will be made to cohort staff.</u> • <u>Facility will follow all guidance from NYSDOH regarding visitation, communal dining, and activities</u>



	• <u>Facility will educate staff as needed and ongoing</u> • <u>Facility will centralize and limit entryways to ensure all persons entering the building are screened</u> • <u>Hand sanitizer will be available on entrance to the facility</u>
☐ 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: <i>Refer to Policy and Procedure on Cohorting</i>
☐ 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. <u>The facility will conduct cleaning/decontamination in response to infectious disease utilizing cleaning and disinfection product/agent specific to infectious disease/organism in accordance with any applicable NYSDOH, and CDC guidance</u>
☐ 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 <u>The facility will implement 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.</u> <u>All residents will receive updated information on the infective agent, mode of transmission, requirements to minimize transmission, and all changes that will affect their daily routines.</u> <i>Refer to Policy and Procedure on Communication During a Pandemic</i>
☐ 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 <u>The facility will contact all staff including Agencies, vendors, other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risk to residents and staff.</u> <u>Consultants that service the residents in the facility were notified and arrangements made for telehealth, remote chart review, or evaluating medically necessary services until the recovery phase according to State and CDC guidelines.</u>

☐ 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: <u>Subject to any superseding NYS EO and/or NYSDOH guidance that may otherwise temporarily prohibit visitors, the facility will advise visitors and vendors to limit/discontinue visits to reduce exposure risk to residents and staff.</u> <u>Emergency Staff including EMS will be informed of required PPE to enter facility</u> <u>Vendors will be directed to drop off needed supplies and deliveries in a designated area to avoid entering the building.</u> <u>The facility will implement closing the facility to new admissions in accordance with any NYSDOH directives relating to disease transmission.</u> <u>Refer to Policy and Procedure:</u> <i>Visitation during a Pandemic</i> <i>Limited services during a Pandemic</i>
☐	
☐	
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) <u>The facility has an implemented Respiratory Protection Plan.</u> <u>Appropriate signage shall be posted at all entry points, and on each unit indicating the type of transmission- based precautions that are needed.</u> <u>Staff members will receive re-education and have competency done on the donning and doffing of PPE.</u> <u>Infection control rounds will be made by the IDT to monitor compliance with proper use of PPE</u> <u>The facility has a designated person to ensure adequate and available PPE is accessible on all shifts and staff are educated to report any PPE issues to their immediate Supervisor.</u>

☐ Required	<i>In accordance with PEP requirements</i>, 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: <u>The Facility will 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.</u> <u>The PEP plan will be available for review and kept in the Administrators office.</u>
☐ Required	<i>In accordance with PEP requirements</i>, 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 utilize Repticity to update families via phone call, text, email whichever is preference of family members. <u>The facility will communicate with Residents, Representatives as per their preference i.e., Email, text messaging, calls/robocalls and document all communication preference in the EMR.</u> <u>Representatives will be notified:</u> • <u>Of residents that are infected will be notified daily by Nursing staff as to the residents status</u> • <u>any change in condition</u> • <u>Weekly on the status of the pandemic at the facility including the number of pandemic infections</u> • <u>Number of cases and deaths in the facility unless they verbalize that they do not wish to be notified</u> <u>The website will be updated indicating any newly confirmed cases and/or deaths related to the infectious agent</u> <u>All residents will be provided with access to communicate with their representatives via video conferencing, telephone calls, and/or email.</u> <u>Refer to Policy and Procedure Change in Condition</u> <u>Communication with Residents and Families during a Pandemic</u>
☐ Required	<i>In accordance with PEP requirements</i>, 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 utilize Repticity to update families via phone call, text, email whichever is preference of family members <i>See above section</i>

☐ Required	<i>In accordance with PEP requirements</i>, 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: Facility will continue to provide video access to their families at no cost. <u>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 (i); and 42 CFR 483.15(e)</u> <u>Prior to Admission/readmission the DON/designee will review hospital records to determine resident needs and the facility's ability to provide care including cohorting and treatment needs.</u> <u>Refer to Policy and Procedure for Admission/readmission</u>
☐ Required	<i>In accordance with PEP requirements</i>, 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): <u>The facility will implement processes 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)</u> <u>Refer to Policy and Procedure for Bed Holds</u>
☐ Required	<i>In accordance with PEP requirements</i>, 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): <u>Refer to Policy and Procedure for Bed Holds</u>

☐ Required	<i>In accordance with PEP requirements</i>, 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) <u>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</u>. 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) <i>Refer to Policy and Procedure on securing PPE</i> <i>Refer to Vendor Contract list, including information for local and State OEM</i>
	Facility will store PPE that is longer than one week in secondary business office location on the premises. <i>Refer to Policy and Procedure on securing PPE</i> <i>Refer to Vendor Contract list, including information for local and State OEM</i>
☐	
☐	
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. <i>Refer to CDC guidelines and recommendations and NYS DAL</i>
☐ Required	The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders <u>The facility will ensure that during the recovery phase all residents and staff will be monitored and tested to identify any developing symptoms related to the infectious agent in accordance with State and CDC guidance.</u> <u>The facility will screen and test outside consultants that re-enter the facility, as per the</u>

NYS DOH guidelines during the recovery phase.
Refer to Policy and Procedure Staff Testing during Pandemic



Humboldt House Rehabilitation & Nursing Center

Comprehensive Emergency Management Plan Template

2022

Humboldt House
64 Hager Street
Buffalo , NY 14208

www.humboldthouse.com

Introduction

This Toolkit Template is meant to supplement the Comprehensive Emergency Management Plan (CEMP) Template to help facilities develop and implement their CEMP. Annex K has been updated to include guidance and format to comply with the new requirements of Chapter 114 of the Laws of 2020 for the development of a Pandemic Emergency Plan (PEP). This document provides a compendium of resources to help empower staff engaged in facility preparedness, response, and recovery operations. Templates and tools should be reviewed and updated on a regular basis.

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

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1. Facility Overview

The facility overview provides an immediate reference sheet about each facility (or individual buildings within a facility's campus) for use when communicating with external parties during an emergency (e.g., law enforcement, fire department, emergency management officials). **Table 1: Facility Overview**

LOCATION AND CONTACT INFORMATION	
Name of Facility	Humboldt House

Address	64 Hager Street
Cross Streets	Delevan Ave
Telephone	716-886-4377
Fax	716-886-0086
Email	admissions@humboldthouse.org
Website	www.humboldthouse.org
CONSTRUCTION	
Construction Type	Concrete/steel/brick
Year Building Constructed	1955
Number of Floors (above/below grade)	4
Square Footage	27,000

CAPACITY AND STAFFING	
Non-Traditional Surge Space	8
Number of Facility-Owned Vehicles (including accessible spots/seats)¹⁰	1
UTILITY AND SERVICE PROVIDERS	
Electric Provider	National Grid
Local Water Provider	Pollack Food Distributors Inc. 216-851-9911
Telephone Provider	Windstream Holdings 800-347-1991

¹⁰ This field is intended to capture number of vehicles, including accessibility level (e.g., number of wheelchair accessible spots, number of seats).

Internet Service Provider	Spectrum Network 355 Chicago Street Buffalo, NY 14204 888-406-7063
Generator Services	PENN Power 716-822-0051
Propane	NA
Plumbing	H.W. Bryk and Sons 716-297-2901
Elevator	Bison Elevator Service 716-852-3031
HVAC Equipment	DWC Mechanical 716-583-2270
Fire Equipment/Sprinklers	Davis Ulmer 716-691-3200

2. Hazard Vulnerability Analysis

2.1. HVA Tools

The Centers for Medicare and Medicaid Services (CMS) requires healthcare facilities to conduct annual facility-specific risk assessments to identify and assess potential hazards and their

impacts. HVAs are used to estimate the hazards (and associated risks) that are most likely to occur and/or may affect a facility's ability to maintain operations and services. The results of the analysis can be used to prioritize planning, mitigation, response, and recovery projects and initiatives.

Below are example HVA tools that facilities can use to conduct a facility-specific HVA. Facilities can modify the tools to suit their needs.

Table 2: Example HVA Tools

Tool Name	Description
Kaiser Permanente HVA Tool¹¹	An excel spreadsheet with incorporated formulas which provide the user with relative risk percentages and summary information.
Children's Hospital Colorado, Community Hazard Vulnerability Assessment Tool	An excel spreadsheet with incorporated formulas which provide the user with relative risk percentages and summary information. The tool includes capabilities throughout the four phases of emergency management (mitigation, preparedness, response, recovery) as a factor in calculating risk.
U.S. Department of Health and Human Services, Healthcare and Public Health Sector Threat/Hazard Assessment Module Automated Tool	An excel spreadsheet that guides facilities through the hazard analysis process through a series of guided questions. After completing all the questions, the tool provides a comprehensive list of risks associated with each hazard.

2.2. HVA Process

The following outlines the process and recommendations for conducting a facility-specific HVA:

¹¹ The Kaiser Permanente HVA Tool (2017) is available at https://www.calhospitalprepare.org/sites/main/files/fileattachments/kp_incident_log_hva_template.xlsb.

2.2.1. Convene Staff with Facility-Specific Knowledge

Conducting an HVA requires an in-depth knowledge of facility preparedness and response capabilities. In addition, understanding the capabilities of response partners is another important piece of completing an HVA. As a result, staff possessing this knowledge should be involved in the HVA process, including:

- Facility Senior Leader
- Lead Clinical Staff
- Head of Administration/Finance
- Communications Staff

Completing the HVA can be done by a single knowledgeable staff member or as a collaborative process with multiple staff members. For example, multiple staff members can complete an individual HVA, then they can be compared to validate each assessment and a consensus can be reached using the variety of assessments.

2.2.2. Identify Facility-Specific Hazards

In order to complete an HVA, staff must know the hazards which might affect their facility. The list of hazards can be developed through a variety of means, including:

- Historical knowledge of hazards
- Subjective predictions of hazards
- Using predetermined hazards in HVA tools
- Using local emergency plans to determine hazards (also known as a “community-based assessment”). Examples of these plans, which can be obtained from your Local Office of Emergency Management, include:
 - Hazard Mitigation Plans
 - Emergency Operations Plans
 - Threat and Hazard Identification and Risk Assessment

2.2.3. Assess Hazards

The risk each hazard poses to the facility is determined through a variety of factors. The table below presents each factor and the considerations to make when evaluating them. **Table 3: HVA Considerations**

Hazard Factor	Considerations
Probability	▪ Current local and regional plans ▪ Manufacturer/vendor statistics ▪ Subjective evaluations or best estimate
Human Impact	▪ Potential for staff, resident, or visitor injury or death ▪ Emotional or psychological impact ▪ Local cultural norms

Property Impact	▪ Cost to replace ▪ Cost to set up temporary replacement ▪ Cost to repair ▪ Time to recover
Business Impact	▪ Business interruption ▪ Staff unable to report to work ▪ Violation of contractual agreements, regulatory standards ▪ Interruption of critical supplies ▪ Reputation and public image ▪ Financial impact or burden
Preparedness	▪ Status of current plans ▪ Staff training completion status ▪ Availability of alternate sources for critical resources
Internal Response	▪ Emergency resource levels ▪ Durability/longevity of resources (without replenishment) ▪ Internal resources ability to withstand disasters ▪ Availability of backup systems
External Response	▪ Types of agreements with community agencies ▪ Relationship with local and state agencies ▪ Relationship with local healthcare facilities ▪ Relationship with community volunteers ▪ Vendor pre-incident response plans and contracts

3. Activation Checklist

Any incident large or small can warrant the activation of the CEMP and the processes contained within. This checklist describes the activities that should take place whenever the CEMP is activated and the position that is responsible. Additional facility specific processes can be added into the checklist.

Table 3: Activation Checklist

Task		Completed By
☐	Upon notification of hazard or threat from staff, residents, or visitors, activate the CEMP.	Martin Mackenzie Administrator
☐	Activate the Communications Plan.	Martin Mackenzie Administrator

☐	Notify staff of CEMP activation and the hazard or threat through the [facility-specific system (e.g., mass notification system, switchboard operator, overhead paging system)].	Administrator
☐	Assess the potential or actual impact of the incident on residents, staff, and the facility.	Martin Mackenzie Administrator
☐	Direct Incident Management Team to convene at designated Command Center location.	Martin Mackenzie Administrator
☐	Based on the hazard and using the “Notification by Hazard Type” table in the CEMP, conduct required notifications.	Martin Mackenzie
☐	Set-up the facility’s Command Center. <i>Refer to section below checklist for more information.</i>	Finance/Administration Section Chief and Logistics Section Chief
☐	Deliver briefing to Incident Management Team, and other staff as appropriate, on the incident including: ▪ Extent or impact of the problem (e.g., hazards, life safety concerns) ▪ Number of residents injured or affected ▪ Status of resident care and ancillary services ▪ Current and projected staffing levels ▪ Status of facility plant, utilities, and environment of care.	Incident Commander
Task		Completed By
☐	Develop an Incident Action Plan to establish goals and objectives to guide incident response throughout the next operational period. Operational period duration will be determined by Incident Commander (e.g., 12 hours, shift change).	Incident Commander
☐	Prepare and distribute position-specific checklists for the Incident Management Team to use during incident response.	Planning Section Chief
☐	Establish a meeting schedule for Incident Management Team to maintain situational awareness of incident and response operations.	Planning Section Chief
☐	Notify residents and their relatives or responsible parties of hazard information and response actions.	Public Information Officer
☐	Task facility staff with completing additional tasks to meet established response goals and objectives.	Incident Management Team

☐	Continue to collect information about incident and its current or projected impacts and perform position duties as assigned.	Incident Management Team
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3.1. Command Center

The facility Command Center serves as the central location for the Incident Management Team to conduct the following activities:

- Plan and execute emergency operations;
- Exchange information (e.g., briefings, check-in meetings); and
- Store incident-related documentation.

Prior to an incident, facilities should consider the following when identifying a primary and contingency location for the Command Center:

- Located within the facility (e.g., not off-site);
- Provide space for tables and chairs; and
- Provide access to computers/internet and communications equipment (e.g., landline telephones, cell phones).

After an incident, if the pre-identified locations are rendered unusable—or if incident conditions require the Command Center to be relocated—the facility can utilize nearby facilities, or if absolutely necessary, a vehicle to serve as an off-site, mobile Command Center.

4. Incident Management Team Position Checklists

The following checklists outline the responsibilities of each Incident Management Team position. They should be adapted as needed based on the internal policies and procedures of the facility.

4.1. Incident Commander

INCIDENT COMMANDER	
☐	Activate the CEMP and necessary Incident Management Team positions.
☐	Analyze potential threats or hazards (e.g., weather forecast, law enforcement intelligence) and assess potential or impacts on residents, staff, and the facility.
☐	Brief the Incident Management Team on the nature of the problem, immediate issues, and the initial plan of action.

☐	Evaluate expected or actual facility damage and assign staff to conduct a thorough site assessment.
☐	In accordance with local plans or procedures, notify emergency management, law enforcement, and fire officials of incident conditions for situational awareness and to relay critical needs.
☐	Facilitate regular briefings to review the status of response operations. Request status reports from staff on resident health and safety.
☐	Observe the Incident Management Team for signs of stress and exhaustion and provide rest periods.
☐	Determine the appropriate protective action based on the presence of potential or actual hazards to resident safety and well-being.
☐	Share regular updates with residents and staff to maintain situational updates.
☐	Authorize procurement and distribution of resources.

4.2. Public Information Officer

PUBLIC INFORMATION OFFICER	
☐	Obtain briefing from Incident Commander.
☐	Draft initial message for notification of relatives and responsible parties regarding facility and resident status.
☐	Answer inquiries from residents' relatives and responsible parties, the general public, and the media and direct questions/requests to appropriate individuals.
☐	Develop and disseminate status updates to be reviewed and approved by the Incident Commander before dissemination to relatives and responsible parties, media, and the public.
☐	Provide guidance to other Incident Management Team members on the appropriate release of information to requesting entities.

☐	Develop regular status updates to keep staff informed of the incident and facility status.
☐	Assist in the development and distribution of signage as needed.
☐	Communicate concerns to the Incident Commander, as needed.

4.3. Safety Officer

SAFETY OFFICER	
☐	Obtain briefing from Incident Commander.
☐	Conduct site assessment to determine safety risks of the incident to residents, staff, and visitors.
☐	Document the treatment plan for injured or ill staff.
☐	Post non-entry signs around unsafe areas.
☐	Evaluate building or incident hazards and identify vulnerabilities.
☐	Assess operations and practices of staff, terminate any unsafe activity, and recommend corrective actions to ensure safety of residents, staff, and visitors.
☐	Direct laundry and housekeeping staff to: ▪ Ensure adequate supplies of linens, blankets, and pillows. ▪ Ensure emergency linens are available for soaking up spills and leaks.
☐	Direct food and dietary staff to: ▪ Provide and prepare food as needed during an emergency. ▪ Ensure gas appliances are turned off before evacuating.

☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

4.4. Operations Section Chief

OPERATIONS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Assign staff to assess the facility and resident well-being.
☐	Determine how facility services will continue as routinely as possible, including the provision of: ▪ Routine nursing services and documentation ▪ Medication dispersal per resident schedules. ▪ Routine hygienic and nutritional care for residents.
☐	Arrange for the provision of and/or documentation, transfer, and transportation critical medical services, such as dialysis and oxygen therapy, and emergency discharges for atrisk residents.
☐	Maintain resident and staff accountability.
☐	Secure resident records during shelter-in-place operations.
☐	Assess pharmacy supplies and contact pharmacy, as needed, to determine: ▪ Cancellation of deliveries. ▪ Availability of backup pharmacy. ▪ Availability of medical supplies.
☐	Evaluate staffing needs and activate additional staff, as needed.

☐	Direct nursing and rehabilitation staff to: ▪ Tend to physical and emotional needs of residents. ▪ Assist in clearing rooms and hallways, exits, etc. ▪ Support movement of residents during an evacuation.
☐	For receiving facility operations, ensure proper management of arriving residents and their records, including documentation of triage, treatment, and disposition of emergency admits.
☐	Document resident injuries (and action plan to ensure treatment) or deaths.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

4.5. Planning Section Chief

PLANNING SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Document Incident Management Team position assignments and contact information for all positions.
☐	Assist Incident Commander with planning response actions for next operational period (e.g., shift).
☐	Ensure backup and protection of existing data including paper-based and digital systems.
☐	Maintain all historical information and records related to the incident.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

4.6. Logistics Section Chief

LOGISTICS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Distribute resource request forms to each Incident Management Team member. Document the request, use, return, and condition of resources used to respond.
☐	Ensure the following resources are mobilized, assigned, and tracked: ▪ Staff and Surge Support ▪ Emergency Supplies ▪ Communications Equipment ▪ Food and Water ▪ Transportation
☐	Document volunteer sign-in and sign-out for each operational period (e.g., shift).
☐	Request Incident Commander approval to activate mutual aid and vendor agreements for additional resources.
☐	Communicate concerns to the Incident Commander, as needed.

4.7. Finance/Administration Section Chief

FINANCE/ADMINISTRATION SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Initiate protection of, or move/relocate facility records, as needed.
☐	Maintain incident cost tracking and analysis, including the documentation, retrieval, safeguarding and distribution of cash, credit card, and receipt/invoice processes.

☐	Document and track facility-wide personnel work hours worked relevant to the emergency.
☐	Contact insurance company to notify them of the incident and identify and document requirements for submitting damage/claim reports.
☐	Consult with government officials regarding reimbursement regulations, requirements, and forms.
☐	Approve and submit a financial status report to the Incident Commander summarizing cost-to-date financial data relative to personnel, supplies, and miscellaneous expenses.
☐	Ensure that required financial and administrative documentation is properly prepared and maintained.
☐	Process invoices received.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

5. Demobilization Checklist

Table 4: Demobilization Checklist

Tasks	
Activate repatriation process.	
☐	Refer to the <i>NYSDOH Evacuation Plan Template</i> for further guidance.
☐	Ensure compliance with all local and NYSDOH requirements regarding inspections, remediation actions, and conditions for approval of repatriation.
☐	Receive approval from NYSDOH to reopen the facility.
☐	Initiate repatriation plans and procedures.
Deactivate IMT positions and surge staffing.	



☐	Determine if there is an adequate number of facility personnel to meet remaining incident needs.
☐	Deactivate IMT positions that are no longer needed.
☐	Reduce surge staff (e.g., off-duty personnel, volunteers, contract support) and provide guidance on close-out procedures (e.g., where to submit documentation).
Return or restore emergency resources.	
☐	Estimate current and anticipated resource requirements.
☐	Determine which facility-owned resources need to be returned to storage locations in the facility; or replenished/repared for future incidents.
☐	Determine processes for transitioning borrowed resources back to sending facility/provider.
☐	Reactivate normal services and operations.
☐	Determine when it is safe to resume normal operations after conferring with the local authority, NYSDOH Regional Office, fire department, law enforcement, public health, and/or any other response authority.

Compile documentation for recordkeeping purposes.	
☐	Collect and manage documentation related to: disaster-related expenses, property damage, direct operating costs, consequential loss, damaged or destroyed equipment, construction-related expenses.
☐	Conduct debriefings with staff and volunteers.
☐	Write an After-Action Report.

6. Stakeholder Engagement

This tool describes the relationships facilities should strive to build with local response partners during pre-incident planning. Building a better relationship with these agencies will streamline incident response and information sharing. Trying to construct these relationships will be considerably more difficult during the middle of an incident.

6.1. County Office of Emergency Management

Forming a partnership with the County Office of Emergency Management is one of the more important relationships a facility can build within the community. Emergency management agencies are often the source of the most current and up to date information regarding incidents and hazards.

Establishing a line of communication with the local office of emergency management will help streamline critical information sharing and coordination with facilities. In addition, emergency management agencies can provide opportunities to better prepare for incidents through informational materials, trainings and exercises.

The following table outlines suggested action items for developing and maturing relationships with emergency management agencies.

Table 5: Office of Emergency Management Engagement

Office of Emergency Management	
☐	Establish point of contact at the County Office of Emergency Management. (Note: A list of county-specific agencies is available at http://www.dhSES.ny.gov/oem/contact/map.cfm)
☐	Clarify protocol and mechanisms for accessing information from the County Office of Emergency Management, including: ▪ Resource availability throughout the region ▪ Pre-determined location list ▪ Current available services and utilities ▪ Hazard forecasts ▪ Mass notification systems
☐	Understand jurisdiction's response processes and capabilities, including available resources and response priorities in a large disaster.
☐	Identify available opportunities for training and exercises with the County Office of Emergency Management.
Office of Emergency Management	

☐	Identify critical information that the facility should relay to the County Office of Emergency Management before and during a disaster (e.g., facility status, number of residents needing transport, or infrastructure status).
☐	Seek County Office of Emergency Management input on CEMP development.

6.2. Fire Department and Law Enforcement

Enhancing relationships with first responder agencies are also critical to expediting the response process. These agencies will often be the first of the group to support facilities and relay critical incident information.

The following table outlines suggested action items for maturing relationships with fire department and law enforcement agencies.

Table 6: Fire Department and Law Enforcement Engagement

Fire Department and Law Enforcement	
☐	Establish point of contact at fire department, emergency medical services, and law enforcement agency.
☐	Identify what critical information should be relayed to fire department, emergency medical services, and law enforcement agencies before, during, and after a disaster.
☐	Identify opportunities for training and exercises with fire department and law enforcement agencies.
☐	Solicit fire department and law enforcement agency input on recommendations to expedite response and recovery actions, including pre-staging equipment/resources, best ingress and egress from facility, and debris removal to restore emergency access.

6.3. Other Stakeholders

6.3.1. Corporate / Parent Organization

If the facility is part of a larger multi-facility system, the facility should coordinate with its parent organization to ensure pre- and post-incident activities adhere to corporate policies, and to ensure the facility is appropriately empowered to execute incident management functions (e.g., permissions for external messaging, clarification of branding standards).

6.3.2. Community Stakeholders

Facilities are encouraged to build relationships with additional community stakeholders to assist with the disaster response and recovery. Some examples of the assistance that can be provided include volunteer support, surge staffing, and resources.

Community stakeholders may be different for every facility, but may include resource providers and vendors (e.g., transportation providers, fuel); local subject matter experts (e.g., engineering, finance and recovery, sustainability and mitigation); and volunteer resources.

The table below outlines potential volunteer resources that may be utilized to augment or supplement facility staff and operations prior to, during, or after an emergency.

Table 7: Volunteer Resources

Entity	Description and Skills
ServNY	Administered by the NYSDOH Office of Health Emergency Preparedness, ServNY is an online registration system for licensed healthcare professionals to volunteer when local and regional resources are exhausted. Volunteers are notified of staffing requests via phone or email. ServNY may also be activated by: ▪ County Office of Emergency Management submits a request to the New York State Office of Emergency Management, which sends the request to Emergency Support Function-8 State Health Desk, and then to the NYSDOH Emergency Preparedness; or ▪ Direct order of the NYSDOH Commissioner or designee.
Entity	Description and Skills
Community Emergency Response Team (CERT)¹²	Community volunteers that are trained in disaster preparedness and basic disaster response skills. These skills include: ▪ Fire Suppression ▪ Simple Triage and Rapid Treatment – Airway obstruction – Bleeding – Shock – Basic first aid – Establishing a medical treatment area ▪ Light Search and Rescue ▪ Team Organization

¹² Facilities can locate their local CERT program at https://community.fema.gov/Register/Register_Search_Programs

⁴ Facilities can locate their local MRC program at <https://mrc.hhs.gov/FindMRC>

Medical Reserve Corps (MRC)⁴	MRC volunteers are imbedded in ServNY. Volunteers include practicing and retired medical and public health professionals. MRC volunteers can support response capabilities such as: ▪ Disaster medical support ▪ Health screenings ▪ Vaccination clinics ▪ Medical facility surge capacity ▪ Planning, logistical, and administrative support
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7. Communications Plan

A communications plan helps facilities maintain situational awareness throughout the duration of an incident and enables facilities to share information effectively across the organization, as well as with any external partners who may be supporting the response.

7.1. Objectives

- Ensure communication policies, roles, and activities are clearly defined and well-understood by staff.
- Ensure internal and external communications are accurate, timely, and informative.
- Provide frequent updates to residents, staff, relatives/responsible parties to mitigate concerns and manage expectations.

- Only share known/confirmed information (i.e., do not speculate).
- Utilize one unified voice to avoid confusion or misinformation.

7.2. Implementation

Table 8: Communications Checklist

Communications Checklist	
Preparedness	
☐	Designate and train personnel to serve as Public Information Officer prior to an incident (i.e., during normal operations). Potential training courses include: ▪ FEMA IS-29: Public Information Officer Awareness (Free Online Course) ▪ FEMA IS-42: Social Media in Emergency Management (Free Online Course)
☐	Develop and refine pre-scripted messaging that can be tailored for incident use.
☐	Determine primary and redundant forms of communication: ▪ Primary forms include landline-dependent communications such as telephones and cellphones. ▪ Redundant forms are not dependent on functioning landline communication (e.g., include two-way radios, satellite radios).
☐	Ensure multiple personnel have administrative access, training, and policies and procedures to the facility's website, social media accounts, and voicemail system.
Communications Checklist	
☐	Maintain up-to-date contact information for designated notification parties for all residents (e.g., relatives/responsible parties).
☐	Maintain up-to-date contact information for all staff.
☐	Clarify approval processes for internal and external messaging content (e.g., peer review, senior leader final approval).
Incident Response	

☐	Request an updated on the incident from the Incident Management Team: ▪ What happened? ▪ What is the status of residents and personnel? ▪ When will the incident be resolved?
☐	Inform internal audiences (e.g., personnel) about incident updates before informing external audiences.
☐	Provide office personnel (e.g., receptionist) with guidance on where to direct incoming inquiries (e.g., media, personnel, relatives/responsible parties, vendors).
☐	Maintain a log of incoming calls, including: ▪ Name of caller ▪ Name of publication or media source ▪ Phone number ▪ Email address ▪ General nature of inquiry and any deadlines
☐	Develop a press release (or official facility statement) to post on facility website and social media pages.
☐	Update the facility's voicemail recording to provide alternative contact information if the facility is evacuated and/or to field incoming inquiries.

7.3. Pre-Scripted Messaging

Depending on the situation, numerous forms of alerts and warnings may be required to reach staff, residents, relatives and responsible parties, and the media.

It is vital to have several staff members who are solely responsible for fielding calls from residents' relatives and responsible parties and who are familiar with pre-scripted messaging usage. Only authorized spokespersons (e.g., Public Information Officer) should manage media and public inquiries.

7.3.1. Internal Pre-Scripted Messaging

To facilitate timely and effective communications, the following pre-scripted messaging templates have been developed for facilities to tailor for incident-specific messaging. During an incident, the facility will manage or coordinate the development and dissemination of these messages.

Immediate Messaging

Please note that for incidents that pose an immediate threat to health or safety (e.g., active threat or fire), messaging should be short and direct (i.e., “Enter the nearest room and lock the door,” or in the case of fire, “Evacuate the area immediately”).

CEMP Activation

The following message should be delivered to on-duty staff members who will assume Incident Management Team positions:

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations have begun in order to manage the incident.

You are receiving this message because of your role on the Incident Management Team. Please report to [Location] immediately. Continue to monitor available communications channels for updates. Refrain from sharing this message or subsequent updates with the public.

For more information, contact [Name, Title] via phone at [Phone Number] or by email at [Email Address].

The following message should be delivered to off-duty staff members who will be needed to support incident operations:

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations have begun in order to manage the incident.

You are receiving this message because of the need to request additional support for incident operations. Please report to [Location] at [Time]. Continue to monitor available communications channels for updates. Refrain from sharing this message or subsequent updates with the public.

Please be prepared to bring [Resources to Support Self-Sufficiency] and [Include IncidentSpecific Safety Information].

For more information, contact [Name, Title] via phone at [Phone Number] or by email at [Email Address].

Pre-Scripted Messaging for Residents

Resident care personnel are responsible for informing their residents of the incident. It is important to accommodate for the unique needs of each resident and provide messaging appropriate to each resident’s level of understanding.

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Please [Directions for residents (e.g., “ready yourself to evacuate”; “remain in your room”; “convene in the cafeteria”)].

If you have any questions or need anything, please call [Name, Title] at [Phone Number]. We will provide more information as it becomes available. Your safety is our top priority. Thank you for your patience.

Messaging to Staff about Evacuation to Receiving Facility

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations are being established to manage the incident.

The impacts of [Incident Name] are [Expected to cause or are causing] significant damage to the following areas: [List of Impacted Areas]

For the health, safety, and well-being of residents, [Facility Name] will be evacuating residents to [Receiving Facility]. This facility is located at [Street Address].

Messaging to Residents about Evacuation to Receiving Facility

Please ready yourself for evacuation. Staff will prepare and assist you. We will be aiding those with mobility issues. At the [Receiving Facility], you will receive food, water, shelter, and support services. We are notifying your relatives and responsible parties of the evacuation.

For more information, please call [Name, Title] at [Number].

7.3.2. External Pre-Scripted Messaging

Voicemail Recording Website/Social Media Message

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations have been initiated to manage the incident. [Provide high level information on residents’ status]. We are taking extensive actions to protect residents. [For your safety and that of others, please do not attempt to come to the facility]. [In the event of evacuation, add] For resident safety and well-being, residents are being evacuated to [Location].

For more information, please contact [Name, Title] at [Phone/Email].

Tweets, limited to 280 characters, or other short messages can include:

[Facility Name] is experiencing [Incident Name]. Responders are working to resolve the incident. Resident safety is our top priority. Do not attempt to visit [Facility Name] at this time. For information and updates, please call [Phone Number].

Proactive Messaging to Relatives and Responsible Parties

When communicating with relatives and responsible parties it is important to provide high level information on the status of residents. If it is known that certain residents have been injured, or there are fatalities, stress the seriousness of the incident but do not release resident information until the status of injured residents and fatalities can be confirmed and the incident is contained.

Hello. This is [Name and Position] from [Facility Name]. We are [Calling/Emailing] you to inform you that [Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name].

Emergency operations have been initiated to manage the incident. [Provide high level information on residents' status]. We are doing as much as we can to protect residents. We will provide information as it becomes available. [In the event of evacuation, add] For resident safety and well-being, residents are being evacuated to [Location].

For more information, please contact [Name, Title] at [Phone/Email].

7.4. Communicating with the Public

The facility should notify media outlets of the incident as deemed necessary by the Incident Commander. Only the Public Information Officer and authorized facility spokespersons should communicate with the public.

Key principles of communicating with the media and public are:

- Be knowledgeable. Know the facts before reporting out.
- Be strategic in what information is shared.
- Be credible. Do not try to distort facts to protect the facility. The facility will be held responsible for any misinformation that is provided by the Public Information Officer.
- Be accessible to inquiries; be transparent.
- Be proactive. Control messaging that is released and do not let the media and public distort messaging. Correct any rumors that arise.
- Be flexible. Ensure the audience understands that the situation is unfolding, and information will be shared as it is made available.
- Be calm and collected.
- Be sure to provide contact information where the media and public can direct inquiries.

8. Protective Action Decision Support

Facilities should use sound decision-making criteria when considering which protective action to implement (e.g., evacuate, defend-in-place). The following questions can be used to arrive at a decision.

Table 9: Protective Action Considerations

Protective Action Considerations	
Information and Intelligence	
☐	Have local authorities issued protective action guidance?
☐	Have adjacent counties/municipalities protective action guidance?
☐	What is the status of traffic near the facility?
☐	What is the acuity of the current resident population?
☐	What is the status of receiving facilities?
☐	What is the capacity of receiving facilities to receive residents?
☐	Have send-receive arrangements been put in place and verified?
Anticipated Impacts	
☐	What are the anticipated impacts on the facility?
☐	What is the forecasted external temperature for the next seven days?
☐	What facility infrastructure might be affected?
☐	Are there any anticipated life safety issues?
Resource Levels	
☐	What are staffing levels?

☐	Have surge-staffing options been implemented?
☐	What is the status of medical, pharmaceutical, and resident care supplies?
☐	What is the status of food and water?
Protective Action Considerations	
☐	What is the status of generators and fuel levels?
☐	What is the status of transportation resources?
☐	Have any vendors/service provider agreements been activated?
☐	What are staffing levels?
☐	Have surge staffing options been implemented?

9. After-Action Review Process

Following every exercise or real-world incident, it is vital to capture best practices, lessons learned, and areas for improvement in an After-Action Report (AAR). Plans, policies, and procedures should be updated to incorporate and address the outcomes outlined in each report.

Table 10: After-Action Review Process

After-Action Review Process	
☐	Designate a staff member(s) to conduct the After-Action Review process and solicit information for the AAR through: - Post-incident/exercise discussions and evaluations. - Surveys and feedback forms from the Incident Management Team, staff, residents, responsible parties, and emergency supply vendors, and local emergency management providers.
☐	Describe the event, be it a real-world incident or an exercise. Include as much detail as possible. Questions to consider: - When and where did the event occur? How long did the response last? - What was the nature and magnitude of the event? (For exercises, what is the summary of exercise activities?) - How did the incident impact residents, services, and the facility/facilities?
☐	Select the focus areas for the AAR based on areas needing improvement.
☐	Under each focus area, describe areas for improvement. Questions to consider: - What gaps, barriers, or challenges emerged? - What resources were needed that were not available? - What disruptions to services occurred? - How well did personnel understand their roles and responsibilities?
☐	Identify next steps for improving future responses. If possible, develop an improvement plan outlining priority levels, responsible parties, and estimated timelines for implementation. Provide additional training to cover areas of weakness.

10. After-Action Report Template

Table 11: After-Action Report Template

Event		Event Date		
[Incident/Exercise Name]		[Date]		
Event Description				
[Brief description of incident/exercise]				
Strengths				
[Placeholder] [Placeholder] [Placeholder]				
Areas for Improvement				
[Placeholder] [Placeholder] [Placeholder]				
Improvement Plan				
Issue/Area for Improvement	Corrective Action	Responsible Party	Start Date	Completion Date

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11. Resource Management

11.1. Resource Considerations

Before a disaster occurs, it is important to have send-receive agreements in place; have lists of vendors and service providers; and have all necessary information about site generator systems on hand. This information is vital to the internal facility response, can help first responders, and can set accountability. When determining which resources may be necessary for facility preparedness, consult the considerations below:

Generators

- What reporting processes are in place in the event that a generator fails inspection, is not properly maintained, or fails a test?
- What positions are routinely trained on the process of establishing emergency power to the building?
 - Who is responsible for performing this task?
- What procedures are in place to troubleshoot generator system failures?
- How long can emergency power be sustained before having to replenish fuel if tank is full?
- What systems, capabilities, and/or resources will be impacted if power is lost and emergency power is unable to be secured (e.g., food, water, ventilation)?

Fuel

- Is the emergency fuel source municipal fuel or local/on-site fuel?
- What is the current onsite fuel storage capacity?

Potable Water

- Where is potable water stored on site?
- What potential barriers are there to reaching the potable water during an emergency?
- Will potable water storage be safe from contamination by flood waters or severe storms?

- Who manages the potable water storage?

Transportation

- Which types of vehicles are immediately available to the facility?
- Are facility-owned vehicles maintained?
- Where can facility-owned vehicles access fuel?
- How many and which staff can operate facility-owned vehicles?
- Should additional staff be trained pre-disaster as alternatives?
 - Where are copies of operator licenses kept?
- Do staff have identification and primary and alternate routes if normal travel is restricted or roads are closed?

12. Glossary

Table 12: Glossary

Term	Definition
Activation	To begin the process of mobilizing a response team, or to set in motion an emergency operations (response) or recovery plan, process, or procedure in response to incident or exercise.
Automatic Sprinkler	Ceiling sprinklers are located throughout the facility and are activated by heat, thereby setting off the water flow and the alarm.
Defend-in-Place	The ability of a facility to safely retain their residents in an incident-related situation (e.g., flood, severe weather, wildfire). This is also known as “hunkering down” during an event.
Demobilization	The orderly, safe, and efficient return of an incident resource to its original location and status.
Evacuation	Organized, phased, and supervised dispersal or removal of people from dangerous or potentially dangerous areas, and their reception and care in safe areas.
Evacuation Holding Area	Temporary refuge for residents and staff during a facility evacuation, and if needed, point of embarkation for transport for longer-term evacuations.
Evacuee	A person removed or moving from areas threatened or struck by a disaster.
Fire Alarm	Loud ringing of bells, which may be activated by detectors, sprinklers, or manually, to alert residents and staff. When the bells sound, one of the systems has been activated and an emergency is occurring.
Fire Doors	These doors cut off a wing or a portion of a wing from adjoining areas to prevent drafts, which carry smoke, and retards the spread of fire.

Hazard	Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.
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Term	Definition
Hazard Vulnerability Analysis	A systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or “vulnerability,” is related to both the impact on organizational function and the likely service demands created by the hazard impact.
Incident Action Plan	An oral or written plan, containing objectives that reflect the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.
Incident Command System	A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.
Incident Management	The broad spectrum of activities and organizations providing effective and efficient operations, coordination, and support applied at all levels of government, utilizing both governmental and nongovernmental resources to plan for, respond to, and recover from an incident, regardless of cause, size, or complexity.

Incident Management Team	The Incident Management Team is comprised of pre-designated personnel who are 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 may decide to activate the entire team or select positions, based on the extent of the emergency.
Lockdown	A security measure taken during an emergency to prevent people from leaving a facility, and to prevent an active threat (one or more persons) from entering a facility.

Term	Definition
Mitigation	Activities providing a critical foundation in the effort to reduce the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster and providing value to the public by creating safer communities. Mitigation seeks to fix the cycle of disaster damage, reconstruction, and repeated damage. These activities or actions, in most cases, will have a long-term sustained effect.
Operational Period	The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually they last 12-24 hours.
Preparedness	A continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response. Preparedness focuses on the following elements: planning; procedures and protocols; training and exercises; personnel qualification and certification; and equipment certification.
Receiving Facility	A facility that has entered into agreement with another facility (nursing home, adult care facility, hospital, etc.), offering to host residents and staff for some part of an emergency response.
Response	Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes.

Recovery	The development, coordination, and execution of service- and site restoration plans; the reconstitution of government operations and services; individual, private-sector, non-governmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.
Secure Area	An area that has been checked and verified to be clear of fire/danger, with windows and doors closed, equipment shut down, and hallways free of obstacles.
Term	Definition
Shelter-in-Place	NYSDOH defines shelter-in-place as the protective action strategy of 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. Can only be done for coastal storms. Requires pre-approval from NYSDOH prior to each hurricane season and pre-authorization at the time of the incident. Please refer to the 2019 Evacuation Plan.
Situational Awareness	Is the ability to identify, process, and comprehend the essential information about an incident to inform the decision-making process in a continuous and timely cycle and includes the ability to interpret and act upon this information.
Smoke Detector	Smoke detectors are located on ceilings throughout the facility and respond to smoke thereby setting off the alarm.
Threat	Natural or manmade occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property.

For all Hazard Annexes below the NYSDOH Regional Office is to be notified during normal business hours. **For events that occur on nights, weekends or holidays, notify the NYSDOH Duty Officer at 866-881-2809.**

Hazard Annex A: Active Threat

An active threat is an individual or group of individuals actively engaged in killing or attempting to kill people in a confined and populated area, often through the use of firearms.

Preparedness	
☐	Conduct a walk-through of the facility to determine vulnerabilities (e.g., publicly accessible entrances), identify emergency escape routes, and determine necessary security measures (e.g., additional locks, cameras).
☐	Train staff on security-related responsibilities and empower staff to report unusual, dangerous, or suspicious activity.
☐	Train staff on the “Run, Hide, Fight” options to enable staff to quickly act during a realworld situation. ¹³
☐	Create and implement policies for access control and security: ▪ Require all persons to display an authorized identification badge or pass. ▪ Ensure locked doors remain closed and locked. ▪ Control dissemination of keys and/or keypad code access.
☐	Identify emergency escape routes for each facility office, which may or may not be the same as normal fire evacuation routes.
☐	Identify outside gathering areas within a half mile of the facility and communicate location to staff members for staff, residents, and visitors to convene during an active threat, as appropriate.
☐	Conduct drills with law enforcement officials to familiarize first responders with the facility (e.g., entrances/exits, building layout, notification procedures).

¹³ For more information, refer to *Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans* at <http://www.phe.gov/Preparedness/planning/Documents/active-shooter-planning-eop2014.pdf>

Response	
☐	In response to an active threat, each individual (staff, residents, and visitors) will determine the most appropriate response based on their proximity to the threat and their mobility level. ▪ RUN: If it is safe to do so, staff and residents should move as far away from the threat as possible until they are in a safe location. ▪ HIDE: If running is not a safe option—or for residents with mobility options—individuals should hide in as safe a place as possible (e.g., thicker walls, fewer windows, lock or barricade doors). ▪ FIGHT: If neither running nor hiding is a safe option, as a last resort and when confronted by the assailant, individuals in immediate danger should consider trying to disrupt or incapacitate the assailant by using aggressive force and items in their environment, such as fire extinguishers, chairs, etc.
☐	The Regional Office or Watch Center should not be contacted as the event is in progress. All DOH or Watch Center notifications should be done after law enforcement has deemed the situation safe. The facility will call 9-1-1 if there is a suspected or actual threat to the facility, staff, or residents and will provide as much of the following information as possible: ▪ Facility name and address; ▪ Location and number of attacker(s); ▪ Description of attacker(s), gender, clothing, among other points; ▪ Number and location of any victims. ▪ Type(s) of weapons if known.
☐	After notifying authorities of the emergency, the facility will use its notification methods to warn visitors, off-site staff, and others.
☐	The facility will notify residents, visitors, and staff when law enforcement has determined that the threat has been neutralized.

Hazard Annex B: Blizzard/Ice Storm

A blizzard has a wind speed of 35 mph or higher with blowing snow and extremely limited visibility. An ice storm also reduces visibility and can immobilize ground and air transportation leaving a facility isolated. Ice storms include freezing rain and sleet, both of which cause sheets of ice to form on the ground, which can cause falls. Ice may also build on tree limbs, wires, and awnings. Blizzards and ice storms can cause extreme cold and power outages, and impede travel to and from the facility, impacting delivery of vital services and supplies.

Preparedness	
☐	Procure sufficient rock salt/snow melt to clear primary passageways.
☐	Monitor weather forecasts via radio and television (e.g., National Weather Service).
☐	Begin preparations for a blizzard/ice storm as soon as a watch (storm is 36 – 48 hours out) or warning (storm is occurring or will occur in 24 hours) is issued.
Response	
☐	Ensure all staff and residents remain inside the facility.
☐	Determine which staff will remain on site for up to 72 hours, as shift changes will not be possible during a blizzard due to blocked roads. Develop and disseminate a schedule to ensure all staff have breaks to rest, eat, and sleep.
☐	If the heating system fails, prepare to evacuate, if possible. Contact the NYSDOH Regional Office for guidance on whether to evacuate. If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .

Hazard Annex C: Coastal Storms

Coastal storms may arrive as tropical depressions (maximum sustained winds of 38 mph or less), tropical storms (maximum sustained winds of 39-73 mph), or hurricanes (maximum sustained winds of 74 mph or more, ranging from Category 1-5). Hazards associated with coastal storms include: flooding; flying debris; extreme winds and tornados; torrential rain; and power outages due to downed trees and power lines.

Preparedness	
☐	Determine which buildings, infrastructure, and essential services would be at risk by flooding.
☐	Assess potential infrastructure impacts from winds and heavy rains: - Assess the ability of facility infrastructure to withstand extreme winds and rain. - Consider infrastructure-hardening measures (e.g., impact-resistant windows).
☐	In the days prior to landfall, review forecast information and intelligence, anticipated impacts, and facility resource levels to determine facility readiness to implement protective actions.
☐	Maintain communication with the County Office of Emergency Management and Health Emergency Preparedness Coalition to receive storm reports for the area.
☐	In the absence of direction from NYSDOH and local authorities (e.g., mandatory evacuation order), determine which protective action to implement.
☐	Implement protective action. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information. If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .
☐	Reassess the situation at regular intervals (e.g., 96 hours, 72 hours, 48 hours, 24 hours) to determine whether additional protective actions are required.
Response	
☐	Evaluate conditions of staff and residents and identify needs and gaps in services.
☐	Assess infrastructure damage and continued threats to staff and residents.

☐	Report status to external partners (e.g., NYSDOH Regional Office, County Office of Emergency Management) and/or relatives and responsible parties, as appropriate.
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Hazard Annex D: Dam Failure

The response to a dam failure will depend on the amount of warning time, which will depend on the cause and extent of flooding or primary dam failure. Heavy rains downstream may give a facility time to prepare for a dam failure while intense storms with flash flooding could cause failure within minutes. It is important to respond immediately to any kind of siren/alarm and/or warning coming from dam officials.

Preparedness	
☐	Identify dams near the facility.
☐	Work with County Office of Emergency Management officials to identify the best preparedness actions specific to nearby dams.
☐	Identify which facility buildings, infrastructure, and essential services would be in the path of flood waters as the result of a dam failure.
☐	Consider mitigation activities in areas susceptible to water intrusion.
☐	Develop procedures for relocating resources, vital records, and equipment to assure continuation of services and to prevent damage or loss.
Response	
☐	If the facility suffers structural damage or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information.

☐	Regularly seek updates on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility's population.
☐	Consider all flood water contaminated. Avoid walking through floodwater and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that have come into contact with floodwater.
☐	Gather critical supplies to take to higher ground (e.g., medications, drinking water, health records, important personal items, communication devices, blankets).
☐	Do not allow electrical devices to come into contact with water.
☐	If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .

Hazard Annex E: Earthquake

Earthquakes cannot be predicted and are considered “no-notice” incidents. Hazards associated with earthquakes include: tsunami (flooding); power outages; fires, and landslides.

Preparedness	
☐	Ensure structures are in full compliance with regional building codes.
☐	Implement earthquake protection measures for utilities: ▪ Repair defective electrical wiring. ▪ Repair leaky gas lines. ▪ Install automatic shut off valves triggered by strong vibrations. ▪ Repair or replace inflexible utility connections and fittings.

☐	Protect staff and residents from movable objects: - Secure water heaters, refrigerators, furnaces and/or boilers, washing machines and dryers, and other gas appliances. - Secure top-heavy items. - Store large or heavy items on lower shelves. - Secure cabinets. - Secure overhead lighting.
☐	Stage multiple small fire extinguishers throughout the facility and provide training on fire extinguisher use and associated hazards. ⁶
Response	
During Earthquake	
☐	Do not attempt to leave the building during an earthquake.
☐	Instruct residents in wheelchairs to lock their wheels in a safe position and cover their head and neck with their arms if they are able to.

⁶ 29 Code of Federal Regulations, 1910.157(g)(1) states that “Where the employer has provided portable fire extinguishers for employee use in the workplace, the employer shall also provide an educational program to familiarize employees with the general principles of fire extinguisher use and the hazards involved with incipient stage fire-fighting.” Paragraph (g)(2) states that the “education” required in paragraph (g)(1) “must be provided to employees upon initial employment and at least annually thereafter.”

☐	Instruct residents in beds to remain in their beds.
☐	Instruct personnel to take cover under a desk, table, in a doorway. Place hands over your head for protection. Stay away from windows, glass, and exterior doors.
☐	Encourage everyone to remain in place for a few minutes after the initial shock as aftershocks may occur.
After Earthquake	
☐	Survey the facility for injuries, structural damage, fire, ruptured gas or water pipes, etc. If necessary, shut off utility lines and/or panels.
☐	Assign staff to assess residents for any injuries that require immediate attention.
☐	Assess the facility for damage that requires immediate attention (e.g., gas leaks, fires, broken glass, spills).
☐	If there is a fire, follow facility protocol.
☐	If a gas leak is suspected, notify the Plant Manager.
☐	If electrical system damage is suspected, follow facility protocol.
☐	If sewage and water line damage is identified, follow facility protocol.
☐	Comply with public health notices/orders regarding water contamination and utilize emergency potable water resources.
☐	If the facility has suffered structural damage, or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information.
☐	If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .

☐	Seek updates from staff on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility's population.
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Hazard Annex F: Extreme Cold

Extreme cold can occur independent of any snow, ice, or storm systems. Extreme cold events involve an extended period with temperatures at or below 32°F. The risk to health and personal safety during extreme cold is exacerbated by utility service interruption or loss. Therefore, the facility maintains its building systems ahead of any extreme weather projections. The facility acknowledges and prepares for the possibility of short staffing due to road conditions.

Preparedness	
☐	Conduct regular building maintenance and inspection, including maintenance of heating and air conditioning systems and thermostats.
☐	Test all generators involved in supplying power to areas for resident care and ensure the facility has sufficient fuel on-site to fuel the generator for the period of extreme cold.
☐	Routinely monitor the indoor facility temperature when the outdoor temperature is below 65 degrees Fahrenheit to ensure the indoor temperature in residents' rooms and all common areas is maintained at a minimum of 75 degrees Fahrenheit. ⁷
☐	Develop resident assessment protocol, including vital sign checks focusing on core temperature and comfort checks.
☐	Develop procedures for internal relocation of residents to warmer parts of the facility.

☐	Document vendors for additional heating units. Establish agreements and/or contracts with vendors, as possible.
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⁷ 10 NYCRR 415.5 and 42 CFR 483.15 The regulations contained in 10NYCRR Part 713 require nursing homes to be equipped with a heating system capable of maintaining all resident areas at a minimum temperature of 75 degrees Fahrenheit.

Response	
☐	Conserve heat: ▪ Avoiding unnecessary opening of doors/windows ▪ Close off unoccupied rooms ▪ Cover windows
☐	If the facility experiences heating equipment malfunctions during normal business hours, immediately contact heating equipment service provider and notify the NYSDOH Regional Office. For malfunctions that occur on nights, weekends or holidays, notify the New York State Watch Center (Warning Point) at 518-292-2200.
☐	If heating equipment has failed, regularly monitor individual room temperatures.
☐	Initiate actions to safely increase resident comfort (e.g., provide additional blankets to residents); offer warm liquids (keeping in mind relevant dietary modifications/restrictions).
☐	Assess residents for signs of distress and/or discomfort.

☐	If the internal temperature of the facility remains low and potentially jeopardizes the safety and health of residents, consider internal relocation to a warmer part of the facility (on sunny side; downwind) or evacuation.
☐	If the decision is made to evacuate, refer to the <i>NYSDOH Evacuation Plan Template</i> .

Hazard Annex G: Extreme Heat

Extreme heat events are defined as periods when the heat index is 100°F or higher for one or more days, or when the heat index is 95°F or higher for two or more consecutive days. Prolonged periods of this heat accompanied by high humidity create a dangerous situation for vulnerable populations. Elderly residents and those with chronic medical conditions such as cardiopulmonary conditions, high blood pressure and residents with mental illness are at increased risk for heat exhaustion, heat stroke and heat cramps.

Preparedness	
☐	Regularly inspect the building's HVAC system.
☐	Maintain cooling supplies: ▪ Portable fans and temporary cooling devices ▪ Non-perishable foods and fluids
☐	Develop procedures to monitor the physical environment of the facility (e.g., temperature, humidity, sun screening, ventilation).
☐	Develop procedures for relocation to cooling centers inside the facility. Procedures for the internal relocation of residents to air-conditioned, or cooler areas, of the facility.
☐	Educate staff on risks of extreme heat, including: heat cramp, heat exhaustion, heat stroke, sunburn, and dehydration.
☐	Develop resident assessment protocol, including vital sign checks focusing on core temperature, comfort checks, and checking for resident dehydration.

Response	
☐	Conduct wellness checks and safety precautions: ▪ Check rooms regularly to ensure that air-conditioning is operational. ▪ Keep drapes and windows closed. ▪ Decrease physical activity for residents. ▪ Keep residents inside facility.
☐	Monitor resident exposure and reactions to heat. Follow protocol for transfer to hospital if resident appears to be suffering from heat-related illness such as heat cramps, heat exhaustion, or heat stroke.
☐	Consider re-locating residents to the coolest locations in the facility or creating “cooling centers” where residents can congregate with limited air conditioning, cool cloths, cold beverages, and similar measures.
☐	If the internal temperature of the facility remains high and potentially jeopardizes the safety and health of residents, notify the NYSDOH Regional Office. On nights, weekends or holidays, notify the New York State Watch Center (Warning Point) at 518292-2200.
☐	If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .
☐	Encourage residents to drink fluids to maintain hydration.

Hazard Annex H: Fire

Fires may occur within the facility or may be a result of external fire activity, including wildfires.

Preparedness	
☐	Identify fire and life safety hazards inside the facility: ▪ Missing or broken fire safety equipment ▪ Blocked fire doors and evacuation routes ▪ Accumulated trash ▪ Burned out exit lights
☐	Plant Manager will document and inspect facility's fire and life safety emergency systems, including: ▪ Manual pull alarms ▪ Smoke detectors ▪ Exit doors and stairwells ▪ Sprinklers System ▪ Fire extinguishers ▪ Fire alarm monitoring service ▪ Self-closing fire doors
☐	Test the facility's fire alarm system and record outcomes, as required by NYSDOH regulation.
☐	Train all staff on the type of fire extinguishers in the building, their location, how to access them, and the types of fires they should be used on.
☐	Conduct quarterly fire drills at unexpected times, under varying conditions, and on each shift.
Response	

☐	If the fire alarm system is out of service for more than four hours in a 24-hour period, notify the Authority Having Jurisdiction, evacuate the building, or if approved, implement a fire watch until the fire alarm system has been returned to service.
☐	Rescue those in immediate danger in accordance with the facility's fire rescue procedures.
☐	Pull the fire alarm and then alert residents and staff members.
☐	Contain the fire if possible. ▪ Shut off air flow, as much as possible. ▪ Close all fire doors and shut off fans, ventilation systems, and air conditioning/heating systems. ▪ Use available fire extinguishers if the fire is small and this can be done safely.
☐	Relocate oxygen-dependent residents away from fire since oxygen supply lines (whether portable or central) may lead to combustion in the presence of sparks or fire. If necessary, remove oxygen and reconnect one resident is in a safe area.
☐	If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .

Hazard Annex I: Flood

Floods may be the result of coastal, lake, river, inland, or indoor flooding.

Preparedness	
☐	Implement indoor flooding protection measures for buildings: ▪ Repair and replace leaky or broken pipes. ▪ Perform maintenance inspections on water heaters and washing machines. ▪ Identify clogged sewer or drain lines and contact plumbing services, as needed.
☐	Determine which buildings, infrastructure, and essential services may be at risk of flooding.
☐	Consider mitigating risks associated with flooding: ▪ Elevate the furnace, water heater, emergency generator, and electrical panel if susceptible to flooding. ▪ Install sewer backwater valves to prevent sewer backups. ▪ Build barriers to prevent floodwater from entering the facility. ▪ Utilize waterproofing materials to seal walls in basements or identified rooms.
Response	
☐	Maintain contact and communication with the County Office of Emergency Management and Health Emergency Preparedness Coalition to receive flooding reports for the area.
☐	If the facility has suffered structural damage, or if supporting utilities are compromised (e.g., power, water), consider the implementation of a protective action. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information.
☐	If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .

☐	If the decision is made to internally relocate, gather critical supplies to take to higher ground (e.g., medications, drinking water, resident records, important personal items, communication devices, blankets).
☐	Regularly seek updates from staff to determine if other protective actions are needed for some or all of the facility's population.
☐	Unplug non-essential appliances, equipment, and computers. Do not allow electrical devices to come into contact with water.
☐	If a gas leak is suspected, notify the Plant Manager.
☐	Check for water line ruptures and sewage contamination and report utility problems to the utility company.
☐	If water lines are disrupted, consider the water supply to be contaminated and utilize the facility's emergency potable water resources.
☐	Comply with public health notices regarding water contamination (e.g., Boil Water, Do Not Drink Water, Do Not Use Water).
☐	Consider all flood water contaminated. Avoid walking through floodwater and wash hands thoroughly after contact. Do not use pre-packaged food and drink products that have come into contact with floodwater.

Hazard Annex J: Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE)

CBRNE incidents occur when a hazardous substance is released into the environment, causing potential harm to the staff and residents of the facility. CBRNE emergencies are particularly dangerous for facilities, as populations are typically confined indoors with compromised health and immune systems. Released toxic substances, even in small amounts, can further weaken the health and well-being of residents.

Preparedness	
☐	Determine the facility's proximity to potential sources of CBRNE exposure (e.g., transportation corridors, nuclear power plant).
☐	Work with local emergency management, public health, environmental health, and other identified stakeholders to develop a decontamination plan.
☐	Properly dispose of potentially toxic substances like unused chemicals, pharmaceuticals, and other substances.
☐	Conduct trainings on safe handling, transportation, and disposal of hazardous wastes.
Response	
☐	Maintain contact and communication with the County Office of Emergency Management and Health Emergency Preparedness Coalitions to receive updated CBRNE threat information for the area.
☐	Based on the type and location of incident, assess potential impacts of a hazardous materials release.

☐	Review threat information and intelligence, anticipated impacts, and resource levels to determine facility readiness to implement protective actions. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information.
☐	If the decision is made to evacuate, refer to the <i>NYSDOH Evacuation Plan Template</i> .
☐	Assess the need to set up “hot, warm, and cold” zones for which access would be restricted. Secure zones accordingly.
☐	Provide guidance and implement protective measures for food handling, mass feeding, and sanitation.
☐	Preemptive methods to mitigate exposure to hazardous substance outside the facility: ▪ Close all windows, doors, and vents. ▪ Limit the amount of foot traffic in and out of the facility. ▪ Do not allow residents outside, as possible. ▪ If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intake.
☐	Carry out established decontamination procedures, as needed.
☐	Monitor staff and residents for delayed physical responses as a direct result of the incident.
☐	Assess residents for worsened health outcomes as an indirect result of the incident.

Hazard Annex K: Infectious Disease

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi. The circumstances of infectious disease emergencies, including ones that rise to the level of a pandemic, vary by multiple factors, including type of biological agent, scale of exposure, mode of transmission and intentionally.

The facility follows effective strategies for preventing infectious diseases. Each county Local Health Department-(LHD) has prevention agenda priorities compiled from community health assessments that can be reviewed and utilized by the facility in fully developing your CEMP Annex E, planning and response checklist for infectious disease and pandemic situations. The information within this Annex includes the identified priorities and focus areas.

Under the Pandemic Emergency Plan (PEP) requirements of Chapter 114 of the Laws of 2020, special focus is required for pandemics. Please use the template's Appendix E and this Hazard Annex, with prompts for the PEP requirements, to ensure that the plans developed meet all requirements.

Chapter 114 of the Laws of 2020 (full text):

Section 2803 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (a) each residential health care facility shall, no later than Ninety days after the effective date of this subdivision and annually thereafter, or more frequently as may be directed by the commissioner, prepare and make available to the public on the facility's website, and immediately upon request, in a form acceptable to the commissioner, a pandemic emergency plan which shall include but not be limited to:

(i) a communication plan:

- a to update authorized family members and guardians of infected residents at least once per day and upon a change in a resident's condition and at least once a week to update all residents and authorized families and guardians on the number of infections and deaths at the facility, by electronic or such other means as may be selected by each authorized family member or guardian; and
- b that includes a method to provide all residents with daily access,

At no cost, to remote videoconference or equivalent communication methods with family members and guardians; and

(ii) protection plans against infection for staff, residents and families, including:

- a a plan for hospitalized residents to be readmitted to such residential health care facility after treatment, in accordance with all applicable laws and regulations; and

b a plan for such residential health care facility to maintain or contract to have at least a two-month supply of personal protective equipment; and

(iii) a plan for preserving a resident's place in a residential healthcare facility if such resident is hospitalized, in accordance with all applicable laws and regulations.

b the residential health care facility shall prepare and comply with the pandemic emergency plan. Failure to do so shall be a violation of this subdivision and may be subject to civil penalties pursuant to section twelve and twelve-b of this chapter.

The commissioner shall review each residential healthcare facility for compliance with its plan and the applicable regulations in accordance with paragraphs (a) and (b) of subdivision one of this section.

c within thirty days after the residential health care facility's receipt of written notice of noncompliance such residential healthcare facility shall submit a plan of correction in such form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall ensure each such residential healthcare facility complies with its plan of correction and the applicable regulations.

d the commissioner shall promulgate any rules and regulations necessary to implement the provisions of this subdivision.

§ 2. This act shall take effect immediately.

1. Communicable Disease Reporting:

1.1. Importance of Reporting

- NYSDOH is charged with the responsibility of protecting public health and ensuring the safety of health care facilities.
- Reporting is required to detect intra-facility outbreaks, geographic trends, and identify emerging infectious diseases.
- The collection of outbreak data enables the NYSDOH to inform health care facilities of potential risks and preventive actions.
- Reporting facilities can obtain consultation, laboratory support and on-site assistance in outbreak investigations, as needed.

1.2. What must be reported?

NYSDOH Regulated Article 28 nursing homes:

- Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10 NYCRR 2.10), as well as by 10 NYCRR 415.19.¹⁴
- Any outbreak or significant increase in nosocomial infections above the norm or baseline in nursing home residents or employees must be reported to NYSDOH. This can be done electronically via the Nosocomial Outbreak Reporting Application (NORA). NORA is a NYSDOH Health Commerce System Application. Alternately, facilities may fax an [Infection Control Nosocomial Report Form \(DOH 4018\)](#) on the DOH public website.
 - Facilities are expected to conduct surveillance that is adequate to identify background rates and detect significant increases above those rates. Healthcare associated infection outbreaks may also be reported to the LHD.

A single case of a reportable communicable disease or any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) must be reported to the local health department (LHD) where the patient/resident resides. In addition, if the reportable communicable disease is suspected or confirmed to be acquired at the NYSDOH regulated Article 28 nursing home, it must also be reported to the NYSDOH. This can be done electronically via the NORA, or, by faxing an [Infection Control Nosocomial Report Form \(DOH 4018\)](#).

- Reports must be made to the local health department in the county in which the facility is located (as the resident's place of residence) and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately by phone.
- Categories and examples of reportable healthcare-associated infections include:
 - An outbreak or increased incidence of disease due to any infectious agent (e.g. staphylococci, vancomycin resistant enterococci, Pseudomonas, Clostridioides difficile, Klebsiella, Acinetobacter) occurring in residents or in persons working in the facility.
 - Intra-facility outbreaks of influenza, gastroenteritis, pneumonia, or respiratory syncytial virus.
 - Foodborne outbreaks.

¹⁴ A list of diseases and information on properly reporting them can be found below.

- Infections associated with contaminated medications, replacement fluids, or commercial products.

-
- Single cases of healthcare-associated infection due to any of the diseases on the Communicable Disease Reporting list. For example, single cases of nosocomial acquired Legionella, measles virus, invasive group A beta hemolytic Streptococcus.
 - A single case involving Staphylococcus aureus showing reduced susceptibility to vancomycin.
 - Clusters of tuberculin skin test conversions.
 - A single case of active pulmonary or laryngeal tuberculosis in a nursing home resident or employee.
 - 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.

■ Additional information for making a communicable disease report:

- Facilities should contact their NYSDOH regional epidemiologist or the NYSDOH Central Office Healthcare Epidemiology and Infection Control Program for general questions and infection control guidance or if additional information is needed about reporting to NORA. Contact information for NYSDOH regional epidemiologists and the Central Office Healthcare Epidemiology and Infection Control Program is located here:
https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/regional_epi_staff.htm. For assistance after hours, nights and weekends, call New York State Watch Center (Warning Point) at 518-292-2200.
- Call your local health department or the New York State Department of Health's Bureau of Communicable Disease Control at (518) 473-4439 or, after hours, at 1 (866) 881-2809; to obtain reporting forms (DOH-389), call (518) 474-0548.
- For facilities in New York City:
 - Call 1 (866) NYC-DOH1 (1-866-692-3641) for additional information.
 - Use the [downloadable Universal Reporting Form \(PD-16\)](#); those belonging to NYC MED can [complete and submit the form online](#).

2.0. PEP Communication Requirements

As per the requirements of the PEP, a facility must develop external notification procedures directed toward authorized family members and guardians of residents.

To adequately address this requirement, the facility will need to develop a record of all authorized family members and guardians, which should include secondary (back-up) authorized contacts, as applicable.

Under the PEP, facilities must include plans and/or procedures that would enable them to (1) provide a daily update to authorized family members and guardians and upon a change in a resident's condition; and (2) update all residents and authorized families and guardians at least once per week on the number of pandemic-related infections and deaths, including residents with a pandemic-related infection who pass away for reasons other than such infection (e.g., COVID positive residents who pass away for reasons other than COVID-19).

Such updates must be provided electronically or by such other means as may be selected by each authorized family member or guardian. This includes a method to provide all residents with daily access, at no cost, to remote videoconference or equivalent communication methods with family members and guardians.

3.0 PEP Infection Control Requirements

In addition to communication-related PEP requirements address above, the facility must develop pandemic infection control plans for staff, residents, and families, including plans for (1) developing supply stores and specific plans to maintain, or contract to maintain, at least a two month (60 day) supply of personal protective equipment based on facility census, including consideration of space for storage; and (2) hospitalized residents to 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); 42 CFR 483.15(e) and 42 CFR § 483.80. .

Additional infection control planning and response efforts and that should be addressed include:

- Incorporating lessons learned from previous pandemic responses into planning efforts to assist with the development of policies and procedures related to such elements as the management of supplies and PPE, as well as implementation of infection control protocols to assist with proper use and conservation of PPE.
- All personal protective equipment necessary for both residents and staff in order to continue to provide services and supports to residents. COVID-specific guidance on optimizing PPE and other supply strategies is available on CDC's website:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>. Supplies to be maintained include, but are not limited to:

- N95 respirators;
- Face shield;
- Eye protection;
- Gowns/isolation gowns;
- gloves;
- masks; and
- sanitizers and disinfectants ([EPA Guidance for Cleaning and Disinfecting](#)):

Other considerations to be included in a facility's plans to reduce transmission regard when there are only one or a few residents with the pandemic disease in a facility:

- Plans for cohorting, including:
 - Use of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, such as at the end of a hallway.
 - Discontinue any sharing of a bathroom with residents outside the cohort
- Proper identification of the area for residents with COVID-19, including demarcating reminders for healthcare personnel; and
- Procedures for preventing other residents from entering the area.

4.0 Other PEP Requirements

PEP further requires that facilities include a plan for preserving a resident's place at the facility when the resident is hospitalized. Such plan must comply with all applicable State and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).

4.1 Covid policy

Coronavirus (COVID-19)

Date Initiated: 6/3/22 (from multiple policies since 3/20)

Date Revised: 6/10/22, 10/14/22, 4/14/23, 5/4/23, 7/31/23

POLICY:

It shall be the policy to utilize accepted infection control methods to prevent and control the spread of a respiratory illness caused by *novel Coronavirus (COVID-19)*.

PURPOSE:

The primary goals of *COVID-19* prevention and control in long-term care facilities are:

1. Preventing the transmission of *COVID-19* to residents, staff, and visitors while preserving the quality of life for residents with *COVID-19*.
2. Screening all hospital patients for *COVID-19*, prior to admission or re-admission to our facilities.

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POLICY DEFINITIONS:

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Healthcare settings: refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others.

Source control: Use of respirators, well-fitting facemasks, or well-fitting cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing one safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control. At a minimum, source control devices should be changed if they become visibly soiled, damaged, or hard to breathe through. Further information about source control options is available at: Masks and Respirators ([cdc.gov](https://www.cdc.gov))

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. Guidance on design, use, and maintenance of cloth masks is available.

Facemask: OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as ‘medical procedure masks’.” Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are approved by CDC/NIOSH, including those intended for use in healthcare.

Immunocompromised: Moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the Interim Clinical Considerations for Use of COVID-19 Vaccines

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- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise. However, people in this category should still consider continuing to use of source control while in a healthcare facility.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Close contact: Being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

SARS-CoV-2 Illness Severity Criteria: (adapted from the NIH COVID-19 Treatment Guidelines)

The studies used to inform this guidance did not clearly define “severe” or “critical” illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the [National Institutes of Health \(NIH\) COVID-19 Treatment Guidelines](#) are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions. Clinical judgment regarding the contribution of SARS-CoV-2 to clinical

severity might also be necessary when applying these criteria to inform infection control decisions.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO₂) $\geq 94\%$ on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO₂ $<94\%$ on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of $>3\%$), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO₂/FiO₂) <300 mmHg, or lung infiltrates $>50\%$.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

PROCEDURE:

SECTION 1: Recommended Routine Infection Prevention and Control (IPC) Practices for COVID-19

1. Encourage everyone to [remain up to date](#) with all recommended COVID-19 vaccine doses.
 - HCP, patients, and visitors should be [offered resources and counseled](#) about the importance of receiving the COVID-19 vaccine.

NOTE: Refer to the “COVID-19 Vaccination Programs Policy” for details regarding the SARSCoV-2 (COVID-19) Vaccine.

2. Establishing a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection

- Ensure everyone is aware of recommended IPC practices in the facility.
- Post [visual alerts](#) (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations.
- Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
 - a positive viral test for SARS-CoV-2
 - [symptoms of COVID-19](#), or
 - close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a [higher-risk exposure \(for healthcare personnel \(HCP\)\)](#).
 - For example:
 - Instruct HCP to report any of the 3 above criteria to their supervisor or another point of contact designated by the facility so these HCP can be properly managed.
 - The definition of higher-risk exposure and recommendations for evaluation and work restriction of these HCP are in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV2 Infection or Exposure to SARS-CoV-2](#).
 - Provide guidance (e.g., posted signs at entrances, instructions when scheduling appointments) about recommended actions for patients and visitors who have any of the above three criteria.
 - Patients should be managed as described in Section 2.

- Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation (see Section 2); this time period is longer than what is recommended in the community. For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at [higher risk for transmission](#), it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet any of the criteria described in Section 2 (e.g., cannot wear source control).
- Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available [at Policy & Memos to States and Regions | CMS](#).

3. Implement Source Control Measures

[Source control](#) refers to use of respirators or well-fitting facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Masks and respirators also offer varying levels of protection to the wearer. Further information about types of masks and respirators, including those that meet standards and the degree of protection offered to the wearer, is available at: [Masks and Respirators](#). People, particularly those at high risk for severe illness, should wear the most protective mask or respirator they can that fits well and that they will wear consistently.

Even when a facility does not require masking for source control, it should allow individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

Source control options for HCP include:

- A NIOSH Approved® particulate respirator with N95® filters or higher;
- A respirator approved under standards used in other countries that are similar to NIOSH Approved N95 filtering face piece respirators (Note: These should not be used instead of a NIOSH Approved respirator when respiratory protection is indicated);

- A [barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks](#); OR
- A well-fitting facemask.
- When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned. Additional information is available in the FAQ: [Can employees choose to wear respirators when not required by their employer?](#)

4. Source control is recommended for individuals in healthcare settings who:

- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had [close contact](#) (patients and visitors) or a [higher-risk exposure](#) (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure

5. Source control is recommended more broadly as described in [CDC's Core IPC Practices](#) in the following circumstances:

- By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or

other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or

- Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission.
- Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when [COVID-19 hospital admission levels](#) are high)

6. Implement Universal Use of Personal Protective Equipment for HCP

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow [Standard Precautions \(and Transmission-Based Precautions\)](#) if required based on the suspected diagnosis).

As [SARS-CoV-2 transmission in the community](#) increases, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during patient care encounters as described below.

NIOSH Approved particulate respirators with N95 filters or higher used for:

- All aerosol-generating procedures (refer to [Which procedures are considered aerosol generating procedures in healthcare settings?](#)).
- All surgical procedures that might pose higher risk for transmission if the patient has SARS-CoV-2 infection (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract).
- NIOSH Approved particulate respirators with N95 filters or higher can also be used by HCP working in other situations where additional risk factors for transmission are present, such as when the patient is unable to use source control and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place.
- To simplify implementation, facilities may consider implementing universal use of NIOSH Approved particulate respirators with N95 filters or higher for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.

Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.

7. Optimize the Use of Engineering Controls and Indoor Air Quality

- Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception /

triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas).

- Take measures to limit crowding in communal spaces, such as scheduling appointments to limit the number of patients in waiting rooms or treatment areas.

8. Perform SARS-CoV-2 Viral Testing

- COVID-19 antigen tests may now include serial (repeat) testing on both symptomatic and
- asymptomatic individuals.
- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.
- Symptomatic individuals should have COVID-19 antigen testing at least twice over three days with at least 48 hours in between tests.
- Asymptomatic individuals with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
 - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
 - Guidance for work restrictions, including recommended testing for HCP with higher-risk exposures, are in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#).

- Guidance for use of empiric Transmission-Based Precautions for patients with close contact with someone with SARS-CoV-2 infection are described in Section 2.
- Testing considerations for healthcare facilities with an outbreak of SARS-CoV-2 are described in this policy.
- The yield of screening testing for identifying asymptomatic infection is likely lower when performed on those in areas with lower levels of SARS-CoV-2. However, these results might continue to be useful in some situations (e.g., when performing higher-risk procedures or for HCP caring for patients who are moderately to severely immunocompromised) to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used) and prevent unprotected exposures. If implementing a screening testing program, testing decisions should not be based on the vaccination status of the individual being screened. To provide the greatest assurance that someone does not have SARS-CoV-2 infection, if using an antigen test instead of a NAAT, facilities should use 3 tests, spaced 48 hours apart, in line with [FDA recommendations](#).
 - In general, performance of pre-procedure or pre-admission testing is at the discretion of the facility.
 - Performance of expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility.

9. Process to Respond to SARS-CoV-2 Exposures Among HCP and Others

Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed.

If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. For example, in an outpatient dialysis facility with an open treatment area, testing should ideally include all patients and HCP. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCP and patients on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.

Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities.

SECTION 2: Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection

The IPC recommendations described below (e.g., patient placement, recommended PPE) also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions based on [close contact](#) with someone with SARS-CoV-2 infection. However, these patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

1. Duration of Empiric Transmission-Based Precautions for Symptomatic Patients being Evaluated for SARS-CoV-2 infection

The decision to discontinue empiric [Transmission-Based Precautions](#) by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test.

- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgment and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric [Transmission-Based Precautions](#).

2. Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection

In general, asymptomatic patients do not require empiric use of [Transmission-Based Precautions](#) while being evaluated for SARS-CoV-2 following [close contact](#) with someone with SARS-CoV-2 infection. These patients should still wear source control and those who have not recovered

from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.

Examples of when empiric Transmission-Based Precautions following close contact may be considered include:

- Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Patient is moderately to severely immunocompromised
- Patient is residing on a unit with others who are moderately to severely immunocompromised
- Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

- Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
- If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

3. Patient Placement

- Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom or commode.
 - If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other

communicable disease should also be taken into consideration during the cohorting process.

- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.
- Limit transport and movement of the patient outside of the room to medically essential purposes.
- Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

4. Personal Protective Equipment

- HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to [Standard Precautions](#) and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
- Respirators should be used in the context of a comprehensive respiratory protection program,
- which includes medical evaluations, fit testing and training in accordance with the
- Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard ([29](#)

[CFR 1910.134](#))

- Additional information about using PPE is available in [Protecting Healthcare Personnel | HAI | CDC](#)

5. Aerosol-Generating Procedures (AGPs)

- Procedures that could [generate infectious aerosols](#) should be performed cautiously and avoided if appropriate alternatives exist.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.

6. Visitation

- For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at [Policy & Memos to States and Regions | CMS](#).
 - Counsel patients and their visitor(s) about the risks of an in-person visit.
 - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
- Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.

7. Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection

The following are criteria to determine when Transmission-Based Precautions could be discontinued for patients with SARS-CoV-2 infection and are influenced by severity of symptoms and presence of immunocompromising conditions. Patients should self-monitor and seek re-evaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these patients should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.

In general, patients who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for patients with severe to critical illness.

In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for patients.

Patients with mild to moderate illness who are not moderately to severely immunocompromised:

- At least 10 days have passed since symptoms first appeared **and**
- At least 24 hours have passed since last fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised:

- At least 10 days have passed since the date of their first positive viral test.

Patients with severe to critical illness and who are not moderately to severely immunocompromised:

- At least 10 days and up to 20 days have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved
- The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific patients. For a summary of the literature, refer to [Ending Isolation and Precautions for People with COVID-19: Interim Guidance \(cdc.gov\)](#)

Patients who are [moderately to severely immunocompromised](#) may produce replication competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved, **and**
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

8. Environmental Infection Control

- Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
 - All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently

touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which AGPs are performed.

- Refer to [List](#) on the EPA website for EPA-registered disinfectants that kill SARS-CoV2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a *difficile* sporicidal agent is recommended to disinfect the rooms of patients with *C. difficile* infection).
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE. The room window should be opened, door closed and no entry should occur for a minimum of 1 hour to allow for enough air changes to remove potentially infectious particles. After this time has elapsed, the room should undergo appropriate terminal cleaning and surface disinfection before it is returned to routine use.

9. Notice to Funeral Director

If, at the time of death, a resident was diagnosed as having a specific communicable disease or an infectious disease, a written report of such disease shall accompany the body when it is released to the funeral director or his or her agent, except that no HIV-related information shall be disclosed to the funeral director unless the funeral director has access in the ordinary course of business to HIV-related information on the death certificate of the deceased individual.

SECTION 3: Nursing Homes

- Assign one or more individuals with training in IPC to provide on-site management of the IPC program
- Stay connected with the local NYS epidemiologist as well as completing the HERDS reporting by 1pm daily. Report SARS-CoV-2 infection data to National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module. See Centers for Medicare & Medicaid Services (CMS) COVID-19 [reporting requirements](#).
- Managing admissions and residents who leave the facility:

- Admission testing is at the discretion of the facility. Pros and cons of screening testing are described in [Section 1](#).
- Residents who leave the facility for 24 hours or longer should generally be managed as an admission.
- Empiric use of Transmission-Based Precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings) and do not meet criteria described in Section 2.
- Placement of residents with suspected or confirmed SARS-CoV-2 infection
 - Ideally, residents should be placed in a single-person room as described in Section 2.
 - If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.
- Responding to a newly identified SARS-CoV-2-infected HCP or resident
 - When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.
 - A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.
 - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
 - Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.

- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
 - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Empiric use of Transmission-Based Precautions for residents and work restriction for HCP are not generally necessary unless residents meet the criteria described in Section 2 or HCP meet criteria in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#), respectively. However, source control should be worn by all individuals being tested.
 - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
 - If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV2](#), respectively.
- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.

- If antigen testing is used, more frequent testing (every 3 days), should be considered.
- **Indoor visitation during an outbreak response:**
 - Facilities should follow guidance from CMS about visitation.
 - Visitors should be counseled about their potential to be exposed to SARS-CoV2 in the facility.
- If indoor visitation is occurring in areas of the facility experiencing transmission, it should ideally occur in the resident's room. The resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit.

SECTION 4: Considerations for Implementing Broader Use of Masking

Use of well-fitting masks in healthcare settings are an important strategy to prevent the spread of respiratory viruses. Well-fitting masks can help block virus particles from reaching the nose and mouth of the wearer (wearer protection) and, if someone is ill, help block virus particles coming out of their nose and mouth from reaching others (source control). Masking by healthcare personnel as part of [Standard and Transmission-Based Precautions](#) and by ill individuals as part of [respiratory hygiene and cough etiquette](#) (i.e., for people with symptoms) are already well-described. This section describes considerations for implementing broader use of masking in healthcare settings. However, even when masking is not required by the facility, individuals should continue using a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

1. When to Implement Broader Use of Masking

The overall benefit of broader masking is likely to be the greatest for patients [at higher risk for severe outcomes](#) from respiratory virus infection and during periods of high respiratory virus transmission in the community.

Facilities should consider several factors when determining how and when to implement broader mask use:

- The types of patients cared for in their facility.
 - Facilities might tier their interventions based on the population they serve. For example, facilities might consider a lower threshold for action in areas of the facility primarily caring for patients at highest risk for severe outcomes. Except when experiencing an outbreak within the facility, facilities with residents or patients that generally do not leave the facility might consider implementing masking only for staff and visitors
- Input from stakeholders.
 - Reviewing plans with stakeholders including patient and family groups and healthcare personnel can help a facility determine practices that will be more broadly supported.
- Plans from other facilities in the jurisdiction with whom the facility shares patients.
 - Some jurisdictions might consider a coordinated approach for all facilities in the jurisdiction.
- What data are available to make decisions.
 - Facilities and jurisdictions might have access to more granular data for their jurisdiction to help guide efforts locally

- **SARS-CoV-2 Specific Metrics**

During the COVID-19 pandemic one of the strongest indicators of increasing cases in nursing homes was increasing community incidence. If a jurisdiction still has access to SARS-CoV-2-community incidence, using these data to guide local recommendations at the levels previously described (community incidence $\geq$ 100/100,000) could be considered.

CDC will also continue to collect and report SARS-CoV-2 hospital admissions data on the [CDC COVID Data Tracker](#). These data continue to be available at the county level and are used by

CDC to help the public decide when masking in the community should be considered. Based on CDC analyses from data from late 2022 and early 2023, these levels might be less useful to inform masking recommendations in healthcare facilities.

CDC continues to recommend that healthcare facilities institute facility-wide masking when masks are recommended in the community.

Section 5: COVID-19 Treatment

Treatment for COVID-19 Positive Residents with Mild to Moderate Symptoms

1. Two oral antivirals have received Emergency Use Authorization from the US FDA: **Paxlovid (nirmatrelvir with ritonavir) and Lagevrio (molnupiravir)**. These antivirals are authorized for the treatment of mild-to-moderate COVID-19 with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. According to the CDC, NIH COVID-19 guidelines and NYS DOH, the two antivirals are expected to be active against newer subvariants.
2. There are no EUA monoclonal antibody treatments currently available to treat COVID-19 in the nursing facility.
3. **Paxlovid (nirmatrelvir with ritonavir) is the preferred treatment in the nursing facility.** Lagevrio is only for residents who are not candidates for Paxlovid or other COVID-19 treatment options (such as outpatient remdesivir where it is available in infusion centers.)

Important:

1. Paxlovid is contraindicated in residents with GFR less than 30 ml/min.
2. Paxlovid is not recommended for residents with severe liver impairment.
3. Residents with GFR 30 to 60 ml/min should receive the renal dose Paxlovid.

4. Potentially significant drug interactions with Paxlovid must be cleared before starting Paxlovid. Review carefully the resident's drug regimen profile. Consult with the Pharmacist. Refer to the EUA for the drug interaction list.
5. Monitor for signs of bacterial superimposed infection. Treat with empiric antibiotic as necessary if bacterial infection is suspected.
6. Pulse oxymetry every 4 hours. If pulse ox is less than 94% on room air (defined as hypoxemia) or for residents with chronic hyoxemia, a decrease from baseline of greater than 3%, review again goals of care with the resident or activated Health Care Proxy, and review MOLST. Consider transfer to the hospital for IV remdesivir.

Steroids:

1. If the resident has a do not transfer to hospital order, or the resident and HCP prefer in-facility care first for severe COVID-19, then can start oral dexamethasone. Document discussion of risks/benefits.
2. Do not use dexamethasone and other systemic corticosteroids to treat patients with mild to moderate COVID-19 who do not require hospitalization or supplemental oxygen (or increase of oxygen from baseline); these drugs have no proven benefit in these patients and can cause harm.

Section 6: Facility Reporting

NHSN (National Healthcare Safety Network) Reporting - Data entered into NHSN pushes to ECLRS or data can be entered directly into ECLRS per below.

1. The information will be used to monitor trends in infection rates and inform public health policies. Information reported will be shared with CMS and will be retained and publicly reported to support protecting the health and safety of residents, personnel, and the general public. Reporting is required on a weekly basis.
2. Requirements for Reporting related to COVID-19 - CMS published an IFC (CMS-5531-IFC) requiring all LTC facilities report COVID-19 information using the Center for Disease Control (CDC) National Healthcare Safety Network (NHSN) (42 CFR 483(g)). This requirement to report information was extended through a final rule (CMS-1747-F) and is set to terminate on December 31, 2024, with the exception of the requirements at § 483.80(g)(1)(viii), which will

continue to be in effect as a requirement to support national efforts to control the spread of COVID-19.

ECLRS (Electronic Clinical Laboratory Reporting System) Reporting

1. Providers are required to report SARS-CoV-2 diagnostic or serology testing results, including those using SARS-CoV-2 point-of-care tests, to the Commissioner of Health through the Electronic Clinical Laboratory Reporting System (ECLRS) within 24 hours. Required reporting includes all positive test results.

HERDS (Health Emergency Response Data System) Reporting

1. Any positive test result must be reported to the Department by 1:00pm of the day following receipt of such test results, in accordance with existing reporting protocols and mechanisms.

Section 7: Passive Staff Screening and Reporting

Signage should be posted to staff regarding the 3 scenarios below which should be reported to their supervisor, infection preventionist/designee.

1. a positive viral test for SARS-CoV-2
2. symptoms of COVID-19, or
3. close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higherrisk exposure (for healthcare personnel (HCP)).

Testing of Staff and Residents During an Outbreak Investigation

1. An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP are discontinued. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission.

Refusal of Testing

1. **Staff Refusal** - Staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member, who is not up-to-date, and refuses testing, the staff member will be restricted from the building until the procedures for outbreak testing have been completed. The facility will follow occupational health and local jurisdiction policies with respect to any asymptomatic staff.

2. **Resident Refusal** - Residents (or resident representatives) may exercise their right to decline COVID-19 testing in accordance with the requirements under 42 CFR § 483.10(c)(6). In discussing testing with residents, staff will use person-centered approaches when explaining the importance of testing for COVID-19. Ensure that residents who have signs or symptoms of COVID-19 and refuse testing are placed on TBP until the criteria for discontinuing TBP have been met. If outbreak testing has been triggered and an asymptomatic resident refuses testing, the facility will thoroughly monitor to ensure the resident maintains appropriate distance from other residents, wears a face mask, and practices effective hand hygiene until the procedures for outbreak testing have been completed.

Section 8: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

1. **Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 Infection** HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays.

When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.

- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses.

2. Return to Work Criteria for HCP with SARS-CoV-2 Infection

The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek reevaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **and**
- At least 24 hours have passed since last fever without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 10 days and up to 20 days have passed since symptoms first appeared, **and**
- At least 24 hours have passed since last fever without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.
- The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction. The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to [Ending Isolation and Precautions for People with COVID-19: Interim Guidance \(cdc.gov\)](https://www.cdc.gov/media/releases/2020/s110320-covid-19-return-to-work.html)

HCP who are [moderately to severely immunocompromised](#) may produce replication competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

Test-based strategy

HCP who are symptomatic could return to work after the following criteria are met:

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

HCP who are not symptomatic could return to work after the following criteria are met:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

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

Exposures that might require testing and/or restriction from work can occur both while at work and in the community. Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure.

Other exposures not classified as higher-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth. When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission.

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolongedⁱ close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure Following a higher-risk exposure, HCP should:
 - Have a series of three viral tests for SARS-CoV-2 infection.
 - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.

- Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Follow all [recommended infection prevention and control practices](#), including wearing well fitting source control, monitoring themselves for fever or [symptoms consistent with COVID-19](#), and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or [symptoms consistent with COVID-19](#) should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include:
 - HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure;
 - HCP is moderately to severely immunocompromised;
 - HCP cares for or works on a unit with patients who are moderately to severely immunocompromised;
 - HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions;

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

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

- (day 0) if they do not develop symptoms.

In addition to above:

- HCP should follow all [recommended infection prevention and control practices](#), including wearing well-fitting source control, monitoring themselves for fever or [symptoms consistent with COVID-19](#), and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or [symptoms consistent with COVID-19](#) should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

Footnotes:

1. For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.
2. For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARS-CoV2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.
3. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious:

- a. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.
 - b. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.
 - c. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with SARS-CoV-2 infection, facemasks still confer some level of protection to HCP, which was factored into this risk assessment if the patient was also wearing a cloth mask or facemask

SECTION 9: Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC

This guidance is for facilities that are expecting or experiencing staffing shortages due to COVID19. Conventional strategies for return to the workplace for HCP with SARS-CoV-2 infection or higher-risk exposures are described in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC

1. Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. If community transmission levels rise, staffing shortages could occur due to HCP illness or the need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these shortages. These plans and processes include communicating with HCP about actions the facility is taking to address shortages, maintaining patient and HCP safety, and providing resources to assist HCP with anxiety and stress.

2. CDC's mitigation strategies offer a continuum of options for addressing staffing shortages. Contingency, followed by crisis capacity strategies, augment conventional strategies and are meant to be considered and implemented sequentially (i.e., implementing contingency strategies before crisis strategies). For example, if, despite efforts to mitigate, HCP staffing shortages occur, healthcare systems, facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that, in order to ensure the availability of healthcare, certain HCP with suspected or confirmed SARS-CoV-2 infection should return to work before the full conventional Return to Work Criteria have been met under the criteria set forth below.
3. Allowing HCP with SARS-CoV-2 infection to return to work before meeting the conventional criteria could result in healthcare-associated SARS-CoV-2 transmission. Healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is utilizing these strategies, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill staffing needs.

As part of conventional strategies, it is recommended that healthcare facilities:

1. Ensure any COVID-19 vaccine requirements for HCP are followed, and where none are applicable, encourage HCP to remain up to date with all recommended COVID-19 vaccine doses.
2. Understand their normal staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care under normal circumstances.
3. Understand the local epidemiology of COVID-19-related indicators (e.g., community transmission levels).
4. Communicate with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed.

Contingency Capacity Strategies to Mitigate Staffing Shortages

1. When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. These include: Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities.
2. Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation and training to work in these areas that are new to them.
3. Attempt to address social factors that might prevent HCP from reporting to work, such as need for transportation or housing that allows for physical distancing, particularly if HCP live with individuals with underlying medical conditions or older adults.
4. Consider that these social factors disproportionately affect persons from some racial and ethnic groups, who are also disproportionately affected by COVID-19 (e.g., African Americans, Hispanics and Latinos, and American Indians and Alaska Natives).
5. Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
6. As appropriate, request that HCP postpone elective time off from work. However, there should be consideration for the mental health benefits of time off and that care-taking responsibilities may differ substantially among staff.
7. Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection.
8. Allowing HCP with SARS-CoV-2 infection who are well enough and willing to work to return to work as follows:

HCP with mild to moderate illness who are not moderately to severely immunocompromised:

1. At least 5 days have passed since symptoms first appeared (day 0), and
2. At least 24 hours have passed since last fever without the use of fever-reducing medications, and
3. Symptoms (e.g., cough, shortness of breath) have improved.

Healthcare facilities may choose to confirm resolution of infection with a negative nucleic acid amplification test (NAAT) or a series of 2 negative antigen tests taken 48 hours apart*.

HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised:

1. At least 5 days have passed since the date of their first positive viral test (day 0).

Healthcare facilities may choose to confirm resolution of infection with a negative NAAT (molecular) or a series of 2 negative antigen tests taken 48 hours apart*.

* Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred if testing asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

Considerations for determining which HCP should be prioritized for this option include:

1. The type of HCP shortages that need to be addressed.
2. The types of symptoms they are experiencing (e.g., persistent fever, cough).
3. Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
4. The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than patients who are immunocompromised).

If HCP are requested to return to work before meeting all conventional Return to Work Criteria, they should still adhere to the recommendations described below.

1. They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
2. Until they meet the conventional return to work criteria:
 - They should wear a respirator or well-fitting facemask at all times, even when they are in nonpatient care areas such as breakrooms.
 - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
 - To the extent possible, they should practice physical distancing from others.
 - Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.

Crisis Capacity Strategies to Mitigate Staffing Shortages

1. When staffing shortages occur, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care:
 - Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing.
 - If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, if they are well enough and willing to work, even if they have not met all the contingency return to work criteria described above.

Considerations for determining which HCP should be prioritized for this option include:

1. The type of HCP shortages that need to be addressed.
2. Where individual HCP are in the course of their illness (e.g., viral shedding is likely to be higher earlier in the course of illness).

3. The types of symptoms they are experiencing (e.g., persistent fever, cough).
4. Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
5. The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than patients who are immunocompromised).
6. If HCP are requested to work before meeting all criteria, they should be restricted from contact with patients who are moderately to severely immunocompromised (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:
 - If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
 - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.
 - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with suspected SARS-CoV-2 infection.
 - As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients without suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies that do not involve care of uninfected patients by potentially infectious HCP. Strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential.

If HCP are requested to return to work before meeting all Return to Work Criteria, they should still adhere to recommendations described below.

1. They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
2. Until they meet the conventional return to work criteria:

- They should wear a respirator or well-fitting facemask at all times, even when they are in nonpatient care areas such as breakrooms.
- If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
- To the extent possible, they should practice physical distancing from others.
- Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.

Emergency Medication Pass

1. At the discretion of the Medical Director and Director of Nursing, when staffing is considered critical non-essential medications and treatments can be held per policy. Every effort will be made to avoid omitted and delayed doses of critical medicines.

Section 10: Source Control (PPE)

1. The facility must possess and maintain at least a 60-day supply of all necessary items of PPE sufficient to protect facility staff, consistent with DOH/CDC guidance. The PPE can be stored at the facility or in a separate storage unit that is within New York State. The facility (or its corporate network) has the right to access as needed and the facility has at least a 10-day supply of all required PPE on site, as determined by the calculations set forth below, to cover resident needs until such time that the off-site PPE can be accessed.
2. PPE stored in offsite central supply can be accessed by the facility within at least 24 hours and is available 24 hours a day/7 days a week. Corporate Security Associates will be contacted in the event PPE is needed at a facility. An Associate will make delivery arrangements with the corporate van/designated service.
3. The facility Administrator/designee will compare existing inventories of PPE (face shields, gowns, gloves, masks, N95 respirators) against the required inventories to determine the quantities needed to be on hand. Optimize and conserve PPE where appropriate as supply chain interruptions have been noted due to the high demand.
4. 60-day stockpile of PPE is based on the following requirements:
 - Single gloves – fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 550;

- Gowns – fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 41;
 - Surgical masks –fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 21; and
 - N95 respirator masks –fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 9.6.
5. The Department will determine the facility’s average census annually, by January 1st of each year, and will communicate such determination to each facility.
 6. The Commissioner has the discretion to increase the stockpile requirements from 60 days to 90 days where there is a State or local public health emergency declared.
 7. In order to maximize shelf life of the stockpiled inventory, facilities will follow the appropriate storage conditions outlined by manufactures and are encouraged to rotate inventory through regular usage and replace what has been used in order to ensure a consistent readiness and level and reduce waste. Expired products will be disposed of when their expiration date has passed.
 8. Applicable positivity rate - defined as the greater of the following positivity rates:
 - The facility’s average COVID-19 positivity rate, based on reports made to the Department, during the period of April 26, 2020 through May 20, 2020; or
 - The facility’s average COVID-19 positivity rate, based on reports made to the Department, during the period of January 3, 2021 through January 31, 2021; or
 - 20.15%, representing the highest Regional Economic Development Council average COVID-19 positivity rate, as reported to the Department, during the periods April 26, 2020 through May 20, 2020 and January 3, 2021 through January 31, 2020.
 9. Facilities that identify a shortage of PPE, should use existing plans and vendor agreements to procure additional assets, by taking the following steps:
 - Use existing vendor agreements and procurement plans to place orders for quantities needed by type and size of PPE.
 - Activate existing Mutual Aid Agreements to obtain available support from those partners.

- Notify County Office of Emergency Management (OEM) when all existing agreements are exhausted and supply needs exceed those available from these sources.
- Coordinate with County OEM to identify and utilize other existing county resources.
- Notify the respective Department's Regional Office of ongoing need.
- If all local resources have been exhausted, submit a request, via your County OEM, to the state OEM. The request should include as much detail as available, but include at a minimum the following elements:
 - Type and Quantity of PPE by size
 - Point of Contact at the requesting facility or system
 - Delivery location
 - Date request is needed to be filled by
 - Record of pending orders

Websites for OEM and county offices:

https://data.ny.gov/widgets/jwkb-x5v6?mobile_redirect=true

<https://data.ny.gov/Public-Safety/County-Emergency-Management-Offices/jwkb-x5v6>

Section 11: Policy References

1. Centers for Disease Control and Prevention (CDC)
2. World Health Organization (WHO)
3. NY State Department of Health (NYSDOH)
4. Centers for Medicare and Medicaid Services (CMS)
5. The Society for Post-Acute and Long Term Care
6. NY State Health Facilities Association (NYSHFA)
7. Greater NY Health Care Facilities Association (GNYHCFA)
8. American Health Care Association (AHCA)
9. AMDA - The Society for Post-Acute and Long-Term Care Medicine
10. US Food and Drug Administration (FDA)

Hazard Annex L: IT/Communications Failure

IT/Communications systems failure can impact the following critical systems: computer network; telephone network; on-site data storage; medical devices; medication replenishment; and HVAC system.

An IT/communications failure incident may hinder standard notification methods. Alternate forms of notification with staff, residents and external agencies include: pagers, hand-held radios, runners, personal cell phones, and social media.

Preparedness	
☐	Utilize cloud-based or off-site servers to store data that also meet resident confidentiality requirements.
☐	Provide staff with training on use of facility computers and potential risks of personal use (e.g., opening attachments from unknown senders).
☐	Ensure redundant communications mechanisms: ▪ Consider procurement of handheld radios or walkie-talkies. ▪ Store paper-based versions of critical forms and documentation, including contact lists.
☐	Identify and protect resident care systems and records, including resident management systems, medical/resident records, resource availability, etc.
☐	Identify and protect clinical support systems including: ▪ Computer desktops, laptops, and tablets at nursing stations, hallways, bedside, laptops, etc. ▪ Electronic and automatic transfer of information between IT systems, dietary, etc.
☐	Identify and protect administrative systems including: ▪ Telephones, fax machines, databases, networks, wireless network, modems, etc. ▪ Fire protection systems, security access, external email, website, etc.

Response	
☐	Implement the facility's business continuity plan, if one exists.
☐	If the disruption is deliberate, contact local law enforcement, the Federal Bureau of Investigation's Cyber Division, and the state cyber terrorism division, as appropriate.
☐	Conduct a risk assessment of affected environmental systems (e.g., utilities) and implement plans to maintain affected systems that support operations. If necessary, consider the implementation of a protective action. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information.
☐	Isolate and repair, replace, or remove affected systems from the facility network.
☐	Address social media issues as warranted and use social media for messaging as situation dictates.
☐	Implement manual documentation systems (e.g., paper-based systems).
☐	Implement manual inventory and resupply processes, including medication distribution.
☐	In the event of heating or air conditioning system failure and/or failure of medical devices, it may be necessary to evacuate some or all residents. If the decision is made to evacuate, please refer to the <i>NYSDOH Evacuation Plan Template</i> .

Hazard Annex M: Landslide

Landslides occur when masses of rock, earth, or debris move down a slope. Mudslides, also known as debris flows, are a fast-moving landslide. Landslides can occur within mere minutes and can travel several miles. Hazards associated with landslides include:

- Rapidly moving water and debris that can lead to injury;
- Broken electrical, water, gas, and sewage lines that can result in injury or illness; and
- Disrupted roadways and railways that can endanger motorists and disrupt transport and access to health care.

Preparedness	
☐	Evaluate the facility for landslide hazards (e.g., recent wildfires or other incidents that have destroyed ground cover, which mitigates against landslides).
☐	Ensure structures are in full compliance with regional building codes.
☐	Educate staff on landslide warning signs, including: ▪ Springs or saturated ground in areas that are not usually wet. ▪ Bulges in the ground; buckling in the ground. ▪ Increasing space between soil and foundations. ▪ Cracks in foundation.
Response	
☐	If indoors, staff and residents should take cover under desks, tables, or other heavy pieces of furniture. Residents with wheelchairs should be told to lock their wheels. If outdoors, staff and residents should get out of the path of the mudflow and get to high ground.
☐	Monitor surrounding area for flooding.
☐	Direct emergency response personnel to possible victims.

☐	Check building and surrounding area for damage or other safety issues once given the “all clear” by emergency response personnel.
☐	Listen to local radio and TV for emergency information and updates.
☐	Report broken utilities and damaged roadways to local authorities.

Hazard Annex N: Power Outage

Loss of electrical services may be the result of natural disasters, industrial accidents at power generation facilities, or damage to power transmission systems. Natural hazards and weather-related incidents that often cause with power outages include: coastal storms; floods; tornados; and blizzards/ice storms.

Preparedness	
☐	Regularly inspect and test all generators involved in supplying emergency power to areas for resident care and ensure the facility has sufficient fuel on-site to fuel the generator.
☐	See <i>Hazard Annex L: IT/Communications Failure</i> for additional preparedness activities.
Response	
☐	Assess the situation. Consult decision support considerations (information and intelligence, anticipated impacts, resources).
☐	Maintain contact and communication with the utility company, County Office of Emergency Management, and Health Emergency Preparedness Coalition to receive utilities restoration reports.
☐	Based on facility decision-making criteria, consider the implementation of a protective action. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information. If the decision is made to evacuate, refer to the <i>NYSDOH Evacuation Plan Template</i> .

☐	Continually seek updates from staff on both staff and resident well-being to determine if other protective actions are needed for some or all of the facility's population.
☐	The emergency generator will start automatically immediately at time of an outage.
☐	If the emergency generator does not start automatically, notify the Plant Manager. If necessary, attempt to start the generator manually by following instructions posted in the generator room.
☐	Use available flashlights as temporary sources of light. These can be found at Reception desk, Nurses Stations.
☐	Take all reasonable steps to protect food and water supplies and maintain a safe environment of care for residents and staff.

Hazard Annex O: Tornado

A tornado is a violently rotating column of air touching the ground, usually attached to the base of a thunderstorm. Winds of a tornado may reach 300 miles per hour. Damage paths can be in excess of one mile wide and 50 miles long.

Preparedness	
☐	Develop procedures for quickly moving residents away from spaces with flat, widespan roofs (e.g. cafeterias, auditoriums), which can collapse in the event of a tornado.
☐	Train staff on what not to do during a tornado, e.g. move to higher floors or shelter in corners, both of which are dangerous.
☐	Monitor local news and radio outlets for tornado watches or warnings issued by the National Weather Service.
Response	



☐	If a tornado watch is issued: ▪ Ensure all residents and assigned staff are inside the facility and accounted for. ▪ Check outdoors and indoors for any objects that might become projectiles. ▪ Ensure that windows are kept tightly closed. ▪ Move residents, staff, and visitors away from windows, skylights, and exterior walls, as possible.
☐	After tornado impact, assign staff to assess residents for any injuries that require immediate attention. Encourage staff to keep residents as calm as possible.
☐	Survey the facility for injuries, structural damage, fire, ruptured gas or water pipes, etc. If necessary, shut off utility lines and/or panels.
☐	Look for electrical system damage. If there are sparks or broken or frayed wires, or the smell of hot insulation, turn off the electricity at the main fuse box or circuit breaker. If you have to step in water to get to the fuse box or circuit breaker, call an electrician before proceeding. Panel(s) can be found on lower floor near kitchen.

Hazard Annex P: Wildfire

Wildfires threatening the facility may emerge with or without warning, however a wildfire evacuation will most likely occur very quickly, as opposed to a coastal storm.

Preparedness	
☐	Implement wildfire protection measures: ▪ Clean roof surfaces and gutters ▪ Use only fire-resistant materials on the exterior of the facility ▪ Consider fire-resistant landscaping
Response	

☐	Maintain contact and communication with County Office of Emergency Management or Health Emergency Preparedness Coalition to receive wildfire-related updates.
☐	Monitor local news for evacuation reports and instructions.
☐	Based on facility decision-making criteria, consider the implementation of a protective action. Refer to <i>Annex A: Protective Actions</i> in the Base Plan for more information.
☐	In case of immediate threat, move residents to a pre-designated staging area for rapid evacuation. If a gas leak is suspected, notify the Plant Manager.
☐	Preemptive methods to mitigate smoke and fire risk: ▪ Close all windows, doors, and vents. ▪ Limit the amount of foot traffic in and out of the facility. ▪ Do not allow residents outside, as possible. ▪ If using heating or air conditioning, set to re-circulate indoor air to shut down exterior air intakes.
☐	Regularly seek updates from staff to determine if protective actions are needed for some or all of the facility's population. If the decision is made to evacuate, refer to the <i>NYSDOH Evacuation Plan Template</i> .
☐	Monitor residents and staff for complications related to smoke exposure.