MANHATTANVILLE

REHABILITATION & HEALTHCARE

For a Brighter Tomorrow

Pandemic

Emergency Plan

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Approval and Implementation

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

Uri Schwartz

Administrator, Manhattanville Healthcare Center

9-14-2020

September 14, 2020

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MANHATTANVILLE HEALTHCARE CENTER

Attestation that all Infection Control Policies Have Been Reviewed

The IPC committee (Medical Director, DNS and IP) and other key clinical and administrative staff will review the infection control policies at least annually. The review will include:

i. Updating or supplementing policies and procedures as needed;
ii. Assessment of staff compliance with existing policies and regulations; and
iii. Any trends or significant problems since the last review.

By signing below facility is I compliance with the above stipulations

Medical Director: _____ Date: 9-15-20

Infection Preventionist: _____ Date: 9-15-20

Director of Nursing: _____ Date: 9/15/2020

Administrator: _____ Date: 9-15-2020

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Emergency Contacts

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

Emergency Contact Information

Organization	Phone Number(s)
Local Fire Department	718-993-3333
Local Police Department	718-543-5700/911
Emergency Medical Services	Senior Care 718-430-9700
Fire Marshal	718-999-2000
Local Office of Emergency Management	212-639-9675
NYSDOH Regional Office (Business Hours)	212-417-5550
NYSDOH Duty Officer (Business Hours)	866-881-2809
New York State Watch Center (Warning Point) (Non-Business Hours)	518-292-2200

Annex E: Infectious Disease/Pandemic Emergency

As the COVID-19 pandemic surged around the world, healthcare policy makers, managment and staff have had to recognize a risk that was talked about, but never really prepared for. Complicating the response further was that this pandemic was caused by a new pathogen, (novel virus), and to which there was no natural immunity or vaccination. We are still learning about how this disease is transmitted, which population is the most vulnerable and the best course of treatment. The most terrible aspect of the experience so far is that COVID-19 takes a terrible toll on the elderly and those sick with co-morbidities. As such, Skilled Nursing Facilities congregate care setting were especially at risk during this outbreak. As a result of this, the State and Federal governments have enacted additional requirements for the safe operation of a home. This document lays out the required elements of new legal and regulatory responsibilities during a pandemic.

(R) = Required Element

** NYSDOH regulation indicates both required and recommended elements need to be addressed in PEP*

Preparedness Tasks for all Infectious Disease Events

1. **Staff Education on Infectious Diseases (R)**
   - The Facility Infection Preventionist (IP) in conjunction with Inservice Coordinator/Designee, must provide education on Infection Prevention and Management upon the hiring of new staff, as well as ongoing education on an annual basis and as needed should a facility experience the outbreak of an infectious disease.
   - The IP/ Designee will conduct annual competency-based education on hand hygiene and donning/doffing Personal Protective Equipment (PPE) for all staff.
   - The IP in conjunction with the Inservice Coordinator will provide in-service training for all staff on Infection Prevention policies and procedures as needed for event of an infectious outbreak including all CDC and State updates/guidance.

Refer to Policy and Procedure: Infection Prevention Staff Training

2. **Develop/Review/Revise and Enforce Existing Infection Prevention Control, and Reporting Policies (R)**

   The facility will continue to review/revise and enforce existing infection prevention control and reporting policies. The Facility will update the Infection Control Manual, which is available in a digital and print form for all staff, annually or as may be required during an event. From time to time, the facility management will consult with local Epidemiologist to ensure that any new regulations and/or areas of concern as related to Infection Prevention and Control are incorporated into the Facilities Infection Control Prevention Plans.

Refer to Facility Assessment for Attestation of Yearly Review or Paper Copy with Signature Review Sheet

3. **Conduct Routine/Ongoing, Infectious Disease Surveillance**
   - The Quality Assurance (QA) Committee will review all resident infections as well as the usage of antibiotics, on a monthly basis so as to identify any tends and areas for improvement.

- At daily Morning Meeting, the IDT team will identify any issues regarding infection control and prevention.
- As needed, the Director of Nursing (DON)/Designee will establish Quality Assurance Performance Projects (QAPI) to identify root cause(s) of infections and update the facility action plans, as appropriate. The results of this analysis will be reported to the QA committee.
- All staff are to receive annual education as to the need to report any change in resident condition to supervisory staff for follow up.
- Staff will identify the rate of infectious diseases and identify any significant increases in infection rates and will be addressed.
- Facility acquired infections will be tracked/reported by the Infection Preventionist.

Refer to Policy and Procedure: Infection Control Surveillance

4. Develop/Review/Revise Plan for Staff Testing/Laboratory Services

- The Facility will conduct staff testing, if indicated, in accordance with NYS regulations and Epidemiology recommendations for a given infectious agent.
- The facility shall have prearranged agreements with laboratory services to accommodate any testing of residents and staff including consultants and agency staff. These arrangements shall be reviewed by administration not less than annually and are subject to renewal, replacement or additions as deemed necessary. All contacts for labs will be updated and maintained in the communication section of the Emergency Preparedness Manual.
- Administrator/ DON/Designee will check daily for staff and resident testing results and take action in accordance with State and federal guidance.

Refer to Vendor List in Emergency Management Plan (EMP)
Refer to P/P Testing

5. Staff Access to Communicable Disease Reporting Tools (R)

- The facility has access to Health Commerce System (HCS), and all roles are assigned and updated as needed for reporting to NYSDOH.
- The following Staff Members have access to the NORA and HERDS surveys: Administrator, Director of Nursing, Infection Preventionist, and Assistant Director of Nursing. Should a change in staffing occur, the replacement staff member will be provided with log in access and Training for the NORA and HERDS Survey
- The IP/designee will enter any data in NHSN as per CMS/CDC guidance

Refer to Annex K Section 1 Communicable Disease Reporting
Refer to Facility Assessment

6. Develop/Review/Revise Internal Policies and Procedures for Stocking Needed Supplies (R)

- The Medical Director, Director of Nursing, Infection Control Practitioner, Safety Officer, and other appropriate personnel will review the Policies for stocking needed supplies.
- The facility has contracted with Pharmacy Vendor to arrange for 4-6 weeks supply of resident medications to be delivered should there be a Pandemic Emergency.

- The facility has established par Levels for Environmental Protection Agency (EPA) approved environmental cleaning agents based on pandemic usage.
- The facility has established par Levels for PPE.

Refer to Policy and Procedure on Personal Protective Equipment: Par Level, Storage and Calculating Burn Rate
Refer to Policy and Procedure on Environmental Cleaning Agents
Refer to Vendor list and Contracts in EMP (Emergency Management Plan)

7. **Develop/Review/Revise Administrative Controls with regards to Visitation and Staff Wellness**
   - All sick calls will be monitored by Department Heads to identify any staff pattern or cluster of symptoms associated with infectious agent. Each Dept will keep a line list of sick calls and report any issues to IP/DON during Morning Meeting. All staff members are screened on entrance to the facility to include symptom check and thermal screening.
   - Visitors will be informed of any visiting restriction related to an Infection Pandemic and visitation restriction will be enforced/lifted as allowed by NYSDOH.
   - A contingency staffing plan is in place that identifies the minimum staffing needs and prioritizes critical and non-essential services, based on residents' needs and essential facility operations. The staffing plan includes collaboration with local and regional DOH planning and CMS to address widespread healthcare staffing shortages during a crisis.

Refer to Policy and Procedure: Visitation Guidelines during Pandemic
Refer to Policy and Procedure Staff Screening and Monitoring During a Pandemic.
Refer to contingency staffing plan in EMP

8. **Develop/Review/Revise Environmental Controls related to Contaminated Waste (R)**
   - Areas for contaminated waste are clearly identified as per NYSDOH guidelines
   - The facility environmental coordinator shall follow all Department of Environmental Conservation (DEC) and DOH rules for the handling of contaminated waste. The onsite storage of waste shall be labeled and in accordance with all regulations. The handling policies are available in the Environmental Services Manual. Any staff involved in handling of contaminated product shall be trained in procedures prior to performing tasks and shall be given proper PPE.
   - The facility will amend the Policy and Procedure on Biohazardous wastes as needed related to any new infective agents.

Refer to Policy and Procedure on Handling of Biohazardous Waste Material

9. **Develop/Review/Revise Vendor Supply Plan for food, water, and medication (R)**
   - The facility currently has a 3-4 days' supply of food and water available. This is monitored on a quarterly basis to ensure that it is intact and safely stored.
   - The facility has adequate supply of stock medications for 4-6 weeks.
   - The facility has access to a minimum of 2 weeks supply of needed cleaning/sanitizing agents in accordance with storage and NFPA/Local guidance. The supply will be checked each quarter and weekly as needed during a Pandemic. A log will be kept by

the Department head responsible for monitoring the supply and reporting to Administrator any specific needs and shortages.

Refer to the following
P/P Subsistence Food and Water EMP
Facility Logs: Water and Food: Food Service Director
Stock Medications: Director of Nursing
Sanitizing/Cleaning Agents: Director of Environmental Services

10. Develop Plans to Ensure Residents are Cohorted based on their Infectious Status (R)

- Residents are isolated/cohorted based on their infection status in accordance with applicable NYSDOH and Centers for Disease Control guidance.
- The facility Administration maintains communication with Local Epidemiologist, NYS DOH, and CDC to ensure that all new guidelines and updates are being adhered to with respect to Infection Prevention.
- The Cohort will be divided into three groups: Unknown, Negative, and Positive as it relates to the infectious agent.
- The resident will have a comprehensive care plan developed indicating their Cohort Group and specific interventions needed.

Refer to Policy and Procedure on Cohorting

11. Develop a Plan for Cohorting residents using a part of a unit, dedicated floor or wing, or group of rooms

- The Facility will dedicate a wing or group of rooms at the end of a unit in order to Cohort residents. This area will be clearly demarcated as isolation area.
- Appropriate transmission-based precautions will be adhered to for each of the Cohort Groups as stipulated by NYS DOH
- Staff will be educated on the specific requirements for each Cohort Group.
- Residents that require transfer to another Health Care Provider will have their Cohort status communicated to provider and transporter and clearly documented on the transfer paper work.
- All attempts will be made to have dedicated caregivers assigned to each Cohort group and to minimize the number of different caregivers assigned.

Refer Policy and Procedure Cohorting Guidelines during a Pandemic
Refer Policy and Procedure Transferring Residents with Infection Diseases.

12. Develop/Review/Revise a Plan to Ensure Social Distancing Measures

- 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.
- 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. Recreation Activities will be individualized for each resident.
- The facility will ensure staff break rooms and locker rooms allow for social distancing of staff
- All staff will be re-educated on these updates as needed

Refer to Policy and procedure: Dining Guidelines during a Pandemic
Refer to Policy and procedure: Recreation Needs During a Pandemic

13. Develop/Review/Revise a Plan to Recover/Return to Normal Operations

- 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.
- The facility will maintain communication with the local NYS DOH and CMS and follow guidelines for returning to normal operations. The decision for outside consultants will be made on a case by case basis taking into account medical necessity and infection levels in the community. 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.

Refer to Policy and Procedure Staff Monitoring during a Pandemic Emergency
Refer to Policy and Procedure Resident Monitoring during the Recovery phase of a Pandemic Emergency

Additional Preparedness Planning Tasks for Pandemic Events

1. Develop/Review/Revise a Pandemic Communication Plan (R)

- The Administrator in conjunction with the Social Service 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 of potential pandemic.

Refer to Section of PEP Additional Response Communication and Notifying Families/ Guardians and Weekly Update page 8

Refer to Policy and Procedure Communication with Residents and Families During Pandemic
Refer to list of Resident representatives/contact information
Refer to Staff Contact List located in EMP

2. Develop/Review/Revise Plans for Protection of Staff, Residents, and Families Against Infection (R)

- Education of staff, residents, and representatives
- Screening of residents
- Screening of staff
- Visitor Restriction as indicated and in accordance with NYSDOH and CDC
- Proper use of PPE
- Cohorting of Residents and Staff

Refer to Infection Prevention and Control Policy and Procedures

Response Tasks for All Infectious Disease Events

1. Guidance, Signage, Advisories

- The facility will 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.
- The Infection Preventionist/Designee will ensure that appropriate signage is visible in designated areas for newly emergent infectious agents
- The Infection Control Practitioner will be responsible to ensure that there are clearly posted signs for cough etiquette, hand washing, and other hygiene measures in high visibility areas.
- The Infection Preventionist/Designee will ensure that appropriate signage is visible in designated areas to heighten awareness on cough etiquette, hand hygiene and other hygiene measures in high visible areas.

Refer to the attached listing of government agencies and contact numbers
Refer to the CDC website for Signage download

2. **Reporting Requirements (R)**
   - The facility will assure it meets all reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYCRR 2.10 Part 2), as well as by 10 NYCRR 415.19 (see Annex K of the CEMP toolkit for reporting requirements).
   - The DON/Infection Preventionist will be responsible to report communicable diseases via the NORA reporting system on the HCS
   - The DON/Infection Preventionist will be responsible to report communicable diseases on NHSN as directed by CMS.

Refer to Annex K CEMP for reportable diseases

3. **Signage** *(Refer to Guidance, Signage, Advisories)*

4. **Limit Exposure**
   - 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.
   - Facility will Cohort residents according to their infection status
   - Facility will monitor all residents to identify symptoms associated with infectious agent.
   - Units will be quarantined in accordance with NYSDOH and CDC guidance and every effort will be made to cohort staff.
   - Facility will follow all guidance from NYSDOH regarding visitation, communal dining, and activities and update policy and procedure and educate all staff.
   - Facility will centralize and limit entryways to ensure all persons entering the building are screened and authorized.
   - Hand sanitizer will be available on entrance to facility, exit from elevators, and according to NYSDOH and CDC guidance
   - Daily Housekeeping staff will ensure adequate hand sanitizer and refill as needed.

Refer Policy and Procedure Cohorting Guidelines during a Pandemic

5. **Separate Staffing**
   - The facility will implement procedures to ensure that as much as is possible, separate staffing is provided to care for each infection status cohort, including surge staffing strategies.

Refer to Policy and Procedure on Cohorting

6. **Conduct Cleaning/Decontamination**
   - The facility will conduct cleaning/decontamination in response to the infectious disease utilizing cleaning and disinfection product/agent specific to infectious disease/organism in accordance with any applicable NYSDOH, EPA, and CDC guidance.

Refer to Environmental Cleaning /Disinfection P/P
Refer to the attached Policy and Procedure on Terminal Room Cleaning

7. **Educate Residents, Relatives, and Friends About the Disease and the Facility's Response (R)**
   - 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.
   - 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.

Refer to the attached Policy and Procedure on Communication During a Pandemic

8. **Policy and Procedures for Minimizing Exposure Risk** (Refer to section 4)
   - The facility will contact all staff including Agencies, vendors, other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents and staff.
   - Consultants that service the residents in the facility will be notified and arrangements made for telehealth, remote chart review, or evaluating medically necessary services until the recovery phase according to State and CDC guidelines.

Refer to Memo regarding vendor delivery during a Pandemic
Refer to P/P Telehealth Services

9. **Advise Vendors, Staff, and other stakeholders on facility policies to minimize exposure risks to residents (R)**
   - Subject to any superseding New York State Executive Orders 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.
   - Emergency staff including EMS will be informed of required PPE to enter facility
   - Vendors will be directed to drop off needed supplies and deliveries in a designated area to avoid entering the building.
   - The facility will implement closing the facility to new admissions in accordance with any NYSDOH directives relating to disease transmission

Refer to Policy and Procedure on Visitation during a Pandemic
Refer to Policy and Procedure on Limited Services During a Pandemic

Refer to Vendor Contact List in EPM

10. Limiting and Restriction of Visitation (R)

- The facility will limit and or restrict visitors as per the guidelines from the NYSDOH
- Residents and Representatives will be notified as to visitation restrictions and/or limitations as regulatory changes are made.

Refer to Policy and Procedure on Visitation during a Pandemic

Additional Response Tasks for Pandemic Events

1. Ensure Staff Are Using PPE Properly

- The facility has an implemented Respiratory Protection Plan
- Appropriate signage shall be posted at all entry points, and on each residents', door indicating the type of transmission-based precautions that are needed.
- Staff members will receive re-education and have competency done on the donning and doffing of PPE.
- Infection Control rounds will be made by the DON, IP, and designee to monitor for compliance with proper use of PPE
- 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

Refer to Policy and Procedure on Respiratory Protection Program
Refer to Infection Control Surveillance Audit
Refer to P/P on PPE

2. Post a Copy of the Facility's PEP (R)

- 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.
- The PEP plan will be available for review and kept in the Lobby/Nursing Office

Refer to attestation that PEP will be readily available

3. The Facility Will Update Family Members and Guardians (R)

- 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 CCP/medical record.
- During a pandemic Representatives of residents that are infected will be notified daily by Nursing staff as to the resident's status.
- Representatives will be notified when a resident experience a change in condition
- Representatives will be notified weekly on the status of the pandemic at the facility including the number of pandemic infections.
- The Hotline message will be updated within 24 hours indicating any newly confirmed cases and/or deaths related to the infectious agent.
- Residents will be notified with regards to the number of cases and deaths in the facility unless they verbalize that they do not wish to be notified. This will be documented in the medical record/CCP

- All residents will be provided with daily access to communicate with their representatives. The type of communication will be as per the resident's preference i.e. video conferencing/telephone calls, and/or email.

Refer to Policy and Procedure Communication with Residents and Families During Pandemic
Refer to CMS guidelines regarding a change in condition

4. **The Facility Will Update Families and Guardians Once a Week (R) –** (See Section 3 Above)

5. **Implement Mechanisms for Videoconferencing (R)**
   - The facility will provide residents with no cost, daily access to remote videoconference or equivalent communication methods with Representatives
   - The Director of Recreation/Designee will arrange for the time for all videoconferencing

Refer to Policy and Procedure Communication with Residents and Families During Pandemic
Refer to P and P on Recreational Needs of Residents during a Pandemic

6. **Implement Process/Procedures for Hospitalized Residents (R)**
   - 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).
   - Prior to Admission/readmission the DON/designee will review hospital records to determine resident needs and facility's ability to provide care including cohorting and treatment needs.

Refer to Policy and Procedure for Bed Hold During a Pandemic

7. **Preserving a Resident's Place (R)**
   - 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).

Refer to Policy and Procedure for Bed Hold During a Pandemic

8. **The Facility's Plan to Maintain at least a two-month supply of Personal Protective Equipment (PPE) (R)**
   - The facility has implemented procedures to maintain at least a two-month (60 day) supply of PPE (including consideration of space for storage) or any superseding requirements under New York State Executive Orders and/or NYSDOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic.
   - This includes, but is not limited to:
     - N95 respirators
     - Face shield
     - Eye protection

- Isolation gowns
- Gloves
- Masks
- Sanitizer and disinfectants (meeting EPA Guidance current at the time of the pandemic)
- Facility will calculate daily usage/burn rate to ensure adequate PPE

Refer to Policy and Procedure on Securing PPE
Refer to Vendor Contract List including information for Local and State OEM in EPM

Recovery of all Infectious Disease Events

1. **Activities/Procedures/Restrictions to be Eliminated or Restored (R)**
   - 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.

Refer to Pandemic Tracking Sheet

2. **Recovery/Return to Normal Operations (R)**
   - The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders.
   - 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.
   - The facility will screen and test outside consultants that re-enter the facility, as per the NYS DOH guidelines during the recovery phase.

Refer to Policy and Procedure: Staff Testing during Pandemic

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan – Infection Control**

POLICY STATEMENT

1. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement (QAPI) program.
2. The elements of the infection prevention and control program consist of co-ordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, employee education, and employee health and safety.

POLICY INTERPRETATION AND IMPLEMENTATION

1. **Coordination and Oversight**
   - *a.* The infection prevention and control (IPC) program is coordinated and overseen by an infection preventionist (IP).
   - *b.* The qualifications and job responsibilities of the IP are outlined in the *Infection Preventionist Job Description*.
   - *c.* The IPC committee is responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include:
     - *i.* Whether physician management of infections is optimal
     - *ii.* Whether antibiotic usage patterns need to be changed because of the development of resistant strains
     - *iii.* Whether there is appropriate follow up of acute infections
   - *d.* The committee meets regularly to review and revise any guidelines or policies
2. **Policies and Procedures**
   - *a.* Policies and procedures are utilized as the standards of the IPC program.
   - *b.* The IPC committee (medical Director, DNS and IP) and other key clinical and administrative staff will review the infection control policies at least annually. The review will include:
     - i. Updating or supplementing policies and procedures as needed;
     - ii. Assessment of staff compliance with existing policies and regulations; and
     - iii. Any trends or significant problems since the last review.
3. **Surveillance**
   - *a.* Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications.
   - *b.* Standard criteria are used to distinguish community-acquired from facility-acquired infections.
4. **Antibiotic Stewardship**
   - *a.* Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.

b. Medical criteria and standardized definitions of infections are used to help recognize and manage infections.
c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews.

5. Data Analysis

a. Data gathered during surveillance is used to oversee infections and spot trends.
b. One method of data analysis is by manually calculating number of infections per 1000 resident days.

6. Outbreak /Epidemic/Pandemic Management

a. Outbreak management is a process that consists of:
  i. Determining the presence of an outbreak
  ii. Managing the affected residents
  iii. Preventing the spread to other residents
  iv. Documenting information about the outbreak
  v. Reporting the information to appropriate public health authorities
  vi. Educating the staff, residents and healthcare representatives
  vii. Monitoring for recurrences
  viii. Reviewing the care after the outbreak has subsided
  ix. Recommending new or revised policies to handle similar events in the future

7. Prevention of Infection

a. Important facets of infection prevention include:
  i. Identifying possible infections or potential complications of existing infections
  ii. Instituting measures to avoid complications
  iii. Educating staff and ensuring that they adhere to proper techniques and procedures
  iv. Enhancing screening for possible significant pathogens
  v. Immunizing residents and staff to try to prevent illness
  vi. Implementing appropriate isolation precautions when necessary, and
  vii. Following established general and disease-specific guidelines such as those of the CDC.

8. Immunization

a. Immunization is a form of primary prevention
b. Widespread use of influenza vaccine in this nursing facility is strongly encouraged
c. Policies and procedures for immunization include the following:
  i. The process for administering vaccines;
  ii. Who should be vaccinated;
  iii. Contraindications to vaccinations;
  iv. Obtaining consent;
  v. Monitoring for side effects of vaccination, and
  vi. Availability if the vaccine.

9. Employee Education

a. Infection Control Inservice on Orientation, and Annually and as necessary
  i. The Chain of Infections
  ii. The Spread of infections

iii. Transmission based Precautions
iv. Hand Hygiene
v. Glove usage
vi. Respiratory Protection Program
vii. Pandemic Emergency Plan

b. Competencies done on orientation and annually and as necessary
i. Hand Hygiene
ii. Use of PPE

c. Inservice any new recommendations made by the CDC and/or WHO

10. Monitoring Employee Health and Safety

a. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, and visitors, including:
i. Situations where these individuals should report their infections or avoid the facility (e.g. draining skin wounds, active respiratory infections with considerable coughing and sneezing, or frequent diarrheal stools);
ii. Pre-employment screening for infections required by law or regulation (such as TB);
iii. Any limitations (such as visiting restrictions) when there are infectious outbreaks in the facility; and
iv. Precautions to prevent these individuals from contracting infections such as Hepatitis and the HIV virus from residents or others

b. Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment (PPE).
i. The facility provides PPE, checks for its proper use, and provides appropriate means for needle disposable.
ii. A protocol is in place for managing those who stick themselves with a needle that was possibly or actually in contact with blood or body fluids.

References:

Infection Control Policy and Procedure Manual. August 2016.

Patterson Bursdall, D. & Marx, J.F. (2019). Infection Prevention in Long Term Care. Association for Professionals in Infection Control and Epidemiology (*2nd Ed.*)

MANHATTANVILLE HEALTHCARE CENTER

Department of Nursing

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Infection Prevention and Control Policy and Procedure**
POLICY:
The infection Preventionist (IP) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventive interventions.

INTERPRETATION AND IMPLEMENTATION

1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent further infections.
2. Infections that will be included in routine surveillance include those with:
    a. Evidence of transmissibility in a healthcare environment;
    b. Available processes and procedures that prevent or reduce the spread of infection;
    c. Clinically significant morbidity or mortality associated with infections (e.g. PNA, UTIs, *C. difficile*);
    d. Pathogens associated with serious outbreaks (e.g. acute viral hepatitis, norovirus, influenza, COVID-19, other novel pandemic infections).
3. Nursing staff will monitor residents for signs and symptoms that may suggest infection (e.g. fever, chills and sweats, change in cough or new cough, sore throat, shortness of breath, nasal congestion, burning or pain with urination, redness/soreness/swelling in any area, vomiting, diarrhea, new onset of pain) and will document and report suspected infections to the RN Supervisor and/or Medical Doctor as soon as possible.
4. If a communicable disease outbreak is suspected, this information will be communicated to the RN Supervisor and/or IP as soon as possible.
    a. Staff at all levels and in all departments will be provided with education if an outbreak or novel pandemic infection is suspected. Education will include, but not be limited to risk factors, signs/symptoms and preventive measures associated with infection.
5. When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures.
6. The Unit nurse will notify the medical doctor and the IP of suspected infections. Same will be discussed with interdisciplinary team (IDT).
    a. A determination will be made whether transmission-based precautions are necessary
    b. Treatment of plan will be determined by the medical doctor and the IDT.
    c. Report infection, if necessary via the HCS NORA reporting and/or NHSN.
7. If transmission-based precautions or other preventive measures are implemented to slow or stop the spread of infection, the IP will collect data to help determine the effectiveness of such measures.
8. When transmission of HAIs continues despite documented efforts to implement infection control and preventive measures, the appropriate State agency and/or specialist in infection control and epidemiology will be consulted for further instructions.

9. When deemed necessary, the DON/Designee will establish Quality Assurance Performance Improvement (QAPI) projects and Performance Improvement Personnel (PIP) teams will be designated to identify root cause(s) and develop action plans. PIPs will report findings/results to the Quality Assurance (QA) Committee.

Gathering Surveillance Data

1. The IP or RN designee is responsible for gathering and interpreting surveillance data.
2. The surveillance should include a review of any or all of the following information to help identify possible indicators of infections:
    a. Laboratory records;
    b. Skin care sheets;
    c. Infection control rounds or interviews;
    d. Verbal reports from staff;
    e. Infection documentation records;
    f. Temperature logs;
    g. Pharmacy records;
    h. Antibiotic review; and
    i. Transfer log/summaries.
3. If laboratory reports are used to identify relevant information, the following findings merit further evaluation:
    a. Positive blood cultures;
    b. Positive wound cultures that do not just represent surface colonization;
    c. Positive urine cultures (bacteriuria) with corresponding signs and symptoms that suggest infection;
    d. Other positive cultures (e.g. stool, sputum); and
    e. All cultures positive for Group A Streptococcus.
4. Prioritize reports as follows:
    a. Signs/symptoms associated with novel pandemic infections
    b. Multi-drug resistant reports:
        i. All multidrug-resistant reports require immediate attention
        ii. Ensure appropriate precautions, if needed, are in place
        iii. If this is a new or unexpected report, notify the DNS and medical director.
    c. Blood cultures
    d. Positive wound cultures if there are corresponding signs and symptoms that indicate infection
    e. Positive sputum cultures
    f. Bacteriuria <u>with</u> corresponding signs and symptoms of UTI;
    g. Other positive cultures

Data Collection and Recording

1. For residents with infections that meet the criteria for definition of infection surveillance, collect the following data as appropriate:
    a. Identifying information (e.g. resident's name, unit, room #, attending physician);
    b. Diagnoses;
    c. Date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test);
    d. Infection site (be as specific as possible, e.g. PNA, right upper lobe)
    e. Pathogen(s)

f. Invasive procedures or risk factors (e.g. surgery, indwelling tubes, Foley, fractured hip, malnutrition, altered mental status, etc);
g. Pertinent remarks (e.g. temperatures, WBC, etc). Also, record if the resident is admitted to the hospital or expires.
h. Treatment measures and precautions (interventions and steps taken that may reduce risk).

2. Using the current suggested criteria for HAIs, determine if the resident has a HAI.
3. DAILY: record signs and symptoms of infection on infection tracking form.
4. MONTHLY: collect information from individual resident infection reports and create line listing of infections by resident for the entire month.
5. MONTHLY: summarize monthly data
6. QUARTERLY: Compare incidence of current infections to previous data to identify trends and patterns. Use an average infection rate over a previous time period (e.g. over the past 12 months) as a baseline. Compare subsequent rates to the average rate to identify possible increases in infection rates.

Calculating Infection Rates:

1. Calculate the month's total resident days.
    a. Total resident days = daily census of each day in the designated time period added together.
2. To determine the incidence of infection per 1000 resident days, divide the # of new HAIs for the month by the total resident days for the month X 1000.

Interpreting Surveillance Data

1. Analyze the data to identify trends
    a. Compare the rates to previous months in the current year and to the same month in previous years to identify seasonal trends.
2. Surveillance data will be provided to the Infection Control Committee and Quality Assurance Performance Improvement Committee regularly.

References:

Infection Control Policy and Procedure Manual. July 2016.

Patterson Bursdall, D. & Schweon, S.J. (2019). Surveillance, Epidemiology and Reporting. Association for Professionals in Infection Control and Epidemiology (*2nd Ed.*)

MANHATTANVILLE HEALTHCARE CENTER

Annex K Section - Communicable Disease Reporting

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.°

- 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.

  — 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.

  — Assingle case involving Staphylococcus aureus showing reduced susceptibility to vancomycin.

  — Clusters of tuberculin skin test conversions.

  — Asingle 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.

MANHATTANVILLE HEALTHCARE CENTER

Department of Nursing

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Personal Protection Equipment - PPE**

POLICY: It is the policy of Manhattanville Healthcare Center to ensure there are adequate numbers and items of PPE during a pandemic. In accordance with NYS Chapter 114 of the Laws of 2020, and based on the HERDS survey data for the period April 13-27, 2020, the facility will have on stock or on contract a 60-day supply of PPEs

PROCEDURE:

1) The facility has an adequate supply of PPE, including types that will be kept in stock, The facility has initiated measures for procuring their own PPE supply (e.g., facemasks, N95 respirators, gowns, gloves and eye protection such as face shields or goggles and hand sanitizer.
2) The Facility has existing contracts with has existing contracts or relationships with PPE vendors to facilitate the replenishment of stock. (See Emergency Prep Manual Vendor list). The storage location(s) for PPE are supply rooms in basement and the fifth floor.
3) The Facility will use PPE conservation strategies outlined by the CDC plan to address PPE supply shortages.
4) The facility will communicate with local and state and federal Emergency Management to procure PPE during a pandemic to ensure adequate supplies as needed.
5) Signs are posted immediately outside of resident rooms and any pandemic designated units indicating appropriate infection control and prevention precautions and required PPE in accordance with NYS and CDC guidance.
6) Residents' rooms requiring transmission-based precautions will have isolation carts containing PPEs outside of the residents' rooms or yellow caddies hanging by resident's room door for easy accessibility.
7) The Central Supply Coordinator in conjunction with Administrator and Infection Preventionist will track PPE usage and ensure adequate PPE is accessible to staff providing care.
8) The Central Supply Coordinator/Designee will distribute PPE for each shift ensuring adequate PPE is available and restocked as needed
9) The IP and Central Supply Coordinator will calculate the burn rate (determines the number/amount of a given supply) of PPEs to ensure adequacy of supplies.

Burn Rate = Quantity used/day
For example, on any given day, there are approximately 200 staff that will need to wear surgical masks. On average, that number of staff will need to each change masks 5-6 times per day. So 6 masks/day x 200 employees = 1200 masks/day. This will be the burn rate – or the number of masks the facility will burn (use) per day.

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Environmental Services – Cleaning Resident Rooms**

DEFINITIONS

Cleaning: the removal of visible soil from surfaces through physical action of scrubbing with a surfactant or detergent and water.

Low-Level Disinfection: destroys all vegetative bacteria (except tubercle bacilli) and most viruses. Does not kill bacterial spores. Examples: hospital disinfectants registered with the EPA with HBV and HIV label claim (purple top wipes). These are generally appropriate for most **environmental surfaces.**

Intermediate-Level Disinfection: kills a wider range of pathogens than a low-level disinfectant. Does not kill bacterial spores. Examples: EPA-registered hospital disinfectants with a tuberculocidal claim (purple top wipes). May be considered for environmental surfaces that are visibly contaminated with blood.

Kill Claim: information about which pathogens the disinfectant kills; found on the product label.

Contact Time: the time a disinfectant should be in direct contact with a surface to ensure that the pathogens specified on the label are killed. In order words, the amount of time a surface has to stay wet after being cleansed/disinfected with the product. Example, purple top wipe, 2 minutes.

PURPOSE

To provide guidelines for cleaning and disinfecting residents' rooms and other environmental surfaces in order to break the chain of infection.

RESPONSIBILITY

Environmental Services (EVS) or Housekeeping staff are primarily responsible for following environmental cleaning and disinfection policies and procedures.

GENERAL GUIDELINES

1. Housekeeping surfaces (e.g. tabletops and floors) will be cleaned daily, when spills occur, and when these surfaces are visibly soiled.
2. All environments/areas (e.g. lobby, hallways, common areas, medication rooms, nurses' stations) and residents' rooms will be disinfected (or cleaned) daily and when surfaces are visibly soiled.
3. When there is an outbreak (e.g. Influenza, Norovirus), residents' rooms and other environmental surfaces (e.g. rails in hallways; elevators, to include keypads; common areas) will be disinfected and/or cleaned more often.
4. When there is a room with a known multi-drug resistant organism (MDRO), room environment will be disinfected and cleaned regularly; mops and cleaning cloths will be dedicated for use in this room only.
5. Utility rooms/porters' closets to be cleaned daily by housekeeping staff as determined by facility's schedule
6. Garbage will be removed at scheduled times per facility protocol.
7. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including:

a. Recommended use-dilution
b. Material compatibility
c. Storage
d. Shelf life, and
e. Safe use and disposal

8. Walls, blinds and window curtains in resident areas will be cleaned at least every 3 months and when these surfaces are visibly contaminated or soiled.
9. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently.
10. Floor mopping solution will be replaced every 3 resident rooms, or at least every hour, whichever comes first.
11. Personnel should remain alert for evidence of rodent activity (droppings) and report findings to Director of EVS/Housekeeping and log in Pest Control Log Book.
12. Clean medical waste containers intended for reuse (e.g. garbage bins/pails) daily or when such receptacles become visibly contaminated with blood, body fluids or other potentially infectious materials.
13. Perform hand hygiene (wash hands with alcohol-based hand rub [ABHR] or soap and water for 20 seconds) after removing gloves.
14. Common intermediate and low-level disinfectants for smooth, hard surfaces and non-critical items include:
    a. Ethyl or isopropyl alcohol (70 - 90%)
    b. Sodium hypochlorite/household bleach (5.25-6.15% diluted 1:500 or per manufacturer's instructions)
    c. Phenolic germicidal detergent (follow product label for use-dilution)
    d. Iodophor germicidal detergent (follow product label for use-dilution)
    e. Quaternary ammonium germicidal detergent for low-level disinfection only (follow product label for use-dilution)

EQUIPMENT and SUPPLIES

1. Environmental service cart (do not take in resident's rooms)
2. Disinfecting solution
3. Cleaning cloths
4. Mop
5. Bucket
6. Personal protective equipment (e.g. gown, mask, gloves, as needed)

PROCEDURE

1. Gather supplies as needed
2. Prepare disinfectant according to manufacturer's recommendations
3. Discard disinfectant/detergent solutions that become soiled or clouded with dirt and grime and prepare fresh solution
4. Change mop solution water at least every three (3) rooms, or at least every hour; whichever comes first.
5. Change cleaning cloths when they become soiled. Wash cleaning cloths daily and allow cloths to dry before reuse.

6. Clean horizontal surfaces (e.g. overbed tables, chairs) daily with a cloth moistened with disinfectant solution. Use appropriate EPA-approved disinfectant for specific pathogens. Do not use feather dusters. In the event of a novel pandemic, refer to the EPA's recommendations for appropriate cleaning/disinfecting agents.
7. Clean personal use items (e.g. lights, phones, call bells, bedrails, bed remote, etc.) with disinfection solution daily.
8. When cleaning rooms of residents on isolation precautions, use personal protective equipment (PPE) as indicated.
9. When possible, isolation rooms should be cleaned last and water discarded after cleaning room.
10. Utilize disinfectant solution based on type of precaution.
11. Clean curtains, window blinds, and walls at least every 3 months or when they are visibly soiled or dusty.
12. Clean spills of blood or body fluids as follows:
    a. Use personal protective equipment, that is, gloves (heavy duty if available)
    b. Spray area with bleach
    c. Wipe spill or splash with a cloth or paper towels
    d. Discard saturated cloth or paper towels into red "biohazard" bag
    e. Repeat as necessary until the spill or splash area is dry.
    f. Spray disinfectant solution onto the discarded cloth or paper towels inside the plastic bag.
    g. Tie the bag. If the outside of the bag becomes contaminated with blood, body fluids, secretions, or excretions, place the contaminated bag into a clean plastic bag.
    h. Place the plastic bag into a designated red container for medical waste, located in the soiled utility room on each unit.
    i. Remove gloves, discard.
    j. Wash hands with soap and water (at least 20 seconds).
13. Refer to checklist for daily room cleaning.

TERMINAL ROOM CLEANING

1. Terminal room cleaning is done when a resident is transferred, discharged, or expires.
2. Gather cleaning equipment and supplies (gloves, disinfectants, cleaning cloth, plastic trash bag, mop, bucket).
3. Prepare disinfectant according to manufacturers' recommendations
    a. Use fresh solutions for terminal and thorough cleaning of all rooms
    b. Discard solution when the procedure has been completed
4. Clean all high-touch furniture items (e.g. overbed tables, bedside tables, chairs, and beds) with disinfectant solution or appropriate wipe
5. Clean all high-touch personal use items (e.g. lights, phones, call bells, bed rails, bed remote, etc.) with disinfectant solution.
6. Discard personal (e.g. toothbrush, toothpaste, mouthwash, lotion, soaps, bodywash, etc.) and single-resident use items (e.g. thermometers)
7. Clean all equipment, if present, in room (ex: nebulizer machine, tube feeding pump, IV poles, concentrator, etc.) and return to designated storage area.
8. Refer to checklist for terminal room cleaning

References:

CDC. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/tables/table1.html

CDC. Options for Evaluating Environmental Cleaning https://www.cdc.gov/hai/toolkits/evaluating-environmental-cleaning.html

EPA. Selected EPA-Registered Disinfectants. https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

Yale, S.L. and Levenson, S.A. (2016). Infection Control Policy and Procedure Manual. Med-Pass, Inc.

MANHATTANVILLE HEALTHCARE CENTER

Adapted from: CDC Environmental Checklist for Monitoring Daily Room Cleaning

Date:	**Unit:**
Initials of ES staff:	**Room Number:**

Evaluate the following priority sites for each patient room:

High-touch Room Surfaces	Cleaned	Not Cleaned	Not Present in Room
Bed rails			
Bed remote			
Overbed/Bedside table			
Call button			
Telephone			
Chair(s)			
Room sink			
Room light switches			
Room door knobs (inner/outer)			
Bathroom inner door knob			
Bathroom light switches			
Bathroom handrails by toilet			
Bathroom sink			
Toilet seat			
Toilet flush handle			
Toilet bowl brush			

Evaluate the following additional sites if these equipment are present in the room: (May be cleaned Weekly)

High-touch Room Surfaces	Cleaned	Not Cleaned	Not Present in Room
IV pole			
Feeding tube pole			
Feeding tube pump			
Nebulizer machine			
Concentrator			

Mark the monitoring method used:

☐ Direct observation ☐ Fluorescent gel
☐ Swab cultures ☐ ATP system ☐ Agar slide cultures

Auditor's Name: _____ Date: _____

MANHATTANVILLE HEALTHCARE CENTER

Adapted from: CDC Environmental Checklist for Monitoring Terminal Room Cleaning

Date:	**Unit:**
Initials of ES staff:	**Room Number:**

Evaluate the following priority sites for each patient room:

High-touch Room Surfaces	Cleaned	Not Cleaned	Not Present in Room
Closet(s) – inside & outside			
Windows, blinds, window sills			
Walls in room			
Bed rails			
Bed/TV remote			
Overbed/Bedside table			
Call button			
TV and Telephone			
Chair(s)			
Room sink			
Room light switches			
Room door knobs (inner/outer)			
Bathroom walls			
Bathroom inner door knob			
Bathroom light switches			
Bathroom handrails by toilet			
Bathroom sink			
Bathroom shower/tub			
Toilet seat			
Toilet flush handle			
Toilet bowl brush			

Evaluate the following additional sites if these equipment are present in the room:

High-touch Room Surfaces	Cleaned	Not Cleaned	Not Present in Room
IV pole			
Feeding tube pole & pump			
Nebulizer machine			
Concentrator			

Mark the monitoring method used:

☐ Direct observation

Auditor's Name: _____ Date: _____

MANHATTANVILLE HEALTHCARE CENTER

Visitation Guidelines

POLICY

It is the policy of Manhattanville Healthcare Center to begin visitation for residents, families and resident representatives while ensuring safety and adherence to infection prevention strategies to minimize any potential spread of infection. This will be done in accordance with all state and federal guidance for the prevention of COVID-19. The following information is provided by the Department of Health.

PURPOSE

To promote and enhance resident quality of life by implementing visitation to combat psychological impacts of isolation from family and representatives.

CRITERIA

Facilities in Phase 3 regions may resume **limited visitation and activities beginning July 15, 2020 and only under the following conditions**:

1. The facility is in full compliance with all state and federal requirements, state Executive Orders and guidance, state reporting requirements including COVID-19 focus surveys, HERDS and staff testing surveys, and federally required submission of COVID-19 data to the NHSN.
2. The facility has protocols to separate residents into cohorts of positive, negative, and unknown as well as separate staff teams to deal with COVID-positive residents and non-positive residents.
3. The facility has completed the NY Forward Safety Plan and submitted a copy of the complete plan to covidnursinghomeinfo@health.ny.gov. The facility must retain a copy of the plan at the facility where it is accessible and immediately available upon request of the Department or local health department.
    a. The plan must clearly articulate the space(s) to be used for visitation (outdoors and indoors) including the number of visitors and residents which could be safely socially distanced within the space
4. The absence of any new onset of COVID-19 among staff or residents as reported to the Department on the HERDS and staff testing surveys and as reported to the NHSN for a period of **no less than twenty-eight days, consistent with CMS FAQ's.**
5. Adherence to written screening protocols for all staff during each shift, each resident daily, and all persons entering the facility or grounds of the facility, including visitors. Resident monitoring must include daily symptom checks, vital signs, and pulse oximetry.
6. A copy of the facility's formal visitation plan is posted to their public website and broadcasted via email or social media to provide visitors with clear guidelines for visiting

and to announce if and when visitation is paused due to an increase in the number of residents and/or staff with confirmed positive COVID-19 diagnosis.

7. Limited visitation, including, but not limited to, family members, loved ones, representatives from the long-term care ombudsman program (LTCOP), and resident advocacy organizations will be permitted.

PROCEDURE:

- Facility visitation will be conducted in outdoor area, weather permitting.
- In inclement weather such as high heat and as facility space allows visitation will be inside, in a well-ventilated space with no more than 10 individuals who are social distanced and wearing a facemask / face covering while in the presence of other. This may include residents visiting each other.
- Visits will be made in advance and scheduled by Social Services staff.
    - The facility will assign staff to assist with the transition of residents, monitoring of visitation, and cleaning and disinfecting areas used for visitation after each visit using an EPA-approved disinfectant.
    - The facility will post signage regarding facemask utilization and hand hygiene and uses applicable floor markings for social distancing.
    - The facility will screen all visitors for signs and symptoms of COVID-19 prior to resident access and visitation will be refused if the individual(s) exhibits any COVID-19 symptoms. This will include temperature checks and screening questions to assess potential exposure to COVID-19, international travel and to states designated under the Commissioner's travel advisory. The facility must maintain screening question asked onsite in an electronic format and make it available upon the Department's request.
    - A log will be kept for all visitors that includes:
        - First and last name of the visitor;
        - Physical (street) address of the visitor;
        - Daytime and evening telephone number;
        - Date and time of visit;
        - Email address, if available; and
        - As per NYSDOH a notation indicating the individual cleared the screening (both temperature and questions) that does not include any individual temperatures or other individual specific information.
    - Visitors and residents must wear a facemask or face covering (must always cover both the nose and mouth when on the premises of the facility). Masks will be available hand for visitors as needed.
    - Visiting areas will have easily accessible alcohol-based hand rub, for residents, visitors, and staff.
    - **No more than 10 percent** of the residents shall have visitors at any one time and only two visitors will be allowed per resident at any one time.
    - Visitors under the age of 18 must be accompanied by an adult 18 years of age or older.

    - Current COVID-19 positive residents, residents with COVID-19 signs or symptoms, and residents in a 14-day quarantine or observation period are not eligible for visits.
    - The facility will provide and post a fact sheet outlining visitor expectations including appropriate hand hygiene and face coverings. The fact sheet will be provided upon initial screening to all visitors.
- Residents will also be assisted to go outdoors with staff supervision weather permitting. The appropriate infection control and safety and social distancing requirements must be maintained.
- The IDT Team will review the Visiting program and monitor for any needed adjustments and report to QA Committee as needed.
- If any visitor fails to adhere to the protocol, he/she/they will be prohibited from visiting for the duration of the COVID-19 state declared public health emergency.

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Staff Screening Tool**

POLICY: In the event of a Pandemic, the facility will implement guidelines to screen staff for signs and symptoms associated with the infectious pathogen. Where applicable, the facility will follow guidelines established by the Centers for Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH).

PROCEDURE:

1. The facility will develop a screening tool/questionnaire for employees to identify those who may be at risk for novel infectious pathogen.
2. The Receptionist will be responsible to ensure that each employee is given a Screening tool, if on paper, when they enter the facility.
    a. This may be done electronically via Kiosks, if available.
3. The employee will complete questionnaire/screening questions appropriately.
4. If temperature screening is indicated, the employee is responsible to document the temperature reading obtained when thermal screening is done.
5. Any employee who has symptoms associated with the infectious pathogen will not be allowed to enter the building beyond the lobby area.
6. The Department Head or RN supervisor is to be notified when an employee has symptoms associated with the infectious pathogen.
7. Employees who are symptomatic will be sent home or to the nearest emergency department if warranted based on presentation of symptomology.
8. The Department Head/RN Supervisor is responsible to notify the Infection Control Nurse who will contact the employee shortly after.
9. Employees who work more than eight hours are responsible to complete a 2nd Screening Tool.
10. Employees are responsible to give this Screening Tool, if done on paper, to their immediate Supervisor when they come to their assigned unit, office, department area.
11. The Daily Screening Tool, if done on paper, will be kept on file by each Department Head.
12. Sick Call logs will be reviewed daily by each Department Head/Designee and the names of employees who triggers for symptoms associated with the infectious pathogen will be communicated to the Infection Preventionist/Designee.
13. The Infection Preventionist/Designee will maintain a line list of all staff, regardless of department, who presents with symptoms associated with the infectious pathogen.
14. All employees are encouraged to stay home, alert the facility, and contact their primary care physician should they develop symptoms associated with the infectious pathogen.

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Resident Screening During a Pandemic**
POLICY: In the event of a Pandemic, the facility will implement guidelines to screen Residents and any prospective admission for signs and symptoms associated with the infectious pathogen. Where applicable, the facility will follow guidelines established by the Centers for Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH).

PROCEDURE:

In-House Residents

1. The facility will develop a screening tool/questionnaire for residents to identify those experiencing symptoms associated with the novel infectious pathogen. The screening tool may include temperature monitoring, symptom check, and other vital signs as stipulated by the NYS DOH/CDC guidelines.
2. The screening tool will be done daily or if indicated with any changes in condition.
3. The following interventions will be taken for Residents that trigger for signs/symptoms associated with the novel infectious pathogen:
    - RNS assessment
    - PMD notification
    - Transmission Based Precautions as indicated
    - Representative notification
    - Lab testing and diagnostic work up as ordered
    - Vital sign monitoring each shift including pulse oximetry as indicated
4. Residents that trigger for signs/symptoms associated with the novel infectious pathogen will be discussed at the Morning QI meeting and placed on the Line List for the novel infectious agent.
5. During the recovery phase all residents will have vital signs monitored daily.

Prospective Admissions/Re-admissions

1. All new and readmissions will be pre-screened by Admission Office for the presence of the novel infectious pathogen
    - The admission office will ascertain from the sending facility if the resident being admitted or re-admitted has been exposed to a confirmed or suspected of the infectious pathogen
    - The admission office will ascertain the type of transmission-based precautions that the resident received during has required airborne precautions while in acute care.
    - The admission department will ascertain if the resident was tested for the novel infectious pathogen in accordance with NYS DOH /CDC criteria.

- The DNS and Infection Control Preventionist will be notified and review information prior to admission to determine if the facility can provide the needed care for the resident.
- New /Readmissions will be cohorted based on infectious status and /or placed on quarantined with transmission-based precautions with vital sign monitoring daily and as needed in accordance with CDC and NYSDOH guidance.

2. Residents that are newly admitted and readmitted will have vital sings monitored each shift in accordance with the number of days the infectious pathogen can incubate.

MANHATTANVILLE REHABILITATION & HEALTHCARE CENTER

Department of Nursing

EMERGENCY STAFFING

GENERAL

- This would apply to situations where staff members refuse to work or are not able to come to work due to situations such as a disaster, or an influx of residents which would over-burden the present staffing complement
- All departments adjust their schedules and assignments to best compensate for reduction in available staff

ADMINISTRATION

- Set up Command Post as necessary, and follow the Emergency Incident Commander Job Action Sheet
- Determine which staff in the building will remain on-duty beyond their normal shift schedule. Determine if it's possible to provide transportation for staff not able to reach the facility.
- Determine the need/ability to call in off-duty staff or contract with healthcare staffing agencies.
- Check with other healthcare facilities and Staffing agencies to determine the feasibility of providing staff.
- In conjunction with Department Supervisors, establish a master schedule for work and rest.
- Establish a sleeping area for staff. (use "STAFF EMERGENCY HOUSING PLAN Bed Assignment List")
- Determine the need to transfer residents to other facilities, release to responsible party, or otherwise decrease census, as appropriate. Contact Local and State Health Departments.
- Ensure provisions are in place for, adequate of building, as necessary.
- Consult with vendors to determine the availability of necessary goods and outside services.
- Ensure all other guidelines of this procedure are completed.

FOOD SERVICE

- Revise routines to compensate for the need to feed staff and residents.

HOUSEKEEPING

- Provide linens, etc. necessary to accommodate staff sleeping arrangements.

PHYSICAL/OCCUPATIONAL THERAPY AND ACTIVITIES

- Assist Nursing with feeding and transfer or residents, per training

SEE ALSO:

Daily Staffing Needs

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Regulated Medical Waste – Biohazard**
POLICY: It is the policy of Manhattanville Healthcare Center to dispose of regulated medical waste in accordance with Chapter 738 of the Public Health law of 1993 and #10 NYCRR 70.

Definition of Regulated Medical Waste

1. "Regulated Medical Waste shall mean waste which is generated in the diagnosis, treatment or immunization of human beings…"

2. There are six (6) sub-categories within the general definition of regulated medical waste. Three (3) of these categories are not applicable to the Nursing Home setting. The three (3) categories that do not apply are as follows:

1. Human Pathological Waste

This waste includes organs, body parts and body fluids. Urine is not considered regulated medical waste, unless it is submitted as a clinical specimen for laboratory testing. However, if a patient is found to have a disease which may be transmitted through urine, then the material containing this fluid, including diapers, must be considered regulated medical waste.

Incontinence Materials (diapers, etc.) are generally not considered regulated medical waste, provided that the patient does not have an infectious disease which can be transmitted by urine. Since feces always contains microorganisms and since these microorganisms, even if potentially pathogenic, cannot be transmitted from trash containers or disposable sites; therefore, fecal contaminated materials, including diapers are not considered to be regulated waste.

2. Human Blood & Body Parts

"This waste shall include discarded human blood, discarded blood components, (9e.g. serum and plasma) containers with free flowing blood or blood components or discarded saturated materials containing free flowing blood or blood components and materials saturated with blood or blood products…"

3. Sharps

This waste includes sharps used in human patient care. Sharps include syringes with attached needles, needles and lancets. Because of the potential to break and give rise to puncture or laceration wounds, glass tubes, flasks, beakers, etc., must also be considered as sharps and be disposed of accordingly.

Procedures for Managing Regulated Medical Waste

1. The soiled utility room on each unit shall contain a sealed container with a leak proof and puncture resistant bag. Both the container and the door leading to the soiled utility room shall have affixed to them the "Bio-Hazard" sign.

2. Once each day, in the morning the Housekeeping Department will pick up the bags, appropriately tie them and place these bags in approved transporting boxes located in the "Infectious Waste" storage areas. This storage area is duly marked by a "Bio-Hazard" sign. This Infectious Waste storage area is to be locked at all times and only Housekeeping and Administration have keys.

Housekeeping personnel are provided with appropriate protective equipment, including gloves, aprons, etc., when handling regulated waste materials.

3. On a monthly basis, all regulated medical waste is picked up at the Home by a licensed Medical Waste Transporter.

4. The licensed Medical Waste Transporter (with whom the home maintains a written contractual agreement for services) prepares a manifest, listing the number of boxes taken. Both the name of the generator (the Home) and the name of the transporter are printed on each box. The manifest also contains name, address, and permit number of the "Disposer."

5. Within thirty (30) days of pick-up, the facility receives via U.S. mail a copy of the manifest, signed by the Disposer. These signed manifests are to be kept by the Home for at least six (6) years.

Internal Procedures for Collecting Regulated Medical Waste

1. The Director of Nursing or her designee will notify the Director of Housekeeping of the need to isolate a resident.

2. Three (3) containers, each with leak proof and puncture resistant bags and Bio-hazard labels will be provided by the Housekeeping Department and Nursing personnel will place these containers in each resident's ante-room. These containers will each be labeled as follows:

a. Linen

b. Personal Clothing

c. Trash

Housekeeping personnel should not enter the isolated room unless supervised by a Registered Nurse and then only with the appropriate protective clothing and equipment.

3. Daily, these labeled bags are collected by the Housekeeping Department from the Soiled Utility Room.

. The **Linen** bags are stored in the Soiled Laundry Room in a secured area. These bags are picked up twice weekly by the outside laundry company and are washed in the double red bags, which are degradable.

b. **Personal Clothing Bags** are stored in the Soiled Laundry Room until they are washed in-house, after all other laundry has been washed. Since personal clothing cannot be washed together, Laundry personnel will wear appropriate protective clothing during the sorting and handling process.

After washing this clothing, the washing machine will be disinfected with Lysol liquid or bleach.

c. **Trash bags** are placed by Housekeeping personnel in approved transportation boxes in the Infectious Waste storage area and are handled in accordance with the guidelines from the above section "Managing Regulated Waste."

Procedures for Managing Sharps/Disposable Razors Generated In-House
The primary container for discarded sharps shall be rigid, leakproof, puncture-resistant and closable, and may serve as a secondary container for purposes of transport, provided it meets the definition of a secondary container.

(e)(1) Under no circumstances shall a sharps container be filled beyond the fill line indicated on the container.

(2) Sharps containers shall be removed from patient care areas to a room or area designated for regulated medical waste storage, whenever the container has reached the fill line indicated on the container. Sharps containers shall be removed from patient care areas within thirty (30) days or upon the generation of odors or other evidence of putrification, whichever occurs first, without regard to fill level.

(f) Regulated medical waste, with the exception of sharps as provided in subdivision (e) of this section, may be held in patient care areas for a period not to exceed twenty-four (24) hours and at a clinical laboratory for a period not to exceed seventy-two (72) hours, at which time the waste shall be moved to a storage area.

(g)(1) Each storage area shall be adequate for the volume of regulated medical waste generated between scheduled waste pick-ups by a transporter, or, for facilities treating the waste on-site, the volume of waste that can be treated on-site within a twenty-four (24) hour period.

(2) Each storage area shall:

(i) display prominent signage indicating the space is used to store regulated medical waste;

(ii) be designed or equipped to prevent unauthorized access;

(iii) be designed or located to protect waste from the elements, and prevent access by vermin;

(iv) hold the waste at a temperature that prevents rapid decomposition and resultant odor generation;

(v) be appropriately ventilated; and

(vi) be of sufficient size to allow clear separation of regulated medical waste from any other waste, whenever waste other than regulated medical waste is stored in the same area.

(3) Regulated medical waste shall not be stored for a period exceeding thirty (30) days, except that a site generating under fifty (50) pounds of regulated medical waste per month and not accepting regulated medical waste for treatment from other facilities, may store waste for a period not exceeding sixty (60) days.

(h) Prior to transport off-site of the generating facility for treatment elsewhere:

(1) primary containers shall have affixed a label or imprint indicating the name and address of the generating facility; and

(2) primary containers, except as provided in (c)(2) of this section, shall be placed in a secondary container with an affixed label or imprint, indicating the name and address of the generating facility, and such container marked prominently with signage indicating that the contents are infectious or regulated medical waste; and, if applicable, with an affixed label indicating that the contents contain or are mixed with hazardous waste, and/or toxic drug waste.

- Sharps containers are located on each nursing unit and each medication cart
- Sharps containers for disposable razors are also located on each nursing unit and shower area
- Sealed Sharps containers are collected from all areas by Housekeeping personnel a minimum of monthly and as needed prior to the licensed Transporter pickup. Sealed Sharps containers are placed in approved transportation boxes and are processed in accordance with the guidelines from the above section "Managing Regulated Waste."

Cleaning Up Spills

The following procedure is to be strictly implemented and adhered to in the event of an accidental spill of Regulated Waste as previously defined above.

1. Blood Spill Kits are located on each unit and will be utilized to clean up spills of Regulated medical Waste.

2. Additional equipment available: Mask, Goggles, Tongs (for picking up sharps), DustPan, Broom, Aprons, Germicidal Solution, and Small Sharps Container.

3. Housekeeping/ Nursing Personnel after having used this equipment to clean a spill should place same in a leak-proof bag, appropriately tie the bag and store in the Soiled Utility room for regular Housekeeping pickup.

4. The Housekeeping Department is responsible for cleaning up both small and large spills of Regulated Medical Waste. If Housekeeping Personnel have left the building, Nursing Personnel is responsible to clean both small and large spills.

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan – Subsistence**

PURPOSE: To ensure adequate supplies and subsistence for all persons in the facility during and emergency event. Provisions include food, pharmaceuticals and medical supplies.

POLICY: Manhattanville Healthcare Center shall maintain for the duration of an emergency or until all its patients have been evacuated and its operations cease: Contracted service for the supply of medical, pharmacy, food and water for staff and residents. The facility shall provide an emergency power system maintained in accordance with NFPA 110. This system shall provide power to areas that are critical to resident care such as HVAC, refrigeration and life safety items.

PROCEDURE:

1. The central supply of medical provisions such as but are not limited to, dressings, stock medications, and wound care will have par levels to provide for 72 hours of care.
2. There shall be an arrangement with the [NAME] pharmacy for the provision of resident and those staff sheltering in place required medications from a backup source if the provider cannot deliver during the emergency.
3. The dietary department shall have in a separate location sufficient supply of emergency food and water for 72 hours and maintain an agreement with suppliers for emergency delivery of potable water. The dietary department shall order additional supplies ahead of any predicted emergency to ensure adequate supplies for any incoming persons who may need shelter in an emergency.
4. If there is a chance of flooding to the central supply areas these emergency supplies shall be relocated to the storage rooms available on the nursing units.
5. The facility shall maintain an emergency generator connected via an automatic transfer switch to supply power to mission critical systems such as heat, fire systems, and lighting. This generator will be tested and inspected in accordance with NFPA 110 and manufacturers' recommendation.
6. The facility shall have a service contract for the generator which can also supply a backup in the event of generator failure.
7. The fuel supply for the generator shall not fall below 72 hours and a contract for fuel delivery shall be in place.
8. Maintaining necessary services include the delivery and access to medical gases.
9. The facility shall maintain a supply of clean linen and contracted services for the removal and treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; for safe and appropriate disposal in accordance with nationally accepted industry guidelines.

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Developing Cohorts During a Pandemic**

POLICY: It is the policy of Manhattanville Healthcare Center to continue to prevent and control the spread of any novel infectious pathogens and to protect and treat all residents affected in accordance with regulatory requirements.

The facility will attempt to separate the residents into groups of Negative, Positive, and Unknown cohorts as recommended by NYSDOH and CDC guidelines.

Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other residents. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent.

PROCEDURE:

1. Residents will be cohorted by category: **Negative, Positive, Unknown** status requiring observation.
2. Residents will be assessed daily for any symptoms of the infectious agent. Symptoms check will include, but is not limited to fever, respiratory symptoms, any symptoms explicit to the specific infectious agent, or any change in condition.
3. If indicated, and when possible, laboratory and/or other testing will be conducted to detect presence of specific infectious agent.
4. The facility will create a designated area/unit for residents who have tested positive for the specific infectious agent.
5. Residents and roommates of residents who are suspected of being infected with the novel infectious agent will be placed on appropriate transmission-based precautions as necessary. If indicated, laboratory and/or other testing will be conducted to detect presence of infectious agent.
6. When feasible, the symptomatic resident will be moved to a private room on the same unit.
7. All Admissions/ Readmissions will have a review of hospital information prior to admission to determine appropriate placement in facility and if adequate infection prevention and treatment needs can be met at the facility.
8. Specific to the novel infectious agent, a screening tool will be done on all prospective admissions and re-admissions by the Admitting Department.
9. Residents who are newly admitted and develop any symptoms associated with the novel infectious agent will be transferred to the dedicated unit upon identification of symptoms.

10. Residents presenting with signs or symptoms of the novel infectious agent will be assessed by an RN and/or PMD.
11. All staff will continue to be actively screened for signs/symptoms associated with the novel infectious agent.
12. Residents and resident representatives will be notified daily of any newly confirmed (positive) cases in the facility as well as any resident deaths related to the infectious agent via the established auto hotline messaging.
13. The facility will continue to promote consistent staff and staff assignment on each unit:
    - The staffing coordinator, in conjunction with the DON/RNS, will make every effort to have residents that have been *confirmed* to be infected with the novel infectious agent to be grouped into one assignment.
    - Every effort will be made to have residents who are *suspected* of being infected with the novel pathogen to grouped into one assignment.
    - Every effort will be made to have residents who are *asymptomatic* to be grouped into one assignment.
14. Residents who are confirmed of being infected with the novel disease will be placed on appropriate transmission-based precautions and have appropriate signage on their room doors. An isolation cart containing necessary PPEs will be placed outside the room for easy accessibility.
15. Should a resident require transfer to another facility/setting, indicate on the Transfer Form the type of infection and type of transmission-based precaution(s) required. Also, relay this information to the transport personnel (e.g. EMTs).

References:

CDC. (Updated 2019). 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Health Care Settings. Taken from: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

CDC. (4/30/2020). Responding to Coronavirus (Covid-10) in Nursing Homes. Taken from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan: Meal Service during** COVID-19 Pandemic and implementing social distancing during meal services.

Police: The facility will promote a safe and comfortable meal service for residents to minimize the potential spread of infection and promote quality of meal service to residents. Residents and staff will be provided with education regarding hand hygiene and infection control as well as social distancing and keeping residents six (6) feet apart during meal services.

Procedure:

1. Provide in-room meal service to residents, assessed capable of feeding themselves without supervision or assistance. Call bells must be placed near residents at meal times. Hand hygiene and clothing protectors should be offered/provided to these residents.
2. Trained Recreation staff may assist in handling out trays efficiently.
3. Trays should be delivered to units in room order rather than by table number, except for those residents eating in dining room.
4. Residents with specific behavioral or nutritional issues may be brought into the dining room in intervals while maintaining social distancing.
5. Identify all residents at risk for choking or on aspiration precautions. These residents may be provided meals in the dining room, while six feet apart or in central corridor where they can be observed. Suction machine must be readily available with extension cord and plugged in.
6. Residents requiring to be fed, may eat in the dining room, spaced six (6) feet apart or no more than one person per table. Staff members providing assistance for more than one residents simultaneously must perform hand hygiene with hand sanitizer each time when switching assistance between residents.
7. Meals may be offered in shifts to allow fewer residents in common areas, and tables must be sanitized between shifts.

MANHATTANVILLE HEALTHCARE CENTER

Reopening Nursing Homes COVID-19

Small Group Activities and Rehab

POLICY:

It is the policy of Manhattanville Healthcare Center to facilitate Small Group [Activities and Rehabilitation to residents while ensuring the prevention and control of infection is prioritized to ensure resident safety and well-being.

PROCEDURE:

1. Small group activities may be facilitated for residents who have fully recovered from COVID-19, and for those residents not in isolation for observation, suspected or confirmed COVID-19 status,
2. Staff will assist residents with hand hygiene before and after activities and Rehab services.
3. Social distancing, including limiting the number of people at each table/area and ensuring that residents are spaced at least 6 feet apart, will be followed.
4. Masks or face coverings must be worn when moving through the facility to the Activity areas and Rehab gym. Alcohol Based Hand Sanitizer (ABHS), tissues and appropriate receptacle for used tissues must be available.
5. All activities will be facilitated with alterations to adhere to the guidelines for preventing transmission, examples include book clubs, crafts, movies, and Bingo.
6. Rehabilitation services will be provided following the review of space in the gym with marked areas for 6 feet social distancing for residents and any equipment utilized.
7. Assigned EVS staff will clean and disinfect Activity areas and Rehab gym in between activities and as needed
8. Rehab staff will be responsible for the cleaning and disinfection of rehab equipment utilizing disinfectants approved by Environmental Service Director.
9. The Infection Preventionist will meet with Activities and Rehab staff to reinforce all Infection Prevention policies and procedures and monitor weekly for adherence to infection prevention strategies.

MANHATTANVILLE HEALTHCARE CENTER

Department of Nursing

TITLE: Policy and Procedure

SUBJECT: Monitoring of Residents for Covid-19

DISTRIBUTION: All Nursing Manuals

POLICY:

It is the policy of Manhattanville Rehabilitation and Healthcare Center to monitor all residents for Covid-19 to ensure prevention of transmission of the disease thus protecting and safeguarding their health and safety.

PROCEDURE:

1. NON-COVID RESIDENTS (NEGATIVE)
   - Vital signs and oxygen saturation daily
   - Observations/questions regarding signs and symptoms of Covid-19

2. CONFIRMED COVID-19 RESIDENTS (POSITIVE)
   - Vital signs and oxygen saturation every shift
   - Observation/questions regarding signs and symptoms of Covid-19

3. UNKNOWN COVID STATUS/COVID TEST REFUSED
   - Vital signs and oxygen saturation every shift
   - Observation/questions regarding signs and symptoms of Covid-19

4. All staff must wear appropriate PPEs when they are in contact with residents.
5. Referral to PMD or care provider for any presence of signs and symptoms of Covid-19.
6. Licensed nurses must document findings regarding Observation and Monitoring of Covid-19 symptoms.

Initial 5/2020 cvaca
Review 7/2020 cvaca/rdl
Revised 9/2020 cvaca/rdl

MANHATTANVILLE HEALTHCARE CENTER

OBSERVATION & MONITORING OF COVID-19 SYMPTOMS

RESIDENT'S NAME:_____ **RM #:**_____
DATE:_____
SHIFT: _____

IF DONE, DATE OF COVID-19 TESTING: _____
RESULTS: ❑**POSITIVE** ❑**NEGATIVE** ❑**PENDING RESULTS**

SIGNS & SYMPTOMS BEING OBSERVED AND MONITORED	**COMMENTS** Include Interventions if applicable)
❑**VITAL SIGNS:** TEMPERATURE: _____ HEART RATE: _____ RESPIRATORY RATE: _____ BLOOD PRESSURE:	
❑ **OXYGEN SATURATION:**	
❑**Cough**	
❑**Shortness of breath or difficulty breathing**	
❑**Fever**	
❑**Chills or Repeated shaking with chills**	
❑**Muscle pain**	
❑**Headache**	
❑**Sore Throat**	
❑ **New Loss of Taste or Smell**	
❑**Diarrhea**	
❑ **Vomiting**	
Other Complaints and/or Indications of Instability (e.g. Weakness; Altered Mental Status; etc.) **SPECIFY:**	

ADDITIONAL NOTES: (e.g. RESIDENT IS ON ACTIVE ISOLATION; PRIVATE ROOM; ETC.)

_____

_____

COMPLETED BY: _____

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Facility Communication During Pandemic/Emergency**

POLICY: Manhattanville Healthcare Center will implement effective, accurate, and ongoing communication with residents, family members and designated representatives during a pandemic.

PROCEDURE:

1. The facility will abide by all HIPPA regulations when disseminating information with regards to individual residents.
2. The Unit RNS/designee will contact family members of residents with an infection because of a pandemic daily.
3. Families/Representatives will be notified by RNS for any significant change in resident condition within 24 hours
4. The SW and IDT Team will determine the Resident Representative/Guardians preferred method of contact and document same in medical record/CCP.
5. The facility will contact all resident representatives weekly via an automated call to provide an update on the status of residents including # of infections of staff and residents and any deaths related to the pandemic.
6. Recreation and Social Services will ascertain if alert resident wishes to be informed when a resident in the facility expires related to the pandemic.
7. The following mechanisms will be utilized to inform residents, family members and designated representatives:
    - Letters sent via the mail
    - Telephone conversations and messages
    - Emails
    - Daily updates in the recorded voice message at facility number
    - Face to face meetings with residents using Social Distancing and appropriate PPE
    - The Overhead Paging System
8. The following information will be disseminated:
    - Any newly confirmed pandemic infections in the past 24 hours
    - The occurrence of 3 or more residents or staff members with new onset of symptoms within a 72-hour period.
    - The actions that the facility is taking to prevent and/or reduce the risk of transmission
    - Cumulative updates on a weekly basis
    - Deaths in the facility that occurred related to the pandemic
9. Incoming calls that are not answered at the unit level will be forwarded to DNS/designee with instruction to leave a message and a return call will be made within 24 hours or less.
10. Representatives and family members provided with direct cell phone number for Director of Nursing and Administrator as per their request.

11. Documentation of communication will be made in the Medical Record for each resident in Progress notes and/or CCP.
12. Weekly phone calls or Letter will be done by Social Work in conjunction with IDT Team to families and representatives to review current infection status at the facility, outline measures the facility is taking regarding infection prevention, as well as facility plans to assist in meeting residents' physical and psychosocial needs during the pandemic. The weekly update will include information to contact designated persons at the facility with contact number and regarding any concerns to designated department head.
13. Residents, family members, and designated representatives will be offered the opportunity to connect via videoconferencing (e.g. FaceTime, WhatsApp, Zoom, etc.) or via traditional telephone call at no cost. All residents' requests will be forwarded to the Director of Recreation.

Manhattanville Healthcare Center
Key Personnel

- Administrator
- Medical Director
- Director of Nursing
- Assistant Director of Nursing
- Admission Director
- HR/Executive Assistant
- Medicaid Coordinator
- Director of Social Services
- Director of Dietary Services
- Dietary Regional Manager
- Dietitian
- Director of Recreation
- Director of Rehabilitation
- Controller
- Payroll Department
- Accounts Payable
- Director of Maintenance
- Maintenance Assistant
- Director of Housekeeping
- Receptionist

Revised 09/15/2020

MANHATTANVILLE HEALTHCARE CENTER

Government Agencies Contact Numbers

CDC – 1-800-232-4636

CMS Regional Office – (212)616-2229

NYS DOH (Public Health Duty Officer Helpline) 1-866-881-2809

NYS COVID19 HOTLINE – 1-888-364-3065

OSHA – Labor Department Tarrytown, NY

914-524-7510

NYC DOH - 311

MANHATTANVILLE
REHABILITATION & HEALTHCARE
for a brighter tomorrow

WEBSITE FOR DOWNLOADING

SIGNAGEWWW.CDC.SINGAGE.COM

311 West 231st Street, Riverdale, New York 10463 ▪ Tel: 718.601.8400 ▪ Fax: 718.543.1614

MANHATTANVILLE HEALTHCARE CENTER

Department of Nursing

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Delivery Systems for Vendors in Pandemic**

POLICY: In the event of a pandemic, Manhattanville Healthcare Center will adjust procedures to managing critical outsourced supplier services and deliveries.

The facility will ensure that critical services continue. If an in-person meeting or onsite service is critical (e.g., a vendor needs to come onsite to fix a piece of equipment or provide a service that can be done only in person), then a vendor may come only with prior approval of manager/point of contact.

PROCEDURE:

1. **All deliveries shall check in at front desk and wait with vehicle for (facility) staff. The deliveries will be dropped at the loading dock/delivery entrance.**

2. **Department staff shall sign for and transfer materials to proper storage room.**

3. We are screening all patients and staff at all our facilities. All vendors must be actively screened and tested in accordance with NYS and federal guidelines. **Any vendor feeling sick must stay home.**

4. All suppliers/contracted staff will be provided a face/procedure mask and any additional PPE required in accordance with CDC and NYS guidance.

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Telehealth During Pandemic**

POLICY: Manhattanville Healthcare Center will incorporate telehealth technology during a pandemic to ensure residents clinical needs will be met while minimizing exposure to infection. The system in place shall comply with HIPPA and any other federal or state requirements and waivers implemented during a public health emergency. Health care professionals who use telehealth must adhere to the requirements and restrictions of their applicable licensure, scope of practice specific to their license, as well as training and experience.

Definitions

1. Telehealth, Telebehavioral Health, and Telemedicine: These terms are used interchangeably at (facility). Both describe the use of digital technologies to deliver medical services by connecting multiple users who are physically located in separate locations. Medical information is exchanged from one site to another via electronic communications to improve a resident's health or medical status.
2. Originating Site: This is the location where the resident is located at the time of service delivery. For psychiatry visits, the resident will be located on the property of (FACILITY), in one of our offices/site locations or room by themselves or if needed with Assistant. For mental health visits, the resident may be located anywhere in a private area.
3. Distant Site: This is the location where the health care provider is located at the time of service delivery. This could be an office location or another site that has been pre-approved. The requirements for this site will be that: the healthcare provider can attest to maintaining confidentiality and the privacy of the resident as well as the security of resident's personal health information in accordance with HIPPA.

Clinical applications include:

- Clinical treatments (medical, behavioral health, etc.)
- Clinical assessments and testing, including interpretation of results, and treatment recommendations
- Transmission of health data/assessment data (i.e., remote monitoring)
- Clinical consultation with other professionals
- Case management with interdisciplinary teams
- Clinical supervision of professional supervisees and trainees

Non-clinical applications include:

- Training (distance learning, continuing education, etc.)
- Administrative collaboration between providers, such as meetings and presentations

Procedures for Service Delivery

1. General hardware requirements include a desktop computer (or lap-top or tablet computer), high definition video camera, and audio system (headphones and/or external speakers). Existing laptop

or desktop can serve as the foundation of a simple system suitable for most videoconferencing sessions by simply adding a USB webcam and a USB desktop microphone to the computer.

2. Regardless of the manufacturer, videoconferencing equipment should meet patient privacy and data security requirements consistent with applicable local guidelines as well as the requirements specified under HIPAA.
3. Any telehealth service should be matched to the needs of the resident to be served. Not all potential patients may be appropriate candidates for telehealth services. For example, some cognitive or physical deficits (e.g., vision problems, loss of use of limbs or fingers) may impair operation of the technology (e.g., seeing a screen, touching small buttons). However, assistance by staff members or other assistive technologies may enable participation.
4. Telehealth will be delivered through a pre-approved platform. Use of any other platform for clinical service delivery will be employed in accordance with waivers during a pandemic.
5. Residents will need to be informed of all the telehealth procedures clinicians will utilize, including those in this policy. Written informed consent must be obtained prior to any telehealth service delivery the patient may make a voluntary choice to accept or refuse participation in the treatment or service unless waived during public health emergency.
6. Originating Site: Telehealth sessions for health will be conducted in a private, confidential manner. Clinicians will be expected to ensure that at their site:
    - Internet connectivity is through a secured network, not an "open" network unless waived during pandemic.
    - Sessions cannot be overheard by others such as family members, guests, colleagues, or others
    - The session is conducted in a quiet setting
    - The backdrop of the clinician's image will show a professional setting, free from clutter in the background, and have adequate lighting to ensure the clinician's image is broadcast clearly to the resident
7. Distant Site: The resident will be informed at the initial contact of the clinicians' expectations regarding where the resident is physically located during sessions. Lighting at the distant site should be assessed during the initial session to allow for full access to resident facial expressions and body language.
8. If the technology fails during the session, the clinician will call the resident and nursing department to explain the problem. Depending on the situation, the session may need to be rescheduled:
9. At any time, the clinician may determine that telehealth services are not benefiting the resident, that the resident is not a good candidate for telehealth or circumstances have arisen where a referral to face-to-face service delivery is warranted. The clinician will make this recommendation verbally to the resident and Facility RNS, put it in writing in the medical record, and provide arrangements or referrals upon request of the resident.
10. Clinicians will document in HER utilizing remote accessed if granted by the facility. Any other documentation will be sent to facility DON via secure mail to be placed in medical record.

1. Password protected; preferably two-factor authentication is to be used
2. Device has been had updates and security patches installed at least once/month
3. Software updates are conducted quarterly

MANHATTANVILLE HEALTHCARE CENTER

TOPIC - Respiratory Protection

I. POLICY

In the event of a suspected or actual outbreak, the following guidelines have been established.

II. PURPOSE

To control the spread of an infectious respiratory disease in the long term care setting.

III. PROCEDURE

A. In the event of a suspected or actual outbreak of an infectious respiratory disease, the infection control committee shall convene to consider the following control measures and implement accordingly:
   1. Notify all attending physicians.
   2. Provide symptomatic relief to affected residents.
   3. Restrict group activities and/or communal dining of symptomatic residents.
   4. Encourage good handwashing technique of both staff and residents.
   5. Instruct staff to wear gloves when handling respiratory secretions and to wear masks if caring for residents with productive coughs.
   6. Maintain surveillance line listing of all affected residents and staff.
   7. Limit staff unit assignment rotation as much as possible.
   8. Maintain extra floor supplies for resident use such as tissues, plastic bags for same.
   9. Encourage increased intake of fluids by residents.
   10. The use of viral studies should be considered for the identification of viral strain.

B. All respiratory outbreaks are to be reported to appropriate City/State/County Health Departments.
C. The Infection Control Committee shall meet as needed to discuss eventual resolution of problems.

Original 1997 Rev 9/2008 cvaca/sls Rev 9/2010 cvaca/sls Rev 8/2012 cvaca/sls Rev 8/2015 cvaca/sls Rev 12/2016 cvaca/kbyagumyum Rev 9/2017 cvaca/kbyagumyum Rev 10/2019 cvaca/kbyagumyum Revised 092020

MANHATTANVILLE REHABILITATION & HEALTHCARE CENTER

Department of Nursing

Handwashing Observation Audit Tool

GUIDELINES :

Provides health-care workers (HCWs) with a review of data regarding handwashing and hand antisepsis in health-care settings. In addition, it provides specific recommendations to promote improved hand-hygiene practices and reduce transmission of pathogenic microorganisms to patients and personnel in health-care settings

The purpose of the handwashing audit tool is to determine whether the employee is in compliance with the guidelines/standards. The information listed on the tool follows the guidelines provided by the NYS Department of Health and Centers for Disease Control and Prevention.

Any area checked "No" should be explained in the comment section. A corrective action should be made for these areas and follow-up should be done on a frequent basis.

Employee Name : _____ Date : _____

Auditor : _____

STEPS	YES	NO	COMMENTS
1. Jewelry is removed except for plain wedding band. Wrist watches should be removed or moved up the arm.			
2. Turn on faucet and adjust temperature.			
3. Completely wet hands, wrists, holding fingertips downward.			
4. Apply liquid soap into one hand.			
a.) Do not touch under part of soap dispenser.			
5. Work up a good lather and spread over hands, wrists, between fingers and under nails.			
6. Use a rotating and rubbing motion for 20 seconds.			
a.) Rub vigorously, and use friction.			
b.) Rub one hand against the other including wrists to two inches above wrists.			
c.) Rub between fingers by interlacing them.			
7. Rinse from two inches above wrists to hands, holding hands and fingertips down.			
8. Dry thoroughly with paper towels and discard.			

9. Use another paper towel to turn off faucet and discard.			
10. Apply lotion to hands as desired.			

Comments :

_____

_____

_____

_____

_____

_____

Employee Signature : _____ Date : _____

RN Supervisor's Signature : _____ Date : _____

Revised : 10/12/2015 kby
Reviewed : 06/2017 cvaca/kby
Reviewed 102019 cvaca/kby
Reviewed 102019 cvaca/kby

Manhattanville Rehabilitation and Healthcare Center

Personal Protected Equipment (PPE) Competency Validation

Donning and Doffing
Standard Precautions and Transmission Based Precautions

Type of validation: Return demonstration	o Orientation o Annual o Other

Employee Name: _____ Job Title: _____

Donning PPE	Competent YES	Competent NO
1. Perform Hand Hygiene		
2. **Don Gown:** Fully covering torso from neck to knees, arms to end of wrists		
3. Tie/fasten in back of neck and waist		
4. **Don Mask/Respirator:** Secure ties/elastic bands at middle of head & neck		
5. Fit flexible band to nose bridge		
6. Fit snug to face and below chin (Fit-check respirator if applicable)		
7. **Don Goggles or Face Shield:** Place over face and eyes; adjust to fit		
8. **Don Gloves:** Extend to cover wrist of gown		
Doffing PPE		
9. Remove Gloves: Grasp outside of glove with opposite gloved hand; peel off		
10. Hold removed glove in gloved hand		
11. Slide fingers of ungloved hand under remaining glove at wrist		
12. Peel glove off over first glove		
13. Discard gloves in waste container		
14. **Remove Goggles or Face Shield:** Handle by head band or ear pieces		
15. Discard in designated receptacle if re-processed or in waste container		
16. Remove Gown: Unfasten ties/fastener		
17. Pull away from neck and shoulders, touching inside of gown only		
18. Turn gown inside out		
19. Fold or roll into bundle and discard		
20. **Remove Mask/Respirator** (respirator removed after exit room/closed door): Grasp bottom, then top ties or elastics and remove		
21. Discard in waste container		

22. Perform Hand Hygiene		
Standard Precautions & Transmission Based Precautions	**Competent**	
	YES	**NO**
23. Staff correctly identifies the appropriate PPE for the following scenarios:		
a. Standard Precautions (PPE to be worn based on anticipated level of exposure)*		
b. Contact/Contact Enteric Precautions (gown & gloves)		
c. Droplet Precautions (surgical mask)		
d. Airborne Precautions (fit-tested respirator if applicable)		

*NOTE: Examples include: mask for coughing/vomiting patient, goggles/face shield for irrigating draining wound, gown for dressing change if scrubs may touch patient, etc.

_____ _____/_____

Employee Signature Validator Signature Date

Initial 7/23/18 cvaca
Reviewed 8/2019 cvaca/kyagumyum
Reviewed 8/2020 cvaca/rdl

COMPETENCY: NASOPHARYNGEAL SWAB

TASKS	TASK COMPLETED (YES/NO)	COMMENTS
1. Perform hand hygiene		
2. Explain procedure		
3. Don gloves		
4. Tilt the resident's head back approx. 70 degrees		
5. Insert swab into nostril (swab should reach depth equal to distance from nostrils to outer opening of the ear). Hold in place 5 - 10 seconds to absorb secretions		
6. Slowly remove swab while rotating it		
7. Remove swab and insert into vial containing 1-3mL of viral transport media		
8. Break the swab handle at scored breakpoint line and cover vial		
9. Remove gloves		
10. Label vial with appropriate resident information and place in specimen bag; double bag for Covid-19 specimens		
11. Perform hand hygiene		
12. Place specimen in specimen refrigerator on Unit 4		
13. Call lab to pick up specimen		
14. Appropriate documentation in resident's chart		

PASS (YES/NO):_____ FAIL: (YES/NO):_____

EMPLOYEE's NAME (PRINT):_____

EMPLOYEE'S SIGNATURE:_____

EVALUATOR'S SIGNATURE:_____

MANHATTANVILLE REHABILITATION & HEALTHCARE CENTER

Department of Nursing

TITLE: Policy and Procedure

SUBJECT: Notification of Changes

DISTRIBUTION: All Nursing Manuals

POLICY

It is the policy of this facility to inform resident / HCP / NOK of any change in medication and condition that may require change in treatment plan or a transfer to the hospital.

PROCEDURE

1. The RNS/Charge nurse will notify the resident/HCP/NOK verbally and/or in writing when the following occur :

    a. Admission/Readmission
    b. Accident/Incident
    c. Significant change in physical, mental and/or psychosocial status
    d. Psychotropic use
    e. Antibiotic therapy
    f. Weight Loss/Weight Gain (3 lbs. in a week / 5 lbs. in a month)
    g. Change in skin integrity
    h. Decision to transfer to hospital
    i. Decision to transfer room/unit
    j. Bedhold (done by Admission Department)
    k. Clinic appointments
    l. Necessary meds (on or off)
    m. COVID-19
    n. Others

2. Document of the notification will be done by nurse's notes (Notification of changes template in Sigma).
3. Notification of changes will be done in a timely manner.
4. When the RNS/Charge nurse is unable to contact HCP/NOK/Significant other, Social Services referral is made to follow up.
5. The Physician will notify family when there is a new onset/episode of CVA.

Original Date of Issue 4/08
Reviewed/Revised 10/21/15 cvaca/kbyagumyum
Reviewed 10/2016 cvaca/kbyagumyum
Reviewed 9/2017 cvaca/kbyagumyum
Revised 9/2018 cvaca/kbyagumyum
Revised 7/2019 cvaca/kbyagumyum
Revised 9/2019 cvaca/kbyagumyum
Revised 07/2020 cvaca/rdl

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan - Readmitting Residents Safely during a Pandemic**

POLICY: During a pandemic, the facility will readmit hospitalized residents safely in accordance with Federal and NYS Bed Reservation Guidance NYS code 415.3 and CMS code 483.15(d).
as well as all State and Federal Infection prevention and control regulations.

PROCEDURE:

1) Manhattanville Healthcare Center, in accordance with New York State Regulations, will reserve a bed for a resident who had been transferred to the hospital, providing the conditions below are met:

   - The facility will be able to provide the care for the resident at the time of readmission. This includes clinical treatment and/or management of infectious diseases as well as provision of appropriate transmission-based precautions.
   - The facility has the ability to group residents into appropriate cohorts.
   - The facility has an available bed in an area that can provide for residents recovering from an infectious disease.

2) Prior to readmission, the Director of Nursing/Designee will review hospital records to determine individual resident care needs. If needed a call will be placed to transferring hospital to clarify any clinical needs and/or concerns.

3) Prior to readmission, Unit Charge nurse will be informed of readmission and any specific isolation and cohorting needs of the resident.

4) For any transfers across care transitions, the RNS will document Infection status on transfer form and notify ambulance/EMT as needed.

5) If the facility cannot care for the resident based on needs, the Administrator/designee will contact the NYSDOH for guidance and inform hospital and resident representative of status.

*All Medicare or Medicaid nursing home eligible residents on leave due to hospitalization, and requiring skilled nursing facility services, will be given priority readmission for the next available bed in a semi-private room. If the facility determines that a resident who has transferred with an expectation of returning to the facility, cannot return, the appropriate discharge procedures will be followed.

MANHATTANVILLE HEALTHCARE CENTER

COVID – 19 RESIDENT TESTING LINE LISTING

Room	Resident Name	DOB	Gender	Race	COVID Status	C&D/ Other MDROs	Date of Collection	Specimen Site	Test Result

MANHATTANVILLE HEALTHCARE CENTER

TITLE: **Policy and Procedure**
SUBJECT: **Pandemic Plan – Facility COVID-19 Testing**

POLICY: Manhattanville Healthcare Center will test all staff and residents for COVID-19 in accordance with both state and federal regulations and as indicated to prevent the spread of infection and to ensure appropriate clinical treatment. The facility will utilize both point of care and PCR testing to promote expedited results as needed. The facility will adjust testing requirements as per State and Federal regulations based on community transmission and potential outbreaks.

An outbreak is defined as a new COVID-19 infection in a staff member or any **nursing home onset** COVID-19 infection in a resident.

CDC defines a Nursing home-onset of SARS-CoV-2 infections specifically to infections that originated in the nursing home. It does not refer to the following:

- Residents who were known to have COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
- Residents who were placed into Transmission-Based Precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.

In addition the CDC recommends Testing practices should aim for rapid turnaround times (e.g., less than 24 hours) in order to facilitate effective interventions

PROCEDURE:

1) The Facility will contract with a certified lab to provide testing as available and in accordance with NYSDOH and FDA approved testing to provide test results for all tests in a timely manner.
2) At present the facility will utilize point of Care testing for these indications: (Facility to choose how they use point of care testing: routine, outbreaks, residents and/or staff*)
   (See P/P for POC testing)
3) At present the facility will utilize PCR testing with contracted lab(s) for testing in accordance with CDC recommendations for follow up PCR test as needed to ensure appropriate diagnosis, treatment and cohorting are done. (SEE CDC algorithm attached)
4) At present under Executive order 202.60 staff testing is required weekly for all staff, including Agency staff and consultants.

5) In accordance with CMS testing requirements (see table below) the facility will test all residents and staff in the event of a new positive COVID-19 infection in the facility. All staff and residents that are negative will be tested between 3-7days until there are no new cases identified for 14 days since the first positive result.

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff with signs and symptoms must be tested	Residents with signs and symptoms must be tested
Outbreak (Any new cases arises in facility)	Testing all staff that previously tested negative until no new cases are identified*	Test all residents that previously tested negative until no new cases are identified*
Routine testing	According to Table 2 below	Not recommended, unless the resident leaves the facility routinely.

***For outbreak testing, all staff and residents should be tested, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.**

6) Residents and Resident Representatives can exercise their right to refuse testing in accordance with 42CFR&483.10(c)(6). Staff will discuss the importance of testing and document any refusals. Any resident with symptoms will be placed on Transmission based Precautions (TBPs) until the criteria for discontinuing TBPs have been met. Presently NYS guidance states this is 14 days from exposure or onset of symptoms.*

7) The Facility will ensure that testing, not provided by the facility, is reasonably accessible for its personnel. Off premises test site locations list will be maintained by department heads and staff shall be informed to check with their departments if they do not or cannot utilize the facility testing.

- Any offsite testing must be submitted by staff on the day the test was completed, and results of the test must be submitted by 4:00pm of the day results received.
- Facility will offer testing to their personnel through the contracted lab.
- Staff may utilize a local drive-through or walk-in testing site.
- Facility shall accept documentation of testing conducted by an individual's healthcare provider.
- Staff with previous positive COVID-19 test that were furloughed for 14 days do not require an additional 14-day furlough but do require a negative COVID test as per NYS.

- All employees, contract staff, medical staff, operators, and administrators that refuse testing shall not be permitted to enter or work at the facility until such test is performed and this list shall be maintained at the security desk. As per the Governor's Executive order A*ny personnel of a nursing home who refuses to be tested for COVID-19 shall be considered to have outdated or incomplete health assessments and shall therefore be prohibited from providing services to such nursing home until such testing is performed.*

NYS Emergency Testing Regulations:

Section 405.11 of 10 NYCRR is amended by adding a new subdivision (h) to read as follows:
415.33 COVID-19 and Influenza Confirmatory Testing

(1) Any resident who is known to have been exposed to COVID-19 or influenza or has symptoms consistent with COVID-19 or influenza shall be tested for both such diseases.

(2) Whenever a person expires while in a nursing home, where in the professional judgment of the nursing home clinician there is a clinical suspicion that COVID-19 or influenza was a cause of death, but no such tests were performed in the 14 days before death, the nursing home shall administer both a COVID-19 and influenza test within 48 hours after death, in accordance with guidance published by the Department. Such tests shall be performed using rapid testing methodologies to the extent available. The facility shall report the death to the Department immediately after and only upon receipt of both such test results through the Health Emergency Response Data System (HERDS). Notwithstanding the foregoing, no test shall be administered if the next of kin objects to such testing. Should the nursing home lack the ability to perform such testing expeditiously, the nursing home should request assistance from the State Department of Health.

Documentation of Testing:

The facility will document all COVID-19 testing for staff and residents.

A. A spreadsheet will be utilized to track the testing of all personnel, including all employees, contract staff, medical staff, operators, and administrators, for COVID-19.

B. For any outbreak, the facility IP/Designee will document the date case identified, the dates and results of all testing.

C. Point of Care Antigen testing performed at the facility will be reported to NYSDOH Wadsworth lab as directed by NYSDOH.

D. The Facility shall maintain records of personnel testing and results for a period of one year.

E. All staff testing positive shall be documented on the log and the number will be reported on all required submissions to NYSDOH HERDS daily

F. Positive staff and resident results will also be reported a minimum of weekly to NHSN by the IP/designee.

G. Any personnel who are ordered or directed to remain isolated because of a positive test result are entitled to certain benefits including paid sick leave pursuant to Chapter 25 of the laws of 2020. Shall be informed of this availability and directed to the below for further information: https://paidfamilyleave.ny.gov/COVID19.

H. All staff will receive Inservice Education on the NH COVID-19 Testing policies/procedures including all updates in accordance with NYSDOH and Federal guidance.

*Note: As guidance is updated from Federal and State entities these items/timeframes may change.

RESOURCES:

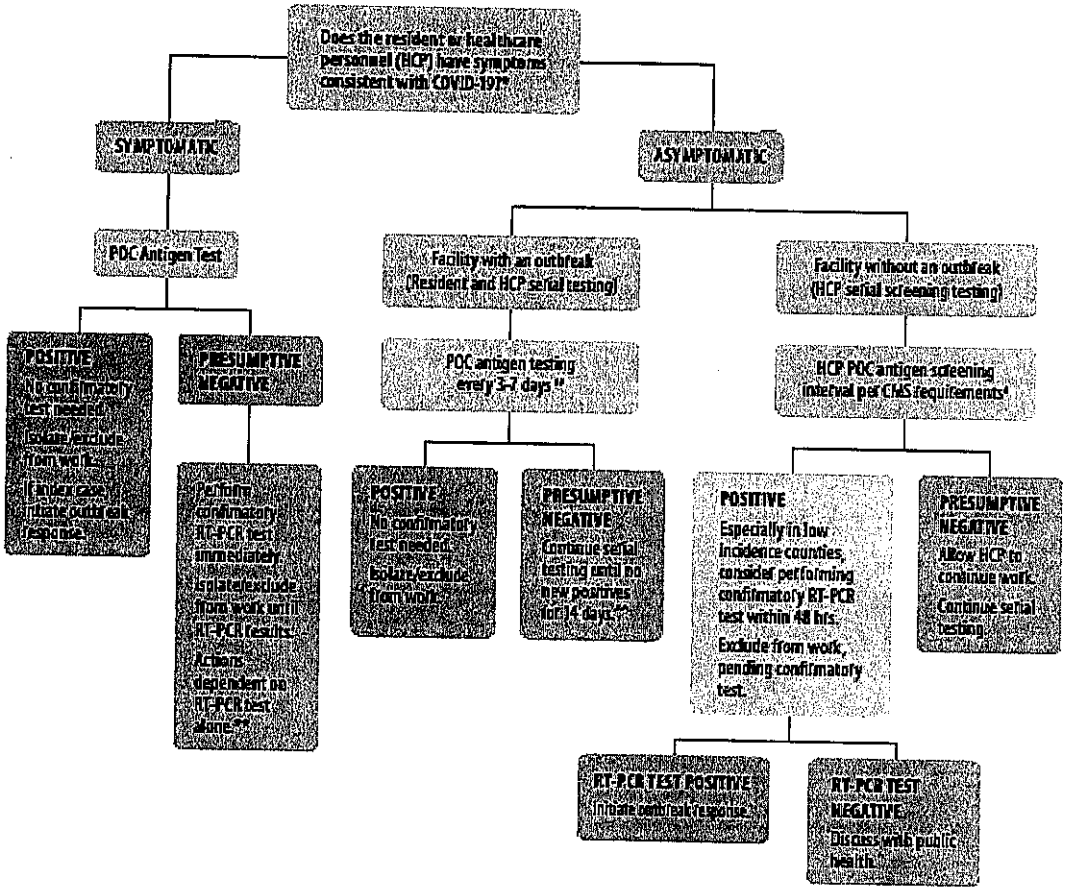
https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html#nursing-home

https://www.cms.gov/files/document/qso-20-38-nh.pdf

https://www.cms.gov/files/document/qso-20-37-clianh.pdf

CONSIDERATIONS FOR INTERPRETING ANTIGEN TEST RESULTS IN NURSING HOMES



This algorithm should be used as a guide, but clinical decisions may deviate from this guide if indicated. Contextual factors including community incidence, characteristics of different antigen testing platforms, as well as availability and turnaround times of RT-PCR, further inform interpretation of antigen test results.

RT-PCR: reverse-transcriptase polymerase chain reaction
POC: point-of-care
HCP: healthcare personnel
Index case: a newly identified case of SARS-CoV-2 infection in a resident or HCP in a nursing home facility with no known infections of SARS-CoV-2 infection in the previous 14-day period.
COVID-19 outbreak response in a nursing home is triggered when one nursing home–onset SARS-CoV-2 infection in a resident or one HCP SARS-CoV-2 infection.

* Asymptomatic individuals who have recovered from SARS-CoV-2 infection in the past 3 months and live or work in a nursing home performing facility-wide testing do not need to be retested. If an individual has recovered from SARS-CoV-2 infection in the past 3 months and develops new symptoms suggestive of COVID-19, alternative diagnoses should be considered prior to retesting for SARS-CoV-2.

** Some antigen platforms have higher sensitivity when testing individuals within 5 days of symptom onset. Clinical discretion should be utilized to determine if retesting by RT-PCR is warranted.

CMS recommendations for testing asymptomatic HCP in facilities without a case

CDC guidance on testing residents of nursing homes, CDC guidance on testing HCP

^ In discussion with the local health department, community incidence and time between antigen test and RT-PCR test can be utilized to interpret discordant results and determine when HCP can return to work.

^^ If an antigen test is presumptive negative in a facility with an outbreak, residents should be placed in transmission-based precautions or HCP should be allowed to continue working while monitoring for symptoms.

August 27, 2020 11:41 AM 313235-A

cdc.gov/coronavirus