NEW YORK STATE OF OPPORTUNITY. Department of Health

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER

Annex E:
Infectious Diseases/ Pandemic Emergency Plan (PEP)

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER
116 E125th Street – New York, NY 10035 – (212) 426-1284
www.nmrehab.org

Northern Manhattan Rehabilitation & Nursing Center

Emergency Contacts

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

Table 1: Emergency Contact Information

Organization	Phone Number(s)
Fire Department - Local	1-212-570-4240
Police Department - Local	1-212-860-6511
Emergency Medical Services	1-212-870-2301
Fire Marshal	1-718-722-3600
Local Office of Emergency Management (OEM)	1-212-639-9675
NYS DOH Regional Office (Business Hours)1	1-212-417-4200
NYS DOH Duty Officer (Business Hours)	1-866-881-2809
NYS State Watch Center (Warning Point) (Non-Business Hours)	1-518-292-2200
New York City – DOH	311 (NYC)
NYS COVID-19 HOTLINE	1-888-364-3065
Centers for Medicare & Medicaid Services (CMS)	1-212-616-2229 (NY Regional Office)
Centers for Disease Control & Prevention (CDC)	1-800-232-4636 (800-CDC-INFO)
Occupational Safety & Health Administration (OSHA)	1-212-337-2378 (NYC) 1-800-321-6742

Northern Manhattan Rehabilitation & Nursing Center

PANDEMIC EMERGENCY PLAN

ANNEX E: INFECTIOUS DISEASE/PANDEMIC EMERGENCY

As the COVID-19 pandemic surged around the world, healthcare policy makers, management 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 settings 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 this Pandemic Emergency Plan (PEP)*

Preparedness Tasks for all Infectious Disease Events

1. **Provide 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 Pandemic Emergency Plan: Infection Prevention & Control P&P
Refer to Infection Control – Staff Guidelines P&P

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 Prevention and Control Manual, which is available in 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 Attestation of Yearly Review 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 Pandemic Emergency Plan: Infection Prevention & Control -Surveillance of Infection P&P
Refer to Infection Control – Staff Guidelines P&P

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

- The Facility will conduct staff testing, as 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.
- Administrator/ DON/Designee will check daily for staff and resident testing results and take action in accordance with State and federal guidance.

Refer to Pandemic Emergency Plan: Employee Testing and Reporting During a Pandemic P&P

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 Pandemic Emergency Plan: Annex K Section - Communicable Disease Reporting P&P

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 2-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 Pandemic Emergency Plan: Personal Protective Equipment (PPE) P&P
Refer to Cleaning and Disinfection of Environmental Surfaces P&P

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 Pandemic Emergency Plan: Visitation Guidelines During a Pandemic P&P
Refer to Visitation Plan and Policy
Refer to Pandemic Emergency Plan: Facility Health Screening Check During a Pandemic P&P
Refer to Pandemic Emergency Plan: Staff Screening and Monitoring During a Pandemic P&P
Refer to Infrared Body Temperature Measuring Device P&P
Refer to Pandemic Emergency Plan: Emergency Staff P&P

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 Pandemic Emergency Plan: Handling of Regulated Medical Waste - Biohazardous Waste P&P

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.
- 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 Pandemic Emergency Plan: Emergency Supplies and Subsistence P&P

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 Pandemic Emergency Plan: Developing Cohorts During a Pandemic P&P

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 to Pandemic Emergency Plan: Developing Cohorts During a Pandemic P&P

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 Pandemic Emergency Plan: Meal Service Guidelines During a Pandemic P&P
Refer to Therapeutic Activities During COVID-19 Pandemic P&P

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 Pandemic Emergency Plan: Staff Screening and Monitoring During a Pandemic Emergency P&P
Refer to Monitoring of Residents for COVID-19 P&P

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 Pandemic Emergency Plan: Facility Communication During a Pandemic

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 Pandemic Emergency Plan: Infection Prevention & Control P&P

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 Pandemic Emergency Plan: Table 1: Emergency Contacts Information
Refer to the CDC website for Signage downloads – www.cdc.signage.com

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 Pandemic Emergency Plan: Annex K Section - Communicable Disease Reporting P&P

3. Signage

Refer to the CDC website for Signage downloads – www.cdc.signage.com

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 to Pandemic Emergency Plan: Developing Cohorts During a Pandemic P&P

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 Pandemic Emergency Plan: Developing Cohorts During a Pandemic P&P

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 Cleaning and Disinfection of Environmental Surfaces P&P

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 Pandemic Emergency Plan: Facility Communication During a Pandemic P&P

8. Policy and Procedures for Minimizing Exposure Risk

- 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 Pandemic Emergency Plan: Delivery System for Vendors During a Pandemic P&P
Refer to Pandemic Emergency Plan: Telehealth During a Pandemic P&P

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 Pandemic Emergency Plan: Visitation Guidelines During a Pandemic P&P
Refer to Pandemic Emergency Plan: Delivery System for Vendors During a Pandemic P&P

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 Pandemic Emergency Plan: Visitation Guidelines During a Pandemic P&P

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 Pandemic Emergency Plan - Respiratory Protection Program During a Pandemic P&P
Refer to Pandemic Emergency Plan: Infection Prevention & Control -Surveillance of Infection P&P
Refer to Infection Control – Staff Guidelines P&P
Refer to Pandemic Emergency Plan: Personal Protective Equipment (PPE) P&P
Refer to Personal Protective Equipment (PPE) Competency Validation Tool
Refer to Handwashing Observation Audit Tool

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 facility's Main Lobby area.

Refer to Facility Attestation of Yearly Review with Signature Review Sheet

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 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 Communication and Notification P&P

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 Communication and Notification P&P
Refer to Therapeutic Activities During COVID-19 Pandemic P&P

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 Pandemic Emergency Plan: Readmitting Residents Safely During a Pandemic P&P
Refer to Pandemic Emergency Plan: Resident Screening During a Pandemic P&P

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 Pandemic Emergency Plan: Readmitting Residents Safely During a Pandemic P&P

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 Pandemic Emergency Plan: Personal Protective Equipment (PPE) P&P

Northern Manhattan Rehabilitation & Nursing Center

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 Pandemic Emergency Plan: Employee Testing and Reporting P&P

NORTHERN MANHATTAN REHABILITATION AND NURSING 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 the facility is in compliance with the above stipulations:

Medical Director: _____ Date: _____

Infection Preventionist: _____ Date: _____

Director of Nursing: _____ Date: _____

Administrator: _____ Date: _____

Northern Manhattan Rehabilitation & Nursing Center

116 E125th Street - New York, New York 10035 - Phone: (212) 426-1284

TAB #	POLICY & PROCEDURES
1	Infection Control & Prevention
2	Infection Control & Prevention - Surveillance of Infection
3	Infection Control - Staff Guidelines
4	Developing Cohorts During a Pandemic
	NYSDOH Health Advisory Nursing Home Cohorting FAQ
	Discontinuation/Criteria of TBPs for Residents with COVID-19 in NHs
5	Employee Testing and Reporting During a Pandemic
	COVID-19 Testing Post the Public Health Emergency
	COVID-19 Point of Care Testing & Competencies
6	Communicable Disease Reporting – Annex K Section
7	Personal Protective Equipment (PPE)
	Personal Protective Equipment (PPE) - Include Burn Rate
	Eye Protection During COVID-19 Public Health Emergency Mask Requirement
	Personal Protective Equipment (PPE) – Mask Guidance and Recommendations
8	Cleaning and Disinfecting Resident Rooms and Equipment
	Cleaning and Disinfection of Environmental Surfaces
	Resident Room Cleaning Log
9	Visitation Guidelines Post COVID-19 Public Health Emergency
	Visitation Guidelines COVID-19 - Visitor's Safety Fact Sheet Personal and Compassionate Caregiving
	Personal and Compassionate Caregiving Visitation During a Declared Public Health Emergency
	Personal and Compassionate Caregiving Visitation Simplified
	Visitation Guidelines During a Pandemic
10	Facility Health Screening Check During a Pandemic
11	Staff Screening and Monitoring During a Pandemic
	COVID-19 Return to Work Criteria
	NYS-Work-Restriction-for-HCP-Algorithm
12	Infrared Body Temperature Measuring Device (Safe Space Scan)
13	Emergency Staffing Call-in for Off-Duty Personnel
	Emergency Staff
	Optimizing Utilization of Staff During Pandemic Crisis
14	Handling of Regulated Medical Waste - Biohazard Waste
15	Emergency Supplies and Subsistence
16	Meal Service Guidelines During a Pandemic
	Communal Dining
17	Group Activities
	Activity Programming During a Pandemic
	Therapeutic Activities During COVID-19 a Pandemic
18	Monitoring Residents with COVID-19
	Observation and Monitoring of COVID-19 Symptoms
19	Facility Communication During a Pandemic
20	Delivery Systems for Vendors During a Pandemic
21	Telehealth During a Pandemic

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 12/2020	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Infection Prevention & Control**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAPI Committee			

POLICY STATEMENT

1. The Infection Prevention and Control (IPC) 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 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
viii. N95 Fit Testing

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.*)

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Infection Prevention & Control: Surveillance of Infection**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

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.*)

NORTHERN MANHATTAN NURSING HOME
POLICIES, PROCEDURES AND INFORMATION

Title: Infection Control - Staff Guidelines

Issued By: Medical Department

Effective Date: 10/95	Last Review Date: 03/23	Supersedes:

Distribution: All Departments

POLICY:

NORTHERN MANHATTAN NURSING HOME will establish and maintain standards and practices of infection control, in accordance with applicable state and city codes and the Guidelines of the Centers for Disease Control (CDC).

PURPOSE:

To prevent the spread of communicable disease(s) within the facility among and between residents, staff, visitors and volunteers.

PROCEDURE:

1. The Medical Director, the Infection Control Nurse, the Director of Nursing and the Director of Staff Education will monitor and maintain an ongoing program of staff education designed to achieve the following objectives:

   a. To prevent cross-contamination and infections between residents, staff, visitors and volunteers.

   b. To apply the principles of asepsis and to minimize the possibility of acquiring and/or transmitting communicable disease(s).

   c. To be aware of the sources and transmission vectors and vehicles involved in the epidemiology of communicable disease(s).

   d. To monitor employees' health as it relates to resident exposure and the spread of infection.

   e. To be concerned with controlling those environmental factors which affect the health and well-being of residents and staff as related to communicable disease(s).

   f. To be aware of the techniques and procedures of disinfection and sterilization.

g. To be aware of the handling of liquid and solid waste material in order to prevent those items from becoming a reservoir and/or vehicle for harboring and/or disseminating micro-organisms involved in the transmission of communicable disease(s).

h. To be aware of and to report behaviors, incidents and/or accidents thought to increase the risk of disease transmission.

2. All employees will wash their hands using proper hand washing technique;

   a. before and after meals;

   b. before and after caring for individual residents;

   c. before and after toileting; and/or

   d. when coming into contact with contaminated materials.

3. All employees will wear disposable gloves using proper techniques for donning and removing same when:

   a. Handling any contaminated materials and/or equipment; and/or

   b. Caring for a resident with open or draining lesions.

4. All employees must have a pre-employment medical examination, which establishes the immunization status of the employee. This record will be kept on file in the Employee Health Services.

5. All required vaccinations will be given via EHS. (Refer to Infection Control Manual - Employee Health Services Policy and Procedures).

6. All employees are screened for TB at pre-employment and every 6 months thereafter.

7. All employees are strongly encouraged to receive Hepatitis B vaccination which is offered at no cost to the employee. Follow-up titers will be drawn after completion to determine effectiveness and/or necessity of booster.

8. Employee symptoms of respiratory infections, dermatitis, open skin lesions, diarrhea or a rise in body temperature must be reported to the Employee Health Service for evaluation and disposition regarding the employment status.

Incidents or accidents believed to create an increased risk of infection are to be reported to the Charge Nurse immediately.

9. Those employees returning to work after having been on sick leave for a period of three (3) days or more must submit a physician's note identifying the reason for the employee's absence and their ability to return to work. This will be reviewed by the Employee Health Service for final consideration.

10. Employees responsible for direct resident care will wear clean, washable outer garments. Any garment which becomes soiled with body secretions are to be removed immediately and replaced with a clean substitute provided by NMNH. NMNH will offer to launder soiled items for employee

11. Staff members will keep themselves clean and neatly groomed at all times. Fingernails will be kept short and clean. No jewelry other than small earrings, wristwatches and/or plain wedding bands will be permitted.

12. All employees will eat only in those areas of the facility specifically designated as appropriate for these activities by Administration.

13. The Charge Nurse will ensure that each resident is provided, as often as necessary, with clean linen and undergarments.

14. Unit nursing staff will ensure that each resident bathes, or is bathed at least twice per week unless medically contraindicated.

15. Each resident will be adequately educated by nursing staff in methods of personal hygiene, and, as necessary, assisted therewith.

16. Nursing staff will ensure that any resident, for whom such measures are indicated, is placed in isolation and that appropriate isolation techniques are employed when caring for such residents.

17. All direct-care staff will observe and employ the following sterilization and disinfections practices when caring for isolated resident(s):

    a. Disposable, non-reusable supplies and equipment will be used, when available.

    b. Medical instruments which come into contact with resident will be "red-bagged", properly marked as "isolation" or "contaminated" material, and sent for appropriate processing.

c. Disposable items will be red double-bagged and sealed for removal as infectious waste by the outside contractor.

d. Bedpans and urinals must be flushed to remove all waste materials after resident use.

e. Basins will be washed with soap or a detergent, rinsed, washed with detergent disinfectant, or 1 part bleach to 9 parts water, rinsed, dried and returned to the resident.

(Bleach mixtures will be prepared by Environmental Services and delivered to the unit each day.)

f. Battery-operated thermometers:

1. Probe covers are changed between residents.

2. Surface of instrument is cleaned using manufacturer's recommended procedures (70% alcohol in some instances).

18. All staff members are responsible for ensuring isolation bed linens, resident clothing and towels are bagged inside the room and sent to Laundry for washing.

19. All solid waste material from waste receptacles is to be double-bagged and sent for disposal by waste disposal contractor.

20. All liquid waste should be disposed of by carefully flushing it down the toilet. Trash receptacles are then cleaned and disinfected.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 09/2020	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Developing Cohorts During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

1. It is the policy of Northern Manhattan Rehabilitation and Nursing 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.

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

3. 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 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.
2. If indicated, and when possible, laboratory and/or other testing will be conducted to detect presence of specific infectious agent.
3. The facility will create a designated area/unit for residents who have tested positive for the specific infectious agent.
4. 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.
5. When feasible, the symptomatic resident will be moved to a private room.
6. 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.
7. Specific to the novel infectious agent, a screening tool will be done on all prospective admissions and re-admissions by the Admitting Department.
8. Residents who are newly admitted and develop any symptoms associated with the novel infectious agent will be transferred to the dedicated area/unit upon identification of symptoms.
9. Residents presenting with signs or symptoms of the novel infectious agent will be assessed by an RN and/or PMD.
10. All staff will continue to be actively screened for signs/symptoms associated with the novel infectious agent.
11. 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.

12. 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 consistent assignments.
    - Every effort will be made to have residents who are *suspected* of being infected with the novel pathogen to grouped into consistent assignments.
    - Every effort will be made to have residents who are *asymptomatic* to be grouped into consistent assignments.
13. 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.
14. 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

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 05/2020	Revision Date: 08/2021	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Developing Cohorts During a Pandemic NYSDOH Health Advisory: Nursing Home Cohorting FAQs**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

1. It is the policy of Northern Manhattan Rehabilitation and Nursing 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.

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

3. 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.

This NYSDOH Health Advisory supersedes the Health Advisory: Nursing Home Cohorting FAQs dated May 13, 2020.

1. If a facility has only one or a few residents with COVID-19, does an entire unit need to be cleared and devoted exclusively to the care of residents with COVID-19?

Answer: No. When there are only one or a few residents with COVID-19 in a facility, they may be cohorted on part of a unit, such as at the end of a hallway. The area for residents with COVID-19 should be demarcated as a reminder for other residents and healthcare personnel. Other residents should be prevented from entering the cohort area. The residents with COVID-19 should not share a bathroom with residents outside the cohort. In their April 24, 2020 guidance, with regard to forming cohorts, the Center for Medicare & Medicaid Services (CMS) states "[t]his could be done by cohorting residents in a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit." When possible, an entire unit should be devoted to residents with COVID-19. If not possible, facilities should develop other means by which residents are isolated, separated from the general population.

2. If a facility has only one or a few residents with COVID-19, do separate staff need to be devoted exclusively to those residents?

Answer: Yes, if possible. The goal of separate staffing teams is to minimize the number of staff who care for both residents with COVID-19 and residents without COVID-19. For staff caring for residents in different cohorts, they should bundle care and plan the order of care to minimize the need to go back and forth between cohorts. Personal protective equipment (PPE) should always be changed before leaving the positive cohort.

It might not be possible to have completely separate staffing teams, such as in very small facilities, with registered nurses and medical consultants, during nights or weekends, or in situations when there are only one or a few residents

with COVID-19 in the facility. In this situation, staffing assignments should be made to maintain separate teams to the greatest extent possible, and facilities should make every effort possible to reduce the number of staff caring for residents in different cohorts.

3. Please define positive, negative, and unknown as they apply to forming resident cohorts.

Outbreak testing is to be completed on both vaccinated and unvaccinated residents and staff. As such, resident cohorting should be based on SARS-CoV-2 diagnostic testing results where a single test defines a resident's status at a single point in time. Three resident cohorts (positive, negative, and unknown) are defined as follows:

Positive cohort The positive cohort should only house residents with a confirmed COVID-19 infection who have tested positive for SARS-CoV-2 by a diagnostic test (e.g., a rapid antigen, rapid molecular test, or a lab based molecular test). See below for testing considerations when using antigen tests.

- Residents who have a confirmed COVID-19 infection should be placed in the positive cohort regardless of vaccination status.
- Residents in the positive cohort should be cared for using transmission-based precautions.
- The positive cohort should include:
    - o Symptomatic and asymptomatic residents who have tested positive for SARS-CoV-2 for the first time.
    - o Symptomatic and asymptomatic residents who test positive for SARSCoV-2 more than three months after the onset (date of symptom onset or, if asymptomatic, date of collection of the positive diagnostic test) of a previous COVID-19 infection.
    - o Symptomatic residents who are within three months of a previous COVID19 infection, who do not have an alternate diagnosis that explains their symptoms, for whom a decision to test for SARS-CoV-2 is made in consultation with an ID specialist, and who test positive. However, because of the difficulty interpreting a positive test result within 3 months of a previous infection, facilities should strongly consider isolating these residents separately from all other cohorts, if feasible.

A resident should remain on the positive cohort until meeting the criteria to discontinue COVID-19 transmission-based precautions, at which time they should move to the negative cohort.

Negative cohort
The negative cohort should house residents who have tested negative for SARS-CoV-2 by a diagnostic test, (e.g., a rapid antigen, rapid molecular test, or a lab based molecular test), excluding residents who test negative before meeting the criteria to discontinue COVID-19 transmission-based precautions (who should remain in the positive cohort until they meet criteria to discontinue precautions). The negative cohort should house residents who have met criteria to discontinue COVID-19 transmission-based precautions after recovery from COVID-19.

A resident should remain on the negative cohort until testing identifies a need to move them, or until the resident refuses indicated testing (at which time they should move to the unknown cohort).

Unknown cohort
The unknown cohort should only house residents who have not been tested (e.g., the resident refused testing).
Residents (who have not tested positive) should be moved to the unknown cohort whenever the resident is not tested during any round of serial outbreak testing as required by CMS. The unknown cohort should include single rooms whenever possible, so residents do not have roommates. Available single rooms should be prioritized for residents who have symptoms concerning for COVID-19 infection. Residents on the unknown cohort should be cared for using transmission-based precautions.

Residents should remain on the unknown cohort as follows:

- Residents who remain asymptomatic should stay in the unknown cohort for a minimum of 14 days from the date of last potential exposure. Additionally, for residents who continue to refuse testing, if transmission is ongoing then facilities could consider keeping them in the unknown cohort beyond the above duration until 14 days from the date the facility completes outbreak testing.

• Residents who are symptomatic should remain in the unknown cohort until they meet the symptom-based criteria to discontinue transmission-based precautions and for 14 days from the date of last exposure or longer as described in the bullet above.

Other information

• Residents who have not tested positive and who develop symptoms that are concerning for COVID-19 should remain on their current cohort and be cared for using the appropriate transmission-based precautions and be prioritized for testing. Ideally, the resident should be placed in a single room. Facilities should follow guidance from CMS regarding management of symptomatic residents who refuse testing.

• Residents who have not tested positive and are exposed to COVID-19 should be placed in quarantine and cared for using appropriate transmission-based precautions. Ideally, the resident should be placed in a single room.

• If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter in place at their current location pending return of test results. An exception to the allowance for sheltering in place are residents who test negative but are roommates of residents who test positive for COVID-19 (see #6 below).

4. Testing considerations for antigen tests.

Facilities using antigen tests should carefully review testing considerations, including implications for nursing home cohorting and the importance of serial testing during outbreaks and among exposed residents.

5. Considerations for asymptomatic residents who have a COVID-19 exposure within 3 months of a prior infection.

Asymptomatic residents who have recovered and are within 3 months of a positive test for SARS-CoV-2 infection may not need to be quarantined or tested following reexposure to someone with COVID-19. However, there are clinical scenarios where SARS-CoV-2 testing or quarantine should be considered, such as when there might be uncertainty about a prior infection (e.g., concern that initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result), uncertainty about the resident's immune response, or when suspicion exists of exposure to variant strains of SARS-CoV-2. See CDC recommendations and testing considerations from CMS.

Residents who have recovered from COVID-19 and are asymptomatic generally do not need to be retested for COVID-19 within 3 months of onset of their most recent infection except according to the considerations described above.

If a resident tests positive less than 3 months from the onset of the latest infection, it is possible that the positive test represents a new infection, or a persistently positive test associated with the previous infection. Until more information is available, the determination of whether a resident with a positive test is contagious to others should be made on a case-by-case basis. Consider consultation with infectious disease specialists to review all available information. If a person is definitively determined to be infectious, they should be placed on the positive cohort and remain isolated until they again meet criteria for discontinuation of transmission-based precautions. However, if this cannot be established, or when there is uncertainty about whether the resident is contagious to others and because of the difficulty involved in interpreting a positive test result within 3 months of a previous infection, facilities should strongly consider isolating these residents separately from all other cohorts and separate from other residents, whether symptomatic or asymptomatic, who also test positive within 3 months of a previous infection.

6. How should negative roommates of residents who test positive for COVID-19 be cohorted?

Roommates of a resident who tests positive for COVID-19, who themselves have a negative test, are at high risk of being infected and a having positive test within the next 14 days.

These residents should be considered exposed contacts and who require quarantine. They should immediately be separated from the resident who tests positive and they should be placed in a single room, regardless of vaccination status.

For further information see:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-aftervaccination.html
https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf

Question about this advisory can be sent to icp@health.ny.gov or covidnursinghomeinfo@health.ny.gov

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 04/2020	Revision Date: 04/2021; 05/2022	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Discontinuation/Criteria of Transmission Based Precautions for Residents with COVID-19 in Nursing Homes**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19.

The facility will follow and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the New York State Department of Health (NYSDOH), to include identification and isolation of any suspected and confirmed cases, as well as discontinuation of transmission-based precautions (TBPs). As recommended, the symptom-based strategy will be utilized to discontinue TBPs for those with Covid-19 infection, to the extent possible.

DEFINITIONS

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

Moderate Illness - individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) 50%.

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

Severely Immunocompromised:
- Being on chemotherapy for cancer,
- Being within one year out from receiving a hematopoietic stem cell or solid organ transplant,
- Untreated HIV infection with CD4 T-lymphocyte count < 200,
- Combined primary immunodeficiency disorder, or
- Receipt of prednisone >20 mg/day for > 14 days.

PROCEDURE

1. Residents who tested positive for SARS-CoV-2 infection will be placed on the Covid-positive cohort area/unit and TBPs (contact and droplet) will be implemented.
2. In order to discontinue TBPs, a person-centered approach will be utilized, taking into account the residents health status
3. **Symptom-based strategy (recommended)**:
   a. **Asymptomatic residents** or residents with **mild-moderate illness**
      - At least 24 hours have passed since last fever without the use of fever-reducing medications; AND

- Symptoms (if present) have improved; AND
- At **least 10 days have passed** since symptoms attributed to COVID-19 first appeared.

b. Residents with **severe to critical illness**
   - At least 24 hours have passed since last fever without the use of fever-reducing medications; AND
   - Symptoms have improved; AND
   - At least **10 days and up to 20 days have passed** since symptoms attributed to COVID-19 first appeared.

c. Residents who are **severely immunocompromised**
   - **Consultation with infectious disease specialists is recommended**
   - Consider utilizing a test-based strategy for discontinuing TBPs
   - At a minimum, when the symptom-based strategy is determined to be appropriate after specialist consultation, residents who are severely immunocompromised will remain on transmission-based precautions until:
     - At least 24 hours have passed since last fever without the use of fever-reducing medications; AND
     - Symptoms (if present) have improved; AND
     - At least **10 days and up to 20 days** have passed since symptoms attributed to COVID-19 first appeared.
       - For severely immunocompromised residents who were asymptomatic at the time of their first positive test and who remain asymptomatic, at least 10 days and up to 20 days have passed since the date of collection of their first positive test.
       - For severely immunocompromised residents who were asymptomatic at the time of their first positive test and subsequently developed symptoms attributed to COVID19, at least 10 days and up to 20 days have passed since symptom onset in addition to the clinical criteria above.

4. **Test-Based Strategy (not recommended, except)**:
   - **All of the following** are required to discontinue transmission-based precautions using the test-based strategy:
     - At least 24 hours have passed since last fever, without fever-reducing medications; AND
     - Symptoms (if present) have improved; AND
     - Results are negative from at least two consecutive respiratory specimens collected greater than or equal to 24 hours apart and tested using an FDA-authorized **molecular viral assay** for detection of SARS-CoV-2 RNA.
5. Discontinuation of TBPs for residents with **suspected Covid-19**:
   - A negative result from at least one respiratory specimen using an FDA-authorized **molecular viral assay** for detection of SARS-CoV-2 (Antigen/Rapid tests cannot be used)
   - A second consecutive negative test collected $\geq$ 24 hours apart should be obtained when there is a higher level of suspicion for COVID-19.
   - For residents suspected of having COVID-19 infection but are never tested, the decision to discontinue COVID-19 transmission-based precautions will be made using the symptom-based strategy
6. Discontinuation of TBPs for residents **exposed to Covid-19**:
   - Residents who are **not *up to date*** with all recommended Covid-19 vaccines and are exposed to Covid-19 will be placed on TBPs x10 days from the date of last exposure
     - Alternatively, residents can be removed from TBPs after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of Transmission-Based Precautions
   - If the resident is discharged to the community during the quarantine period, requirements applicable for quarantine in the community applies.
     - The local health department (LHD) will be notified of the discharge.

REFERENCES

CDC (Updated 2/6/2021). Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 Infection in Health Care Settings. https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

NYSDOH (5/3/2021). Health Advisory: Discontinuation of TBPs for Patients with Covid-19 Who are Hospitalized or in Nursing Homes… Retrieved from https://commerce.health.state.ny.us/HCSRestServices/HCSContentServices/docs?docPath=/hcs_Documents/Source/hpn/hpnSrc/C1849138447D6CA4E0530547A8C0BC81.pdf

CDC (2/2/2022). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2Spread in Nursing Homes. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#%3A%7E%3Atext%3DExpanded%20screening%20testing%20of%20asymptomatic%20HCP%20should%20be%20as%20follows%3A

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 05/11/2020	Revision Date: 03/2021	Review Date: 03/2023	Prepared by: Administration; Nursing Administration
Policy Subject: **Pandemic Emergency Plan - Employee Testing and Reporting During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

Northern Manhattan Rehabilitation and Nursing Center will comply with New York State Executive Order issued requiring nursing home operators and Administrators to test or make arrangements for testing of all personnel, including all employees, contracted staff, medical staff, operators and Administrators for COVID-19. Such testing must occur twice weekly pursuant to a plan developed by the Administrator and approved by New York State Department of Health.

PROCEDURES

1. The facility Administrator submitted a COVID-19 testing plan to the DOH via the New York State Health Electronic Response Data System (HERDS) per requirements set forth in the NH DAL for the Executive Order.
2. All personnel will be tested for COVID-19 twice per week pursuant to the plan developed by the Administrator.
3. The facility has obtained an agreement with a Certified Diagnostic Laboratory to provide COVID-19 testing as available and in accordance with FDA Emergency Use Authorization (EUA) and NYSDOH.
    - The facility will ensure that testing, not provided by the facility, is reasonably accessible for its personnel. The Human Resource Director will maintain a list of off-site testing locations and distribute to all Department Heads. The Department Heads will inform personnel of these alternative testing locations when they do not or cannot be tested at the facility.
        (1) Any offsite testing must be submitted by staff on the day the test was completed and results of the test must be submitted by 4:00 p.m. of the day results received.
        (2) Facility will offer testing to their personnel through their contracted lab.
        (3) Facility may direct their personnel to a local drive-through or walk-in testing site.
        (4) Personnel can call 1-888-364-3065 to inquire about testing, or they can go to https://coronavirus.health.ny.gov/covid-19-testing#protocol-for-testing.
        (5) The facility will advise the personnel to find out how to obtain documentation of their test results, such as through a laboratory portal.
        (6) Facilities may contract with a third party to offer testing.
        (7) Facilities will accept documentation of testing conducted by an individual's healthcare provider.
        (8) Facility will accept certified laboratory results from another nursing home as proof of documentation whenever the employee is tested at that facility (e.g. per diem employee, part-time employee, contracted employee, etc.).
4. Personnel exempt from additional testing are:
    - Personnel who have had a previous laboratory confirmed positive test, which have been out of work, and have met the NYSDOH criteria to return to work.

5. Any release of information will be adhered strictly to the Health Insurance Portability and Accountability Act (HIPAA) and any other applicable Federal and State laws governing personal health information.

5. The facility will report any positive test result of personnel to the NYSDOH daily by 5:00 p.m. of the day following receipt of such test results.

6. All staff testing positive shall be documented on the COVID-19 spreadsheet/log and be reported on the required NYSDOH HERDS and CDC electronic data submission reports.

7. The facility will notify residents, their representatives and families of confirmed or suspected COVID-19 infections among staff and residents. These notifications will be done by 5:00 p.m. the next calendar day following the occurrence of either a single confirmed COVID-19 infection, or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other.

8. The facility will maintain records of all personnel's COVID-19 laboratory test results completed on site and at off-site locations for a period of one (1) year. The facility will track all personnel's results of testing on a computerized spreadsheet (tracking log).

9. All employees including contract staff, medical staff, operators and Administrators who refuse testing will not be scheduled for or permitted to work or provide services for the facility in any capacity until such testing is performed.

10. Any personnel who test positive for COVID-19 will be immediately taken off the schedule, remain at home in isolation, and will not return to work as follows:

    - Nursing home employees who test positive for COVID-19 but remained asymptomatic <u>are not eligible to return to work</u> for 14 days from first positive test date.

    - Symptomatic nursing home employees <u>may not return to work</u> until 14 days after the onset of symptoms, provided at least 3 days (72 hours) have passed since resolution of fever without the use of fever-reducing medications and respiratory symptoms are improving.

      (See attached NYSDOH Nursing Home and Adult Care Facility Staff Testing Requirement Frequently Asked Questions dated May 12, 2020 and May 19, 2020.)

11. Any personnel who are ordered or directed to remain isolated at home as a result of a positive COVID-19 test result, are entitled to certain benefits including paid sick leave pursuant to Chapter 25 of the Laws of 2020 available at https://paidfamilyleave.ny.gov/COVID19.

12. The NYSDOH protocol for COVID-19 testing applicable to all healthcare providers issued on April 26, 2020 for diagnostic and/or serologic testing for COVID-19 will be implemented and testing will be obtained when:
    (1) An individual is symptomatic or has a history of symptoms of COVID-19 (e.g. fever, cough, and/or trouble breathing), particularly if the individual is 70 years of age or older, the individual has a compromised immune system, or the individual has an underlying health condition), or
    (2) An individual has had close (e.g. within six feet) or proximate contact with a person known to be positive with COVID-19, or
    (3) An individual is subject to a precautionary or mandatory quarantine, or
    (4) An individual is employed as a health care worker, first responder, or other essential worker who directly interacts with the public while working, or
    (5) An individual present with a case where the facts and circumstances – as determined by the treating clinician in consultation with state or local department of health officials – warrant testing. Based on individual clinical factors, health care providers should use clinical judgment to determine the appropriate COVID-19 test(s) (e.g. diagnostic or serologic) that should be obtained.

    (6) Symptomatic individuals, particularly if the individual is part of a high-risk population, including persons who are hospitalized; persons residing in nursing homes, long-term care facilities, or other congregate care settings; persons who have a compromised immune system; persons who have an underlying health condition; and persons who are 70 years of age or older.

(7) Individuals who have had close (e.g. within six feet) or proximate contact with a person known to be positive with COVID-19.

(8) Individuals who are employed as health care workers, first responders, or in any position within a nursing home, long-term care facility, or other congregate care setting.

13. All personnel will receive in-service education and notification on the nursing home COVID-19 testing requirements and policy and procedures.

14. The facility will ensure all personnel will continue to be checked for COVID-19 symptoms (e.g. fever, cough, difficulty breathing or other respiratory symptoms), including temperature checks upon the start of each shift and every 12 hours while on duty.

15. The Administrator and operator will submit certification of compliance with Executive Order No. 202.30, requiring COVID-19 testing of all facility personnel pursuant to the plan filed with the NYSDOH as required.

SELF TESTING MADE EASY FOR COVID WITH i-HEALTH TEST

TESTING SUPPLIES:

- COLLECTION SWAB
- MIXING TUBE
- TEST CARD

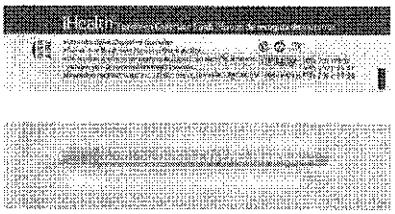


Figure 1 COLLECTION SWAB

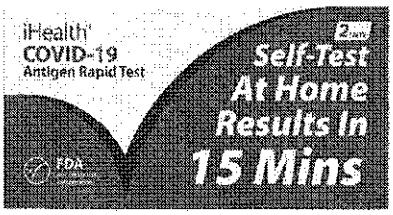
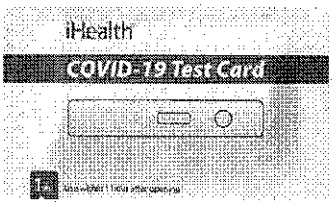


Figure 2 Test kit box



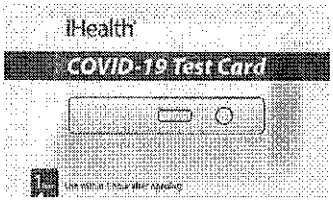


Figure 3 TEST CARD

Figure 4 Mixing Tube

STEP ONE: **SWAB 5 times each nostril**

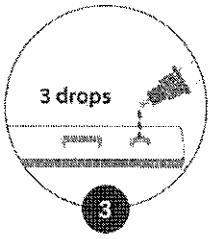
Brush against the inner wall of both nostrils 5 times each in a circular motion with a non-invasive nasal swab. Our nasal swab is soft, highly absorbent, and only needs to be inserted ½ - ¾ inches so you can test yourself comfortably.

STEP TWO: **DIP and STIR 15 times in mixing tube**

Insert the swab with the sample into the bottom of the tube and stir it in the fluid 15 times. Squeeze the sides of the tube around the swab as you pull it out.

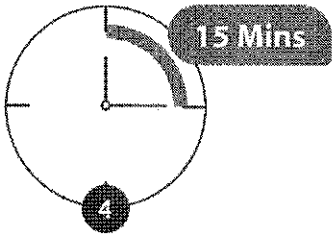
STEP THREE: **DRIP X 3 ON TEST CARD (remove the clear plastic tip to allow the drips to come out)**

Put 3 drops of the mixed solution onto the sample port of the COVID-19 test card.



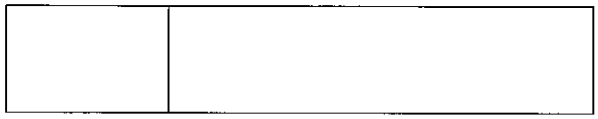
WAIT 15 MINUTES

Start the timer, or check your watch



Negative result:

C T



POSITIVE RESULT:

C T

SHOW YOUR RESULTS TO THE RECEPTIONSIST

DISCARD ALL MATERIALS AND PERFORM HAND HYGIENE

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 05/11/2020	Revision Date: 01/07/2021; 06/14/2021; 07/14/2021; 01/05/2022; 03/16/2022; 06/08/2022; 10/14/2022; 03/20/2023;	Review Date: 03/2023	Prepared by: Administration; Nursing Administration
Policy Subject: **Pandemic Emergency Plan – COVID-19 Testing Post the Public Health Emergency**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY

The facility 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 Covid-19 infection and to ensure appropriate clinical treatment. The facility will utilize both Point of Care (POC) Antigen tests and PCR tests, as applicable, 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.

DEFINITION(S)

Outbreak: a new Covid-19 infection in any healthcare personnel (HCP) or any nursing home-onset Covid-19 infection in a resident.

Fully Vaccinated: ≥2 weeks following receipt of the 2nd dose in a 2-dose series, or ≥2 weeks following receipt of 1 dose of a single-dose vaccine

"Up To Date" Covid Vaccination: a person has received all recommended Covid 19 vaccines including any booster dose(s) when eligible

Close Contact: refers to someone who has been within 6 feet of a Covid-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period.

Higher-risk Exposure: refers to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure (AGP).

Level of Community Transmission: refers to a facility's level of Covid-19 transmission. This metric uses two indicators for categorization: (1) total number of new cases per 100,000 persons within the last 7 days and (2) percentage of positive diagnostic and screening nucleic acid amplification tests (NAAT) during the past 7 days.

PROCEDURE:

1. The Facility will contract with a certified lab to provide testing as needed and in accordance with NYSDOH and FDA approved testing to provide test results for all tests in a timely manner (within 48 hours of specimen collection)
2. The facility will utilize POC Antigen tests and/or PCR tests via contracted lab(s) and facility "lab" (if facility - has a CLIA waiver) for testing in accordance with CMS/NYSDOH recommendations as needed to ensure appropriate diagnosis, management, and cohorting are implemented
    - Facility will follow manufacturer's instruction for use (MIFU) for each type Covid-19 test kit used for outbreak testing (e.g., Abbott Binax or iHealth OTC tests)
3. Staff will utilize all PPEs (gown, N95 mask (if fit-tested) otherwise procedure mask, eye protection and gloves) while performing nasal/nasopharyngeal swabs

4. The facility will test or arrange for the testing for Covid-19 according to CMS QSO-20-38-NH (REVISED 9/23/22)
5. Staff with signs/symptoms of Covid 19, regardless of vaccination status, will be tested as soon as possible and will be restricted from the facility pending results.
6. Residents that have signs/symptoms of Covid 19, regardless of vaccination status, will be tested as soon as possible and placed on Contact and Droplet Transmission Based Precautions pending results
7. The Facility will not perform routine testing of asymptomatic staff
8. In accordance with CMS testing requirements, in the event of a new positive Covid 19 case, the facility will conduct outbreak testing.
    - An outbreak investigation will **not** be triggered if a resident admitted with Covid 19 and placed on TBPs or when a resident is a close contact with someone Covid positive is placed on immediately on TBPS and develops Covid 19 while on TBPs
    - The facility will identify close contacts of the individual with COVID-19 and conduct focused testing based on known close contacts rather than testing all staff and all residents.
    - If a facility does not have the expertise, resources, or ability to identify all close contacts, the facility will instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility).
9. When contact tracing reveals that the infected resident/staff member had close contact with a specific group of residents and/or unit, the serial testing will be limited to the identified residents/staff members who had close contact and subsequently have been exposed to COVID-19.
10. The facility will document on the line listing for all positive staff/residents what the contact tracing revealed and how the determination was made to proceed with limited testing versus facility wide testing.
11. All staff and residents that are negative will be tested every 3-7days until there are no new cases identified for 14 days since the most recent positive result.
    - For individuals (staff or residents) who tested positive for Covid-19 within 30 days, repeat testing is not necessary
    - Testing should be considered for those who have recovered in the prior 31-90 days.
        i. However, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended.

TABLE 1

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, regardless of vaccination status, with signs or symptoms must be tested.	Residents, regardless of vaccination status with signs and symptoms must be tested
Newly identified Covid-19 positive staff or resident in a facility that can identify close contacts	Test staff, regardless of vaccination status, that had a higher-risk exposure with a Covid-19 positive individual.	Test residents, regardless of vaccination status, that had close contact with a Covid-19 positive individual.
Newly identified Covid-19 positive staff or resident in a facility that is unable to identify close contacts	Test all staff, regardless of vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility).	Test all residents regardless of vaccination status, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility).
Routine testing	Not generally recommended	Not generally recommended

12. Residents and Resident Representatives can exercise their right to refuse testing in accordance with 42CFR&483.109c) (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.

13. In addition to providing Covid testing at the facility, a list of easily accessible testing centers will be made available for staff. 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.
    - Staff are required to submit to Employee/Occupational Health Services or Designee proof of Covid test(s) done outside of facility and provide record of result(s) promptly.
    - Facility will offer testing to their personnel through the contracted lab.
    - Facility shall accept documentation of testing conducted by an individual's healthcare provider.
    - Staff with previous positive COVID-19 test who were already furloughed do not require additional furlough if subsequent positive test(s) are <30 days of the first and staff is asymptomatic.
        - o If positive test is >30 days of first positive test, this is considered a new case and furlough is required
        - o In general testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 in the prior 30 days, however if testing performed/needed an antigen test instead of a nucleic acid amplification test (NAAT) is recommended
        - o Healthcare personnel who have signs or symptoms of Covid-19 and refuse testing will be prohibited from entering the building until the return-to-work criteria are met
        - o If an outbreak testing has been triggered and a staff member refuses testing, the staff member will be restricted from the facility until they produce a Covid-negative test or until the procedures for outbreak testing have been completed.
14. Staff and residents with signs or symptoms of Covid-19, regardless of vaccination status, must receive a Covid-19 test immediately, along with any other medically appropriate testing (e.g., viral respiratory pathogens)
    - Staff will be restricted from the facility pending the results of a confirmatory Covid-19 test by PCR if facility is not experiencing an outbreak; otherwise, result from an antigen test is acceptable
    - If Covid-19 is confirmed, facility will follow CDC return to work criteria (*refer to P/P specific to Covid-19*)
    - Residents will be placed on transmission-based precautions until receipt of confirmatory Covid-19 test by PCR if facility is not experiencing an outbreak; otherwise, result from an antigen test is acceptable
    - The facility will take appropriate actions based on the results (*refer to P/P specific to Covid-19*)
15. Per NYS Code 415, 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 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 test within 48 hours after death, along with any other clinically appropriate testing. Such COVID-19 test 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 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.

1. 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.
2. For any outbreak, the facility IP/Designee will document the date case identified, the dates and results of all testing.
3. Point of Care Antigen positive results of Covid 19 testing performed at the facility will be reported to NYSDOH ECLRS as directed by NYSDOH by 1:00PM of the day following receipt of the results
4. All staff and residents testing positive shall be documented on the log and the results will be reported on all required submissions to the CDC via NHSN (at least weekly) and NYSDOH via HERDS (daily reporting)
    - Currently NHSN does not require reporting **individual** POC tests, but requires a cumulative number via the Covid-19 Pathway Report.
5. All staff will receive Inservice Education on the NH COVID-19 Testing policies/procedures, including all updates in accordance with NYSDOH and Federal guidance.

RESOURCES:

NYSDOH (5/11/2020). ACF DAL #20-14, NH-20-07. Required Covid19 Testing for all Nursing Home and Adult Care Facility Personnel https://www.health.ny.gov/professionals/hospital_administrator/letters/2020/docs/dal_20-14_covid_required_testing.pdf

CMS (8/26/2020). Ref: QSO-20-38-NH. Interim Final Rule, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long Term Care Facility Testing Requirements and Revised COVID-19 Focused Survey Tool. Retrieved from https://www.cms.gov/files/document/qso-20-38-nh.pdf

NYSDOH Health Advisory Covid 19 Updated 10 13 22 https://commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/Health_Advisory__Nursing_Home_Testing,_Cohorting_and_Visita_1665772061063_0.pdf.

CMS QSO 20-38 (revised 9 /23/2022) https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/interim-final-rule-ifc-cms-3401-ifc-additional-policy-and-regulatory-revisions-response-covid-19-0.

CDC (revised 9/23/22) https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

NYSDOH (2/10/23) Microsoft Word - HCF Mask Guidance Advisory final 2.9.23 (002).docx (state.ny.us)

NYSDOH Health Advisory (3/17/23) NH_Visitor_Testing_Health_Advisory_3_1679063367607_0.17.23.pdf (state.ny.us)

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 05/11/2020	Revision Date: 01/07/2021; 06/14/2021; 07/14/2021; 01/05/2022; 03/16/2022; 06/08/2022; 10/14/2022; 03/20/2023;	Review Date: 03/2023	Prepared by: Administration; Nursing Administration
Policy Subject: **Pandemic Emergency Plan – COVID-19 Point of Care Testing**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY:
The facility will use Point of Care testing approved by the Food and Drug Administration (FDA) as needed to assist with early identification of COVID-19 in residents and staff as well as ensure compliance with State and Federal regulations.

PROCEDURE:

1. Licensed personnel will be trained in utilization of available Point of Care Test Kits for rapid detection of COVID-19.
2. Upon completion of training, licensed personnel will follow procedures outlined in the competency in the use of available POC antigen test kits. (See attached competencies for BD Veritor and Abbott BinaxNOW)
3. Facility may choose to use POC Antigen tests kits to fulfill bi-weekly staff testing.
4. Facility may choose to use POC Antigen test kits to satisfy requirements for serial testing when there is an outbreak. (*Refer to NYSDOH POC Testing Algorithm for when to follow up PCR test is required).
5. When a resident displays symptom of COVID-19 and/or Influenza, an order will be obtained for both Covid and Influenza.
   - If there is a roommate, same will be done for roommate.
6. Residents and roommates (when applicable) who are tested for Covid-19 or Influenza will be placed on appropriate transmission-based precautions pending the test results.
7. The facility shall comply with all requirements as set forth in CDC Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Covid-19 including:
   - Utilizing required/recommended PPE not limited to face shield or other eye protection, N95 mask (fit tested) or surgical mask if not available, isolation gown, and disposable gloves.
   - Maintaining social distancing of at least 6 feet apart
   - Using equipment in the specified area/location as associated with current CLIA Waiver certificate.
   - Following standard precautions when handling specimens, including hand hygiene, correct usage of PPE, and proper specimen/device disposal in biohazardous container
8. The results of all POC antigen tests will be documented and reported to NYSDOH daily via the HERDS Survey and the Electronic Clinical Laboratory Reporting System (ECRLS).

COMPETENCY: Collecting and Analyzing SARS-CoV-2 Specimen Using the BD Veritor System

TASKS	TASK COMPLETED (YES/NO)	COMMENTS
1. Ensure clean work surface with adequate lighting		
2. Gather supplies a. BD Veritor Analyzer b. Reader Verification Cartridge (orange & white) c. SARS-CoV-2 Device (blue & white) d. Swab stick e. Extraction Reagent Tube (yellow top) f. Biohazard waste container g. PPEs (gown, gloves, N95 respirator, eye/face shield) h. Alcohol-based hand sanitizer (ABHS)		
3. Perform hand hygiene		
4. Don PPEs		
5. Before testing patient specimens, perform a system verification check a. Using Analyze Now Test Mode, insert reader verification cartridge (orange & white) into the test device slot - A distinct click indicates when the cartridge is fully inserted b. After 3 seconds, VERIFY PASS, appears on the screen to indicate the device is ready for use c. Remove and store the verification cartridge in the orange zip-loc pouch for use every time the device is used for testing specimens		
6. Collect specimen via nasal swab a. Insert swab into anterior aspect of one nostril b. Swirl the swab about 5 times along the mucosa inside the nostrils (*rationale*: to ensure that both mucus & cells are collected) c. Using the same swab, repeat this process for the other nostril d. Withdraw swab from the nasal cavity.		
7. Insert patient sample swab in reagent tube and vigorously plunge the swab up and down for 15 secs		
8. Remove swab and dispose in biohazard container		
9. Close cap on reagent tube and mix sample by swirling the bottom of the tube.		
10. Label reagent tube with patient identifier – first and last initials		

11. Add 3 drops of the processed sample to the test device sample well (blue & white cartridge)		
12. Label test device with patient identifier – first and last initials		
13. Allow sample to sit/incubate for 15 mins		
14. Turn on analyzer (press blue power button)		
15. Await prompt – Insert Test Device OR Double-Click Button for Walk Away Mode		
16.		
17. **ANALYZE NOW MODE**: Specimen incubates for 15 mins outside of the device a. Insert cartridge (blue & white) with specimen b. Result will display on screen c. Record result and remove test device d. Discard device in biohazard container		
18. **WALK AWAY MODE**: Specimen incubates for 15 mins inside of the device a. Double click power button to enter Walk-Away Mode; Ensure power plug is plugged in to power b. Follow steps #6-11 c. 3-min countdown timer displays time remaining for test device insertion d. Insert device with specimen to start assay timing and analysis e. Result will appear on the screen after analysis is complete (15 mins) f. Record result and remove test device g. Discard device in biohazard container		

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

EMPLOYEE's NAME (PRINT): _____

EMPLOYEE'S SIGNATURE: _____

EVALUATOR'S SIGNATURE: _____ DATE_____

COMPLETED BD CERTIFICATION: YES/NO

COMPETENCY: Collecting and Analyzing SARS-CoV-2 Specimen Using the Abbott BinaxNOW COVID-19 Ag Card

TASKS	TASK COMPLETED (YES/NO)	COMMENTS
1. Ensure clean work surface with adequate lighting		
2. Gather supplies a. BinaxNOW COVID-19 Ag Card b. Extraction Reagent bottle c. Swab stick d. Biohazard waste container e. PPEs (gown, gloves, N95 respirator (fit tested) or surgical mask, eye/face shield) f. Alcohol-based hand sanitizer (ABHS)		
3. Perform hand hygiene		
4. Don PPE		
5. Label new BinaxNOW card with patient identifier (e.g., name, DOB, etc.)		
6. Prep BinaxNOW COVID-19 Ag Card with extraction reagent solution a. Open card and lay flat b. Hold extraction reagent bottle vertically, hovering about ½ inch above the top hole c. Slowly **add 6 drops to the top hole** of the swab well *DO NOT touch the card with the dropper tip while dispensing		
7. Collect specimen via nasal swab a. Insert swab into anterior aspect of one nostril e. Swirl the swab about 5 times along the mucosa inside the nostrils (*rationale*: to ensure that both mucus & cells are collected) f. Using the same swab, repeat this process for the other nostril g. Withdraw swab from the nasal cavity.		
8. Insert sample swab into **bottom hole** and firmly push upwards so that the swab tip is visible in the top hole.		
9. Rotate (twirl) swab shaft 3 times **clockwise** (to the right). Do not remove swab.		
10. Peel off adhesive line from the right edge of the test card, close and securely seal the card		
11. **Read result** in the window **15 minutes after** closing the card. *Result should not be read after 30 mins		
12. Interpret result a. Negative: a single pink/purple Control Line in the top half of the window		

b. Positive: two pink/purple lines		
13. Record result and discard used BinaxNOW COVID-19 Ag Card in biohazard container		
14. Perform hand hygiene		

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

EMPLOYEE's NAME (PRINT): _____

EMPLOYEE'S SIGNATURE: _____

EVALUATOR'S SIGNATURE: _____ DATE_____

COMPETENCY: Collecting and Analyzing SARS-CoV-2 Specimen Using the Sofia/Sofia 2 System

TASKS	TASK COMPLETED (YES/NO)	COMMENTS
1. Ensure clean work surface with adequate lighting		
2. Gather supplies a. Sofia 2 Analyzer b. Test Cassette c. Reagent tube d. Reagent solution e. Swab stick f. Biohazard waste container g. PPEs (gown, gloves, N95 respirator, eye/face shield) h. Alcohol-based hand sanitizer (ABHS)		
3. Perform hand hygiene		
4. Don PPEs		
5. Before testing patient specimens, perform a system calibration check (every 30 days) a. Enter Zip Code of the facility (only required the very 1st time machine is turned on) b. Enter supervisor code 1234, then select "Run" c. Follow prompts, insert calibration cassette into drawer		
6. Prepare the reagent by dispensing all the reagent solution into the reagent tube		
7. Collect specimen via nasal swab h. Insert swab into anterior aspect of one nostril i. Swirl the swab about 5 times along the mucosa inside the nostrils (*rationale*: to ensure that both mucus & cells are collected) j. Using the same swab, repeat this process for the other nostril k. Withdraw swab from the nasal cavity.		
8. Place the patient swab sample into the reagent tube. Roll the swab at least 3 times while pressing the head against the bottom and side of the reagent tube (**let swab sit in tube for at least 1 minute**)		
9. Roll the swab head inside of the reagent tube as you remove it		
10. Dispose of the used swab in a biohazardous waste container		
11. Fill the 120 µL fixed volume pipette with patient sample from reagent tube		

12. Firmly squeeze the top bulb to empty the contents of the pipette into the Test Cassette sample well ****Do not pour sample from reagent tube; use the small, clear 120 µL fixed volume pipette**		
13. **READ NOW MODE**: Specimen incubates for 15 mins outside of the Sofia/Sofia 2 a. Insert cassette into device e. Result will display on screen in approx. 11 secs f. Record result and remove sample cassette g. Allows for multiple tests to be run with high throughput (~ 40 – 50 tests/hr.)		
14. **WALK AWAY MODE**: Specimen incubates for 15 mins inside of the device **a.** Pipette sample onto Test Cassette and insert into Sofia/Sofia 2 **b.** Sofia/Sofia 2 will automatically time the test and report results in 15 mins		

Resources: https://www.quidel.com/sites/default/files/product/documents/EF1439004EN01.pdf
https://www.youtube.com/watch?v=BOrPGjtgHyE

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

EMPLOYEE's NAME (PRINT): _____

EMPLOYEE'S SIGNATURE: _____

EVALUATOR'S SIGNATURE: _____ DATE_____

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 09/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Annex K Section – Communicable Disease Reporting**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

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 415.19.1

- 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.

    i. 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 prompts action and should be reported immediately by phone.

- Categories and examples of reportable healthcare-associated infections include:

    i. 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.

    ii. Intra-facility outbreaks of influenza, gastroenteritis, pneumonia, or respiratory syncytial virus.

    iii. Foodborne outbreaks.

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

    v. 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.

    vi. A single case involving Staphylococcus aureus showing reduced susceptibility to vancomycin.

    vii. Clusters of tuberculin skin test conversions.

    viii. A single case of active pulmonary or laryngeal tuberculosis in a nursing home resident or employee.

    ix. Increased or unexpected morbidity or mortality associated with medical devices, practices or procedures resulting in significant infections and/or hospital admissions.

    x. Closure of a unit or service due to infections.

- Additional information for making a communicable disease report:

    i. 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:

    ii. 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.

    iii. 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:

    i. Call 1 (866) NYC-DOH1 (1-866-692-3641) for additional information.

    ii. Use the downloadable Universal Reporting Form (PD-16); those belonging to NYC MED can complete and submit the form online.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 12/2020	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Personal Protective Equipment (PPE)**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			Page 1

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing 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 or relationships with PPE vendors to facilitate the replenishment of stock. The storage location(s) for PPE are on each respective unit, nursing office and in the basement.
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 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.
10) In accordance with NYS Chapter 114 of the Laws of 2020, the facility assures and preserves a 60-day supply of PPEs at our storage center adjacent to the facility. During a pandemic, the Central Supply Coordinator/Designee will distribute PPE from the 60-day supply as needed.

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.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 12/2020	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Personal Protective Equipment (PPE) - Include Burn Rate**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing Center to ensure employees are adequately fitted for N95 respiratory masks in the event of a suspected outbreak.

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 or relationships with PPE vendors to facilitate the replenishment of stock. The storage location(s) for PPE are on each respective unit, nursing office and in the basement.
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 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.
10) In accordance with NYS Chapter 114 of the Laws of 2020, the facility assures and preserves a 60-day supply of PPEs at our storage center adjacent to the facility. During a pandemic, the Central Supply Coordinator/Designee will distribute PPE from the 60-day supply as needed.

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 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.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: Infection Prevention and Control		Policy #	
Issue Date: 07/2020	Revision Date: 10/2020; 11/2020; 05/2021; 01/2023	Review Date: 03/2023	Prepared by: Nursing Services
Policy Subject: **Pandemic Emergency Plan: Eye Protection During the COVID-19 Public Health Emergency**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			Page 1 of 3

BACKGROUND

SARS-CoV-2, commonly known as COVID-19, is primarily a viral respiratory infection. It is most commonly spread between people who are in close proximity of each other (within 6 feet). It spreads through respiratory droplets or small particles produced when an infected person coughs, sneezes, sings, talks or breathes. These particles can be inhaled into the nose and mouth, and eventually into the lungs, causing an infection. Droplets can also land on surfaces and inanimate objects and spread when dirty hands touch the eyes, nose and mouth. The incubation period is between 2-14 days. The Centers for Disease Control and Prevention (CDC) and the New York State Department of Health (NYSDOH) strongly recommends the use of goggles or face shields as universal source control for healthcare personnel (HCP) in facilities located in counties where community transmission is high.

PURPOSE

To reduce the risk of transmission of the Coronavirus Disease (COVID-2019) in this healthcare setting.

RESPONSIBLITY

Physicians, physician assistants, nurse practitioners, and facility staff are responsible for following Standard and Transmission-Based Precautions to break the chain of infection and prevent the spread of Covid-19 infection.

POLICY

The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19. In addition to universal masking as source control, the facility may consider adopting universal use of eye protection (goggles or face shields) for all resident encounters when the Covid-19 community transmission rate is high. Staff will continue to use eye protection when interacting with residents who are Covid-positive, are persons under investigation (PUI), and for aerosol generating procedures, irrespective of county community transmission rates. The facility will follow and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC) and the New York State Department of Health (NYSDOH). Staff will be informed of any changes during change of shift huddle and as often as necessary.

PROCEDURE

1. Facility Administrator, Director of Nursing, and/or the Infection Preventionist will be responsible for checking and logging Covid community transmission rates in an Excel spreadsheet weekly on Mondays using the following CMS link https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&data-type=CommunityLevels.
2. Provide education to staff regarding use of goggles or face shields as universal source control for resident encounters.
3. Wear eye protection (goggles or a face shield), in addition to facemask, to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters.
4. Wear an N95 or equivalent or higher-level respirator, instead of a facemask, for aerosol generating procedures
    a. Suctioning
    b. Nebulizer treatments
    c. High flow oxygen, including nasal canula >15L
    d. Non-invasive positive pressure ventilation (e.g. CPAP, BIPAP)
    e. Cardiopulmonary resuscitation/Chest compressions
5. Conduct inventory to ensure adequate supply of goggles and/or face shields.
    a. Determine utilization rate

b. Ensure there is a supplier/vendor to procure supplies as needed.
c. May need to communicate with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional supplies.

6. Clean and disinfect eye protection for reuse, if applicable
    a. Utilize the following when manufacturer instructions for cleaning and disinfection are unavailable:
        i. While wearing clean gloves, carefully wipe the *inside*, followed by the outside of the goggles or face shield using a clean cloth saturated with neutral detergent solution or wipe
        ii. Next, wipe the outside of the goggles or face shield using a wipe or clean cloth saturated with an EPA-registered hospital disinfectant solution.
        iii. Wipe the outside of the goggles or face shield with clean water or alcohol to remove residue
        iv. Dry fully (may air dry or use clean absorbent towels)
        v. Remove gloves and perform hand hygiene
7. The facility will implement any and all of the following possible engineering and control measures to optimize the utilization and availability of PPE.

    a. Reduce the number of residents going to the hospital or other outpatient settings

    b. Exclude non-essential employees for resident care from entering the care area

    c. Reduce the number of face-to-face encounters with residents

    d. Cohort residents and/or health care workers

References:

CDC (7/15/2020). Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (Covid-19) Pandemic. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

CDC (10/21/2020). Coronavirus Disease 2019 (COVID-19): Frequently Asked Questions. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Spread

CMS. Covid Data Tracker. Retrieved from https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&data-type=CommunityLevels.

NYSDOH (11/24/2020). Health Advisory: Universal Use of Eye Protection. Retrieved from https://coronavirus.health.ny.gov/system/files/documents/2020/11/hcp_eye_protection_guidance_112520.pdf

CDC (9/23/2022). Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: Infection Prevention and Control		Policy #	
Issue Date: 02/2023	Revision Date: 02/2023	Review Date: 03/2023	Prepared by: Nursing Services
Policy Subject: **Pandemic Emergency Plan: Personal Protective Equipment - Mask Guidance and Recommendations**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			Page 1 of 3

BACKGROUND

Source control refers to the use of respirators or well-fitting masks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

POLICY

It is the policy of this facility to follow all New York State Department of Health (NYSDOH) and Centers for Disease Control and Prevention (CDC) guidance and/or recommendations for the use of masks as source control to prevent the spread of respiratory infections.

PROCEDURE

Mask Use as Source Control for Covid-19 Infection

1. **HIGH SARS-CoV-2 Community Transmission**
    a. The facility will utilize CDC's Community Transmission levels (see Table 1 below) are high to determine using masks as universal source control.
    b. The Facility IP/Designee will monitor community transmission levels weekly and as needed and report any change in transmission levels to the Administrator and Director of Nursing.
    c. When the SARS-CoV-2 Community Transmission level is high in the County in which the facility is located, everyone (e.g., employees, residents, visitors, consultants, vendors, etc.) in the facility will wear masks as source control.

2. **Substantial, Moderate, Low SARS-CoV-2 Community Transmission**

When the SARS-CoV-2 Community Transmission level is **substantial**, **moderate**, or **low** in the County in which the facility is located, the facility may choose not to implement masks as universal source control. However, even if source control is not universally required, it remains recommended for individuals who:

- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure; or
- Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or
- Have otherwise had source control recommended by public health authorities

TABLE 1: CDC's Indicators of Community Transmission

Indicator	Low Transmission	Moderate Transmission	Substantial Transmission	High Transmission
Total new cases per 100,000 persons in the past 7 days	0-9	10-49	50-99	≥100
Percentage of Nucleic Acid Amplification Test results that are positive during the past 7 days	<5.0%	5.0%-7.9%	8.0%-9.9%	≥10.0%

Mask Use as Source Control for Influenza Season

1. Per NYSDOH, all healthcare personnel not vaccinated for influenza for the current influenza season will wear a surgical or procedure mask while in areas where residents/patients are typically present when the NYS Health Commissioner announces Influenza is widespread.
2. The facility will maintain a line list of all staff who are not vaccinated against influenza and cross reference to ensure compliance with flu masking requirement.

REFERENCES

CDC (9/23/2022). Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

CDC. Covid Data Tracker. https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk

CDC (2/25/2022). Indicators for Monitoring Covid-19 Community Levels and Covid-19 and Implementing Covid-19 Prevention Strategies. https://www.cdc.gov/coronavirus/2019-ncov/downloads/science/Scientific-Rationale-summary-COVID-19-Community-Levels.pdf

NYSDOH (2/10/2023). NH DAL #23-02. NYSDOH Guidance for Use of Face Masks and Face Coverings in Healthcare Facilities. https://www.health.ny.gov/professionals/hospital_administrator/letters/2023/docs/dal_23-02.pdf

NYSDOH (11/19/2014). Prevention of Influenza Transmission by Healthcare and Residential Facility and Agency Personnel. https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/2014-11-19_prevention_of_influenza_transmission.pdf

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy# **ENV-48 (b)**	
Issue Date: 03/2021	Revision Date: 07/2021	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Cleaning and Disinfecting Resident's Rooms and Equipment**			
Approved by: Environmental Services, Administrator, Director of Nursing, Infection Preventionist, QAA Committee			Page 1 of 5

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, Covid-19), 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. 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
6. 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.
7. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently.
8. Floor mopping solution will be replaced every 3 resident rooms, or at least every hour, whichever comes first.
9. 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.
10. 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.
11. Perform hand hygiene (wash hands with alcohol-based hand rub [ABHR] or soap and water for 20 seconds) after removing gloves.
12. 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. May use purple top wipes, unless *Clostridium difficile* or *Candida auris* present (then use orange top wipe). Do not use feather dusters.
7. Clean personal use items (e.g. lights, phones, call bells, bedrails, bed remote, etc.) with disinfection solution daily. May use purple top wipes for surfaces other than floor, unless *Clostridioides difficile Candida auris* or norovirus (then use orange top wipe)
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. May use orange top wipe for *Clostridioides difficile*, *Candida auris*, and Norovirus, for surfaces other than floor.
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 OR when room is/has been occupied by someone with a multi-drug resistant organism (MDRO)
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, ventilator, 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.

NORTHERN MANHATTAN NURSING HOME
POLICIES, PROCEDURES AND INFORMATION

Manual Code No: ENV-48
Page No: 1 of 1

Title: Cleaning and Disinfection of Environmental surfaces

Issued By: Environmental Services

Effective Date: 10/95	Last Review Date: 03/23	Supersedes:

Distribution:

POLICY:

Environment surfaces will be disinfected on a regular basis or when surface are visibly soiled according to current CDC and DOH recommendation for disinfection of health care facilities. All surfaces are cleaned in the following manner.

- **SUPPLIES AND EQUIPMENT**

Clorox Bleach
Germicidal Cleaner (Sodium Hypochlorite)
Gloves, Mask, Safety Glass
Paper Towels
Trigger Spray Bottles (1Quart)
Caution Signs

PROCEDURE:

1. Set up caution sign.
2. Remove all item from surface.
3. Spray surface with Clorox Bleach Germicidal cleaner.
4. Allow three minutes contact time.
5. Wipe clean with paper towel.
6. After cleaning surface discard paper towels.
7. Leave to air dry.
8. Repeat as needed.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER

RESIDENT ROOM CLEANING LOG

TIME STARTED THE CLEANING _____

Floor:_____ **Room #s:**_____ **Name:**_____

	(Initial when) (completed)	(Super.ENV) (Initial)
Empty trash in all resident rooms		
High dust vents/light & all dispensers in bathroom /resident room		
Replenish liquid soap		
Replenish paper towels		
Clean the toilet bowl w/bowl cleaner		
Clean the sink & mirror		
Clean windowsill & blinds		
Clean overbed table		
Dust/wet mop floor bathroom floor		
Dust furniture		
Disinfect phone		
Move furniture off the walls and dust/wet mop behind bed		
Check curtain drapes to ensure that they are clean		
Spot clean walls (smudges & marks)		
Make sure furniture in the room is uniformed		
Dust /wet mop the entire room from the farthest corner to the door		
Make sure the room is free of odors		
Place wet floor sign in the doorway		
Remove wet floor sign from the doorway once the floor is dry		

1. All surfaces cleaned with: Bleach germicidal cleaner (Sodium Hypochlorite)

2. Floors cleaned with: (3M) 5H Quat Disinfectant (Quaternary Disinfectant)

3. Toilet bowl cleaned with: Comet with chlorine

PLEASE CHECK OFF BOX WHEN ROOM IS CLEAN

ADDITIONAL COMMENTS:

901[]	905[]	909[]	913[]	917[]	921[]
902[]	906[]	910[]	914[]	918[]	922[]
903[]	907[]	911[]	915[]	919[]	Dining Room []
904[]	908[]	912[]	916[]	920[]	Day Room[]

Northern Manhattan Rehabilitation and Nursing 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:
(Facility to determine frequency of cleaning – e.g., daily/weekly, etc.)

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

Mark the monitoring method used:

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

Auditor's Name: _____ Date: _____

Northern Manhattan Rehabilitation and Nursing 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/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			
Ventilator			

Mark the monitoring method used:

☐ Direct observation

Auditor's Name: _____ Date: _____

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 06/28/2020	Revision Date: 07/13/2020; 09/16/2020; 02/24/2021; 03/26/2021; 04/16/2021; 07/09/2021; 11/18/2021; 01/14/2022; 09/08/2022; 10/13/2022; 03/20/2023;	Review Date: 03/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – Visitation Guidelines Post COVID-19 Public Health Emergency.**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			

POLICY

It is the policy of this facility to promote and support visitation for residents, families and resident representatives while ensuring safety as well as adherence to infection prevention strategies to minimize any potential spread of infection. This will be done in accordance with all regulatory requirements.

PURPOSE

To promote residents' quality of life and psychosocial well- being by ensuring and promoting visitation for all residents.

PROCEDURE

General Visitation Guidelines

1. The facility will provide immediate access to all residents by the following individual(s): any representative of the Secretary of the Department of Health and Human Services, any representative of the State, the resident's primary care physician, the Ombudsman, and the agencies responsible for the protection and advocacy system for the developmentally disabled and mentally ill.
2. The resident has the right to receive visitors of his/her choosing at a time of his/her choosing, subject to the resident's right to deny visitation when applicable, in a manner that does not impose on the rights of other residents.
3. The facility will provide:
    a. immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny/withdraw consent at any time;
    b. immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;
    c. reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.
4. Visitors are not subject to visiting hour limitations unless imposed by the resident.
5. The facility may place reasonable clinical and safety restrictions on visitation to protect the health and security of all residents and staff under the following circumstances:
    a. To prevent community-associated infection or transmission of communicable diseases to one or more residents.
    b. When a visitor is suspected of abusing, exploiting, or coercing a resident until an investigation into the allegation has been completed or has been found to be abusing, exploiting, or coercing a resident. In such instances, visitation may be supervised or denied.
    c. When visitor(s) have been found to have been committing criminal acts such as theft.
    d. When visitor(s) have been found to be inebriated or disruptive.
    e. When visitor(s) who have a history of bringing illegal substances into the facility which places residents' health and safety at risk. In such instances, visitation may be supervised or denied.
6. Visitation will be deferred for visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication), or according to CDC guidelines, and/or local health department recommendations.
7. Any visitor who behaves in an inappropriate manner and violates the rights of any resident, staff, or visitor will be asked to leave the facility. If they are assessed to be an immediate danger, the security guard will be called to the specific location and escort the individual(s) out of the facility. Local law enforcement may be called for visitors whose behavior(s) escalates and refuses to leave the facility.
8. Residents and/or their visitors may request private spaces. For example, privacy for visitation or meetings can be arranged in lounges or dining areas between meal times. Arrangements for private space can be made in advance with the Therapeutic Recreation Department.
9. Visitors may not bring in food from the outside until they are informed about dietary restrictions such as diabetic, renal, or dysphagia diets.

10. Visitors may not purchase or assist with purchasing of items from the cafeteria or vending machines for residents who are not their own loved ones for safety reasons.
11. Visitors may not perform activities that require specific training, unless they have been educated and deemed competent by professional staff to perform the activity. Facility staff will provide periodic monitoring of visitor participating in simple caregiving activities.

Guidelines for Visitation During a Communicable Disease Outbreak

- The facility may modify visitation practices when there are infectious outbreaks or pandemics to align with current NYSDOH, CMS guidance and CDC guidelines that enables maximum visitation.
- Residents on transmission-based precautions may still receive visitors. Visitors will be cautioned of the potential risks associated with visiting.
- Facility visitation may be conducted through a variety of means - in resident rooms, outdoors (weather permitting), designated visitation spaces, and virtually.
- The facility will post signage in highly visible areas with instructions for infection prevention; for example, hand hygiene, cough etiquette, physical distancing, immunizations, etc.
- The facility will have readily available access to hand hygiene supplies, for example, alcohol-based hand sanitizers.
- The facility will allow the number of visitors based on the ability to adhere to infection control principles, including the ability to maintain physical distancing between residents and visitors, as applicable.
- The facility will collaborate with Local and State health departments, when applicable, for guidance on how to structure visitation to reduce the risk of communicable disease transmission during an outbreak.
- If any visitor fails to adhere to the visitation protocols, he/she/they will be asked to leave and may not be permitted to visit in the future (CMS QSO-20-39-NH, rev 11/12/2021)

COVID-19 Visitation Guidelines (CMS QSO-20-39-NH, rev 9/23/2022)

1. Facility will utilize the core principles of Covid-19 infection prevention to promote safe visitation and decrease the risk of Covid-19 spread.
2. The facility will allow the number of visitors based on the ability to adhere to infection control principles, including the ability to maintain physical distancing between residents and visitors, as applicable.
3. The facility may choose to encourage visitor testing when community transmission levels are high.
    - Visitors may continue to use either PCR testing or antigen testing.
    - Facility cannot deny visitor the right to visit if they do not have a Covid-negative test. Consider designated visitation area for visit to take place.
4. Facility visitation may be conducted through a variety of means - in resident rooms, outdoors (weather permitting), designated visitation spaces, and virtually.
5. The facility will post signage in highly visible areas (e.g., entrances, exits, elevator banks, etc.) with instructions for infection prevention, including Covid-19 (example, hand hygiene, cough etiquette, physical distancing, immunizations, etc.).
6. The facility will post signage in highly visible areas (e.g., at entrances) about recommended actions for visitors who have a positive viral test for Covid-19, symptoms of Covid-19, or have had close contact with someone with Covid-19.
7. Residents on transmission-based precautions may still receive visitors. Visitors will be cautioned of the potential risks associated with visiting.
    - In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated).
8. Visitors with confirmed Covid-19 infection or compatible symptoms will be advised to *defer* non-urgent in-person visits until they meet the CDC criteria for healthcare settings to end isolation.
9. Visitors who have had close contact with someone with Covid-19 infection will be advised to *defer* non-urgent in-person visitation until 10 days after their close contact if they meet the criteria described in CDC healthcare guidance (e.g., cannot wear source control).
10. All visitors age two and older are required to wear a face mask/covering, as medically tolerated, regardless of vaccination status, while visiting when county transmission levels are high(refer to facility Mask PP.
11. In order to limit movement in the facility during visitation while there is an outbreak investigation, the following guidelines will be followed:
    - Visitor(s) will go directly to the resident's room or designated area.
    - If a resident shares a room, the facility will attempt to facilitate in-room visitation while adhering to the core principles of infection prevention as related to Covid-19.
    - Visitors will be encouraged to physically distance themselves from other residents and staff, when possible.

REFERENCES:

CMS (Rev 173, 11-22-17). State Operations Manual. F563: Right to Receive Visitors, pp 27 – 30.

CMS (Rev 9/23/2022). Nursing Home Visitation – COVID-19. https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

CDC (9/23/2022). Interim Infection Prevention and Control Recommendation for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

CMS (Rev 9/26/2022). QSO-20-38-NH: Interim Final Rule (IFR), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to Covid-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf

CMS (Rev 9/26/2022). QSO-20-39-NH. Nursing Home Visitation – Covid-19. https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

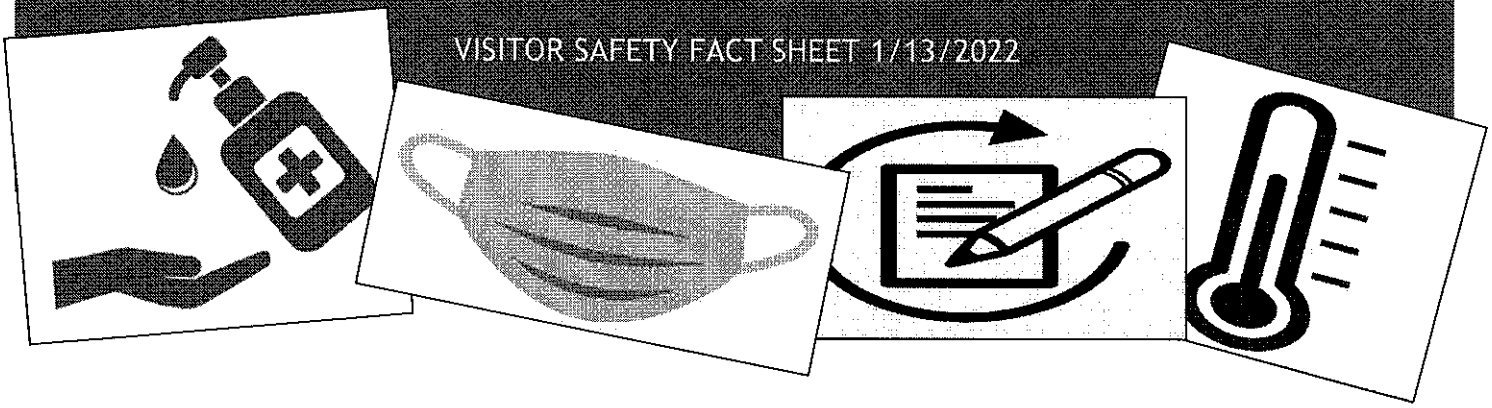
NYSDOH (10/13/2022). Health Advisory: Nursing Home Testing, Cohorting and Visitation Guidance. https://commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/Health_Advisory__Nursing_Home_Testing,_Cohorting_and_Visita_1665772061063_0.pdf

NYSDOH (2/10/23) Health Advisory: Microsoft Word - HCF Mask Guidance Advisory final 2.9.23 (002).docx (state.ny.us)

NYSDOH Health Advisory (3/17/23) NH_Visitor_Testing_Health_Advisory_3_1679063367607_0.17.23.pdf (state.ny.us)

COVID-19 VISITOR GUIDANCE

VISITOR SAFETY FACT SHEET 1/13/2022



Welcome Back Families & Healthcare Representatives:

Northern Manhattan may conduct limited visitation and activities under the following revised NYSDOH guidelines, which align with CMS and CDC guidelines.

1. All Visitors must follow the core principles and best practices to reduce the risk of Covid-19 transmission by:
    a. performing hand hygiene upon entering the building and before leaving visitation area,
    b. wearing a paper face mask or higher-level mask to cover mouth and nose at all times when the county's transmission rate is substantial too high or as instructed by the Facility.
    c. maintain physical distancing of at least 6 feet from residents, staff, and other visitors.
2. Visitors are required to notify the facility's **Infection Preventionist, Mrs. Ngozi Nwaiwu, Director of Nursing Services 1-212-426-1284 Ext. 1104** if they experience any Covid-like symptoms, have been exposed to someone with Covid or tests positive for Covid within 48 hours of the visit.
3. Visitors are not permitted to walk throughout the facility and must stay in the resident's room or designated visiting area.
4. While there is no limitation on the number of visitors a resident can receive, we respectfully ask that you limit the number of visitors in order to ensure social distancing rules are followed. If you would like to visit in a larger group, please contact **Mr. Donald Devore, Director of Therapeutic Recreation, 1-212-426-1284 Ext. 1141** so that appropriate accommodation can be made for you and your loved ones.
5. The facility may need to make accommodations for visiting to ensure safety of the roommate when visiting in a multi-resident room.
6. While not recommended because of increased risk of getting Covid, residents who are on isolation precautions or quarantine can still receive visitors. Visits will be limited to the resident's room. Facility requires all visitors to wear a mask and may require visitors to wear additional personal protective equipment (PPE) to include gown, gloves, mask, and eye protection.
7. Visitors who are unable to adhere to the facility's protocols will not be permitted to visit and will be asked to leave.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 06/2021	Revision Date:	Review Date: 03/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – Personal and Compassionate Caregiving Visitation During a Declared Public Health Emergency.**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			

POLICY STATEMENT

In accordance with New York State (NYS) Public Health Law (PHL), Chapter 108, Section 2801-h, this facility will allow residents visitation access to their designated personal and compassionate caregivers, notwithstanding general visitation restrictions in the facility during a public health emergency to meet the physical, emotional, and psychosocial needs of the residents.

PURPOSE

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

DEFINITIONS:

Personal Caregiving Visitor (PCV): a family member, close friend, or legal guardian of a resident designated by such resident, or such resident's lawful representative, to assist with personal caregiving or compassionate caregiving for the resident.

Personal Caregiving: care and support of a resident to benefit such resident's mental, physical, or social well-being.

Compassionate Caregiving: personal caregiving provided in anticipation of the end of the resident's life or in the instance of significant mental, physical, or social decline or crisis. It includes providing care to a resident who is at the end of life; is struggling with the change in environment and lack of physical family support; is grieving after a friend or family member recently passed away; needs cueing and encouragement with eating or drinking, and such cueing was previously provided by family and/or caregiver(s), and the resident is now weight loss or dehydration; used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

PROCEDURE:

1. The facility will provide education to residents and/or designated health care representatives regarding personal and compassionate caregiving visitation. Education will include:
    - The number of personal or compassionate caregivers at a time (maximum 2)
    - The need to test for any communicable disease, as applicable (currently, NYS recommends visitors test for Covid-19, but it is not a requirement).
    - Temperature and health screening
    - Utilizing personal protective equipment (PPE), as applicable
    - Maintaining social distancing (except as necessary for personal caregiving by the personal caregiving or compassionate caregiving visitor)
    - Any additional requirement as set forth by NYS Department of Health
2. The Department of Social Services will be responsible for determining which individual(s) residents and/or their designated healthcare representatives would like to elect to serve as their personal and/or compassionate care visitor(s), including if the resident is determined to lack decision making capacity
    - This can be done via phone/video call, e-mail, or mailed letter
3. The facility will maintain a record of the resident's designated personal and/or compassionate caregiving visitors in the resident's comprehensive plan of care and document when personal and/or compassionate caregiving is provided in the resident's comprehensive plan of care.
4. The facility will update designated personal and/or compassionate care visitors upon admission/re-admission, quarterly, upon resident's change in condition, and as necessary.

5. The facility reserves the right to determine the frequency and duration of personal and/or compassionate care visitation based on the resident's clinical and/or personal care needs.
    - Visits and duration will be adjusted based on individual resident needs
6. In situations where there is a roommate, the facility will stagger the visits to ensure the roommate has adequate privacy and space to receive care.
7. The facility may temporarily suspend, limit, or prohibit personal caregiving visitors to protect the health, safety, and welfare of residents if:
    - The facility has reasonable cause to believe that a resident will not benefit from accessing their designated personal caregiving visitors (has to be documented in comprehensive plan of care)
    - The declared public health emergency (PHE) is related to a communicable disease and the Department determines that local infection rates are at a level that presents a serious risk of transmission of such communicable disease within local facilities;
    - The facility is experiencing inadequate staffing and has reported such staffing shortage to the Department of Health;
    - An acute emergency situation exists at the facility (e.g., loss of heat, loss of elevator service, or other temporary loss of an essential service).
    - The facility has reasonable cause to believe that permitting the personal caregiving visitor to meet with the resident is likely to pose a threat of serious physical, mental, or psychosocial harm to a resident.
        - In this situation, the facility will document the date of and reason for visitation refusal in the resident's comprehensive plan of care. Facility will also notify the resident and/or designated representative on the same date of the refusal.
8. In the event that personal caregiving visitation is temporarily suspended or limited, the facility will:
    - Notify all residents, designated personal caregiving visitors, and the applicable DOH Regional Office within 24 hours of implementing the suspension or limitation.
    - Document the specific reason for the suspension or limitation in administrative records daily.
9. The facility will refuse access to or remove from the premises any personal and/or compassionate caregiving visitor who is causing or reasonably likely to cause physical injury to any facility resident or personnel.
10. The facility will require all personal and compassionate caregiving visitors to adhere to infection control measures including screening and testing for communicable disease, temperature screening (access will be denied to anyone with temp >100°F), utilizing personal protective equipment (will be provided by facility) as applicable, and maintaining social distancing when not providing personal care.
11. All personal and/or compassionate care visitors are required to perform hand hygiene, get temperature checked, and perform health screening prior to proceeding beyond entry point/lobby area of facility.
    - May be done by front desk personnel.

EFFECTIVE: 6/9/2021

REFERENCE:

NYSDOH (6/1/2021), Personal Caregiving and Compassionate Caregiving Visitors in Nursing Homes and Adult Care Facilities. https://regs.health.ny.gov/sites/default/files/pdf/emergency_regulations/Personal%20Caregiving%20and%20Compassionate%20Caregiving%20Visitors%20in%20Nursing%20Homes%20and%20Adult%20Care%20Facilities.pdf

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 06/2021	Revision Date:	Review Date: 03/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – Personal and Compassionate Caregiving Visitation Simplified**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			

POLICY STATEMENT

In accordance with New York State (NYS) Public Health Law (PHL), Chapter 108, Section 2801-h, this facility will allow residents visitation access to their designated personal and compassionate caregivers, notwithstanding general visitation restrictions in the facility during a public health emergency to meet the physical, emotional, and psychosocial needs of the residents.

PURPOSE

To prevent emotional and social isolation

Compassionate Caregiving Visitation

- Occurs, notwithstanding general visitation restrictions
- Provided in anticipation of the end of the resident's life or in the instance of significant mental, physical, or social decline or crisis.

Personal Caregiving and Compassionate Caregiving Visitation

- **Personal Caregiving Visitor**: a family member, close friend, or legal guardian of a resident designated by such resident, or such resident's lawful representative, to assist with personal caregiving or compassionate caregiving for the resident.
- Personal caregiving visitation may be subject to certain limitations
    - Increased local infection rates
    - Temporary inadequate staff capacity
    - Acute emergency situation (e.g., loss of an essential service)
    - Personal caregiver poses a threat to the safety and well-being of the resident or any resident or personnel in the facility.
- Resident and/or designated healthcare representative to elect individuals to provide personal caregiving and/or compassionate caregiving visits – no more than 2 visitors)
- Can have no more than 2 visitors at a time
- Facility to determine frequency and duration of visits
- If there's a roommate, coordinate visits so each resident has adequate privacy and space to receive care
- Health and temperature screening to be done before entering beyond lobby area
- Infection control protocols to be followed (PPE as necessary, maintaining social distancing except when providing personal care)
- Facility reserves the right to temporarily suspend, limit, or prohibit personal caregiving visitors to protect the health, safety, and welfare of residents in certain situations.
- The facility has the right to refuse access to or remove from the premises any personal and/or compassionate caregiving visitor who is causing or reasonably likely to cause physical injury to any facility resident or personnel.

REFERENCE:

NYSDOH (6/1/2021). Personal Caregiving and Compassionate Caregiving Visitors in Nursing Homes and Adult Care Facilities. https://regs.health.ny.gov/sites/default/files/pdf/emergency_regulations/Personal%20Caregiving%20and%20Compassionate%20Caregiving%20Visitors%20in%20Nursing%20Homes%20and%20Adult%20Care%20Facilities.pdf

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 07/15/2020	Revision Date: 02/24/2021; 03/26/2021; 04/16/2021;	Review Date: 03/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – Visitation Guidelines During a Pandemic.**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing Center to promote and support 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.

PURPOSE

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

NYSDOH CRITERIA (revised 3 25 21)

Northern Manhattan may conduct limited visitation and activities under the following revised NYSDOH guidelines.

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.

1. 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 nonpositive residents.
2. 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(s)
3. 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. Visitors may be asked for ID as needed. Visitors are required to submit a COVID-19 negative test result within 3 days of the scheduled visit (regardless of the visitor's vaccination status).
4. The facility will conduct screening of all who enter the facility for signs and symptoms of COVID-19, including temperature checks, questions about and observations of signs or symptoms. This includes denial of entry for those with signs/symptoms or close contact with someone with COVID-19 infection in the past 14 days.

    In addition to screening questions, the visitor will agree that they will report any positive COVID-19 test or symptoms that occur 48 hours after a visit. Exposures will follow Contact Tracing guidelines. This will include initiating Contact Tracing upon notification from a visitor that he/she tested positive for SARS-CoV-2 by a diagnostic test, and/or developed symptoms associated with COVID-19 during the forty-eight hours following visitation. The facility will use the following guidelines to determine the potential for exposure:
    a. The visit was supervised by a staff member and all IC principles were followed, including the use of face mask/face covering, 6 feet physical distancing between the resident/visitor and all other residents/visitors.
    b. The visit was conducted in a common area or outdoor area that does not require the visitor to enter a resident unit.

5. If all IC principles were not met in an exposure, the facility will initiate outbreak response including Transmission-Based Precautions on affected unit(s) or entire facility as necessary. Serial testing for all staff and residents every 3-7 days until there are no positives in 14 days.
6. Documentation of screening will be maintained in an electronic format and available upon request of the NYSDOH.
7. Monitoring symptomatic residents must include daily symptom checks, vital signs, and pulse oximetry.
8. 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 regulatory reasons associated with COVID-19 infection.

PROCEDURE

- The facility will expand visitation and/or activities while following NYSDOH and Federal guidance.
- Facility visitation can be conducted through a variety of means:
    a. In resident rooms
    b. Dedicated visitation spaces
    c. Outdoors (preferred, weather permitting)
- At the discretion of the facility and in order to limit movement in the facility during visitation, the following guidelines will be followed:
    a. If weather permits, visitation may take place in the designated outdoor area(s) or designated monitored indoor area. The outdoor patio area can accommodate up to three (3) visiting stations.
    b. If weather does not permit, visitation will take place in the designated monitored indoor area(s). The Recreation Room located on the Main floor can accommodate up to five (5) visiting stations.
    c. In instances when the resident cannot leave his/her room due to medical/psychosocial reasons, visitation may take place in the resident's room.
        - Visitor(s) will be escorted to the resident's room or designated area.
        - If a resident shares a room, visitation will not be conducted in the resident's room (arrangement will be made for designated room/area)

Visits will be made in advance and scheduled online via the facility's website or by Therapeutic Recreation, Social Services, Nursing and/or Administration representatives via phone. Visits allow for no more than two visitors in the visiting station. Visits will be limited to 45-minutes.

OUTDOOR VISITATION

Outdoor visitation is preferred and can continue during an outbreak for residents who are not on transmission-based precautions or quarantine. Facilities will need to determine on a case-by-case basis whether an outbreak would affect outdoor visitation. For example, if the outbreak is larger or responding to the outbreak requires more attention by staff, then outdoor visitation may need to be on hold temporarily (*CMS DNH Triage 4/11/21).

INDOOR VISITATION

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), **except for** a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. An exception for compassionate care visits should be permitted at all times. These scenarios include limiting indoor visitation for:

- Unvaccinated residents if the nursing home's COVID-19 county positivity rate is >10% AND less than 70% of residents are vaccinated.
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met criteria to discontinue Transmission-Based Precautions or
- Residents in quarantine, whether they are vaccinated or unvaccinated until they have met criteria for release from quarantine.

Indoor visitation can still occur when there is an outbreak, but there is evidence that transmission is contained to a single area /unit. The facility will initiate serial testing and resume visiting based on the following:

a. If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. Example - if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

b. If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitations for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing in accordance with CMS guidance 42CFR 483.80(h) of testing all residents and staff every 3-7 days until there are no new positives for 14 days.

* Note: The facility will follow all NYS Executive Orders that are in effect, including 202.88 which presently requires staff testing twice weekly.

- 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 N-List disinfectant.
- The facility will post signage regarding facemask utilization and hand hygiene and uses applicable floor markings for social distancing.
- 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;
- 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 on hand for visitors as needed.
- Visiting areas will have easily accessible Alcohol-Based Hand Rub for residents, visitors, and staff.
- Visitors who are younger than 18 years old must be accompanied by an adult 18 years of age or older.
- The facility will allow the number of visitors based on the ability to adhere to IC principles, including the ability to maintain 6 feet physical distancing between all residents and all visitors.
- Facility staff will ensure residents /visitors do not interact with other residents and their visitors
- The facility will provide times allocated for each visit session to ensure all residents/loved ones can be accommodated with scheduling.
- 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.
- Newly admitted residents that are fully vaccinated and residents who have recovered from covid-19 infection within the last 90 days do not need to be quarantined when admitted to a nursing home. This is in alignment with CDC guidance on new admissions (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#new-admissions).
  Note: Fully vaccinated refers to a person who is greater or equal to two (2) weeks following receipt of the second dose in a 2-dose series, or greater or equal to two (2) weeks receipt of one dose of a single dose vaccine, per CDC's Public Health Recommendations for Vaccinated Persons.
- 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.
- Facilities should limit movement in the facility.
    a. i.e., Visitors should not walk around throughout the facility. Instead, they should go directly to the area dedicated to visitation or the resident's room. If a resident shares a room, visitation should not be conducted in the resident's room. For situations where there is a roommate and health status of the resident prevents them from leaving the room, facilities should try to facilitate in-room visitation while following principles of COVID-19 infection prevention.
- 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.

COMPASSIONATE CARE VISITS

Compassionate Care Visits are permitted when visitation may not otherwise be permitted (in accordance with NYSDOH current visitation guidance), and facilities may waive requirement of a visitor presenting a negative COVID-19 test prior to

commencement of such visit. Companionate care situations may be considered by the facility on a resident-specific basis. Testing to be encouraged / facilitated wherever possible.

END OF LIFE VISITS

For any resident assessed to potentially be at the end-of-life, family/resident representative will be contacted by Social Worker/Designee to allow visitation. Testing is not required for end-of-life visits. Family will be screened, provided with PPE and escorted to resident's room.

REFERENCES:

NYSDOH (9/15/2020). Health Advisory: Skilled Nursing Facility Visitation. https://health.ny.gov/facilities/nursing/docs/2020-09-15_nursing_facility_visitation.pdf

CMS (9/17/2020). Ref: QSO-20-39-NH. Nursing Home Visitation: Covid-19. Nursing Home Visitation-COVID-19 (mo.gov)

NYSDOH (Rev 2/22/2021). Health Advisory: Skilled Nursing Facility Visitation. https://www.governor.ny.gov/sites/default/files/atoms/files/NH_Visitation_update_2-22-2021.pdf

CMS (3/10/2021). Ref: QSO-20-39-NH. Nursing Home Visitation: Covid-19 (Revised). QSO-20-39-NH Revised (cms.gov)

NYSDOH (3/25/2021). Health Advisory: Skilled Nursing Facility Visitation. https://coronavirus.health.ny.gov/system/files/documents/2021/03/updated_nursing_home_visitation_guidance.pdf

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Facility Health Screening Check During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

Northern Manhattan Rehabilitation and Nursing Center will conduct required COVID-19 screening checks for anyone entering the facility during COVID-19 outbreaks.

PROCEDURES

1. The facility will have one accessible entrance into the building to conduct COVID-19 screening checks. All individuals being screened will be required to adhere to social distancing practices and wear a facemask/face cloth covering the entire time in the facility.

2. The following **essential employees/HCP and individuals** listed below **will be allowed** to enter the facility but only after a COVID-19 screening has been conducted.
   - Facility employees and agency staff,
   - Essential healthcare personnel including hospice staff, Medical Providers/Consultant contractors,
   - Laboratory and diagnostic personnel,
   - EMS personnel,
   - Transportation personnel (dialysis and chemotherapy appointments),
   - Government personnel from NYSDOH, local DOH, CMS, and CDC,
   - Family members, visitors, clergy, bereavement counselors (only during compassionate care visits approved by Administrator),
   - Pharmacy vendor personnel (medication delivery),
   - Essential contractors involved in meeting the resident needs or for maintaining the operations of the facility.

3. The following **non-essential individuals** listed below **will be restricted** from entering the facility to prevent potential transmission of COVID-19 illness:
   - Visitor/family routine social visits (except for end-of-life/compassionate visits),
   - Non-urgent medical consultation visits (telemedicine visits are preferred),
   - Food delivery drivers,
   - Barbers/hairstylist, etc.,
   - Activity entertainment vendors,
   - Volunteers,
   - Non-essential supply vendors (see below).

4. Whenever possible, supply vendors will not enter the facility when making deliveries. The facility will coordinate with the vendors the time and drop-off location (e.g. loading dock) when delivering supplies.

5. The Administrator may authorize a vendor facility access whenever supplies being delivered outside the facility are not feasible (e.g. vending machine personnel). Whenever the Administrator has authorized vendor access, those personnel will be required to undergo a health screen check and enter the designated accessible entrance screening station/area prior to delivery of supplies.

6. The screening station/area will be equipped with thermometer, PPE supplies, alcohol-based hand rub and EPA approved COVID-19 disinfectant wipes to clean and disinfect the screening area between each individual being screened.

7. Visitors/contractors will be asked the purpose of their visit and be reminded to frequently wash their hands or use alcohol-based hand rub (ABHR) during their visit. Visitors will be advised to restrict their visit to the resident's room or other location designated by the facility, adhere to social distancing, not to touch surfaces, not shake hands with, touch or hug individuals. They will be educated on mask-wearing procedure.

8. All employees and HCP/Consultants, etc. will be required to wear a surgical face mask or N-95 or equivalent respirator upon arrival to the facility and during the duration of their scheduled shift. HCP whose duties do not require PPE (e.g. clerical personnel) can wear a cloth face mask covering for source control while in the health care facility. Hand hygiene will be performed immediately before and after any contact with facemask.

9. Designated staff will be assigned on each shift to conduct the COVID-19 screenings. All individuals being screened will be required to complete a COVID-19 questionnaire to obtain information related to active signs and symptoms of illness (e.g. new or change in cough, shortness of breath, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, confusion, rhinorrhea, hemoptysis, nausea, vomiting, diarrhea), recent international travel and infection control practices.

10. Health screen checks will also include actively taking the individual's temperature. Whenever temperature reading is above 100°F or individual is complaining of not feeling well, the Infection Control Preventionist (ICP) will be notified. The individual will be asked to wear a facemask and leave the facility and seek medical treatment. Employees/HCP cannot return to work until free of communicable disease.

    Note: A medical evaluation may also be warranted for a temperature lower than 100°F when other COVID-19 symptoms are evident.

11. All employees, agency staff and HCP will be required to have their temperature taken on each shift and no less than every 12 hours.

12. The ICP will be notified whenever the HCP/individual has an elevated temperature or the COVID-19 screen check questionnaire indicates COVID-19 illness or international travel. The individual will be asked to put on a facemask, and leave the facility. They will be advised that they **cannot** return to work until approved by their Physician.

13. The designated personnel conducting the COVID-19 health screening checks will document presence or absence of symptoms on the COVID-19 Health Screening Log and maintain the log with daily questionnaire as proof of conducting screen checks. This log will be utilized to track symptomatic and asymptomatic individuals entering the facility.

14. The ICP will conduct random infection control surveillance rounds on all shifts to ensure PPE is being properly used and employees are able to properly demonstrate knowledge of donning/doffing of PPE and transmission-based precautions.

15. The Director of Nursing/ICP will document employees/agency staff and HCPs signs and symptoms of illness on the respiratory line listing and report to government agencies as required.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Staff Screening and Monitoring During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

In the event of a Pandemic, Northern Manhattan Rehabilitation and Nursing Center 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.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 08/12/2021	Revision Date: 12/29/2021; 01/05/2022; 01/12/2022; 02/09/2022; 04/24/2022; 10/13/2022; 11/30/2022;	Review Date: 03/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – Return to Work After Exposure to or COVID-19 Infection**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of this facility to follow Centers for Disease Control and Prevention (CDC) and New York State Department of Health (NYSDOH) guidance to guide decision making about return to work for nursing home staff after a Covid-19 exposure or after a Covid-19 infection. The facility will maximize interventions to protect staff, residents, and visitors at all times, including when considering strategies to address staffing shortages.

DEFINITION

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

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

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

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

Severely Immunocompromised:
- Being on chemotherapy for cancer,
- Being within one year out from receiving a hematopoietic stem cell or solid organ transplant,
- Untreated HIV infection with CD4 T-lymphocyte count < 200,
- Combined primary immunodeficiency disorder, or
- Receipt of prednisone >20 mg/day for > 14 days.

Prolonged Close Contact: a cumulative time period of ≥15 minutes during a 24-hour period.

Fully Vaccinated: ≥2 weeks following receipt of the 2nd dose in a 2-dose series, or ≥2 weeks following receipt of 1 dose of a single-dose vaccine

Up to Date: a person has received all recommended Covid-19 vaccines, including any booster dose(s) when eligible.

PROCEDURE
The facility will follow all DOH and CDC guidance to determine when employees can return to work after a Covid-19 **infection or exposure.**

1. **Conventional Strategies**

Staff with confirmed SARS-CoV-2 Infection:

- Staff with mild to moderate illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:
  - At least 7 days have passed *since symptoms first appeared* if a negative viral test is obtained within 48 hours prior to returning to work or 10 days if testing is not performed or if a positive test at day 5-7), **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
  - Symptoms (e.g., cough, shortness of breath) have improved
  - Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

- HCP who were *asymptomatic* throughout their infection and are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:
  - At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).
  - Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.
- HCP with severe to critical illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:
  - At least 10 days and up to 20 days have passed *since symptoms first appeared,* **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
  - Symptoms (e.g., cough, shortness of breath) have improved.
  - The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

- **A Test Based Strategy may be considered for return to work as outlined below**:

  - **HCP who are symptomatic could return to work after the following criteria are met:**
    - Resolution of fever without the use of fever-reducing medications, **and**
    - Improvement in symptoms (e.g., cough, shortness of breath), **and**
    - Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

  - **HCP who are not symptomatic could return to work after the following criteria are met:**
    - Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

2. **Staff with a Higher Risk Exposure:**
Work restriction is not necessary for asymptomatic HCP following a higher-risk exposure, regardless of vaccination status
   - Higher-risk exposures are classified as HCP who had prolonged close contact with a resident, visitor, or HCP **with** confirmed SARS-CoV-2 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an **aerosol-generating procedure**

- Following a higher-risk exposure, HCP will:
  - Have a series of three viral tests for SARS-CoV-2 infection.
    - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will be day 1 (where day of exposure is day 0), day 3, and day 5.
    - Testing will not be done for asymptomatic staff that have recovered from SARS-CoV-2 infection in the prior 30 days.
    - Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. (This is because some people may remain NAAT positive but not be infectious during this period.)
    - Staff will follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive

- Work restriction may be necessary for asymptomatic HCP following a higher-risk exposure if
  - HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure.
  - HCP is moderately to severely immunocompromised.
  - HCP cares for or works on a unit with patients who are moderately to severely immunocompromised.
  - HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

3. If work restriction is recommended, HCP could return to work after either of the following time periods:
   - HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and **all viral testing** as described for asymptomatic HCP following a higher-risk exposure is negative.
   - If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

Mitigating Staffing Shortages that Threaten Provision of Essential Services:

This strategy will be implemented if the facility is expecting or experiencing staffing shortages due to COVID 19 outbreaks

- The facility will Inform residents and staff when the facility is utilizing these strategies, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2
- The Facility will allow staff with SARS-CoV-2 infection who are well enough and willing to work to return to work as follows:

Contingency Strategy:

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

- At least 5 days have passed *since symptoms first appeared* (day 0), **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.
- The facility may choose to confirm resolution of infection with a negative nucleic acid amplification test (NAAT) or a series of 2 negative antigen tests taken 48 hours apart*.

Staff that are asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 5 days have passed since the date of their first positive viral test (day 0).
- During Contingency and/or crisis mode staff will utilize well fitting mask/N95, including in break rooms, and maintain physical distancing

Crisis Staffing Strategy:

- The Facility will notify NYSDOH Surge and Flex **(917 909- 2676)** if "crisis" strategies are required and follow NYSDOH and CDC guidance.
- The Facility will initiate Incident Command Structure to address crisis emergency staffing
- The facility will temporarily stop new admissions and evaluate if any residents need to be transferred to other health care settings
- **If shortages continue despite other mitigation strategies, as a last resort the facility will consider allowing HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, if they are well enough and willing to work, even if they have not met all the contingency return to work criteria described above.**
- Considerations for determining which HCP should be prioritized for this option include:
    - Where individual HCP are in the course of their illness (e.g., viral shedding is likely to be higher earlier in the course of illness).
    - The types of symptoms they are experiencing (e.g., persistent fever, cough).
    - Their degree of interaction with patients and other staff in the facility.
    - The type of residents they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than patients who are immunocompromised).
- If staff are requesting to work before meeting all criteria, they should be restricted from contact with patients who are moderately to severely immunocompromised.
- Evaluate if staff with confirmed SARS-CoV-2 infection to provide direct care for residents with confirmed SARS-CoV-2 infection and/or exposed, preferably in a cohort setting.
- *Staff who are immunocompromised will consult with facility's employee health and/or Infectious Disease/PMD prior to returning to work.
- The Facility will communicate with NYSDOH Epidemiology as indicated

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Work Restrictions for Healthcare Personnel				
	Vaccination status	**Conventional**	**Contingency**	**Crisis**
Infected	Boosted, fully vaccinated	CDC Conventional Strategies: 10 days; or 7 days with negative test; asymptomatic or mildly symptomatic and improving	NYSDOH Shortening Isolation: 5 days, asymptomatic or mildly symptomatic and improving	Facilities contact NYSDOH and follow CDC Crisis Strategies
	UN-boosted, fully vaccinated	CDC Conventional Strategies: 10 days; or 7 days with negative test; asymptomatic or mildly symptomatic and improving	NYSDOH Shortening Isolation: 5 days, asymptomatic or mildly symptomatic and improving	Facilities contact NYSDOH and follow CDC Crisis Strategies
	Not fully vaccinated	CDC Conventional Strategies: 10 days; or 7 days with negative test; asymptomatic or mildly symptomatic and improving	CDC Conventional Strategies: 10 days; or 7 days with negative test; asymptomatic or mildly symptomatic and improving	Facilities contact NYSDOH and follow CDC Crisis Strategies
Exposed	Boosted, fully vaccinated	CDC Conventional Strategies: No work restrictions, negative test on days 2 and 5-7	CDC Contingency Strategies: No work restrictions	CDC Crisis Strategies: No work restrictions
	UN-boosted, fully vaccinated	CDC Conventional Strategies: 10 days, or 7 days with negative test	CDC Contingency Strategies: No work restrictions with negative tests on days 1, 2, 3, and 5-7	CDC Crisis Strategies: No work restrictions (test if possible). Facilities contact NYSDOH if unable to test.
	Not fully vaccinated	CDC Conventional Strategies: 10 days, or 7 days with negative test	CDC Contingency Strategies: No work restrictions with negative tests on days 1, 2, 3, and 5-7	CDC Crisis Strategies: No work restrictions (test if possible). Facilities contact NYSDOH if unable to test.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 9/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Infrared Body Temperature Measuring Device (Safe Space Scan)**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

As part of Northern Manhattan Rehabilitation and Nursing Center's Forward Safety Plan, which includes mandatory health screening assessments and temperature checks, an infrared body temperature measuring device (Safe Space Scan™) may be utilized as an alternative device for **non-contact temperature monitoring.**

PROCEDURE

The following safety protocols will be in place while conducting infrared body temperature checks utilizing the Safe Space Scanner™

- The security personnel/receptionist will ask persons who enter the facility to answer the COVID-19 questionnaire.
- Following the questions being answered, the receptionist will direct the individual to the Safe Space Scan™ device **ensuring at least 6 feet distance from others while awaiting screening**.
- Screened individuals must continue to wear a face covering while temperature check is being performed.
- Individuals will be instructed to approach the device from the side and stand 1-3 feet away from the device.
- Screened individuals should remove any glasses, hats, jewelry, etc. that could affect the temperature reading.
- The red and green box indicates the temperature is beginning to scan.
- The temperature displayed is to be documented on the COVID-19 Screening Log.
- If the temperature is abnormal (100°F or greater), the individual must be escorted outside the facility and the supervisor on duty notified.
- This is a non-contact device. Should the device inadvertently be touched, disinfect the device using 70% isopropyl alcohol (Purple PDI wipes in accordance with the appropriate contact time for disinfection).
- The housekeeping staff will disinfect the device daily.

References:

https://safespacescan.com

Forward Safety Plan: https://forward.ny.gov/

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 09/2020	Review Date: 03/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – Emergency Staffing Call-in for Off-Duty Personnel**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

In case of an emergency or disaster to meet minimum staffing and resident care needs, off-duty personnel shall be recalled to the facility as needed.

PROCEDURES

1. In case of an emergency or disaster in our facility, the Administrator or the ranking employee in charge shall have the authority to decide whether to recall off-duty personnel.
2. When the decision to recall off-duty personnel has been made, department directors shall be notified first. Department Directors shall notify respective department personnel.
3. Department directors shall maintain a current roster of their department of their department personnel, which must include emergency contact telephone numbers.
4. The Nursing Administration staff will be on-call to cover for emergency such as excessive licensed nurse call offs, weather emergencies etc.
5. The on-call schedule will be maintained by the Director of Nursing (DON) and updated monthly.
6. The on-call schedule will be located and filed in the Staffing Coordinator Binder.
7. The Administrator/designee will contact the following Department Heads to contact ALL staff to come into the facility and assist the nursing staff with non-care interventions during emergency situations as follows:
   - Clerical Staff – will assist with contacting facility personnel during emergency situations/critical staffing,
   - Activities Staff - will assist with resident with transport, making beds etc. under the direction of a Licensed Nurse,
   - Therapy Staff – will assist with mealtime routine, resident transport under the direction of a Licensed Nurse,
   - Dietary Staff –will assist with mealtime routine passing trays, picking up trays etc. under the direction of the Licensed Nurse,
   - Housekeeping Staff – will assist nursing staff with making resident beds with transport under the direction of a Licensed Nurse,
   - Maintenance Staff – will assist with w/c transport to and from dining rooms, activities, therapy etc. under the direction of a Licensed Nurse, and
   - Admissions Staff - will assist with w/c transport to and from dining rooms, activities, therapy etc. under the direction of a Licensed Nurse.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: NURSING		Policy#: 240	
Issue Date: 04/2020	Revision Date:	Review Date: 3/2023	Prepared by:
Policy Subject: Emergency Staff			
Approved by:			Page 1 of 2

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

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administration**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan –** **Emergency Preparedness; Optimizing Utilization of Staff During Pandemic Crisis**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

OBJECTIVE:

1) To be able to optimize staffing productivity during staffing shortages as a result of a surge in capacity.
2) To understand the different levels of surge capacity and be able to prioritize what tasks are essential to resident care and what tasks can be suspended or modified.

Staffing Surge Capacity- the ability to manage a sudden, unexpected increase in resident volume or staff shortages that would otherwise be severely challenged or exceed the present capacity of the facility's staffing capability.

Conventional Capacity- Measures consist of providing resident care without any change in daily contemporary practices. The staff allocated should be based on the facility's established needs and assessment.

Contingency Capacity- Measures may change daily standard practices but may not have any significant impact on the care delivered to the residents or safety of the healthcare provider. These practices may be used temporarily during periods of expected staffing shortages.

Crisis Capacity-Measures that are not commensurate with Facility's standards or care. These measures or a combination of measures may need to be considered during periods of known staffing shortages.

Vital Care- Care that is required to maintain residents' physical safety and clinical stability.

Nonclinical Services-Services provided by ancillary departments/staff such as Food Service, Housekeeping, Maintenance, Bookkeeping, Admissions, Secretarial Staff, and Security.

Clinical Services- Services provided by both contracted or facility employed staff that directly impact the residents clinical care and wellbeing such as physicians, physician assistance, nurse practitioners, registered and licensed nurses, certified nursing aids, physical, occupational and speech therapist, clinical dietitians, social workers and activity leaders.

POLICY STATEMENT:
It is the policy of Northern Manhattan that during emergency situations, that impacts or limit the facility's staffing patterns, the facility may adopt a series of strategies to optimize the utilization of the staffs' time and only provide care and treatments that are vital to the residents' care and wellbeing.

PROCEDURE:

1. When there is an event which results in a surge of utilization of staffing in the facility, the Administrator in conjunction with other designated staff members will meet to determine the following:
    - Identify their staffing needs and the facility's contracted staffing agencies.
    - Identify the current staffing patterns and which facility staff can be cross trained in assisting other departments as indicated.
    - Establish which local healthcare unions, coalitions/associations, federal, state, and local public health partners (OEM) will be and have been contacted to find out about additional staffing resources that may be available. Keep a log of all efforts/response.
    - Establish a phone/contact list of all key employees and disseminate information to all department heads.
    - Check with other healthcare facilities to determine the feasibility of "borrowing" staff.
    - Determine which staff in the building will remain on duty beyond their normal shift schedule.
    - Establish a sleeping area for staff.
    - 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.

2. The facility will implement all the following changes to optimize the utilization and availability of staffing.
    - Provided employees with cross training competencies for specific tasks.
    - Redistribute staffing assignments.
    - Maximizing use of telemedicine.
    - Cohort residents or relocate residents within the facility to maximize utilization of the available staff.
    - Determine the need to transfer residents to other facilities, release to responsible party, or otherwise decrease census, if indicated.
    - Inservice Education for staff during the emergency on all procedures relating to the emergency.
    - Set up Command Post as necessary, and follow the Emergency Incident Commander Job Action Sheet

3. Facility residents and families/representatives will be informed by SW/Designee initially and on an ongoing basis as to the measures being implemented during the emergency event as indicated.

*During **crisis capacity**, when there are known staffing shortages, the following alternative strategies may be implemented but are not limited to:

A) For Non-Clinical Care/Service

1) Reassign cross-trained staff to needed areas.

2) Provide only essential tasks/services. (Tasks that are required to maintain the safety and wellbeing of the residents and staff).
   i.e., **Housekeeping staff-** clean resident areas only.
   Dietary- altering menu to meet staffing demands. Ensure that adequate nutrition is provided, but variety and options are not a priority.
   Maintenance- maintain the overall plant operation of facility infrastructure. Only conduct repairs to maintain stability of the facility's infrastructure.
3) Revise/stagger employees work schedules to meet facility's needs.
4) Revise employees' job breakdowns to accommodate facility's needs.
5) Request vital employees who are out ill or unable to come into the facility, to be available via phone to provide guidance as indicated.
6) Implement the use of single use, disposable items, as appropriate, to minimize time and staffing constraints.

B) For Clinical Care Services

1) Reassign cross-trained staff to needed areas.
2) Revise/stagger employees work schedules to meet facility's needs.
3) Revise employees' job breakdowns to meet facility's needs.
4) Suspend non-essential care to residents. (Care and treatments that will not impact the overall health and safety of the residents)
   Examples include but are not limited to:
   a) Discontinue all showers/baths and grooming. Provide bed baths or assistance with bathing on a case-by-case need. Peri and hygiene care will continue.
   b) Discontinuing vitamins, minerals, and other non-essential medications.
   c) Review and discontinue finger sticks for those residents with history of stable blood glucose levels.
   d) Consolidate medication distribution times, as applicable.
   e) Discontinue out of and back to bed schedules. All residents remain in bed/in their room.
   f) Discontinue weekly weights and reassess needs for monthly weights for those residents that will negatively be impacted by being taken out of bed for weighing.
   g) relocate rehab staff to resident care units to assist with ADL care and ROM as indicated.
   h) Alter the locations and the times of the activity services.
   i) Provide telemedicine as applicable.

****All revisions and alterations in the plan of care will be done in direct correlation with each individual resident's clinical need and facility's staffing availability. The goal is to continue to provide care and services to maintain residents' safety.***

During **Crisis Capacity when there is no staffing available to provide the care and services required**, the following alternative strategies may be implemented:

1) Conduct vertical and/or horizontal cohorting of resident and staff, within the facility, to promote/optimize staff to resident ratio and for easy in deliverance of care.
2) Contact State and Local Health Departments for guidance on potential evacuation .
1. Relocate residents to another health care facility that will have the required staffing to meet the residents' healthcare needs and wellbeing as necessary.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services; EVS
Policy Subject: **Pandemic Emergency Plan – Handling of Regulated Medical Waste – Biohazard Waste**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing 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 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.
    a) 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

1. 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.
2. Under no circumstances shall a sharps container be filled beyond the fill line indicated on the container.
3. 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.
4. 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.
5. 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.

6. Each storage area shall:
    a) Display prominent signage indicating the space is used to store regulated medical waste;
    b) Be designed or equipped to prevent unauthorized access;
    c) Be designed or located to protect waste from the elements, and prevent access by vermin;

d) Hold the waste at a temperature that prevents rapid decomposition and resultant odor generation;
e) Be appropriately ventilated; and
f) 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.

7. 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.
8. Prior to transport off-site of the generating facility for treatment elsewhere:
   a) Primary containers shall have affixed a label or imprint indicating the name and address of the generating facility; and
   b) 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.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; QAA Committee Members
Policy Subject: **Pandemic Emergency Plan – Emergency Supplies and Subsistence**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing Center to ensure adequate supplies and subsistence for all persons in the facility during an emergency event. Provisions include food, pharmaceuticals and medical supplies. Facility shall maintain for the duration of an emergency or until all its patients have been evacuated and its operations cease.

Northern Manhattan Rehabilitation and Nursing Center has 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 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.

SAMPLE INVENTORY FOR 400 PEOPLE ON REGULAR CONSISTENCY DIET

QUANTITY	MEASURE OF UNIT	ITEM
3	CASES	ORANGE JUICE
3	CASES	APPLE JUICE
3	CASES	CRANBERRY JUICE
6	CASES	RICE KRISPIES
5	CASES	CORN FLAKES
5	CASES	RAISIN BRAN
4	CASES	DRY MILK
3	CASES	FRUIT COCKTAIL IN LIGHT SYRUP
5	CASES	PEANUT BUTTER
3	CASES	JELLY
3	CASES	GREEN BEANS
16	CASES	CRACKERS
3	CASES	BUTTER SCOTCH
1	CASE	BUTTER SCOTCH DIABETIC
3	CASES	CHOCOLATE PUDDING
1	CASE	CHOCOLATE PUDDING DIABETIC
3	CASES	VANILLA PUDDING
1	CASE	VANILLA PUDDING DIABETIC
3	CASES	CAN PEACHES IN LIGHT SYRUP
3	CASES	BEAN SALAD
3	CASES	CHICK PEA SALAD
3	CASES	V-8 JUICE
1	CASE	SANKA
1	CASE	TEA
1	CASE	SUGAR
1	CASE	SWEET & LOW
3	CASES	MAYONNAISE
3	CASES	TUNA
2	CASES	SALMON
4	CASES	CHICKEN
4	CASES	RICE PUDDING

SAMPLE PUREE ITEMS

QUANTITY	MEASURE OF UNIT	ITEM
3	CASES	PUREE CHICKEN
3	CASES	PUREE BEEF
3	CASES	PUREE VEAL
3	CASES	PUREE LAMB
3	CASES	PUREE GREEN BEANS
3	CASES	PUREE SQUASH
3	CASES	PUREE CARROTS
3	CASES	PUREE PEAS
3	CASES	PUREE BEETS
4	CASES	PUREE FRUITS
2	CASEs	APPLE SAUCE
1	CASE	CREAM OF RICE
1	CASE	MASH POTATO
1	CASE	CREAM OF WHEAT
1	CASE	STERNO CANS
1	CASE	STERNO SHAFING DISH HOLDER
1	CASE	SHAPING PANS
1	CASE	HONEY THICK WATER
1	CASE	HONEY THICK JC. (NOTE TYPE)
1	CASE	NECTAR THICK WATER
1	CASE	NECTAR THICK JC (NOTE TYPE)

SAMPLE THREE DAY EMERGENCY MENU REGULAR CONSISTENCY

BREAKFAST

DAY I	DAY II	DAY III
Orange juice 4 oz.	Apple juice 4 oz.	Cranberry juice 4 oz.
Cold cereal/Rice Krispies 1 box	Cold cereal/Corn Flakes 1 box	Hot or cold cereal 1 box
Milk 8 oz.	Milk 8 oz.	Milk 8 oz.
Sanka/tea 6 oz.	Sanka/tea 6 oz.	Sanka/tea 6 oz.
Sugar 3 pkgs.	Sugar 3 pkgs.	Sugar 3 pkgs.

LUNCH

Chicken Salad 3 oz.	Tuna fish 3 oz.	Salmon steak 3 oz.
Fruit cocktail 4 oz.	Three bean salad 4 oz.	Chick pea salad 4 oz.
Crackers 3 pkgs.	Crackers 3 pkgs.	Crackers 3 pkgs.
Rice Pudding 4 oz.	Chocolate pudding 4 oz.	Vanilla pudding 4 oz.
Sanka/tea 6 oz.	Sanka/tea 6 oz.	Sanka/tea 6 oz.
Sugar 2 pkgs.	Sugar 2 pkgs.	Sugar 2 pkgs.
Milk 4 oz.	Milk 4 oz.	Milk 4 oz.

DINNER

Peanut butter 3 oz. and jelly 1 pkg.	Chicken salad 3 oz.	Peanut butter 3 oz. and jelly 1 pkg.
Green beans 4 oz.	Bean salad 4 oz.	V-8 juice 4 oz.
Crackers 3 pkgs.	Crackers 3 pkgs.	Crackers 3 pkgs.
Butterscotch pudding 4 oz.	Can fruit (peaches) 4 oz.	Fruit cocktail 4 oz.
Sanka/tea 6 oz.	Sanka/tea 6 oz.	Sanka/tea 6 oz.
Sugar 2 pkgs.	Sugar 2 pkgs.	Sugar 2 pkgs.
Milk 4 oz.	Milk 4 oz.	Milk 4 oz.

SAMPLE THREE DAY EMERGENCY MENU PUREE CONSISTENCY

BREAKFAST

DAY I	DAY II	DAY III
Orange juice 4 oz.	Apple juice 4 oz.	Cranberry juice 4 oz.
Cold cereal/Cream of Wheat 1 pkg.	Cold cereal/Cream of Wheat 1 pkg.	Cold cereal/Cream of Wheat 1 pkg.
Apple Sauce 4 oz.	Puree Fruit 4 oz.	Apple Sauce 4 oz.
Milk 8 oz.	Milk 8 oz.	Milk 8 oz.
Sanka/tea 6 oz.	Sanka/tea 6 oz.	Sanka/tea 6 oz.
Sugar 3 pkgs.	Sugar 3 pkgs.	Sugar 3 pkgs.

LUNCH

Puree chicken 3 oz.	Puree veal 3 oz.	Puree beef 3 oz.
Puree green beans 4 oz.	Puree carrots 4 oz.	Puree beets 4 oz.
Cream of rice 4 oz.	Cream of rice 4 oz.	Cream of rice 4 oz.
Vanilla pudding 4 oz.	Chocolate pudding 4 oz.	Vanilla pudding 4 oz.
Sanka/tea 6 oz.	Sanka/tea 6 oz.	Sanka/tea 6 oz.
Sugar 2 pkgs.	Sugar 2 pkgs.	Sugar 2 pkgs.
Milk 4 oz.	Milk 4 oz.	Milk 4 oz.

DINNER

Puree beef 3 oz.	Puree lamb 3 oz.	Puree chicken 3 oz.
Puree squash 4 oz.	Puree peas 4 oz.	Puree spinach 4 oz.
Mashed potato 4 oz.	Mashed potato 4 oz.	Mashed potato 4 oz.
Rice pudding 4 oz.	Puree fruit 4 oz./applesauce	Puree fruit 4 oz.
Sanka/tea 6 oz.	Sanka/tea 6 oz.	Sanka/tea 6 oz.
Sugar 2 pkgs.	Sugar 2 pkgs.	Sugar 2 pkgs.
Milk 4 oz.	Milk 4 oz.	Milk 4 oz.

All puree foods will be heated in sternos to a temperature of 165°F and maintained at 135°F or above.

Residents requiring thicken liquids will be given the appropriate thicken liquids in place of the noted liquids above.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 09/2021	Review Date: 03/2023	Prepared by: Administration; Nursing Services; Nutrition
Policy Subject: **Pandemic Emergency Plan – Meal Service Guidelines During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing Center to 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, physical distancing, and any needed monitoring during meal service.

PROCEDURES

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). The facility considers additional limitations based on status of COVID-19 infections in the facility. Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering.

1. Residents on each unit will be reviewed to identify any special care needs during Meal Service.
2. Residents who are capable of feeding themselves, and are not at risk for choking will have their meals served in their room.
3. Residents who are served meals in their room will be provided with education on the importance of:
    - Performing hand hygiene prior to consuming meal
    - Utilizing the call bell to alert staff of any difficulties while consuming meal (i.e. coughing, difficulty swallowing etc.)
4. Caregivers will be educated to assist/provide hand hygiene for all residents prior to meal service and to ensure that the resident's call bell is within reach.
5. Residents with specific behavioral or nutritional issues may be brought into the dining room in intervals while maintaining social distancing.
6. Residents at risk for choking or on aspiration precautions may be provided meals in the dining room, while seated six feet apart or in a central corridor where they can be observed. Suction machine must be readily available with extension cord and plugged in.
7. Unit assignments will reflect staff members specific responsibilities during mealtime:
    - Tray distribution
    - Specific residents to feed
    - Corridors/Hallways to monitor during meal
8. Trays will be delivered to units in room order rather than by table number, except for those residents eating in dining room.
9. Residents requiring to be hand fed, may eat in the dining room, spaced six apart and caregivers will only feed one resident at a time.
10. When necessary, meals may be offered in intervals to allow fewer residents in common areas, and to ensure that the food temperature is maintained within desired range.
11. Dining room tables must be sanitized after each meal is completed.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 03/2020	Revision Date: 04/02/2021; 07/09/2021	Review Date: 03/2023	Prepared by: Administration; Nursing Services; Nutrition
Policy Subject: **Pandemic Emergency Plan – Communal Dining**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing Center to 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, physical distancing, and any needed monitoring during meal service.

PROCEDURES

1. Residents on each unit will be reviewed to identify any special care needs during Meal Service.
2. The facility will facilitate communal dining, to the extent possible, while adhering to the core principles of Covid-19 infection prevention including hand hygiene, masks when not eating, and physical distancing.
3. Communal dining may occur without the use of face coverings (for both residents and staff) or physical distancing *if* everyone is fully vaccinated
    - If partially or unvaccinated persons are present in the communal dining area, all individuals will wear a face mask (for residents – face mask as tolerated) and maintain physical distancing when not eating or drinking.
4. Residents may eat in the same room with physical distancing as necessary
    - Residents who are fully vaccinated may dine at the same table
    - Residents who are partially or unvaccinated will be socially distanced at least 6ft apart
5. Each Unit Manager will maintain a line list of Covid-vaccination status of residents on unit
6. Residents who are capable of feeding themselves and are not at risk for choking will have their meals served in their room if it is their preference
7. Residents who are served meals in their room will be provided with education on the importance of:
    - Performing hand hygiene prior to consuming meal
    - Utilizing the call bell to alert staff of any difficulties while consuming meal (i.e. coughing, difficulty swallowing etc.)
8. Caregivers will be educated to assist/provide hand hygiene for all residents prior to (and after) meal service and to ensure that the resident's call bell is within reach.
9. Suction machine will be available and ready for use.
10. Residents who require spoon feeding will be served meals last and caregivers will remain with resident to assist with meal consumption.
11. Unit assignments will reflect staff members specific responsibilities during meal time:
    - Tray distribution
    - Specific residents to feed
    - Corridors/Hallways to monitor during meal
12. Trays will be delivered to units in room order rather than by table number, except for those residents eating in dining room.

13. Residents requiring to be spoon fed, as well as those who prefer to eat in the dining room, may consume meals in the dining room, spaced six feet apart and caregivers will only feed one resident at a time.
14. When necessary, meals may be offered in intervals to allow fewer residents in common areas, and to ensure that the food temperature is maintained within desired range (e.g. if there is an outbreak on the unit).
15. Dining room tables will be sanitized after each meal is completed.
16. Representatives will be notified of changes in meal service during as necessary
17. Every effort will be made to redirect residents living with Dementia to ensure protocols are maintained.

REFERENCES

NYSDOH (3/25/2021). Health Advisory: Revised Skilled Nursing Facility Visitation. updated_nursing_home_visitation_guidance.pdf (ny.gov)

CDC (Updated 4/27/2021). Updated Healthcare Infection Prevention and Control Recommendations in Response to Covid-19 Vaccination. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

CMS (Rev 4/27/2021). QSO-20-39-NH: Nursing Home Visitation- Covid-19. https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

NYSDOH (7/8/2021). Health Advisory: Revised Skilled Nursing Facility Visitation. https://coronavirus.health.ny.gov/system/files/documents/2021/07/nh_visitation_guidance_-7-8-2021.pdf

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Administrative**		Policy#	
Issue Date: 04/2021	Revision Date: 07/2021	Review Date: 03/2023	Prepared by: Administration; Nursing Administration, Therapeutic Recreation
Policy Subject: **Pandemic Emergency Plan – Group Activities**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing Center to facilitate group activities for residents while following the core principles and best practices of infection control (social distancing, hand hygiene, and face covering/mask) to reduce the risk of Covid-19 transmission and maintaining the safety and well-being of residents.

PROCEDURE

1. The facility will facilitate group activities (e.g. bingo, clubs. music, crafts, movies, exercise, etc.) for residents who have fully recovered from Covid-19, and for those not in isolation, or with suspected or confirmed Covid-19 status.
2. Staff will assist residents with hand hygiene before and after group activities.
    - Alcohol-based hand sanitizer/wipes will be readily available for use at all times.
3. Social distancing of at least 6 feet apart will be maintained, as necessary
    - Group activities may occur without the use of face coverings or social distancing if all residents (and staff) participating are fully vaccinated
    - If there are partially or unvaccinated residents (or staff) in the same room, all persons will wear a face mask (for residents – face mask as tolerated) and partially and unvaccinated residents will be physically distanced from others.
4. Each Unit Manager will maintain a line list of Covid-vaccination status of residents on unit; list will be shared with all staff working on unit
5. Face covering/mask will be worn to and from group activity area(s).
6. For residents on transmission-based precautions, designated activities staff will provide 1:1 activity based on individual resident preferences.
7. Staff in the recreation department will be responsible for safe cleaning, disinfection and storage of recreational materials that are used by residents.
8. Clean and dirty recreational materials will be clearly separated at point of use.
    a. Designated labeled containers will separate dirty or used equipment/devices from those that are clean and ready for use
    b. Recreational materials that have come into contact with resident's mucous membranes (e.g., mouth and nose) and/or are soiled will be removed from circulation and cleaned/disinfected prior to return to use.
9. Recreational materials used by multiple residents (e.g. busy boards) should be cleaned and disinfected between residents, especially when visibly soiled, or if used by resident on isolation precautions (contact and/or droplet).
10. Recreational materials used in rooms under transmission-based precautions will remain with resident and will be cleaned and disinfected with EPA-approved disinfectant as determined effective for the condition and/or organism that required isolation. Alternatively, consider discarding items.

11. All healthcare personnel will perform hand hygiene with soap and water or alcohol-based hand rub (ABHR) before and after contact with each resident.
12. All healthcare personnel will utilize personal protective equipment (PPE) as necessary while interacting with residents who are on transmission-based precautions during recreational activities.

REFERENCE(S)

APIC Text, 4th Ed., Section 42-10, "Toys"

Infection Control in Pediatric Office Settings. *Pediatric Child Health*. 2008;13(5):408–435.

NYSDOH (3/25/2021). Health Advisory: Revised Skilled Nursing Facility Visitation. updated_nursing_home_visitation_guidance.pdf (ny.gov)

CDC (Updated 4/27/2021). Updated Healthcare Infection Prevention and Control Recommendations in Response to Covid-19 Vaccination. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

CMS (Rev 4/27/2021). QSO-20-39-NH: Nursing Home Visitation- Covid-19. https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

NYSDOH (7/8/2021). Health Advisory: Revised Skilled Nursing Facility Visitation. https://coronavirus.health.ny.gov/system/files/documents/2021/07/nh_visitation_guidance_-7-8-2021.pdf

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 09/17/2020	Review Date: 03/2023	Prepared by: Administration; Nursing Administration
Policy Subject: **Pandemic Emergency Plan – Activity Programming During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

Northern Manhattan Rehabilitation and Nursing Center will modify, restrict and/or cancel communal activities and dining services during a pandemic or communicable disease outbreaks during the emergency, in accordance with the recommendations or guidance of CDC, Local, State or Federal Health Agencies.

Implementation of Avoidance of Large Groups

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). The facility considers additional limitations based on status of COVID-19 infections in the facility. Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering.

The facility offers a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.

- **Communal Activities.** Any gathering for a mutually accomplished task or activity such as but not limited to, meal services in a group of ten individuals or less or an activity where social distancing principles are enacted for the purposes of the prevention of disease transmission (e.g. 6-feet distances between residents, and all residents will be required to wear cloth face covering at all times for universal source control and continue social distancing).
- **Social Distancing.** For the purposes of this policy, social distancing is the practice of remaining out of communal activities, avoiding religious service gatherings and maintaining physical distance to reduce the spread of disease per facility infection control policies and procedure related to disease requiring droplet and airborne precautions governed by CDC, State and Federal guidelines.
- **Notification.** The facility will notify residents and their representatives of COVID-19 positive cases for any single case of a resident or employee testing positive for COVID-19. Resident and representatives will receive ongoing updates including mitigating actions implemented in the facility to stop the spread of infection.

PROCEDURES

1. Upon recognition or announcement of a pandemic or communicable disease emergency necessitating the modification, restriction or cancellation or communal activities, including but not limited to communal dining services, the facility Infection Control Preventionist, facility Administrator and/or Director of Nursing (DON) will notify staff and residents of the communicable disease pandemic and the need to modify communal activities and practice social distancing and infection control policies and procedures (e.g. Influenza, COVID type illnesses).

2. Visitation will be restricted during COVID-19 outbreaks. Alternative forms of communication/electronic technology with the resident's family/representative such as Skype, Facetime, phone calls, face-to-face window viewing activities, will be utilized whenever applicable.

3. The facility will implement various best practices and develop innovative ways to keep residents connected to their families and community to meet the psychosocial needs of the residents, including emotional and physical well-being, self-determination, self-respect and dignity.

4. To accommodate universal source control measures, all residents are required to wear a face cloth covering at all times when out of room and/or when activity programming is provided in their room.

5. Activities designed for life enrichment, such as but not limited to bingo, games, entertainment will be either be cancelled or where appropriate, modified in order to achieve proper social distancing and prevent the transmission of disease.

6. Activities requiring sharing of supplies for quiet games, crafts, puzzles will not be utilized during a COVID-19 outbreak.

7. External or contracted entertainment will be cancelled whenever virtual entertainment is not feasible.

8. Activity programming including ball bouncing, indoor bowling, ring toss, etc., will only be utilized if resident wears gloves, cloth face covering, frequent handwashing, and 6 feet distancing occurs.

9. All infection control practices for cleaning and disinfecting activity room and supplies will be strictly enforced.

10. The facility will adjust practices to ensure residents continue to receive nutritional support by adjusting meal services which may include:

    - serving meals in the resident's room,
    - providing supervised dining while preventing communal activities and adhering to 6-feet social distancing practices; in these instances, residents who meet the following criteria may be included in supervised meal services that are otherwise not communal,
        (1) residents with swallowing problems or that are a choking hazard,
        (2) behavioral problems that put themselves or others at risk if left unsupervised in a dining situation, and
        (3) residents that require full assist with feeding,
    - in supervised dining situations to minimize the risk of disease transmission, staff will wear PPE where appropriate for the type of care being provided. All staff will wear a mask and utilize gloves when applicable,
    - All residents that must be supervised in the dining room for choking and aspiration reasons will be required to wear a face cloth covering to and from the dining room.

11. Activity programming with internet technologies will be utilized for individual and small group activities as recommended by the NYS DOH.

12. The facility will adjust practices for residents who smoke to avoid communal activities and promote proper social distancing. This may include:

    - offering nicotine replacement when applicable,
    - adjusting supervised smoking times to facilitate social distancing,
    - in crisis situations, smoking privileges may be prohibited.

13. All other communal activities not otherwise listed will be modified, restricted, or cancelled in keeping with the nature of the activity and the ability of the residents to maintain appropriate social distancing and infection control practices.

14. Only the Administrator, the DON or Infection Control Preventionist may resume normal communal activities and only upon resolution of the emergency pandemic per the guidance of CDC, State and Federal government agencies.

NORTHERN MANHATTAN NURSING HOME
POLICIES, PROCEDURES AND INFORMATION

Title: Therapeutic Activities During Covid-19 Pandemic

Issued by: Nursing

Effective Date: 3/20 | Last Review Date: 3/23 | Supersedes:

Distribution: All Department

POLICY: The facility will promote each resident's highest level of well-being in alignment with the prevention of the spread of Covid-19 infection in alignment with Federal guidelines restricting group activities.

PROCEDURE:

1. The Activities Director in conjunction with the resident/resident representative and IDT team will identify resident specific activities needs by interviewing residents for in room activities that they would be interested in and reviewing care plans.
2. The Activities Director will inform the team of revised Activities and provide a calendar listing daily activities.
3. Small resident groups incorporating social distancing of 6 feet can be conducted. These small groups will be scheduled each day to include residents with dementia or behavior issues that increase risk of accidents and/or change in condition.
4. Other small groups will be scheduled throughout the day/evening to prevent social isolation.
5. Residents to be notified of small group programs they could sign up for and then notified of their scheduled program.
6. Any resident with fever or symptoms of infection will not participate in small group activities

Daily Activities staff with available rehab aides will ;make room visits including hallway music programs encouraging resident engagement and physical activity as indicated i.e. stretching at room doorway;, ambulating in room in accordance with CCP.

7. The Activities Team will ensure residents in room have arts/crafts, music, movies reading materials, crossword puzzles, Ipads and sensory items are disinfected with EPA approved disinfectant.
8. Resident Council will be informed of activities changes with input as needed.
10. If a resident has a specific request or need the Activity staff assigned to the unit will notify the Director and IDT team for follow up.
11. Through QA, residents plans of care will maintained with updates as indicated during the Covid-19 outbreak.

NORTHERN MANHATTAN NURSING HOME
POLICIES, PROCEDURES AND INFORMATION

Manual Code No: NUR -236
Page No: 1 of 1

Title: Monitoring of Residents for Covid-19

Issued by: Nursing

Effective Date: 3/20

Last Review Date: 3/23

Supersedes:

Distribution: All Department

POLICY:

It is the policy of Northern Manhattan Rehabilitation & Nursing 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. UNKOWN 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.

NORTHERN MANHATTAN REHABILITATION & NURSING 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:_____

NORTHERN MANHATTAN REHABILITATION & NURSING 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:_____

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 11/2020	Review Date: 03/2023	Prepared by: Administration; Nursing Services; Social Services
Policy Subject: **Pandemic Emergency Plan – Facility Communication During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

Northern Manhattan Rehabilitation and Nursing 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 Attending Physician/RNS/designee will contact family members of residents with an infection because of a pandemic daily.
3. Families/Representatives will be notified by Attending Physician/RNS/designee for any significant change in resident condition within 24 -48 hours
4. The SW and IDT Team will determine the Resident Representative/Guardians preferred method of contact.
5. The facility will contact all resident representatives via a daily automated call to provide an update on the status of residents including number of confirmed COVID-19 cases and of new resident 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 may 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 to disseminate may include but not be limited to:
    - 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
    - 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. 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.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Delivery Systems for Vendors During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

In the event of a pandemic the Northern Manhattan Rehabilitation and Nursing Center will adjust procedures to managing critical outsourced supplier services and deliveries.

Northern Manhattan Rehabilitation and Nursing Center 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.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Telehealth During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

Northern Manhattan Rehabilitation and Nursing 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 Northern Manhattan Rehabilitation and Nursing Center, 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 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.
    - Password protected; preferably two-factor authentication is to be used
    - Device has been had updates and security patches installed at least once/month
    - Software updates are conducted quarterly

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: NURSING		Policy# 239	
Issue Date: 03/20	Revision Date:	Review Date: 03/23	Prepared by: Nursing Services
Policy Subject **Pandemic Emergency Plan – Respiratory Protection During a Pandemic**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			Page 1 of 1

POLICY

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

PURPOSE:

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

PROCEDURE:

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. Resident will be isolated/quarantine.
2. Notify all attending physicians.
3. Provide symptomatic relief to affected residents.
4. Restrict group activities and/or communal dining of symptomatic residents.
5. Encourage good handwashing technique of both staff and residents.
6. Instruct staff to wear gloves when handling respiratory secretions and to wear masks if caring for residents with productive coughs.
7. Maintain surveillance line listing of all affected residents and staff
8. Limit staff units assignment rotation as much as possible
9. Maintain extra floor supplies for resident use such as tissues, plastic bags for same.
10. Encourage increased intake of fluids by resident.
11. The use of viral studies should be considered for the identification of viral strain

A. All respiratory outbreaks are to re reported to appropriate City/State/County Health Department
B. The Infection Control Committee shall meet as need to discuss eventual resolution of problems

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Nursing**		Policy # 239 (b)	
Issue Date: 03/2020	Revision Date: 08/2021	Review Date: 03/2023	Prepared by: Nursing Services
Policy Subject: **Respiratory Protection Program**			
Approved by: Administration, Medical Director, Director of Nursing, Infection Prevention, QAA Committee			Page 1 of 8

POLICY STATEMENT

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

PURPOSE

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

PROCEDURE

Northern Manhattan Rehabilitation and Nursing Center has developed a written respiratory protection program with required work-site specific procedures and elements in the event it is determined that respirator use is necessary.

The facility shall provide respirators when such equipment is necessary to protect the health of the employee. The facility shall provide the respirators, which are appropriate and suitable for the intended purpose. The respiratory protection program shall be updated as necessary to reflect changes in workplace conditions that require the use of respirators. The facility's Respiratory Protection Program includes the following components in compliance with (the) OSHA Standards:

- Procedures for selecting respirators for use in the workplace;
- Medical evaluations of employees required to use respirators;
- Fit testing procedures for tight-fitting respirators;
- Procedures for proper use of respirators;
- Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding and otherwise maintaining respirators;
- Procedures to ensure adequate air quality, quantity and flow of breathing air for atmosphere supplying respirators;
- Where respirator use is required.

The facility will provide respirators at the request of employees, if the facility determines that respirator use will not in itself create a hazard. If the facility determines that any voluntary respirator use is permissible, the facility shall provide the respirator users with the necessary training and information for proper use before a respirator is issued or authorized for use.

The facility has established and implemented those elements of a written respiratory protection program necessary to ensure that any employee using a respirator voluntarily is medically able to use that respirator, and that the respirator is cleaned, stored, and maintained so that its use docs not present a health hazard to the user.

The Medical Director, the Safety Officer and the RN Infection Control Preventionist/Coordinator shall oversee the respiratory protection program and conduct required evaluations of program effectiveness.

Where respirator use is necessary, the facility shall provide respirators, training and medical evaluations at no cost to the employee.

Program Administration

RN Infection Control Preventionist/Coordinator will be responsible for the administration of the respiratory protection program and thus is called the Respiratory Protection Program Administrator (RPA).

Roles and Responsibilities

Respiratory Program Administrator (RPA)

The Respiratory Program Administrator is responsible for administering the respiratory protection program. Duties of the RPA include:

- Identify work areas, processes, or tasks that require respiratory protection.
- Monitor OSHA/PESH standards for changes and revise policy as needed.
- Monitor CDC and DOH recommendations and guidelines as they relate to respiratory protection and other recommended infection control measures.
- Select respiratory protection products. Involve users in selection whenever possible.
- Monitor respirator use to ensure that respirators are used in accordance with this program, training received, and manufacturer's instructions.
- Coordinate medical evaluations with licensed healthcare professional.
- Evaluate any feedback information or surveys.
- Arrange for and/or conduct training and fit testing.
- Ensure proper storage and maintenance of respiratory protection equipment.
- Conduction a periodic evaluation of the program and revising as needed.

Supervisor

- Supervisors are responsible for ensuring that the respiratory protection program is implemented in their particular units.
- In addition to being knowledgeable about the program requirements for their own protection, supervisors must also ensure that the program is understood and followed by the employees under their change.
- Duties of the Supervisor include:
  - Knowing the hazards in the area in which they work.
  - Knowing types of respirators that need to be used.
  - Ensuring the respirator program and worksite procedures arc followed.
  - Ensuring employees receive medical evaluations.
  - Ensuring employees receive annual training and fit testing.
  - Ensuring staff use respirators, as required.
  - Notifying Respiratory Protection Program Administrator of any problems with respirator use or changes in work processes what would impact program.
  - Ensuring proper storage and maintenance of respirators in their unit.

Employee

- Participate in all training and fit testing
- Wear respirator when indicated
- Maintain equipment
- Inspect respirator and perform user seal check before every use
- Report malfunctions or concerns

Identifying Work Hazards

The respirators selected will be used for personal protection as part of an overall infection control plan which incorporates engineering and work practice controls.

This agency will follow the most current CDC and NYC Department of Health Guidance on appropriate infection control practices.

Routine infection control and isolation practices for typical work situations are well known and tend to remain consistent over time. However, during an outbreak of a new virus type or pandemic flu, infection control guidance may change as the situation unfolds, based on available epidemiological data. In these situations, it will be the responsibility of the respiratory protection program manager to keep current with CDC/NYSDOH recommendation. The program will be adjusted, and employees will be kept informed as changes occur.

Selection of Respirators:

The facility shall evaluate(d) respiratory hazards in the workplace, identify relevant workplace and user factors, and base respirator selection on these factors.

Only respirators approved by the National Institute for Occupational Safety and Health (NIOSH) will be selected and used. In making the determination of which respirators to select, the RPA will consider the type of settings and job activities employees will perform the capabilities and limitations of the respirator and duration of respirator use.

DESCRIPTION

The NIOSH N95 approved particulate respirator mask is designed to help provide respiratory protection for the wearer. This product has filter efficiency level of 95% or greater against particulate aerosols free of oil and is fluid resistant and disposable.

The NIOSH approved particulate respirator masks are intended to reduce wearer exposure to certain airborne particles including those generated by powered medical instruments. It is fluid resistant to splash and splatter of blood and other infectious material when worn properly.

Use Instructions:

1. Before use for respiratory protection, training and fit testing requirement must be met. The "sweet solution" or "bitter solution" qualitative fit testing is recommended for this respirator.
2. If respirator becomes damaged, contaminated with blood or body fluids, or breathing becomes difficult, leave the area and replace the respirator, otherwise it may be stored and re-used. Discard after every use when used for surgical procedure.
3 Inspect respirator before use to ensure that it is in good operating condition. Examine all the respirator parts for signs of damage, including the two headbands, staples, nose clip and nose foam. The respirator should be disposed of immediately upon observation of damage or missing parts.
4. Filtering face pieces are to be inspected prior to each use to assure there are no holes in the breathing zone other than the punctures around the staples and no damage has occurred. Enlarge holes resulting to ripped or torn filter material around staple punctures is considered damage. Immediately replace respirator if damaged.

General Requirements

The facility shall select and provide an appropriate respirator based on the respiratory hazard(s) to which the worker may be exposed, workplace and user factors that affect respiratory performance and reliability.

The facility identifies and evaluates the respiratory hazard(s) in the workplace. This evaluation includes a reasonable estimate of employee exposures to respiratory hazard(s) and an identification of the contaminant's chemical state and physical form. This evaluation is based upon information from MSDS sheets or information that was otherwise available. The facility shall identify hazards and potentially hazardous materials that require the use of respirator protection. When selecting products for use in the facility, where possible, the least hazardous product shall be purchased. Products that do not require the use of respirators for respiratory protection are preferable and will be purchased for use instead of a product that does require a respirator for personal protection.

In those instances where a job requires the use of a respirator for respiratory protection, this respiratory protection plan shall be implemented for the proposed respirator use.

The facility shall select NIOSH-certified respirators to ensure that the respirator is acceptable to, and correctly fits the user. The respirator shall be used in compliance with the condition of its certification.

For protection against gases and vapors, where the MSDS indicates that respiratory protection is required, the facility shall provide:

A respirator that is equipped with an end-of-service-life indicator (ESLI) certified by NIOSH for the contaminant.

If there is no ESLI appropriate for conditions in the workplace, the facility shall implement a change schedule for canisters and cartridges that is based on objective information or data that will ensure that canisters and cartridges arc changes before the end of the service life.

The facility shall rely upon manufacturer's recommendation and specifications regarding replacement of the canister/cartridge.

Medical Evaluation:

The facility recognizes that a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used, and the medical status of the employee. The facility shall implement a medical evaluation procedure to determine the employee's ability to use a respirator.

General:

The facilit shall provide a medical evaluation to determine the employee's ability to use a respirator before the employee is fit tested or required to use the respirator in the workplace. The facility may discontinue an employee's medical evaluations for respirator use when the employee is no longer required to use a respirator.

Medical Evaluation Procedures:

A. The facility shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
B. The medical evaluation shall obtain all required information to determine the safety of respirator use for each employee to be tested.
C. As far as possible, the company will provide help in reading the questionnaire to employees who have difficulty reading on their own. The facility should illicit the employee's ability to understand English.

Follow-Up Medical Examination:

The facility shall ensure a follow-up medical examination for any employee whose initial medical examination demonstrates the need for a follow-up examination.

The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the medical evaluator deems necessary to make a final determination.

Administration of the Medical Questionnaire and Examination:

A. The medical questionnaire and examinations shall be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee. The medical questionnaire shall be administered in a manner that ensures that the employee understands its content. (See Appendix B).
B. Northern Manhattan Rehabilitation and Nursing Center shall provide the employee with an opportunity to discuss the questionnaire and examination results with the medical evaluator.

Supplemental Information for the Medical Evaluator:

The following information will be provided to the medical evaluator before the medical evaluator makes a recommendation concerning an employee's ability to use a respirator:

1. The employees work area or job title
2. The type and weight of the respirator to be used by the employee
3. The duration and frequency of respirator uses
4. The expected physical work effort
5. Additional protective clothing to be worn
6. Temperature and humidity extremes that may be encountered
7. The list of hazardous substances found in work area
8. The length of time the employee will wear respirator per day
9. The Northern Manhattan Rehabilitation and Nursing Center shall provide the medical evaluator with a copy of the written respiratory protection program.

Any supplemental information provided previously to the medical evaluator regarding an employee need not to be provided for a subsequent medical evaluation if the information and the medical evaluator remain the same.

When the facility replaces a medical evaluator, the facility will ensure that the new medical evaluator obtains this information by providing the documents directly to the medical evaluator.

Medical Determination:

In determining the employee's ability to use a respirator, the facility shall:

Obtain a written recommendation regarding the employee's ability to use the respirator from the medical evaluator. The recommendation shall provide only the following information:

A. Any limitations on respiratory use related to the medical condition of the employee or relating to the workplace conditions in which the respirator will be used.
B. Whether or not the employee is medically able to use the respirator.
C. The need, if any, for follow-up medical evaluations.

Additional Medical Evaluations:
At a minimum, the facility shall provide additional medical evaluations if:

- The employee reports signs and or symptoms related to the ability to use a respirator, such as shortness of breath, dizziness, chest pain, or wheezing.
- The Medical evaluator, supervisor, or the respiratory administrator informs the facility that an employee needs to be reevaluated.
- Information form the respiratory protection program, including observations made during fit testing and program evaluation indicates a need for employee reevaluation.
- A change occurs in workplace conditions (e.g., physical work effort, protective clothing, and temperature) that may result in a substantial increase in the physiological burden on an employee.

Fit Testing:
Before an employee is required to use any respirator with a tight-fitting face piece, the employee will be fit tested with the same make, model, style and size of the respirator that will be used.

The facility shall ensure that employees using a tight-fitting face piece respirator pass an appropriate fit test.

A. The facility shall ensure that an employee using a tight-fitting face piece respirator is fit tested prior to initial use of the respirator, whenever a different respirator face piece (size, style, model or make) is used, and at least annually.
B. The facility shall conduct an additional fit test whenever the employee reports, or the employer, medical evaluator, supervisor, or program administrator makes visual observations of changes in the employee's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.
C. If after passing a manufacturer's recommended fit test, the employee subsequently notifies the employer, program administrator, supervisor, or medical evaluator that the fit of the respirator is unacceptable; the employee shall be given a reasonable opportunity to select a different respirator face piece and be retested.
D. The fit test shall be administered using an OSHA-accepted protocol.

Any modifications to the respirator face piece by employee shall cause fit testing to be redone and the face piece restored to NIOSH-approved configuration before that face piece can be used in the workplace.

Use of Respirators:
The facility has established procedures for the proper use of respirators. These requirements include prohibiting conditions that may result in face piece seal leakage, preventing employees from removing respirators in hazardous environments, taking actions to ensure continued effective respirator operation throughout the work shift.

A. The following fit-test protocol(s) will be used.

Type of Respirator	Fit-Test Protocol(s)
NIOSH Approved N95 Health Care Particulate Respirator	OSHA-Accepted Fit Test Protocols (See Appendix A).

B. Testing records will document the type, model, and size of respirator for which reach employee bas been tested, as well as the fit test protocol used.

RESPIRATOR USE

A. The following personnel require respiratory protection:

Name	Department	Operation/Task	Respirator
RNs	Nursing	Suctioning; Infection Control	NIOSH Approved N95
LPNs	Nursing	Suctioning; Infection Control	NIOSH Approved N95
CNAs	Nursing	Infection Control	NIOSH Approved N95
PT; OT; SLP	Rehabilitation Services	Infection Control	NIOSH Approved N95
Environmental/Maintenance Services	Environmental Services Maintenance Services	Environmental Infection Control	NIOSH Approved N95
Others as directed by the ICP/Coordinator.	Other Departments	Infection Control	NIOSH Approved N95

B. GENERAL USE PROCEDURES

Face Piece Seal Protection:
The employer shall not permit respirators with tight-fitting face pieces to be worn by employees who have:

1. Facial hair that comes between the sealing surface of the face piece and the face piece that interfe1·es with valve function.
2. Any condition that interferes with the face-to-face piece seal or valve function.
3. If an employee wears corrective glasses or goggles or other personal protective equipment, the facility shall ensure that such equipment is worn in a manner that does not interfere with the seal of the face piece to the face of the user.
4. For all tight-fitting respirators, the facility shall ensure that employees perform a user seal check each time they put on the respirator using procedures recommended by the respirator manufacturer.

Continuing Respirator Effectiveness:

Appropriate surveillance shall be maintained of work area conditions and degree of employee exposure or stress. When there is a change in work area conditions or degree of employee exposure or stress that may affect respirator effectiveness, the facility shall re- evaluate the continued effectiveness of the respirator.

The facility shall ensure that employees leave the respirator use area:

A. To wash their faces and respirator face pieces as necessary to prevent eye or skin irritation associated with respirator use.
B. If they detect vapor or gas break through changes in breathing resistance, or leakage of the fact piece.
C. To replace the respirator or the filter, cartridge, or canister elements.
D. If the employee detects vapor or gas break through changes in breathing resistance, or leakage of the face piece, the facility shall replace the respirator before allowing the employee to return to the work area.

Maintenance and Care of Respirators:

The facility shall provide for the cleaning and disinfecting, storage, inspection and repair of respirators used by employees.

Cleaning and Disinfecting:
The facility shall provide each respirator user with a respirator that is clean, sanitary and in good working order. The facility shall ensure that respirators are cleaned and disinfected using the procedures recommended by the respirator manufacturer in a manner that prevents damage to the respirator and does not cause harm to the user. The respirations shall be cleaned and disinfected at the following intervals:

- Respirators issued for the exclusive use of an employee shall be cleaned and disinfected as often as necessary to be maintained in a sanitary condition;
- Respirators maintained for emergency use shall be cleaned and disinfected after each use; and
- Respirators used in fit testing and training shall be cleaned and disinfected after each use.

Storage:
The facility shall ensure that:

- All respirators arc stored to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals, and they shall be packed or stored to prevent deformation of the face piece and exhalation valve.
- N95 respirators will be stored in the Central Supply Department and the Nursing Supervisors office.

Inspection:

- All respirators used in routine situations shall be inspected before each use and during cleaning: The facility shall ensure that respirator inspections include the following:
- A check of respirator function, tightness of connections and the condition of the various parts including but not limited to, the face piece, head straps, valves, connecting tube and cartridges, canisters, or filters; and
- A check of elastomeric parts for pliability and signs of deterioration.

Repairs:
The facility shall ensure that respirators that fail an inspection or are otherwise found to be defective arc removed from service, and arc discarded or adjusted in accordance with the following procedures.

- Adjustments to respirators are to be made only by persons appropriately trained to perform such operations.

- An employee who discovers a defective respirator must immediately notify his/her supervisor.
- Supervisor will notify the program administrator and then discard the respirator(s).

Training and Information:
The facility shall provide effective training to employees who are required to use respirators. The training is comprehensive, understandable, recurs annually and more often, if necessary. The facility provides basic information on respirators to employees who wear respirators upon their request but not required by the facility.

The facility shall ensure that each employee who is required to use respirators can demonstrate knowledge of at least the following:

- The employees use of or knowledge about the respirator indicates insufficient understanding or skill;
- Why the respirator is necessary and how improper fit, usage or maintenance can compromise the protective effect of the respirator;
- What the limitations and capabilities of the respirators are;
- How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions;
- How to inspect, put on and remove, use and check the seals of the respirator;
- What the procedures are for the disposal of the respirator;
- How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.

A. The training shall be conducted in a manner that is understandable to the employee.

B. Training records will include the dates of training, employees' names, the trainers name, and the type of training conducted.

C. The facility shall provide the training prior to requiring the employee to use a respirator in the workplace.

Subsequently, retraining shall be administered annually and when the following situations occur:

- Changes in the workplace or the type of respirator rendering previous training obsolete
- Inadequacies in the employee's knowledge or use of the respirator indicate the employee has not retained the requisite understanding or skill; or
- Any other situation arises in which retraining appears necessary to ensure safe respirator use.

Program Evaluation:

A. The facility shall conduct evaluations of the workplace to ensure that the written respiratory protection program is being properly implemented, and to consult employees to ensure that they are using the respirators properly.

B. The facility shall conduct evaluations of the workplace as necessary to ensure that the provisions of the current written program are being effectively implemented and that it continues to be effective.

C. The facility shall regularly consult employees required to use respirators to assess the employee's views on program effectiveness and to identify any problems. Any problems that are identified during this assessment shall be corrected. Factors to be assessed include, but are not limited to:

    - Respirator fit (including the ability to use the respirator with effective workplace performance);
    - Appropriate respirator selection for the hazards to which the employee is exposed;
    - Proper respirator use under the workplace conditions the employee encounters; and
    - Proper respirator maintenance.

Medical Evaluation:
Records of medical evaluations shall be retained by the physician or licensed healthcare professional performing medical evaluations.

Fit Testing:
The facility shall establish a record (See Appendices A & D) of the fit tests administered to an employee including:

- The name or identification of the employee tested;
- Type of fit test performed;
- Specific make, model, style, and size of respirator tested;
- Date of test; and
- The pass/fail results for the fit test.

Fit test records shall be retained for respirator users until the next fit test is administered.

A written copy of the current respirator program shall be retained by Northern Manhattan Rehabilitation and Nursing Center.

Record Keeping:
The facility shall retain written information regarding medical evaluations, fit testing and the respirator program. This information facilitates employee involvement in the respirator program, assists the facility in auditing the adequacy of the program, and provides a record for compliance determinations by OSHA.

RECORD KEEPING

A. The Program Administrator will maintain the following records:

1. Training records will be kept with the Education Department.
   Fit test records will be kept with the Employees Medical Records. These will be updated as necessary

2. Copies of the PLHCP's written opinion as to each employee's ability to wear a respirator. These records will be maintained in the Nursing Office and in the employee's medical file

3. A written copy of this respirator program and the OSHA respiratory protection standard will be maintained at

B. The evaluating PLHCP will maintain records of the completed medical questionnaire and any documented findings. These records will remain confidential and will be maintained at

Written materials shall be made available upon request to affected employees and to any regulatory agency for examination and copying.

ATTACHMENTS:
Forms

Appendix A	Appendix A to 1910.134 – Fit Testing Procedures Part I. OSHA – Accepted Fit Testing Protocol A. Fit Testing Procedures – General Requirements
Appendix B	OSHA INFOSHEET: Respirator Medical Evaluation Questionnaire
Appendix C	Employee Respirator Fit Test Record - ALLEGRO
Appendix D	Respirator Fit Test Record Log

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 12/2020	Review Date: 3/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Respiratory Protection Program N95 Fit Testing Procedure**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of Northern Manhattan Rehabilitation and Nursing Center to ensure employees are adequately fitted for N95 respiratory masks in the event of a suspected outbreak.

PROCEDURE:

STEP BY STEP PROCEDURE FOR FIT TESTING

Prior to participating in a Fit test, you must complete a medical evaluation form. The form can be found at: www.xxxx

Do not eat or drink for 15 minutes prior to test

PART 1: First step is a sensitivity check which establishes your ability to taste the test agent.

- The instructor will place a hood over your head. There should be 6" between your face and the hood, this allows for free movement of your head.
- Using nebulizer #1, containing the sensitivity solution, the instructor will spray 10 squeezes into the hood through the hood opening. You must breath through the mouth with your tongue slightly extended. When you report tasting the solution, regardless of the number of squeezes done, the threshold will be noted as "10".
- If after the initial 10 squeezes, you cannot taste the solution, the test will be performed again with another 10 squeezes. If you can taste it then, the threshold will be noted as "20".
- If you still cannot taste the solution, the instructor will add 10 more squeezes. If detected, the threshold is noted as "30". If you still cannot taste the solution, another test method is required.
- Remove the hood. You may rinse your mouth with water.

PART 2: Actual Fit Test

- Put on your face mask. The instructor will then place the test hood over your face
- Using testing nebulizer #2, the instructor will squeeze the solution into the opening of the hood. The number of squeezes is based upon previously established thresholds (10, 20, or 30).
- To maintain the concentration of solution during the test, the instructor will then start by inject one-half the previously established threshold (5,10, or 15) every 30 seconds thereafter.
- Continue to breath through your mouth during the entire test.
- Perform the following exercises for 60 seconds each, as directed by the instructor.
- Breath normally for 60 seconds. (The instructor will inject half the number of "threshold squeezes" at the start of the task and 30 seconds after)
- Deep breathing for 60 seconds. (The instructor will inject half the number of "threshold squeezes at the start of the task and 30 seconds after)
- Turn your head from side to side taking a moment to breath on each side for 60 seconds. (The instructor will inject half the number of "threshold squeezes" at the start of the task and 30 seconds after)
- Nod head up and down holding your head in each position for one or two breaths for 60 seconds. (The instructor will inject half the number of "threshold squeezes" at the start of the task and 30 seconds after)
- Talks. Read rainbow passage slowly out loud for 60 seconds. (The instructor will inject half the number of "threshold squeezes" at the start of the task and 30 seconds after)
- Bend at waist or jog in place (hold hood in place) for 60 seconds. (The instructor will inject half the number of "threshold squeezes" at the start of the task and 30 seconds after)
- Breath normally
- If at any point during the test, you detect the taste of the solution, inform the instructor immediately. Either refit the face mask of select another size. Start over.

The instructor will disinfect hood between uses.

3M Science. Applied to Life.™

Guide to 3M qualitative fit testing.

Reusable half masks

Filtering facepiece respirators

3M™ FT-10 (sweet) and 3M™ FT-30 (bitter) fit test kits are suitable for filtering facepiece respirators and half-face masks fitted with particulate or combination filters.

! Wearers must be clean shaven to get a good fit with a respirator for the fit test and every time the respirator is worn.

! Please note that in order to carry out a full fit test, all the steps detailed below must be followed (parts one and two).

The taste test

Part one: the sensitivity test

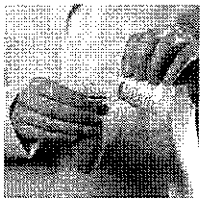
1 Add half a teaspoon of sensitivity solution (in red labelled bottle) into the sensitivity nebuliser (marked in red).

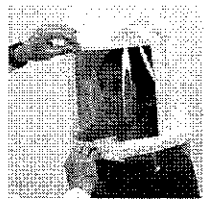
2 Put test hood on person.

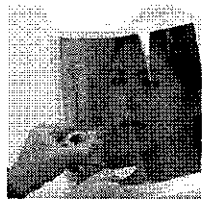
3 Ask person to breathe through their mouth with their tongue at the front and ask them to indicate immediately when they taste solution.

4 Slowly squeeze solution into the hood and count the number of squeezes it takes for the solution to be tasted.

5 Ask the person to take a drink of water and wait until the taste has cleared, making sure that they wipe their lips to remove any traces of solution.







Stop the test if solution is not tasted after 30 squeezes. Try an alternative solution:

Sweet taste	3M FT 11 (Sensitivity solution) 3M FT12 (Fit test solution)
Bitter taste	3M FT 31 (Sensitivity solution) 3M FT32 (Fit test solution)

3M Personal Safety Division
3M Centre, Cain Road, Bracknell, Berkshire RG12 8HT. Tel: 0870 60 800 60
Personal Safety Division
3M Ireland, The Iveagh Building, The Park, Carrickmines, Dublin 18, Ireland

Part two: the fit test

1 Add half a teaspoon of the fit test solution (in black labelled bottle) into the sensitivity nebuliser (marked in black).

2 Make sure respirator is fitted correctly. Refer to 3M fitting instructions or posters for correct procedure. Please ensure any other headworn PPE required by the wearer is worn during the fit test.

3 Put test hood on person.

4 Introduce solution in an 'initial dose' and start the exercises.

Number of squeezes needed in part one	Number of squeezes needed for initial dose	Number of squeezes for 'top-up' dose every 30 seconds
1–10	10	5
11–20	20	10
21–30	30	15

Add a 'top-up' dose after every 30 seconds as per below:

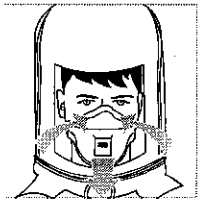
5 After the initial dose, ask the person to carry out the seven exercises shown in the images to the right for one minute and indicate immediately if solution is tasted. Remember to add 'top-up' dose every 30 seconds.

6 **Record results**
If solution is not tasted after all seven exercises, they have passed the test with that respirator. If solution is tasted, **stop test**, clean mouth, face and hands, refit respirator and start part one of the test again.

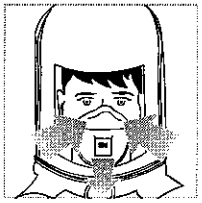
If solution is still tasted on the second attempt, **stop test**, clean hands, mouth and face, and try another face fit test with an alternative 3M respirator.

In the event of another failure, please call the 3M Health and Safety Helpline on 0870 60 800 60 (UK) or 1 800 320 500 (Ireland).

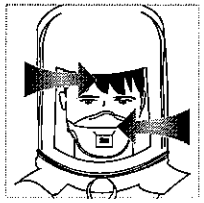
The seven exercises



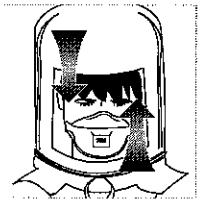
1 Breathe normally.



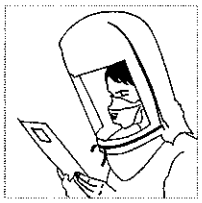
2 Breathe deeply.



3 Head side-to-side.

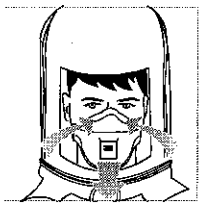


4 Head up-and-down.



5 Talking.

6 Bend over at waist.



7 Breathe normally.

For 3M fit testing support tools visit **3M.co.uk/fittestrespirator**

@3M_UK_Safety

For further information or advice on correct selection and use of 3M PPE, call 3M Personal Safety Division on 0870 60 800 60 (UK) and 1 800 320 500 (Ireland) or visit 3M.co.uk/safety

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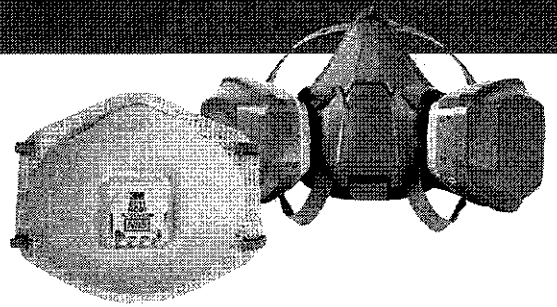
Quick Reference Guide: Qualitative Fit Testing

3M™ FT-10 (sweet) and 3M™ FT-30 (bitter) fit test kits are suitable for disposable respirators, half facepiece fitted with particulate filters, and full facepieces fitted with particulate filters.[1]

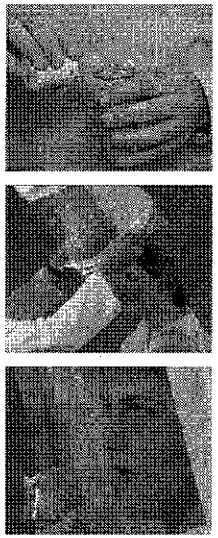


Wearers must be clean-shaven to get a proper fit with a respirator.

Please note, in order to carry out a full fit test, all the steps detailed below must be followed (Parts 1 & 2).

Part 1 - Sensitivity Testing (The "Taste Test")

1. Add 1/2 teaspoon of sensitivity solution (in red labeled bottle) into the sensitivity nebulizer (marked in red). Visually confirm that the nebulizer produces a cloud of aerosol when the bulb is squeezed.
2. Place test hood on participant. A respirator should not be worn during the sensitivity test.
3. Ask the participant to breathe through their mouth with their tongue slightly extended and ask them to indicate immediately when they taste the solution.
4. Squeezing the bulb completely and aiming the nebulizer to the side rather than directly at the subject, squeeze solution into the hood and count the number of squeezes it takes for the solution to be tasted.
5. If desired, participant may drink some water.



Stop the test if solution is not tasted after 30 squeezes. Try an alternative solution from below.

Sweet taste	3M-FT11 (sensitivity solution) 3M-FT12 (test solution)
Bitter taste	3M-FT31 (sensitivity solution) 3M-FT32 (test solution)

[1]Quantitative fit testing must be used when an assigned protection factor higher than 10 is needed for a full facepiece used in negative pressure mode, per 29 CFR 1910.134

Part 2 - Fit Testing

1. Add 1/2 teaspoon of test solution **(in black labeled bottle)** into the test nebulizer **(marked in black)**. Visually confirm that the nebulizer produces a cloud of aerosol when the bulb is squeezed.
2. Don the respirator and make sure respirator is fitted correctly. Refer to the 3M fitting instructions or poster for correct procedure. After the respirator is correctly donned, wait five minutes before beginning the next step.
3. Place test hood on participant.

Number of Squeezes Needed in Part 1	Number of Squeezes for Initial Dose	Number of Squeezes for a Replenishing Dose Every 30 Seconds
1-10	10	5
11-20	20	10
21-30	30	15

4. Introduce solution in an initial dose and start the exercises. Add a replenishing dose after every 30 second per the table below.
5. After the initial dose, ask the participant to carry out the 7 exercises shown in turn for 1 minute each and indicate immediately if solution is tasted. Remember to add a replenishing dose every 30 seconds. **Throughout the test, remind the participant to breathe through their mouth and visually confirm that the nebulizer is not clogged.**
6. Record all results.
   If solution is not tasted after all 7 exercises. they have passed the test with that specific respirator. If **solution is tasted, stop the test, rinse mouth, face, and hands, refit respirator and restart at Part 1 - Sensitivity Testing.**
   If solution is still tasted on the second attempt, stop the test, rinse hands, mouth, and face, and consider trying an alternative 3M respirator.
7. Discard all unused solution.

7 Exercises

1. Breathe normally 2. Breathe deeply 3. Head side-to-side 4. Head up and down 5. Talking 6. Bend over at waist 7. Breathe normally

This product is part of a system that helps reduce exposures to certain airborne contaminants. Before use, the wearer must read and understand these User Instructions. Follow all local regulations. In the U.S., a written respiratory protection program must be implemented meeting all the requirements of 29 CFR 1910.134, including training, fit testing and medical evaluation. In Canada, CSA standard Z94.4 requirements must be met and/or requirements of the applicable jurisdiction, as appropriate. Misuse may result in injury, sickness or death. For correct use, consult supervisor and User Instructions, or call 3M Technical Service in USA at 1-800-243-4630 and in Canada at 1-800-267-4414.

Personal Safety Division
3M Center, Building 235-2W-70
St. Paul, MN 55144-1000

3M PSD products are occupational use only.

In United States of America
Technical Service: 1-800-243-4630
Customer Service: 1-800-328-1667
3M.com/workersafety

In Canada
Technical Service: 1-800-267-4414
Customer Service: 1-800-364-3577
3M.ca/Safety

For a demonstration video, visit the link below.

go.3M.com/Fit

By Standard Number / 1910.134 App A - Fit Testing Procedures (Mandatory).

- **Part Number:** 1910
- **Part Number Title:** Occupational Safety and Health Standards
- **Subpart:** 1910 Subpart I
- **Subpart Title:** Personal Protective Equipment
- **Standard Number:** 1910.134 App A
- **Title:** Fit Testing Procedures (Mandatory).
- **GPO Source:** e-CFR

Appendix A to § 1910.134 - Fit Testing Procedures (Mandatory)

Part I. OSHA-Accepted Fit Test Protocols

A. Fit Testing Procedures - General Requirements

The employer shall conduct fit testing using the following procedures. The requirements in this appendix apply to all OSHA-accepted fit test methods, both QLFT and QNFT.

1. The test subject shall be allowed to pick the most acceptable respirator from a sufficient number of respirator models and sizes so that the respirator is acceptable to, and correctly fits, the user.

2. Prior to the selection process, the test subject shall be shown how to put on a respirator, how it should be positioned on the face, how to set strap tension and how to determine an acceptable fit. A mirror shall be available to assist the subject in evaluating the fit and positioning of the respirator. This instruction may not constitute the subject's formal training on respirator use, because it is only a review.

3. The test subject shall be informed that he/she is being asked to select the respirator that provides the most acceptable fit. Each respirator represents a different size and shape, and if fitted and used properly, will provide adequate protection.

4. The test subject shall be instructed to hold each chosen facepiece up to the face and eliminate those that obviously do not give an acceptable fit.

5. The more acceptable facepieces are noted in case the one selected proves unacceptable; the most comfortable mask is donned and worn at least five minutes to assess comfort. Assistance in assessing comfort can be given by discussing the points in the following item A.6. If the test subject is not familiar with using a particular respirator, the test subject shall be directed to don the mask several times and to adjust the straps each time to become adept at setting proper tension on the straps.

6. Assessment of comfort shall include a review of the following points with the test subject and allowing the test subject adequate time to determine the comfort of the respirator:

(a) Position of the mask on the nose

(b) Room for eye protection

(c) Room to talk

(d) Position of mask on face and cheeks

7. The following criteria shall be used to help determine the adequacy of the respirator fit:

(a) Chin properly placed;

(b) Adequate strap tension, not overly tightened;

(c) Fit across nose bridge;

(d) Respirator of proper size to span distance from nose to chin;

(e) Tendency of respirator to slip;

(f) Self-observation in mirror to evaluate fit and respirator position.

8. The test subject shall conduct a user seal check, either the negative and positive pressure seal checks described in appendix B-1 of this section or those recommended by the respirator manufacturer which provide equivalent protection to the procedures in appendix B-1. Before conducting the negative and positive pressure checks, the subject shall be told to seat the mask on the face by moving the head from side-to-side and up and down slowly while taking in a few slow deep breaths. Another facepiece shall be selected and retested if the test subject fails the user seal check tests.

9. The test shall not be conducted if there is any hair growth between the skin and the facepiece sealing surface, such as stubble beard growth, beard, mustache or sideburns which cross the respirator sealing surface. Any type of apparel which interferes with a satisfactory fit shall be altered or removed.

10. If a test subject exhibits difficulty in breathing during the tests, she or he shall be referred to a physician or other licensed health care professional, as appropriate, to determine whether the test subject can wear a respirator while performing her or his duties.

11. If the employee finds the fit of the respirator unacceptable, the test subject shall be given the opportunity to select a different respirator and to be retested.

12. Exercise regimen. Prior to the commencement of the fit test, the test subject shall be given a description of the fit test and the test subject's responsibilities during the test procedure. The description of the process shall include a description of the test exercises that the subject will be performing. The respirator to be tested shall be worn for at least 5 minutes before the start of the fit test.

13. The fit test shall be performed while the test subject is wearing any applicable safety equipment that may be worn during actual respirator use which could interfere with respirator fit.

14. Test Exercises.

(a) Employers must perform the following test exercises for all fit testing methods prescribed in this appendix, except for the two modified ambient aerosol CNC quantitative fit testing protocols, the CNP quantitative fit testing protocol, and the CNP REDON quantitative fit testing protocol. For the modified ambient aerosol CNC quantitative fit testing protocols, employers shall ensure that the test subjects (*i.e.*, employees) perform the exercise procedure specified in Part I.C.4(b) of this appendix for full-facepiece and half-mask elastomeric respirators, or the exercise procedure specified in Part I.C.5(b) for filtering facepiece respirators. Employers shall ensure that the test subjects (i.e., employees) perform the exercise procedure specified in Part I.C.6(b) of this appendix for the CNP quantitative fit testing protocol, or the exercise procedure described in Part I.C.7(b) of this appendix for the CNP REDON quantitative fit testing protocol. For the remaining fit testing methods, employers shall ensure that the test exercises are performed in the appropriate test environment in the following manner:

(1) Normal breathing. In a normal standing position, without talking, the subject shall breathe normally.

(2) Deep breathing. In a normal standing position, the subject shall breathe slowly and deeply, taking caution so as not to hyperventilate.

(3) Turning head side to side. Standing in place, the subject shall slowly turn his/her head from side to side between the extreme positions on each side. The head shall be held at each extreme momentarily so the subject can inhale at each side.

(4) Moving head up and down. Standing in place, the subject shall slowly move his/her head up and down. The subject shall be instructed to inhale in the up position (i.e., when looking toward the ceiling).

(5) Talking. The subject shall talk out loud slowly and loud enough so as to be heard clearly by the test conductor. The subject can read from a prepared text such as the Rainbow Passage, count backward from 100, or recite a memorized poem or song.

Rainbow Passage

When the sunlight strikes raindrops in the air, they act like a prism and form a rainbow. The rainbow is a division of white light into many beautiful colors. These take the shape of a long round arch, with its path high above, and its two ends apparently beyond the horizon. There is, according to legend, a boiling pot of gold at one end. People look, but no one ever finds it. When a man looks for something beyond reach, his friends say he is looking for the pot of gold at the end of the rainbow.

(6) Grimace. The test subject shall grimace by smiling or frowning. (This applies only to QNFT testing; it is not performed for QLFT)

(7) Bending over. The test subject shall bend at the waist as if he/she were to touch his/her toes. Jogging in place shall be substituted for this exercise in those test environments such as shroud type QNFT or QLFT units that do not permit bending over at the waist.

(8) Normal breathing. Same as exercise (1).

(b) Each test exercise shall be performed for one minute except for the grimace exercise which shall be performed for 15 seconds. The test subject shall be questioned by the test conductor regarding the comfort of the respirator upon completion of the protocol. If it has become unacceptable, another model of respirator shall be tried. The respirator shall not be adjusted once the fit test exercises begin. Any adjustment voids the test, and the fit test must be repeated.

B. Qualitative Fit Test (QLFT) Protocols

1. GENERAL

(a) The employer shall ensure that persons administering QLFT are able to prepare test solutions, calibrate equipment and perform tests properly, recognize invalid tests, and ensure that test equipment is in proper working order.

(b) The employer shall ensure that QLFT equipment is kept clean and well maintained so as to operate within the parameters for which it was designed.

2. ISIAMYL ACETATE PROTOCOL

Note:
This protocol is not appropriate to use for the fit testing of particulate respirators. If used to fit test particulate respirators, the respirator must be equipped with an organic vapor filter.

(a) Odor Threshold Screening

Odor threshold screening, performed without wearing a respirator, is intended to determine if the individual tested can detect the odor of isoamyl acetate at low levels.

(1) Three 1 liter glass jars with metal lids are required.

(2) Odor-free water (e.g., distilled or spring water) at approximately 25 °C (77 °F) shall be used for the solutions.

(3) The isoamyl acetate (IAA) (also known at isopentyl acetate) stock solution is prepared by adding 1 ml of pure IAA to 800 ml of odor-free water in a 1 liter jar, closing the lid and shaking for 30 seconds. A new solution shall be prepared at least weekly.

(4) The screening test shall be conducted in a room separate from the room used for actual fit testing. The two rooms shall be well-ventilated to prevent the odor of IAA from becoming evident in the general room air where testing takes place.

(5) The odor test solution is prepared in a second jar by placing 0.4 ml of the stock solution into 500 ml of odor-free water using a clean dropper or pipette. The solution shall be shaken for 30 seconds and allowed to stand for two to three minutes so that the IAA concentration above the liquid may reach equilibrium. This solution shall be used for only one day.

(6) A test blank shall be prepared in a third jar by adding 500 cc of odor-free water.

(7) The odor test and test blank jar lids shall be labeled (e.g., 1 and 2) for jar identification. Labels shall be placed on the lids so that they can be peeled off periodically and switched to maintain the integrity of the test.

(8) The following instruction shall be typed on a card and placed on the table in front of the two test jars (i.e., 1 and 2): "The purpose of this test is to determine if you can smell banana oil at a low concentration. The two bottles in front of you contain water. One of these bottles also contains a small amount of banana oil. Be sure the covers are on tight, then shake each bottle for two seconds. Unscrew the lid of each bottle, one at a time, and sniff at the mouth of the bottle. Indicate to the test conductor which bottle contains banana oil."

(9) The mixtures used in the IAA odor detection test shall be prepared in an area separate from where the test is performed, in order to prevent olfactory fatigue in the subject.

(10) If the test subject is unable to correctly identify the jar containing the odor test solution, the IAA qualitative fit test shall not be performed.

(11) If the test subject correctly identifies the jar containing the odor test solution, the test subject may proceed to respirator selection and fit testing.

(b) Isoamyl Acetate Fit Test

(1) The fit test chamber shall be a clear 55-gallon drum liner suspended inverted over a 2-foot diameter frame so that the top of the chamber is about 6 inches above the test subject's head. If no drum liner is available, a similar chamber shall be constructed using plastic sheeting. The inside top center of the chamber shall have a small hook attached.

(2) Each respirator used for the fitting and fit testing shall be equipped with organic vapor cartridges or offer protection against organic vapors.

(3) After selecting, donning, and properly adjusting a respirator, the test subject shall wear it to the fit testing room. This room shall be separate from the room used for odor threshold screening and respirator selection, and shall be well-ventilated, as by an exhaust fan or lab hood, to prevent general room contamination.

(4) A copy of the test exercises and any prepared text from which the subject is to read shall be taped to the inside of the test chamber.

(5) Upon entering the test chamber, the test subject shall be given a 6-inch by 5-inch piece of paper towel, or other porous, absorbent, single-ply material, folded in half and wetted with 0.75 ml of pure IAA. The test subject shall hang the wet towel on the hook at the top of the chamber. An IAA test swab or ampule may be substituted for the

IAA wetted paper towel provided it has been demonstrated that the alternative IAA source will generate an IAA test atmosphere with a concentration equivalent to that generated by the paper towel method.

(6) Allow two minutes for the IAA test concentration to stabilize before starting the fit test exercises. This would be an appropriate time to talk with the test subject; to explain the fit test, the importance of his/her cooperation, and the purpose for the test exercises; or to demonstrate some of the exercises.

(7) If at any time during the test, the subject detects the banana-like odor of IAA, the test is failed. The subject shall quickly exit from the test chamber and leave the test area to avoid olfactory fatigue.

(8) If the test is failed, the subject shall return to the selection room and remove the respirator. The test subject shall repeat the odor sensitivity test, select and put on another respirator, return to the test area and again begin the fit test procedure described in (b) (1) through (7) above. The process continues until a respirator that fits well has been found. Should the odor sensitivity test be failed, the subject shall wait at least 5 minutes before retesting. Odor sensitivity will usually have returned by this time.

(9) If the subject passes the test, the efficiency of the test procedure shall be demonstrated by having the subject break the respirator face seal and take a breath before exiting the chamber.

(10) When the test subject leaves the chamber, the subject shall remove the saturated towel and return it to the person conducting the test, so that there is no significant IAA concentration buildup in the chamber during subsequent tests. The used towels shall be kept in a self-sealing plastic bag to keep the test area from being contaminated.

3. SACCHARIN SOLUTION AEROSOL PROTOCOL

The entire screening and testing procedure shall be explained to the test subject prior to the conduct of the screening test.

(a) Taste threshold screening. The saccharin taste threshold screening, performed without wearing a respirator, is intended to determine whether the individual being tested can detect the taste of saccharin.

(1) During threshold screening as well as during fit testing, subjects shall wear an enclosure about the head and shoulders that is approximately 12 inches in diameter by 14 inches tall with at least the front portion clear and that allows free movements of the head when a respirator is worn. An enclosure substantially similar to the 3M hood assembly, parts # FT 14 and # FT 15 combined, is adequate.

(2) The test enclosure shall have a ¾ -inch (1.9 cm) hole in front of the test subject's nose and mouth area to accommodate the nebulizer nozzle.

(3) The test subject shall don the test enclosure. Throughout the threshold screening test, the test subject shall breathe through his/her slightly open mouth with tongue extended. The subject is instructed to report when he/she detects a sweet taste.

(4) Using a DeVilbiss Model 40 Inhalation Medication Nebulizer or equivalent, the test conductor shall spray the threshold check solution into the enclosure. The nozzle is directed away from the nose and mouth of the person. This nebulizer shall be clearly marked to distinguish it from the fit test solution nebulizer.

(5) The threshold check solution is prepared by dissolving 0.83 gram of sodium saccharin USP in 100 ml of warm water. It can be prepared by putting 1 ml of the fit test solution (see (b)(5) below) in 100 ml of distilled water.

(6) To produce the aerosol, the nebulizer bulb is firmly squeezed so that it collapses completely, then released and allowed to fully expand.

(7) Ten squeezes are repeated rapidly and then the test subject is asked whether the saccharin can be tasted. If the test subject reports tasting the sweet taste during the ten squeezes, the screening test is completed. The taste threshold is noted as ten regardless of the number of squeezes actually completed.

(8) If the first response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the saccharin is tasted. If the test subject reports tasting the sweet taste during the second ten squeezes, the screening test is completed. The taste threshold is noted as twenty regardless of the number of squeezes actually completed.

(9) If the second response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the saccharin is tasted. If the test subject reports tasting the sweet taste during the third set of ten squeezes, the screening test is completed. The taste threshold is noted as thirty regardless of the number of squeezes actually completed.

(10) The test conductor will take note of the number of squeezes required to solicit a taste response.

(11) If the saccharin is not tasted after 30 squeezes (step 10), the test subject is unable to taste saccharin and may not perform the saccharin fit test.

Note to paragraph 3(a):
If the test subject eats or drinks something sweet before the screening test, he/she may be unable to taste the weak saccharin solution.

(12) If a taste response is elicited, the test subject shall be asked to take note of the taste for reference in the fit test.

(13) Correct use of the nebulizer means that approximately 1 ml of liquid is used at a time in the nebulizer body.

(14) The nebulizer shall be thoroughly rinsed in water, shaken dry, and refilled at least each morning and afternoon or at least every four hours.

(b) Saccharin solution aerosol fit test procedure.

(1) The test subject may not eat, drink (except plain water), smoke, or chew gum for 15 minutes before the test.

(2) The fit test uses the same enclosure described in 3. (a) above.

(3) The test subject shall don the enclosure while wearing the respirator selected in section I. A. of this appendix. The respirator shall be properly adjusted and equipped with a particulate filter(s).

(4) A second DeVilbiss Model 40 Inhalation Medication Nebulizer or equivalent is used to spray the fit test solution into the enclosure. This nebulizer shall be clearly marked to distinguish it from the screening test solution nebulizer.

(5) The fit test solution is prepared by adding 83 grams of sodium saccharin to 100 ml of warm water.

(6) As before, the test subject shall breathe through the slightly open mouth with tongue extended, and report if he/she tastes the sweet taste of saccharin.

(7) The nebulizer is inserted into the hole in the front of the enclosure and an initial concentration of saccharin fit test solution is sprayed into the enclosure using the same number of squeezes (either 10, 20 or 30 squeezes) based on the number of squeezes required to elicit a taste response as noted during the screening test. A minimum of 10 squeezes is required.

(8) After generating the aerosol, the test subject shall be instructed to perform the exercises in section I. A. 14. of this appendix.

(9) Every 30 seconds the aerosol concentration shall be replenished using one half the original number of squeezes used initially (e.g., 5, 10 or 15).

(10) The test subject shall indicate to the test conductor if at any time during the fit test the taste of saccharin is detected. If the test subject does not report tasting the saccharin, the test is passed.

(11) If the taste of saccharin is detected, the fit is deemed unsatisfactory and the test is failed. A different respirator shall be tried and the entire test procedure is repeated (taste threshold screening and fit testing).

(12) Since the nebulizer has a tendency to clog during use, the test operator must make periodic checks of the nebulizer to ensure that it is not clogged. If clogging is found at the end of the test session, the test is invalid.

4. BITREX™ (DENATONIUM BENZOATE) SOLUTION AEROSOL QUALITATIVE FIT TEST PROTOCOL

The Bitrex™ (Denatonium benzoate) solution aerosol QLFT protocol uses the published saccharin test protocol because that protocol is widely accepted. Bitrex is routinely used as a taste aversion agent in household liquids which children should not be drinking and is endorsed by the American Medical Association, the National Safety Council, and the American Association of Poison Control Centers. The entire screening and testing procedure shall be explained to the test subject prior to the conduct of the screening test.

(a) Taste Threshold Screening.

The Bitrex taste threshold screening, performed without wearing a respirator, is intended to determine whether the individual being tested can detect the taste of Bitrex.

(1) During threshold screening as well as during fit testing, subjects shall wear an enclosure about the head and shoulders that is approximately 12 inches (30.5 cm) in diameter by 14 inches (35.6 cm) tall. The front portion of the enclosure shall be clear from the respirator and allow free movement of the head when a respirator is worn. An enclosure substantially similar to the 3M hood assembly, parts # FT 14 and # FT 15 combined, is adequate.

(2) The test enclosure shall have a ¾ inch (1.9 cm) hole in front of the test subject's nose and mouth area to accommodate the nebulizer nozzle.

(3) The test subject shall don the test enclosure. Throughout the threshold screening test, the test subject shall breathe through his or her slightly open mouth with tongue extended. The subject is instructed to report when he/she detects a bitter taste.

(4) Using a DeVilbiss Model 40 Inhalation Medication Nebulizer or equivalent, the test conductor shall spray the Threshold Check Solution into the enclosure. This Nebulizer shall be clearly marked to distinguish it from the fit test solution nebulizer.

(5) The Threshold Check Solution is prepared by adding 13.5 milligrams of Bitrex to 100 ml of 5% salt (NaCl) solution in distilled water.

(6) To produce the aerosol, the nebulizer bulb is firmly squeezed so that the bulb collapses completely, and is then released and allowed to fully expand.

(7) An initial ten squeezes are repeated rapidly and then the test subject is asked whether the Bitrex can be tasted. If the test subject reports tasting the bitter taste during the ten squeezes, the screening test is completed. The taste threshold is noted as ten regardless of the number of squeezes actually completed.

(8) If the first response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the Bitrex is tasted. If the test subject reports tasting the bitter taste during the second ten squeezes, the screening test is completed. The taste threshold is noted as twenty regardless of the number of squeezes actually completed.

(9) If the second response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the Bitrex is tasted. If the test subject reports tasting the bitter taste during the third set of ten squeezes, the screening test is completed. The taste threshold is noted as thirty regardless of the number of squeezes actually completed.

(10) The test conductor will take note of the number of squeezes required to solicit a taste response.

(11) If the Bitrex is not tasted after 30 squeezes (step 10), the test subject is unable to taste Bitrex and may not perform the Bitrex fit test.

(12) If a taste response is elicited, the test subject shall be asked to take note of the taste for reference in the fit test.

(13) Correct use of the nebulizer means that approximately 1 ml of liquid is used at a time in the nebulizer body.

(14) The nebulizer shall be thoroughly rinsed in water, shaken to dry, and refilled at least each morning and afternoon or at least every four hours.

(b) Bitrex Solution Aerosol Fit Test Procedure.

(1) The test subject may not eat, drink (except plain water), smoke, or chew gum for 15 minutes before the test.

(2) The fit test uses the same enclosure as that described in 4. (a) above.

(3) The test subject shall don the enclosure while wearing the respirator selected according to section I. A. of this appendix. The respirator shall be properly adjusted and equipped with any type particulate filter(s).

(4) A second DeVilbiss Model 40 Inhalation Medication Nebulizer or equivalent is used to spray the fit test solution into the enclosure. This nebulizer shall be clearly marked to distinguish it from the screening test solution nebulizer.

(5) The fit test solution is prepared by adding 337.5 mg of Bitrex to 200 ml of a 5% salt (NaCl) solution in warm water.

(6) As before, the test subject shall breathe through his or her slightly open mouth with tongue extended, and be instructed to report if he/she tastes the bitter taste of Bitrex.

(7) The nebulizer is inserted into the hole in the front of the enclosure and an initial concentration of the fit test solution is sprayed into the enclosure using the same number of squeezes (either 10, 20 or 30 squeezes) based on the number of squeezes required to elicit a taste response as noted during the screening test.

(8) After generating the aerosol, the test subject shall be instructed to perform the exercises in section I. A. 14. of this appendix.

(9) Every 30 seconds the aerosol concentration shall be replenished using one half the number of squeezes used initially (e.g., 5, 10 or 15).

(10) The test subject shall indicate to the test conductor if at any time during the fit test the taste of Bitrex is detected. If the test subject does not report tasting the Bitrex, the test is passed.

(11) If the taste of Bitrex is detected, the fit is deemed unsatisfactory and the test is failed. A different respirator shall be tried and the entire test procedure is repeated (taste threshold screening and fit testing).

5. IRRITANT SMOKE (STANNIC CHLORIDE) PROTOCOL

This qualitative fit test uses a person's response to the irritating chemicals released in the "smoke" produced by a stannic chloride ventilation smoke tube to detect leakage into the respirator.

(a) General Requirements and Precautions

(1) The respirator to be tested shall be equipped with high efficiency particulate air (HEPA) or P100 series filter(s).

(2) Only stannic chloride smoke tubes shall be used for this protocol.

(3) No form of test enclosure or hood for the test subject shall be used.

(4) The smoke can be irritating to the eyes, lungs, and nasal passages. The test conductor shall take precautions to minimize the test subject's exposure to irritant smoke. Sensitivity varies, and certain individuals may respond to a greater degree to irritant smoke. Care shall be taken when performing the sensitivity screening checks that determine whether the test subject can detect irritant smoke to use only the minimum amount of smoke necessary to elicit a response from the test subject.

(5) The fit test shall be performed in an area with adequate ventilation to prevent exposure of the person conducting the fit test or the build-up of irritant smoke in the general atmosphere.

(b) Sensitivity Screening Check

The person to be tested must demonstrate his or her ability to detect a weak concentration of the irritant smoke.

(1) The test operator shall break both ends of a ventilation smoke tube containing stannic chloride, and attach one end of the smoke tube to a low flow air pump set to deliver 200 milliliters per minute, or an aspirator squeeze bulb. The test operator shall cover the other end of the smoke tube with a short piece of tubing to prevent potential injury from the jagged end of the smoke tube.

(2) The test operator shall advise the test subject that the smoke can be irritating to the eyes, lungs, and nasal passages and instruct the subject to keep his/her eyes closed while the test is performed.

(3) The test subject shall be allowed to smell a weak concentration of the irritant smoke before the respirator is donned to become familiar with its irritating properties and to determine if he/she can detect the irritating properties of the smoke. The test operator shall carefully direct a small amount of the irritant smoke in the test subject's direction to determine that he/she can detect it.

(c) Irritant Smoke Fit Test Procedure

(1) The person being fit tested shall don the respirator without assistance, and perform the required user seal check(s).

(2) The test subject shall be instructed to keep his/her eyes closed.

(3) The test operator shall direct the stream of irritant smoke from the smoke tube toward the faceseal area of the test subject, using the low flow pump or the squeeze bulb. The test operator shall begin at least 12 inches from the facepiece and move the smoke stream around the whole perimeter of the mask. The operator shall gradually make two more passes around the perimeter of the mask, moving to within six inches of the respirator.

(4) If the person being tested has not had an involuntary response and/or detected the irritant smoke, proceed with the test exercises.

(5) The exercises identified in section I.A. 14. of this appendix shall be performed by the test subject while the respirator seal is being continually challenged by the smoke, directed around the perimeter of the respirator at a distance of six inches.

(6) If the person being fit tested reports detecting the irritant smoke at any time, the test is failed. The person being retested must repeat the entire sensitivity check and fit test procedure.

(7) Each test subject passing the irritant smoke test without evidence of a response (involuntary cough, irritation) shall be given a second sensitivity screening check, with the smoke from the same smoke tube used during the fit test, once the respirator has been removed, to determine whether he/she still reacts to the smoke. Failure to evoke

a response shall void the fit test.

(8) If a response is produced during this second sensitivity check, then the fit test is passed.

C. Quantitative Fit Test (QNFT) Protocols

The following quantitative fit testing procedures have been demonstrated to be acceptable: Quantitative fit testing using a non-hazardous test aerosol (such as corn oil, polyethylene glycol 400 [PEG 400], di-2-ethyl hexyl sebacate [DEHS], or sodium chloride) generated in a test chamber, and employing instrumentation to quantify the fit of the respirator; Quantitative fit testing using ambient aerosol as the test agent and appropriate instrumentation (condensation nuclei counter) to quantify the respirator fit; Quantitative fit testing using controlled negative pressure and appropriate instrumentation to measure the volumetric leak rate of a facepiece to quantify the respirator fit.

1. GENERAL

(a) The employer shall ensure that persons administering QNFT are able to calibrate equipment and perform tests properly, recognize invalid tests, calculate fit factors properly and ensure that test equipment is in proper working order.

(b) The employer shall ensure that QNFT equipment is kept clean, and is maintained and calibrated according to the manufacturer's instructions so as to operate at the parameters for which it was designed.

2. GENERATED AEROSOL QUANTITATIVE FIT TESTING PROTOCOL

(a) Apparatus.

(1) Instrumentation. Aerosol generation, dilution, and measurement systems using particulates (corn oil, polyethylene glycol 400 [PEG 400], di-2-ethyl hexyl sebacate [DEHS] or sodium chloride) as test aerosols shall be used for quantitative fit testing.

(2) Test chamber. The test chamber shall be large enough to permit all test subjects to perform freely all required exercises without disturbing the test agent concentration or the measurement apparatus. The test chamber shall be equipped and constructed so that the test agent is effectively isolated from the ambient air, yet uniform in concentration throughout the chamber.

(3) When testing air-purifying respirators, the normal filter or cartridge element shall be replaced with a high efficiency particulate air (HEPA) or P100 series filter supplied by the same manufacturer.

(4) The sampling instrument shall be selected so that a computer record or strip chart record may be made of the test showing the rise and fall of the test agent concentration with each inspiration and expiration at fit factors of at least 2,000. Integrators or computers that integrate the amount of test agent penetration leakage into the respirator for each exercise may be used provided a record of the readings is made.

(5) The combination of substitute air-purifying elements, test agent and test agent concentration shall be such that the test subject is not exposed in excess of an established exposure limit for the test agent at any time during the testing process, based upon the length of the exposure and the exposure limit duration.

(6) The sampling port on the test specimen respirator shall be placed and constructed so that no leakage occurs around the port (e.g., where the respirator is probed), a free air flow is allowed into the sampling line at all times, and there is no interference with the fit or performance of the respirator. The in-mask sampling device (probe) shall be designed and used so that the air sample is drawn from the breathing zone of the test subject, midway between the nose and mouth and with the probe extending into the facepiece cavity at least ¼ inch.

(7) The test setup shall permit the person administering the test to observe the test subject inside the chamber during the test.

(8) The equipment generating the test atmosphere shall maintain the concentration of test agent constant to within a 10 percent variation for the duration of the test.

(9) The time lag (interval between an event and the recording of the event on the strip chart or computer or integrator) shall be kept to a minimum. There shall be a clear association between the occurrence of an event and its being recorded.

(10) The sampling line tubing for the test chamber atmosphere and for the respirator sampling port shall be of equal diameter and of the same material. The length of the two lines shall be equal.

(11) The exhaust flow from the test chamber shall pass through an appropriate filter (i.e., high efficiency particulate filter) before release.

(12) When sodium chloride aerosol is used, the relative humidity inside the test chamber shall not exceed 50 percent.

(13) The limitations of instrument detection shall be taken into account when determining the fit factor.

(14) Test respirators shall be maintained in proper working order and be inspected regularly for deficiencies such as cracks or missing valves and gaskets.

(b) Procedural Requirements.

(1) When performing the initial user seal check using a positive or negative pressure check, the sampling line shall be crimped closed in order to avoid air pressure leakage during either of these pressure checks.

(2) The use of an abbreviated screening QLFT test is optional. Such a test may be utilized in order to quickly identify poor fitting respirators that passed the positive and/or negative pressure test and reduce the amount of QNFT time. The use of the CNC QNFT instrument in the count mode is another optional method to obtain a quick estimate of fit and eliminate poor fitting respirators before going on to perform a full QNFT.

(3) A reasonably stable test agent concentration shall be measured in the test chamber prior to testing. For canopy or shower curtain types of test units, the determination of the test agent's stability may be established after the test subject has entered the test environment.

(4) Immediately after the subject enters the test chamber, the test agent concentration inside the respirator shall be measured to ensure that the peak penetration does not exceed 5 percent for a half mask or 1 percent for a full facepiece respirator.

(5) A stable test agent concentration shall be obtained prior to the actual start of testing.

(6) Respirator restraining straps shall not be over-tightened for testing. The straps shall be adjusted by the wearer without assistance from other persons to give a reasonably comfortable fit typical of normal use. The respirator shall not be adjusted once the fit test exercises begin.

(7) The test shall be terminated whenever any single peak penetration exceeds 5 percent for half masks and 1 percent for full facepiece respirators. The test subject shall be refitted and retested.

(8) Calculation of fit factors.

(i) The fit factor shall be determined for the quantitative fit test by taking the ratio of the average chamber concentration to the concentration measured inside the respirator for each test exercise except the grimace exercise.

(ii) The average test chamber concentration shall be calculated as the arithmetic average of the concentration measured before and after each test (i.e., 7 exercises) or the arithmetic average of the concentration measured before and after each exercise or the true average measured continuously during the respirator sample.

(iii) The concentration of the challenge agent inside the respirator shall be determined by one of the following methods:

(A) Average peak penetration method means the method of determining test agent penetration into the respirator utilizing a strip chart recorder, integrator, or computer. The agent penetration is determined by an average of the peak heights on the graph or by computer integration, for each exercise except the grimace exercise. Integrators or computers that calculate the actual test agent penetration into the respirator for each exercise will also be considered to meet the requirements of the average peak penetration method.

(B) Maximum peak penetration method means the method of determining test agent penetration in the respirator as determined by strip chart recordings of the test. The highest peak penetration for a given exercise is taken to be representative of average penetration into the respirator for that exercise.

(C) Integration by calculation of the area under the individual peak for each exercise except the grimace exercise. This includes computerized integration.

(D) The calculation of the overall fit factor using individual exercise fit factors involves first converting the exercise fit factors to penetration values, determining the average, and then converting that result back to a fit factor. This procedure is described in the following equation:

$$\text{Overall Fit Factor} = \frac{\text{Number of exercises}}{1/ff_1 + 1/ff_2 + 1/ff_3 + 1/ff_4 + 1/ff_5 + 1/ff_7 + 1/ff_8}$$

Where ff_1, ff_2, ff_3, etc. are the fit factors for exercises 1, 2, 3, etc.

(9) The test subject shall not be permitted to wear a half mask or quarter facepiece respirator unless a minimum fit factor of 100 is obtained, or a full facepiece respirator unless a minimum fit factor of 500 is obtained.

(10) Filters used for quantitative fit testing shall be replaced whenever increased breathing resistance is encountered, or when the test agent has altered the integrity of the filter media.

3. AMBIENT AEROSOL CONDENSATION NUCLEI COUNTER (CNC) QUANTITATIVE FIT TESTING PROTOCOL.

The ambient aerosol condensation nuclei counter (CNC) quantitative fit testing (PortaCount®) protocol quantitatively fit tests respirators with the use of a probe. The probed respirator is only used for quantitative fit tests. A probed respirator has a special sampling device, installed on the respirator, that allows the probe to sample the air from inside the mask. A probed respirator is required for each make, style, model, and size that the employer uses and can be obtained from the respirator manufacturer or distributor. The primary CNC instrument manufacturer, TSI Incorporated, also provides probe attachments (TSI mask sampling adapters) that permit fit testing in an employee's own respirator. A minimum fit factor pass level of at least 100 is necessary for a half-mask respirator (elastomeric or filtering facepiece), and a minimum fit factor pass level of at least 500 is required for a full-facepiece elastomeric respirator. The entire screening and testing procedure shall be explained to the test subject prior to the conduct of the screening test.

(a) PortaCount® Fit Test Requirements. (1) Check the respirator to make sure the sampling probe and line are properly attached to the facepiece and that the respirator is fitted with a particulate filter capable of preventing significant penetration by the ambient particles used for the fit test (e.g., NIOSH 42 CFR 84 series 100, series 99, or series 95 particulate filter) per manufacturer's instruction.

(2) Instruct the person to be tested to don the respirator for five minutes before the fit test starts. This purges the ambient particles trapped inside the respirator and permits the wearer to make certain the respirator is comfortable. This individual shall already have been trained on how to wear the respirator properly.

(3) Check the following conditions for the adequacy of the respirator fit: Chin properly placed; Adequate strap tension, not overly tightened; Fit across nose bridge; Respirator of proper size to span distance from nose to chin; Tendency of the respirator to slip; Self-observation in a mirror to evaluate fit and respirator position.

(4) Have the person wearing the respirator do a user seal check. If leakage is detected, determine the cause. If leakage is from a poorly fitting facepiece, try another size of the same model respirator, or another model of respirator.

(5) Follow the manufacturer's instructions for operating the Portacount® and proceed with the test.

(6) The test subject shall be instructed to perform the exercises in section I. A. 14. of this appendix.

(7) After the test exercises, the test subject shall be questioned by the test conductor regarding the comfort of the respirator upon completion of the protocol. If it has become unacceptable, another model of respirator shall be tried.

(b) PortaCount® Test Instrument.

(1) The PortaCount® will automatically stop and calculate the overall fit factor for the entire set of exercises. The overall fit factor is what counts. The Pass or Fail message will indicate whether or not the test was successful. If the test was a Pass, the fit test is over.

(2) Since the pass or fail criterion of the PortaCount® is user programmable, the test operator shall ensure that the pass or fail criterion meet the requirements for minimum respirator performance in this Appendix.

(3) A record of the test needs to be kept on file, assuming the fit test was successful. The record must contain the test subject's name; overall fit factor; make, model, style, and size of respirator used; and date tested.

4. MODIFIED AMBIENT AEROSOL CONDENSATION NUCLEI COUNTER (CNC) QUANTITATIVE FIT TESTING PROTOCOL FOR FULL-FACEPIECE AND HALF-MASK ELASTOMERIC RESPIRATORS.

(a) When administering this protocol to test subjects, employers shall comply with the requirements specified in Part I.C.3 of this appendix (ambient aerosol condensation nuclei counter (CNC) quantitative fit testing protocol), except they shall use the test exercises described below in paragraph (b) of this protocol instead of the test exercises specified in section I.C.3(a)(6) of this appendix.

(b) Employers shall ensure that each test subject being fit tested using this protocol follows the exercise and duration procedures, including the order of administration, described in Table A-1 of this appendix.

Table A-1 - Modified Ambient Aerosal CNC Quantitative Fit Testing Protocol for Full Facepiece and Half-Mask Elastomeric Respirators

Exercises[1]	Exercise procedure	Measurement procedure
Bending Over	The test subject shall bend at the waist, as if going to touch his/her toes for 50 seconds and inhale 2 times at the bottom[2]	A 20 second ambient sample, followed by a 30 second mask sample.
Jogging-in-Place	The test subject shall jog in place comfortably for 30 seconds	A 30 second mask sample.
Head Side-to-Side	The test subject shall stand in place, slowly turning his/her head from side to side for 30 seconds and inhale 2 times at each extreme[2]	A 30 second mask sample.

Exercises[1]	Exercise procedure	Measurement procedure
Head Up-and-Down	The test subject shall stand in place, slowly moving his/her head up and down for 39 seconds and inhale 2 times at each extreme[2]	A 30 second mask sample followed by a 9 second ambient sample.

[1]Exercises are listed in the order in which they are to be administered.

[2]It is optional for test subjects to take additional breaths at other times during this exercise.

5. MODIFIED AMBIENT AEROSOL CONDENSATION NUCLEI COUNTER (CNC) QUANTITATIVE FIT TESTING PROTOCOL FOR FILTERING FACEPIECE RESPIRATORS.

(a) When administering this protocol to test subjects, employers shall comply with the requirements specified in Part I.C.3 of this appendix (ambient aerosol condensation nuclei counter (CNC) quantitative fit testing protocol), except they shall use the test exercises described below in paragraph (b) of this protocol instead of the test exercises specified in section I.C.3(a)(6) of this appendix.

(b) Employers shall ensure that each test subject being fit tested using this protocol follows the exercise and duration procedures, including the order of administration, described in Table A-2 of this appendix.

Table A-2 - Modified Ambient Aerosal CNC Quantitative Fit Testing Protocol for Filtering Facepiece Respirators

Exercises[1]	Exercise procedure	Measurement procedure
Bending Over	The test subject shall bend at the waist, as if going to touch his/her toes for 50 seconds and inhale 2 times at the bottom[2]	A 20 second ambient sample, followed by a 30 second mask sample.
Talking	The test subject shall talk out loud slowly and loud enough so as to be heard clearly by the test conductor for 30 seconds. He/she will either read from a prepared text such as the Rainbow Passage, count backward from 100, or recite a memorized poem or song	A 30 second mask sample.
Head Side-to-Side	The test subject shall stand in place, slowly turning his/her head from side to side for 30 seconds and inhale 2 times at each extreme[2]	A 30 second mask sample.
Head Up-and-Down	The test subject shall stand in place, slowly moving his/her head up and down for 39 seconds and inhale 2 times at each extreme[2]	A 30 second mask sample followed by a 9 second ambient sample.

[1]Exercises are listed in the order in which they are to be administered.

[2]It is optional for test subjects to take additional breaths at other times during this exercise.

6. CONTROLLED NEGATIVE PRESSURE (CNP) QUANTITATIVE FIT TESTING PROTOCOL.

The CNP protocol provides an alternative to aerosol fit test methods. The CNP fit test method technology is based on exhausting air from a temporarily sealed respirator facepiece to generate and then maintain a constant negative pressure inside the facepiece. The rate of air exhaust is controlled so that a constant negative pressure is maintained in the respirator during the fit test. The level of pressure is selected to replicate the mean inspiratory pressure that causes leakage into the respirator under normal use conditions. With pressure held constant, air flow out of the respirator is equal to air flow into the respirator. Therefore, measurement of the exhaust stream that is required to hold the pressure in the temporarily sealed respirator constant yields a direct measure of leakage air flow into the respirator. The CNP fit test method measures leak rates through the facepiece as a method for determining the facepiece fit for negative pressure respirators. The CNP instrument manufacturer Occupational Health Dynamics of Birmingham, Alabama also provides attachments (sampling manifolds) that replace the filter cartridges to permit fit testing in an employee's own respirator. To perform the test, the test subject closes his or her mouth and holds his/her breath, after which an air pump removes air from the respirator facepiece at a pre-selected constant pressure. The facepiece fit is expressed as the leak rate through the facepiece, expressed as milliliters per minute. The quality and validity of the CNP fit tests are determined by the degree to which the in-mask pressure tracks the test pressure during the system measurement time of approximately five seconds. Instantaneous feedback in the form of a real-time pressure trace of the in-mask pressure is provided and used to determine test validity and quality. A minimum fit factor pass level of 100 is necessary for a half-mask respirator and a minimum fit factor of at least 500 is required for a full facepiece respirator. The entire screening and testing procedure shall be explained to the test subject prior to the conduct of the screening test.

(a) CNP Fit Test Requirements.

(1) The instrument shall have a non-adjustable test pressure of 15.0 mm water pressure.

(2) The CNP system defaults selected for test pressure shall be set at −15 mm of water (-0.58 inches of water) and the modeled inspiratory flow rate shall be 53.8 liters per minute for performing fit tests.

Note:
CNP systems have built-in capability to conduct fit testing that is specific to unique work rate, mask, and gender situations that might apply in a specific workplace. Use of system default values, which were selected to represent respirator wear with medium cartridge resistance at a low-moderate work rate, will allow inter-test comparison of the respirator fit.)

(3) The individual who conducts the CNP fit testing shall be thoroughly trained to perform the test.

(4) The respirator filter or cartridge needs to be replaced with the CNP test manifold. The inhalation valve downstream from the manifold either needs to be temporarily removed or propped open.

(5) The employer must train the test subject to hold his or her breath for at least 10 seconds.

(6) The test subject must don the test respirator without any assistance from the test administrator who is conducting the CNP fit test. The respirator must not be adjusted once the fit-test exercises begin. Any adjustment voids the test, and the test subject must repeat the fit test.

(7) The QNFT protocol shall be followed according to section I. C. 1. of this appendix with an exception for the CNP test exercises.

(b) CNP Test Exercises.

(1) Normal breathing. In a normal standing position, without talking, the subject shall breathe normally for 1 minute. After the normal breathing exercise, the subject needs to hold head straight ahead and hold his or her breath for 10 seconds during the test measurement.

(2) Deep breathing. In a normal standing position, the subject shall breathe slowly and deeply for 1 minute, being careful not to hyperventilate. After the deep breathing exercise, the subject shall hold his or her head straight ahead and hold his or her breath for 10 seconds during test measurement.

(3) Turning head side to side. Standing in place, the subject shall slowly turn his or her head from side to side between the extreme positions on each side for 1 minute. The head shall be held at each extreme momentarily so the subject can inhale at each side. After the turning head side to side exercise, the subject needs to hold head full left and hold his or her breath for 10 seconds during test measurement. Next, the subject needs to hold head full right and hold his or her breath for 10 seconds during test measurement.

(4) Moving head up and down. Standing in place, the subject shall slowly move his or her head up and down for 1 minute. The subject shall be instructed to inhale in the up position (i.e., when looking toward the ceiling). After the moving head up and down exercise, the subject shall hold his or her head full up and hold his or her breath for 10 seconds during test measurement. Next, the subject shall hold his or her head full down and hold his or her breath for 10 seconds during test measurement.

(5) Talking. The subject shall talk out loud slowly and loud enough so as to be heard clearly by the test conductor. The subject can read from a prepared text such as the Rainbow Passage, count backward from 100, or recite a memorized poem or song for 1 minute. After the talking exercise, the subject shall hold his or her head straight ahead and hold his or her breath for 10 seconds during the test measurement.

(6) Grimace. The test subject shall grimace by smiling or frowning for 15 seconds.

(7) Bending Over. The test subject shall bend at the waist as if he or she were to touch his or her toes for 1 minute. Jogging in place shall be substituted for this exercise in those test environments such as shroud-type QNFT units that prohibit bending at the waist. After the bending over exercise, the subject shall hold his or her head straight ahead and hold his or her breath for 10 seconds during the test measurement.

(8) Normal Breathing. The test subject shall remove and re-don the respirator within a one-minute period. Then, in a normal standing position, without talking, the subject shall breathe normally for 1 minute. After the normal breathing exercise, the subject shall hold his or her head straight ahead and hold his or her breath for 10 seconds during the test measurement. After the test exercises, the test subject shall be questioned by the test conductor regarding the comfort of the respirator upon completion of the protocol. If it has become unacceptable, another model of a respirator shall be tried.

(c) CNP Test Instrument.

(1) The test instrument must have an effective audio-warning device, or a visual-warning device in the form of a screen tracing, that indicates when the test subject fails to hold his or her breath during the test. The test must be terminated and restarted from the beginning when the test subject fails to hold his or her breath during the test. The test subject then may be refitted and retested.

(2) A record of the test shall be kept on file, assuming the fit test was successful. The record must contain the test subject's name; overall fit factor; make, model, style and size of respirator used; and date tested.

7. CONTROLLED NEGATIVE PRESSURE (CNP) REDON QUANTITATIVE FIT TESTING PROTOCOL.

(a) When administering this protocol to test subjects, employers must comply with the requirements specified in paragraphs (a) and (c) of part I.C.6 of this appendix ("Controlled negative pressure (CNP) quantitative fit testing protocol,") as well as use the test exercises described below in paragraph (b) of this protocol instead of the test exercises specified in paragraph (b) of part I.C.6 of this appendix.

(b) Employers must ensure that each test subject being fit tested using this protocol follows the exercise and measurement procedures, including the order of administration described in Table A-3 of this appendix.

Table A-3 - CNP REDON Quantitative Fit Testing Protocol

Exercises[1]	Exercise procedure	Measurement procedure
Facing Forward	Stand and breathe normally, without talking, for 30 seconds	Face forward, while holding breath for 10 seconds.
Bending Over	Bend at the waist, as if going to touch his or her toes, for 30 seconds	Face parallel to the floor, while holding breath for 10 seconds
Head Shaking	For about three seconds, shake head back and forth vigorously several times while shouting	Face forward, while holding breath for 10 seconds
REDON 1	Remove the respirator mask, loosen all facepiece straps, and then redon the respirator mask	Face forward, while holding breath for 10 seconds.
REDON 2	Remove the respirator mask, loosen all facepiece straps, and then redon the respirator mask again	Face forward, while holding breath for 10 seconds.

[1]Exercises are listed in the order in which they are to be administered.

(c) After completing the test exercises, the test administrator must question each test subject regarding the comfort of the respirator. When a test subject states that the respirator is unacceptable, the employer must ensure that the test administrator repeats the protocol using another respirator model.

(d) Employers must determine the overall fit factor for each test subject by calculating the harmonic mean of the fit testing exercises as follows:

$$\text{Overall Fit Factor} = \frac{N}{\left[1/FF_1 + 1/FF_2 + \ldots\ 1/FF_N\right]}$$

Where:

N = The number of exercises;

FF_1 = The fit factor for the first exercise;

FF_2 = The fit factor for the second exercise; and

FF_N = The fit factor for the nth exercise.

Part II. New Fit Test Protocols

A. Any person may submit to OSHA an application for approval of a new fit test protocol. If the application meets the following criteria, OSHA will initiate a rulemaking proceeding under section 6(b)(7) of the OSH Act to determine whether to list the new protocol as an approved protocol in this appendix A.

B. The application must include a detailed description of the proposed new fit test protocol. This application must be supported by either:

1. A test report prepared by an independent government research laboratory (e.g., Lawrence Livermore National Laboratory, Los Alamos National Laboratory, the National Institute for Standards and Technology) stating that the laboratory has tested the protocol and had found it to be accurate and reliable; or

2. An article that has been published in a peer-reviewed industrial hygiene journal describing the protocol and explaining how test data support the protocol's accuracy and reliability.

C. If OSHA determines that additional information is required before the Agency commences a rulemaking proceeding under this section, OSHA will so notify the applicant and afford the applicant the opportunity to submit the supplemental information. Initiation of a rulemaking proceeding will be deferred until OSHA has received and evaluated the supplemental information.
[63 FR 20098, April 23, 1998; 69 FR 46993, August 4, 2004]

NORTHERN MANHATTAN REHABILITATION AND NURSING CENTER

Personal Protected Equipment (PPE) Competency Validation
Donning and Doffing
Standard Precautions and Transmission Base Precautions

Type of Validation: Return demonstration	0 Orientation 0 Annual 0 Other

Employee Name:_____ **Job Title:**_____

Donning PPE	Competent YES	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. Fix 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		
9. Remove Gloves: Grasp outside of gloves with opposite gloved hand; peel off		
10. Hold removed gloved in gloved hand		
11. Slide fingers of ungloved hand under remaining glove at wrist		
12. Peel gloves in waste container		
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	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

Valuator

Date

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: NURSING		Policy#: 241	
Issue Date: 04/2020	Revision Date:	Review Date: 3/2023	Prepared by:
Policy Subject: Handwashing Observation Audit Tool			
Approved by:			Page 1 of 2

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 microorganism 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 are 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, wrist, 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			
10. Apply lotion to hands as desired.			

COMMENTS:

Employee Signature:_____ Date:_____

RN Supervisor's Signature:_____ Date:_____

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: _____

rev 2021

NORTHERN MANHATTAN NURSING HOME
POLICIES, PROCEDURES AND INFORMATION

Title: COMMUNICATION AND NOTIFICATION

Issued By: Administration

Effective Date : 04/20

Last Review Date: 3/2023

Supersedes:

Distribution: All Departments

POLICY:

In conjunction with our COVID-19 Management Plan, DOH and CMS requirements, the Facility will provide ongoing communication and notification to our Staff, Physicians and Clinicians as well as Family members and Significant others. All relevant notifications and communications will be kept in a COVID-19 Binder for compliance validation and reference.

PROCEDURE:

1. Staff, Physicians Department Heads and Clinicians
   - The Administrator and/or DNS will keep our staff, Department Heads and Clinical team notified of all DOH, CDC and CMS mandates to ensure awareness and ongoing quality of care to our residents.
   - All pertinent Covid-19 information from DOH/CMS has been reviewed and kept in a file for reference and police development
   - All Facility developed Policies for COVID-19 are distributed to all Nursing Units and to all Department Heads for awareness and consistent implementation of our interventions.
   - Notification to our staff will be done via in-serviced and during unit rounds by nursing Supervisors to ensure all policy revisions concerning resident care are effectively communicated.
   - In-service education regarding COVID-19 Care will be provided unit to unit (as needed) as opposed to classroom setting to ensure ongoing safety to our staff.
   - The Administrative Team is available to all staff for any questions or clarifications relative to COVID-19 Policies and Practiced
2. Family Members/Significant Others
   In a continuous effort to provide effective communication to our Resident's Families and Significant Others; the following notification practices will be implemented:
   - The Administrator will continue to send letters to Family members/and Significant others to inform them of the Facility's current status in the care of our Residents relative to COVID-19 care including updates on infections within the Facility. Our concentration and concerted effort to Families is to allay fears and promote confidence in the Quality of care our Facility stand by I

- Communication to Families will not violate HIPAA regulations, but will provide an overview of information in conjunction with our Infection Control practices and regulatory process.
- Residents identified with any change in condition ie: covid-19 suspect, or positive test will have the Family/Significant other within 24-48 hours notified by attending physician, charge nurse, nurse supervisors, Nurse Practitioners, Social Work via telephone which will be documented in the medical record.
- Residents who have a change in condition consistent with clinical decline which may require transfer to Hospital and/or implementation of Advance Directives; will have the Family notified by the Nurse or NP/MD, within 24-48 hours which will be documented in the medical record.
- Residents who decline and expire in house; will have family notified by the MD/NP, within 24-48 hours, which will be documented in the medical records
- The Facility will assign staff, as available, to provide weekly updated to Families regarding the status of their loved one and Facility function.
- Updates can be made in a variety of ways: Face-time, telephone, skype and video messages sent via text or email.
- Resident who have a decline will have notification within 24-48 hours via telephone in conjunction with the clinical condition of the resident.
- Facility will post updated information on our call-in-hot to Families and other interested Parties, as well as contact information regarding Facility Status and Resident Care.

3. Resident Communication:
   - New Admission to the Facility who have capacity will be informed prior to Admission that the Facility has Covid-19 cases. New Residents will be given a CDC Fact Sheet with signs and symptoms of the Virus and will be informed of NO VISITOR POLICY and of ways to communicate with Family.
   - Residents with capacity will be informed of their clinical condition by the MD/NP during visits as well as in daily conversation with Nursing Care, within 24-48 hours.
   - Resident Council criteria can be held with Social Distancing and individual interviews on units. Resident will be updated by Assigned Staff regarding the Facility Status and Care protocols relative to COVID-19 Council meetings
   - Resident's Council meetings will continue to have attendance and minutes regarding topic of conversations and resident concerns, via individual interviews. Residents will be encouraged to voice questions and or concerns in order for staff to best meet the needs of the residents.
   - The Social Workers, Psychologist and Recreation staff will continue to provide visits to the Residents in order to meet Psycho-social needs.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 03/2020	Revision Date: 03/2021	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Prospective Admissions Screening During a Pandemic**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

In the event of a Pandemic, Northern Manhattan Rehabilitation and Nursing Center 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.

3. Residents that are newly admitted or readmitted that are fully vaccinated and residents who have recovered from covid-19 infection within the last 90 days do not need to be quarantined when admitted to a nursing home. This is in alignment with CDC guidance on new admissions (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#new-admissions).

   Note: Fully vaccinated refers to a person who is greater or equal to two (2) weeks following receipt of the second dose in a 2-dose series, or greater or equal to two (2) weeks receipt of one dose of a single dose vaccine, per CDC's Public Health Recommendations for Vaccinated Persons.

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 12/17/2020	Revision Date: 04/2021; 05/2021; 06/2021; 08/2021; 09/2021; 01/2022; 02/2022; 06/2022; 09/2022;	Review Date: 09/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – COVID–19 Vaccination for Staff Members**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			Page1 of 6

POLICY STATEMENT

To prevent the spread of infectious disease and to decrease the morbidity and mortality associated with the SARS-CoV-2 virus, commonly known as Covid-19, this facility will offer Covid-19 vaccine to all staff.

In accordance with Section 16 of the NYS Public Health Law, Long Term Care Facility employees are required to be vaccinated with at least one dose of a Covid-19 vaccine by September 27, 2021, and to be fully vaccinated after having met the eligibility criteria. Facility will follow NYSDOH and CDC guidance as it relates to Covid vaccine booster doses.

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PROCEDURE

EDUCATION

1. Education will be provided to all staff of the facility, regarding the COVID-19 vaccination to include the mechanism of action, known efficacy, common side effects, and adverse reactions in accordance with information obtained from NYSDOH, CDC, ACIP, and the Emergency Use Authorization (EAU) Fact Sheet and the VIS. The Education will include:
    - The significant known and potential risks and benefits of the COVID-19 vaccine, and the extent to which such risks and benefits are unknown.
    - CDC/NYS DOH handouts to include Emergency Use Authorization Fact Sheet for Recipients and the VIS
    - Based on an updated risk-benefit analysis, use of mRNA COVID-19 vaccines is preferred over the Janssen COVID-19 Vaccine for all vaccine-eligible persons https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#considerations-Janssen
2. Staff will be informed that all employees are required to be fully vaccinated as recommended by CDC and NYSDOH unless they meet the criteria for a medical exemption.
    a. **Medical**: A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component; a documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine; physical condition/medical circumstance; other (medical provider will complete exemption form) https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf

b. **Religious Accommodation:** The facility will review requests for an accommodation and if it should be provided to an employee who is unvaccinated because of a sincerely held religious belief, consistent with Federal, State and local laws, including Title VII of the Civil Rights Act and NYS Human Rights Law. This determination will be made on a case-by-case basis, taking into consideration whether there is a reasonable accommodation available for that particular employee's job description that would not cause an undue hardship. An example of a reasonable accommodation could be remote work if the job description indicates that the work can be done remotely.

3. The facility will encourage employees to receive Covid-vaccine booster doses upon meeting eligibility criteria. See below:

As of September 6, 2022, the CDC new booster recommendations for people ages 12 years and older to be up to date with covid vaccination is to receive one <u>bivalent</u> mRNA booster after completion of a monovalent primary series; it replaces all prior booster recommendations for this age group

- **Recommendations for use of a bivalent Moderna booster dose in people ages 18 years and older**
- **Recommendations for use of a bivalent Pfizer-BioNTech booster dose in people ages 12 years and older**

<u>Vaccination schedule:</u> In accordance with CDC recommendations the facility will adhere to the following recommended vaccination schedule below:

Staff who are <u>not</u> moderately or severely immunocompromised:

Adults ages 18 years and older are recommended to receive one primary dose and one booster dose **at least 2 months after the primary dose**. A bivalent mRNA booster dose is recommended.

Staff <u>who are</u> moderately or severely immunocompromised:

Adults ages 18 years and older are recommended to receive one primary dose, a second (additional) dose using a monovalent mRNA COVID-19 vaccine, and one booster dose; a bivalent mRNA booster dose is recommended. The primary series dose and the additional dose are separated by at least 4 weeks. **The booster dose is administered at least 2 months after the additional dose.**

5. Employees who seek an exemption will be required to submit a written request, to include the reason for seeking exemption.
6. The medical exemption must be signed and dated by a licensed practitioner, who is not the same as the individual applying for the exemption, in accordance with all State and Local laws.
    i. Documentation must include all information specifying which of the authorized Covid-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications. The licensed practitioner is also required to provide a statement recommending that the staff be exempted from the facility's Covid-19 vaccination requirements for staff based on the recognized clinical contraindications.
7. Request will be reviewed by the Quality Assurance Committee to determine if reason(s) for exemption meet the requirements and a response will be provided within 14 days.
8. In accordance with NYS Covid-19 vaccine mandate regulation of 8/26/2021 and CMS QSO-22-07-ALL (12/28/2021), employees will need to provide proof of Covid-19 vaccination or a documented exemption. The exemption will be reviewed by QA committee and HR prior to hiring.
9. Employees who have not received at least a single dose of a Covid-19 vaccine, due to a medical exemption, will be required to get tested for Covid-19 once weekly if working on-site $\leq$3 days per week or twice weekly if working $\geq$4 days per week (facility to insert parameter)

a. Failure to comply will result in removal from schedule until such time that staff member presents proof of taking a Covid-19 test (Taking a was added)
b. Employees who have not completed their primary vaccination series are required to always wear a fit-test N95 or equivalent or higher-level respirator for source control (changed language to make clearer) (except when eating or drinking), regardless of whether they are providing direct care to or otherwise interacting with residents.

10. In general, the same monovalent vaccine product should be used for all doses in the primary series. Therefore, if a 2-dose series vaccine is used, the second dose should be the same product (added) as the first. (Clinical Guidance for COVID-19 Vaccination | CDC).
11. Facility will track all Staff Members wishing to receive the COVID-19 Vaccine at the facility and schedule a specific date and time to arrive at the Vaccine Clinic/dedicated area. The facility will provide community vaccination site information upon request
12. The facility will assign a "point of contact" or designee for providing information on how staff are educated about and offered the Covid-19 vaccines, including samples of educational materials.

CONSENT/DECLINATIONS/EXEMPTIOMS

1. The facility will utilize the COVID-19 vaccination consent form from NYS or partnering pharmacy
2. Staff members will be provided with a copy of the consent for review as well as a copy of the Emergency Use Authorization Fact Sheet for recipients COVID-19 Vaccination.
3. When a staff member declines the COVID-19 Vaccination due to a medical exemption, a signed Covid-19 Vaccination Declination Form along with proof of exemption will be placed in the employee's health folder.
    - Staff member will be provided with education that it is his/her responsibility to request a Covid-19 vaccine should they now qualify for a Covid-19 vaccine and wish to receive it
4. The facility will post signage in high-trafficked areas throughout the building alerting staff that the facility offers Covid-19 vaccines and of vaccine clinic dates
    - Staff to notify Department Head or Designee of date they wish to be vaccinated based on clinic dates
    - Staff may choose to get vaccinated in the community and present proof of same to facility

VACCINE ADMINISTRATION

1. Staff members will be assigned specific times for vaccine administration on the scheduled Vaccine Clinic days.
2. Staff members presenting with the following conditions/symptoms will not be eligible to receive the COVID-19 Vaccination:
    - Verbal report of feeling sick
    - Exhibiting acute respiratory illness
    - Diagnosed with COVID -19 within the last 14 days
    - Acute febrile condition with temperature above 100°F
    - Other active infection
3. The COVID-19 Vaccination Clinic will be set up as per the Pharmacy, in conjunction with facility guidelines, including adequate space for physical distancing, and an area for post vaccination monitoring
4. Staff identification will be verified by name and date of birth.
5. Staff member's temperature will be taken and recorded prior to vaccination
6. At the time of the vaccination the staff member will inform Immunizer regarding the following:
    - Restrictions for injections on specified arm due to surgery
    - Presence of AV shunt
7. The immunizer will administer the vaccine as per Emergency Authorization Use Protocol and the VIS

8. Should the facility be administering the vaccine (designated vaccinator), transportation, storage, handling, and preparation of the vaccine will be adhered to in collaboration with the pharmacy partner and in accordance with the specific Covid vaccine recommendations for approved Covid vaccines.
    - The facility will complete all required reporting, including the Vaccine Tracker, HERDS Survey, and NYSIIS/CIR (as applicable)
        - In stances when syringes will be pre-filled/pre-drawn:
            - A dedicated area will be utilized for vaccine preparation
            - Each vaccine type will be labeled to prevent medication error
            - Pre-filled/pre-drawn syringes will be stored at the manufacturer recommended temperatures throughout the day
9. The facility will maintain a list of "standby" eligible individuals to be notified for open appointments for vaccine administration on short notice.
10. The Staff Member will be monitored following COVID-19 vaccination administration for a minimum of 15 minutes post vaccination in the designated area of the Vaccine Clinic.
11. The facility will have readily available and accessible Epinephrine 1mg/1ml in the event of an anaphylactic/hypersensitivity reaction during vaccine administration.
12. Staff Members experiencing an anaphylactic reaction will be administered the Epi-pen by the Immunizer and 911 will be activated.
13. Staff Members will be provided with a Vaccination Card indicating the dates that the COVID Vaccine was administered
14. A copy of the COVID-19 Consent form and Vaccination Card will be placed in the employee health folder for each staff member.

POST VACCINATION MONITORING AND REPORTING

1. Staff Members will be educated on common reactions post COVID-19 vaccination
    - Injection site pain, redness or swelling
    - Fatigue
    - Headache
    - Muscle pain
    - Chills
    - Fever
    - Nausea
    - Malaise
2. If a staff member develops any symptoms related to potential Covid 19 infection such as cough, shortness of breath or loss of taste or smell, they should be tested for Covid 19.
3. Staff members will be educated to notify the facility immediately regarding any serious adverse reactions including:
    - Cases of Multisystem Inflammatory Syndrome
    - Cases of COVID-19 that result in hospitalization
    - Cases of death following the administration of the COVID-19 Vaccination.
    - Life threatening adverse event
    - Inpatient hospitalization
    - An important medical event that based on medical judgement of the PMD may jeopardize the individual and may require medical or surgical intervention to prevent outcomes listed above
4. The partnering pharmacy or the facility's designated personnel will be responsible to enter vaccine information NYSIIS/CIR as applicable
5. In accordance with CMS QSO-21-19-NH, the facility will report Covid-19 vaccination data via NHSN (Survey Tag F884)

6. The facility will communicate with the partner pharmacy (if applicable) when any of the mandatory adverse events are identified and assist **with or report** same on the Vaccine Adverse Event Reporting System. (VAERS@hhs.gov)
7. The Covid-19 Vaccine may be given without regarding to timing of other vaccines as ordered by a Physician (CDC, 5/14/2021)
    a. If multiple vaccines are administered at the same time, each injection will be administered at a different injection site.
8. Staff Members will be provided with immunization card including date for second vaccine administration schedule as applicable.
9. If a Staff Member resigns after receiving the first dose of the two-part COVID-19 primary vaccine series, they will be requested to return to the facility or go to a vaccination site in the community on the set date to receive the second dose.
    - If it is not feasible to adhere to the recommended interval and a delay in vaccination is unavoidable, the second dose of the Pfizer and Moderna Covid Vaccines may be administered up to 8 weeks after the first dose.
10. The facility will maintain a system for tracking Covid-19 vaccinations, i.e., first dose, 2nd doses, booster doses, and medical exemptions. Tracking system will indicate which employees are facility staff, contracted staff, volunteers, or students (Survey Tag F888)

REVISED:

4/21/2021; 5/5/2021; 6/2/2021; 8/18/2021; 8/25/2021; 8/27/2021; 9/23/2021; 10/6/2021; 10/21/2021; 12/29/2021; 1/6/2022; 1/27/2022; 2/24/2022,6/22/22,9/21/22

REFERENCES:

CDC(Updated 9/2/22) Interim Clinical Considerations for Use of COVID-19 Vaccines: Appendices, References, and Previous Updates | CDC

CDC (Updated 9/ 7/ 22)COVID-19 Vaccine Interim COVID-19 Immunization Schedule for 6 Months of Age and Older (cdc.gov)

CDC (Updated 12/13/2020). Post Vaccine Considerations for Residents. https://www.cdc.gov/coronavirus/2019-ncov/hcp/post-vaccine-considerations-residents.html

Moderna Health Care Provider Fact Sheet (updated 8/31/22) bivalent-dose-HCP.pdf (modernatx.com)

Moderna Fact Sheet (updated 6/21/22) eua-fact-sheet-recipients.pdf (modernatx.com)

Pfizer Health Care Provider Fact Sheet Booster (Updated 8/31/22)Pfizer HCP FS Bivalent Booster Grey 8.31.2022 (fda.gov)

Pfizer Recipient Fact Sheet (updated 8/31/22) Recipients and Caregivers 12 years of age and older 08312022 (fda.gov)

Updated 5/21/22Janssen COVID-19 Vaccine - EUA Fact Sheet for Recipients and Caregivers (janssenlabels.com)

Training and Education for COVID-19 Vaccination | CDC

NYSDOH (9/19/22)DAL_COVID-19_Booster_Flu_2022-23_9-19-2022_1663608172645_0.pdf (state.ny.us)

NYSDOH (9 /16/ 22) NH 22-18; DACF 22-37 (ny.gov)

CMS (5/11/2021). Interim Final Rule – COVID-19 Vaccine Immunization Requirements for Residents and Staff. https://www.cms.gov/files/document/qso-21-19-nh.pdf

Northern Manhattan
Rehabilitation & Nursing Center

VACCINE MEDICAL EXCEPTION FORM
REQUEST FOR MEDICAL EXCEPTION FROM COVID-19 VACCINATION

PLEASE PRINT THE FOLLOWING INFORMATION:

Name:_____
E-mail:_____
Department:_____
Physician Name:_____

Date of Birth:_____/_____/
Phone #: _____
Supervisor/Manager_____
Physician Phone No.:

Dear Physician:

Northern Manhattan Rehabilitation and Nursing Center requires COVID-19 vaccination similar to other required vaccinations such as MMR and varicella. COVID-19 vaccination has been mandated by NYS for all healthcare workers because it has been shown to be effective in reducing the incidence and severity of COVID-19 infection. If any licensed physician or certified nurse practitioner certifies that immunization with COVID-19 vaccine is detrimental to a staff member, based upon an allergy to components of the vaccine or a specific pre-existing health condition, the requirements of this section relating to COVID-19 immunization shall be subject to a reasonable accommodation of such health condition only until such immunization is found no longer to be detrimental to the health of such member. The nature and duration of the medical exemption must be stated in the personnel employment medical record and must be in accordance with generally accepted medical standards.

The above named person is requesting an exception from this vaccination requirement.

Please complete the form below. Should you have any questions, please contact Northern Manhattan Rehabilitation and Nursing Center at 1-212-426-1284 ext. 1113. Thank you.

The above person should not be immunized for COVID-19 for the following reasons (check all that applies):

Option 1 - Allergy

☐ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine NOTE: since egg free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

- Moderna - List the component(s): _____
- Pfizer (Comirnaty) - List the component(s): _____
- Janssen/Johnson & Johnson - List the component(s) _____

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction

- Moderna - Date of Vaccine & Reaction:_____
- Pfizer - Date of Vaccine & Reaction: _____
- Janssen/Johnson & Johnson - Date of Vaccine & Reaction: _____

Option 2 – Physical Condition/Medical Circumstance

☐ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state the basis for why the medical condition or circumstances contraindicate immunization with the COVID-19 vaccine.

Explanation:

Option 3 – Other

☐ Other. Please provide this information in a separate narrative that describes why you opine that the patient should be exempt from vaccination, including reference to the medical condition or disability that forms the basis for your opinion.

Explanation:

Certification

I certify that_____(patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at_____.

Provider Information

Medical Provider Name: _____ Provider License #: _____

Medical Provider Specialty: _____

Signature: _____ Date: _____
(Note: Signature Stamp Not Acceptable)

Name of Provider Company: _____

Address:_____

Email:_____

Phone number:_____

I certify that_____has the above contraindication and request a medical exception from COVID-19 vaccination.

PLEASE FAX, E-MAIL OR MAIL THIS TO:
Mitchell Rebhun - 116 East 125th Street, New York, NY, 10035 - (Fax) 1-212-426-1297 – Email: Mrebhun@nmrehab.org

DESIGNATED OFFICE USE ONLY:
Medical Exception Approved on:_____/_____/_____ Approving Staff Signature: _____

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 12/17/2020	Revision Date: 04/21/2021; 05/05/2021; 06/02/2021; 08/25/2021; 09/23/2021; 10/06/2021; 10/21/2021; 01/06/2022; 01/26/2022; 04/19/2022 06/22/2022; 09/21/2022;	Review Date: 09/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – COVID–19 Vaccination for Residents**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

To prevent the spread of infectious disease and to decrease the morbidity and mortality associated with the SARS-CoV-2 virus, commonly known as Covid-19, this facility will offer Covid-19 vaccination including all approved primary series and /or booster does for all residents in accordance with CDC eligibility requirements.

PROCEDURE

1. The Facility will designate a Registered Nurse (RN) as the Vaccine Coordinator with support staff as needed.
2. The RN Vaccine Coordinator will be the liaison for the LTC Pharmacy partner
3. All residents and resident representatives will be provided with education and the FDA approved Covid 19 Vaccination FDA EAU/VIS Fact sheets by the MD or RN.
4. For situations in which a resident lacks capacity to make healthcare decisions and there is no next of kin or designated healthcare representative, a risk vs. benefit analysis will be done, and a two-physician consent/declination will be required.
5. The facility will assign a "point of contact" or designee for providing information on how residents and their representatives are educated about and offered the Covid-19 vaccines, including samples of educational materials.
6. The facility will obtain a signed consent form for the administration of the Covid vaccine from the resident or the resident's designated health care representative(s).
    - Telephone consent is acceptable with two licensed personnel signing as witnesses.
7. The resident's Primary Medical Doctor (PMD) will provide order for Covid 19 vaccination following review of allergies, medications, and plan of care to determine if there are any contraindications.
8. The facility will track consents, declinations, and vaccinations for all residents.
    - Residents who declined Covid-19 vaccine will be provided with education that they can request a Covid-19 vaccine at any time should they change their mind.
9. All new and re-admissions will be evaluated by the nurse and/or physician for previous immunization and will be offered the vaccine as appropriate.
    - As of 4/15/2021 (NYSDOH), the facility will provide, or make arrangements, for all consenting new and re-admissions to receive a first dose Covid-19 vaccine within 14 days of admission. Arrangements will be made for any subsequent doses as applicable.
10. For any discharges, the resident will receive immunization card, if only one dose received in a 2-dose series, a date will be provided to receive the second dose either at facility or in the community.
11. The vaccine will not be offered or administered to residents with contraindications:
    - History of severe allergic reaction after a previous dose of the vaccine
    - History of severe allergic reaction to any ingredient of the vaccine

- Residents with acute Covid-19 infection and still under isolation (can be vaccinated after resolution of infection)

12. Administration of the vaccine will be deferred in residents with acute respiratory disease, active infection, or acute febrile illness until resident has recovered.
13. The Covid-19 Vaccine may be given without regarding to timing of other vaccines (CDC, 5/14/2021) as ordered by a Physician
    a. If multiple vaccines are administered at the same time, each injection will be administered at a different injection site.
14. The Pfizer [Comirnaty] (3-8 weeks) and Moderna (4-8 weeks) and Novavax (3-8weeks) vaccines are a two-dose series; both doses must be administered to be fully vaccinated
    - If Janssen vaccine is used it is a one dose series only (Johnson and Johnson) In most situations, **Pfizer-BioNTech or Moderna COVID-19 vaccines are preferred** over Johnson & Johnson's Janssen (J&J/Janssen) COVID-19 vaccine. J&J/Janssen should only be considered in some cases. J&J/Janssen COVID-19 vaccine cannot be used as a second booster dose. (CDC 6/10/22)
15. The facility will offer a CDC booster dose of the covid vaccines to residents as recommended and approved by the CDC in alignment with NYSDOH regulations:

- **As of September 6, 2022, the CDC new booster recommendations for people ages 12 years and older is to receive one <u>bivalent</u> mRNA booster after completion of a monovalent primary series; it replaces all prior booster recommendations for this age group**
    - **Recommendations for use of a bivalent Moderna booster dose in people ages 18 years and older**
    - **Recommendations for use of a bivalent Pfizer-BioNTech booster dose in people ages 12 years and older**

<u>Vaccination schedule:</u> In accordance with CDC recommendations the facility will adhere to the following recommended vaccination schedule below:

Residents who are <u>not</u> moderately or severely immunocompromised:

Adults ages 18 years and older are recommended to receive one primary dose and one booster dose **at least 2 months after the primary dose.** A bivalent mRNA booster dose is recommended.

Residents <u>who are</u> moderately or severely immunocompromised:

Adults ages 18 years and older are recommended to receive one primary dose, a second (additional) dose using a monovalent mRNA COVID-19 vaccine, and one booster dose; a bivalent mRNA booster dose is recommended. The primary series dose and the additional dose are separated by at least 4 weeks. **The booster dose is administered at least 2 months after the additional dose.**

16. In general, the same monovalent vaccine product should be used for all doses in the primary series. Therefore, if a 2-dose series vaccine is used, the second dose should be the same as the first. (<u>Clinical Guidance for COVID-19 Vaccination | CDC</u>).
17. The facility Vaccine Coordinator will work with Pharmacy and/or Local Health Dept partner (if applicable) to provide immunization on established clinic dates.
18. Should vaccination be done in a dedicated area, the following will be adhered to:
    - Social distancing to be maintained between each vaccination station
19. Prior to vaccine administration, the Vaccine Coordinator will validate that consent has been obtained, MD order received, and education has been provided.
    - Should the facility be administering the vaccine (designated vaccinator), transportation, storage, handling, and preparation of the vaccine will be adhered to in collaboration with the pharmacy partner and in accordance with the specific Covid vaccine recommendations for approved Covid vaccines. The

facility will complete all required reporting, including the Vaccine Tracker, HERDS Survey, and NYSIIS/CIR (as applicable)

- Instances when syringes will be pre-filled/pre-drawn:
  - A dedicated area will be utilized for vaccine preparation
  - Each vaccine type will be labeled to prevent medication error
  - Pre-filled/pre-drawn syringes will be stored at the manufacturer recommended temperatures throughout the day

20. After administration, assigned nursing staff will monitor the resident closely x 15minutes after administration and then every shift x 72 hours for potential side/adverse effects of the vaccine.
    - If a resident has a history of anaphylaxis they will be monitored after immunization for 30 minutes.
    - Potential side effects following Covid 19 Vaccine that have been reported in clinical trials include injection site pain, fatigue, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, malaise, and lymphadenopathy.
21. If a resident experiences post vaccination signs/symptom, as outlined above, PMD/NP/RN will assess resident to determine if any treatment or follow up is needed.
22. Any side/adverse effects will be documented in the medical record with MD notification and Vaccine Adverse Event Reporting System (VAERS) follow up documentation. The **vaccination administrator** is responsible for MANDATORY reporting of reportable events that include
    - Vaccine administration errors whether associated with an adverse event
    - Serious adverse events* (irrespective of attribution to vaccination)
    - Cases of Multisystem Inflammatory Syndrome (MIS) in children and adults
    - Cases of COVID-19 that result in hospitalization or death
23. The vaccine administrator/facility will
    a. Document the name of the vaccine, manufacturer information, Lot #, expiration date, site, and date of administration
    b. The Pharmacy vaccine administrator or designated personnel will enter vaccination information into the NY State/ NYC Immunization Registry as required within 24 hours of vaccine administration
24. The charge nurse/unit manager is responsible for updating the immunization record (acceptance/declination) and the immunization care plan (acceptance/declination).
25. In accordance with CMS QSO-21-19-NH, the facility will report Covid-19 vaccination data via NHSN (Survey Tag F884)
26. Epinephrine will be available in the facility's emergency box(es) and in immunization area(s) for utilization in the event of severe allergic reactions
27. Should resident develop acute distress, a "Code Blue" will be initiated, and EMS system will be activated immediately to transfer resident to an acute care setting as needed.
28. A list of residents who have refused the Covid vaccine will be forwarded to the Director of Nursing Services (DNS) and Infection Preventionist for review and follow up as needed.

REVISED:

4/21/2021; 5/5/2021; 6/2/2021; 8/25/2021; 9/23/2021; 10/6/2021; 10/21/2021; 1/6/2022; 1/26/2022; 4/19/2022, 6/22/22,9/21/22

REFERENCES:

CDC(Updated 9/2/22) Interim Clinical Considerations for Use of COVID-19 Vaccines: Appendices, References, and Previous Updates | CDC

CDC (Updated 9/ 7/ 22)COVID-19 Vaccine Interim COVID-19 Immunization Schedule for 6 Months of Age and Older (cdc.gov)

CDC (Updated 12/13/2020). Post Vaccine Considerations for Residents. https://www.cdc.gov/coronavirus/2019-ncov/hcp/post-vaccine-considerations-residents.html

Moderna Health Care Provider Fact Sheet(updated 8/31/22) bivalent-dose-HCP.pdf (modernatx.com)

Moderna Fact Sheet (updated 6/21/22) eua-fact-sheet-recipients.pdf (modernatx.com)

Pfizer Health Care Provider Fact Sheet Booster (Updated 8/31/22)Pfizer HCP FS Bivalent Booster Grey 8.31.2022 (fda.gov)

Pfizer Recipient Fact Sheet (updated 8/31/22) Recipients and Caregivers 12 years of age and older 08312022 (fda.gov)

Updated 5/21/22Janssen COVID-19 Vaccine - EUA Fact Sheet for Recipients and Caregivers (janssenlabels.com)

Training and Education for COVID-19 Vaccination | CDC

NYSDOH (9/19/22)DAL_COVID-19_Booster_Flu_2022-23_9-19-2022_1663608172645_0.pdf (state.ny.us)

NYSDOH (9 /16/ 22) NH 22-18; DACF 22-37 (ny.gov)

CMS (5/11/2021). Interim Final Rule – COVID-19 Vaccine Immunization Requirements for Residents and Staff. https://www.cms.gov/files/document/qso-21-19-nh.pdf

AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

COVID-19 Vaccine Screening and Consent Form

Sign-in Sheet #_____

Screening Questionnaire

Patient Name _____ Patient DOB _____ Patient Temp_____
Clinician Initials_____

1. Have you ever had a serious or life-threatening allergic reaction, such as your throat closing or difficulty breathing?	☐ Yes	☐ No	
2. Are you breastfeeding and/or is there a chance you are pregnant?	☐ Yes	☐ No	
3. Are you feeling sick today?	☐ Yes	☐ No	☐ Unknown
4. Have you had any vaccine within the past 14 days?	☐ Yes	☐ No	
5. In the last 10 days, have you been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No	
6. Have you been treated with monoclonal antibody therapy for treatment of COVID-19 in the past 90 days? (need to wait 90 days from last treatment)	☐ Yes	☐ No	
7. Are you **UNDER** 18 years old?	☐ Yes	☐ No	

If you answered 'Yes' or 'Unknown' to any question 1-7, you cannot get a vaccine today(you may be able to get one at your doctor's office)

8. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes	☐ No	
9. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes	☐ No	
10. Is this your first dose of COVID vaccine?	☐ Yes	☐ No	
If second dose: Date of first dose_____ Manufacturer of first dose:	☐ Pfizer	☐ Moderna	

Informed Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described. I understand all COVID vaccine treatments are reported to CIR for vaccine tracking purposes. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Date:_____

Patient/Guardian/Surrogate Signature:_____

Patient/Guardian/Surrogate Printed Name:_____

Witness Printed Name:_____

Witness Signature:_____

Relationship to Patient_____

AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Sign-in Sheet #

COVID-19 Vaccination & Demographic Form

Demographic Information

Hispanic, Latino, or Latina? (check one)
☐ Hispanic ☐ Not Hispanic

Race (select all that apply)
☐ Asian, including South Asian
☐ Black, including African American or Afro-Caribbean
☐ Native American or Alaska Native
☐ Native Hawaiian or Pacific Islander
☐ White
☐ I do not identify as any of these races

Specific ethnic or cultural group(s):

Gender identity (check one)
☐ Male ☐ Female
☐ Gender Neutral

Sex assigned at birth (check one)
☐ Male ☐ Female

Sexual orientation (check one)
☐ Gay or lesbian ☐ Straight or heterosexual
☐ Another orientation:

Last Name

First Name

Street Address

City **State**

Zip Code **Date of Birth** MM/DD/YYYY **Age**

Phone Number **Marital Status** ☐ M ☐ S ☐ D

Patient/Guardian Email:

Company Name **Company Location**

Vaccine Information - Clinician Use Only

I, _____, have reviewed side effects with patient (and parent, guardian or surrogate, as applicable). I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

MFR

Brand:

Lot:

☐ Moderna	Lot 026L20A expires 6/28/2021
☐ Moderna	
☐ Pfizer/BioNTech	
☐ Astra- Zeneca	
☐ Janssen	

Administration Information:

☐ Vaccine Dose #1 - Moderna 0.5mL IM ☐ Vaccine Dose #1 - Pfizer 0.3mL IM
☐ Vaccine Dose #2 - Moderna 0.5mL IM ☐ Vaccine Dose #2 - Pfizer 0.3mL IM

*Note- dose #1 and dose #2 should be from the same manufacturer

Injection Site:
☐ R Deltoid
☐ L Deltoid

Educational Material:
☐ EUA Fact Sheet provided - Moderna - version 12/2020
☐ EUA Fact Sheet provided - Pfizer - version 12/2020

Clinician Signature:_____ Clinician Initials:_____ Date:_____

AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

COVID-19 Vaccine Screening and Consent Form

Sign-in Sheet #

Screening Questionnaire

Patient Name _____ Patient DOB _____ Patient Temp _____ Staff Initials _____

MODERNA DOSE #2 FORM

1. Is this your second dose of Moderna COVID-19 Vaccine? ☐ Yes ☐ No
2. If 'yes', what was the date of your first COVID-19 vaccine dose_____

SCREENING QUESTIONNAIRE

1. Did you have a severe reaction (anaphylaxis) within 4 hours of receiving a COVID vaccine dose? ☐ Yes ☐ No
2. Did you have any of the following immediate allergic reaction(s) within 15 minutes of receiving a previous COVID vaccine? ☐ Yes ☐ No
   skin reaction (rash and/or hives), angioedema (swelling beneath the skin), stridor (harsh vibrating noise when breathing) confusion, disorientation, difficulty breathing, shortness of breath, wheezing, fast heart rate, nausea, vomiting, abdominal pain?
3. Have you ever had a serious or life-threatening allergic reaction, such as your throat closing or difficulty breathing? ☐ Yes ☐ No
4. Are you feeling sick today? ☐ Yes ☐ No
5. Have you had any vaccine within the past 14 days? ☐ Yes ☐ No
6. In the last 10 days, have you been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? ☐ Yes ☐ No
7. Have you been treated with monoclonal antibody therapy for treatment of COVID-19 in the past 90 days? (need to wait 90 days from last treatment) ☐ Yes ☐ No
8. Are you UNDER 18 years old? ☐ Yes ☐ No

If you answered 'Yes' to any screening question 1-8, you will not be able to get a vaccine today; we encourage you to follow up with your PCP to make other arrangements.

9. Do you have a history of vasovagal (faint or passing out)? ☐ Yes ☐ No
10. Are you pregnant and/or breastfeeding? ☐ Yes ☐ No
11. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system? ☐ Yes ☐ No
12. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments? ☐ Yes ☐ No

Informed Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described. I understand all COVID vaccine treatments are reported to CIR for vaccine tracking purposes. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Date:_____ **Staff Initials:**_____

Patient/Guardian/Surrogate Printed Name:_____ **Relationship to Patient**_____

Patient/Guardian/Surrogate Signature:_____

Witness Printed Name:_____ **Witness Signature:**_____

AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Sign-in Sheet #

COVID-19 Vaccination & Demographic Form

Site Location

Demographic Information

Hispanic, Latino, or Latina? (check one)
☐ Hispanic ☐ Not Hispanic

Race (select all that apply)
☐ Asian, including South Asian
☐ Black, including African American or Afro-Caribbean
☐ Native American or Alaska Native
☐ Native Hawaiian or Pacific Islander
☐ White
☐ I do not identify as any of these races

Specific ethnic or cultural group(s):

Gender identity (check one)
☐ Male ☐ Female
☐ Gender Neutral

Sex assigned at birth (check one)
☐ Male ☐ Female

Sexual orientation (check one)
☐ Gay or lesbian ☐ Straight or heterosexual
☐ Another orientation:

Last Name

First Name

Street Address

City **State**

Zip Code **Date of Birth** MM/DD/YYYY **Age**

Phone Number **Marital Status** ☐ M ☐ S ☐ D

Patient/Guardian Email:

Emergency Contact- Name **Emergency Contact- Number**

Occupation **Company Location**

Vaccine Information - Clinician Use Only

I, _____, have reviewed side effects with patient (and parent, guardian or surrogate, as applicable). I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

MFR

☐ Moderna	Lot 026L20A expires 06/28/2021	
☐ Moderna	Lot 013L20A expires 07/08/2021	
☐ Moderna	Lot:	Expires:

Administration Information:
☐ Vaccine Dose #1- Moderna 0.5mL IM
☐ Vaccine Dose #2 - Moderna 0.5mL IM
*Note- dose #1 and dose #2 should be from the same manufacturer

Injection Site:
☐ R Deltoid
☐ L Deltoid

Educational Material:
☐ EUA Fact Sheet provided - Moderna - version 12/2020

Clinician Signature:_____ Date:_____ Time of Vaccine:_____

NEW YORK STATE | Department of Health

New York State Department of Health
Bureau of Immunization

MedWiz PHARMACY

COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print)		Preferred Name
DOB	Current Gender ID Indicate ID Below: [ ]	**Key:** W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming Q – Not Sure/Questioning NR – Chose not to Respond GNL – Gender not Listed (write-in) * Gender Pronouns: write-in by client's name
Sex Assigned at Birth Indicate Sex Below: [ ]	**Key:** M – Male F – Female I – Intersex NR – Chose not to Respond SNL – Sexual Orientation not Listed (write-in)	Marital Status Indicate Status Below: [ ]	**Key:** S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner
Address	City State Zip	Email Address	
Parent/Guardian/ Surrogate (if applicable, please print)	Phone	Preferred Language	
Ethnicity Indicate Ethnicity Below: [ ]	**Ethnicity Key:** DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown	Race Indicate Race Below: [ ]	**Race Key:** AIA – Native American or Alaskan ASN – Asian BAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial
Primary Insurance Name		Primary Insurance ID#	Subscriber Name/DOB / Subscriber Relation to Patient
Primary Insurance Address		Primary Insurance Group #	Primary Insurance Phone #
Secondary Insurance Name		Secondary Insurance ID#	Subscriber Name/DOB / Subscriber Relation to Patient
Secondary Insurance Address		Secondary Insurance Group #	Secondary Insurance Phone #
Clinic/Office Site Where Vaccine is Administered		Primary Care Physician Address/Phone Number	

Screening Questionnaire

1.	Are you feeling sick today?	☐ Yes	☐ No	
2.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection, exposure or travel?	☐ Yes	☐ No	☐ Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?* Date: _____	☐ Yes	☐ No	☐ Unknown
4.	Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	☐ Yes	☐ No	☐ Unknown
5.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot? *If yes, how long ago was your most recent vaccine?* Date: _____	☐ Yes	☐ No	☐ Unknown
6.	Are you pregnant or considering becoming pregnant?	☐ Yes	☐ No	☐ Unknown

7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes	☐ No	☐ Unknown
8.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes	☐ No	☐ Unknown
9.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Unknown
10.	Have you received a previous dose of the COVID-19 vaccine? If yes, which vaccine? ☐ Moderna ☐ Pfizer		☐ No	Date: _____ (if applicable)

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Recipient/Surrogate/Guardian (Signature) Date / Time Print Name Relationship to Patient (if other than recipient)
recipient

Telephonic Interpreter's ID # Date / Time
OR

Signature: Interpreter Date/ Time Print Interpreter's Name and Relationship to Patient

Which vaccine is the patient receiving today?

Vaccine Name	Administration		EUA Fact Sheet Date	Manufacturer & Lot Number
Pfizer/ BioNTech	☐ First Dose	☐ Second Dose		
Moderna	☐ First Dose	☐ Second Dose		
Astra-Zeneca	☐ First Dose	☐ Second Dose		
Janssen	☐ Single Dose			

Administration Site ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.3 ml

☐ I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____

Use of this form is optional. In the ongoing effort to address health disparities it is essential that all demographic information is collected at the time of COVID-19 vaccination including sex/gender identity and race/ethnicity.* **Updated January 20, 2021

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 12/17/2020	Revision Date:	Review Date: 03/2023	Prepared by: Administration
Policy Subject: **Pandemic Emergency Plan – Fact Sheet: COVID–19 Vaccine**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

Fact Sheet: COVID–19 Vaccine

1. Why should I get vaccinated? •
   - To prevent the spread of COVID-19 and protect myself, my family, the residents, and my community, and to set an example for others.

2. How do we know the vaccine is safe?
   - The technology used to make the vaccine has been studied for more than 10 years. COVID-19 mRNA vaccines give instructions for our cells to make a harmless piece that looks like the "spike protein." The spike protein is found on the surface of the COVID-19 virus. Our bodies recognize that this protein should not be there, so they build antibodies that will remember how to fight the virus that causes COVID-19. The vaccine does NOT contain any live or killed virus and cannot cause COVID-19 infection.

3. Why should we trust the vaccine?
   - The FDA is using the same strict standards that it has for decades
   - No steps are "skipped"
   - The FDA advises a minimum of 3,000 participants to assess safety. The phase 3 trials have 30,000 to 50,000 participants. This really demonstrates how safety is a top priority for the FDA and the medical community
   - Two independent advisory committees are reviewing the results. Members and experts of these committees have no conflict of interest and are not associated with any vaccine manufacturers
     - I The Vaccine and Related Biological Products Advisory Committee (VRBPAC) that advises the FDA
     - II The Advisory Committee on Immunization Practices (ACIP) that advises the CDC

4. Can mRNA vaccine give me Covid-19?
   - No, because the vaccine is not made of live virus.

5. Can mRNA change my DNA?
   - No. mRNA stands for messenger ribonucleic acid and can most easily be described as instructions for how to make a protein or even just a piece of a protein. mRNA is not able to alter or modify a person's genetic makeup (DNA). The mRNA from a COVID-19 vaccine never enter the nucleus of the cell, which is where our DNA are kept. This means the mRNA does not affect or interact with our DNA in any way. Instead, COVID19 vaccines that use mRNA work with the body's natural defenses to safely develop protection (immunity) to disease.

6. What is an EUA and what does it mean for me?
   - An Emergency Use Authorization (EUA) for a vaccine is based on the need to use a vaccine quickly to save lives during a public health emergency

- EUA is a shorter process but no steps are skipped in the safety evaluation process
- The FDA will assess if the vaccine known and potential benefits outweigh the known and potential risks
- Two separate advisory boards (VRBPAC and ACIP) will also review the data and make recommendations
- Fact Sheet: Covid-19 Vaccine
- An EUA does NOT imply that the authorization was done too quickly or that the vaccine is not safe

7. What can I expect post-vaccination?
   - You may have short-term discomfort: fatigue, headache, muscle pain, chills, fever, and pain at injection site after vaccination.
   - These reactions will last for 24-48 hours and are typically more pronounced after the second dose
   - Side effects mean your body is doing its job and making antibodies (IT IS A GOOD THING)
   - These side effects are normal, common, and expected

8. When and how long will I be protected by the Covid-19 vaccine?
   - Protection occurs 1-2 weeks after the second dose
   - We will most likely not know how long the vaccine will be protective once we receive it. We will know more as more time passes in the current research
   - May need to have vaccine shots for COVID-19 on a regular basis (like the flu shot)

9. Is it safe to get the Covid-19 vaccine even if you have had Covid-19?
   - Yes. Even if you have had COVID-19, it is important to get vaccinated. It could give you longer or better protection against the disease
   - Even if you have positive antibodies, you should get the COVID-19 vaccine

10. Who should not get the vaccine?
    - History of severe allergic reaction after a previous dose of the vaccine
    - History of severe allergic reaction to any ingredient of the vaccine
    - People with acute Covid-19 infection and still under isolation/ quarantine (can be vaccinated after resolution of infection)

Resources/References: American Association of Post-Acute Care Nursing (AAPACN). https://www.aapacn.org/coronavirusresources-for-ltpac

CDC (11/2020). Benefits of Getting a Covid-19 Vaccine. https://www.cdc.gov/coronavirus/2019ncov/vaccines/vaccine-benefits.html

CDC (12/13/2020). Facts about Covid-19 Vaccines. https://www.cdc.gov/coronavirus/2019ncov/vaccines/vaccine-benefits/facts.html

FACT SHEET FOR RECIPIENTS AND CAREGIVERS
EMERGENCY USE AUTHORIZATION (EUA) OF THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

You are being offered the Moderna COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of the Moderna COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Moderna COVID-19 Vaccine is a vaccine and may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Moderna COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Moderna COVID-19 Vaccine.

The Moderna COVID-19 Vaccine is administered as a 2-dose series, 1 month apart, into the muscle.

The Moderna COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please visit www.modernatx.com/covid19vaccine-eua.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?
COVID-19 is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE MODERNA COVID-19 VACCINE?
The Moderna COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine to prevent COVID-19 in individuals 18 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE MODERNA COVID-19 VACCINE?

Tell your vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

WHO SHOULD GET THE MODERNA COVID-19 VACCINE?

FDA has authorized the emergency use of the Moderna COVID-19 Vaccine in individuals 18 years of age and older.

WHO SHOULD NOT GET THE MODERNA COVID-19 VACCINE?

You should not get the Moderna COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine

WHAT ARE THE INGREDIENTS IN THE MODERNA COVID-19 VACCINE?

The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate trihydrate, and sucrose.

HOW IS THE MODERNA COVID-19 VACCINE GIVEN?

The Moderna COVID-19 Vaccine will be given to you as an injection into the muscle.

The Moderna COVID-19 Vaccine vaccination series is 2 doses given 1 month apart.

If you receive one dose of the Moderna COVID-19 Vaccine, you should receive a second dose of the same vaccine 1 month later to complete the vaccination series.

HAS THE MODERNA COVID-19 VACCINE BEEN USED BEFORE?

The Moderna COVID-19 Vaccine is an unapproved vaccine. In clinical trials, approximately 15,400 individuals 18 years of age and older have received at least 1 dose of the Moderna COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE MODERNA COVID-19 VACCINE?

In an ongoing clinical trial, the Moderna COVID-19 Vaccine has been shown to prevent COVID-19 following 2 doses given 1 month apart. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE MODERNA COVID-19 VACCINE?
There is a remote chance that the Moderna COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Moderna COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Side effects that have been reported in a clinical trial with the Moderna COVID-19 Vaccine include:

- Injection site reactions: pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness), and redness
- General side effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever

Side effects that have been reported during post-authorization use of the Moderna COVID-19 Vaccine include:

- Severe allergic reactions

These may not be all the possible side effects of the Moderna COVID-19 Vaccine. Serious and unexpected side effects may occur. The Moderna COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?
If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Moderna COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to ModernaTX, Inc. at 1-866-MODERNA (1-866-663-3762).

You may also be given an option to enroll in **v-safe. V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides second-dose reminders if

needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET THE MODERNA COVID-19 VACCINE?
It is your choice to receive or not receive the Moderna COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES MODERNA COVID-19 VACCINE?
Currently, there is no FDA-approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE MODERNA COVID-19 VACCINE WITH OTHER VACCINES?
There is no information on the use of the Moderna COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?
If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE MODERNA COVID-19 VACCINE GIVE ME COVID-19?
No. The Moderna COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD
When you receive your first dose, you will get a vaccination card to show you when to return for your second dose of the Moderna COVID-19 Vaccine. Remember to bring your card when you return.

ADDITIONAL INFORMATION
If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Moderna COVID-19 Vaccine website	Telephone number
www.modernatx.com/covid19vaccine-eua	1-866-MODERNA (1-866-663-3762)

HOW CAN I LEARN MORE?

- Ask the vaccination provider
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization
- Contact your state or local public health department

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs, visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, HRSA COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?

The United States FDA has made the Moderna COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Moderna COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of the scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of

these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

The EUA for the Moderna COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

Moderna US, Inc.
Cambridge, MA 02139

Patent(s): www.modernatx.com/patents
Revised: Mar/26/2021

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 04/2021

VACCINE INFORMATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT COMIRNATY (COVID-19 VACCINE, mRNA), THE PFIZER-BIONTECH COVID-19 VACCINE, AND THE PFIZER-BIONTECH COVID-19 VACCINE, BIVALENT (ORIGINAL AND OMICRON BA.4/BA.5) TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 12 YEARS OF AGE AND OLDER

FOR 12 YEARS OF AGE AND OLDER

You are being offered either COMIRNATY (COVID-19 Vaccine, mRNA), the Pfizer-BioNTech COVID-19 Vaccine, or the Pfizer-BioNTech COVID-19 Vaccine, Bivalent (Original and Omicron BA.4/BA.5), hereafter referred to as the Pfizer-BioNTech COVID-19 Vaccine, Bivalent, to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2.

This Vaccine Information Fact Sheet for Recipients and Caregivers comprises the Fact Sheet for the authorized Pfizer-BioNTech COVID-19 Vaccine and the Pfizer-BioNTech COVID-19 Vaccine, Bivalent, and also includes information about the U.S. Food and Drug Administration (FDA)-licensed vaccine, COMIRNATY (COVID-19 Vaccine, mRNA) for use in individuals 12 years of age and older[1].

The FDA-approved COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine authorized under Emergency Use Authorization (EUA) for individuals 12 years of age and older, when prepared according to their respective instructions for use, can be used interchangeably.[2]

COMIRNATY (COVID-19 Vaccine, mRNA) is an FDA-approved COVID-19 vaccine made by Pfizer for BioNTech. It is approved as a 2-dose series for prevention of COVID-19 in individuals 12 years of age and older. It is also authorized under EUA to provide:

- **a third primary series dose to individuals 12 years of age and older with certain kinds of immunocompromise.**

[1] You may receive this Vaccine Information Fact Sheet even if your child is 11 years old. Children who will turn from 11 years to 12 years of age between doses in the primary regimen may receive, for any dose in the primary regimen, either: (1) the Pfizer-BioNTech COVID-19 Vaccine authorized for use in individuals 5 through 11 years of age; or (2) COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine authorized for use in individuals 12 years of age and older.

[2] When prepared according to their respective instructions for use, the FDA-approved COMIRNATY (COVID-19 Vaccine, mRNA) and the EUA-authorized Pfizer-BioNTech COVID-19 Vaccine for individuals 12 years of age and older can be used interchangeably without presenting any safety or effectiveness concerns.

The Pfizer-BioNTech COVID-19 Vaccine has received EUA from FDA to provide:

- **a 2-dose primary series to individuals 12 years of age and older; and**
- **a third primary series dose to individuals 12 years of age and older with certain kinds of immunocompromise.**

The Pfizer-BioNTech COVID-19 Vaccine, Bivalent has received EUA from FDA to provide either:

- **a single booster dose to individuals 12 years of age and older at least 2 months after completion of primary vaccination with any authorized or approved COVID-19 vaccine; or**
- **a single booster dose to individuals 12 years of age and older at least 2 months after receipt of the most recent booster dose with any authorized or approved monovalent[3] COVID-19 vaccine.**

This Vaccine Information Fact Sheet contains information to help you understand the risks and benefits of COMIRNATY (COVID-19 Vaccine, mRNA), the Pfizer-BioNTech COVID-19 Vaccine, and the Pfizer-BioNTech COVID-19 Vaccine, Bivalent, which you may receive because there is currently a pandemic of COVID-19. Talk to your vaccination provider if you have questions.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please see www.cvdvaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOU GET ANY OF THESE VACCINES

WHAT IS COVID-19?

COVID-19 disease is caused by a coronavirus called SARS-CoV-2. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness leading to death. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

[3] Monovalent refers to any authorized or approved COVID-19 vaccine that contains or encodes the spike protein of only the Original SARS-CoV-2.

HOW ARE COMIRNATY (COVID-19 VACCINE, mRNA), THE PFIZER-BIONTECH COVID-19 VACCINE, AND THE PFIZER-BIONTECH COVID-19 VACCINE, BIVALENT RELATED?

COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine, when prepared according to their respective instructions for use, can be used interchangeably. The Pfizer-BioNTech COVID-19 Vaccine, Bivalent is made in the same way as COMIRNATY and Pfizer-BioNTech COVID-19 Vaccine but it also contains an Omicron component to help prevent COVID-19 caused by the Omicron variant of SARS-CoV-2.

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET ANY OF THESE VACCINES?

Tell the vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine
- have ever fainted in association with an injection

HOW ARE THESE VACCINES GIVEN?

The Pfizer-BioNTech COVID-19 Vaccine, the Pfizer-BioNTech COVID-19 Vaccine, Bivalent, or COMIRNATY (COVID-19 Vaccine, mRNA) will be given to you as an injection into the muscle.

Primary Series: The Pfizer-BioNTech COVID-19 Vaccine and COMIRNATY (COVID-19 Vaccine, mRNA) are given for the primary series. The vaccine is administered as a 2-dose series, 3 weeks apart. A third primary series dose may be administered at least 4 weeks after the second dose to individuals with certain kinds of immunocompromise.

Booster Dose: Pfizer-BioNTech COVID-19 Vaccine, Bivalent is administered as a single booster dose at least 2 months after:

- completion of primary vaccination with any authorized or approved COVID-19 vaccine; or
- receipt of the most recent booster dose with any authorized or approved monovalent COVID-19 vaccine

The vaccine may not protect everyone.

WHO SHOULD NOT GET COMIRNATY (COVID-19 VACCINE, mRNA), THE PFIZER-BIONTECH COVID-19 VACCINE, OR THE PFIZER-BIONTECH COVID-19 VACCINE, BIVALENT?

You should not get any of these vaccines if you:

- had a severe allergic reaction after a previous dose of COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine
- had a severe allergic reaction to any ingredient in these vaccines.

WHAT ARE THE INGREDIENTS IN THESE VACCINES?

COMIRNATY (COVID-19 Vaccine, mRNA), Pfizer-BioNTech COVID-19 Vaccine, and Pfizer-BioNTech COVID-19 Vaccine, Bivalent include the following ingredients:

- mRNA and lipids (((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol).

Pfizer-BioNTech COVID-19 Vaccine for individuals 12 years of age and older contains 1 of the following sets of additional ingredients; ask the vaccination provider which version is being administered:

- potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose

OR

- tromethamine, tromethamine hydrochloride, and sucrose

Pfizer-BioNTech COVID-19 Vaccine, Bivalent for individuals 12 years of age and older contains the following additional ingredients:

- tromethamine, tromethamine hydrochloride, and sucrose

COMIRNATY (COVID-19 Vaccine, mRNA) contains 1 of the following sets of additional ingredients; ask the vaccination provider which version is being administered:

- potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose

OR

- tromethamine, tromethamine hydrochloride, and sucrose

HAVE THESE VACCINES BEEN USED BEFORE?

In clinical trials, approximately 23,000 individuals 12 years of age and older have received at least 1 dose of Pfizer-BioNTech COVID-19 Vaccine. Millions of individuals have received the Pfizer-BioNTech COVID-19 Vaccine under EUA since December 11, 2020.

In a clinical trial, approximately 300 individuals greater than 55 years of age received one dose of a bivalent vaccine that differs from the Pfizer-BioNTech COVID-19 Vaccine, Bivalent in that it contains a different Omicron component.

WHAT ARE THE BENEFITS OF THESE VACCINES?

COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine have been shown to prevent COVID-19. FDA has authorized Pfizer-BioNTech

COVID-19 Vaccine, Bivalent to provide better protection against COVID-19 caused by the Omicron variant of SARS-CoV-2.

The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THESE VACCINES?

There is a remote chance that these vaccines could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to 1 hour after getting a dose. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) have occurred in some people who have received COMIRNATY (COVID-19 Vaccine, mRNA) or Pfizer-BioNTech COVID-19 Vaccine, more commonly in adolescent males and adult males under 40 years of age than among females and older males. In most of these people, symptoms began within a few days following receipt of the second dose of vaccine. The chance of having this occur is very low. You should seek medical attention right away if you have any of the following symptoms after receiving the vaccine:

- Chest pain
- Shortness of breath
- Feelings of having a fast-beating, fluttering, or pounding heart

Side effects that have been reported with these vaccines include:

- Severe allergic reactions
- Non-severe allergic reactions such as rash, itching, hives, or swelling of the face
- Myocarditis (inflammation of the heart muscle)
- Pericarditis (inflammation of the lining outside the heart)
- Injection site pain
- Tiredness
- Headache
- Muscle pain
- Chills
- Joint pain
- Fever
- Injection site swelling
- Injection site redness
- Nausea
- Feeling unwell
- Swollen lymph nodes (lymphadenopathy)

- Decreased appetite
- Diarrhea
- Vomiting
- Arm pain
- Fainting in association with injection of the vaccine
- Dizziness

These may not be all the possible side effects of these vaccines. Serious and unexpected side effects may occur. The possible side effects of these vaccines are still being studied.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?
If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include either "COMIRNATY (COVID-19 Vaccine, mRNA)", "Pfizer-BioNTech COVID-19 Vaccine EUA", or "Pfizer-BioNTech COVID-19 Vaccine, Bivalent EUA" as appropriate, in the first line of box #18 of the report form.

In addition, you can report side effects to Pfizer Inc. at the contact information provided below.

Website	Fax number	Telephone number
www.pfizersafetyreporting.com	1-866-635-8337	1-800-438-1985

You may also be given an option to enroll in v-safe. V-safe is a voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. V-safe asks questions that help CDC monitor the safety of COVID-19 vaccines. V-safe also provides second-dose reminders if needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET COMIRNATY (COVID-19 VACCINE, mRNA), THE PFIZER-BIONTECH COVID-19 VACCINE, OR THE PFIZER-BIONTECH COVID-19 VACCINE, BIVALENT?
Under the EUA, it is your choice to receive or not receive any of these vaccines. Should you decide not to receive any of these vaccines, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES COMIRNATY (COVID-19 VACCINE, mRNA), THE PFIZER-BIONTECH COVID-19 VACCINE, OR THE PFIZER-BIONTECH COVID-19 VACCINE, BIVALENT?
For primary vaccination, another choice for preventing COVID-19 is SPIKEVAX (COVID-19 Vaccine, mRNA), an FDA-approved COVID-19 vaccine. Other vaccines to prevent COVID-19 may be available under EUA, including bivalent vaccines that contain an Omicron component of SARS-CoV-2.

CAN I RECEIVE COMIRNATY (COVID-19 VACCINE, mRNA), PFIZER-BIONTECH COVID-19 VACCINE, OR THE PFIZER-BIONTECH COVID-19 VACCINE, BIVALENT AT THE SAME TIME AS OTHER VACCINES?
Data have not yet been submitted to FDA on administration of COMIRNATY (COVID-19 Vaccine, mRNA), the Pfizer-BioNTech COVID-19 Vaccine, or the Pfizer-BioNTech COVID-19 Vaccine, Bivalent at the same time with other vaccines. If you are considering receiving COMIRNATY (COVID-19 Vaccine, mRNA), the Pfizer-BioNTech COVID-19 Vaccine, or the Pfizer-BioNTech COVID-19 Vaccine, Bivalent with other vaccines, discuss your options with your healthcare provider.

WHAT IF I AM IMMUNOCOMPROMISED?
If you are immunocompromised, you may receive a third primary series dose of Pfizer-BioNTech COVID-19 Vaccine or COMIRNATY (COVID-19 Vaccine, mRNA). Individuals 12 years of age and older may receive a booster dose with Pfizer-BioNTech COVID-19 Vaccine, Bivalent. Vaccinations may not provide full immunity to COVID-19 in people who are immunocompromised, and you should continue to maintain physical precautions to help prevent COVID-19. Your close contacts should be vaccinated as appropriate.

WHAT IF I AM PREGNANT OR BREASTFEEDING?
If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THESE VACCINES GIVE ME COVID-19?
No. These vaccines do not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD
When you get your first COVID-19 vaccine, you will get a vaccination card. Remember to bring your card when you return.

ADDITIONAL INFORMATION

If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Global website	Telephone number
www.cvdvaccine.com 	1-877-829-2619 (1-877-VAX-CO19)

HOW CAN I LEARN MORE?

- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- Contact your local or state public health department.

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THESE COVID-19 VACCINES?

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, Health Resources & Services Administration [HRSA] COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or https://TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including these vaccines. Generally, a claim must be submitted to the CICP within one (1) year from the

date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?
An EUA is a mechanism to facilitate the availability and use of medical products, including vaccines, during public health emergencies, such as the current COVID-19 pandemic. An EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic. A product authorized for emergency use has not undergone the same type of review by FDA as an FDA-approved product.

FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of the scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

An EUA is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of this product, unless terminated or revoked (after which the product may no longer be used).

BIONTECH
Manufactured for
BioNTech Manufacturing GmbH
An der Goldgrube 12
55131 Mainz, Germany

Pfizer
Manufactured by
Pfizer Inc., New York, NY 10017

LAB-1451-24.0

Revised: 8 December 2022

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

GDTI: 0886983000332

FACT SHEET FOR RECIPIENTS AND CAREGIVERS

EMERGENCY USE AUTHORIZATION (EUA) OF THE JANSSEN COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

You are being offered the Janssen COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of receiving the Janssen COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Janssen COVID-19 Vaccine may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Janssen COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Janssen COVID-19 Vaccine.

The Janssen COVID-19 Vaccine is administered as a **single dose**, into the muscle.

The Janssen COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please visit www.janssencovid19vaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?

COVID-19 is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Common symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE JANSSEN COVID-19 VACCINE?

The Janssen COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Janssen COVID-19 Vaccine to prevent COVID-19 in individuals 18 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE JANSSEN COVID-19 VACCINE?

Tell the vaccination provider about all of your medical conditions, including if you:

- have any allergies,
- have a fever,
- have a bleeding disorder or are on a blood thinner,
- are immunocompromised or are on a medicine that affects your immune system,
- are pregnant or plan to become pregnant,
- are breastfeeding,
- have received another COVID-19 vaccine,

WHO SHOULD GET THE JANSSEN COVID-19 VACCINE?

FDA has authorized the emergency use of the Janssen COVID-19 Vaccine in individuals 18 years of age and older.

WHO SHOULD NOT GET THE JANSSEN COVID-19 VACCINE?

You should not get the Janssen COVID-19 Vaccine if you:

- had a severe allergic reaction to any ingredient of this vaccine.

WHAT ARE THE INGREDIENTS IN THE JANSSEN COVID-19 VACCINE?

The Janssen COVID-19 Vaccine includes the following ingredients: recombinant, replication-incompetent adenovirus type 26 expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride.

HOW IS THE JANSSEN COVID -19 VACCINE GIVEN?

The Janssen COVID-19 Vaccine will be given to you as an injection into the muscle.

The Janssen COVID-19 Vaccine vaccination schedule is a **single dose**.

HAS THE JANSSEN COVID-19 VACCINE BEEN USED BEFORE?

The Janssen COVID-19 Vaccine is an unapproved vaccine. In an ongoing clinical trial, 21,895 individuals 18 years of age and older have received the Janssen COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE JANSSEN COVID-19 VACCINE?

In an ongoing clinical trial, the Janssen COVID-19 Vaccine has been shown to prevent COVID-19 following a single dose. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE JANSSEN COVID-19 VACCINE?

Side effects that have been reported with the Janssen COVID-19 Vaccine include:

- Injection site reactions: pain, redness of the skin and swelling.
- General side effects: headache, feeling very tired, muscle aches, nausea, and fever.

There is a remote chance that the Janssen COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Janssen COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing,
- Swelling of your face and throat,
- A fast heartbeat,
- A bad rash all over your body,
- Dizziness and weakness.

Blood clots involving blood vessels in the brain, abdomen, and legs along with low levels of platelets (blood cells that help your body stop bleeding), have occurred in some people who have received the Janssen COVID-19 Vaccine. In people who developed these blood clots and low levels of platelets, symptoms began approximately one to two-weeks following vaccination. Most people who developed these blood clots and low levels of platelets were females ages 18 through 49 years. The chance of having this occur is remote. You should seek medical attention right away if you have any of the following symptoms after receiving Janssen COVID-19 Vaccine:

- Shortness of breath,
- Chest pain,
- Leg swelling,
- Persistent abdominal pain,
- Severe or persistent headaches or blurred vision,
- Easy bruising or tiny blood spots under the skin beyond the site of the injection.

These may not be all the possible side effects of the Janssen COVID-19 Vaccine. Serious and unexpected effects may occur. The Janssen COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS).** The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Janssen COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Janssen Biotech, Inc. at the contact information provided below.

e-mail	Fax number	Telephone numbers
JNJvaccineAE@its.jnj.com	215-293-9955	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

You may also be given an option to enroll in **v-safe. V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET THE JANSSEN COVID-19 VACCINE?

It is your choice to receive or not receive the Janssen COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES JANSSEN COVID-19 VACCINE?

Currently, there is no FDA approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE JANSSEN COVID-19 VACCINE WITH OTHER VACCINES?

There is no information on the use of the Janssen COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?

If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE JANSSEN COVID-19 VACCINE GIVE ME COVID-19?

No. The Janssen COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD

When you receive the Janssen COVID-19 Vaccine, you will get a vaccination card to document the name of the vaccine and date of when you received the vaccine.

ADDITIONAL INFORMATION

If you have questions or to access the most recent Janssen COVID-19 Vaccine Fact Sheets, scan the QR code using your device, visit the website or call the telephone numbers provided below.

QR Code	Fact Sheets Website	Telephone numbers
	www.janssencovid19vaccine.com.	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

HOW CAN I LEARN MORE?

- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.

Contact your local or state public health department.

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, HRSA COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURE INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses for certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?

The United States FDA has made the Janssen COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Janssen COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

The EUA for the Janssen COVID-19 Vaccine is in effect for the duration of the COVID-19 declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

Manufactured by:
Janssen Biotech, Inc.
a Janssen Pharmaceutical Company of Johnson & Johnson
Horsham, PA 19044, USA

For more information, call US Toll Free: 1-800-565-4008, US Toll: (908) 455-9922 or go to www.janssencovid19vaccine.com

Revised: Apr/23/2021

cp-205985v3

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Barcode Date: 02/2021

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 04/08/2021	Revision Date: 04/15/2021; 04/19/2022	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Resident Going into the Community**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

BACKGROUND

The global Covid-19 pandemic has been stressful and isolating for many people, including our nursing home residents. Physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. Some residents feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find the restrictions brought on by the pandemic confusing and/or upsetting.

POLICY STATEMENT

The global Covid-19 pandemic has been stressful and isolating for many people, including our nursing home residents. Physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. Some residents feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find the restrictions brought on by the pandemic confusing and/or upsetting.

DEFINITIONS

Close Contact: refers to someone who has been within 6 feet of a Covid-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period.

"Up To Date" Covid Vaccination: a person has received all recommended Covid 19 vaccines including any booster dose(s) when eligible

PROCEDURE

1. The facility will provide education to residents, families, and others, as applicable, to follow all recommended infection prevention and control (IPC) practices – wearing a mask, social/physical distancing, and hand hygiene – to prevent the spread of Covid-19.
2. Families/healthcare representatives will be provided with education to report to the facility if they or anyone the resident has come into close contact with while out on pass have developed symptoms consistent with Covid-19 or have had a Covid-positive test within 48hours of being with the resident.
3. For residents who have been out of facility for <24 hours (e.g., medical appointments, dialysis, community outings with family or friends:
   - Resident will be placed in their room on the Unit on which they live, **if** they have not had any close contact (within 6ft for >15 consecutive minutes, regardless of whether the contact was wearing a mask) with someone with Covid-19 infection
   - No testing required (facility may choose to perform point-of-care test upon return)
   - Resident will be assessed for signs/symptoms consistent with Covid-19 infection - temp ≥99°F, chills, body aches, cough, difficulty breathing, shortness of breath, poor oxygenation, nausea, diarrhea, loss of taste, loss of smell. Assessment will include daily temperature and pulse oximetry checks.
4. Residents who are not *up to date* with all recommended Covid vaccines or have not recovered form SARS-CoV-2 infection in the prior 90 days, and leave the facility for >24 hours will be managed in general as New and Re-admissions:
   - placed on quarantine (contact and droplet precautions) x10 days

- Alternatively, residents can be removed from quarantine after Day 7 if a viral test is negative for SARS-COV-2 and they do not have symptoms. The specimen should be collected and tested within 48 hours before TBPs are discontinued
    - Quarantine is no longer recommended for residents who are *up to date* with all recommended Covid vaccines or have recovered from Covid-19 infection within 3 months **AND** have **not** had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days (CDC 2/2/2022).
- Residents in quarantine will be placed in a single room, to the extent possible
    - If a single room is unavailable, resident will remain in their current location
- Unit staff will utilize full PPEs (face mask; gown; eye protection; gloves)

5. A risk assessment to determine Covid-19 exposure will be done to determine appropriate room/unit placement upon return to facility.

EFFECTIVE: 4/8/2021

REVISED: 4/15/2021; 4/19/2022

REFERENCE(S)

CDC (12/2/2020). Science Brief: Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing. https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/scientific-brief-options-to-reduce-quarantine.html

NYSDOH (3/25/2021). Health Advisory: Revised Skilled Nursing Facility Visitation. https://coronavirus.health.ny.gov/system/files/documents/2021/03/updated_nursing_home_visitation_guidance.pdf

CDC (3/29/2021). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

CDC (2/2/2022). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2Spread in Nursing Homes. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#%3A%7E%3Atext%3DExpanded%20screening%20testing%20of%20asymptomatic%20HCP%20should%20be%20as%20follows%3A

NYSDOH (3-25-2022). DAL 22-09. Nursing Home Visitation and Covid-19 Testing. https://www.health.ny.gov/professionals/nursing_home_administrator/dal/docs/dal_nh_22-09.pdf

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 04/19/2021	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Resident Going Into the Community COVID-19 Infection Risk Assessment**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

POLICY STATEMENT

It is the policy of the facility to support residents and families to go on outings, including out on pass, while minimizing the potential spread of Covid-19 infection. As per CDC guidance, the facility may consider quarantining residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention and control (IPC) measures.

PROCEDURE

1. For residents leaving the facility for greater than 24 hours, the IDT team will conduct a brief risk assessment to determine the ability of the resident and resident representative's understanding and ability to adhere to basic Infection Control Principles.

2. The assessment tool will evaluate the potential risks to resident safety regarding going out into community. This includes principles such as physical distancing, mask wearing, hand hygiene and reporting by the resident/resident representative if resident was exposed to Covid 19 while out of facility.

3. The RN / IP will review with family risks identified from the assessment to educate resident/ resident representative.

4. If the assessment identifies risk of IC principles not being able to be maintained the facility will quarantine resident on return to the facility for 14 days and may request a diagnostic test for SARS COV-2.

5. The resident/ resident representative will be requested to sign the risk assessment indicating they have been educated and informed of risks and IC core practices.

6. For residents going to medical appointments, the facility will request that communication from the medical facility be provided to assist to identify residents with potential exposures to COVID-19 before the return to the facility so that proper precautions and contact tracing can be implemented. If there is an identified area of noncompliance with IC principles, residents may be quarantined for 14 days and testing for SARS COV-2 be conducted.

REFERENCE(S)

CDC (3/29/2021). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

NORTHERN MANHATTAN REHABILITATION & NURSING CENTER			
Section: **Infection Control**		Policy#	
Issue Date: 04/19/2021	Revision Date:	Review Date: 03/2023	Prepared by: Administration; Nursing Services
Policy Subject: **Pandemic Emergency Plan – Risk Assessment: COVID-19 Exposure**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee			

Residents Going Out on Pass with Responsible Party

Name or Responsible Party: _____

Phone # of Responsible Party: _____

As the responsible party, I hereby certify that I:

1. Have been provided with education to follow all recommended infection prevention and control practices as related to the prevention and transmission on Covid-19 infection. These include wearing a mask when not eating or drinking, maintaining social distance of at least 6 feet, and hand hygiene.
   □ Yes □No □N/A
2. Will the resident be out of the facility >24 hours?
   □ Yes □No □N/A
3. Will ensure that the resident maintains social distancing, avoids large gatherings, wear facemasks to the extent tolerated, perform frequent hand hygiene, and avoid sharing of communal foods and drinks
   □ Yes □No □N/A
4. Will notify the facility if the resident becomes ill ≥48 hours of leaving the facility (applicable to residents leaving for ≥48 hours)
   □ Yes □No □N/A
5. Has the resident come into close contact (within 6ft for >15 consecutive minutes, regardless of whether the contact was wearing a mask) with anyone suspected or confirmed with Covid-19 infection?
   □ Yes □No □N/A

Doctor's Appointments/Dialysis/Outpatient Treatment Centers

1. Was the resident wearing a mask during appointment and transport?
   □ Yes □No □N/A
2. Has the resident come into close contact (within 6ft for >15 consecutive minutes, regardless of whether the contact was wearing a mask) with anyone suspected or confirmed with Covid-19 infection within the last 48 hours?
   □ Yes □No □N/A

*Upon return, facility may conduct a diagnostic Covid-19 test and/or place resident on quarantine based on identified risk factors.

Northern Manhattan
Rehabilitation & Nursing Center

116 East 125th Street | New York, N.Y. 10035 | Tel: 212.426.1284 | Fax: 212.426.1299 | Web: www.nmrehab.org

ESCORTED PASS

DATE: _____ TIME: _____

NAME: _____ ROOM NO. _____
(RESIDENT/PATIENT)

NAME: _____ MOBILE NO. _____
(DESIGNATED REP/RESPONSIBLE PARTY)

ADDRESS: _____
(DESIGNATED RESPONSIBLE PARTY)

ADDRESS: _____
(DESTINATION)

I _____ (DESIGNATED EPRESENTATIVE/RESPONSIBLE PARTY)

assume responsibility for _____ (RESIDENT/PATIENT) while

outside the facility. We will be returning to the facility at _____ (TIME) on _____ (DATE).

As the responsible party, I hereby certify that I:

1. Have been provided with education to follow all recommended infection prevention and control practices as related to the prevention and transmission on Covid-19 infection. These include wearing a mask when not eating or drinking, maintaining social distance of at least 6 feet, and hand hygiene.
   □ Yes □No □N/A
2. Will the resident be out of the facility >24 hours?
   □ Yes □No □N/A
3. Will ensure that the resident maintains social distancing, avoids large gatherings, wear facemasks to the extent tolerated, perform frequent hand hygiene, and avoid sharing of communal foods and drinks
   □ Yes □No □N/A
4. Will notify the facility if the resident becomes ill ≥48 hours of leaving the facility (applicable to residents leaving for ≥48 hours)
   □ Yes □No □N/A
5. Will the resident come into close contact (within 6ft for >15 consecutive minutes, regardless of whether the contact was wearing a mask) with anyone suspected or confirmed with Covid-19 infection?
   □ Yes □No □N/A

I have been informed of the facility's policy and I understand non-compliance with the policy may result in possible discharge of the resident from the facility.

Prior to leaving, a duplicate of the pass must be presented to Reception/Security.

_____ _____
DESIGNATED RESPONSIBLE PARTY Date NURSE MANAGER/DESIGNEE Date

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Rehabilitation & Nursing Center

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UNESCORTED PASS

DATE: _____ TIME: _____ ROOM NO. _____

NAME: _____ MOBILE NO. _____
(RESIDENT/PATIENT)

ADDRESS: _____
(DESTINATION)

I _____ (RESIDENT/PATIENT) assume responsibility for myself while outside the facility and any equipment I require that is the property of the facility. I will be returning to the facility at _____ (TIME) on _____ (DATE).

As a responsible resident/patient of Northern Manhattan, I hereby certify that I:

1. Have been provided with education to follow all recommended infection prevention and control practices as related to the prevention and transmission on Covid-19 infection. These include wearing a mask when not eating or drinking, maintaining social distance of at least 6 feet, and hand hygiene.
   □ Yes □No □N/A
2. Will I be out of the facility >24 hours?
   □ Yes □No □N/A
3. Will ensure that I maintain social distancing, avoids large gatherings, wear facemasks to the extent tolerated, perform frequent hand hygiene, and avoid sharing of communal foods and drinks
   □ Yes □No □N/A
4. Will notify the facility if I become ill ≥48 hours of leaving the facility (applicable if I am leaving for ≥48 hours)
   □ Yes □No □N/A
5. Will I come into close contact (within 6ft for >15 consecutive minutes, regardless of whether the contact was wearing a mask) with anyone suspected or confirmed with Covid-19 infection?
   □ Yes □No □N/A

I have been informed of the facility's *Unescorted Pass* policy and I understand that non-compliance with the policy will result in re-assessment of my comprehensive care plan and possible discharge from the facility.

I understand prior to leaving the facility, a duplicate of this pass must be presented to Reception/Security.

RESIDENT/PATIENT Date NURSE MANAGER/DESIGNEE Date