



SKILLED NURSING FACILITY POLICY
Pandemic Emergency Plan

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Introduction

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

Pandemics occurs when a novel virus appears that causes readily transmissible human illness against which most of the population lacks immunity. Several features set a pandemic apart from other public health emergencies or community disasters:

- Pandemics are expected but arrive with very little warning.
- Outbreaks can be expected to occur simultaneously throughout much of the U.S., preventing sharing of human and material resources that usually occur in the response to other disasters. Localities should be prepared to rely on their own resources to respond. The effect of a pandemic on individual communities will be relatively prolonged (weeks to months) in comparison to disasters of shorter duration.
- Because of widespread susceptibility to a pandemic strain, the number of persons affected will be high.
- Health care workers and other first responders will be at higher risk of exposure and illness than the general population, further straining the health care system.
- Effective preventive and therapeutic measures, including vaccine and antiviral agents, are likely to be delayed and in short supply.
- Widespread illness in the community could result in sudden and potentially significant shortages of personnel in other sectors that provide critical public safety services.

Clinical Guidelines for the Interpandemic and Pandemic Alert Periods:

During the Interpandemic and Pandemic Alert Periods, the primary goal of rapid detection is to quickly identify and contain cases of novel viruses. To limit the need to evaluate an overwhelming number of residents, the screening criteria should be specific, relying on a combination of clinical and epidemiologic features. Although febrile respiratory illnesses are one of the most common indications for medical evaluation, particularly during the winter, during the interpandemic and pandemic alert period human cases of novel viruses are expected to be quite rare; laboratory diagnosis will most likely be sought for those with severe respiratory illness, such as pneumonia.



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Criteria for evaluation of residents with a possible novel virus:

The following criteria are based on the features of recent avian influenza A (HSN 1) cases but are intended for use in evaluating suspected cases of infection with any novel influenza A virus strain. During the Pandemic Alert Period, human infections with novel influenza A viruses will be an uncommon cause of influenza-like illness (temperature of $>38^{\circ}\text{C}$ plus either sore throat, or cough with dyspnea as an additional criteria); therefore, **both clinical and epidemiologic criteria should be met.**

1. Clinical criteria

Any suspected cases of human infection with a novel influenza virus must first meet the clinical criteria:

- Severe illness: hospitalized with severe influenza like illness, including pneumonia or ARDS
- Mild to moderate illness:
 - Fever (temperature $>38^{\circ}\text{C}$ or 100.4°F) and
 - Either sore throat, cough, or dyspnea.

2. Epidemiologic criteria

Epidemiologic criteria for evaluation of residents with possible novel influenza focus on the risk of exposure to a novel influenza virus with pandemic potential. Although the incubation period for seasonal influenza ranges from 1 to 4 days, the incubation periods for novel types of influenza are currently unknown and might be longer. **Therefore, the maximum interval between potential exposure and symptom onset is set conservatively at 10 days.**

Exposure risks—Exposure risks fall into two categories: travel and occupational.

Travel risks:

Persons have a travel risk if they have:

1. Recently visited or lived in an area affected by highly pathogenic influenza A outbreaks in domestic poultry or where a human case of novel influenza has been confirmed,
2. Had direct contact with poultry (see definition below) or other infected animals
3. Had close contact with a person with confirmed or suspected novel influenza.

Close contact with a person from an infected area with confirmed or suspected novel influenza is defined as being within 6 feet of that person during their illness. Because specific testing for human infection with novel influenza might not be locally



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available in an affected area, persons reporting close contact in an affected area with a person suffering from a severe, yet unexplained, respiratory illness should also be evaluated.

Occupational risks:

Persons at occupational risk for infection with a novel strain of influenza include:

1. Persons who work on farms or live poultry markets or who process or handle poultry infected with known or suspected avian influenza viruses,
2. Workers in laboratories that contain live animal or novel influenza viruses, and
3. HCW indirect contact with a suspected or confirmed novel influenza case.

During the Interpandemic and Pandemic Alert Periods, when there is no sustained human-to-human transmission of any novel influenza viruses, direct contact with animals in an affected area or close contact with a case of suspected or confirmed human novel influenza- for any reason- requires further evaluation.

During the Pandemic Alert Period, the majority of human cases of novel influenza/virus will result from animal to- human transmission. Therefore, a history of direct contact with poultry (well-appearing, sick or dead), consumption of uncooked poultry or poultry products, or direct exposure to environmental contamination with poultry feces in an affected area will be important to ascertain.

During the Pandemic Alert Period, a history of close contact with an ill person suspected or confirmed to have novel influenza in an affected area will be even more important.

Initial management of residents who meet the criteria for novel virus/ influenza:

When a resident meets both the clinical and epidemiologic criteria for a suspected case of novel virus/ influenza, healthcare personnel should initiate the following activities:

1. **Notify the local health department (LHD).** Report each resident who meets the clinical and epidemiologic criteria for a suspected case of novel virus/influenza to the LHD as quickly as possible to facilitate initiation of public health measures.
2. **Implement infection control precautions for novel virus/ influenza, including Respiratory Hygiene/Cough Etiquette.** Residents should be placed on Droplet Precautions for a minimum of 7 days (unless otherwise directed by DOH), unless there is full resolution of illness or another etiology has been identified before that



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period has elapsed. Healthcare personnel should wear surgical or procedure masks on entering a resident's room, as per Droplet Precautions, as well as gloves and gowns, when indicated for Standard Precautions.

3. **Obtain clinical specimens for novel virus/ influenza A virus testing after consulting with the LHD to arrange testing.** Testing will be directed by public health authorities. The following respiratory specimens should be collected for novel virus/ influenza A virus testing: nasopharyngeal swab; nasal swab, wash, or aspirate; throat swab.
4. **Evaluate alternative diagnoses.** An alternative diagnosis should be based only on laboratory tests with high positive predictive value (e.g., blood culture, viral culture, PCR, *Legionella* urinary antigen, pleural fluid culture). If an alternate etiology is identified, the possibility of co-infection with a novel influenza virus may still be considered if there is a strong epidemiologic link to exposure to novel virus/influenza.
5. **Decide on inpatient or outpatient management.** The decision to hospitalize a suspected novel virus/ influenza case will be based on the physician's clinical assessment and assessment of risk and whether adequate precautions can be taken to prevent the potential spread of infection.
6. **Initiate antiviral treatment** as soon as possible, even if laboratory results are not yet available.
7. **Assist public health officials** with the identification of potentially exposed contacts. After consulting with state and local public health officials, clinicians might be asked to help identify persons exposed to the suspected novel virus/ influenza case-patient (particularly healthcare workers). In general, persons in close contact with the case-patient at any time beginning one day before the onset of illness are considered at risk.

Management of residents who test positive for novel virus/ influenza:

If a resident is confirmed to have an infection with a novel virus/ influenza virus, healthcare personnel should continue antiviral treatment and all isolation and infection control precautions, and isolate residents with novel virus/ influenza from seasonal influenza patients.

Management of residents who test positive for seasonal influenza:

Many suspected novel influenza cases may be found to have seasonal human influenza, particularly



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during the winter season. For residents with confirmed seasonal influenza, maintain Standard and Droplet Precautions, and continue antiviral treatment for a full treatment course (e.g., 5 days).

Management of residents who test negative for novel virus/ influenza:

The sensitivity of the currently available tests for detecting novel virus/ influenza viruses in clinical specimens has not been thoroughly evaluated with a full range of specimen types. Consequently, false-negative test results may occur. Therefore, if test results are negative but the clinical and epidemiologic suspicion remains high, continuing antiviral treatment and isolation procedures should be considered.

When virus/influenza tests are negative and an alternative diagnosis is established, isolation precautions and antiviral drug therapy for novel virus/influenza may be discontinued based on clinician's assessment, particularly in the absence of a strong epidemiologic link, if the alternative diagnosis is made using a test with a high positive-predictive value, and if the clinical manifestations are explained by the alternative diagnosis.

Clinical Guidelines for the Pandemic Period:

During the Pandemic Period, the primary goal of rapid detection is to appropriately identify and triage cases of pandemic influenza or pandemic virus. During this period, outpatient clinics and emergency departments might be overwhelmed with suspected cases, restricting the time and laboratory resources available for evaluation. In addition, if the pandemic virus/ influenza exhibits transmission characteristics similar to those of seasonal influenza viruses, illnesses will likely spread throughout the community too rapidly to allow the identification of obvious exposures or contacts. Evaluation will therefore focus predominantly on clinical and basic laboratory findings, with less emphasis on laboratory diagnostic testing (which may be in short supply) and epidemiologic criteria.

Nevertheless, clinicians in communities without pandemic virus/ influenza activity might consider asking patients about recent travel from a community with pandemic influenza activity or close contact with a suspected or confirmed pandemic virus/ influenza case.

Criteria for evaluation of residents with possible pandemic virus/ influenza:

1. Clinical criteria

Suspected cases of pandemic virus/ influenza infection should meet the criteria of: **fever (temperature of >38°C) plus one or more of the following: sore throat, cough, or dyspnea.**

2. Epidemiologic criteria

Once pandemic virus/ influenza has arrived in a particular locality, **clinical criteria will be sufficient**



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for classifying the resident as a suspected pandemic virus/ influenza case.

Initial management of patients who meet the criteria for pandemic virus/ influenza:

When a resident meets the criteria for a suspected case of pandemic virus/ influenza, healthcare personnel should initiate the following activities:

1. **Follow local and state health department recommendations on reporting** for residents who meet the criteria for pandemic virus/ influenza.
2. **Implement infection control precautions for pandemic virus/ influenza, including Respiratory Hygiene/Cough Etiquette.** Place the resident on Droplet Precautions for a minimum of 5 days from the onset of symptoms. Healthcare personnel should wear surgical or procedure masks on entering a resident's room, as per Droplet Precautions, as well as gloves and gowns when indicated, as per Standard Precautions. Once a pandemic is underway, hospital admission of residents should be limited to those with severe complications who cannot be cared for in the Long Term Care setting. Resident movement and transport outside the isolation area should be limited to medically necessary purposes.
3. **Obtain -clinical specimens for general evaluation, as clinically indicated.** Once pandemic virus/ influenza has arrived in a community, virus/influenza testing will likely not be needed for most residents.
4. **Decide on inpatient or outpatient management.** The decision to hospitalize a suspected pandemic virus/ influenza case will be based on the physician's clinical assessment of the resident as well as the availability of hospital beds and personnel.

Clinical management of pandemic virus/ influenza residents:

The targeted use of antiviral agents could, as part of a response strategy to susceptible strains, decrease the health impact of an influenza/virus pandemic. Use of antiviral prophylaxis has been up to 70% to 90% effective in preventing symptomatic influenza infection caused by susceptible strains, if prophylaxis is begun before exposure to influenza. Also, treatment with one class of agents, neuraminidase inhibitors, has been shown to decrease severe complications such as pneumonia and bronchitis and to reduce hospitalizations. These interventions may be particularly important before vaccine is available and for those in whom vaccination may be medically contraindicated.

Protection afforded by antiviral medications is virtually immediate and does not interfere with the response to inactivated influenza vaccines. It is important to avoid inappropriate use of antiviral medications that may lead to viral resistance.



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Drugs with activity against influenza viruses (antivirals) include the adamantanes, amantadine and rimantadine, and the neuraminidase inhibitors, oseltamivir and zanamivir. Appropriate use of these agents during an influenza pandemic may reduce morbidity and mortality and diminish the overwhelming demands that will be placed on the healthcare system.

In addition to use of antivirals, clinical management of severe influenza should address supportive care and the rapid identification and treatment of secondary complications.

Infection Control Measures:

The key to successfully controlling transmission of influenza (and other communicable respiratory infections) is the early identification of potentially infectious residents, and the immediate implementation of control measures for containment.

Residents are a vulnerable population for the acquisition and development of complications of novel virus/ influenza due to advanced age, co-morbidities, regular close contact with other at-risk persons, and decreased response to the influenza vaccine.

Pandemic virus/influenza presents additional challenges. A pandemic may occur any time of the year. There would be an increased susceptibility in the community, further impacting on potential exposures in the LTCF setting. Additionally, acute medical management of residents in the LTCF setting should be anticipated and planned for, as hospitals may be unable to meet all of the medical needs of the community. This may be achieved by utilizing Telemedicine.

Plan to preserve the resident's place at the facility during a hospitalization:

- Any resident who requires hospitalization will retain their room & belongings.

Basic infection control principles for preventing the spread of pandemic viral influenza for all pandemic periods:

- Limit exposure to infectious/potentially infectious persons (i.e., febrile respiratory symptoms).
- Identify potentially infectious individuals and physically isolate if possible/indicated.
- Promote spatial separation in common areas (i.e., maintain at least 6 feet from symptomatic persons).
- Protect healthcare workers from exposure to the influenza & novel virus while delivering care.
 - Wear a surgical or procedure mask for close contact with infectious residents



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- (i.e., within 6 feet).
 - Wear personal protective equipment (i.e., gloves; gowns, mask and eye protection) to prevent contact with respiratory secretions and skin, mucous membranes and clothing (i.e., standard precautions).
 - Perform hand hygiene after contact with infectious residents or their immediate environment. Reinforce compliance with hand hygiene by educating on the importance of hand hygiene for the prevention of transmission of infectious agents and providing easy access to hand hygiene products at the point of care.
 - Educate healthcare workers to avoid touching their eyes, nose or mouth with contaminated hands (gloved or ungloved) while delivering care and until they perform hand hygiene.
 - Food and drink should not be consumed by healthcare workers in patient care areas where contamination is likely.
- Contain infectious respiratory secretions:
 - Implement the use of respiratory hygiene/cough etiquette;
 - Promote the use of masks by symptomatic persons in common areas (e.g., waiting areas) or when being transported (e.g., in emergency vehicles).
 - Assure adequate cleaning of the resident environment. It should minimally include:
 - Daily cleaning of:
 - A. Horizontal surfaces (e.g., over-bed table, night stand);
 - B. Frequently touched surfaces (e.g., bed rails, phone, light switches and door knobs);
 - C. Lavatory surfaces;
 - Discharge cleaning of:
 - A. Surfaces described above;
 - B. Visibly soiled vertical surfaces (e.g., walls, curtain dividers).
 - The Environmental Services Supervisor will perform daily rounds to inspect cleanliness.

Management of infectious/potentially infectious residents:

- Respiratory hygiene/cough etiquette detailed below should be utilized at all times. Key points for successful implementation of respiratory hygiene/cough etiquette include:
 - Provide surgical masks to all residents with symptoms of a respiratory illness. Provide instructions on the proper use and disposal of masks.
 - For residents who cannot wear a surgical mask, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal



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secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material.

- Provide hand hygiene materials in common areas and encourage residents with respiratory symptoms to perform hand hygiene.
- Place residents with respiratory symptoms in a separate area as soon as possible for further evaluation.
- Implement use of surgical or procedure masks and gloves by healthcare personnel during the evaluation of residents with respiratory symptoms.

Droplet precautions and resident placement:

Residents with known or suspected pandemic virus/ influenza should be placed on droplet precautions for the duration of their illness, and a minimum of 5 days from the onset of symptoms. Droplet precautions include:

- Donning a surgical or procedural mask upon room entry.
- Discard the mask after leaving the resident room. If the healthcare worker is attending multiple residents in the same room (e.g., in a cohort situation), the same mask may be utilized until the healthcare worker leaves the room.
- Hand hygiene must be performed after each resident encounter.
- Place the resident in a private room, if feasible. Residents may be cohorted if necessary. As residents may be infected with different strains of influenza/ novel virus or other infectious agents, care must be taken to prevent transmission within the cohort (i.e., spatial separation of at least 6 feet).

Aerosol-generating procedures for residents with pandemic virus/ influenza:

Aerosol-generating procedures (e.g., suctioning, nebulizer treatments) may increase the potential for dissemination of droplet nuclei in the immediate vicinity of the resident. Therefore, healthcare workers should wear the following personal protective equipment (PPE) when performing aerosol-generating procedures on residents with suspected, or known to be infected with, pandemic influenza:

- Gloves
- Gown
- Face/eye protection
- Respirator or other appropriate particulate respirator (N95)
 - Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance, and training.



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Additional work practice controls may further reduce transmission during an aerosol generating procedure, and should be implemented for residents with suspected or confirmed pandemic virus/ influenza:

- Limit the numbers of HCWs present during the procedure to essential staff only.
- Utilize closed systems for suctioning to prevent splattering/spraying of potentially infectious secretions.

Prevention or delay of pandemic virus/ influenza entry into the facility during a state/regional pandemic:

- Signs will be placed at all entrances and strategic locations detailing:
 - The signs and symptoms of influenza/ novel virus and any current epidemiological risk factors for a pandemic virus/ influenza strain, if identified.
 - Visitors with Influenza, Novel Virus like illness should not visit the facility.
- The Infection Preventionist will routinely access (at least weekly during routine epidemic influenza season) the NYSDOH Influenza Activity Surveillance Reports on the NYSDOH Public Website at <http://www.health.state.ny.us/diseases/communicable/influenza/surveillance.htm> to obtain current information on the epidemiology of epidemic and pandemic influenza. For any other novel virus, obtain updates via county, state and national data. This information will be communicated to all appropriate clinical staff and direct care providers.
- Assign personnel to verbally and visually screen visitors for respiratory illness and actively enforce visitor restrictions. Consider restriction of those visitors who have had recent travel within 10 days) to areas affected by the pandemic, as they may be incubating illness.
- Implement respiratory hygiene/cough etiquette at all entry points into the facility and in common areas.
- Perform careful screening for respiratory infections of residents being admitted to the facility. Admit residents with a respiratory infection of unknown etiology on droplet



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precautions, and to a private room, if feasible.

- Employee Health guidelines:
 - The Employee Health Office will be responsible for the monitoring of employee health concerns in regard to respiratory infections.
 - Instruct all health care personnel to report influenza-like, novel virus like illnesses to the Nursing Supervisory immediately. If onset of employee illness occurs while working, instruct the health care Personnel to don a surgical mask and report to the Supervisor, and the Supervisor will notify the Employee Health office.
 - If onset of illness occurs at home, instruct the employee to not report to work until symptoms resolve.
 - Investigate any clusters of virus-like illness identified in healthcare personnel and report to the NYSDOL Regional Epidemiology Program.
 - Personnel at high risk for complications of pandemic virus influenza (e.g., pregnant women, immunocompromised persons) should be informed of their medical risk and offered an alternate work assignment away from influenza-patient care.
 - Closely monitor healthcare personnel with direct contact with influenza/novel virus patients for early identification of secondary transmission to contain local spread. The following recommendations may be helpful to operationalize:
 - Limit patient contact to essential staff.
 - Eliminate or minimize floating
 - Have staff complete a daily self-assessment to document symptoms. A self-evaluation tool can be utilized for this purpose. The tool should provide guidance for symptomatic individuals (i.e., how, when and whom to report symptoms to).
 - Administer vaccine to healthcare personnel when available.
 - Administer antivirals for treatment of ill healthcare personnel and for prophylaxis of exposed healthcare personnel as per the antiviral section of the NYSDOH Pandemic Influenza Plan.
 - Remove staff members, medical reason for not being vaccinated, to a region that does not have an outbreak.

Prevention or delay of influenza/ novel virus entry into the facility during a local pandemic:

During a local pandemic, the facility should have tight control over persons entering and



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should be limited to essential staff only. The following *additional measures* should be incorporated:

- Personnel monitoring entry into the facility should wear a surgical or procedural mask for this task. Masks are to be changed when moist with condensation or visibly soiled or ill fitting.
- Limit visitors to persons who are needed to perform resident care, should a staffing shortage necessitate. Visitors will be educated on tasks to be performed, Standard Precautions, Droplet Precautions, Handwashing and Respiratory Hygiene/Cough Etiquette.
- Carefully screen new admissions for symptoms of, and exposure to, pandemic virus/ influenza.
- Suspend all group activities (e.g., close the dining room, activity centers/gyms, etc.) during the local pandemic.
- Administer traditional group therapies (e.g., physical, occupational and recreational therapy) individually to residents or within the cohorts.
- Curtail floating of direct care staff as feasible.

New Admissions/ Readmissions/ER Visits:

- Perform resident placement of new admissions/ readmissions/ER visits with the following considerations:
 - Perform viral/influenza testing per CDC/CMS/DOH guidelines
 - Residents with respiratory symptoms who require admission to the facility (e.g., acute care facilities beyond patient capacity, persons in the community in need of extended care, etc.) should be admitted preferably to a private room on droplet & contact precautions for the duration of illness, and for a minimum of 5 days. If a private room is not available, consider cohorting during a local pandemic.
 - Residents with exposure to pandemic virus/ influenza (e.g., stay in a hospital with an identified pandemic virus/ influenza outbreak, household exposure) that require admission to the facility should be admitted to a private room on droplet & contact precautions for the duration of the pandemic virus/ influenza strain incubation period. If a private room is not available, consider cohorting during a



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- local pandemic.
- Establish cohorts and place all new admissions on droplet precautions for entire incubation period if widespread pandemic virus/ influenza is identified in the local community.

Cohorting during a local pandemic:

Cohorting can be a considered control measure for a local pandemic, with cohorts (symptomatic and asymptomatic) established for **all new admissions /readmissions/ ER visits** into the facility for the duration of incubation period, or illness, if symptomatic. These cohorts should be established very early in the local pandemic.

- Use part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit. These areas will be clearly identified for residents with the pandemic infectious disease, including demarcating reminders for healthcare workers.
- Personnel (clinical and non-clinical) assigned to the pandemic virus/ influenza cohorts should not float to other resident care areas.
- Measures will be implemented to prevent unauthorized staff or other residents from entering the area. i.e. temporary barrier.
- Discontinue any sharing of a bathroom with any residents who are outside of the cohort area.
- Limit the number of personnel assigned to the pandemic virus/ influenza cohort.
- Reinforce adherence to infection control practices (i.e., hand hygiene, standard precautions) to prevent the transmission of healthcare associated infections within the cohort.
- Laboratory testing for confirmation is likely to be limited and/or not timely during a local pandemic, in which case cohorting should be based on having symptoms consistent with pandemic virus/ influenza.
- Personnel who have recovered from pandemic virus/ influenza should be prioritized for the cohort of residents with active known or suspect pandemic virus/ influenza.
- If staffing crisis necessitates that HCWs work while ill, they should be placed on antiviral medication and assigned to the ill cohort of residents.



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- Facility Administrators will continually monitor cohorting needs on a regular basis. In the event the facility is not able to establish a cohort area or cannot continue to sustain cohorting efforts, the regional & local offices of The Department of Health will be notified.

Personal Protective equipment (PPE)

The facility will maintain a three month (90 day) supply of PPE. Determining the supply needs during a Pandemic episode the facility should base such needs on existing guidance & regulations, in the absence of such guidance, facilities should consult the CDC PPE Burn rate Calculator. Facilities may also follow the CDC guidance on conserving PPE.

Supplies to be maintained include, but are not limited to:

1. N95 respirators
2. Face shield
3. Eye protection
4. Gowns/isolation gowns
5. Gloves
6. Masks
7. Sanitizer and disinfectants in accordance with current EPA guidance.

Regarding N95 Respirators

Procedure:

- 1) Fit-tested 95 respirators will be worn for all close contact with resident with suspected or confirmed novel virus/influenza as directed by NYSDOH. Close contact is defined as working within 6 feet of the resident.
- 2) Employees will be Fit tested via job title and duties