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Pandemic Emergency Plan (PEP) 2023

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Pandemic Response Plan (PEP)

The circumstances of infectious disease emergencies, including ones that rise to the level of a pandemic, vary due to multiple factors, including type of biological agent, scale of exposure, mode of transmission and intentionality. Infectious disease emergencies can include outbreaks, epidemics, and pandemics. The facility must plan effective strategies for responding to all types of infectious diseases, including those that rise to the higher level of pandemic.

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.

Under the Pandemic Emergency Plan (PEP) requirements of Chapter 114 of the Laws of 2020, special focus is required for pandemics.

The Pandemic Emergency Plan requirements include:

- Pandemic Communication Plan
- Protection Plans for Staff, Residents and Families
- Procedures for Sufficient Personal Protective Equipment (PPE) Supplies

Continuing to perform essential functions and provide essential services during a pandemic outbreak is vital to Archcare's ability to remain a viable entity during times of increased threats. A pandemic outbreak has been identified in the Hazard Vulnerability Analysis (HVA) as a potential emergency/disaster for Archcare nursing homes.

Purpose: This plan provides guidance to Archcare's nursing facilities and may serve as the plan for maintaining essential functions and services during a pandemic. This guidance neither replaces nor supersedes any current, approved Archcare continuity plan, but instead supplements it, bridging the gap between all-hazards continuity planning and the specialized planning that may be necessary to appropriately manage a pandemic outbreak in a unique healthcare setting such as a nursing home.

This guidance stresses that essential functions can be maintained during a pandemic outbreak through appropriate mitigations strategies, including:

- Social distancing
- Appropriate Infection Prevention & Control protocols
- Increased hand hygiene
- Temporary suspension of non-essential activities
- Temporary suspension of communal activities, such as dining or activities
- Temporary suspension of in-person visitation from members of the community
- Appropriate inventory management and use of Personal Protective Equipment (PPE)

Planning Assumptions: Archcare's pandemic plan is based on assumptions included in the Federal Office of Emergency Management (FEMA) National Strategy for Influenza

Implementation Assumptions as well as lessons learned from the COVID-19 pandemic. These include:

- Susceptibility to pandemic viruses will be universal, but also elevated in congregate nursing facilities due to the resident population
- Efficient and sustained person-to-person transmission serves as a signal of an imminent pandemic
- Rates of absenteeism will depend on the severity of the pandemic. A pandemic outbreak threatens Archcare's human resources by potentially removing essential personnel from the workplace for extended periods of time. Public health measures such as quarantining household contacts of infected individuals or mandatory self-quarantine for workers potentially exposed to a virus may increase absenteeism.
- Multiple waves/periods during which outbreaks occur in a community can be expected, as is historically seen with influenza.
- Appropriate guidance and/or direction will be provided by federal, state and/or local governments regarding current pandemic status in the areas where Archcare facilities are located.

Infectious Disease Preparedness Planning

As part of its preparedness planning for any infectious disease event, the facility takes the following steps:

- Educates staff on infectious diseases, including any reporting requirements, exposure risks, symptoms, prevention, infection control, proper use of PPE, and any related regulations, guidance or directives. It is Archcare's policy that all employees receive specific training on their individual, departmental and facility-wide roles during any emergency/disaster at the time of orientation, and at least annual thereafter, with an increasing frequency as needed.
- Reviews and revises, if necessary, existing Infection Prevention and Control policies, including mandatory reporting. Policy updates are reviewed by the Executive Committee and disseminated to all employees based on their role/department. Inservice training and competencies are conducted to enforce compliance with procedures.
- As new guidance arises from the Centers for Disease Control, NYSDOH, CMS or other regulatory body, new policies or practices will be developed and implemented consistent with these best practices.
- The Infection Preventionist conducts routine, ongoing infectious disease surveillance to adequately identify background rates of infectious diseases and detect significant increases above baseline rates. Appropriate action will be taken. Please refer to the **Archcare Infection Surveillance Program Policy and Procedure**.
- Reviews the plan for testing staff and reviews the emergency staffing plan should the need arise to have staff out of work for periods of time while under observation or quarantine. When directed to do so, and testing capabilities are available for the specific infectious disease concerned, staff are tested per requirements.
- Ensures that adequate facility staff members have access to and have been trained for use of communicable disease reporting tools and other outbreak-specific reporting tools, including the Nosocomial Outbreak Reporting Application (NORA), the Health Commerce System (HCS) and HERDS.

- Reviews and revises, if needed, facility policies and procedures for inventory management of items such as environmental cleaning agents, specific PPE, and medications. Policies are approved by Archcare.
- Develops and implements administrative controls, including visitation policies, employee absenteeism plans and staff wellness/symptom monitoring. **Refer to Appendix D** for plans and policies.
- Reviews and revises procedures for environmental controls as necessary.
- Reviews and revises, as necessary, vendor supply plans to ensure adequate supplies of food, water, medications, sanitizing agents and other supplies are available. **Please refer to Facility Emergency Preparedness Plan.**
- Develops, reviews, or revises the facility's plan to ensure that residents are isolated/cohorted and/or transferred based on their infection status in accordance with applicable NYSDOH and Centers for Disease Control and Prevention (CDC) guidance. Facility cohorting plans include using distinct areas within the facility, depending on the type of outbreak and cohorting required. Any sharing of bathroom facilities with residents outside of the cohort is discontinued. **Please refer to COVID-19 System-Wide Policy and Procedures.**
- Reviews and revises, as necessary, the facility's plan to ensure social distancing measures can be put into place where indicated and required. The facility has plans in place to effectively suspend all non-essential activities, communal dining and activities/programs, and if required, suspend outside visitation.
- In accordance with State, NYSDOH, CMS, and CDC guidance at the time of a specific infectious disease outbreak or pandemic event, the facility will develop and implement a plan to recover/return to normal operations as specified in regulatory guidance. Updates will be made in accordance with changes to recommendations and requirements. If approval by the State is required, such as in the case of COVID-19 Visitation Plans, plans will be developed and submitted timely.

Infectious Disease Response Tasks

- During an infectious disease outbreak, the facility will implement procedures to ensure that current guidance and advisories from NYSDOH and CDC on disease-specific response actions are obtained and followed. Education will be provided to all staff consistent with their roles. Archcare Corporate Communications will send an email message and update the Archcare public website to provide pertinent information to authorized family members and guardians. Residents will be provided with relevant information and the protections that the facility is putting into place for their safety.
- Current signage will be obtained and posted throughout the facility. The Infection Preventionist will ensure signage for cough etiquette, hand washing and other hygiene measures are posted in high visibility areas. The Director of Plant Operations/designee will ensure hand sanitizer is available throughout the facility, as well as other source control supplies if practical and warranted.
- The Infection Preventionist will ensure that the facility meets all reporting requirements for suspected or confirmed communicable diseases as mandated by New York State. **Refer to Appendix B Communicable Disease Reporting Policy.**
- The Administrator will ensure that the facility meets all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting within required timeframes.

- In order to limit exposure between infected and non-infected residents, the facility will develop and implement a plan, in accordance with any applicable NYSDOH and CDC guidance and facility Infection Prevention and Control Policies and Procedures, to segregate impacted residents.
- If the need to develop cohorts arises, the facility will implement procedures to ensure that as much as possible, staff are separated and do not provide care outside of a specific cohort. **Refer to Appendix C Surge Staffing Strategies.**
- In response to the infectious disease outbreak, the facility will conduct cleaning/ decontamination in accordance with any applicable NYSDOH, CDC and Environmental Protection Agency (EPA) guidance and facility policy for cleansing and disinfection of isolation rooms.
- The facility will provide education to residents, family members and other related parties about the disease and the facility's response strategy at a level appropriate to their need for information and interest level. This education will occur during Level 1 Management when family meetings are conducted and residents are advised about the potential disease threat.
- All staff, vendors and relevant stakeholders will be contacted and provided with information on the facility's policies and procedures related to minimizing exposure risks to residents, such as by limiting the types of staff, contract staff or vendors who may enter the premises, resident care areas or other changes from normal operations.
- Corporate Communications will advise family members that their visits should be limited to reduce exposure risk to residents and staff, subject to any superseding New York State Executive Orders and/or NYSDOH guidance that may otherwise temporarily prohibit visitors. Signage will be placed on all entrance doors alerting visitors. Security will be responsible for implementing any necessary screening procedures for visitation.
- If necessary, and in accordance with applicable New York State Executive Orders and/or NYSDOH guidance, the facility will implement procedures to close the facility to new admissions, implement limits to visitors when there are confirmed cases in the community, and/or screen all permitted visitors for signs of infection. Security will be responsible for screening all visitors.
- All staff will be provided with re-education on the appropriate use of PPE, including donning and doffing and utilizing the appropriate PPE. Competencies will be conducted and supervisors will monitor for compliance. Immediate re-education will occur if non-compliant practice is identified.

Infectious Disease Event Recovery Activities

- The facility will maintain, review and implement procedures provided in NYSDOH and CDC recovery guidance that is issued at the time of a specific infectious disease outbreak or pandemic event, regarding:
 - How, when and which activities/ procedures/ restrictions may be eliminated
 - How, when and which activities/ procedures/ restrictions may be restored
 - The timing of when specific changes may be executed
- The facility will communicate any relevant activities regarding the recovery process or return to normal operations to staff, authorized families and guardians, residents and other relevant stakeholders.

Pandemic Management Approach

Archcare's approach to managing a pandemic, including its plan for managing resident and staff safety and communications with interested parties, will be determined by the level of spread of the associated virus, such as COVID-19, in the population:

- Level 1: No New York State, New York City cases, no impact on staff and patients.
- Level 2: Cases in New York State and/or New York City, no impact on staff or patients.
- Level 3: Cases within nursing facilities or in our community members

Section 1 - Pandemic Communication Plan

The Pandemic Communication Plan follows the overall Archcare Corporate Emergency Preparedness Plan, and includes the required elements for notifications needed in the Pandemic Emergency Plan (PEP).

The Archcare Emergency Management Program Committee, which is comprised of members of all facilities, is responsible for oversight, has developed this specific Communication Plan based on regulatory requirements and lessons learned from the COVID-19 pandemic.

Included in the Plan are the following elements, required in the PEP:

- Plan to update authorized family members and guardians at least once per day and upon a change in a resident's condition
- Plan to update Resident Representatives/Guardians on the number of infections and deaths at the facility, by electronic or such means as may be selected by each authorized family members and guardians.
- Plan for ensuring all residents have daily access, at no cost, to remote videoconference or equivalent communication methods with authorized family members and guardians.

The facility follows the 3-Level Management protocol followed by all Archcare facilities for pandemic event management.

Level 1 Communication Plan

The communication plan for Level 1 will be activated when there is growing concern about a pandemic outbreak, but there are currently no New York State or New York City cases, and there is no impact on staff and patients.

Level 1 activates that communication plan to include frequent updates to internal stakeholders, residents and family members.

- At Level 1, the frequency of updates is defined as one time per week. There is no impact to staff or residents at Level 1.
- Updates are sent out via email, text message, Robo calls and traditional mail. Traditional mail is only to be used for broader updates that are not time sensitive.
- A record of all authorized family members and guardians including a secondary/ backup authorized contact (as applicable) is maintained in the E.H.R. Facility leadership will generate family contact lists to be used in the communications plan. The list will be submitted to the Director, System Marketing and Corporate Communications.

IT will establish a dedicated hotline for those have questions and concerns.

Nursing homes will have family meetings and educate the families at our facilities so they know the measures we are taking and why. At this time, Social Services will determine, if not already known, what the preferred method of contact is for the authorized family members and guardians is for Level 3 updates.

Provide known information regarding the virus, including information about signs and symptoms, to residents, staff and family members/representatives.

Corporate Communications will send an email communication/written letter to family members reminding them not to visit when they are ill or have known exposure to someone with the virus.

Residents will be provided with updates daily via broadcast so they know what measures are being taken for their safety and why.

Level 2 Communication Plan

The communication plan for Level 2 will be activated when there are cases in New York State and/or New York City, with no impact on staff or patients.

Level 2 communication includes:

- Bi-weekly update webinars held with the President and Chief Executive Officer and members of the Archcare senior team.
- Two separate webinars are hosted for internal stakeholders and external stakeholders.
- Text messages and email alerts continue to be provided with updates.
- The community at large is encouraged to submit questions to info@archcare.org for the duration of the pandemic. This inbox will be used for back and forth communication and enable issues to be resolved as soon as they are raised.

Authorized family members and guardians will be kept notified via email alerts, Archcare public website updates, text messages and other means which will be updated per regulatory requirements for updates.

Refer to Emergency & Disaster Preparedness Plan Policies:

- **Communications – Internal**
- **Communications – Residents and Family**
- **Communications – Notifying External Authorities**

Level 3 Communication Plan

The communication plan for Level 3 will be activated when there are cases within our nursing facilities or in our community members.

Level 3 includes all of the communication methods in Level 1 and Level 2, including the use of text alerts, email alerts and webinars for both team members and family members. Per the regulatory requirements for PEP, each authorized contact will be communicated with in the manner he/she prefers. This method was selected during the family meetings that occurred in Level 1 Management.

- A dedicated hotline for calls and email inbox will be opened, maintained and monitored.

Communication with Family Members and Resident Representatives

Procedure for When a Resident is Infected

In accordance with PEP requirements, the facility will utilize the following methods to update authorized family members and guardians of infected residents (i.e.) those infected with a

pandemic-related infection) **at least once per day and upon a change in a resident's condition:**

- Nursing will provide a list of all residents who have become ill to Social Services.
- Social Services/Nursing will call each family member/guardian to provide an update once per day and upon a change in condition.

Procedure for Weekly Updates on Facility Status

In accordance with PEP requirements, the facility will implement the following procedures/methods to ensure that all residents and authorized family members/guardians are updated at least once per week on the number of pandemic-related infections and deaths at the facility, including residents with a pandemic-related infection who pass away for reasons other than such infection:

- Archcare facilities will use multiple methods to notify all residents in the facility, their representatives and families regarding the status of the facility and its residents, not just those who are suspected/confirmed cases (per CMS QSO Memo QSO-20-29-NH and DAL NH 20-09).
- Notification will include all regulatorily-required information, such as through notification requirements when confirmed or suspected cases have been identified.
- All required reporting timeframes will be adhered to, with updates provided at a minimum of 1x per week for general facility status updates.
- Communications will be respectful of privacy laws, considering HIPPA-compliant protocols and protecting PHI.
- The facility will make all reasonable efforts to properly inform their residents, representatives and families of the information required, including through means authorized representatives have selected as preferred, such as :
 - Archcare facility website posting/updates
 - Email list serves
 - Recorded telephone messages

Procedure for Keeping Residents and Families in Communication

In accordance with PEP requirements and NYSDOH guideline C20-01, the facility will implement the following mechanisms to provide all residents with no-cost daily access to remote video conference or equivalent communication methods with family members/guardians.

- Face-to-face video calls
- Phone calls
- Outdoor visitation when allowed.
Please refer to Archcare Resumption of Visitation Policy.

Communication Requirements for Facility Pandemic Emergency Plan

Posting of Facility Pandemic Emergency Plan

In accordance with PEP requirements, the facility will follow procedures to post a copy of the facility's PEP, in an acceptable form to the Commission and on the facility's public website. The PEP will also be available immediately upon request.

- To the Commissioner
 - The finalized PEP will be sent to NYSDOH as required on or before September 15, 2020.
 - The Executive Director will be responsible for transmitting this plan.
- On the facility's public website
 - The finalized PEP will be provided in .pdf format for viewing on the Archcare public website at the same time that it is transmitted to NYSDOH.
 - Systems manager is responsible for uploading the plan to the website.

Section 2 - Protection of Staff, Residents and Families Against Infection

The facility's Pandemic Emergency Plan includes:

- A plan for hospitalized residents to be readmitted to the facility after treatment, in accordance with all applicable laws and regulations
- A plan to preserve a resident's place in the facility if such resident is hospitalized, in accordance with all applicable laws and regulations
- A plan for the facility to maintain or contract to have at least a two-month (60 day) supply of Personal Protective Equipment (PPE)

General considerations for protection staff, residents and families against infection at Levels 1, 2, and 3 Management

Level 1 – Staff, Resident and Family Member Safety

- Post signs at the entrance instructing visitors not to visit if they have symptoms of the flu. Individuals (regardless of illness presence) who have a known exposure to someone with a confirmed case or who have recently traveled to areas with virus transmission should not enter the nursing home or health center.
 - Visitors who enter the facility will be reminded of the importance of practicing appropriate hand hygiene for their safety.
- Reinforce sick leave policies. Ask employees to stay home if they have symptoms of the flu or are ill. They should call rather than coming in for medical advice. Management should monitor sick calls for compliance. If they notice an employee exhibiting signs of infection, they should send that person home.

Addressing Global Spread:

- Follow CDC guidelines for screening international travelers. As these guidelines change rapidly, the Chief Medical Officer will provide updates on at least a weekly basis.
- If required by the Centers for Disease Control (CDC) or federal, state or local authorities, all employees who have travelled within the time period set out by the authorities to impacted countries/states/locations will be screened for international travel.
 - If they have traveled to a Level 3 area, they should be sent home, educated about the risk of their exposure. ArchCare's Chief Medical Officer (CMO) should be contacted to assess whether or not NYCDOHMH should be informed.

Level 2 – Staff, Resident and Family Member Safety

- All nursing homes will monitor all entrances and screen those entering as per ArchCare's Pandemic Screening policy, including staff, visitors and vendors.
- When circumstances warrant it, the President & Chief Executive Officer will decide when it is appropriate to allow some or all those Care Members previously identified during Level 1 to work from home.

- No travel – business or personal – should be allowed for all care members that are in managerial position or above.
- Avoid as much as possible all in person meetings across Archcare facilities and non-Archcare persons, like external vendors. Instead use conference calls, zoom meetings and other electronic methods.
- All facilities and programs will follow and monitor for compliance with ArchCare's Infection Control Policies (**Refer to: Human Resources, Infection Control Standard of Care, System-Wide**).

Level 3 – Staff, Resident and Family Member Safety

- Family members may be restricted from visitation if mandated by NYSDOH or other agency for their protection. When visitation is allowed or the facility is re—opened to visitors under certain circumstances, the Archcare Visitation Policy will be followed.
- When circumstances warrant it, the Chief Executive Officer will decide when it is appropriate to allow some or all those Care Members previously identified during Level 1 to work from home.
- Standard Precautions, Contact Precautions, Airborne Precautions, and Eye Protection should be used in caring for an infected person. This means wearing a gown, gloves, facemask, and goggles or a face shield.
- Patients who have confirmed diagnoses or are PUIs will be cohorted in a single unit whenever possible or as required by regulation.
- Post signs on the door or wall outside of the resident room or confirmed positive wing that clearly describe the type of precautions needed and/or required PPE. Ensure proper signage is in place to demarcate that this is a restricted area to prevent residents from entering unknowingly and to ensure staff are reminded of the need for precautions.
- Provide the right supplies to ensure easy and correct use of PPE, if available. If there is a short supply of PPE, gowns, N95 masks, and /or face shields or goggles should only be used on those Residents that are coughing, require suctioning, unable to keep a face mask on or receiving nebulizer/aerosolized treatments. In all other instances, care members should wear gloves and a surgical/face mask. (Face shields and goggles can be reused by staff and cleaned at the end of the shift or when soiled, with an approved disinfectant. The shield and goggles should be labeled with the staffs' name and stored in a brown paper bag.)
- Residents with suspected cases should be prioritized for testing, if appropriate testing is available.
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, to at least 3 times daily to identify and quickly manage serious infection.

- Actively monitor all residents on affected units once per shift. This monitoring must include a symptom check, vitals, and pulse oximetry.
- Patients with confirmed or possible infections should wear a surgical facemask when being evaluated medically, if tolerated.
- Avoid floating staff between units whenever possible, or when required by NYSDOH or other regulatory entity.
- **Surveillance:** Use Line List for data collection and active monitoring of both residents and staff. This tool will provide a line listing of all individuals monitored for or meeting the case definition for the pandemic outbreak.
- Make PPE, including surgical/KN95/N95 masks, eye protection, gowns, and gloves, available immediately outside of the resident room or outside the entrance to the unit/wing.
- Have alcohol-based hand rub available in the wing/unit, preferably in each resident's room.
- Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.
- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- **Supplies** including alcohol based disinfectant wipes, water, hand sanitizer are to be available. Contact the Purchasing Manager if there is a need for more supplies.
 - **Mask Management:** Each facility and program will generate an inventory of masks and submit it to the Purchasing Manager at Level 1.
 - Masks will be secured in a room. Masks are not to be given out unless approved by the Chief Executive Officer.
 - Mask supply will be managed by the Vice President of Support Services so as to redistribute them in case one facility or program does not have enough.
 - Gowns, N95, faceshields will be managed centrally to ensure proper use in order to conserve the supply.

Refer to Archcare COVID-19 PPE Re-Use Strategies for additional information.

Admissions, Readmissions and Bed Hold

The facility's PEP considers that hospitalization residents may need to be readmitted to the facility after treatment. The plan also considers that a plan should be in place for preserving a resident's place in the facility if that resident is hospitalized.

The facility has developed and put into place a thorough plan with these considerations in mind, with the overall goal of protecting all residents and staff. This includes planning for protecting residents who remain in the facility, are readmitted to the facility or are new admissions from the hospital, consistent with New York State and NYSDOH directives and all regulatory requirements. This includes implementation of dedicated units/wings for residents of differing pandemic-related health status and drives the decisions for where a resident will reside upon readmission or admission from the hospital.

Accepting Patients from Hospitals

Should it be necessary to accept pandemic virus positive patients from hospitals, the NYSDOH guidance provided during COVID-19 will serve as the basis for admitting new patients.

DOH Guidance: "Separate residents into cohorts of positive, negative, and unknown as well as separate staffing teams to deal with COVID-19 positive residents and non-positive residents. In order to effectuate this policy, nursing home facilities should transfer residents within a facility, to another long-term care facility, or to another non-certified location if they are unable to successfully separate out patients in individual facilities.

If your facility is unable to meet cohorting standards or any infection control standards, admission must be suspended to the facility. Failure to adhere to these standards will result in civil monetary penalties and/or revocation of your license".

For the new admits, please ask your hospital partners to do the "Rapid Test" so that you can comply with the new absolute regulations about cohorting. This is a request of a Partner, not a requirement for transfer. This will make it possible to admit to a negative or positive unit. Please remember, this is exclusively a Regulatory Compliance Issue. Only 100% compliance will be accepted to DOH.

Archcare Interpretation:

1. Positive means anyone who has tested positive and has not converted.
 2. Tested negative(Covid 19) means anyone who is 10 days from positive, has no fever or symptoms. All other viruses follow CDC/NYSDOH guidelines
 3. Presumed negative(Covid 19) means anyone, is asymptomatic All other viruses follow CDC/NYSDOH guidelines
 4. Unknown means anyone whom a test is pending. In addition, an unknown is also someone who we admit from the hospital as not having COVID-19. They should not be in a COVID-19 unit but may be in a regular unit as long as we use PPE and isolation until we can confirm that they are negative.
 5. You should transfer to another facility if you are unable to comply with the above and suspend admissions.
- We should not accept patients if we are not able to care for them properly and are able to follow proper infection control protocols
 - They should not require ventilation or potentially be in respiratory distress.
 - The hospital should provide clear discharge instructions.
 - The hospital should provide PPE equipment if we do not have any available.
 - There should be doctor to doctor, nurse to nurse hand off.

In addition to following the standard infection protocols during new admissions:

- Before accepting the admission, the Admissions department should notify the Medical Director.
- We should not accept patients if we are not able to care for them properly and are able to follow proper infection control protocols.
- Sharing of bathroom facilities will not be permitted for any residents outside of the cohort that will be established.
- The designated areas/units that will be used will be clearly identified, including demarcating reminders for facility staff.
- To prevent other residents from entering these areas, the fire doors will be closed with signage indicating “Isolation: Staff only” will be implemented.

When new positive cases come in:

Placement of new patients in the facility once admitted

- **When a new patient is admitted with confirmed pandemic virus positive diagnosis (refer to workflow below):**
 - Cohort the positive patient in a private room/with another confirmed positive Resident
- **When a new patient is admitted with pandemic virus negative (refer to workflow below):**
 - Monitor the new patient for virus symptoms & perform virus test on admission then 48 hours after and repeat 48 hours thereafter for a total of 3 tests
 - If the patient later tests positive, or develops virus-like symptoms, then:
 - Cohort the positive patient in a private room and/or with another positive Resident.
 - If the new patient tests negative or remains stable, then admit as per policy.

Bed Hold, Return to Facility & Readmission of Hospitalized Residents

Bed Hold: In accordance with PEP requirements, the facility will implement the following process to preserve a resident’s place in the facility if such resident is hospitalized, in accordance with applicable laws and regulations, including, but not limited to: 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e).

Readmission of Residents Who Were Hospitalized

In accordance with PEP requirements, the facility will implement the following process/procedures to assure hospitalized residents will be admitted or readmitted to the facility after treatment, in accordance with all applicable laws and regulations, including, but not limited to: 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); and 42 CFR 483.15(e).

Refer to Appendix E – Bed Hold & Return to Facility Policy & Procedure.

Pandemic Emergency Plan Infection Control Considerations

Per the PEP requirements, the facility will develop pandemic infection control plans for staff, residents and families. This includes:

- Developing supply stores and specific plans to maintain, or contract to maintain, at least a two-month (60 day) supply of personal protective equipment (PPE) based on facility census, including consideration of space for storage.
- Developing a plan to ensure that hospitalized residents are admitted or readmitted to the facility after treatment in accordance with all applicable laws and regulations, including, but not limited to: 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80.

Personal Protective Equipment Supply

In accordance with PEP requirements, the facility will implement the following planned procedures to maintain or contract to have at least a two-month (60-day) supply of personal protective equipment (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 during a specific disease outbreak or pandemic. As a minimum, all types of PPE found to be necessary in the COVID-19 pandemic should be included in the 60-day stockpile. This includes, but is not limited to:

- N95 respirators
- Face shields
- Eye protection
- Gowns/Isolation Gowns
- Gloves
- Masks
- Sanitizer
- Disinfectants (meeting EPA Guidance current at the time of the pandemic)

A 60-day supply of necessary PPE will be maintained at the nursing home. An additional supply of PPE will be stored at an off-site facility and distributed to the Archcare facilities as the need arises.

The facility will continue maintain the proper 60 day supply on site as stated in the guidelines from NYSDOH for identifying what quantities of PPE will be required for 60 days.

Facility P.P.E. Requirements- Stock-on-hand

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NYSDOH HERDS PPE Requirement	N95 Resp.	Masks	Pairs of Gloves	Gowns
As of January 2023	5596	5996	47969	11992

Facility Positivity Rate

0.201536

Average Census

330.5802

Appendices

Appendix A - Communicable Disease Reporting

The facility will assure that it meets all reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYC.RR 2.10 Part 2), as well as by 10 NYCRR 415.19.

Reporting to NYSDOH:

- 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
- The facility will conduct adequate surveillance to identify background rates and detect significant increases above those rates. Healthcare-associated infection outbreaks may also be reported to the LHD. Please see **Surveillance Program**.
- 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.

Reporting of Communicable Diseases and Nosocomial Infections to the New York State and City Department of Health

Policy:

The facility will comply with New York State Health Department requirement for the reporting of communicable diseases, outbreaks or significant increases in Health care Acquired infections.

Purpose:

To prevent secondary transmission, identify new emerging infections, identify outbreaks, and evaluate the effectiveness of control measures and comply with the New York State Department of Health reporting requirements

Procedure:

- A. Report to the NYC – DOH all communicable diseases including sexually transmitted diseases and tuberculosis via Health Commerce System
- B. All cases of poisoning are to be reported.
- C. Notify the Department of Health and Mental Hygiene if there is a known outbreak or suspected outbreak of any disease or condition whether or not the source is known, which may present a danger to public health. (A suspected outbreak is to be considered when there is a disease identified in 3 or more persons or any unusual manifestation of a disease in a single individual).
- D. Multiple cases, clusters, outbreaks, and/ or increased incidents of nosocomial acquired infections in both residents and staff are to be reported to the NYS – DOH via the Nosocomial Outbreak Reporting Application (NORA). This report is to be filed electronically via the Health Commerce System (HCS).
- E. The determination of a facility outbreak or significant increase in Health Care Acquired Infections will be determined by the Infection Control Committee and the Medical Director.
- F. Reporting should be initiated within 24 hours of determining the presence of an outbreak, communicable disease, or significant increase of Health Care Facility Acquired infections.
- G. Persons associated with the clinical recognition of known or suspected cases of AIDS shall have the responsibility of notifying the NYS – DOH via mail (AIDS Confidential Case Report) or by phone.

The NYSDOH requires facilities to report the following:

- Outbreaks or increased incidence of disease due to any infectious agent i.e. staphylococcus, vancomycin resistant enterococci, pseudomonas, C diff, klebsiella, Acinetobacter
- Facility outbreaks of Influenza, gastroenteritis, pneumonia, or respiratory syncytial virus, COVID19
- Food borne illness / outbreaks
- Infections associated with transfusions, biologics, contaminated medications, replacement fluids or commercial products
- Single cases of nosocomial infection due to any of the diseases on the Communicable Disease Reporting List – i.e. Legionella, invasive Strep A beta-hemolytic streptococcus
- Single case of Staphylococcus Aureus with reduced susceptibility to vancomycin
- Clusters of TB skin test conversions
- Single case of Active Pulmonary / Laryngeal TB (staff or resident)
- Increased / unexpected mortality / morbidity associated with medical devices, practices or procedures resulting in significant infections / or hospital admissions
- Closure of a unit or service due to an outbreak

- Suspected cases of West Nile Virus, Eastern Equine Encephalitis, and pesticide poisoning.

Cases of pesticide poisoning are to be reported to the NYS – DOH Pesticide Poisoning Registry within 24 hours of treating affected individual (1-800-322-6850)

During mosquito season (June 1 – November 1) the facility shall report immediately any evidence of viral encephalitis or viral meningitis. At all other times, they are considered routine reportable conditions.

Following Flu season (September 1 – March 31) vaccine administration reporting is required. (Refer to Flu Prevention Program for reporting procedures re: vaccine administration and suspected outbreaks).

For Further information on reporting, contact the NYSDOH Regional Epidemiology and Infection Control Program Offices:

Capital District (518) 408- 5396

Central New York (315) 477-8166

Metropolitan Area (914) 654 -7149

Western New York (716) 847-4503

HERDS – Health Emergency Response Data System

NYSDOH Health Provider Network (HPN) – to obtain a user ID call 1-866-529-1890.

This system is used statewide to identify and monitor public health incidents.

Appendix B - Surveillance Program

Policy:

The infection Prevention and Control Program included a comprehensive, total surveillance protocol which is based on the principles of epidemiology.

Purpose:

To provide a systematic method of collecting, consolidating, and analyzing data concerning the distribution and determinants of a given disease or event followed by dissemination of that information to those who can improve the outcomes. The program is designed to prevent, investigate, and control infections within the facility through routine monitoring and determination of the appropriate measures to be implemented for residents with infections as a means of limiting exposure to staff and other residents.

Procedure:

A. Data Sources

Sources of data for infection surveillance include but are not limited to the following:

1. Clinical records
2. Microbiology reports
3. Antibiotic reports
4. Radiographic report
5. Activity logs/ 24- hour report
6. Clinical rounds/ staff reports
7. Closed medical records/ autopsy reports

B. Data Collection and Tabulation

1. A line listing form is maintained for each unit. It is a concise summation of the information gathered from the above sources.
2. Potential as well as actual infections are listed on this form.
3. Statistics are kept on a monthly basis; therefore, a new line listing is begun each month.
4. Infections are tabulated according to body site and geographic location.
5. Acquisition source is identified (i.e. facility, hospital, or community acquired).

C. Analysis and Interpretation of Data

1. Infection rates are calculated per unit per body site.
2. Analysis and interpretation include comparison to previous rates within the facility and identification of patterns/ trends with methods used to prevent the spread of infection within the facility.
3. Review of all data to include medication reviews/ use of antibiotics – whether or not use is appropriate and effective.

D. Report Preparation and Dissemination

1. Reportable occurrences may include an increase or decrease in infection rates, clustering of infections, increase in the numbers of a single pathogen and one more report of multiple antibiotic resistant organisms.

2. The Administrator, Medical Director, and Director of Nursing are informed of surveillance findings on an ongoing basis but no less than quarterly.
3. The Infection Control Committee/ Quality Assurance / Performance Improvement Committee receives a quarterly report. At each meeting comparisons are made with infection rates from the previous months, years, or year to date.
4. Tables and graphs are utilized along with verbal explanation.

E. Procedure Related Process Surveillance

1. Compliance with specific procedures related to infection control, i.e., dressing change, isolation precautions is evaluated on an ongoing basis.
2. All or selected steps of the procedure are observed, and competency/compliance is recorded.
3. In addition to providing data, procedure related surveillance serves as an educational and training tool for infection control practices.

F. Environmental Surveillance

1. Routine environmental cultures are not done.
2. Routine environmental rounds, emphasizing careful observation of the entire facility, are done on a monthly basis by the IC nurse.
3. Daily environmental rounds are done by the Unit Supervisors and reported to the IC nurse.

G. Intervention and Performance Improvement Action

1. When a problem is identified, the facility develops an action plan and implements a corrective plan. A plan for follow-up is included.
2. As needed, the Quality Assurance/ Performance Improvement Committee or the Infection Control Sub-committee will review problems, trends and/ or patterns identified.
3. A plan will be developed and implemented to prevent transmission of infection inclusive of device and procedure related infections.
4. Policies and procedures are reviewed annually and as needed. Revisions are made as needed to maintain compliance with current accepted standards of practice.

H. Calculation of Nosocomial Rates

A. Outbreak Infection Rates

- Numerator = the number of nosocomial infections that occurred
- Denominator= the number of persons at risk during the known period of time (i.e. number of residents on unit).
- Number of Nosocomial Infections

Population at Risk X 100 = Attack Rate

EX: 13 Eye Infection

240 residents X 100 = 5.4%

B. Nosocomial Infections per 1,000 Patient Care days

- Numerator = the number of nosocomial infections that occurred
- Denominator= the number of patient care days in a specific period of time (month).

Ex.: 5 Eye Infections

2000 Patient Care Days X 1000 = 2.5 Infections per 1000 patient care days

Appendix C Surge Staffing:

Surge Staffing and Use of Volunteers in an Emergency Situation

Policy:

It is the policy of Carmel Richmond Health Care & R.C. to accept volunteers and utilize staffing agency support during an emergency from individuals with varying levels of skills and training.

The facility has flexibility in determining how best to utilize volunteers/staffing agencies during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy.

Assigning disaster responsibilities to volunteers/agency staff shall be made on a case-by-case basis, taking into consideration the needs of the organization, the resident population and the qualifications of the practitioner.

- Non-medical volunteers/staff agency would only be able to perform non-medical tasks.
- Volunteering/agency staff healthcare professionals will only be able to perform services within their scope of practice and training.

Purpose:

To ensure that the facility's resident population receives, to the facility's best capability, appropriate care and services in an emergency situation.

Procedure:

1. Prior to any volunteer/agency staff performing any services, the facility will verify all required privileging and credentialing of volunteers/ staffing agencies following state regulations and laws as guidance.
 - Primary source verification of licensure, certification of registration (as defined and required by law and regulation to practice profession) shall begin as soon as the immediate disaster situation is under control and shall be completed within 72 hours from the initial time the volunteer/staff agency presents to the organization by Human Resource Department.
2. If primary source verification cannot be completed with 72 hours, verification will be completed as soon as possible. Documentation of why this could not be completed will be provided and should include:
 - Reason why the primary source documentation could not be completed with 72 hours (i.e. ongoing power outage, lack of resources, inability to get control over disaster situation)
 - Evidence of demonstrated ability by the volunteer to continue to provide adequate treatment/care/services

- That an attempt to rectify the situation will occur as soon as possible
3. Volunteers/agency staff, consistent with their expected roles, will be provided initial training in the Emergency Preparedness Program, specifically the Emergency Operations Plan.
 4. The facility may utilize federally designated health care professionals, such as Public Health Service (PHS) staff, National Disaster Medical System (NDMS) medical teams, Department of Defense (DOD) Nurse Corps, Medical Reserve Corps (MRC), or personnel such as those identified in federally designated Health Professional Shortage Areas (HPSAs) to include licensed primary care medical, dental, and mental/behavioral health professionals as well as agency staff from local, city, state federal outreach programs.
 5. All Volunteers/agency staff are required to sign-in/out at the Staging Area.
 6. Proper identification is necessary to gain entry into the facility. At a minimum, this will include government-issued photo identification and at least one of the following:
 - Facility picture identification card that identifies professional designation
 - Current official license, certification or registration
 - Primary source verification (if required by law and regulation to practice profession)
 - Identification that shows the individual has been granted the authority to deliver resident care, treatment and services in disaster circumstances by an authority having federal, state or local jurisdiction
 - Identification by current organization members who have personal knowledge of the individual regarding his/her qualifications to serve as a voluntary practitioner
 7. All volunteers/agency staff will be provided with an identification badge according to their role in the Emergency Operations Plan.
 8. All volunteers/agency shall wear a facility identification badge at all times.
 9. Labor Pool Leader shall be responsible for assigning disaster responsibilities to volunteers and maintaining a list of all volunteer/agency staff practitioners and the responsibilities they have been assigned.
 10. All Volunteers/agency staff will:
 - Be provided with clearly defined job descriptions and Standard Operating Procedures (SOPs).
 - Have a designated supervisor. Oversight by the supervisor will include:

- Direct observation
- Mentoring
- Medical record review
- Conduct themselves within the limits of their authority (i.e., what they can and cannot do without specific authorization). These limits shall be written in the job description and stated clearly on-site.

11. All volunteers/agency staff shall report to the Labor Pool for assignment. Volunteer/agency staff assignments may include the following:

- Assisting with evacuation as appropriate
- Placement as hosts in the lobby and cafeteria
- Assist at the Facility Command Center and act as runners
- Assignment to resident care units
- Other tasks essential to the relief of the emergency crisis as requested

For Internal Emergencies:

12. Upon hearing the announcement of the activation of the facility's Emergency Operations Plan:

- Volunteers/agency staff outside the department will go to the Labor Pool to be utilized as necessary.

13. If the emergency originates in the volunteer area and evacuation is required:

- All volunteers/agency staff will evacuate the area and proceed calmly to an area of safety
- If additional help is needed to assist, the Labor Pool will be contacted
- Medical equipment such as med-sleds and wheelchairs will be obtained from resident care units and storage
- Injured will be transferred to triage area.

14. The decision to continue a volunteer's disaster privileges shall be made after 72 hours and be based on necessity and information obtained regarding the professional practice of the volunteer.

The Volunteer Protection Act of 1997 provides legal immunity for volunteers working in disaster-related functions who are working within the scope of their assigned responsibilities, are acting in good faith, and are not guilty of gross negligence.

Appendix D: Administrative Control Plan

Our approach to managing COVID-19 will be determined by the level of spread of the virus in the population:

- Level 1: No New York State, New York City cases, no impact on staff and patients.
- Level 2: Cases in New York State and/or New York City, no impact on staff or patients.
- Level 3: Cases within programs or in our community members.

Level 1 Management

All facilities and programs will designate a COVID-19 liaison. This person will monitor to ensure that the facility or program is adhering to this policy; will serve as an in-house resource to answer questions from Care Members as well as coordinate educational programs occurring at the facility for Care Members, patients, and families. The liaison should have infection control training.

All facilities and programs will follow and monitor for compliance with ArchCare's Infection Control Policies (See Human Resources, Infection Control Standard of Care, System-Wide).

Facility and program clinical leadership will participate in all pertinent DOH briefings concerning COVID-19.

Post signs at the entrance instructing visitors not to visit if they have symptoms of the flu. Individuals (regardless of illness presence) who have a known exposure to someone with a COVID-19, or who have recently traveled to areas with COVID-19 transmission should not enter the nursing home or health center.

Ask employees to stay home if they have symptoms of the flu. They should call rather than coming in for medical advice. Management should monitor sick calls for compliance. If they notice an employee exhibiting signs of infection they should send that person home.

Assess residents symptoms of respiratory infection upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.

Monitor residents and employees for fever or respiratory symptoms.

Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).

In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).

Ensure hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees.

Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).

Make sure tissues are available and any sink is well-stocked with soap and paper towels for hand washing.

Follow CDC guidelines: screening international travelers. As these guidelines change rapidly the Chief Medical Officer will provide updates on at least a weekly basis.

IT will establish a dedicated hotline for those have questions and concerns.

Those programs that care for community members will risk stratify them and develop a plan for those that are at high risk in case their aide fails to show up for work.

Those same programs will contact vendors, including those that provide aides, as to their plans in the event of a pandemic.

Facilities and programs will contact temporary worker agencies regarding their contingency plans in case their staff fail to come to work.

Human Resources will:

- Identify office staff who are able to work from home and have resources to do so.
- Work with IT to build out lists of personal email addresses & cell phones
- Identify where Care Members live by zip code

The communication plan for Level 1 will be activated.

Nursing homes should have family meetings and educate the families at our facilities so they know the measures we are taking and why.

The Director of Plant Operations should be notified if there are no hand sanitizers on each floor and in convenient areas.

Level 2 Management

The Chief Executive Officer, in consultation with the Chief Medical Officer, will determine when to activate Level 2 actions.

All nursing homes and ASL health centers will monitor all entrances and screen those entering as per ArchCare's COVID-19 Screening policy.

When circumstances warrant it, the Chief Executive Officer will decide when it is appropriate to allow some or all those Care Members previously identified during Level 1 to work from home.

No travel – business or personal – should be allowed for all care members that are in managerial position or above. Avoid as much as possible all in person meetings across Archcare programs and facilities and non-Archcare persons, like external vendors. Instead use conference calls and other electronic methods.

All facilities and programs will follow and monitor for compliance with ArchCare's Infection Control Policies (See Human Resources, Infection Control Standard of Care, System-Wide).

Facility and program clinical leadership will participate in all pertinent DOH briefings concerning COVID-19.

Facility and program leadership will generate a family contact lists to be used in the communications plan. The list will be submitted to the Director, System Marketing and Corporate Communications.

The AT Home and the PACE programs will contact a patient/participant's family to determine who should be the back-up in case an aide fails to come to the home.

The communication plan for Level 2 will be activated.

Senior leadership as well as facility and program leadership will identify volunteers from family or community to help. This list will be given to the Chief Medical Officer.

Contact the Vice President of Support Services if there is a need to increase the water supply.

Level 3 Management

The Chief Executive Officer, in consultation with the Chief Medical Officer, will determine when to activate Level 3 actions.

The communication plan for Level 3 will be activated.

Standard Precautions, Contact Precautions, , and Eye Protection should be used in caring for an infected person. This means wearing a gown, gloves, facemask, and goggles or a face shield.

Whenever possible cohort patients that are COVID-19.

Provide the right supplies to ensure easy and correct use of PPE, if available. If there is a short supply then gowns , N95 masks, and or face shields or goggles should only be used on those patients that are coughing, unable to keep a face mask on, for example if they have dementia or behavioral health issues, or if they are being suctioned. In all other instances care members should wear gloves and a surgical/face mask.

Post signs on the door or wall outside of the resident room or COVID-19 positive wing that clearly describe the type of precautions needed and/or required PPE.

Residents with suspected COVID-19 should be prioritized for testing.

Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, to at least 3 times daily to identify and quickly manage serious infection.

In NHs, actively monitor all residents on affected units once per shift. This monitoring must include a symptom check, vitals, and pulse oximetry.

Patients with confirmed or possible COVID-19 infection should wear a surgical facemask when being evaluated medically

Avoid floating staff between units whenever possible.

Use Line List for data collection and active monitoring of both residents and staff. This tool will provide a line listing of all individuals monitored for or meeting the case definition for Covid-19 illness

Make PPE, including surgical/KN95/N95 masks, eye protection, gowns, and gloves, available immediately outside of the resident room or outside the entrance to the unit/wing.

Have alcohol-based hand rub available in the wing/unit, preferably in each resident's room.

Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.

For those in the home, the infected person will be placed in a room, with the door closed and given a mask. The clinician will ask the person about possible contacts during the previous two weeks.

Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.

When circumstances warrant it, the Chief Executive Officer will decide when it is appropriate to allow some or all those Care Members previously identified during Level 1 to work from home.

Appendix E: Bedhold and Return to Facility Policy and Procedure

ARCHCARE AND AFFILIATED ENTITIES
POLICY AND PROCEDURE

SUBJECT: Clinical, BED HOLD & RETURN TO FACILITY Protocol, Policy and Procedure (All Nursing Homes)

Originating Department: Corporate Compliance

Original Effective Date: November 28, 2016

Last Reviewed / Revised: 07/15/2019

Version: 2

PURPOSE:

To provide resident and/or the resident's representative with knowledge of resident's rights for holding his/her bed in the facility while they are hospitalized or go on a therapeutic leave of absence.

POLICY:

It is the policy of ArchCare to ensure residents who are transferred to the hospital or go on a therapeutic leave are provided with written notice about the bed hold duration and payment amount before the transfer. Additionally, ArchCare permits residents to return to the facility after hospitalization or therapeutic leave if their needs can be met by the facility, they require the services provided by the facility and they are eligible for Medicaid/Medicare covered services or services covered by another payer.

DEFINITIONS:

Bed Hold: reserving a resident's bed while they are not physically in the facility. This may be due to transfer to the ED, Hospital or on therapeutic leave, and may be paid for by 3rd party payer or privately.

RESPONSIBILITIES:

Resident and representative will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave. The facility will maintain in contact with the resident and representative while the resident is absent from the facility and arrange for their return if appropriate.

Nursing and social work staff are educated about the resident's bed hold and return rights to ensure that required information is provided at the time the resident leaves the facility. [Clinical, BED HOLD NOTIFICATION Protocol, Policy and Procedure \(All Nursing Homes\)](#)

PROCEDURES:

A. Bed Hold and Return Notice before/upon transfer.

The facility will provide a written notice for the resident/resident representative before the resident is transferred to a hospital or the resident goes on therapeutic leave that specifies the following:

- a. The duration of the bed hold policy during which the resident is permitted to return and resume residence in the facility.
- b. The reserve bed payment policy is:
 - i. If the resident is private pay status and wishes the accommodation to be held, he/she will continue to pay the scheduled rate for accommodation.
 - ii. If the resident is receiving Medicaid and wishes the accommodation to be held, his/her bed will be held in accordance with Medicaid policies. Reserve bed hold days for temporary hospitalizations are not available unless the resident is under 21 years of age or is 21 years of age or older and is receiving hospice services within the nursing home and may not exceed a combined aggregate of 14 days in any 12 month period. Reserved bed hold days are available to residents age 21 years or older who are receiving Medicaid who leave the nursing home overnight to visit friends or relatives or to participate in a medically acceptable therapeutic or rehabilitative plan of care. For a longer period of time, the resident can opt to pay the private pay rate and any applicable taxes. Payment must be made by an interested party/family member other than the spouse because direct payment by the spouse would be considered income to the recipient. For therapeutic leaves of absence the reserve bed hold may not exceed 10 days in any 12 month period.
 - iii. A Medicaid recipient who is currently on a Medicare covered stay in the nursing facility must be a resident of the facility for at least 30 days prior to hospitalization that resulted in the current Medicare stay for the bed to be held and prior to therapeutic leave of absence. The resident can opt to pay the scheduled rate if payment is made by an interested party/family member, other than the spouse because direct payment by the spouse would be considered income to the recipient) If the bed is not held, the resident will be re-admitted to the nursing home at the first available and appropriate bed. A private pay resident that is currently on a Medicare covered stay in the facility can opt to pay the private pay rate and any applicable taxes for said accommodation.

- c. Notification to the resident/resident representative of:
 - i. The transfer or discharge
 - ii. Reasons for the move
 - iii. In writing in a language and manner they can understand
 - iv. Readmission standards
 - v. Admission standards
- d. The facility will provide the bed hold policy upon admission along with admission packet (*See Admissions Policy and Procedure*)
- e. In case of emergency transfer, the facility will send a notice to the resident representative and the receiving setting along with necessary paperwork.
- f. Documentation of bed hold notice will be completed in the individual medical record.

Note:

The resident must be absent from the facility overnight for the day to be considered a reserved bed day. A resident is considered to be absent overnight when he or she is absent later than the time at which the facility normally conducts its patient census. The day the resident departs for temporary hospitalization or the leave of absence begins is counted as a reserved bed day, but the day he/she returns is not counted as a reserved bed day.

B. Readmission or Return to the Facility

The facility will readmit or allow the opportunity for return to the facility for residents who resided in the nursing home for 30 days or more when:

- a. Residents to return to the facility after hospitalization or therapeutic leave if their needs can be met by the facility
- b. The resident requires the services provided by the facility
- c. The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services
- d. Beyond Bed Hold Period

- i. A resident, whose hospitalization or therapeutic leave exceeds the bed hold period, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semiprivate room if the resident
 - (A) Requires the services provided by the facility; and
 - (B) Is eligible for Medicaid/Medicare skilled nursing facility services.
- e. If the facility determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility will comply with the requirements of discharge notice regulations. [Clinical, Transition Planning Protocol, Form, Acknowledgement of Receipt of Transfer/Discharge Notice & Notice of Appeal Rights 10 2018 \(All Nursing Homes\)](#)
- f. Respite Residents
- g. If the facility can no longer provide the needed services for the resident and are unable to accept the resident in return after transfer. [Clinical, TRANSFER AND DISCHARGE FROM THE FACILITY Protocol, Policy and Procedure](#)

RELATED DOCUMENTS:

[Clinical, BED HOLD NOTIFICATION Protocol, Policy and Procedure \(All Nursing Homes\)](#)
[Clinical, Transition Planning Protocol, F625 F626 11.28.17 Bed Hold and Return \(All Nursing Homes\)](#)
[Clinical, Transition Planning Protocol, F622 F623 F624 Transfer and Discharge New Incl. Ombudsman Info 11.2017 \(All Nursing Homes\)](#)