Infection Control				
POLICY:	**OUTBREAK PLAN**			
DEPT:	Clinical Operations	☐NEW ☒REVISION	**LAST REVIEWED:**	04/2023

PURPOSE:

To create a constant state of readiness; prepare for challenges through the development of an adequate Outbreak Plan (the Plan) that can be integrated with external agencies; and to educate and respond effectively. The Plan will address prevention, mitigation, response and recovery from an outbreak; to lessen the impact should an outbreak occur.

GUIDELINES:

1. If an outbreak begins in another country, heighten surveillance for outbreak and prepare to activate facility plan, as necessary.

2. If an outbreak begins in or enters the United States, activate plan, identify and isolate all potential residents with the virus , implement infection control practices to prevent transmission, ensure rapid and frequent communication within facility and between healthcare facilities and health departments, implement surge-capacity plan to sustain healthcare delivery.

DEFINITIONS:

Infectious diseases

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

Examples of which are ZIKA virus, Ebola Virus, Avian Influenza (Bird Flu), NoroVirus, H1N1 Influenza Virus (Swine Flu), Chikungunya Virus, and SARS-CoV-2 (Corona Virus/COVID-19)

Isolation – Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.

Quarantine – Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

GENERAL PREPAREDNESS FOR INFECTIOUS DISEASE (ID) OUTBREAK:

- The facility's Emergency Preparedness Plan will include a response plan for a community-wide infectious disease outbreak such as the COVID-19 outbreak. This plan will:
  - build on the workplace practices described in the infection prevention and control policies

- include administrative controls (screening, isolation, visitor policies and employee absentee plans
- address environmental controls (isolation rooms, sanitation stations, and special areas for contaminated wastes)
- Address human resource issues such as employee leave
- Be compatible with the facility's business continuity plan

- The facility's Infection Control Preventionist (ICP) will be vigilant and stay informed about IDs around the world. The ICP will keep administrative leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.
- As part of the Emergency Preparedness Plan, the facility will maintain adequate emergency stockpile of personal protective equipment (PPE) including moisture-barrier gowns, face shields, surgical masks, assorted sizes of disposable N95 respirators, and gloves; essential cleaning and disinfection supplies so that staff, residents and visitors can adhere to recommended infection prevention and control practices.
- The facility will coordinate with vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including an ID outbreak.
- The facility will regularly train employees and practice the ID response plan through drills and exercises as part of the facility's emergency preparedness training.

LOCAL THREAT:

a. Once notified by the public health authorities at either the federal, state and/or local level that the infectious disease is likely to or already has spread to the facility's community, the facility will activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities.

b. The facility's ICP will research the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies.

c. The facility's Infection Control Committee (ICC) will serve as the authority for outbreak preparedness and response. The ICC comprises of the Medical Director, Infection Control Preventionist, Infectious Disease Doctor, Administrator, Director of Nursing, Director of Environmental Services, and Human Resources Director.

d. Working with advice from the ICC, local and state public health authorities, and others as appropriate, the ICP will review and revise internal policies and procedures, ensure that facility has stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.

e. Staff will be educated on the exposure risks, symptoms, and prevention of the ID. Placing special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.

f. If ID is spreading through an airborne route, then the facility will activate its respiratory protection plan to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.

g. Provide residents and families with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information.

h. Brief vendors/contractors on the facility's policies and procedures related to minimizing exposure risks to residents.

i. Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along with the instruction that anyone who is sick must not enter the building.

j. To ensure that staff, and/or new residents are not at risk of spreading the ID into the facility, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work.

k. Self-screening – Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
   i. Reporting any suspected exposure to the Infectious Disease while off duty to their supervisor.
   ii. Precautionary removal of employees who report an actual or suspected exposure to the ID.
   iii. Self-screening for symptoms prior to reporting to work.
   iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.

l. Self-isolation - in the event there are confirmed cases of the ID in the local community, the facility may consider closing the facility to new admissions, and limiting visitors based on the advice of local public health authorities.

m. Environmental cleaning - the facility will follow current CDC guidelines for environmental cleaning specific to the ID in addition to routine cleaning for the duration of the threat.

n. Engineering controls – The facility will utilize appropriate physical plant alterations such as use of private rooms for high-risk residents, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

SUSPECTED CASE IN THE FACILITY:

- Place a resident or on-duty staff who exhibits symptoms of the ID in an isolation room and notify local public health authorities.
- Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible.
- If the suspected infectious person requires care while awaiting transfer, follow facility's policies for isolation procedures, including all recommended PPE for staff at risk of exposure.
- Assign dedicated staff to enter the room of the isolated person as feasible. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room.

- Provide all assigned staff additional training and supervision in the mode of transmission of this ID, and the use of the appropriate PPE.
- Ask the isolated person to wear a well-fitted facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless it is advised otherwise by public health authorities.
- Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposed individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.
- Implement the isolation protocol in the facility (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the facility's infection prevention and control plan and/or recommended by local, state, or federal public health authorities.
- Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

IDENTIFICATION OF A COVID-19 CASE IN THE FACILITY:

- The ICP or designee will perform a risk assessment to determine any potential exposures and/or infection control breaches at the facility.
- ICP or designee will determine any possible exposures the new case of COVID-19 (e.g., resident, HCP, essential caregiver) may have had prior to diagnosis including contact with other known COVID-19 positive persons or those who later developed symptoms consistent with COVID-19.
- Director of Nursing/ICP/Administrator will alert the local health department to the newly identified case.
- ICP or designee will Identify close contacts including 48 hours prior to symptom onset/date of specimen collection of associated case, if applicable.

  Close contact is identified as being within approximately 6 feet of a COVID-19 case for a prolonged period of time, a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic residents, 2 days prior to test specimen collection) until the time the resident is isolated; or

  Having direct contact with infectious secretions from an individual with COVID-19. Infectious secretions may include sputum, serum, blood, and respiratory droplets (e.g., being coughed or sneezed on).
- Facility will quarantine close contacts for 14 days from last exposure and provide care using all COVID-19 recommended personal protective equipment (PPE).
- Any newly positive residents should be cohorted appropriately.
- Any newly positive Health Care Personnel (HCP) should be provided information on duration of isolation and when they can return to work.
- Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents regardless of vaccination status, should be tested immediately, and all staff and residents that tested negative should be retested every 3 days to seven days until testing identifies no new cases of COVID-19 among staff and residents for a period of at least 14 days since the most recent positive result.
- Facility will perform HCP testing in accordance with CDC and NJDOH COVID-19 Guidelines.
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FACILITY OUTBREAK:

1. The Infection Control Preventionist (ICP) will direct the facility's planning and response efforts.
2. The Infection Control Committee (ICC) will work with the ICP and assist with decision-making during an outbreak.
3. The ICC should plan to remain active throughout the outbreak period, which could be several weeks or months.
4. Planning for an outbreak should consider concurrent public health, community, and healthcare planning efforts at the local, state and regional levels.
5. Surveillance:

   The ICP shall serve as the leader in the surveillance for:

   - the type of infectious disease outbreak, to include mechanisms for monitoring employee absenteeism for increases that might indicate early cases of outbreak
   - mechanisms for tracking facility admissions and discharges of suspected or laboratory-confirmed cases of the specific infectious disease outbreak in residents to support local public health personnel in monitoring the progress and impact of the outbreak
   - assess bed capacity and staffing needs, and detect a resurgence in cases that might follow the first wave of cases
   - updated information on the types of data that should be reported to the state agency and/or local health departments (e.g., admission; discharges/deaths; resident characteristics such as age, underlying disease, and secondary complications;
   - illnesses in healthcare personnel and plans for how this data will be collected during an outbreak
   - criteria for distinguishing the type of outbreak from other respiratory diseases.

   The ICP/designee will provide the facility's respiratory surveillance line list for both residents and staff to the state agency and/or the local public health authorities on a daily basis or as directed.

6. The facility's ICP will periodically review specific Infection Prevention and Control guidance for healthcare facilities caring for residents with suspected or confirmed infectious disease, including COVID-19.

7. The facility's Infectious Disease Physician will assess the status of infectious disease at the facility, assure proper infection control measures are implemented and ensure monitoring of all residents. As member of the Infection Control Committee, the Infectious Disease Physician will make follow-up visits as needed and is available for telephone consultation.

EVALUATION AND MANAGEMENT OF RESIDENTS AND HEALTHCARE PERSONNEL DURING OUTBREAK:

- Facility will assess close contacts including HealthCare Personnel (HCP) and other residents based on their exposures to positive case(s) of the infectious disease.
- **HCP** with exposure will be identified and using the NJ DOH Healthcare Personnel Exposure to Confirmed COVID-19 Case Risk Algorithm, an appropriate risk assessment completed to determine if HCP should be restricted from work.
- Prolonged close contact is defined as 15 cumulative minutes of exposure at a distance of less than 6 feet to an infected person during a 24-hr period or had unprotected direct contact with infectious secretions or excretions of a confirmed case should be considered potentially exposed.
- Prolonged close contact should be determined by taking the cumulative contact the potentially exposed individual had with the infected case over any 24 hour period within the period from 2 days before symptom onset (or positive test collection date in an asymptomatic infected individual) until the positive case has been effectively isolated.
- Asymptomatic fully vaccinated HCP with higher risk- exposures do NOT need to be restricted from work for 14 days following their exposure except for HCP with underlying immunocompromising conditions.
- Symptomatic HCP should be excluded from work. At minimum HCP should be excluded from work for at least 24 hours after symptoms resolve, including fever, if applicable.
- Residents who have been identified as close contact of someone testing positive for COVID-19 will be placed on Transmission Based Precautions.
- Facility will conduct active screening of all residents:
  - Nursing Staff will monitor residents every shift for symptoms of COVID-19 and any other illness. Vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry. The Nursing staff will inform the residents' Attending Physician and Responsible Party for any change in their baseline.
  - Facility shall screen and log HCP and everyone entering the facility for symptoms of the infectious disease.
    - Screening will include:
      a. Temperature checks including subjective and/or objective fever equal to or greater than 100.4 degrees Fahrenheit or as further restricted by the facility.
      b. Completion of questionnaire about symptoms and potential exposure which shall include at a minimum:
         1. Exhibit signs and symptoms of and infectious disease, including COVID-19, such as fever equal to or greater than 100.4, chills, cough, shortness of breath or difficulty of breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea.
         2. Has had contact with someone with a confirmed diagnosis of infectious disease, or someone under investigation for the infectious disease, or someone ill with respiratory illness in the last 14 days.
         3. In the last 14 days, has returned from a designated state under the 14-day quarantine travel advisory; or

4. Has been diagnosed with the infectious disease and has not yet met the criteria for the discontinuation of isolation per guidance issued by the NJDOH.

- Facility will screen all HCP at the beginning of their shift.
- Facility will implement universal use of N-95 facemask for all staff while in the facility.
- Facility will implement use of eye protection for staff while in resident units.
- Stop current communal dining and all group activities such as internal and external group activities.
- Encourage residents to remain in their rooms. Restrict residents (to the extent possible) to their rooms except for medically necessary purposes
- Residents will be provided with masks (who can tolerate masks) whenever they leave their room, including for procedures outside the facility; if masks are limited or not tolerated or resident refuses to wear mask, resident will be provided with a tissue to cover the nose and mouth.
- Educate residents and staff regarding the current precautions being taken in the facility and protective actions such as practicing social distancing and performing frequent hand hygiene.
- Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along will the instruction that anyone who sick must not enter the building and visible areas in the building.

COHORTING FOR COVID-19:

Facility will cohort residents as follows:

1) SARS-CoV-2 positive residents (COVID-19 care unit/area)

This cohort consists of both symptomatic and asymptomatic residents who test positive for SARS-CoV-2, regardless of vaccination status. This also includes any new or re-admitted patients/residents known to be positive who have not met the criteria for discontinuation of transmission-based precautions.

Patients/residents should be placed in the COVID-19 care unit/area, regardless of symptoms, if they have confirmed SARS-CoV2 infection. If the resident has been confirmed positive with an antigen test, they must first be confirmed positive with a PCR. The facility should establish a plan (including appropriate placement, staffing plan, and PPE use) to manage patients/residents exposed to SARS-CoV-2, those suspected of COVID-19, and those who are new or readmissions. Management of these patients/residents includes:

2) Symptomatic residents with suspected SARS-CoV-2 infection

All symptomatic residents should be evaluated for causes of their symptoms. Residents who test negative for SARS-CoV-2 could be incubating and later test positive. If feasible, resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2 or other pathogens unless it poses safety risks to the resident. If limited single rooms are available, or if numerous residents are simultaneously identified to have symptoms concerning for COVID-19, residents will remain in their current location pending return of test results.

3) Asymptomatic residents who are not up to date with all recommended COVID-19 vaccine doses, have a viral test that is negative for SARS-CoV-2, **and have had close contact** with someone with SARS-CoV-2

These residents should be placed in quarantine after their exposure and cared for using full PPE (gowns, gloves, eye protection, and NIOSH-approved N95 or equivalent or higher-level respirator). Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure.

Residents can be removed from quarantine, either:

a. After day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, facilities may consider testing for SARS-CoV-2 within 48 hours before the time of planned discontinuation of quarantine. OR

b. After day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of quarantine.

4) Asymptomatic residents who are up to date with all recommended COVID-19 vaccine doses and have a viral test that is negative for SARS-CoV-2 OR had a viral test that was positive for SARS-CoV-2 in the past 90 days, **and have had close contact** with someone with SARS-CoV-2

These residents should wear well-fitting source control based on CDC recommendations, and at minimum, for 10 days after their exposure. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure.

In general, these residents do not need to be quarantined, restricted to their room, or cared for by HCP using the full COVID-19 recommended PPE unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.

Quarantine might also be considered if the patient/resident is moderately to severely immunocompromised.

5) **New or readmitted asymptomatic residents** who are not up to date with all recommended COVID-19 vaccine doses and have a viral test negative for SARS-CoV-2 upon admission or readmission.

These residents should be placed in quarantine and cared for using full PPE (gowns, gloves, eye protection that covers the front and sides of face, and NIOSH-approved N95 or equivalent or higher-level respirator), even if they have a negative test upon admission.

Testing is recommended immediately (upon admission) and, if negative, again 5–7 days after their admission. Quarantine may be discontinued after day 7 if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of quarantine. In most circumstances, quarantine is not recommended for residents who are not up to date with all recommended COVID-19 vaccine doses that routinely leave the facility for less than 24 hours and do not have close contact with a suspected or known COVID-19 positive person.

6) New or readmitted asymptomatic residents who are up to date with all recommended COVID-19 vaccine doses and have a viral test that is negative for SARS-CoV-2 OR had a viral test positive for SARS-CoV-2 in the past 90 days.

Testing is recommended immediately (upon admission) and, if negative, again 5–7 days after their admission.

In general, these residents do not need to be quarantined, restricted to their room, or cared for by HCP using the full COVID-19 recommended PPE unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.

Quarantine might also be considered if the resident is moderately to severely immunocompromised.

FACILITY COMMUNICATION METHODS:

- In the event of an outbreak, the facility will immediately report/notify and consult with the Local/State Public Health Department for specific directions.
- Facility will notify all Health Care Personnel regarding the status of the facility and mitigating actions implemented by the facility to prevent and reduce the risk of infection through in-services/staff education/ signage/emails and/or memos.
- Facility will notify residents through broadcasting, 1:1 sessions, resident council meetings, facility website, emails, weekly conference calls when applicable regarding outbreak status of facility, actions implemented by the facility to prevent and reduce risk of transmission, ongoing impact of the infectious disease outbreak on the facility and on the community and status of activities and happenings in the facility.
- Facility will notify resident representatives and families through facility website, emails, weekly conference calls and phone calls any infectious disease outbreaks, information on mitigating actions implemented by the facility to prevent and reduce the risk of transmission, ongoing impact of the infectious disease outbreak on the facility and on the community and status of activities and happenings in the facility.
- Facility will notify resident representatives and families through facility website and other social media platforms, phone calls, emails, weekly conference calls advising them of visitation restrictions or limitations due to an outbreak of infectious disease or in the event of an emergency.
- Facility will notify families regarding identification of case(s) by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of the infectious disease is identified, or whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other via phone calls, emails and conference calls.
- In the event of visitation restriction, the facility will establish other alternative methods for visitation (e.g. phone, video conferencing, FaceTime, etc.) and will notify the families through emails and weekly conference calls. Signs will be posted at the entrances to the facility advising that no visitors may enter the facility and if there are any exceptions.
- Facility will host weekly conference calls where families can log on to a conference line where families will receive updates regarding facility status and can ask questions or make suggestions.
- Facility's website will display a phone number or method of communication for urgent calls or complaints.
- Facility's website will be updated on a weekly basis with information that will help families know what is happening in their loved one's environment, such as food menus and scheduled activities.
- Facility will consult with local or state health departments on plans for coordinating or facilitating communication among healthcare facilities.
- Facility will have ongoing communication with state and/or local health departments regarding staffing needs, bed capacity, durable and consumable medical equipment and device needs.

EDUCATION AND TRAINING:

- Facility will provide Staff education regarding the Outbreak as follows:

1. General topics for staff education will include:
    - Prevention and control of the infectious disease which includes practicing social distancing and performing frequent hand hygiene.
    - Implications of the disease.
    - Identify signs and symptoms of infectious disease that can result to an Outbreak.
    - Infection control strategies for the control of the infectious disease, including respiratory hygiene/cough etiquette, hand hygiene, standard precautions, droplet precautions, and, as appropriate, airborne precautions, proper donning, doffing and discarding of Personal Protective Equipment (PPE).

2. Specific topics for staff education should include:
    - Policies and procedures for the care infected residents, including how and where infected residents will be cohorted.
    - Staffing contingency plans, including how the facility will deal with illness in personnel.
    - Self-screening of symptoms prior to reporting to work.
    - Reporting any suspected exposure to the Infectious Disease while off duty to their supervisor.
    - Communication methods with families such as facility website, weekly conference calls, emails and phone calls.
    - Policies for restricting visitors and mechanisms for enforcing these policies.
    - Reporting to the health department suspected cases of infection caused by the disease during the Outbreak periods.
    - Measures to protect family and other close contacts from secondary occupational exposure.

3. ICP/Designee will provide competency-based training of staff and auditing adherence to recommended infection prevention and control practices.

4. Facility will participate in educational resources for clinicians, including federally sponsored teleconferences, state and local health department programs, web-based training materials, and locally prepared presentations.

5. Residents and others should know what they can do to prevent disease transmission in the facility, as well as at home and in the community.
    - Facility will provide language-specific and reading-level appropriate materials for education. If language-specific materials are not available, facility will arrange for translations.
    - Facility will distribute information to all persons who enter the facility, identify staff to answer questions about procedures for preventing transmission of the infectious disease.

FACILITY ACCESS:

- Facility shall screen and log all persons entering the facility and all staff at the beginning of the shift.
- Facility shall follow federal and state directives in regards to restricting or allowing entry in the facility (e.g. not requiring EMS personnel any additional screening).
- Indoor visitation during an outbreak or investigation can occur when there is evidence that the transmission of SARS-CoV-2 is contained to a single unit of the facility.
    - The facility will suspend visitation on the affected unit until the facility has no new cases identified in the staff/residents for 14 days.
    - If the first round of testing (performed on day 3-7) reveals no additional cases in other units of the facility, then visitation can resume for those areas/units with no cases.
    - If the first round of testing (performed on day 3-7) reveals one or more additional cases in other units of the facility, then visitation is suspended for all residents, regardless of vaccination status until the facility has no new cases identified in the staff/residents for 14 days.
- Facility will ensure that all visits are conducted as safely as possible and require infection control practices, hand hygiene and appropriate PPE in accordance with CDC guidance.
- Visitors will be provided with the visitation guidelines upon check in. The facility will provide graphics in assisting residents and visitors in maintaining social distancing and infection control standards.
- All visits are by appointments only to limit the number of visitors inside the building at the same time.
- Upon screening, the facility shall prohibit entry into the building for those who meet the one or more of the following criteria:
- Exhibit signs and symptoms of and infectious disease, including COVID-19, such as fever equal to or greater than 100.4, chills, cough, shortness of breath or difficulty of breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea.
- Has had contact with someone with a confirmed diagnosis of infectious disease, or someone under investigation for the infectious disease, or someone ill with respiratory illness in the last 14 days.
- In the last 14 days, has returned from a designated state under the 14-day quarantine travel advisory; or
- Has been diagnosed with the infectious disease and has not yet met the criteria for the discontinuation of isolation per guidance issued by the NJDOH.

If after undergoing screening, the visitor is permitted to enter the building, the facility shall:

- Require the visitor to wear a facemask.
- Provide instruction on hand hygiene, limiting surfaces touched, use of PPE and inform them of the location of hand hygiene stations in the facility.

- Advise the visitor to limit physical contact with anyone other than the resident while in the facility. For example, practice social distancing with no hand shaking, kissing or hugging and remaining six feet apart.
- Limit the visitor's movement within the facility to the resident's room or designated space (e.g. reduce walking the halls, avoid going to dining room, etc.)
- Advise the visitor to monitor for signs and symptoms of infectious disease, including COVID-19 for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individual(s) they are in contact with and the locations within the facility they visited.

- Restrict a person from entering the facility if they are unable to demonstrate the proper use of infection prevention and control techniques.

If after undergoing screening, the visitor is permitted to enter the building, the facility shall:

- Require the visitor to wear a facemask.
- Provide instruction on hand hygiene, limiting surfaces touched, use of PPE and inform them of the location of hand hygiene stations in the facility.
- Advise the visitor to limit physical contact with anyone other than the resident while in the facility. For example, practice social distancing with no hand shaking, kissing or hugging and remaining six feet apart.
- Limit the visitor's movement within the facility to the resident's room or designated space (e.g. reduce walking the halls, avoid going to dining room, etc.)
- Advise the visitor to monitor for signs and symptoms of infectious disease, including COVID-19 for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individual(s) they are in contact with and the locations within the facility they visited.

- Restrict a person from entering the facility if they are unable to demonstrate the proper use of infection prevention and control techniques.

EMERGENCY STAFFING CONTINGENCY:

In the event of an emergency or when staffing shortages are anticipated, the Administrator or designee will make the decision to utilize emergency staffing strategies as necessary to provide for care and treatment of residents.

1. In case of an anticipated or an emergency staffing shortage, administrator or designee will communicate with local healthcare coalitions, federal, state, and local public health partners.
2. All employees in the facility will be notified of the decision to utilize emergency staffing strategies.
3. The facility will adjust staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities.
4. Cancel all non-essential procedures and visits.
5. Attempt to address social factors that might prevent HCP from reporting to work such as transportation or housing if HCP live with vulnerable individuals.

6. Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
7. Request that HCP postpone elective time off from work.
8. Administrator or designee will contact staffing agencies to secure staff.
9. Remove tasks from the nursing department that does not need to be completed by a CNA or nurse including but not limited to passing out water, answering call bells, passing out snacks and designate these tasks to alternate employees such as recreation or housekeeping.
10. Unit Clerks will assist on the unit as well as Rehab staff within the scope of their practice.
11. Nursing Administration (DON, ADON, Unit Managers, Supervisors, MDS) may need to work on the units as needed.
12. Social Services and Administration to assist on the units as necessary i.e. answering phone calls, call bells, passing out meal trays etc.
13. Dietary may utilize paper goods in order to free staff to assist in other areas.
14. Utilizing agency staff as necessary.
15. Utilizing emergency waivers or changes to licensure requirements as appropriate.

In addition, the following measures will be put in place:

- Facility will contract with healthcare recruiters for low level staff.
- Facility will reach out to schools and colleges for new CNA and nurse graduates.
- Monetary compensation will be in effect as necessary.
- All department heads can be mandated to work 7 days a week for the duration of the crisis.
- Licensed aids and nurses in other departments (i.e. admissions, liaisons etc.) will be mandated to work on the floors.
- Aggressive recruiting and ads will be placed with the emergency rates to attract new staff.
- Any additional measures needed will be considered on a day to day basis.

Crisis capacity strategies include:

a. Implementing regional plans to transfer patients with infectious disease, including COVID-19 to alternate care sites with adequate staffing.
b. Implementing criteria to allow HCP with suspected or confirmed infectious disease, including COVID-19 who have not met Return to Work Criteria to work, in accordance with CDC guidelines.

RETURN-TO-WORK:

COVID-19 POSITIVE HCP - FULLY VACCINATED OR UNVACCINATED

ASYMPTOMATIC:

HCP who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

SYMPTOMATIC:

HCP with <u>mild to moderate illness</u> who are *not* <u>moderately to severely immunocompromised</u>:

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

HCP who were asymptomatic throughout their infection and are *not* <u>moderately to severely immunocompromised</u>:

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

HCP with <u>severe to critical illness</u> and are *not* <u>moderately to severely immunocompromised</u>:

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

HCP who are <u>moderately to severely immunocompromised</u> may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work. The criteria for the test-based strategy are:

HCP who are symptomatic:

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

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

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

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

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

EXPOSED HCP

Work Restriction for HCP who have received all COVID-19 vaccine and booster doses as recommended by CDC:

Higher-risk: HCP who had prolonged close contact with a resident, visitor, or HCP with confirmed SARS-CoV-2 infection -

- No work restrictions
- Perform SARS-CoV-2 testing immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure.
- Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

Lower-risk: HCP with exposure risk other than those described as higher-risk above

- No work restrictions of testing
- Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

Work Restriction for HCP who have not received all COVID-19 vaccine and booster doses as recommended by CDC:

- Exclude from work.
- HCP can return to work after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and HCP do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned return to work .

CONSUMABLE AND DURABLE SUPPLIES:

- Facility will use the CDC's PPE Burn Rate Calculator in order to estimate the amount of PPE needed for the required supply.
- Facility will maintain PPE in stock as mandated by state and federal authorities.
- Facility will anticipate needs for consumable and durable resources (e.g., respiratory equipment, IV pumps), and determine a trigger point for ordering extra resources.
- Facility will anticipate needs for antibiotics to treat bacterial complications of infectious diseases, and will coordinate with the pharmacy how supplies can be maintained during an outbreak.
- Furlough or reassignment of staff at high risk for complications of the infectious disease.
- Re-assigning non-essential staff to support other facility services or placing them on administrative leave; cohort staff caring for residents afflicted with the virus.
- Assign staff recovering from the infectious disease to care for infected residents.
- Staff who have signs and symptoms of the infectious disease must notify their supervisor and not report to work.

- Facility will report the number of positive and suspected cases, resident bed and census, staffing shortages, status of PPE and hand hygiene supplies, to the local and state health departments as directed.

- Facility will coordinate with local and state health departments about access to the national stockpile during an emergency.

ENVIRONMENTAL CLEANING AND DISINFECTION:

- Housekeeping Department will increase the frequency of routine cleaning and disinfection of frequently touched surfaces and shared medical equipment using frequently using products that have EPA-approving emerging viral pathogens claims that have demonstrated effectiveness against viruses similar to COVID-19 on hard non-porous surfaces.
- Adhere to internal environmental cleaning protocols to ensure appropriate measures are being taken to clean and disinfect throughout the facility.
- Housekeeping Department will adhere to infection control protocols when handling laundry.

TESTING:

- Facility has a contracted laboratory that will ensure prioritization of test results and testing capacity for repeat facility-wide testing of residents and staff. Facility will contract with other laboratories or vendors if needed to meet testing requirements.

- Facility also uses rapid Point of Care testing for employees to meet testing requirements.

- Facility will perform continued testing of residents and staff whenever required according to CDC and NJDOH guidance.

- Facility will report testing data to the state and/or local health department and other agencies as directed.

OUTBREAK TESTING

- For newly identified COVID-19 staff or resident where close contacts are identified (CONTACT TRACING APPROACH): Facility will test all residents and staff regardless of vaccination status who had a higher-risk exposure with a COVID-19 positive individual.

- If all potential contacts cannot be determined, or managed with contact tracing, facility will use a BROAD-BASED approach, regardless of vaccination status: Facility will test all residents and staff on the affected unit(s) or other specific area(s) of the facility.

- Testing will be done 24 hours after the exposure (Day 1, where day of exposure is Day 0) and, if negative, 48 hours after the first negative test (Day 3) and if negative, again 48 hours after the second negative test (Day 5).

- If no additional cases are identified during contact tracing or broad-based testing, no further testing is indicated.

- If additional cases are identified, a broad-based approach will be used (if not already being performed) and will implement quarantine for residents in the affected unit(s). If using antigen tests, testing will continue on affected unit(s) or facility-wide every 3 days until there are no new cases for 14 days. If using PCR tests, testing can be done every 3-7 until no new cases are identified for 14 days.

- Facility will report testing data to the state and/or local health department and other agencies as directed.

- If a resident refuses to undergo COVID-19 testing, the resident will be placed on transmission-based precautions, make a notation in the resident's chart, notify any authorized family members or legal representatives of this decision, and continue to monitor resident for COVID-19 symptoms. Onset of temperature or other symptoms consistent with COVID-19 require immediate cohorting. At any time, the resident may rescind their decision not to be tested.

  If outbreak testing has been triggered and an asymptomatic resident refuses testing, the resident will be placed on transmission-based precautions (TBP) until the procedures for outbreak testing have been completed.

- If a staff refuses to undergo COVID-19 testing, the staff should adhere to the following guidance:

  - Wear a N95 for source control at all times while in the healthcare facility.

  - Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms of COVID-19 occurs.

  - **If outbreak testing has been triggered,** and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed.

- Staff and residents who have recovered from COVID-19 and are asymptomatic do not need to be retested for COVID-19 within 90 days after symptom onset.
- Facility will document the date the case was identified, the date that all other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests.
- Facility will continue testing every 3 days until there are no new cases identified in residents and staff for 14 days.

Routine Testing of Staff

Facility will test staff who are unvaccinated or not up to date on their vaccinations, at a minimum, twice weekly, if community transmission rates are high or substantial AND the staff:

a.) Have not yet submitted proof of full primary series vaccination,

b.) Have not yet submitted proof of being up to date on COVID-19 vaccination, and/or

c.) Have requested and received an authorized medical or religious exemption to COVID-19 vaccination.

Routine testing of unvaccinated staff and staff not up to date with their vaccinations, should be based on the extent of transmission of the virus in the community. Staff who are up to date on their COVID vaccinations do not have to be routinely tested. The facility will test all unvaccinated staff and staff not up to date with their vaccinations based on the community transmission rate reported in the past week.

Facility will document the community transmission rate, the corresponding testing frequency indicated and the date each positivity rate was collected. Facility will also document the date(s) that testing was performed for all staff, and the result of each test.

Routine Testing of Residents - New Admissions and Re-Admissions

According to updated DOH guidance, facility no longer tests new admissions or re-admissions unless they are symptomatic.

Please note this document is intended to help guide decisions in consultation with the clinical team and facility specific resources. We are experiencing a rapidly evolving situation and as more guidance and resources become available, the Plan will be adjusted and revised as needed. To ensure you have the most updated Plan, please reach out to the facility.