DEPTFORD CENTER

OUTBREAK RESPONSE PLAN

The facility will follow the Outbreak Response Plan when a suspected cluster of either respiratory or gastro-intestinal symptoms exist within the facility. An Ad Hoc meeting with department heads will be implemented. The infection preventionist will start a line listing to monitor for signs and symptoms of the illness. The medical director will be informed and determine the course of treatment. Facility staff will be monitored for any signs/ symptoms of the illness. The facility will place the resident(s) on the appropriate precautions as per CDC recommendations. Necessary lab testing will be determined by the medical director. The facility will notify the NJ Department of Health about any outbreaks of communicable diseases within the facility.

An outbreak will be defined as an excess over expected (usual) level of a disease within the Center or according to defined clinical parameters or state regulations.

Case definitions are based on nationally accepted standards. Case definitions may change during an outbreak period based upon the prevalence of symptoms in a particular Center.

COVID 19:

A COVID19 outbreak is defined as one confirmed laboratory case in the center. Additionally, sudden acute respiratory symptoms including fever over ≥ 100.0F of three or more residents in a unit within a 7-day period would be considered an outbreak.

Influenza:

One or more laboratory proven cases (patients and staff) of influenza along with other cases of respiratory infection in a Unit within a seven-day period

Influenza-Like Illness (ILI):

Two or more clinically defined cases (patients and staff) in a Unit within a seven-day period.

Pneumonia:

Two or more patients with nosocomial cases of non-aspiration pneumonia within a seven-day period should be reviewed for outbreak potential.

Gastroenteritis:

Three or more persons (patients and staff) from a single unit or 3% or more of the entire Center who develop diarrhea or vomiting AND the onset occurs within a seven-day period.

Scabies:

Two or more persons (patients and staff) within four to six weeks of each other may constitute an outbreak.

Multi-Drug Resistant Organisms (MDROs):

An increase from baseline of healthcare acquired infections requires additional surveillance to determine the source of transmission.

Other reportable diseases per state regulation.

COVID 19 positive will be reported to the county and state health departments. All other outbreaks will be reported as required. Common examples of reportable outbreaks include (but are not limited to) tuberculosis, varicella, and hepatitis. Refer to 2012 Nationally Notifiable Diseases and Conditions or state specific list.

PROTOCOL FOR ISOLATING AND/OR COHORTING INFECTED RESIDENTS

The facility will initiate the following procedure(s) for isolating and/ or co-horting residents:

The facility shall make every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-Based Precautions shall only be used when transmission cannot be reasonably prevented by less restrictive measures.

AIRBORNE ORGANISMS are those which remain infectious when suspended in the air. (Examples: M. tuberculosis, varicella zoster or shingles)

DROPLET transmission occurs with organisms in the respiratory tract. Droplets are generated when the person coughs, sneezes, or talks. Organisms are contained in the droplets and can travel from 3 to 10 feet. (Examples: influenza, MRSA in sputum or nares with coughing or sneezing)

CONTACT transmission occurs through direct contact with the organism and then contact with another person or surface. (Examples: Infected wounds, urine, or feces)

PROCEDURE:

1. All known or suspected infections are reported to the Infection Preventionist or designee.
2. If a resident is identified as being infected with an infectious organism that requires transmission-based precautions, the nurse implements the precautions as soon as possible.
1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection.
3. Precautions are maintained for as long as necessary to prevent the spread of the infection, but no longer than the course of treatment.
4. The infected resident will be placed in a single room whenever possible. He/she may be co-horted with another resident infected with the same organism and as last option in a room with a roommate who is not immunocompromised or at risk, if applicable.
5. Accommodations will be made to provide a commode to the roommate of a patient exhibiting for urinary or gastrointestinal diseases.
6. The least restrictive measures possible are used to prevent social isolation

of the resident.

7. Visitors are instructed as to necessary precautions before visiting with a resident on transmission-based precautions. Visitors are also discouraged from visiting if exhibiting symptoms of infection.
8. In the event of an outbreak that requires restricted or suspension of visitation, families will be notified and every reasonable accommodation will be made to allow communication between the patient and family.

TRANSMISSION BASED PRECAUTIONS:

1. All linen is considered as contaminated and is handled accordingly; linen is bagged inside the room prior to placing in soiled linen containers. No other special precautions are necessary except in cases of airborne precautions (see procedure).
2. Food trays are all considered contaminated and are handled accordingly; therefore, no special precautions are required for food trays.
3. The infection preventionist will monitor all residents on transmission-based precautions and monitor for compliance with appropriate precautions.
4. Obtain and use disposable blood pressure cuff, stethoscope, and thermometer for resident. Any other equipment needed for the resident (IV pole, IV pump, wound vac, etc.) must remain in the resident's room during the period when precautions are being maintained or cleaned with the appropriate disinfectant before being removed from the room. Consult with the infection preventionist for the appropriate disinfect and insure that it is available on the unit. Blood glucose meters will be wiped with provided disinfectant wipes. **If the resident has c-diff clean equipment with bleach wipes or an acceptable substitute rated for c-diff.**
5. Negative air-flow rooms are not available in the facility. Any resident suspected / diagnosed to have an airborne infection will be placed in a single room until transfer to an appropriate facility. No one with a known airborne infection will be admitted to the facility until the infection has been verified as no longer infectious
6. Staff receives training on standard and transmission-based precautions during orientation and annually. Additional training is provided during outbreaks or for special circumstances as identified by the infection preventionist
7. When a resident has been moved or discharged after being in transmission-based precautions, the room will be terminally cleaned according to Housekeeping procedures.

CONTACT PRECAUTIONS:

1. Implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect

contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions are necessary will be evaluated on a case by case basis.

2. Resident Placement:
    a. Place the individual in a private room if possible
    b. If a private room is not available, the Infection Preventionist / Designee will assess various risks associated with other resident placement options (e.g., co-horting, placing with a low risk roommate).
3. Place "isolation" sign at door of resident's room directing staff and visitors to see the nurse prior to entering the room. The nurse will follow HIPPA protocol identifying the type of precautions required.
4. Wear gloves when handling infective material.
5. Wear a gown if body/clothing contact with infective material is likely.
6. Bag linen inside of room prior to placing in soiled linen containers.
7. Wash hands before entering room and after removing gloves. **If the resident has c-diff, soap and water must be used.**
8. Cover any potentially infected areas with a secure dressing before the resident leaves the room.
9. If the resident is transported to another unit within the facility or to another facility, the Licensed Staff will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions
10. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, bedside commode, or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents.
11. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. Provide use of resident on precautions last.

DROPLET PRECAUTIONS:

1. Implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning).
2. Resident placement:
    a. Place the resident in a private room if possible.
    b. When a private room is not available, residents with the same infection with the same microorganism but with no other infection may be co-horted.
    c. When a private room is not available and co-horting is not achievable, use a curtain and maintain at least 3 feet of space between the infected resident and other residents and visitors.

    d. Special air handling and ventilation are unnecessary and the door to the room may remain open
3. Place “isolation” sign at door of resident’s room directing staff and visitors to see the nurse prior to entering the room. The nurse will follow HIPPA protocol identifying the type of precautions required.
4. Wear mask when entering room or providing care of the resident
5. Wear goggles or a mask with eye shield when within 3 feet of resident or when providing direct care if there is potential for coughing or sneezing
6. Bag linen inside room prior to putting in soiled linen containers
7. Wash hands before entering room and after removing PPE
8. Wipe any equipment with the appropriate disinfectant before removing from the room
9. Limit movement of resident from the room to essential purposes only. If transport or movement from the room is necessary, place a mask on the infected individual and encourage the resident to follow respiratory hygiene/cough etiquette to minimize dispersal of droplets
10. If the resident is transported to another unit within the facility or to another facility, the Licensed Staff will notify the unit or facility of the type of precautions the resident is on and the resident’s suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions
11. If the resident can tolerate a mask and control respiratory secretions, some activities outside the room may be acceptable
12. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, bedside commode, or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents
13. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. Provide use of resident on precautions last

AIRBORNE PRECAUTIONS:

1. Implement Airborne Precautions for anyone who is documented or suspected to be infected with microorganisms transmitted by airborne droplet that remain suspended in the air and can be widely dispersed by air currents within a room or over a long distance).
2. Resident health activities related to infection control include tuberculosis (TB) screening and management of active cases, consistent with State requirements. Management of some airborne infections such as active TB requires a single- resident airborne infection isolation room (AIIR) that is equipped with special air handling and ventilation capacity.
3. Place “isolation” sign at door of resident’s room, identifying type of infection, location of infection and type of precautions required
4. Personnel caring for residents on airborne precautions should wear a mask prior to room entry (or may need to wear an N 95 respirator depending on the disease-specific recommendations) In some cases, depending on the condition, staff can wear masks if N95 respirators are not available.
5. Resident Placement

a. Keep the room door closed and the resident in the room

b. If there is not a room in the facility that meets these criteria, then cohort the individual with someone else who is infected with the same microorganism.
c. If isolation in a negative pressure room is essential to prevent transmission of the illness (for example, with active TB), transfer the individual to a setting that can provide the appropriate kind of isolation room.
d. If facility does not have a negative air pressure room and if a resident has positively been confirmed as having TB, the resident will be masked and placed in a room with the door closed until the resident can be transferred to acute care setting.

6. Anyone who is pregnant or anyone susceptible (i.e., not immune) to measles (rubeola) or varicella (chickenpox) may not enter the room of someone who has, or is suspected of having, these infections.
7. The resident should only leave an isolation room when absolutely essential.
8. Someone who is on Airborne Precautions, should wear a mask when leaving the room or coming into contact with others. Depending on the organism, a special filtration mask may be necessary.
9. If the resident is transported to another unit within the facility or to another facility, the Licensed Staff will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions.
10. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, bedside commode, or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents
11. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. Provide use of resident on precautions last.

DISCONTINUING:

2. Residents will remain on appropriate precautions until the Attending Physician or the Infection Preventionist orders them discontinued.
3. The Infection Preventionist has the authority to order and discontinue Isolation Precautions when necessary. The Infection Preventionist shall consult the Attending Physician and/or Medical Director and the Infection Control Committee regarding such decisions.
4. The nursing staff will inform the Infection Preventionist (or designee) when an order for discontinuing isolation has been received from the attending physician.
5. When isolation has been terminated, the Charge Nurse will:
    a. Remove notices that were posted to alert persons of the restrictions;
    b. Return the resident to his/her original room if moved; and
    c. Inform environmental services to clean and disinfect the room.

When a resident expires while still under Isolation Precautions, the Charge Nurse or supervisor shall inform the mortician that isolation precautions were implemented.

OUTBREAK MANAGEMENT- COVID 19

Outbreak Defined: A COVID19 outbreak is defined as one confirmed laboratory case in the center. Additionally, sudden acute respiratory symptoms including fever over ≥ 100.0F of three or more residents in a unit within a 7-day period would be considered an outbreak.

- Patients testing positive for COVID-19 will be evaluated by the physician and determine the need for additional testing or hospitalization.
    - If hospitalization is not medically necessary, the resident will remain in the facility.
- Patients with known or suspected COVID-19 will be transferred to isolation room, and when feasible provided with a private room ideally with their own bathroom.
    - Residents that have a confirmed case of COVID –19 can cohort with other residents who have a confirmed COVID-19. (see C-IC-42)
- Residents with suspected COVID-19 can cohort with other residents who are suspected
- Exposed residents can cohort with other exposed residents as long as the exposure is within 3 days of each other.
- New admissions / readmissions can cohort with another resident who is a new admission if they are admitted within 5 days of each other.
    - Initiate droplet and contact precautions
- Provide and assist resident with wearing surgical or procedural mask, assess resident's ability to tolerate wearing a mask.
- Residents with suspected or confirmed COVID –19 should have the door in their room closed as tolerated and able to with safety concerns.
- Staff should wear a mask at all times while they are in the facility.
- Employees and other direct care providers should wear gown, gloves, eye protection (goggles or a face shield) when caring for positive, symptomatic residents under suspicion, or unknown.
    - N95 masks should be worn:
        - If caring for resident with a confirmed case of COVID-19; or a suspected COVID-19 is actively coughing / sneezing during care
        - If a confirmed or suspected resident requires aerosol or nebulizing medication
- Notify physician
- Notify responsible party
- Immediately contact the local health department for confirmed COVID-19
    - Obtain guidelines from the local health department
- When residents with known or suspected COVID – 19 require transfer to an acute care hospital setting, the licensed nurse will:
    - Relay to 911 personnel that resident is suspected of having COVID-19 (to alert

the EMS crew to take appropriate measures to protect themselves during resident handling and transfer).
    - Alert receiving hospital that resident is suspected of having COVID-19.
    - If a resident receives Dialysis, the Dialysis Center will be contacted and informed of resident status
    - Residents should wear a facemask to contain secretions during transport from room for any medically necessary testing.
- Place resident on infection control line listing
    - Pertinent information regarding each resident and employee case should be entered into the surveillance log and updated daily.
    - Once an outbreak has been identified, cases should be placed on a "line list" (see line listing form.)
- Other residents on affected units should be placed on droplet and contact precautions, regardless of the presence of symptoms and regardless of COVID-19 status.
    - Facility should attempt to manage staff assignments based on symptomatic / asymptomatic to streamline care processes and PPE use (gowns, goggles and mask)
    - When caring for asymptomatic residents;
        - Staff should wear mask and provide resident mask as they can tolerate
- Monitor:
    - All Residents daily, or
    - Residents with known COVID-19 at least TID, or
    - Residents with Suspected COVID-19 at least TID for 14 days (or symptoms reside, whichever is longer), or
    - Exposed Residents BID for 14 days
    - Monitoring to include:
        - Respiratory Symptom check
        - Vital signs
        - Lung auscultation
        - Pulse oximetry
        - Experiencing chills or repeated shaking form chills
        - Muscle pain
        - Headache
        - New symptom of loss of smell or taste
- Assure that all residents in affected units remain in their rooms.
- Avoid floating staff between units. Cohort residents with COVID-19 with dedicated HCP and other direct care providers. Minimize the number of HCP and other direct care providers entering rooms.
- For suspected cases – if through testing a diagnosis is identified (i.e. Influenza, PNA) facility can discontinue isolation precautions
- Facility should establish a routine testing plan for residents who are “negative” to maintain control over any potential spread
- Facility should establish system to make all PPE easily accessible to staff

- Facility should place trash cans in easily accessible areas for staff use when entering and exiting resident room identified to be on isolation
- Facility should make alcohol-based gel easily accessible to staff for use. It is recommended to have enough dispensers to "gel in and gel out"
- Ensure facility sinks are adequately supplied with hand soap and paper towels
- Implement Social Distancing Measures
    - Cancel Communal dining and group activities
    - Remind residents to practice social distancing, wear a cloth face covering (if tolerated) when out of room and perform hand hygiene
    - Encourage staff to practice social distancing, wear a face mask (when applicable) in break rooms and common areas
- Restrict visitations
- Consider implementing telehealth to offer remote access to care activities

LABORATORY TESTING:

The MD will order all necessary microbiological and/or molecular testing necessary to determine the microorganism responsible for an active infection. Laboratory testing is available daily. In the event a test cannot be completed in a reasonable amount of time and/or a resident's clinical status declines, the MD and/or medical director may issue a directive to send the resident to the ER.
If an outbreak were to occur (one or more COVID positive laboratory test of either staff or resident) requires the following testing:

- All residents and staff tested immediately.
- Testing of staff and residents to occur every three to seven days until no positive results for 14 consecutive days.
- Resident refusal of testing requires isolation for 14 days.
- Employee refusal of testing requires furlough from work until compliance is met.

NOTIFICATION OF RESIDENTS, RESIDENT VISITORS AND/ OR FAMILIES:

Family and/or visitors will be notified of an outbreak through the facility website. The facility website is updated daily with COVID 19 information. Visitation is determined by the community phase of opening and the current COVID status of residents and staff in the facility.

Visitors will be discouraged to visit if they exhibit any symptoms. In the event of a widespread community outbreak, a screening tool will be developed to check for symptoms of visitors, vendors, and staff.

The DON or designee will be notified of anyone trying to enter the facility exhibiting symptoms. The DON/ designee will determine if visitation is appropriate at that time.

The nursing staff will notify families/ designee of their family member that has developed symptoms of a communicable disease. The family/ designee will be notified of treatment

ordered and any change of condition. The family will be notified of any precautions initiated. The nursing team will notify family / designee regularly on the status of the resident.

MONITORING STAFF:

Any staff member calling in sick will be asked to disclose if they have any symptoms consistent with an active outbreak within the facility. The staff member will be asked to not return to work until symptoms subside and/ or a clearance note is obtained from their personal physician. The infection preventionist will be notified of the staff member exhibiting symptoms and a line listing will be kept and updated as any staff member reports symptoms. During an active community public health crisis, a questionnaire and/ or screen may be initiated by the facility to monitor staff arriving to work from the community. Each time a staff member arrives to work, a screen will be completed to ensure that an active infectious agent is not brought into the facility. If any symptoms on the screen exist, the DON/ designee will be notified to evaluate the staff member and to potentially disqualify the staff member from entering the facility.

COVID 19 STAFF SCREENING:

PROCEDURE:

- Staff should be screened for at risk upon arrival to work and prior to work assignment (C-IC-39a)
- Screening should include:
    - *Fever and respiratory symptoms.*
    - *Actively take their temperature*
    - Document absence of shortness of breath or difficulty breathing,
    - New or change in cough, and sore throat.
    - Any new or worsening sings on conjunctivitis (eye redness, drainage, pain)
    - Experiencing any chills or repeated shaking with chills
    - Muscle pain
    - Headache
    - Experiencing new loss of taste or smell
    - Staff should be monitored for travel to any area with increased COVID 19 cases.
    - If they are ill, have them put on a facemask and self-isolate at home.
    - Any staff identified to be at risk should be sent home
    - *Facility staff performing health checks must wear facemasks.*
- Facility should actively take temperatures of staff every 12 hours if they remain on duty
- Any staff that develop signs and symptoms of a respiratory infection or above listed symptoms while on-the-job, should:
    - Immediately stop work, put on a facemask, report to supervisor and self-isolate at home;
    - Inform the facility's infection preventionist, and include information on

individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Staff who test positive for COVID-19:
    - Asymptomatic staff can return to work after 7 days of furlough.
    - Symptomatic staff may not return to work until 14 days after the onset of symptoms, provided at least 3 days (72 hours) have passed since resolution of fever without the use of fever-reducing medications and respiratory symptoms are improving.
- When staff returns to work:
    - Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility.
    - Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset.
    - Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.
- Staff traveling:
    - Staff who travel from areas / States that are identified by the State as areas of concern are exempt from Quarantine if:
        - They receive COVID testing with 24-hours of arrival to or back in the State
            - Negative result must be obtained prior to returning to work
            - Receive regular weekly testing per facility policy and schedule
        - Display no active symptoms of COVID-19
        - They should monitor temperature and signs of symptoms, wear a face covering when at work, maintain social distancing, clean and disinfect workspaces for a minimum of 14 days.
- Staff with known exposure can work in the absence of symptoms. They must:
    - Wear masks at all times in resident areas
    - Take and record temperature regularly
    - Must take temperature at the beginning of shift and after hours if still on duty.
- Facility should initiate a Respiratory Line listing for any staff sent home or denied work assignment.
- Facility should remain in contact with local Board of Health on length of time away from work.
- Staff shall wear a facemask while within 6 feet of any resident
    - Extended wearing is permitted.
    - Facemasks should be changed when soiled, torn, wet or when staff goes on break.
    - Facility should attempt to bundle care to reduce the amount of PPE use per staff member.
- Facility should not float staff from unit where there is an identified positive

COVID case or patient under suspicion.

- Facility should attempt to arrange assignments based on resident status (positive COVID / under suspicion) to maximize staffing pattern and PPE use.
- Facility should educate staff regularly on status of facility with COVID residents and updates from CDC, CMS and other regulatory guidance.

MONITORING RESIDENTS:

The nursing staff will discuss resident's status during morning report and at shift to shift report. Any resident exhibiting symptoms of an infectious disease will be reported to the infection preventionist. The infection preventionist will monitor for any other resident exhibiting symptoms.

The following procedure will be implemented:

1. The medical director will be notified of a potential outbreak and order any testing required.
2. Vital sign monitoring for all residents on a unit or within the facility may be implemented but will be determined on a case by case basis.
3. Additional testing may be implemented for the newly infected residents' roommate(s) or other residents on the unit.

STAFF EDUCATION:

In the event of an outbreak, the inservice coordinator will implement education specifically focusing on the infectious agent and precautions required to reduce the spread of the infectious organism. Additional inservices and/ or competencies may be initiated on hand washing and/ or the use of personal protective equipment.

INFLUENZA VACINATION

All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.

The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy.

Procedure:

Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized.

- Employees are required to have the current Influenza vaccine no later than December 31st of the current year as a co9ndition of continued employment as per New Jersey requirement.
- Employees hired or residents admitted between October 1st and March 31st shall be offered the vaccine within five (5) working days of the employee's job assignment or the resident's admission to the facility.
- Employees will be offered the influenza vaccine at no charge, at a location onsite. Employees refusing the vaccine, other than for medical contraindications or proof of previously administered vaccine, may be required to wear masks in resident care areas.
- Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. (See current vaccine information statements at http://www.cdc.gov/vaccines/hcp/vis/index.html for educational materials.) Provision of such education shall be documented in the resident's/employee's medical record.
- For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record.
- A resident's refusal of the vaccine shall be documented on the *Informed Consent for Influenza Vaccine* and placed in the resident's medical record.
- If an employee refuses the vaccine for reasons other than medical contraindication, this shall be documented on the *Employee Informed Consent for Influenza Vaccine*.
- The Infection Preventionist will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. Surveillance data will be made available to staff as part of educational efforts to improve vaccination rates among employees.
- Only inactivated influenza vaccine will be offered to residents, pregnant employees, and employees who work directly with severely immunocompromised residents.
- Residents and staff may obtain their influenza vaccines from their personal physicians. Documentation of previous vaccination should be provided to the facility.

Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.

COVID 19 VACCINATION

This guidance is based on the current vaccine information and data as well as Local and Federal Guidance. As per the New Jersey Department of health guidelines, all active staff is to receive the COVID 19 vaccination including the booster unless applicable exemption documentation has been provided to the facility.

"Staff" – Individuals who work in the facility on a regular (that is, at least once a week) basis, including individuals who may not be physically in the LTC facility for a period of time due to illness, disability, or scheduled time off, but who are expected to return to work. This also includes individuals under contract or arrangement, including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, or volunteers, who are in the facility on a regular basis

"EUA" - is a mechanism to facilitate the availability and use of medical countermeasures, including vaccines, during public health emergencies, such as the current COVID-19 pandemic. The EUA process is a way to ensure safety while still expediting approval in emergent situations.

PROCEDURE

- Facility to offer COVID-19 Vaccine to each resident and staff member when available, unless vaccination is medically contraindicated or they have been previously vaccinated.
- Prior to offering the vaccine staff, residents or their representatives should be provided with proper education regarding the vaccination.
- Staff, residents or their representatives should be provided additional education on additional dosing if required with use of vaccine
- Staff, residents or their representatives are provided to accept or decline the vaccine after proper education
- Facility should offer COVID vaccination to all new admissions and readmission the opportunity to receive the first dose or required next dose of COVID vaccine.
- Facility should hang postings throughout facility to remind residents and staff that the facility offers the COVID Vaccine
- Facility to have proper documentation of staff and resident's education and decision on COVID-19 Vaccines

ENVIRONMENTAL SERVICES:

In order to facilitate the investigation of COVID-19 and other acute respiratory disease outbreaks and implementation of control measures, the following guidelines have been established. These guidelines emphasize priorities regarding prevention and control of influenza and pneumococcal disease including pneumonia as follows:

- to prevent disease transmission

- to prevent outbreaks through proper use of PPEs
- to detect the occurrence of an outbreak
- to stop transmission of the COVID19 through control measures
- to measure the level of morbidity and mortality

Facility has established policies to attempt to prevent and control the spread of COVID-19, this includes but is not limited to environmental cleaning and infection control practices.

PROCEDURE:

Hand Hygiene:

Hand hygiene is considered as the single most important practice to reduce the transmission of infectious agents in healthcare settings, and is an essential element of Standard Precautions. The term "hand hygiene" includes both handwashing with either plain or antiseptic-containing soap and water, and use of alcohol-based products (gels, rinses, foams) that do not require the use of water. All health care personnel (HCP) and non-essential personnel should practice hand hygiene.

Personal Protective Equipment (PPE) for Healthcare Personnel

- PPE refers to a variety of barriers and respirators used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents.
- The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission.
- All HCP and non-essential personnel should wear appropriate PPE when interacting with residents.
- Facility should ensure ample amount of alcohol-based gel dispensers or alternate disinfecting agent as well as a system to keep full and ready for use by staff and visitors
- During environmental cleaning procedures, personnel must wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection)

Cleaning / Disinfection:

- Facility disinfect / clean high touch surfaces (knobs, had rails, tables etc..) on regular basis throughout the day, at a minimum twice a day with increase amount warranted based on facility activity.
    - Facility should attempt to track
- Facility should use dedicated equipment for identified isolation rooms.
- Facility should sanitize any rental equipment upon receipt.
- Facility should attempt to limit sharing of personal items between residents.
- If sharing is necessary ensure proper cleaning of item in between residents
- Disinfect activity supplies between each resident. Clean activity carts when moving from each resident to another resident.

- Clean computers and kiosks routinely throughout the day, especially with multiple users. Use approved disinfectant wipes.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Follow environmental cleaning and disinfection procedures consistently and correctly.
- Surfaces should be cleaned with soap and water prior to disinfectant
- Use disinfectants on List N of the EPA website for EPA-registered
- Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).
- Environmental surfaces in patient care areas are cleaned and disinfected, using an EPA-registered disinfectant

Resident Rooms:

- Isolation:
    - Patient isolations rooms, cohort areas and clinical rooms must be decontaminated at least daily.
    - Use dedicated medical equipment for isolated residents. Oximeter, B/P cuff, Stethoscope etc.
    - Ensure isolation carts with isolation supplies and isolation signs are outside the room. Retrain staff on proper donning of PPE.
- Once isolation is removed; room needs to have a complete and thorough decontamination cleaning
    - All surfaces including bed rails, bed frames, bed controls, call lights etc.
    - Privacy curtains should be removed and laundered / replaced
    - Water / cleaning solution and supplies should be switched out after each room is terminally cleansed
    - Any personal care items left behind should be discarded
    - Any unopened supplies left should be discarded

Linen

- All linen used in the direct care of patients with suspected and confirmed COVID-19 can be managed as all other linen from a room on isolation
- All linen must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment.
- When handling linen do not:
    - Rinse, shake or sort linen on removal from beds/trolleys;
    - Place used/infectious linen on the floor or any other surfaces e.g. a locker/table top;
    - Re-handle used/infectious linen once bagged;
    - Overfill laundry receptacles; or
    - Place inappropriate items in the laundry receptacle e.g. used equipment/needles.

- Laundry hampers / receptacles should be cleaned at least daily and when visibly soiled.

VISITATION DURING COVID 19 RESTRICTIONS

Facilities with + COVID, Suspicion of COVID or Current exposures should restrict visitation except for the following:

- Current health status (e.g. end of life, critical) is in question
    - Visitor should be limited to a specific room only (resident they are visiting)
    - Visitor is required to go through screening process prior to entry. Visitor displaying any signs / symptoms of concern or fever will be denied access to facility
    - Facility should require visitor to perform hand hygiene regularly and use proper PPE during
    - Facility should encourage visitor to wear a mask while in the facility.
    - Facility should not suspend visitation unless directed by the health department.
    - Facility should encourage visitors to provide a negative PCR test from 48 hours prior or take a rapid test for visitation.
- Under these identified circumstances, facilities should offer alternative means for residents and families to communicate. May include but limited to:
    - Video conferencing (Skype, Zoom etc..)
    - Phone calls
    - Emails
    - Texting
- Facility should consider reopening to family visitation after town or County where facility resides is identified within Phase III or higher of “reopening”
- Facility should consider identifying a limited visitation schedule of at least 4 hours a day
- The facility should honor each resident’s right to have and choose visitors and to make preferences. The facility should consult every resident to determine who the resident would wish to visit with in person.

OUTDOOR VISITATION PLAN:

- The facility should use a patio area limiting resident visitors between the hours of 9 am and 4:30 pm. Scheduled visitation should not occur during resident meal times.
- Visitors should not be allowed into the facility during visits (this includes the use of facility bathrooms) and must wait in designated area prior to visiting.

- The visitor and resident must remain 6 feet apart at all times during the visit. Physical contact during the greeting and termination of the visit is prohibited
- A staff member should transport the resident to and from the visitation area. During transport, the resident will wear a face mask. A staff member should be designated to monitor the visitation area.
- Residents should be provided appropriate protection for weather conditions (i.e. sunblock, jacket, etc.)

SCREENING PROCESS

- The facility should screen visitors and residents immediately prior to visit. Visitors and residents must pass a COVID 19 screen for visitation to commence.
- The visitor(s) must wear a face covering during check in and during the visit.
- A resident who is suspected or confirmed to be infected with COVID-19; or quarantined for an exposure to a COVID-19 case cannot be visited except for an end of life situation. A resident who has been diagnosed with COVID-19 may be visited only after they have met the criteria for discontinuation of isolation as defined in guidance from NJDOH and CDC.
- It is encouraged that visitors provide a negative COVID- 19 test result within the previous 7 days.

VISITATION

- Visits should be limited to 30 minutes maximum.
- The facility should limit the number of visitors to 2 per resident.
- The visit must be scheduled in advance with recreation and must be scheduled 24 hours prior to the visit. The visitors must be listed when the visit is scheduled. Visitors must show identification at check in.
- The resident must wear a face mask during transport to and from visit. The resident is required to wear a mask during the visit.
- Visitation is dependent on permissible weather conditions, availability of outdoor space, and sufficient staffing at the facility to meet resident care needs, as well as the health and well-being of the resident. Visits may be cancelled because of inclement or unsafe weather conditions (e.g. high humidity/heat, poor air quality).
- Food is not permitted during the visits. Visitors may bring items for the resident but must leave the package at reception or another location, as directed by the facility.
- Visitors may bring their own water which cannot be shared with the resident. The facility shall provide appropriate hydration for the resident during the visit
- The facility reserves the right to terminate a visit and suspend future visitation if a breach of the visitation requirements is observed by staff.

- A staff member should transport the resident to and from the visitation area. During transport, the resident will wear a face mask. A staff member should be designated to monitor the visitation area.
- Each resident participating in visitation should be monitored q shift for signs and symptoms of COVID 19 for 14 days following visitation.
- The facility reserves the right to suspend outdoor visitation if an increase in COVID 19 infections occur with residents and/or staff.

INDOOR VISITATION PLAN

- The facility should use the large dining room on the first floor adjacent to the lobby.
- Visitors should not be allowed into the facility common hallways during visits (this includes the use of facility bathrooms) and must wait in designated area prior to visiting.
- The visitor and resident must remain 6 feet apart at all times during the visit. Physical contact during the greeting and termination of the visit is prohibited
- A staff member should transport the resident to and from the visitation area. During transport, the resident will wear a face mask. A staff member should be designated to monitor the visitation area.

SCREENING PROCESS

- The facility should screen visitors and residents immediately prior to visit. Visitors and residents must pass a COVID 19 screen for visitation to commence.
- The visitor(s) must wear a face covering during check in and during the visit.
- A resident who is suspected or confirmed to be infected with COVID-19; or quarantined for an exposure to a COVID-19 case cannot be visited except for an end of life situation. A resident who has been diagnosed with COVID-19 may be visited only after they have met the criteria for discontinuation of isolation as defined in guidance from NJDOH and CDC.
- It is encouraged that visitors provide a negative COVID- 19 test result within the previous 7 days.

VISITATION

- Visits should be limited to 30 minutes maximum.
- The facility should limit the number of visitors to 2 per resident.
- The visit must be scheduled in advance with recreation and must be scheduled 24 hours prior to the visit. The visitors must be listed when the visit is scheduled. Visitors must show identification at check in.

- The resident must wear a face mask during transport to and from visit. The resident is required to wear a mask during the visit.
- Visitation is dependent on sufficient staffing at the facility to meet resident care needs, as well as the health and well-being of the resident.
- Food is not permitted during the visits. Visitors may bring items for the resident but must leave the package at reception or another location, as directed by the facility.
- Visitors may bring their own water which cannot be shared with the resident. The facility shall provide appropriate hydration for the resident during the visit
- The facility reserves the right to terminate a visit and suspend future visitation if a breach of the visitation requirements is observed by staff.
- A staff member should transport the resident to and from the visitation area. During transport, the resident will wear a face mask. A staff member should be designated to monitor the visitation area.
- Each resident participating in visitation should be monitored q shift for signs and symptoms of COVID 19 for 14 days following visitation.
- The facility reserves the right to visitation if an increase in COVID 19 infections occur with residents and/or staff. In addition, visitation may be suspended by increased cases of COVID 19 in the county in which the facility is located.

COMMUNICATION

The facility should require a signed statement from each visitor and resident (if the resident is unable to consent then the consent needs to be signed by the authorized representative) with a copy provided to the visitor and resident, that they are aware of the risk of exposure to COVID-19 during the visit, that they should strictly comply with the facility policies during outdoor visitation, and that the visitor will notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID-19 within fourteen days of the visit.

PLAN FOR TESTING OF STAFF AND RESIDENTS

To comply with the New Jersey Executive Order for required testing of residents and staff the facility will implement the following measures:

1. All residents without a positive COVID history will be tested on or before 5/26/2020.
2. All new admissions from the previous testing date of 5/3/2020 with negative test results will have testing completed on or before 5/26/2020.
3. All negative test results will have a repeat test administered 3-7 days status post initial test date.
4. All staff without a previous positive test on file will have an initial test completed on or before 5/26/2020. A repeat test of all negative staff members will be completed 3-7 days status post initial testing.

5. All positive residents will be placed on contact and droplet precautions and will be co-horted to meet CDC guidelines. The medical director will determine the treatment regime based on current symptoms.
6. All residents with two negative tests will continue to be monitored daily for COVID symptoms.
7. Screening of staff members will continue as per CDC guidelines in the beginning of their shift.
8. All outside contractors that have direct contact with residents will be required to comply with facility wide testing requirements.
9. The facility will continue facility wide testing of negative residents and staff weekly as per CMS guidelines.
10. Staff with a positive test will furlough as per CDC and NJ DOH guidelines.
11. Staff with a positive test result will be required to begin retesting 3 months following the positive test.
12. Staff that is newly hired will be tested within in the first week of employment and follow up testing for negative employees will be completed within 3-7 days of initial testing.
13. Test results will be kept on file with the HR department and will be surrendered to the NJ DOH upon request.
14. A list of test results of residents from Cooper Health testing will be kept on file with the facility Outbreak Management Plan. The list will be surrendered to the NJ DOH upon request.
15. Test results for residents completed by the facility contracted lab will be part of the electronic medical record and will be surrendered upon request to the NJ DOH.
16. Staff members that do not comply with the mandatory testing will not qualify for employment after 5/26/2020 and will be required to voluntarily resign from any position at the facility.
17. The plan is subject to change based on any subsequent executive order.

REPORTING TO PUBLIC HEALTH OFFICIALS:

The Facility will make every effort to ensure that timely reporting to the health department meets county and New Jersey State requirements.