



Policy for Emergent Infectious Diseases (COVID-19) **(Outbreak Plan V9)**

PURPOSE

To provide guidance to long term care providers on how to prepare for new or newly evolved Infectious diseases whose incidence in humans has increased or threatens to increase in the near future and that has the potential to pose a significant public health threat and danger of infection to the residents, families and staff of the skilled nursing center.

ASSUMPTIONS

This document contains general policy elements that are customizable depending on the specific care center demographics, location, and current disease threats. It is not comprehensive and does not constitute medical or legal advice.

Every disease is different. The local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing center response related to a specific disease threat.

This document contains recommendations that may not be applicable to all types of long- term care facilities. Modifications should be made based upon the regulatory requirements and the structure and staffing for the specific care setting.

GOAL

To protect our residents, families, and staff from harm resulting from exposure to an emergent infectious disease while they are in our care center.



1. General Preparedness for Emergent Infectious Diseases (EID)

- a. The care center's emergency operation program will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza. This plan will:
 - i. build on the workplace practices described in the infection prevention and control policies
 - ii. include administrative controls (screening, isolation, visitor policies and employee absentee plans)
 - iii. address environmental controls (isolation rooms, plastic barriers sanitation stations, and specific areas for contaminated wastes)
 - iv. Address human resource issues such as employee leave
 - v. Be compatible with the care center's business continuity plan
- b. Clinical leadership will be vigilant and stay informed about EIDs around the world. They 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.
- c. As part of the emergency operations plan, the care center will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, foot and head coverings, surgical masks, assorted sizes of disposable N95 respirators, and gloves. The amount that is stockpiled will minimally be enough for several days of center-wide care but will be determined based on storage space and costs.
- d. The care center will develop plans with their vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including an EID outbreak.
- e. The care center will regularly train employees and practice the EID response plan through drills and exercises as part of the center's emergency preparedness training

2. Local Threat

- a. Once notified by the public health authorities at either the federal, state and/or local level that the EID is likely to or already has spread to the care center's community, the care center 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.



COMPLETECARE
— MANAGEMENT —

- b. The care center's Infection Preventionist (IP) 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. Working with advice from the care center's medical director or clinical consultant, Facility laboratory safety officer, human resource director, local and state public health authorities, and others as appropriate, the IP will review and revise internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.
- d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.
- e. If EID is spreading through an airborne route, then the care center 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.
- f. Provide residents and families with education about the disease and the care center's response strategy at a level appropriate to their interests and need for information.
- g. Brief contractors and other relevant stakeholders on the care center's policies and procedures related to minimizing exposure risks to residents.
- h. Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the care center along with the instruction that anyone who is sick must not enter the building.
- i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the care center, 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. All administrative staff, including Director of Nursing, Administrator, the Infection Control Preventionist, Caregiver, Contractors, Consultants, Volunteers, and visitors shall complete screening questionnaire and complete temperature checks prior to entrance of the facility.



- j. Self-screening – Staff will be educated on the care center’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 EID while off duty to their supervisor and public health.
 - ii. Precautionary removal of employees who report an actual or suspected exposure to the EID.
 - 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.
- k. Self-isolation - in the event there are confirmed cases of the EID in the local community, the care center may consider closing the care center to new admissions, and limiting visitors based on the advice of local, state and federal public health authorities.
- l. Environmental cleaning - the care center will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
- m. Engineering controls – The care center will utilize appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and specific areas for contaminated wastes as recommended by local, state, and federal public health authorities.

3. Suspected case in the care facility

- a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation room and notify local public health authorities.
- b. 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.
- c. If the suspected infectious person requires care while awaiting transfer, follow care center policies for isolation procedures, including all recommended PPE for staff at risk of exposure.
- d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. 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 “just in time” training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.

- e. If feasible, ask the isolated person to wear a facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless it advised otherwise by public health authorities.
- f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.
- g. Implement the isolation protocol in the care center (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the care center’s infection prevention and control plan. Please refer to: **(Isolation Categories of Transmission Based Precautions Policy)** [IsolCategoriesTransBasedPrec.pdf](#) and/or recommended by local, state, or federal public health authorities.
- h. 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. Please refer to: **(Quarantine Policy)** [Quarantine.pdf](#)

4. Employer Considerations

- a. Management will consider its requirements under OSHA, (Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and other employees shall be of paramount concern. Management shall consider:
 - i. The degree of frailty of the residents in the care center.
 - ii. The likelihood of the infectious disease being transmitted to the residents and employees.
 - iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces)
 - iv. The precautions which can be taken to prevent the spread of the infectious disease and



- v. Other relevant factors
 - b. Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.
 - c. Apply whatever action is taken uniformly to all staff in like circumstances.
 - d. Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.
 - e. Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.
 - f. Generally, accepted scientific procedures, whenever available, will be used to determine the level of risk posed by an employee.
 - g. Permit employees to use sick leave, vacation time, and FMLA where appropriate while they are out of work.
 - h. Permit employees to return to work when cleared by a licensed physician, however, additional precautions may be taken to protect the residents.
 - i. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline.
 - j. Please refer to notification for families in staff: **(Corona Virus Letter to Families) (Employee Information FAQ COVID-19)**

5. Definitions

Emerging Infectious disease -- Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:

- i. New infections resulting from changes or evolution of existing organisms.
- ii. Known infections spreading to new geographic areas or populations.



- iii. Previously unrecognized infections appearing in areas undergoing ecologic transformation.
- iv. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

Pandemic -- A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

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.

Cohorting – The practice of grouping patients who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other patients.

When Cohorting residents the facility shall identify a minimum of three cohort groups:

1. Individuals who are showing symptoms of COVID-19 or who have tested positive for COVID-19.
2. Individuals who have been exposed to someone who has tested positive for COVID-19 or has shown symptoms of COVID-19 (i.e., individuals who are not themselves symptomatic, but may potentially be incubating the virus); and
3. Individuals who are not ill and has not been exposed.

Facility shall assign dedicated staff to each cohort and allow for necessary space to do so at the onset of an outbreak.

6. Test Based Prevention Strategy

Testing of Residents

1. If testing capacity allows, **facility-wide testing of all residents** should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience from nursing homes with COVID-19 cases suggests that when residents with COVID-19 are identified, there are often asymptomatic residents with SARS-CoV-2 present as well.



2. Testing of all residents in the facility can identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility. If undertaking facility-wide testing, facility leadership should be prepared for the potential to identify multiple asymptomatic residents with SARS-CoV-2 infection and make plans to cohort them.
3. If testing capacity is not sufficient for facility-wide testing, performing testing on **units with symptomatic residents** should be prioritized.
4. **Refusal of testing-** If a resident /patient refuses to undergo testing, then the LTC shall treat the individual as a Person Under Investigation, make a notation in the resident's chart, notify any authorized family members or legal representatives of this decision, and continue to check temperature on the resident at least twice per day. Onset of temperature or other symptoms consistent with COVID-19 require immediate cohorting in accordance with the plan. At any time, the resident may rescind their decision not to be tested.

When testing capacity is available and facility spacing permits, patients/residents should be organized into the following **cohorts**:

Covid Positive -Individuals consisting of both symptomatic and asymptomatic patients/residents who test positive for SARS-CoV-2, regardless of vaccination status, including any new or re-admitted patients/residents known to be positive who have not met the criteria for discontinuation of transmission-based precautions require 10 days of quarantine with appropriate Transmission-based Precautions. Patients/residents should be placed in the COVID-19 care unit/area, regardless of symptoms, if they have confirmed SARS-CoV-2 infection.

1. Both symptomatic and asymptomatic patients/residents who test positive for SARS-CoV-2, regardless of vaccination status.
2. New or re-admitted patients/residents known to be positive who have not met the criteria for discontinuation of transmission-based precautions.

Persons Under Investigation [PUI]-Individuals consisting of all symptomatic and asymptomatic patients/residents who are **not up to date*** and test negative for SARS-CoV-2 with an identified exposure (i.e., close contact) to someone SARS-CoV-2 positive require up to 10 days of observation with appropriate Transmission-based Precautions. Symptomatic patients/residents with suspected SARS-CoV-2 infection.



1. **Asymptomatic patients/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
 - Require 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** immediately (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure.
 - Patients/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.
 - 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
2. **New or readmitted asymptomatic patients/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.
 - Quarantine and full PPE (gowns, gloves, eye protection that covers the front and sides of face, and NIOSH-approved N95 or equivalent or higher-level respirator) is required, 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.
 - Quarantine is ***not*** recommended for patients/residents who are **not up to date** with all recommended COVID-19 vaccine doses ***that routinely leave the facility for <24 hours and do not have close contact with a suspected or known COVID-19 positive person.***
 - All symptomatic patients/residents should be evaluated for causes of their symptoms. Patients/residents who test negative for SARS-CoV-2 could be incubating and later test positive. A patient/resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. The door to the room remains closed to reduce transmission of SARS-CoV-2 or other pathogens.



- However, in some circumstances (e.g., memory care units), keeping the door closed may pose patient/resident safety risks and the door might need to remain open. If doors must remain open, attempt to implement strategies to minimize airflow into the hallway. If limited single rooms are available, or if numerous patients/residents are simultaneously identified to have symptoms concerning for COVID-19, they should remain in their current location pending return of test results.

Negative- Fully up to date* asymptomatic patient/residents and unvaccinated patients/residents who are no longer PUI and are asymptomatic. *Note: Fully up to date* asymptomatic patient/resident could be placed with an unvaccinated or partially vaccinated roommate upon assessment of risk. In this case, routine infection prevention and control practices should also apply.*

1. Asymptomatic patients/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***

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

2. New or readmitted asymptomatic patients/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.
- These patients/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.

* CDC defines **up to date** as a person receiving all recommended COVID-19 vaccines (e.g., fully vaccinated) including any booster dose(s) when eligible

**In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days. If testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

Testing of nursing home HCP

1. If testing capacity allows, PPS of **all HCP** should be considered in Complete Care facilities with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well.
2. Testing will be completed in a cyclic approach as designated by NJ DOH guidance.
3. Testing Consent will be obtained from each employee.



4. Retesting of HCP will be completed in accordance with the CDC guidance, amended and supplemented.
5. If a staff member tests positive for COVID-19 (Symptomatic or Asymptomatic), Complete Care facilities may permit them to return to work subject to the CDC/NJDOH guidance.
6. All unvaccinated staff will complete weekly/biweekly testing according to the NJDOH guidance and Cali score.
7. Any staff member who missed weekly testing due to LOA, must be tested prior to returning to work. Staff who tested positive will be excluded from work in accordance with the CDC/NJDOH recommended guidance.
8. Staff Refusal – If a staff member refuses to participate in COVID-19 testing or refuses to authorize release of their testing results to the NJDOH via the LTC facility, then the staff member will not be permitted to work until such time as such staff undergoes required testing and the results of such testing are disclosed to the LTC.

**Testing related to (+) COVID-19 exposure and/or symptoms associated with SARS-CoV-2
(Outbreak Testing)**

1. **Contact tracing approach.** Identifies all patient/resident close contacts and staff high-risk exposures. All individuals with close contact and/or high-risk exposure should be tested as described below. If testing reveals additional cases, contact tracing will continue to be performed.
2. **Broad-based approach.** Testing is performed for all patients/residents and staff on the affected unit(s), regardless of vaccination status, who have not been previously positive within the past 90 days.
3. Patients/residents and staff should continue to wear well-fitting source control, practice physical distancing, and monitoring for symptoms for 14 days from the last exposure to the SARS-CoV-2 positive individual even if they test negative.
4. As available, PCR testing should confirm any positive rapid antigen test.

Testing of Residents and Staff as follows:

1. If a symptomatic individual is identified:
 - **Residents:** Vaccinated and unvaccinated, with signs or symptoms must be tested.
 - **Staff:** Vaccinated and unvaccinated, with signs or symptoms must be tested.
2. If there is a newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, then:



- **Residents:** Vaccinated and unvaccinated, who had close contact* with a COVID-19 positive individual must be tested.
 - **Staff:** Fully up to date with Vaccinations test and monitor and unvaccinated, who had a higher-risk exposure** with a COVID-19 positive individual must be excluded from work.
3. If a newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts, then:
- **Residents:** Up-to-date, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility) must be tested. Not up-to-date or unvaccinated, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility), must be placed on PUI precautions and tested.
 - **Staff:** Vaccinated and unvaccinated, facility-wide or at a group level if staff are assigned to specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility) must be tested.
4. Routine testing: All staff testing must be completed prior to entering the facility and Units to decrease exposure to the residents and staff.
- **Residents:** Not generally recommended
 - **Staff:** All staff who have not yet submitted proof of full vaccination must be tested, at a minimum, on a once or twice weekly basis in accordance with E.O. 252 and NJDOH E.D. 21-011.
 - If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days and no further testing is indicated.
 - If additional cases are identified, testing should continue on the affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days.
 - If antigen testing is used, more frequent testing (every 3 days), should be considered.

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

****higher-risk exposure** – refers to exposure of an individual’s eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff do not wear adequate PPD during care with an individual.

[7. Staffing Capacity Strategies](#)



Complete Care facilities will review and adjust staff schedules, hire additional HCP, and rotate HCP to positions that support patient care activities within Complete Care facilities. Additional guidance includes but is not limited to:

1. Cancel all non-essential procedures and visits.
2. Shift HCP who work in other areas to support patient care activities in the facility.
3. Complete Care facilities will need to ensure these HCP have received appropriate cross- training to work in these areas that are new to them.
4. Initiate Staff Communication meetings to attempt to address social factors in **(Staff Meetings/ Individual Meetings)** that might prevent HCP from reporting to work such as transportation or housing if HCP with vulnerable individuals.
5. Identify additional HCP to work in the facility via Agency Assistance.
6. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP assistance.
7. Request that HCP postpone elective time off from work where applicable.

Work Restrictions for HCP with SARS-CoV-2 Infection and Exposures

1. Work Restrictions are dependent upon the vaccination status of the Healthcare worker, indicated as:
 - Up to Date
 - Not Up to Date
2. Work Restrictions are differentiated with regards to the availability of staffing, staffing patterns and identified staffing shortages, indicated as:
 - Conventional
 - Contingency - *when staffing shortages are anticipated*
 - Crisis -*when staffing shortages occur*



In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction if they have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC, and do not develop symptoms or test positive for SARS-CoV-2.

A. Work Restrictions for HCP **with SARS-Co-V-2 Infection**

- a. Up to Date and Not Up to Date HCP who test positive for SARS-CoV-2 infection must follow work restrictions:
 - i. **Conventional** - 10 days OR 7 days with negative test result within 48 hours before returning to work, if asymptomatic or mildly symptomatic (with improving symptoms).
 - ii. **Contingency** – 5 days with/without negative test, if asymptomatic or mildly symptomatic (with improving symptoms)
 - iii. **Crisis** – No work restriction, with prioritization considerations (e.g., types of patients they care for)

B. Work Restrictions for Asymptomatic HCP **with SARS-CoV-2 Exposures**

- a. Up to Date HCP must follow:
 - i. **Conventional** - - **No work restrictions**, with negative test on days 1 and 5-7.
 - ii. **Contingency** – No work restrictions
 - iii. **Crisis** – No work restrictions
- b. Not Up to Date HCP must follow work restrictions:
 - i. **Conventional** - 10 days OR 7 days with negative test within 48 hours before returning to work
 - ii. **Contingency** – No work restriction with negative tests on days 1, 2, 3, & 5-7 (If shortage of tests prioritize Day 1 to 2 and 5-7.)
 - iii. **Crisis** – No work restrictions (test if possible)

8. Visitation

1. Visitation is permitted in all phases.
2. The facility is to honor the resident’s right to have and choose visitors and to make preferences. The facility should consult each resident to determine who the resident would wish to visit in person. These



consultations also serve as a personalized communication (document this in their record) with the resident to explain how visitation will work and what the resident can expect.

3. Clear communication of the visitation policy should be provided to residents, resident's visitors, staff, and others, as needed in writing, or via the methods the facility uses to convey information or policy changes. Consider providing these in various languages as determined by your resident and staff population.
4. A designated area for visitors to be screened will be maintained and all visitors will be offered/provided guidelines upon check in. Visitors should receive information on the guidelines for proper hand hygiene and appropriate personal protective equipment [PPE] when they register.
5. Staff member familiar with the resident and the protocol must always remain with the resident during the visit.
6. Residents and visitors must wear an appropriate face covering or mask for the duration of the visit.
7. The facility must receive acknowledgement from the visitor(s) that they are aware of the possible dangers of exposure of COVID-19 for both the resident and the visitor and they are to follow the rules set by the facility regarding visitation. The visitor(s) also agree to notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID- 19 within fourteen (14) days of the visit.

9. Knowledge Acquired

Through this uncharted territory Complete Care has gain insight in serval areas. No nation, state, hospital system, LTC organization or single individual can foresee the challenges associated with a pandemic however, we can learn valuable information along the way from our response to, and experience with COVID-19. The lessons drawn from the Corona Virus remain a focus within the facility as follows:

1. Following the guidance of the healthcare experts such as the CDC, HHS, NJDOH and Local DOH.
2. Constant review and revision of Infection Control policies and procedures.
3. Continued education in Infection Control policies and procedures.
4. Importance of the Screening Process.
5. Importance of Testing and Continued Testing.
6. Continued Notification of Residents, Families and Staff on COVID-19 updates.
7. Hypervigilance of and oversight of the environment to search anything reminiscent of activity or threat of the spread of COVID-19.

10. Communication Strategy



Complete Care Utilizes the following alternatives to in-person visits:

- **Virtual Communication Coordinators** provide alternative means of communication for all residents are available such as virtual communications (phone calls, video-communication, Facetime, Zoom Google Docs etc.).
- Established email list serve as a direct communication to update families are currently utilized.
- **Information Officers** serve as primary contact to families for inbound calls and conducting regular outbound calls to keep families up to date and offers phone line with a voice recording (ROBO CALLS) updated at set times (e.g., daily) with the facility's general operating status.
- Complete Care updates the websites weekly: Updating the facility's website to share the status of the facility and include information that helps families know what's happening in the loved one's environment, such as food menus and activities that residents can do while still practicing social distancing.
- Complete Care also through the Information Officer updates resident's, representatives, and families of residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Resources:

New Jersey Department of Health <https://www.cdc.gov/> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html> Implemented: March 06,2020

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