Policy for Emergent Infectious Diseases (COVID-19)

(Outbreak Plan V10)

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.

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 will the instruction that anyone who 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.

n. When reporting please refer to: **(Exposure Reporting and Investigating Policy)** **ExposureReportingInvestigating.pdf**

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, symptomatic or asymptomatic, who have tested positive for COVID-19.
2. Individuals who have been exposed to someone who has tested positive for COVID-19 and have met designated criteria requiring transmission-based precautions (i.e., individuals who are not themselves symptomatic, but may potentially be incubating the virus) and individuals who are exhibiting symptoms of COVID-19 and are being evaluated for SARS-CoV-2; and
3. Individuals who are not ill and have 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 as warranted.

6. Test Based Prevention Strategy

1. Residents who are **newly admitted or readmitted to the facility and those who leave the facility for 24 hour or longer** are tested on admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. They should also be advised to wear source control for the 10 days following their admission. Residents who leave the facility for 24 hours or longer should generally be managed as an admission.

   - In general, asymptomatic newly admitted or readmitted, residents do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2.

   - Examples of when empiric Transmission-Based Precautions may be considered include:

     - Patient is unable to be tested or wear source control as recommended for 10 days
     - Patient is moderately to severely immunocompromised
     - Patient is residing on a unit with others who are moderately to severely immunocompromised
     - Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

2. **Residents with ongoing need for transmission based precautions based on immunocompromised status** - Immunocompromised residents residing on the same unit as new admissions must be maintained on transmission based precautions for the duration of their stay.

3. **Residents who have signs or symptoms of COVID-19**, regardless of vaccination status, must be tested as soon as possible. While test results are pending, residents with signs or symptoms should be place on transmission-based precautions (TBP) in accordance with CDC guidance.

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/symptoms of COVID-19 on the resident every shift. Onset of temperature or other symptoms consistent with COVID-19 require immediate initiation of Transmission-based Precautions in accordance with the plan. At any time, the resident may rescind their decision not to be tested

5. **Other testing considerations** - In general, testing is not necessary for asymptomatic residents who have recovered from SARS- CoV-2 infection in the prior 30 days. Antigen testing is to be utilized for those who have recovered in the prior 31-90 days. Facilities should continue to monitor CMS and CDC guidance and FAQs for the latest information.

When testing capacity is available and facility spacing permits and if a high level of identified cases or exposures exist, patients/residents may [as determined by the facility] 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.

*10 days of quarantine where day 0 is the known onset of symptoms or the date of first positive SARS-CoV-2 viral diagnostic test as applicable.

Persons Under Investigation [PUI]- Individuals who have been exposed to someone who has tested positive for COVID-19 and have met designated criteria requiring transmission-based precautions (i.e., individuals who are not themselves symptomatic, but may potentially be incubating the virus) and individuals who are exhibiting symptoms of COVID-19 and are being evaluated for SARS-CoV-2 require up to 10 days of quarantine with appropriate Transmission-based Precautions and testing as designated.

Asymptomatic patients with close contact with someone with SARS-CoV-2 infection

- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. Day 1 (where day of exposure is day 0), day 3, and day 5.
- In general, asymptomatic patients do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection.

Examples of when empiric Transmission-Based Precautions following close contact may be considered include:

- Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Patient is moderately to severely immunocompromised
- Patient is residing on a unit with others who are moderately to severely immunocompromised
- Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

1. Symptomatic patients being evaluated for COVID-19

- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. Day 1 (where day of exposure is day 0), day 3, and day 5.
- Symptomatic patients require empiric use of Transmission-based Precautions while being evaluated for SARS-CoV-2.

Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

- Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing is negative.
- If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

Patient Placement

- Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom.
  - If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
- Facility could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.
- Limit transport and movement of the patient outside of the room to medically essential purposes.
- Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility and to other healthcare facilities.

Negative- Asymptomatic patient/residents with no known close contact with someone with SARS-CoV-2 infection and patients/residents who are no longer PUI and are asymptomatic.

Testing of nursing home HCP

1. CDC clarified that screening testing of asymptomatic healthcare personnel, including those in nursing homes, **is at the discretion of the healthcare facility**.
    - Complete Care will continue to test non vaccinated staff weekly while community transmission is at a level of high or substantial.
2. Facility staff, regardless of their vaccination status, are to report any of the following criteria to occupational health or another point of contact designated by the facility so they can be properly managed:
    - a positive viral test for SARS-CoV-2,
    - symptoms of COVID-19, or
    - a higher-risk exposure to someone with SARS-CoV-2 infection
3. Testing will be completed in a cyclic approach as designated by NJDOH guidance.
4. Testing Consent will be obtained from each employee.
5. Retesting of HCP will be completed in accordance with the CDC guidance, amended and supplemented.
6. 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.
7. 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. An outbreak investigation is initiated when a single new case of COVID-19 occurs among the residents or staff to determine if others have been exposed. Testing during an outbreak would be determined in accordance with CDC guidance.

2. An outbreak investigation *would not* be triggered when a resident with known COVID-19 is admitted directly in to TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP are discontinued.
3. Upon the identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). The facility has the option to perform outbreak testing through two approaches: contact tracing, or broad-based.

    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 30 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**: regardless of vaccination status, with signs or symptoms must be tested as soon as possible. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance.
    - **Staff**: regardless of vaccination status, with signs or symptoms must be tested as soon as possible.

Testing is completed as soon as possible, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. Testing should be completed in accordance with the recommendations by local health department (LHD).

2. If there is a newly identified COVID-19 positive staff of resident in a facility that can identify close contacts, then:

    - **Residents**: regardless of vaccination status, who had close contact* with a COVID-19 positive individual must be tested.
    - **Staff:** regardless of vaccination status, that had a higher-risk exposure** with a COVID-19 positive individual must be tested.

Testing is completed on Day 1 – Day 3 – Day 5 or in accordance with the recommendations by local health department (LHD).

3. If a newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts, then:

    - **Residents**: regardless of vaccination status, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility) must be tested.
    - **Staff**: regardless of vaccination status, 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.

Testing is completed on Day 1 – Day 3 – Day 5 or in accordance with the recommendations by local health department (LHD).

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**: Routine testing of asymptomatic staff is no longer recommended but may be performed at the discretion of the facility.

If no additional cases are identified during the broad-based testing, room restriction and full PPE use related to empiric use of transmission-based precautions 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 any room restriction and full PPE use related to empiric use of transmission-based precautions, 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 PPE 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.

8. Return to Work Criteria for HCP

1. HCP with Confirmed SARS-CoV-2 Infection

HCP with mild[1] to moderate[2] illness who are _not_ moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed), **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.

Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP who were asymptomatic throughout their infection and are _not_ moderately severely immunocompromised could return to work after the following criteria have been met:

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

Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP with severe[3] to critical[4] illness who are _not_ moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 10 days and up to 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 below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

Test-based strategy

HCP who are symptomatic could return to work after the following criteria are met:

- 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 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

HCP who are not symptomatic could return to work after the following criteria are met:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

2. HCP Exposed to Individuals with Confirmed SARS-CoV-2 Infection

Exposures that might require testing and/or restriction from work can occur both while at work and in the community. Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure.

Higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

Following a higher-risk exposure, HCP should:

- Have a series of three viral tests for SARS-CoV-2 infection. Test at day 1 (where day of exposure is day 0), day 3, and day 5.
- 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 is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include:

- HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure;
- HCP is moderately to severely immunocompromised;
- HCP cares for or works on a unit with patients who are moderately to severely immunocompromised;
- HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions;

If work restriction is recommended, HCP could return to work after either of the following time periods:

- HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following a higher-risk exposure is negative.
- If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

[1]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.

[2]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.

[3]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%.

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

9. Visitation

1. Visitation is permitted in all phases.
2. Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. During peak times of visitation and large gatherings (e.g., parties, events) physical distancing is encouraged. Guidance or direction on how to structure visitation to reduce the risk of COVID-19 transmission may be directed by the local health authorities.
3. Face Coverings and masks during visits: If the county COVID-19 Community Transmission Level is high, everyone in a healthcare setting should wear face coverings or masks. If the county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility could choose not to require visitors wear face coverings or masks while in the facility, except during an outbreak. Regardless of the community transmission level, residents, and their visitors when alone in the resident's room or in a designated visitation area, may choose not to wear face coverings or masks and may choose to have close contact (including touch). If a roommate is present during the visit, the visitor is encouraged to wear a face covering or mask.
4. Indoor Visitation during an Outbreak Investigation: While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Face coverings or masks are encouraged during visits and visits should ideally occur in the resident's room. Visitor movement in the facility may be limited. Visitors should maintain social distancing from other residents and staff, when possible. Guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation may be directed by the local health authorities.
5. Visitors are not required to be tested or vaccinated (or show proof of such) as a condition of visitation.

6. 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.
7. 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.
8. 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.

10. 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.

11. 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

Revised: June 21, 2020

CDC Interim Infection Prevention and Control Recommendations for HCP During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022

Department of Health & Human Services, CMS, QSO-20-38-NH Revised: 9/23/22

Department of Health & Human Services, CMS, QSO-20-39-NH Revised: 9/23/22

Updated: 8/24/ 2020, 12/18/2020, 1/ 6/2021, 1/28/2021,
2/24/2021 8/20/2021, 2/3/2022 ,3/1/2022, 4/28/22, 9/23/22, 11/4/22, 11/21/22