Crystal Lake
HEALTHCARE & REHABILITATION

PANDEMIC INFLUENZA/COVID-19 PREPAREDNESS & READINESSPLAN

Revised on October, 2021

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INTRODUCTION

The Centers for Disease Control and Prevention (CDC) defines a pandemic as a global outbreak of disease that causes serious illness and spreads from person to person worldwide, causing devastating, widespread mortality. This occurs when a newly emerging virus develops the ability to transmit from person to person.

HOW THE CORONAVIRUS/INFLUENZA BECOMES A PANDEMIC

A new virus subtype occurs when there is a major and sudden change in the virus due to that is termed Antigenic Shift. This comes about because of a process called Viral Re-assortment, which refers to the mixing of genes from both a human and animal subtype. There is concern that the coronavirus/influenza virus may mingle with human strains in human hosts or in intermediate hosts such as pigs or cats. It would then mutate and develop genetic characteristics of both the animal and human strain, and a new subtype would emerge with the ability to transmit from one person to another.

When a new coronavirus/influenza subtype appears, there would be little or no immunity to the virus among humans, and present vaccines would be ineffective. New routes of transmission such as persons traveling worldwide would spread the disease from areas where the virus is endemic. The virus would then spread very quickly throughout the world, causing serious disease and a high rate of mortality, and a worldwide pandemic would ensue.

PANDEMIC PERIODS

To help in determining the imminence of the next flu pandemic, the World Health Organization (WHO) has defined a progression of periods that describe the phases of an influenza pandemic. These phases are as follows:

INTERPANDEMIC PERIOD	**Phase 1:**	• No new virus in humans • Virus subtype present in animals causes human infections • Risk of human infection is low • Exception: persons who have contact with the animals or their excrement
	Phase 2:	• No new virus subtypes • An animal subtype circulates • Increased risk of human disease
PANDEMIC ALERT PERIOD	**Phase 3:**	• Human infections with a new subtype • No person-to-person transmission • Rare instances of spread to close contacts
	Phase 4:	• Small, highly localized cluster(s) of transmission • Limited person-to-person transmission • Virus not yet well-adapted to humans • Not yet genetically compatible for easy person-to-person spread
PANDEMIC PERIOD	**Phase 5:**	• Cluster(s) will grow • Person-to-person transmission remains localized • Increasingly better adapted to humans • May not yet be fully transmissible from person to person • Larger, localized clusters
	Phase 6:	• Full-blown coronavirus/influenza pandemic • Increased and sustained transmission • High mortality rate • Spread outward from the cluster locations • Periods of sporadic disease activity (Pandemic waves)

RESPONSE COORDINATION TEAM

PURPOSE: To plan appropriately for preparedness, with input from facility departments.

POLICY: A committee will be formed with individuals representing facility departments and will meet regularly to discuss preparedness issues.

I. REPRESENTATION:

The following individuals will be needed to serve on the Response Coordination Team:

- Facility Administrator – Susan Smith
- Director of Nursing – Patricia Lindo
- Assistant Director of Nursing- Amaris Reeves
- Medical Director – Dr. Joshua Shua-Haim
- Facility Infection Control/Education – Timothy Grau
- Maintenance Director- Marvin Worthy
- Dietary Services – Juan Castillo
- Pharmacy Services - Jennifer Regaspi, Pharma Care Kathleen Batchelor
- Therapy Services- Mina Lim
- Transportation Services – Responsive
- Purchasing Agent – Budget purchasing
- Human Resources – Misti Secula
- Activities Director- Linda Dellapetrio
- Director Social Services – Frances Rodriguez
- Director Admissions – Kelly Lerche
- Dietician – Wleid Hussein
- Ocean County Department of Health - 732-341-9700
- NJ Department of Health – 609-292-7838/After Hours – 609-392-2020
- Berkeley Township OEM –732-341-1132
- Ocean County OEM – 732-341-3451 Michael Mastronardy
- **Hospitals:**
    - Community medical center– 732-557-8000
    - Ocean Medical Center – 732-840-2200

II. MEETINGS

The committee will meet regularly and discuss the following:

A. Current situation in the community
    1. Pandemic phase/update
    2. Mortality and spread of the influenza virus
    3. Any other surveillance data needed

B. Current preparedness level by department
    1. Use checklists to measure Progress
    2. Measure against standards set in plan

C. Policies to change or revise

D. Update on availability of vaccine
    1. Priority groups-High Risk and Immunocompromised residents
    2. Projected time for availability

F. Update on availability of effective oral antivirals (e.g. Tamiflu)

III. RESPONSIBILITIES

It is recommended that tasks pertaining to individual departments be assigned to the heads or representatives of those departments.

G. Administrative and management
H. Allocation of funds
I. Preparedness written plan/checklist by department
J. Liaison with local public health official
K. Surveillance - community and center
L. Employee education
M. Resident & family education
N. Prevention
O. Preparing for influx of infectious residents
P. Hospitalization policies
Q. Vaccine/employee health
R. Counseling
S. Availability of human resources/use of alternate staff.

RESPONSE COORDINATION TEAM-ROSTER

NAME	DEPARTMENT	PHONE/EXT	RESPONSIBILITIES
Susan Smith	Administrator	732 269 0500 EXT.2103	Direct all Efforts/Ensure compliance
Patricia Lindo	Director of Nursing	EXT. 2121	Lead Triage
Susan Smith	QAPI Director	EXT. 4023	Ensure Compliance
Timothy Grau	Infection Control/ Education	EXT. 2127	Communication, Team meeting leader, Employee health coordination/Education. Resident/Staff testing.
Misti Secula	HR Director	EXT. 2138	Assist in Staff counseling during crisis, assist with staffing needs, training volunteers to basic policies. Track staffing and needs of the facility.
Juan Castillo	Director of Food Service	EXT. 2212	Ensure proper nutrition to residents, and staff if needed, when quarantine in place, and ensure supplies are enough.
Marvin Worthy	Director of Environmental Services/ Maintenance	EXT. 2119	Ensure cleaning of infected areas. Ensure maintenance of areas and equipment.
Linda Dellapietro	Activity Director	EXT. 2136	Enlist Volunteers to aid in basic resident care, assist in coordination of Quarantine Areas and communication of residents with families. Virtual visitation coordinator.
Missy Reeves	MDS Director	EXT. 2167	Assist as needed to support and relieve if no quarantine is present.
Frances Rodriguez	Director of Social Services	EXT.2137	Help residents and families to cope with pandemic.

ADMINISTRATIVE MEASURES

PURPOSE: To ensure that administrative measures are taken to facilitate preparedness in the center.

POLICY: The center will take the appropriate administrative measures necessary to ensure that there are adequate resources in the event of a respiratory pandemic.

I. DEPARTMENT C O O R D I N A T I O N

A. Center resources will be evaluated to determine needs.

B. Departments and units may be asked to share resources.

II. ALLOCATION FUNDS

A. Budgeting will be done to determine the dollar amount of resources needed in the event of a respiratory pandemic ie. coronavirus/influenza. These resources may include:
   I. Staffing
   2. Treatment options
   3. PPE's
   4. Equipment
   5. Vaccine/antiviral drugs
   6. Patient/employee counseling

B. If a quarantine is instated, administration will take an active role in determining allocation of human and financial resources.

III. EXTERNAL COMMUNICATIONS

A. A person will be designated as being responsible for external communications about respiratory pandemic.

B. A contact will be established with the local, state, or regional public health officer.

C. Communications between local and regional healthcare centers will be handled by maintaining a list of contact numbers of public health and/or local and regional hospitals.

D. Offering alternative means for communication for people who would otherwise visit, such as virtual communications (phone, video, virtual communications).

IV. INTERNAL COMMUNICATIONS

A. Administration will manage internal communications pertaining to all staff. (i.e., in the event of a quarantine, administration will communicate the plan to employees.)

B. Administration will delegate responsibility for communications pertaining to specific departments to the heads of those departments.

C. Administration will interface with all department heads to ensure smooth communications between departments.

D. There may need to be a system in place for communications with the residents. A person may need to be delegated to handle this.

STAFFING

PURPOSE: To ensure that facility is prepared for a possible decrease of qualified staff during a pandemic.

POLICY: Staffing shortages during a pandemic will be planned for, considering alternate employees to provide resident care and other tasks. A multidisciplinary team will be in charge of planning and resident care training. The unit charge nurses will be in charge of supervision of alternate employees. Department managers will supervise alternate personnel for their departments.

I. General Staff Management

A. Assign responsibility for the assessment and coordination of staffing during an emergency.

B. Estimate the minimum number and categories for personnel needed to care for a single resident or a small group of residents with Covid-19/influenza complications on a given day.

C. Collaborate with local and regional healthcare-planning groups in an attempt to achieve adequate staffing.

I. Determine whether and how staff will be shared with other healthcare centers.

2. Determine how salary issues will be addressed for employees shared between centers.

3. Consider ways to increase the number of home healthcare staff to reduce hospital admissions during the emergency.

D. State and local health departments can help assess the feasibility of recruiting staff from different healthcare centers and/or regions, working in coordination with federal centers, including Veterans Administration and Department of Defense hospitals.

E. Increase cross-training of personnel to provide support for essential resident care areas at times of severe staffing shortages.

F. Create a list of essential support personnel titles (e.g., environmental and engineering services, nutrition and food services, administrative, clerical, medical records, information technology, laboratory) that are needed to maintain center operations.

G. Have staffing agencies as a backup for staffing shortages during pandemic.

II. Sick Employees

A. A system will be established for detecting signs and symptoms of Covid-19/influenza in employees before they report for duty.

B. If an employee develops symptoms during work duties, they should be given treatment and/or prophylaxis and sent home or to a designated

area for sick employees.

C. Employees who have been ill but have recovered will be given care of residents with Covid-19/influenza.

D. There will be an effort to assure that employees not perform patient care for both infected and non-infected residents.

E. Employees who fall ill during the pandemic will be excluded from caring for residents who are not infected.

F. If the sick employee feels well enough to work, they should be allowed to care for only those residents who have been infected.

G. If hospitalization is required for any sick employees, and the employee's symptoms do not require supportive or extensive treatment, they may be allowed to convalesce in a designated area in the center for sick employees.

III. Staff Management During Quarantine Periods

A. There could be one of two types of quarantine put into effect, depending on public health decisions:

1. Quarantine that prohibits movement of all persons from their current location.
2. Quarantine that prohibits movement outside a city/county perimeter.

B. If either of these quarantines is in place, the staffing manager will need to consider:

1. All employees in duty at the center when the quarantine goes into effect will be offered accommodations during the quarantine period. These accommodations can be in the form of pallets or cots in an area not being used for beds for the ill.
2. A designated area for sick employees will be established to care for those employees who fall sick on the job. These accommodations may need to be makeshift, and might be located in areas not normally used for that purpose.
3. Employees who are not at work when the quarantine goes into effect will be required to stay at home. Provisions may need to be in place for a long-term absenteeism, and finance departments may need to determine how individuals who remain at home will be paid.

IV. Alternate Employees

A. Staffing may consider the use of employees not usually involved in resident care to perform basic patient care with supervision.

I. Employees from other departments:

a. Housekeeping
b. Food Service
c. Maintenance
d. Counseling
e. Administrative

2. Staff who may have retired or resigned but are willing to work
3. Trainees or nursing students
4. Resident's family members in ancillary healthcare capacity (can help to solve problem of resident feeling isolated from a long separation during quarantine periods)

B. Volunteers from the community

1. Volunteers should be recruited and trained in early planning. A list of potential volunteers should be maintained to make sure there will be sufficient time to contact them when the pandemic begins.
2. Sources from which volunteers may be recruited:
    a. Churches/faith-based community organizations
    b. Corporate volunteer programs
    c. Media/public service announcements
    d. Civic organizations

C. Training for alternate employees

1. A basic resident care training program will be established to for alternate employees.
2. The volunteer's duties will include only those tasks which do not require a registered nurse or physician or other professional.
3. Training will include infection control measures such as hand hygiene, Standard Precautions and use of Personal Protective Equipment (PPE).
4. Training should also include blood borne pathogens and Tuberculosis, as required by OSHA

D. Alternate employee's screening/supervision

1. All alternate employees who perform resident care will be under the supervision of the charge nurse.
2. Alternate employees will be used for resident care only if staffing is inadequate to perform these tasks.
3. Alternate employees will be screened for Covid-19/influenza symptoms before allowing them to care for residents who are not infected.
4. Alternate employees will be offered vaccine and/or prophylaxis, if available, and as availability and priority dictates.
5. Alternate employees will be offered vaccine for other types of pathogens (including blood borne pathogens).

INFLUENZA

EMPLOYEE EDUCATION AND TRAINING

PURPOSE: To ensure that all healthcare workers receive education and training or pandemic flu preparedness.

POLICY: An employee training program will be instituted to educate all employees about the influenza virus, prevention, vaccination, and preparedness in the center. This program should be in place before a pandemic occurs, and should be updated regularly so that employees will be apprised of the current worldwide situation

I. **Influenza Virus:** All employees will receive training on:

A. Influenza

B. Pandemic phases

C. Influenza disease

1. Signs and symptoms
2. Modes of transmission
3. Prevention methods
4. Treatment

II. **Facility's Preparedness plan** for Crystal Lake Healthcare Center will be communicated to employees

A. The facility's written preparedness plan will be outlined for all employees as their job duties dictate.

B. All employees will be given information on who to contact if a situation arises for which managerial/administrative assistance is required.

III. **Current situation:** all employees will receive updated information on the status of the influenza pandemic:

NOTE: An Employee bulletin board or newsletter, or Banner on COMS may be used to provide continuous updates.

A. Community, regional, national and worldwide situation

B. Influenza surveillance data

C. Current estimations on morbidity and mortality of a flu pandemic

D. Estimated imminence of a flu pandemic, or current pandemic phase as defined by World Health Organization (WHO)

IV. **Prevention:** all employees will receive training on preventing transmission of influenza within the facility by their Department Directors as well as the Infection

Preventionist, including:

A. Droplet Precautions

NOTE: CDC may recommend Airborne and/or Strict Isolation. Many centers do not have the ability to provide these precautions. Public health will have to notify centers if it is considered safe to adapt these precautions to rooms that do not have negative pressure.

B. Personal Protective Equipment (PPE)
C. Hand hygiene
D. Respiratory hygiene/cough etiquette

V. **Vaccine:** all employees will be educated on the value of regular vaccinations and the status of a vaccine for the pandemic strain.

A Regular flu season vaccine

1. Vaccine in regular flu season is important in reducing disease spread
2. Viral re-assortment risk is lowered when human strains are controlled
3. Vaccine and antiviral drugs help reduce complications

B. Availability/priority groups as determined by Public Health

C. Update on vaccine development for pandemic strains

INFECTION PREVENTIONIST AND/OR ID DOCTOR

PURPOSE: Reporting and liaison with public health officials

POLICY: A plan will be in place for surveillance of the pandemic Covid-19/flu virus in the center. The Infection Preventionist will oversee this function. Pandemic Covid-19/influenza surveillance should be an on-going process in the center, and should be initialized during the interim pandemic phases.

I. Public health data will be accessed on a regular basis to keep apprised of the current situation, on a local nation and worldwide basis.

II. Surveillance will be done within the facility, collecting information on:

   A. Regular flu season cases in non-pandemic periods

   B. Incoming residents - confirmed or suspected cases with the pandemic strain

   C. Number of new Covid-19/influenza infections within the center during a pandemic

III. A system will be in place for determining new or incoming residents who may come into the center carrying the virus. If infected, treatment options or hospitalization will be considered as symptoms dictate.

IV. Provisions will be made to differentiate the pandemic strain from other strains of Covid-19/influenza, or from other respiratory diseases.

V. Reporting of confirmed or suspected cases will be done in the event of a Covid-19/influenza pandemic, as indicated by local public health officials.

CRITERIA FOR EVALUATION OF POSSIBLE PANDEMIC INFLUENZA

PURPOSE: To establish standards for triage or resident evaluation to determine probable or suspected cases of pandemic or novel influenza, and to establish reporting procedures for any novel influenza virus.

POLICY: All employees performing triage or evaluations on residents or employees will use the following criteria for determining a suspected case of either a novel influenza virus (during Interpandemic or Pandemic Alert periods), or the Pandemic Influenza virus (during Pandemic period). All novel viruses found during interpandemic or pandemic alert periods will be reported to the appropriate authorities, and specimens properly transported to qualified laboratories for testing. See table: Clinical Evaluation of Patients with Influenza-Like Illness

I. CLINICAL CRITERIA FOR INFLUENZA

A. **Interpandemic or Pandemic Alert Periods:** These criteria are used to establish a suspected infection with a novel influenza virus strain (i.e., a strain that has not been endemic or a strain which is normally found only in animal hosts.)

1. Influenza-like Illness (ILI) (If no to either, treat as clinically indicated, but re-evaluate if suspicion):
    a. Fever (>100°F, 37.8°C) AND
    b. Sore throat, cough or dyspnea (shortness of breath)
2. If resident's symptoms meet the above criteria, the case can be considered as suspected novel influenza, and an extensive evaluation may be done (see table: Clinical Evaluation of Patients with Influenza like Illness)
3. Laboratory confirmation is only recommended for
    a. Residents requiring hospitalization OR
    b. Non-hospitalized residents with epidemiologic link (see below)

B. **Pandemic Period:** These criteria will be used to determine suspected cases of pandemic influenza during the pandemic.

1. Influenza-like Illness (ILI) (If no to either, treat as clinically indicated, but re-evaluate if suspicion):
    a. Fever (>l00°F, 37.8°C) AND
    b. Sore throat, cough or dyspnea (shortness of breath)
2. These criteria are sufficient to determine a case of probable or suspected influenza during a pandemic period, as the likelihood is very high during this time that an influenza-like illness is caused by the pandemic influenza virus. Further evaluation may or may not be feasible given the increase in patients/residents in the center.

NOTE: Respiratory illness will be the most likely from taken by the pandemic strain, but it is possible that it may present a different clinical syndrome. Updates on other clinical presentations will be provided a **www.pandemicflu.gov** and **www.cdc.gov/flu**.

II. EPIDEMIOLOGICAL CRITERIA

A. Interpandemic or Pandemic Alert Periods:

1. Travel Risk:
    a. History of travel to an affected area (human case of novel influenza virus) AND
    b. Had direct contact with influenza (e.g., touching pigs, touching surfaced contaminated with feces) OR
    c. Close contact with known or suspected human case for influenza (being within 3 feet) of person during their illness
2. Occupational Risk:
    a. Agricultural
    b. Processing or handling influenza products
    c. Laboratory workers in labs containing live animal or novel influenza viruses
    d. Healthcare workers in direct contact with suspected or confirmed novel influenza case

B. Pandemic Period:

I. If disease is widespread in the community, an exposure history will be marginally useful

2. Any case with ILI symptoms during this time period is most likely pandemic influenza
3. During a pandemic period, the above clinical criteria is sufficient for classifying the patient as a suspected pandemic influenza case.

CLINICAL EVALUATION OF PATIENTS WITH INFLUENZA/CORONA LIKE ILLNESS

During Interpandemic and Pandemic Alert Periods

Name of patient:_____	**Evaluator Name: _____**	**Date: _____**
Hospitalization required?	**Yes**	**No**
If no to above, outpatient with strong epidemiological risk factors and mild or moderate illness?	**Yes**	**No**
Meets above criteria for influenza-like illness?	**Yes**	**No**
If Yes to all of the above, AND no alternative diagnoses:	**Yes**	**No**
Travel to an area affected by influenza		
Direct contact with influenza	**Yes**	**No**
Close contact with suspected or confirmed cases of novel influenza	**Yes**	**No**
Occupational exposure to novel influenza virus (e.g. healthcare, agriculture, laboratory activities)	**Yes**	**No**
Immunization History (for seasonal influenza/pneumococcal vaccination)		**Date**
Type:		
Diagnostic testing: • Collect all of the following specimens, place in viral transport media & refrigerate at 39.2"F until specimens can be transported for testing • Immediately contact the local and state health departments to report suspected case and arrange for novel influenza testing		
Specimen:	**Collected**	**Result**
Nasopharyngeal swab, nasal swab, wash or aspirate		
Other diagnostic testing: (dependent on clinical presentation and underlying health status)	**Date Performed**	**Result**
Pulse oximetry		
Chest radiograph		
Complete blood count (CBC) with Differential		
Blood cultures		
Sputum (in adults), tracheal aspirate, and pleural effusion aspirate (if effusion is present) Gram stain and culture		
Antibiotic susceptibility testing (encourage for all bacterial isolates)		

Multivalent immunofluorescent antibody testing or PCR of nasopharyngeal aspirates or swabs for common viral respiratory pathogens		
Adults with radiographic evidence of pneumonia, Legionella and pneumococcal urinary antigen testing		
Testing for M. pnuemoniae and C. pneumoniae (if accessible) (adults & children< 5 yrs. With radiographic pneumonia)		
Comprehensive serum chemistry panel if metabolic derangement or other end-organ involvement (e.g. liver or renal failure) is suspected		

INFLUX OF INFECTIOUS PATIENTS

PURPOSE: To ensure that the facility is prepared for a massive inflow of infectious patients/residents

POLICY: Provisions will be made to prevent overcrowding and to ensure that such an inflow of infectious patients does not overstretch the center's resources.

I. Information will be regularly collected on:

   A. Capacity of facility

   B. Number of empty beds

   C. Patient care equipment

   D. Availability of treatment options

   E. Availability of vaccine and antiviral drugs

   F. Staffing resources

II. Provisions will be made to ensure that all of the above resources exist in sufficient quantity and are adequately distributed for each unit

III. Provision will be made for residents requiring hospitalization

   A. Resident transport

   B. Lists of hospitals with contact information

   C. Communicate with public health regarding surge capacity of area hospitals

IV. Alternate bed areas may be set up as needed for excess patients/residents

   A. May be located in areas such as dining hall, dayrooms or recreational areas. The areas may also be used for sick employees.

   B. Hospitals may ask center to take hospital overflow patients into requiring supportive treatment

   C. Consider designating one of these areas for all confirmed or suspected cases, keeping them separate from those who have been infected.

PREVENTION

PURPOSE: To help prevent new transmission of the virus in the center.

POLICY: Droplet precautions will be observed for all residents. The possibility exists that additional precautions will be recommended by CDC. All employees will use appropriate infection control measures, including had hygiene, use of Personal Protective Equipment (PPE), and respiratory hygiene/cough etiquette. Compliance will be monitored by the charge nurses or supervisors for each unit.

I. Droplet Precautions

A. Prevents contact of the conjunctiva or mucous membranes of the nose or mouth of susceptible person with large-particle droplets from a confirmed or suspected case of influenza

B. Droplets may be generated by the resident's coughing, sneezing, talking or during the performance of procedures, e.g. suctioning.

C. Personal Protective Equipment indicated in Droplet Precautions:

1. **Gloves-** as needed; perform hand hygiene before and after use; discard after each resident.
2. **Goggles or Face Shield-** if infected person is coughing or sneezing.
3. **Gown-** if there is a risk of contamination of clothing.
4. **Mask-** worn if within 3 feet of infected resident.

D. Hand Hygiene

1. Perform hand hygiene before and after treating each resident.
2. Perform hand hygiene when coming into contact with contaminated objects or surfaces
3. Hand hygiene may be either alcohol hand rub or soap and water

II. Resident Cohorting

A. Cohorting of influenza cases- there will be an effort to place all confirmed or suspected influenza cases in a room with other confirmed or suspected cases.

B. If cohorting is not feasible, maintain spatial separation of at least 3 feet between infected resident and other residents.

C. Visitors should be discouraged or limited as much as possible. (Consider recruiting family member to remain in center and assist with resident care if family member desires).

III. Respiratory Hygiene/Cough Etiquette

A. Signs and posters will be placed in strategic locations throughout the center, illustrating the need for appropriate respiratory hygiene, or "Cough Etiquette".

B. Tissues, alcohol hand rubs and other articles needed for respiratory hygiene will be placed in strategic locations

C. Visitors, residents, and employees will be encouraged to observe good

respiratory hygiene to help reduce transmission of the virus.

D. Visitors and residents will be offered a mask for their protection. They should refrain from visiting if they are coughing or sick with flu-like symptoms.

E. Respiratory hygiene entails the following.

1. Cover the nose/mouth when coughing or sneezing
2. Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use
3. Perform hand hygiene after having contact with respiratory secretions and contaminated objects/materials
4. Sit at least 3 feet away from others if they are coughing
5. Wear a mask if within 3 feet of someone who is coughing

IV. Environmental Measures

A. Resident rooms/bed areas

1. Special air handling and ventilation are not necessary (unless recommended by public health during the pandemic).
2. Door may remain open (unless recommended by public health during the pandemic).
3. Beds will be placed at least 6 feet apart, if feasible, when in resident rooms or alternate bed areas.

B. Laundry/linen

1. Routine procedures will be used for laundering all laundry and linen.

C. Infectious waste

1. Routine policies and procedures will be used in handling waste.

D. Environmental cleaning & disinfection

1. Resident care areas, rooms, and bed areas will be cleaned regularly
2. Persons performing cleaning and disinfection will wear the appropriate Personal Protective Equipment (PPE) and discard after completion of each resident room.
3. Increase cleaning of high touch surfaces/areas.

E. Resident care equipment

1. Resident care equipment will be cleaned and disinfected after use, as indicated by manufacturer's recommendations and routine policies.
2. If resident care equipment is for one use only, it will be discarded after use.

V. Resident Transport

A. Limit the movement and transport of the infected resident

B. If transport is necessary, masking the resident may minimize dispersal of droplets

INFLUENZA VACCINE

PURPOSE: To help prevent new transmission of the virus in the center.

POLICY: Droplet precautions will be observed for all residents. The possibility exists that additional precautions will be recommended by CDC. All employees will use appropriate infection control measures, including had hygiene, use of Personal Protective Equipment (PPE), and respiratory hygiene/cough etiquette. Compliance will be monitored by the charge nurses or supervisors for each unit.

RATIONALE: The influenza virus is an extremely adaptable organism, with the ability to mutate using characteristics of other strains that exist in its host. The process of Viral Reassortment allows the virus to mix its genetic material with other strains and eventually a new strain will emerge. Humans will have little or no resistance to the new strain, and it will cause disease with a high rate of morbidity and mortality. Steps taken to reduce outbreaks of the disease and its complications before viral reassortment occurs will lower the change that the virus can mutate.

I. REGULAR FLU SEASON VACCINE

A. Employees and residents will be encouraged to be vaccinated for the influenza virus during the regular flu season

B. Routine vaccinations can prevent prevalence of the disease, reduce the risk of viral reassortment and delay the overall progress of a pandemic.

C. Antiviral chemoprophylaxis can help control the severity of disease and prevent transmission in those who have been infected. Priority will be dictated by current CDC recommendations and availability.

II. PANDEMIC FLU VACCINE

A. Pandemic flu vaccine, when available, will be offered to healthcare workers and residents as available.

B. Antiviral prophylaxis may be indicated for health care workers

C. Availability of the vaccine will be limited:

1. It could be as long as 6 to 8 months after the pandemic begins before a vaccine is available against the pandemic strain.
2. The vaccine is likely to be in short supply at first.

D. Availability will be targeted to defined priority groups as defined by CDC.

RESIDENT AND EMPLOYEE COUNSELING

PURPOSE: To ensure that emotional needs of employees and resident are met in the event of an influenza pandemic.

POLICY: Provisions will be made by the center's Social Services Department to offer emotional counseling for residents and employees during an influenza pandemic.

I. It is likely that a pandemic would have a devastating effect on the morale of residents and employees.

IL There will be drastic changes that occur in the community, especially if a quarantine is in place. This may incite panics or false alarms.

III. As mortality rates begin to mount, this will have a debilitating effect on the level of service that employees can provide for the residents.

IV. Employees will be overworked and over-fatigued, which will cause emotional stress added to the fear the pandemic induces.

V. Employees will need to learn how to cope with the loss of their fellow workers or with residents under their care who may die from the disease.

VI. Residents will be frightened, confused, or grief-stricken if other residents succumb to the disease and die.

VII Residents will need to be assured that the center is taking all precautions to minimize transmission, and that adequate resources will be available.

VIII. A good counselor would help to keep the level of panic down and prevent situations of unrest among the residents.

IX. Centers may consider holding discussion groups involving all residents and/or employees so that they may all talk about the issues involved and share ideas.

X. Those who grieve for lost loved ones may require more individual counseling.

COVID-19

Description: Typical COVID-19 symptoms include fever, cough, and shortness of breath. Other symptoms can be very mild and might include fatigue, muscle or body aches, headache, loss of sensation of smell and/or taste, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea. Additionally, experience with outbreaks in nursing homes has reinforced that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms.

Suspect COVID-19 case: individual with clinical illness as described above.

Confirmed COVID-19 case: an individual with a positive SARS-CoV-2 PCR or a positive SARS-CoV-2 antigen test, regardless of signs and symptoms.

COVID-19 Outbreak: One or more confirmed cases of COVID-19 in a resident or staff member. A single COVID-19 case in a resident admitted < 3 days will NOT be considered an outbreak, unless otherwise determined by the local or state health department.

Testing/Laboratory Diagnosis:

- Relationship with a CLIA-certified lab is in place to provide adequate COVID-19 testing to meet needs of the facility for both resident and staff testing.

- Rapid SARS-CoV-2 testing with results in 15 minutes is in place for residents and staff.
- Written procedures for addressing residents or staff that decline required testing or are unable to be tested are in place.
- Staff and residents are tested in accordance with NJDOH, CDC, CDS guidance.

PHASES OF COVID-19

Phase 0: Any facility with an active outbreak of COVID-19, as defined by the Communicable Disease Service (CDS), per the COVID-19 Communicable Disease Manual Chapter, any facility that cannot attest to criteria to advance phases, and all facilities in New Jersey is in maximum restrictions per the *Road Back to Recovery:* https://covid19.nj.gov/faqs/nj-information/reopening-guidance-and-restrictions/when-and-how-is-new-jersey-lifting-restrictions-what-does-a-responsible-and-strategic-restart-of-new-jerseys-economy-look-like

Phase 1: Facilities that never had an outbreak or that concluded an outbreak and 14 days have passed since New Jersey moved to Stage 1 (May2, 2020) of the *Road Back to Recovery* and the facility has submitted all the attestations required in Executive Directive No. 20-026.

Phase 2: Facilities that never had an outbreak or that concluded an outbreak and 14 days have passed since New Jersey moved to Stage 2 (June 15, 2020) of the *Road Back to Recovery* and the facility has submitted all the attestations required in Executive Directive No. 20-026.

Phase 3: Facilities that never had an outbreak or that concluded an outbreak and 14 days have passed since New Jersey moved to State 3 (DATE TBD) of the *Road Back to Recovery*, and the facility has submitted all the attestations required in Executive Directive No. 20-026.

REQUIRED STANDARDS FOR SERVICES DURING EACH PHASE

I. Phase 0:

1. Screen and log all persons entering the facility
2. Entry of non-essential personnel is prohibited. Those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers are prohibited from entering the building.
3. Screen all residents for signs of symptoms of COVID-19 by monitoring vital signs.
4. When facility is experiencing an outbreak, communal dining and all group activities are limited. Residents stay in their rooms as much as possible and cohort in accordance with CDS.
5. Avoid non-medically necessary trips outside the building. For medically necessary trips away from the facility, the resident must wear a cloth face covering or facemask.
6. Perform ongoing weekly testing of all staff until guidance from NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive should be re-tested according to CDC and CDS guidance.

II. Phase 1:

1. Screen and log all persons entering the facility.
2. Entry of non-essential personnel is prohibited as above.
3. Restrict communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.
4. Restrict group activities in general. Limited activities may be conducted for COVID-19 negative and asymptomatic or COVID-19 recovered residents only in their small groups.
5. Avoid non-medically necessary trips outside the building. For medically necessary trips away from the facility, the resident must wear a cloth face covering or facemask.
6. Screen all residents, at a minimum daily.
7. Continue to perform ongoing weekly testing of all staff until guidance from NJ DOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive should be re-tested according to CDC and CDS guidance.

III. Phase 2:

1. Screen and log all persons entering the facility.
2. Indoor visitation by appointment is allowed. Visitors must be screened and logged.

3. For medically necessary trips away from the facility, the resident must wear a cloth face covering or facemask.
4. Entry of non-essential personnel/contractors into the building is permitted. Personnel/contractors must be logged, screened, and must follow infection prevention and control precautions, including social distancing, cloth face coverings or facemasks.
5. Limit communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.
6. Limit group activities to no more than 10 people, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only.
7. Maintain infection prevention and control measures including social distancing and source control measures.
8. Continue to perform ongoing weekly testing of all staff until guidance from the NJ DOH changes based on epidemiology and data about the circulation of virus in the community.
9. Screen all residents, at minimum daily, with temperature checks, questions and observations for other signs or symptoms of COVID-19.

IV. Phase 3:

1. Resume indoor visitation. Screen and log all persons entering the facility and all staff at the beginning of each shift.
2. Allow entry of non-essential healthcare personnel/ contractors. All must be screened and must follow infection prevention and control precautions, social distancing, hand hygiene, and cloth face coverings or facemasks.
3. Allow entry of volunteers, based on screening and including infection prevention and control precautions, social distancing, hand hygiene, and cloth face coverings or facemasks.
4. Screen all residents, at minimum daily, with temperature checks, questions and observations for other signs or symptoms of COVID-19 and test if symptomatic.
5. Limit communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.
6. Resume group activities, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only.
7. Maintain infection prevention and control measures including social distancing and source control measures.
8. For medically trips away from the facility the resident must wear a cloth face covering or facemask.
9. Continue to perform ongoing weekly testing of all staff until guidance from the NJ DOH changes based on epidemiology and data about the circulation of virus in the community.

PREVENTATIVE MEASURES AGAINST COVID-19

Personal Protective Equipment (PPE) Use and Infection Control

- As part of source control efforts, healthcare personnel (HCP) and essential visitors must wear a facemask covering at all times while they are in the facility.
- If tolerated, residents wear mask coverings if they leave their rooms and when they are within six (6) feet of anyone else, including staff members.
- All staff must wear appropriate PPE when indicated in accordance with CDC guidance on optimization of PPE.
- All staff follow Infection prevention and control measures, including hand hygiene and selection and use of the appropriate PPE for Standard and Transmission-based Precautions.
- Educate staff on the appropriate and safe use of PPE and have HCP demonstrate competency with putting on and removing PPE.
- Program for observing and monitoring adherence to hand hygiene and PPE, all days and shifts is in place.
- Dedicate equipment (e.g., blood pressure cuffs, pulse oximetry sensors, etc.) to each resident, particularly those on transmission-based precautions, as much as possible. Clean and disinfect shared equipment between residents.

Ensure Adequate Supplies for Infection Prevention and Control Practices

- Assess supply of PPE and initiate measures to optimize current supply.
- PPE are rapidly available and kept well-stocked in areas where resident care is provided.
- Alcohol-based hand sanitizers are available in common areas.
- Sinks are well-stocked with soap and paper towels for handwashing.

Management of Staff

- Staff with symptoms should not report to work. Signs and symptoms of COVID-19 can be very mild, so even mild signs of illness should result in HCP exclusion. Crystal Lake Healthcare Center has non-punitive sick leave policies and procedures in place that allow staff to stay home while symptomatic.
- We observe and enforce social distancing among staff, including in hallways, break rooms, and outdoors. We ensure staff are wearing masks and consider eye protection when interacting with each other.
- Crystal Lake Healthcare Center continues to screen all staff at the beginning of each shift. Screening includes performance of temperature checks, observing for signs and symptoms of COVID-19, including temperature $\geq$100.0F, while working must keep their facemask on, inform their supervisor, and leave the workplace as soon as possible. Symptomatic staff members must be tested for COVID-19.
- Crystal Lake Healthcare Center performs ongoing weekly testing of all COVID-19 negative staff or as otherwise required. Re-testing staff who previously tested positive is done in accordance with CDC and CDS guidance.

- Crystal Lake Healthcare Center is prepared for staff shortages; we have arrangements with staffing agencies in place.

Enhance Surveillance to Identify Infections Early

- We actively screen all residents daily for fever and new or worsening symptoms of COVID-19; immediately isolate anyone who is symptomatic in a single-person room on contact and droplet precautions. Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Additional symptoms may include new or worsening fatigue, muscle or body aches, headache, loss of sensation of smell and/or taste, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.
- We maintain provided by the local health department line list of all residents and staff with positive COVID-19 if any.

Prepare to house COVID-19 cases, residents exposed to COVID-19 cases, and suspect COVID-19 cases

- Determine the location(s) of the COVID-19 care unit(s) and create a staffing plan.
- Desirable characteristics include:
    - Physical separation from other rooms or units housing residents without confirmed COVID-19. Can be a separate floor, wing, or cluster of rooms.
    - Separate entrance and a door that can be closed, if possible.
    - Separate PPE donning and doffing area. Separate staff restroom, break room, and work area, as available.
    - Dedicate equipment such as vitals machines and carts for the unit.
- Staffing:
    - Plan to dedicate staff to work only on the COVID-19 care unit, especially nursing staff, but also environmental staff, therapy staff, and other staff if possible.
    - Train these staff members on infection control, donning and doffing of PPE, extended use and limited re-use of PPE (when allowed), cleaning and disinfection of surfaces in resident rooms, hallways, and staff areas, and cleaning and disinfection of equipment between uses.

Admissions and Re-admissions

- Crystal Lake Healthcare Center has dedicated observation/quarantine area to house new non-COVID-19-positive residents being admitted, or current residents being re-admitted from an outside facility where the resident spent 24 hours or longer, or after leaving for 24 hours or longer. This area has private rooms with private bathrooms.
- This unit will provide dedicated staff, if feasible.
- Residents are screened for COVID-19 symptoms prior to admission or re-admission using at least the following methods:
    - One negative COVID-19 test result from the transferring facility
    - In-house rapid COVID-19 test performed upon admission

- Temperature taken (cutoff for fever is ≥100.4F)
- Questions asked about symptoms, e.g. fever, cough, shortness of breath, fatigue, muscle or body aches, headaches, loss of sensation of smell and/or taste, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.
- If a new or re-admitted resident screens and/or tested negative for COVID-19, they should be admitted to the observation unit/area for 14 days; a negative test result does not mean that the resident was not exposed, and it is still possible that they could develop symptoms.
- If a new or re-admitted resident screened/tested positive for COVID-19, they will be isolated to a private room in the dedicated area for suspect COVID-19 patients.
- Residents in the observation unit are placed in isolation using contact and droplet precautions.
- Residents in the observation unit are monitored daily with temperature and symptom checks.
- After 14 days on the observation/quarantine unit, if the resident does not ever screen positive for COVID-19 symptoms, they can be relocated to the general population.

Visitor Restrictions (unless otherwise allowed based on a facility entering a reopening phase as specified in NJDOH guidance):

- All visitors should be restricted from entering the facility except for in extenuating circumstances (e.g., a resident is at the end of life).
- Crystal Lake Healthcare Center screens all persons who enter the facility (e.g., staff, volunteers, vendors, and visitors when permitted) for signs and symptoms of COVID-19, including temperature checks. Crystal Lake HealthCare prohibits entrance to anyone screening positive for symptoms of COVID-19.
- Visitors that are permitted inside must wear a facemask or cloth face covering while in the building. Visitors should perform frequent hand hygiene.
- Limited outdoor visitation may be permitted in certain circumstances:
    - See NJDOH Executive Directive NO. 20-026
    - Cancel communal and all group activities in the facility, unless otherwise allowed based on a facility's phase in the Road Back to Recovery.
    - Residents who have signs or symptoms of illness, are on a COVID-19 observation unit, or with suspected or confirmed COVID-19 (including those without symptoms) must remain in their room with the door shut if possible until they have been cleared from observation or Transmission-Based Precautions.
    - For the purpose of increased physical activity, on a limited basis residents may be allowed outside of their room or outside of the building if the following conditions are met:
        - There is adequate staffing to supervise residents.
        - Residents must be masked anytime they are out of their room, as feasible; staff must also be wearing appropriate PPE.
        - Residents must stay at least six (6) feet apart from others.
        - Residents who are on transmission-based precautions should

not leave their rooms except for medically necessary purposes.
    - Have all residents who leave their rooms, including those who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis) wear a facemask or cloth face covering if tolerated when outside of their room, including for procedures outside of the facility.
    - Avoid transferring residents between units, except as needed for proper cohorting.
    - Remind residents not to congregate in hallways or other areas. Remind residents not to share food, drinks, or personal items.
- Staff:
    - Avoid the floating of staff between units, if sufficient staffing levels. Dedicate staff to a single unit as much as possible.
    - Cohort staff who care for COVID-19-positive residents. When feasible they should avoid providing care for other residents in the facility.
    - Employ strategies to limit traffic between units. For example, have dietary staff deliver food to the entrance of the unit and have unit staff deliver trays.
    - Non-nursing staff that enter the rooms of the residents should follow the facility Standard and Transmission-Based Precautions.

Communications

- Crystal Lake Healthcare Center has established internal and external communication protocols in the event of a COVID-19 case being identified in the facility.
- Response Coordination Team is in place in the event of a suspected or confirmed case (e.g. ensuring vigilant infection control).
- An updated phone tree with public health communicable disease contacts and leadership contacts is place readily accessible.
- Frequent and ongoing communication with all staff is in place.

Memory Care

Caring for residents with dementia presents a formidable challenges to maintain social distancing, movement restrictions, and other infection prevention measures. Changes in routines, environments, and caregivers can result in anxiety and behavioral changes.

- Try to maintain routines while reminding and assisting residents to perform frequent hand hygiene and to wear face masks or face coverings as tolerated.
- Provide activities that can be conducted in residents' rooms or at staggered times to maintain social distancing.
- Attempt to redirect and remind residents not to congregate if they walk around the unit.
- Clean and disinfect frequently touched surfaces regularly.

Rehab Therapy Rooms

- Rehab therapy rooms may be opened for physical activity if the following considerations are met:
    - There is adequate staffing to supervise residents during out-of-room therapy.
    - Only one resident and one staff member at the time are allowed in the rehab therapy room.
    - Residents will be masked anytime they are out of their room, as feasible; staff must also be wearing appropriate PPE.
    - Residents will stay at least six (6) feet apart from others.
    - The rehab therapy room and equipment will be thoroughly cleaned and disinfected between each use.
    - Residents who are on Transmission-based precautions will not leave their rooms except for medically necessary purposes.

WHEN YOU HAVE SUSPECTED COVID-19 CASE(s)

Preventative measures implemented before a suspended/confirmed case still apply

Admissions and transfers

- Facility will remain open to new admissions unless specifically instructed otherwise by public health officials.
- Transport personnel and any facility receiving residents with suspect COVID-19 will be verbally notified about the suspected diagnosis prior to transfer.
- While awaiting transfer, symptomatic residents will wear a facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE will be used by HCP when coming in contact with the resident.

Environmental Cleaning

- In general, only essential personnel enter the room of patients with COVID-19. Nursing personnel could be assigned to perform daily cleaning and disinfection of high-touch surfaces due to being already in the room and providing care to the residents.
- Frequently touched surfaces (e.g., tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones) will be disinfected frequently and as needed with an EPA-registered disinfectant on List N.
- Facility environmental services staff will follow Standard Precautions and any appropriate Transmission-Based Precautions while performing daily cleaning of resident rooms; if this includes rooms of residents with suspect or confirmed COVID-19, PPE must include eye protection.
- To the extent possible, facility will use dedicated medical equipment for residents with fever or signs or symptoms of COVID-19. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to the facility policies.

Care of Residents

- Resident(s) with suspected case will be placed in a private room with a private bathroom, if possible. If the suspect case had a roommate, the roommate should also be kept in a separate room without a roommate. Unless COVID-19 and observation units or units for suspected cases have been set up, do not move the residents between units. Do not move a resident to the COVID-19 unit unless they test positive. Perform in-house Rapid test.
- Facility uses Standard, Contact and Droplet precautions with eye protection (i.e., gown, gloves, face mask, and face shield or goggles) for residents with signs or symptoms consistent with COVID-19.
- Aerosol-generating procedures should be avoided. If unavoidable, they will be performed in a private closed room with a closed door while wearing appropriate PPE (i.e., gown, gloves, N95 or higher-level respirator, and eye protection).

When You Have Suspected Staff Case(s)

- Perform testing of any symptomatic staff members.
- Conduct contact tracing to identify residents and staff who had close contact with the suspect or confirmed case. For any staff who had possible close contact with the suspect or confirmed case, in consultation with the local health department, follow CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.

WHEN YOU HAVE A CONFIRMED COVID-19 CASE

Preventative measures implemented before confirming a COVID-19 case still apply.

When a COVID-19 case is confirmed

- If the new case is in a resident, staff will move the resident to the unit dedicated to the care of COVID-positive residents.
- If the new case is in a staff member, facility will ensure the staff member is excluded from work and, in consultation with the local health department, follows CDC's Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19.
- Facility will perform an investigation to identify other potentially exposed individuals:
    - For any staff who had possible close contact with the confirmed case, in consultation with the local health department, facility will follow CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.
    - Residents who had close contact with a confirmed case within 48 hours of the case's symptom onset will be moved to the observation/quarantine unit (if asymptomatic), or if available, a unit for persons under investigation for COVID-19 (if symptomatic). If such a unit is not available, isolate the resident in a private room.

    - As part of outbreak investigation and in consultation with public health, the facility will consider additional interventions for residents with unknown levels of exposure to the case or who are at risk for exposure to the case that do not meet the strict definition of a close contact, e.g.,:
        - Increase use of PPE by staff caring for these residents to include gloves, gowns, N95 respirator.
        - Quarantine these residents for 14 days after the last possible exposure, with increased monitoring of residents for new symptoms of COVID-19, dedicated staff, and dedicated equipment is possible.
- Facility will increase monitoring of all residents in the facility by assessing for new or worsening symptoms, taking vital signs and oxygen saturation via pulse oximetry at least 3 times daily for all residents.
- Facility will dedicate staff to each resident care area and avoid floating of nursing staff between resident care areas to avoid spreading COVID-19 to different areas of the facility.
- Facility will ensure universal mask use and consider universal eye protection for staff. Residents will wear masks when outside of their rooms or within six (6) feet of another person.
- Facility will reinforce hand hygiene practices and respiratory etiquette for staff and residents.
- Facility will re-educate staff about and observe the correct donning and doffing of PPE.
- Facility will enforce social distancing among staff in hallways, breakrooms, and outdoors.
- Housekeeping department will conduct enhanced environmental cleaning of frequently touched surfaces frequently.
- Facility will conduct additional staff and resident testing as describe below.
- Facility will ensure ongoing compliance with strict visitor restrictions.
- Facility will communicate frequently and transparently with public health.

Note: Risk for exposure among residents will vary in each individual situation and might depend on how well staff have been adhering to infection control guidance. Examples of residents who might be at risk for exposure without having close contact with a confirmed case might include the following: roommate of a case, residents cared for by the same nursing staff as a case, or residents housed on the same hallway or wing as a case.

Testing

Residents:

- Facility will continue weekly testing of all residents until no new facility-onset cases* of COVID-19 are identified among residents and positive cases in staff **and** at least 14 days have elapsed since the most recent positive result **and** during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative.
- Retesting of residents who have been confirmed positive whenever required according to CDS and CDC guidance

**Facility onset SARS-CoV-2 infections refer to SARS-CoV-2 infections that originated in the facility. It does not refer to the following:*

- *Residents who were known to have COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.*
- *Residents who were placed into Transmission-Based Precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.*

Staff:

- Facility will continue weekly testing of all negatively tested staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community.
- Retesting staff who have previously tested positive according to CDC and NJDOH guidance: http://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html.
- Any resident or staff who is newly symptomatic consistent with COVID-19 must be retested at the onset of symptoms, regardless of the interval between the most recent negative test and symptom onset.

Refusal of Testing

- Staff who refuse testing will be prohibited from entering the facility until such staff member has had and can show proof of a negative test result and agrees to follow facility testing procedures.
- Residents may exercise their right to decline testing. Staff will use person-centered approaches and involve family members/responsible party as appropriate when explaining the importance of testing to residents. Residents will be monitored for signs and symptoms, monitor for appropriate social distancing from other residents, monitor face coverings as tolerated and monitor effective hand washing technique. Residents may be offered different types of testing (nasal swab vs. saliva) as available.

Staff Exclusion

- Staff with COVID-19 will be excluded from work. They will follow NJDOH/CDC "NJ Residents with a positive COVID-19 test instructions and next steps."
- If facility is in Crisis Capacity and facing staffing shortages, contracted staffing agencies will be utilized for meeting staffing needs to provide safe care to residents while infected staff are excluded from work.

Personal Protective Equipment (PPE)

- All staff must wear appropriate PPE, including use of procedure or surgical facemasks (i.e. not cloth coverings) whey they are interacting with residents, to the extent PPE is available and consistent with CDC Guidance on Optimization of PPE:
    - Residents on COVID-19 observation/quarantine unit – gloves, gown, KN95 respirator or facemask, eye protection.
    - Residents with suspect or confirmed COVID-19 – gloves, gown, N95

respirator or facemask, if N95 respirator is unavailable, eye protection.
    - Residents in the general population – facemasks and Standard Precautions and Transmission-Based Precautions based on underlying diagnoses and presence of colonization or infection with multidrug-resistant organisms. NJDOH or the local health department might provide alternate recommendations in an outbreak setting.
- Other essential visitors must wear a facemask or cloth face covering at all times while they are in the facility.

Discontinuation of Transmission-Based Precautions and Staff Return-to-Work

- Outbreaks are considered concluded when there are no symptomatic/asymptomatic probable or confirmed COVID-19 cases after 28 days (2 incubation periods) have passed since the last case's onset date of specimen collection date, whichever is later, as defined and updated per the NJDOH COVID-19 Communicable Disease Manual: ED NO. 20-025, p.2.
- Symptom-based strategy for determining when HCP can return to work as per CDC 's Criteria for Return to Work for Healthcare Personnel:
    - *HCP with mild to moderate illness who are not severely immunocompromised:*
        - At least 10 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.

Note: HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their positive viral diagnostic test.

- *HCP with severe to critical illness or who are severely immunocompromised:*
    - At least 10 days and up to 20 days have passed *since symptoms first appeared.*
    - 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
    - Consider consultation with infection control experts

Note: HCP who are **severely immunocompromised** but who were **asymptomatic** throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

Communications

- Facility will inform residents (and family members or other persons who serve as designated decision makers for residents) and staff of confirmed case(s) with prepared communication materials. Information updates will be provided by 5 PM 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.
- Facility will provide alternative means of communication when in-person visits are not permitted, such as virtual communications (phone, video-communication, etc.)
- Facility will have assigned staff as primary contact to families for inbound calls, and conduct outbound calls to keep families up to date (e.g., "virtual visitation coordinator").
- Facility's website/social media pages will be updated at minimum on a weekly basis, to share the status of the facility and include information that would help families know what is happening in the loved one's environment, such as food menus and any scheduled activities.
- Facility will discuss response to confirmed case(s) with public health authorities. Line list will be updated and sent to local healthcare department daily.
- Staff/Leadership rounds at the facility are in place on every shift to ensure staff have an opportunity to discuss concerns with leadership.
- Facility will coordinate public communications with state and local authorities.

LESSONS LEARNED – OUTBREAK OF COVID-19

Supplies

- N95 masks – develop plan to control usage.
- Isolation Carts
    - Facility may need 2 or 3 times the number we normally have
- Isolation Trash Cans – double or triple the numbers we normally have
    - Facility will also need the same increase in red bags for bio-waste and extra bags for linen to double bag.
- Gowns
    - One option is to use re-washable cloth gowns.
- Gloves
    - Not usually a supply problem

Develop plan to move and cohort patients based on status; including those with fever (likely COVID-19+); confirmed COVID-19+; and/or comfort care.

- Ideally, an entire unit would be cleared and ready to accept COVID patients
- Next to ideal: set aside a hallway to accept COVID patients
- Basic: designate rooms at the end of a hallway for COVID patients.
- Do not underestimate how much time and personnel will be involved in moving patients
    - Increase staff and hours in housekeeping
        - They will need to be prepared to quickly deep clean any room vacated by COVID-positive or suspended residents
    - Designate personnel to move beds
        - Ideally this would involve maintenance, nursing or CNA staff

Develop a spreadsheet to track all patients under suspicion for COVID. Minimum data would include:

- Unit/Room number
- Name
- Age
- Onset of symptoms
- Resolved/End of quarantine
- Date of testing
- Results of testing
- Hospitalization
- Date of death

Start goals of care conversations early. Talking points:

- Comfort care in a familiar setting by nurses, aids and doctors that know resident

history, personality to ensure comfort and dignity at the end of life.

- Ensure resuscitation and transfer preference information is clearly marked/accessible for all healthcare workers.

Local Health system should consider obtaining a list of employed medical staff that support local nursing facilities as secondary roles. This information may be critical for communication if there is an outbreak at a specific facility.

- Facility should consider assessing the % of staff that have secondary positions at other nursing facilities as if there is an outbreak, facility's staffing may be reduced by this amount.

Acting fast

- After restricting visitors, staff and newly admitted residents will be the main source of COVID-19 in the facility. COVID-19 symptoms could be delayed, initially mild, and widely varied. Be able to test residents and staff quickly became crucial; in-house rapid testing of residents and staff in place helped staff quickly initiate a contact investigation to isolate and to prevent wide spread of the virus.

Proper communication

- Proper communication with families, residents and staff has been one of the biggest priorities for operations during pandemic. To keep families informed facility utilized additional means of communication, including virtual, phone, zoom and etc. In addition, facility has utilized facility media webpage to regularly post all facility activities for the families to be connected with their loved ones due to non-visiting time.

Assume everyone has COVID-19

- Assume everyone has COVID-19 in an outbreak until test negative. Residents exposed to infected staff should be in private rooms until their tests return negative. Exposed staff should not return to work until they test negative and remain asymptomatic.

Prevent spreading

- After controlling outbreak , focus on measures to prevent spread in the event that an asymptomatic carrier of COVID-19 comes to work, such as:

    Daily surveillance/health screening of both staff and residents for COVID-19 symptoms and exposures.

APPENDIX A
Outbreak Management Checklist for COVID-19

Outbreak Management Checklist for COVID-19

Facility Name:	
Address/City/Zip Code:	
E-number (Investigation Number):	
Telephone	**Fax #:**
Contact Name:	**Email:**

Outbreak Intervention	Date Instituted	Date Reinforced	Date Suspended
Communication			
Notify facility Administrator			
Notify facility Medical Director and Infection Disease Physician			
Notify Infection Preventionist			
Report any suspect or confirmed outbreak to local health department (LHD). • Camden County Health Department www.camdencounty.com: Communicable Disease Investigator – Rianna DeLuca; phone # 856-374-6051, fax# 856-374-6358			
Notify staff of the presence of a COVID-19 case and/or outbreak in the facility			
Notify patients/residents and their families, as appropriate, of the presence of a COVID-19 case and/or outbreak in the facility			
General Control Measures			
Review pandemic influenza and disaster preparedness plans to support containment and response efforts.			
Review **testing capacity** to identify SARS-CoV-2 in the facility. • Identify commercial or public health laboratories who will conduct the test(s), turnaround time, personnel who will collect the specimen(s), and appropriate specimen collection materials.			
Implement use of **universal source control measures (**e.g., cloth facial coverings) for persons (e.g., clergy, vendors, visitors) while in the facility			
Increase accessibility of **hand hygiene** resources in the facility. • Put alcohol-based hand sanitizer with 60-95% alcohol in common areas. • Make sure that sinks are well-stocked with soap and paper towels.			
Evaluate personal protective equipment (PPE) and report levels to http://report.covid19.nj.gov or any successor reporting mechanism required by NJ DOH or NJ Office of Emergency Management until registered and entering data to the CDC National Healthcare Safety Network (NHSN) COVID-19 Module.			
Daily Reporting			
Complete line list for **patients/residents.** For more information refer to LHD for COVID-19 specific line list.			
Complete line list for **staff.** (Refer to LHD for COVID-19 specific line list).			

Note: Line list should include all confirmed (i.e., COVID-19 positive, both symptomatic and asymptomatic) and probable (i.e., symptomatic, epi linked) cases. Refer to the COVID-19 *Communicable Disease Chapter* at http://www.nj.gov/health/cd/documents/topics/NCOV/NCOV chapter.pdf , for definitions. NHSN Long-term Care Facility COVID-19 Module is required by NJ DOH and CMS Nursing Homes.			
Complete NJ DOH NoviSurvey questionnaire for outbreak updates.			
Send completed line lists and facility floor plan to LHD.			
Admissions, Transfers, and Re-Admissions			
Identify area or unit to receive new and readmissions for 14-day quarantine.			
Consider closing to new admissions if you are unable to appropriately cohort. This may not include readmissions back to the facility.			
When transferring any patient/resident, **notify** the transporting agency and receiving facility of outbreak status at the facility and the patient/residents COVID-19 status.			
Note: COVID-19 diagnostic test results should be provided (in addition to other pertinent clinical information) to the receiving facility for any transferred patients/residents upon receipt of lab results. Upon identification of a case of COVID-19 in a patient/resident who was recently admitted (within 14 days), the *admitting facility* should provide these results back to the sending facility to allow for the appropriate response and investigation. Facilities should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Refer to NJ DOH *Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities at* http://www.nj.gov/health/cd/topics/covid2019 healthcare.shtml for information on cohorting including management of new and re-admissions. Re-testing individuals who previously tested positive should be done in accordance with CDC and CDS guidance (e.g.,>3months after the date of onset of the prior infection).			
Infection Prevention and Control			
Educate on infection prevention practices, including control measures for COVID-19.			

Outbreak Intervention	**Date Instituted**	**Date Reinforced**	**Date Suspended**
Infection Prevention and Control(cont'd)			
Restrict visitors, in general. Refer to NJ DOH *COVID-19 Temporary Operational Waivers and Guidelines* for state specific COVID-19 legal and regulatory compliance information at http://www.nj.gov/health/legal/covid19/.			
Restrict entry of non-essential personnel, such as those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers, from entering the building in accordance with applicable NJ DOH *COVID-19 Temporary Operational Waivers and Guidelines at* http://www.nj.gov/health/legal/covid19/.			
Evaluate all persons who enter the facility for signs and symptoms of communicable diseases, including fever (temperature checks including subjective and/or objective fever equal to or greater than 100.4F or as further restricted by facility) and other symptoms of COVID-19 (e.g., gastrointestinal upset, fatigue, sore throat, dry cough, shortness of breath). Refer to CDC Symptoms of Coronavirus for updated symptoms at http://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.			
Note: Any persons who enters Crystal Lake Healthcare Center should be advised to monitor for fever and other COVID-19 symptoms for at least 14 days after exiting the facility. If symptoms occur advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the persons they were in contact with , and the locations within the facility they visited			
Implement **active screening** of patients/residents for fever and other COVID-19 symptoms, at minimum, **each shift.**			
Note: Older adults may manifest symptoms of infection differently, especially at illness onset. Check for patients/residents with malaise, confusion, falling, diarrhea, or vomiting in addition to traditional respirator symptoms such as coughing, shortness of breath, and fever. Vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry. The facility staff should increase the frequency of wellness checks in all patients/residents and have a heightened awareness for any changes in their baseline.			

Stop current communal dining and **all group activities** such as internal and external group activities (e.g., beauty shop, physical therapy gym sessions, activities). Encourage patients/residents to stay in their room and/or cohort.			
Identify **unused space** such as therapy gym, activity, and dining rooms **to cohort** residents.			
Make necessary **PPE** available in areas where resident care is provided.			
Make adequate **waste receptacles** available for used PPE. Position these near the exit inside the room to make it easy for staff to discard PPE prior to exiting, or before providing care for another resident in the same room.			
Implement **Standard and Transmission-Based Precautions** including use of a N95 respirator or higher (or facemask if unavailable), gown, gloves, and eye protection for new and re-admissions, confirmed and suspected COVID-19 case(s), and any resident cared for by a confirmed or suspected COVID-19 positive HCP. Refer to NJ DOH *Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities at* http://www.nj.gov/health/cd/topics/covid2019 healthcare.shtml for information on PPE use in each cohort.			
Note: HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents. Universal use of appropriate PPE for eyes, nose, and mouth may protect HCP from exposure. Refer to the *NJDOH HCP Exposure to Confirmed COVID-19 Case Risk Algorithm at* https://www.nj.gov/health/cd/topics/covid2019 healthcare.shtml.			
Place appropriate **isolation signage** outside of resident(s) room.			
Dedicate equipment in isolation rooms, when able. If not possible, clean and disinfect equipment before use with another resident within that cohort.			
Evaluate internal **environmental cleaning protocols** to ensure appropriate measures are being taken to clean and disinfect throughout the facility.			
Conduct routine cleaning and disinfection of **high touch surfaces and shared medical equipment** using an EPA-registered, hospital-grade disinfectant on List N (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2).			
Consider **increasing the frequency** of routine cleaning and disinfection.			
Prioritize **rounding** in a "well to ill" flow to minimize risk of cross-contamination (i.e., beginning with standard precaution care areas and working toward transmission-based precaution, then finally outbreak rooms).			
Identify **Airborne Infection Isolation Rooms or AllRs (e.g., negative pressure rooms).**If available, AIIRs should be prioritized for residents undergoing aerosol generating procedures (e.g., cardiopulmonary resuscitation, open suctioning of airways, nebulizer therapy, sputum induction).			
Outbreak Intervention	**Date Instituted**	**Date Reinforced**	**Date Suspended**
Patient/Resident Management			
Test all previously negative residents weekly until no new facility-onset cases of COVID-19 are identified among **patients/residents and positive cases in staff <u>and</u>** at least 14 days have elapsed since the most recent positive result **<u>and</u>** during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative. • Test any resident showing new signs or symptoms consistent with COVID-19. • Re-testing individuals who previously tested positive should be done in accordance with CDC and CDS guidelines (e.g., > 3 months after the date of onset of the prior infections).			
Implement **cohorting plan** that allows for separation of residents, dedicating staff and medical equipment to each of these cohorts and allowing for necessary space to do so at the onset of an outbreak. Prefer to the NJDOH *COVID-19 Cohorting in Nursing Homes and other Post-Acute Care Settings* document at https://www.nj.gov/health/cd/topics/covid2019 healthcare.shtml.			

Identify the COVID-19 positive cohort and **place signage** that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask, if unavailable) at all times while in that area. Gowns and gloves should be added when entering resident rooms.			
Relocate laboratory confirmed COVID-19 positive residents to the designated cohort, in a **private room** with their own bathroom. If there is no designated area, the person should be in a private room with their own bathroom with door closed.			
Note: Ensure appropriate use of engineering controls such as curtains to reduce or eliminate exposures between roommates. Roommates of COVID-19 case(s) should be considered exposed and potentially infected and, if at all possible, should mot share rooms with others unless they remain asymptomatic and/or have tested negative for COVID-19 14 days after their last exposure. Refer to CDC Responding to COVID-19 in Nursing Homes at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html for additional information.			
Staff Management			
Test all COVID-19 negative staff weekly or as otherwise required. Prioritize testing of staff showing new signs or symptoms consistent with COVID-19. Re-testing staff who previously tested positive should be done in accordance with CDC and CDS guidance (e.g., > 3 months after the date of onset of the prior infection). Refer to NJDOH *COVID-19 Temporary Operational Waivers and Guidelines* for state specific COVID-19 legal and regulatory compliance information at https://www.nj.gov/health/legal/covid19/.			
Provide **source control** for all residents when providing direct care.			
Note: All residents, whether they have COVID-19 symptoms or mot, should cover their nose and mouth (i.e., source control) when around others, as tolerated. Source control may be provided with tissue, facemasks, or cloth face coverings.			
Implement use of **universal source control** (e.g., cloth face coverings or facemasks) for staff while in the facility, in addition to active screening for symptomatic staff.			
Note: Cloth face coverings are not PPE. They are not appropriate substitutes for PPE (e.g., N95, respirator, surgical mask) when PPE are recommended or required to protect the wearer. Staff who work in multiple locations may pose higher risk and should be asked about exposures to facilities with recognized COVID-19 cases. If staff develop even mild symptoms consistent with COVID-19, they must cease resident care activities, keep their mask on, and notify their supervisor or occupational health services prior to leaving work.			
Identify staff who may be at higher risk for severe COVID-19 disease and attempt to assign to unaffected wings/units.			
Educate and train staff on sick leave policies, including not to report to work when ill.			
Assess staff **competency** on infection prevention and control measures including demonstration of putting on and taking off PPE.			
Note: Review CDC's Optimizing Supply of PPE and Other Equipment during Shortages at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Contingency and then crisis capacity measures augment conventional capacity measures and are meant to be considered and implemented sequentially. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices.			
Consider **cross-training** staff to conserve resources.			
Review or develop **staff contingency plans** to mitigate anticipated shortage.			
Note: Review NJDOH COVID-19 Temporary Operational Waivers and Guidelines page at https://www.nj.gov/health/legal/covid19/ and NJDOH Guideline for COVID-19 Diagnosed and/or Exposed Healthcare Personnel at https://www.nj.gov/health/cd/topics/covid2019 healthcare.shtml.			

Resources

NJDOH COVID-19: Information for Healthcare Professional: https://www.nj.gov/health/cd/topics/covid19 healthcare.shtml
CDC Coronavirus (COVID-19): https://www.cdc.gov.coronavirus/2019-ncov/index.html
CDC Responding to Coronavirus (COVID-19) in Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html
CMS Coronavirus (COVID-19) Partner Toolkit: https://www.cms.gov/outreach-education/partner-resources/coronavirus=covid-19-partner-toolkit

APPENDIX B
Respiratory Surveillance List

Line Listing

APPENDIX C
Staff, Visitors & Vendors COVID-19 Risk Assessment Form

STAFF, VISITORS & VENDORS

COVID-19 RISK ASSESSMENT

RISK FACTORS	YES	NO
Fever and symptoms of cough and/or shortness of breath		
Acute respiratory symptoms without a reason		
Traveled outside the United States within the last month		
Had close contact with a person who has traveled outside of the United States in the last month		
Had close contact with a person who has/has a confirmed case of COVID-19		
Have a cough		
Have shortness of breath		
During the last 14 days have you traveled to any State the New Jersey has designated as an impacted State?		

Temperature_____

If you have answered YES to 2 or more questions, you will not be allowed to visit.

Print Name_____

Signature_____

Date_____ Time_____

PLEASE REMEMBER TO WASH YOUR HANDS!

Thank you for your understanding and cooperation.