- Comply with all current CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, as amended and supplemented, including Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-controlrecommendations.html and Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesmenthcp.html.
- Comply with all current CMS requirements, when applicable, as amended and supplemented.
- Implement source control as per regulatory requirements. Source control refers to use of respirators, well-fitting facemasks, or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing for all persons entering the facility. All residents, whether they have COVID-19 symptoms or not, should cover their nose and mouth (i.e., source control) when around others, as tolerated.
- A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance
- Facilities located in counties with high community transmission levels are more likely to encounter asymptomatic or pre-symptomatic individuals with COVID-19 incubation or infection. Community transmission levels can be assessed by referring to the CDC's COVID-19 Community Transmission levels, to inform public health guidance. CDC COVID Data Tracker. https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=CommunityLevels
- During high CDC Community Transmission Levels eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.
- Assess staffing needs if increased clinical support is needed to safely care for the residents
- CSH leaders shall develop contingency staffing plans to include utilization of non LTC team members to support LTC and utilizing NJDOH waivers to expand staffing
- Ensure appropriate use of engineering controls such as drawing curtains between residents to reduce or eliminate exposures from infected individuals. This is especially important when semi-private rooms must be used. Allocate private rooms to maintain separation between residents, based on test results and clinical presentation.
- For rooms on transmission based precautions; laundry should be transported to washers in plastic bags and plastic bags disposed. If plastic bags are not available use container or bags that can be disinfected after each use.
- Visitation is allowed for all residents, including pediatric and those covered by the Americans with Disabilities Act (ADA) or the Law Against Discrimination (LAD).
- Only EPA-registered disinfectants that are on the approved EPA List "N" with activity against Sars-CoV-2 (COVID-19) can be used
- Avoid fans in rooms when Special Droplet/Contact Precautions are in effect. If a fan is medically necessary, move resident to negative pressure room if available.
- Residents, staff, and visitors must be educated about COVID-19, current precautions being taken in the facility, and protective actions
- Physical distancing with physical separation of at least six feet must be encouraged at all times

Management of Residents	Facilities shall separate COVID-19 positive and negative residents (cohort):

COVID-19 Positive: Special Droplet/Contact Precautions

This cohort consists of both symptomatic and asymptomatic residents who test positive for COVID-19, regardless of vaccination status, including any new or re-admitted residents known to be positive who have not met the criteria for discontinuation of Transmission-Based Precautions. If feasible, care for COVID-19 positive residents on a separate closed unit. Residents who test positive for COVID-19 are known to shed virus, regardless of symptoms; therefore, all positive residents would be placed in this positive cohort. Rooms may be shared.

- Place residents with known or suspected COVID-19 in a private negative pressure room (if available) and keep door closed
- Negative pressure rooms, if available, should be prioritized for symptomatic residents and residents undergoing aerosol generating procedures (e.g., cardiopulmonary resuscitation, open suctioning of airways, nebulizer therapy, sputum induction)
- If negative pressure room is not available use a private room with its own bathroom, with the door closed, on the COVID + designated team (Cohort 1)
- If private room is not available cohort based on resident acuity
- Residents who are laboratory confirmed COVID-19 should not be housed in the same room as a person with an undiagnosed respiratory infection
- Remain in Special Droplet/Contact Precautions as per CSH protocol
- Roommates of COVID positive residents, and any resident identified as a close contact should be closely monitored for symptoms and tested and, if negative, again 48 hours after the first negative test and, if also negative, again 48 hours after the second negative test. Testing will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5.

COVID-19 Negative, Exposed

A. <u>Patient exposed to COVID-19:</u> Prolonged close contact during the 48 hours prior to symptom onset or if asymptomatic date of positive test.

- A close contact is considered any patient/resident/visitor having 15 cumulative minutes of exposure at a distance of less than 6 feet to an infected person during a 24-hr period or had direct contact with infectious secretions with inadequate PPE. They should be considered potentially exposed regardless of whether either/both of them were wearing masks.
- Date of exposure is day 0

1. Asymptomatic close contact COVID exposures:

   a) All identified close contact COVID exposures require testing:

   - Testing (antigen or PCR) 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, 48 hours after the second negative test.

     Testing will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5.

   - A patient who has clinically recovered from confirmed SARS-CoV-2 infection in the last 30 days typically does not require COVID testing unless they develop symptoms of COVID-19.

- A patient who has clinically recovered from confirmed SARS-CoV-2 infection in the last 31-90 days should be considered for testing. however, an antigen test instead of a PCR is recommended. This is because some people may remain PCR positive but not be infectious during this period.

b) Special Droplet/Contact Precautions can be considered for 7 full days (date of exposure is day 0) if patient cannot wear a well-fitting mask as source control for the 10 days following their exposure.

New or Re-admissions:
This cohort consists of all new and re-admitted residents from the community or other healthcare facilities.

- Newly-admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have COVID testing (antigen or PCR) immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, 48 hours after the second negative test.

  Testing will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5.

Exceptions to Consider:

- For medically necessary trips away from the facility the resident must wear a cloth face covering or facemask. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

Operational:

- COVID-19 positive persons may share a semi-private room to keep them grouped together.
- Residents who are colonized with or infected with multidrug-resistant organisms (MDROs), including *Clostridium difficile*, should not be placed in a semiprivate room or group area when possible, unless their potential roommate(s) is/are colonized or infected with the same organism(s).
- Private rooms may be allocated to isolate COVID-19 positive persons or quarantine close contacts, based on availability.
- Close curtains when performing aerosol producing procedures
- Allow for separation of residents, dedicating staff and medical equipment to each of these cohorts and allow team necessary space to do so at the onset of an outbreak
- If there are multiple cases on the LTC unit and when movement would otherwise introduce Sars-CoV-2 to another occupied unit, do not relocate them. Ensure appropriate use of engineering controls such as curtains to reduce or eliminate exposures from infected individuals. Rapid isolation is key. Once there are multiple cases or exposures on a unit, transition the unit to the appropriate cohort and

	focus efforts on rapid implementation of control measures for unaffected units (i.e., containment efforts). • Bundle tasks to limit exposures and optimize the supply of PPE • Daily - provide Environmental Services leadership with anticipated room changes due to cohorting and update as needed • Dedicate resident specific equipment and supplies. If not possible, restrict dedicated equipment to a specific cohort with routine cleaning and disinfection between resident uses. Consider labelling equipment, med carts, etc. • HCP assigned to COVID positive residents should not rotate to COVID negative residents. . This restriction includes prohibiting HCP from working on unaffected teams after completing their usual shift on the affected team. • If there is limited staffing and a team member must provide care to multiple cohorts, strict infection prevention practices must be followed which includes: ➢ Resident care should flow from COVID negative to COVID positive residents. Outbreak Recommendations: • New admissions should stop until control measures are effectively instituted. If the facility is unable to cohort; CSH will not take any new admissions or readmissions until ability to cohort is reestablished. • Consider implementing universal Transmission-Based Precautions using COVID-19 recommended PPE (i.e., NIOSH approved N95 or higher level respirator, eye protection, gloves, and isolation gown) for the care of all residents, regardless of presence of symptoms or COVID-19 status. • Refer to CDC Optimizing PPE Supplies. These strategies offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted. • Optimization strategies are meant to be considered and implemented sequentially (i.e., conventional > contingency > crisis). • Healthcare facilities should promptly resume conventional or standard practice as PPE availability returns to normal. • Maintain a clean environment: Keep med carts, nursing station, resident rooms, breaks rooms, etc. clutter free. Only essential things should be out. These areas will be disinfected regularly as per CSH policy. • Limit use of shared workstations • Bedside Report: Please give bedside report outside of each room. Remember to respect the resident's sensitivity and privacy. *Note: Consider repurposing unused space such as therapy gyms, activity, and dining rooms during this time. If the facility is unable to effectively cohort the impacted residents, then rapid isolation of the unaffected residents is imperative.*
Communal Dining	• Limit communal dining to COVID-19 negative residents only a) Residents may eat in the same room while practicing infection prevention and control precautions including physical distancing measures. This includes limiting the number of people at tables and using barriers and/or maintaining separation of space by at least 6 feet. b) When feasible, seat the same small group of residents together each day, so that each resident is in contact with the same small group. There should be no mixing of residents across these groups.

	c) When feasible, staff should be assigned to specific tables in order to minimize the number of residents they interact with and remain with that group each day, whenever possible. d) The sharing of condiments and serving utensils is prohibited. Sanitize/clean high touch surfaces (e.g. chairs, tables) between seating/meals. e) The facility should use disposable utensils and cups when possible.
Discontinuation of Transmission-Based Precautions/ Return to Work	Residents will have transmission based precautions discontinued as per Medical decision in conjunction with and NJDOH/CDC recommendations <u>Discontinuation of Transmission-Based Precautions for Patients with Confirmed SARS-CoV-2 Infection</u> The decision to discontinue Transmission-Based Precautions for patients with confirmed SARS-CoV-2 infection should be made using a symptom-based strategy as described below. The time period used depends on the patient's severity of illness and if they are severely immunocompromised. Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge from a healthcare facility. A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. <u>Symptom-Based Strategy for Discontinuing Transmission-Based Precautions.</u> Patients 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: For patients who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test. Patients 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 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 • Consider consultation with infection control experts • Note: Patients who are severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when Transmission-Based Precautions may be discontinued could be considered.

	<u>Test-Based Strategy for Discontinuing Transmission-Based Precautions.</u> In some instances, a test-based strategy could be considered for discontinuing Transmission-based Precautions earlier than if the symptom-based strategy were used. The criteria for the test-based strategy are: Patients who are symptomatic: • Resolution of fever without the use of fever-reducing medications and • Symptoms (e.g., cough, shortness of breath) have improved, and • Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). Patients who are not symptomatic: • Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). <u>Discontinuation of empiric Transmission-Based Precautions for Patients Suspected of having SARS-CoV-2 Infection:</u> • The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with suspected SARS-CoV-2 infection can be made based upon having negative results from at least one respiratory specimen tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. • If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA. • If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made using the symptom-based strategy described above. • Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions. Staff return to work managed by RWJ Barnabas Health System Corporate Care as per RWJBH Return to work policy
Entry to LTC	• In emergency situations EMS personnel shall be permitted to go directly to the resident • Signs will be posted at the entrances informing visitors that they should defer their visit: ➢ If you have a fever or have felt feverish in the last 24 hours or are experiencing COVID-19 or flu-like symptoms. Possible symptoms include, but are not limited to: ○ Fever or chills

	○ Shortness of breath or difficulty breathing ○ Muscle or body aches ○ New loss of taste of smell ○ Congestion or runny nose ○ Diarrhea ○ Cough ○ Fatigue ○ Headache ○ Sore throat ○ Nausea or vomiting ➢ If you have been diagnosed with COVID-19 within the last 10 days ➢ If you have had close contact with someone with COVID-19 infection in the last 10 days and cannot wear a mask • When visiting our facility, all visitors are expected to adhere to the following safety recommendations: ➢ Wear an appropriate face mask. We will offer you a new mask for source control or may ask you to replace your own mask with a hospital-supplied mask ➢ Clean your hands before and after your visit. ➢ Maintain social distance. • Entry of non-essential personnel (those providing elective consultations, personnel providing non-essential services {e.g., barber, hair stylist}, and volunteers) are allowed providing screening and Infection Prevention protocols including COVID vaccination requirements are met. The protocol must include, but not be limited to infection prevention and control precautions, physical distancing, hand hygiene, cleaning between clients and and the use of well-fitting source control.
Environmental Services	• Routine cleaning and disinfection procedures are appropriate. Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2, the virus that causes COVID-19: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 • Any substitute disinfection products must be approved by the Infection Prevention committee
Group Activities	• Maintain infection prevention and control precautions including physical distancing and source control measures, and limit the numbers of residents who participate • As much as possible, keep the same residents in the same group each day so that each resident is in contact with the same group, including the same staff, in order to minimize multiple interactions and remain with that group daily. • Activity items that cannot be appropriately cleaned and disinfected should not be shared between residents. For example, residents should be given their own personal bingo cards and tiles.
Outbreak and Routine COVID-19 testing	A. Residents • Perform contact tracing and testing of close contacts when a new case of COVID-19 is identified in a staff member or resident. • Retesting of residents who have been confirmed positive whenever required according to NJDOH and CDC guidance. • Transmission-based precautions are not required while COVID-19 test results are pending if testing is being required for medical appointments or transfers. • If a resident/patient refuses to undergo COVID-19 testing, then the LTC shall treat the individual as a COVID-19 suspected person, make a notation in the resident's

	chart, notify any authorized family members or legal representatives of this decision, and continue to check temperature on the resident at least twice per day. Onset of temperature or other symptoms consistent with COVID-19 require immediate cohorting in accordance with this protocol specifically in the Sars-CoV-2 testing section. At any time, the resident may request to be tested. B. Healthcare Personnel • Testing as per guidance from the NJDOH • HCP testing positive are excluded from work as per CSH policy • If HCP refuses to be tested or share the results of their test, they will not be able to work until tested or results shared.
SARS-CoV-2 testing	• Viral testing is considered screening when conducted among asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification and considered surveillance when conducted among asymptomatic individuals to detect transmission hot spots or characterize disease trends. • Authorized assays for viral testing include those that detect COVID-19 nucleic acid (nucleic acid amplification test [NAAT]) or COVID Rapid antigen. • Any resident who is newly symptomatic consistent with COVID-19 must be tested at the onset of symptoms, regardless of the interval between the most recent negative test and symptom onset ➢ If an antigen test is negative and resident is symptomatic, confirmatory testing with a nucleic acid amplification test (PCR NAAT) should be performed as soon as possible (within 1 to 2 days of the antigen test). Residents should be kept on Transmission-Based Precautions. • Be prepared for the potential to identify multiple asymptomatic residents with SARS-CoV-2 infection and make plans to cohort them. • Testing strategies may change based on available epidemiological, situational data, NJDOH and/or CMS directives and CDC guidance. • Facilities shall take appropriate action on the results including, but not limited to, the guidance below: ➢ Sending Facility: COVID-19 diagnostic test results must be provided (in addition to other pertinent clinical information) to the receiving facilities for any transferred residents upon receipt of lab results. ➢ Receiving Facility: Upon identification of a case of COVID-19 in a resident who was recently admitted (within 14 days), the receiving facility must provide these results back to the sending facility to allow for the appropriate response and investigation. • Repeat testing ➢ Residents - Retest any resident who develops symptoms consistent with COVID-19 ➢ HCP – Symptomatic HCP are excluded from entering the building and must leave. Follow up is managed by Corporate Care. ➢ Residents and staff who previously tested positive should not be retested within 3 months of last positive test ➢ For persons who develop new symptoms consistent with COVID-19 <3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended.

	➢ If an individual tests COVID-19 positive (viral test) >3 months after an initial positive test, it should be managed as a new infection or reinfection and control measures should be implemented • Use of Antigen Testing: ➢ Antigen testing is a form of viral testing and may be used as an alternative to molecular diagnostic PCR tests subject to the following parameters: ✓ Antigen testing may be used to fulfill any testing requirements and also may be used on asymptomatic individuals at the facility's discretion. Please refer to NJDOH and CDC guidance for test interpretation and to determine when RT-PCR confirmation testing is necessary. • Collecting and handling specimens ➢ For healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a gown. ➢ For healthcare providers who are handling specimens, but are not directly involved in collection (e.g. handling self-collected specimens) and not working within 6 feet of the patient, follow Standard Precautions. Healthcare providers should wear a form of source control (face mask) at all times while in the healthcare facility.
Staff	• Send ill personnel home • Sick leave policies should be flexible and non-punitive • If staff develop even mild symptoms consistent with COVID-19, offer POC COVID-19 antigen testing and staff are expected to: ➢ Cease resident care activities, leave the work area immediately and notify their supervisor ➢ Supervisor informs the facility's Infection Preventionist, and include information on individuals, equipment, and locations the person came in contact with ➢ Contact their health care provider • Identify staff that may be at higher risk for severe COVID-19 disease and attempt to assign to unaffected team • 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 personal protective equipment (PPE).
Standard Precautions	<u>For all patients in all settings</u> • Hand hygiene ➢ Hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings ➢ CDC recommends using ABHR with greater than 60% ethanol or 70% isopropanol in healthcare settings. ➢ Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. • Environmental cleaning and disinfection • Injection and medication safety

	• Use of appropriate personal protective equipment (e.g., gloves, gowns, face masks) based on activities being performed • Minimizing potential exposures (e.g. respiratory hygiene and cough etiquette • Disinfection of reusable medical equipment between each patient and when soiled as per CSH policy • Implement universal eye protection, in addition to source control and other infection prevention and control measures, for all staff and for visitors unable to maintain physical distancing when the CDC COVID Community transmission level is substantial or higher
Transmission-Based Precautions	• Special Droplet and Contact Transmission-Based Precautions should be used for all residents : ➢ COVID-19 positive ➢ COVID-19 suspected (pending COVID test) • Place Special Droplet/Contact Precautions signage prominently directly outside resident's room • Use of N95 respirator or higher, eye protection, gown and gloves required when entering resident rooms • Consider protocols for extended use and reuse of PPE, if resources are limited
Visitors	• Advise the person to limit physical contact with anyone other than the resident while in the facility. For example, practice physical distancing with no handshaking, kissing or hugging and remaining six feet apart. • CSH may require the visitor to use additional forms of personal protective equipment (PPE), as determined by the facility. • Window visits: no limit on how many visitors are permitted • Outdoor visits for all residents are allowed. • Provide graphics to assist residents and visitors in maintaining physical distancing and infection control standards • Provide instruction on hand hygiene, limiting surfaces touched and the use of PPE, and inform visitors of the location of hand hygiene stations, before the visitor enters the facility and resident's room. • Require the person to wear a CSH provided facemask. • Restrict a person from entering the facility if they are unable to demonstrate the proper use of infection prevention and control techniques • The facility must advise anyone entering the facility to monitor for signs and symptoms of COVID-19 for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals of a reported contact, and take all necessary actions based on any findings. • Visitors should be provided with the visitation guidelines upon check in

Departmental Responsibilities	
Employee Health /Corporate Care	• Monitor compliance with RWJBH Respiratory Protection Plan (compliance with OSHA standards) • Maintain oversight of staff illnesses and return to work statuses
Infection Preventionist	• At least twice weekly enter COVID-19 data into the National Healthcare Safety Network (NHSN) Long-Term Care Facility COVID-19 Module • Immediately report to Local Health Department: ≥1 facility-onset COVID-19 case in a patient/resident o Facility-onset COVID-19 infection in a patient/resident is defined as a laboratory-confirmed diagnosis that originated in the facility. Does not apply to patients/residents who were positive for COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions (TBP) OR patients/residents who were placed into TBP on admission and developed SARS-CoV-2 infection (unless there is confirmation of possible transmission or exposure through a breach in PPE). ▪ Note: In scenarios where a patient/resident has probable exposure to COVID-19 at 2 or more separate healthcare facilities, a public health investigation may be initiated at both locations (including enhanced surveillance for additional cases, contact tracing, and testing and/or quarantine of susceptible contacts). ○ ≥3 cases in HCP of laboratory-confirmed (RT-PCR or antigen) or suspect (detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight) COVID-19 cases who are epidemiologically linked (e.g., having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms) AND no other likely source of exposure is identified for at least 1 of the cases. Outbreaks are considered concluded when there are no new symptomatic/asymptomatic probable or confirmed COVID-19 outbreak-associated cases after 28 days (2 incubation periods) has passed since the last case's onset date or specimen collection date (whichever is later).
Leadership	• Facilities must continue to report testing and vaccination data as per NJDOH requirements. • LTC: Notify team members of the presence of a positive or suspected COVID-19 resident or team member • LTC: Notify residents and their guardians but no later than 5:00pm the next calendar day for the occurrence in a resident or team member of either: ➢ single confirmed or suspected infection of COVID-19 resident or team member is identified ➢ whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other • Communication Plan for families and residents

	➢ The Administrator or their designee will host a scheduled weekly family and guardian conference call open to any family or guardian to participate • Contingency staffing plan: ➢ CSH Policy: Labor Pool ➢ Contact with staffing agencies as needed.
Materials Management	• CSH has used the CDC burn rate calculator to calculate the burn rate at the peak of the COVID-19 pandemic. This burn rate was used to establish a one month stockpile of PPE. This stockpile is labeled and separated from the everyday PPE inventory • Material Management will monitor this stockpile weekly for inventory and expiration dates • If the stockpile is used Materials Management will notify the Administrator. The Administrator will notify the NJDOH. Materials Management will contact the PPE providers and/or RWJBH partner facilities to acquire additional PPE and replenish the stockpile. Material Management will notify the Administrator the stockpile has been replenished. The Administrator will notify the NJDOH.
Pharmacy	• Clean out medication bins with Oxivir 1 or bleach wipes • Report any medication shortages that may affect LTC
Therapy	• Support visits as needed
Contact Tracing of Exposed Staff and Residents	Supervisor becomes aware of a COVID positive CSH staff member: • Supervisor directs employee to complete Redcap survey: • https://redcap.childrens-specialized.org/redcap/surveys/?s=P3T3MATWMP • Corporate Care/Employee Health provides follow up to positive HCP. • Using the CSH COVID-19 Healthcare Personnel Exposure Checklist and the HCP Exposure algorithm, supervisor evaluates all possible exposures to other HCP AND patients. • HCP contact tracing: ➢ Prolonged close contact: over 15 cumulative minutes at a distance of less than 6 feet to an infected person during a 24-hr period OR having unprotected direct contact with infectious secretions or excretions of a confirmed case. Determine contacts within the period from 2 days before symptom onset (or positive test collection date in an asymptomatic infected individual) until the positive case has been effectively isolated. i. Complete exposure form and send to Infection Prevention. ii. Infection Prevention confirms High Risk Exposures and sends list of high-risk staff exposures to Corporate Care/Employee Health who then will notify employee of next steps. iii. Regarding employee exposures identified as a high-risk exposure by the facility Infection Preventionist, testing is recommended by the CDC to identify pre-symptomatic or asymptomatic employees who could contribute to COVID-19 transmission. The employee will be notified and tested by Corporate Care. • Resident contact tracing:

	➢ Supervisor identifies all residents that the positive HCP had contact with during the 48 hours prior to the positive test or when symptoms began if HCP is symptomatic. o Prolonged close contact with resident is being within 6 feet of patient for over 15 cumulative minutes during a 24 hour period. o This is irrespective of whether the person with COVID-19 or the contact was wearing a mask or whether the contact was wearing respiratory personal protective equipment (PPE) ➢ Contact Infection Prevention and Medical Provider with a list of resident names i. Residents who are identified as a close contact of a positive HCP should be assessed ii. Residents who are identified as a close contact of a COVID positive individual should be managed as above "COVID-19 Negative, Exposed" iii. Patients who have been transferred or discharged will be notified by medical provider. • Employees do NOT need to be restricted from work following exposure to COVID-19. ➢ Corporate Care manages the post exposure COVID testing and should occur immediately and at day 5-7 after exposure. • Work restrictions for employees with exposures should still be considered for those HCP who have underlying immunocompromising conditions https://thebridge.rwjbh.org/Resource.ashx?sn=COVID-19-EmployeeInformationFAQs

Lessons Learned
1. The room placement of asymptomatic COVID-19 positive long-term care residents required rooms with negative airflow. CSH converted a number of rooms at each long-term care location to negative pressure rooms. 2. CSH is always placing the health and safety of our residents and healthcare providers as the number one priority. 3. Stockpile PPE and identified cleaning equipment and supplies in sufficient numbers to manage any similar emergency 4. Maintain an effective and accurate daily count and burn rate of PPE and applicable cleaning equipment and supplies 5. Ensure there is effective backup leadership in case current leadership is unable to perform due to the effects of the emergency

Definitions	
Exposed	HCP who have PROLONGED CLOSE CONTACT with confirmed COVID-19 patient, visitor, or other HCP (e.g. within 6 feet for over 15 minutes) OR having UNPROTECTED DIRECT CONTACT WITH INFECTIOUS SECRETIONS OR EXCRETIONS of a confirmed case
Facility onset SARS-CoV-2 infections	Refers 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 or readmission and developed SARS-CoV-2 infection within 14 days after admission.
Healthcare Personnel (HCP)	All direct care workers and non-direct care workers within the LTC (e.g. nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees) contractual staff not employed by the healthcare facility), and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).
Outbreak (Resident)	≥1 facility-onset COVID-19 case in a resident - confirmed diagnosis >14 days or more after admission for a non-COVID condition, without an exposure during the previous 14 days to another setting where an outbreak was known or suspected to be occurring unless there is confirmation of possible transmission or exposure through a breach in PPE
Outbreak (Staff)	≥3 cases in HCP of laboratory-confirmed (RT-PCR or antigen) or suspect (detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight) COVID-19 cases who are epidemiologically linked (e.g., having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms) AND no other likely source of exposure is identified for at least 1 of the cases.
Outbreak concluded	No symptomatic/asymptomatic probable or confirmed COVID-19 cases among employees or residents after 28 days (two incubation periods) have passed since the last case's onset date or specimen collection date (whichever is later)
Recovered resident	A resident is considered recovered from COVID-19 only after they have met the criteria for discontinuation of isolation as defined by the NJDOH and CDC
Suspect COVID-19 person	Pending a COVID test due to reasonable suspicion of the disease (not a routine screening test). Reasonable suspicion includes symptoms consistent with COVID-19 or recent close contact with someone known to be positive.
Up to date with COVID-19 vaccine	CDC defines up to date as a person receiving all recommended COVID-19 vaccines (e.g., fully vaccinated) including any booster dose(s) when eligible based on CDC Stay Up to Date with Your Vaccines (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html).

Related RWJBH and CSH Policies:

- Infection Prevention Management of COVID-19 Pandemic

- CSH Pandemic Response Plan/Surge Plan
- General COVID-19 Information available on RWJBH Bridge

New Jersey Administrative Code 8:57

New Jersey Department of Health (NJDOH) and Local Health Department (LHD) Contact Information

Daily electronic update to the LHD to report residents (confirmed or PUI) or staff with confirmed COVID-19 by phone. Contact information for LHD can be found at: www.localhealth.nj.gov and after hours at: www.nj.gov/health/lh/documents/lhd_after_hours_emerg_contact_numbers.pdf

When LHD staff cannot be reached, the facility shall make the report by phone directly to NJDOH who will then contact the LHD. Call numbers are 609-826-5964 during business hours or 609-392-2020 on nights/weekends and holidays

CSH facility	**Jurisdiction**	**County information**
Mountainside Long Term Care	Westfield Regional Health Department	www.westfieldnj.gov/health 908-789-4070
Toms River Long Term Care	Ocean County Health Department	www.ochd.org 732-341-9700
New Brunswick Inpatient Rehab	Middlesex County Office of Health Services	www.co.middlesex.nj.us/Pages/Main.aspx 732-745-3100 *Emergency after hours: 732-745-3271*

References:

COVID-19 Patient/Resident Management in Post-acute Care Settings. NJDOH 23 January 2023.

"COVID-19 Also Known as Severe Acute Respiratory Syndrome Coronavirus 2 or SARS-CoV-2." Investigation Guidance for New Jersey Local Health Departments, New Jersey Department of Health Communicable Disease Service, Updated 29 September 2022.

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 Centers for Disease Control and Prevention. Updated 23 September, 2023. https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Diversey Products efficacy against coronavirus. Received communication of efficacy statement, February 2020.

Director Quality, Safety & Oversight Group. "Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes Center for Clinical Standards and Quality/Quality, Safety & Oversight Group." Department of Health and Human Services, CMS Centers for Medicare and Medicaid Services, 6 May 2020. www.cms.gov/files/document/qso-20-29-nh.pdf. Ref: QSO-20-29-NH Accessed July 13,2022.

Ending Isolation and Precautions for People with COVID-19: Interim Guidance. Centers for Disease Control and Prevention. Updated 31 August 2022. https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html#:~:text=Isolation%20can%20be%20discontinued%20at,and%20other%20symptoms%20are%20improving.

Executive Directive No. 21-001 (revised) – Visitation Protocols Supplementing Executive Directive No. 20-026 for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37 and Executive Directive No. 20-025 for Protocols and Conditions for Visitation of Pediatric, Developmentally Disabled, Intellectually Disabled Residents and Residents with Major Neurocognitive Disorder or Serious Mental Illness in Long-Term Care Facilities Licensed Pursuant to N.J.A.C. 8:35 https://www.state.nj.us/health/legal/covid19/3-22-21_ExecutiveDirectiveNo21-001_StandardsProtocolsVisitorsFacilityStaff.pdf Accessed July 22, 2022. ,

Executive Directive No. 21-012 (revised) – Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:36, N.J.A.C. 8:39, and N.J.A.C. 8:37 updated December 22, 2022.

Fisher, Margaret MD consultations. Active member of CSH Infection Prevention and Control Committee

Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html#:~:text=Healthcare%20providers%20should%20wear%20a,%2C%20gloves%2C%20and%20a%20gown. Updated July 15, 2022. Accessed February 24,2023.

NJDOH Quick Reference: Discontinuation of Transmission-Based Precautions for Persons with COVID-19 in Healthcare Settings. https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-QuickRef_Discont_TBP%20in%20HC%20Settings_031622.pdf 16 March 2022. Accessed 29 March 2022.

NJDOH Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Diag_Exp_HCP_Guidance.pdf 13 December 2022.

RWJBH Human Resources COVID-19 information for staff/Frequently Asked Questions https://thebridge.rwjbh.org/Resource.ashx?sn=COVID-19-EmployeeInformationFAQs