

**Children's Specialized Hospital (CSH)
SARS-CoV-2 Pandemic Plan Long-term Care (LTC)
Attachment A to IC-23**

Practices for ALL Phases at ALL times

- Implement source control. 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 areas with moderate to substantial community transmission 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 NJDOH COVID-19 Activity Level Index (CALI) Score at <https://www.nj.gov/health/cd/statistics/covid/index.shtml>. Universal eye protection in addition to source control and other infection prevention and control measures, should be instituted to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions, for all HCP and for all individuals who are unable to maintain social distancing.
- 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.
- Indoor End-of-Life, Compassionate Care, and Essential Caregiver visitation is allowed for all residents, including pediatric and those covered by the Americans with Disabilities Act (ADA) or the Law Against Discrimination (LAD), in all phases and must be preapproved and scheduled by facility
- Only EPA-registered disinfectants that are on the approved EPA List "N" with activity against Sars-CoV-2 (COVID-19) can be used
- Remove fans from rooms when Special Droplet/Contact Precautions are in effect. If 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

Cohorting	<p>Facilities shall separate COVID-19 positive and negative residents in accordance with NJDOH guidance at:</p> <p>https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Cohorting_PAC.pdf</p> <p>Cohort 1 – COVID-19 Positive: Special Droplet/Contact Precautions</p> <p>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</p>
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	<p>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.</p> <ul style="list-style-type: none"> • 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 Cohort 1 until transmission based precautions are discontinued as per CSH protocol <p>Cohort 2 – COVID-19 Negative, Exposed: Special Droplet/Contact Precautions</p> <p>This cohort consists of symptomatic and asymptomatic residents who test negative for COVID-19 with an identified exposure (i.e., close contact) to someone who was positive, regardless of vaccination status. This includes new or re-admitted residents who have tested negative and have been identified as a close contact in the past 14 days. Exposed individuals should be quarantined for 14 days from last exposure, regardless of negative test results or vaccination status. All symptomatic residents in this cohort should be evaluated for causes of their symptoms. Residents who test negative for COVID-19 could be incubating and later test positive. To the best of their ability, facilities should separate symptomatic and asymptomatic residents, ideally having symptomatic housed in private rooms. Even though symptomatic COVID-19 negative residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Asymptomatic residents should be closely monitored for symptom development. Residents who are identified as close contacts should be quarantined for 14 days and initially tested. If testing is negative, resident should be tested again 5-7 days after exposure. If testing remains negative, residents should complete the remainder of their 14-day quarantine period. Testing at the end of this period could be considered to increase certainty that the person is not infected.</p> <ul style="list-style-type: none"> • Roommates of COVID positive and suspected residents should remain in same room for 14 full days after exposure and closely monitored for symptoms • Roommates of symptomatic residents may already be exposed; it is generally not recommended to separate them given spatial limitations • Remove suspected COVID resident under investigation to a private room, place remaining residents on 14-day quarantine. If suspected COVID resident is negative, the roommates may be removed from quarantine. • Remain in Cohort 2 until transmission-based precautions are discontinued as per CSH protocol • Exposed individuals should be quarantined for 14 days from last exposure, regardless of test results • All symptomatic residents in this cohort should be evaluated for causes of their symptoms
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	<ul style="list-style-type: none"> Residents who test negative for COVID-19 could be incubating and later test positive Attempt to separate symptomatic and asymptomatic residents, ideally having one group housed in private rooms <p>Cohort 3 – COVID-19 Negative, Not Exposed: No Transmission based Precautions</p> <p>This cohort consists of residents who test negative for COVID-19 with no COVID-19 like symptoms and are thought to have no known exposures. This cohort includes all individuals who have clinically recovered from SARS-CoV-2 within 90 days of symptom onset or positive test, and all fully vaccinated individuals who have not been in close contact with a suspected or known COVID-19 case. The index of suspicion for an exposure should be low, as COVID-19 has been seen to rapidly spread throughout the post-acute care setting. In situations of widespread COVID-19 transmission in a facility, all negative persons in a facility would be considered exposed. Cohort 3 should only be created when the facility is relatively certain that residents have been properly isolated from all COVID-19 positive and incubating residents and HCP. Given facility-wide transmission levels, Cohort 3 may or may not be applicable.</p> <p>Cohort 4 – New or Re-admissions: Special Droplet/Contact Precautions</p> <p>This cohort consists of all new and re-admitted residents from the community or other healthcare facilities who are not fully vaccinated. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be clinically compatible with COVID-19. Testing at the end of this period could be considered to increase certainty that the person is not infected.</p> <ul style="list-style-type: none"> Cohort 4 residents are placed in a single room and quarantined for 14 days to monitor for symptoms that may be compatible with COVID-19 (day of admission or re-admission is considered Day 0). After 14 days without signs or symptoms of COVID-19 resident can be removed from Cohort. Testing at the end of this period can be considered to increase certainty that the resident is not infected <p>Exceptions to Consider:</p> <ul style="list-style-type: none"> COVID-19 positive persons who have not met the criteria for discontinuation of Transmission-Based Precautions should be placed in Cohort 1. Individuals who have met the criteria for discontinuation of Transmission-Based Precautions and it has been < 3 months after the date of symptom onset or positive viral test (for asymptomatic) of prior infection generally require no further restrictions based on their history of COVID-19 and may go to Cohort 3. <i>*Consideration needs to be given to determine whether there is concern that there may have been a false positive viral test, whether the patient/resident is immunocompromised, and whether there is evidence of exposure to a novel SARS-CoV-2 variant. If a resident experiences new symptom consistent with COVID-19 and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then repeat viral diagnostic testing and isolation may be warranted even if they have clinically recovered within 3 months.</i> New or re-admitted residents who are fully vaccinated and have not been in close contact with a suspected or known COVID-19 case can go to Cohort 3.
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	<ul style="list-style-type: none"> Traveling to a medical appointment does not require quarantine, so long as the resident returns the same day and no identified exposure to COVID positive individual was identified. Residents will require quarantine if they remain out of the building past 11:59pm, regardless of whether they are within or outside of the RWJBH system. 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. <p>All cohorts:</p> <ul style="list-style-type: none"> 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 <i>Clostridium difficile</i>, 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). <p>Operational:</p> <ul style="list-style-type: none"> 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 Cohort-1 or Cohort-2 should not rotate to Cohort-3 or Cohort-4. 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: <ul style="list-style-type: none"> ➤ Resident care should flow from Cohort-3 to Cohort-4, Cohort-2 to Cohort-1. Cohort-1 should be last.
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	<p>Outbreak Recommendations:</p> <ul style="list-style-type: none"> • In the event of widespread identified cases, focus should be placed on Cohorts 1 and Cohort 2. • New admissions should stop until control measures are effectively instituted. If the facility is unable to cohort; especially cohort 4, CSH will not take any new admissions or readmissions until ability to cohort is reestablished. • Implement 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. <ul style="list-style-type: none"> ➤ 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. <p><i>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.</i></p>
Communal Dining	<ul style="list-style-type: none"> • Phase 0: no communal dining permitted • Limit communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only <ul style="list-style-type: none"> 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	<p>Residents will have transmission based precautions discontinued as per Medical decision in conjunction with and NJDOH/CDC recommendations</p> <p><u>Discontinuation of Transmission-Based Precautions for Patients with Confirmed SARS-CoV-2 Infection</u></p>

	<p>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.</p> <p>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.</p> <p><u>Symptom-Based Strategy for Discontinuing Transmission-Based Precautions.</u></p> <p>Patients with mild to moderate illness who are not severely immunocompromised:</p> <ul style="list-style-type: none"> • 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. <p>Patients with severe to critical illness or who are severely immunocompromised:</p> <ul style="list-style-type: none"> • 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. <p><u>Test-Based Strategy for Discontinuing Transmission-Based Precautions.</u></p> <p>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:</p> <p>Patients who are symptomatic:</p> <ul style="list-style-type: none"> • 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
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	<p>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).</p> <p>Patients who are not symptomatic:</p> <ul style="list-style-type: none"> • 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). <p><u>Discontinuation of empiric Transmission-Based Precautions for Patients Suspected of Having SARS-CoV-2 Infection:</u></p> <ul style="list-style-type: none"> • 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. <p>Staff return to work managed by RWJ Barnabas Health System Corporate Care as per RWJBH Return to work policy</p>
Entry to LTC	<ul style="list-style-type: none"> • In emergency situations EMS personnel shall be permitted to go directly to the resident • Facilities shall screen and log all persons entering the facility and all staff at the beginning of each shift <ul style="list-style-type: none"> ➢ Temperature checks including subjective and/or objective fever equal to or greater than 100.0 F or as further restricted by facility ➢ Completion of a questionnaire about symptoms and potential exposure which shall include at a minimum: <ul style="list-style-type: none"> a) Whether in the last 14 days, the visitor has had an identified exposure to someone with a confirmed diagnosis of COVID-19, someone under investigation for COVID-19, or someone suffering from a respiratory illness. b) Whether the visitor has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC. c) Whether the visitor has traveled Internationally in the past 7 days <ul style="list-style-type: none"> • Unvaccinated individuals who do travel should get tested 1-3 days before their trip, 3-5 days after travel, and stay home and self-quarantine for 7 days after domestic travel.

	<ul style="list-style-type: none"> ➤ If travel is unavoidable, travelers should consider being tested with a viral test (not an antibody test) 1-3 days before the trip and again 3-5 days after the trip. ➤ If travelers test positive, they should self-isolate for at least 10 days and should postpone travel during that time. ➤ If travelers test negative, they should quarantine for a full 7 days after travel. ➤ If testing is not available (or if the results are delayed), travelers should quarantine for 10 days after travel. ➤ You no longer need to quarantine or get tested before/after domestic travel if you are fully vaccinated or have clinically recovered from COVID-19 in the past three months. <ul style="list-style-type: none"> ● Facilities must observe anyone entering the facility for any signs or symptoms of COVID-19, including, but not limited to: <ul style="list-style-type: none"> a) chills b) cough c) shortness of breath or difficulty breathing, d) sore throat e) fatigue f) muscle or body aches g) headache h) new loss of taste or smell i) congestion or runny nose j) nausea or vomiting k) diarrhea <ul style="list-style-type: none"> ● Prohibit entry for those who meet one or more of the following criteria: <ul style="list-style-type: none"> a) Exhibit signs or symptoms of an infectious communicable disease, including COVID-19, such as a subjective and/or objective fever (evidenced by a temperature check of the visitor equal to or greater than 100.0 F or as further restricted by facility), chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea; b) In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or someone under investigation for COVID-19, or someone ill with respiratory illness <ul style="list-style-type: none"> ➤ Excluding fully vaccinated individuals and those who have tested positive for COVID 19 less than 90 days ago c) Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH or CDC <ul style="list-style-type: none"> ● Phase 0,1: 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. ● Phase 2: Entry of non-essential personnel/contractors into the building is permitted. Personnel /contractors must be logged and screened. This includes personnel providing elective consultations and nonessential services (e.g., barber, hair stylist) as determined necessary by the facility. Such personnel are permitted access only to
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	<p>COVID-19 negative and asymptomatic or COVID-19 recovered residents. Entry of Volunteers is not permitted in Phases 0,1 &2</p> <ul style="list-style-type: none"> Phase 3: Allow volunteers
Environmental Services	<ul style="list-style-type: none"> 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 Phases 1,2 & 3	<ul style="list-style-type: none"> Group Activities not allowed during Phase 0 unless deemed medically necessary based on risk assessment 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. <ul style="list-style-type: none"> 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. Phases 1 and 2: Group size should not exceed more than 10 individuals. 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. Phases 0 and 1: Cancel field trips. Avoid non-medically necessary trips outside the building. Phases 2 and 3: Limit group activities to no more than 10 people, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only, as deemed appropriate based on facility risk assessment. Phase 3: Resume Group activities, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only
Routine Surveillance COVID-19 testing as per Executive Directive 20-026	<p>A. Residents</p> <ul style="list-style-type: none"> Repeat 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. Use post-testing protocols for residents such as cohorting of residents when indicated 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

	<p>immediate cohorting in accordance with the Plan. At any time, the resident may rescind their decision not to be tested.</p> <p>B. Healthcare Personnel</p> <ul style="list-style-type: none"> • Ongoing testing of all 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: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcarepersonnel.html • HCP testing positive are excluded from work as per CSH policy • If a 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	<ul style="list-style-type: none"> • 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 antigen. <p>Reverse transcription polymerase chain reaction (RT-PCR) molecular testing for SARS-CoV-2 infection among residents and healthcare personnel (HCP) in nursing homes has become a priority .</p> <ul style="list-style-type: none"> • Any resident or HCP 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 • 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: <ul style="list-style-type: none"> ➢ 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 <ul style="list-style-type: none"> ➢ 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 and were asymptomatic should not be retested within 3 months of last positive test ➢ Residents and staff who previously tested positive and were symptomatic should not be retested within 3 months of onset of symptoms ➢ 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.

	<ul style="list-style-type: none"> ➤ 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: <ul style="list-style-type: none"> ➤ 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: <ul style="list-style-type: none"> ✓ Antigen testing may be used to fulfill any testing requirements as per Executive Order 20-026 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 <ul style="list-style-type: none"> ➤ For providers collecting specimens or within 6 feet of persons under investigation (PUI) or suspected to be infected with COVID-19, maintain proper infection prevention and control measures and use all COVID-19 recommended PPE, which includes an N95 or higher-level respirator, eye protection, gloves, and a gown. ➤ For providers who are handling specimens but are not directly involved in collection (e.g. self-collection) and not working within 6 feet of the COVID-19 PUI, maintain proper infection prevention and control measures, including source control, and follow Standard Precautions; gloves are recommended.
Staff	<ul style="list-style-type: none"> • Send ill personnel home • Sick leave policies should be flexible and non-punitive • If staff develop even mild symptoms consistent with COVID-19, they are expected to: <ul style="list-style-type: none"> ➤ 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	<p style="text-align: center;"><u>For all patients in all settings</u></p> <ul style="list-style-type: none"> • Hand hygiene <ul style="list-style-type: none"> ➤ 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)

	<ul style="list-style-type: none"> • Reprocessing of reusable medical equipment between each patient and when soiled • Implement universal eye protection, in addition to source control and other infection prevention and control measures, for all staff and for compassionate care or essential caregiver visitors unable to maintain physical distancing when the NJDOH CALI Level is Very High/High or Moderate
Transmission-Based Precautions	<ul style="list-style-type: none"> • Special Droplet and Contact Transmission-Based Precautions should be used for all residents who are Cohort-1, Cohort-2 and Cohort-4: <ul style="list-style-type: none"> ➢ COVID-19 positive ➢ COVID-19 suspected ➢ Exposed to a COVID-19 HCP positive or suspected person ➢ Newly admitted and readmitted • 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	<ul style="list-style-type: none"> • 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. • Establish a designated area for visitors to be screened that accommodates social distancing and infection control standards. • Food is not permitted • Items for resident must be checked prior to visit • Window visits: no limit on how many visitors are permitted • Indoor and Outdoor visits: No more than two visitors are permitted at one time per resident. The facility must use appointments in order to limit the number of visitors inside the building at one time • Outdoor visits for negative and asymptomatic or COVID-19 recovered residents allowed through all phases • Indoor visits allowed during Phases 1,2 & 3 and must be preapproved and scheduled by facility • Compassionate Care visits can occur during all phases. • 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

	<p>screen the individuals of a reported contact, and take all necessary actions based on any findings.</p> <ul style="list-style-type: none">• Visitors should be provided with the visitation guidelines upon check in
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Departmental Responsibilities	
Employee Health /Corporate Care	<ul style="list-style-type: none"> • Monitor compliance with RWJBH Respiratory Protection Plan (compliance with OSHA standards) • Maintain oversight of staff illnesses and return to work statuses
Infection Preventionist	<ul style="list-style-type: none"> • At least twice weekly enter COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-Term Care Facility COVID-19 Module • Immediately report to Local Health Department: <ul style="list-style-type: none"> ➢ ≥1 probable or confirmed COVID-19 case in a resident or HCP; ➢ ≥3 cases of acute illness compatible with COVID-19 in residents with onset within a 72h period
Leadership	<ul style="list-style-type: none"> • Facilities must continue to report testing data daily through the New Jersey Hospital Association (NJHA) portal https://report.covid19.nj.gov/ • LTC: Notify team members within 12 hours of the presence of a positive or suspected COVID-19 resident or team member • LTC: Notify residents and their guardians within 12 hours but no later than 5:00pm the next calendar day for the occurrence in a resident or team member of either: <ul style="list-style-type: none"> ➢ 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 <ul style="list-style-type: none"> ➢ The Administrator or their designee will send a weekly letter via email to all residents' guardians. ➢ 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: <ul style="list-style-type: none"> ➢ CSH Policy: EM-27 Labor Pool ➢ Contact with Symmetry Workforce Solutions
Materials Management	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Clean out medication bins with Oxivir 1 or bleach wipes • Report any medication shortages that may affect LTC

Therapy	<ul style="list-style-type: none"> Virtual visits between visitors and residents will be facilitated electronically via CSH LTC policy V-2. Outdoor and Indoor visits will be facilitated via CSH LTC policy V-4 and policy V-5
Contact Tracing of Exposed Staff and Residents	<p>Supervisor becomes aware of a COVID positive CSH staff member:</p> <ul style="list-style-type: none"> Supervisor directs employee to email Employee Health/Corporate Care: COVID19Selfquarantine@rwjbh.org with Name, Facility, Employee ID, date of onset of symptoms/positive test, Phone/email contact and COVID-19 status and results if known. 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: <ul style="list-style-type: none"> ➤ 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. <ul style="list-style-type: none"> i. Complete exposure form and send to Infection Prevention. ii. Infection Prevention confirms High Risk Exposures and sends list of high-risk 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: <ul style="list-style-type: none"> ➤ 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. <ul style="list-style-type: none"> ○ Prolonged close contact with resident is being within 6 feet of patient for over 15 cumulative minutes during a 24 hour period. ○ 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 with a list of resident names ➤ Infection Prevention notifies Medical Attending of exposure to positive. <ul style="list-style-type: none"> i. Residents who are identified as a close contact of a positive HCP should be assessed

	<ul style="list-style-type: none"> ii. Place exposed residents who are currently admitted to the healthcare facility in appropriate Transmission-Based Precautions and monitor them for onset of COVID-19 until 14 days after their last exposure. iii. Patients who have been transferred or discharged will be notified by Medical Attending. • Asymptomatic fully vaccinated employees, who are not immunocompromised, do NOT need to be restricted from work for 14 days following exposure to COVID-19. <ul style="list-style-type: none"> ➤ Fully vaccinated refers to a person who is 2 weeks following receipt of the second dose in a 2-dose series, or 2 weeks following receipt of one dose of a single-dose vaccine. • Work restrictions for fully vaccinated employees with exposures should still be considered for those HCP who have underlying immunocompromising conditions <p>https://thebridge.rwjbh.org/Resource.ashx?sn=COVID-19-EmployeeInformationFAQs</p>
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Lessons Learned
<ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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)	≥2 laboratory-confirmed COVID-19 cases among HCP within a 14-day period
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.

Phases of Reopening If at any point during the public health response the state returns to the “maximum restrictions Stage”, all facilities covered by this Directive must return to the maximum restrictions of Phase zero (0)	
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 if New Jersey is in maximum restrictions per the Road Back to Recovery.
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 (May 2, 2020) of the Road Back to Recovery
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
Phase 3	Facilities that never had an outbreak or that concluded an outbreak, and 14 days have passed since New Jersey moved to Stage 3 (DATE TBD) of the Road Back to Recovery
	<ul style="list-style-type: none"> • The detection of a NEW COVID-19 outbreak returns the facility to Phase 0 regardless of the facility's current Phase

Related RWJBH and CSH Policies:

- IC-23 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 <i>Emergency after hours: 732-745-3271</i>

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Mandatory Guidelines for the Provision of Services, Group Activities, Visitation, and Testing in all Long-Term Care Facilities https://www.state.nj.us/health/legal/covid19/5-12-21_Memo_StandardsProtocolsVisitorsFacilityStaff.pdf Accessed September 24, 2021.

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