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COVID-19 Outbreak and Pandemic Plan (RS-80)

United Methodist Communities System Policy

SECTION: Resident Services

NUMBER: RS-80

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SUBJECT: COVID -19 Outbreak and Pandemic Plan

nature

SUPERSEDES: all previous of similar

POLICY

United Methodist Communities is committed to the safety and well-being of its residents and associates.

PURPOSE

To mitigate the potential for transmission and spread of COVID-19 in UMC communities.

SPECIAL INSTRUCTIONS/FORMS OR EQUIPMENT TO BE USED *(may be eliminated if no special instructions/forms/equipment apply)*

Outbreak Management Checklist for COVID-19 in Nursing Homes and other Post-Acute Care Settings

DEFINITIONS

Eye protection- goggles or a face shield that covers the front and sides of the face.

Face mask- OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA cleared, authorized by an FDA emergency use authorization. Facemasks should be used according to product

labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures.

Respirator- personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/National Institute for Occupational Safety and Health (NIOSH), including those intended for use in health care.

Source control- using respirators, well-fitting facemasks, to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing one safely; or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control.

Up to date on vaccination- is define as a person receiving all recommended COVID-19 vaccines (e.g., fully vaccinated) including any recommended booster dose(s) when eligible. Have completed a COVID-19 vaccine primary series and received the most recent booster dose recommended by CDC.

Contingency- Occurs when local resources are exhausted. It may include canceling events or activities to balance workloads; readjusting facility schedules to allow for maximization of in-house staff; adding incentives or bonuses for staff who take on additional shifts; bringing on additional staff from outside of the community (i.e., supplemental staff); and using volunteers to serve nonclinical roles to assist with critical daily tasks.

Endemic- represents the usual level of a disease within a geographic area

Epidemic- The occurrence of more cases of a disease than would be expected in a community or region during a given time period. Such as designation is not mutually exclusive with respect to an outbreak.

Pandemic- A pandemic is the worldwide spread of a new or novel disease.

PROCEDURE

Identification:

An outbreak will be identified utilizing current information from NJDOH , CDC, or CMS

- Greater than or equal to 1 probable or confirmed case in a resident or staff member
- Greater than or equal to 3 cases of acute illness compatible with COVID -19 in residents with onset within 72 hour period
- Confirm an outbreak exist
- Alert key staff; Executive Director, NHA, DON, Medical Director, Managers, Receptionist, Public Relations, Risk Management, Home Office
- Communicate what you know
- Confirm Diagnosis
- Establish case definition and start line list
- Implement control measures
- Communicate findings

- Continue surveillance

Infection Control Plan and Staff Education

- The Staff Educator to utilize just-in-time training to reinforce knowledge of communicable disease symptoms, transmission, and other important clinical information. This training should include a review of donning and doffing of appropriate personal protective equipment (PPE).
- Each community's infection preventionist and resident service staff educator will provide education on Infection Prevention and Management upon hiring of new staff, as well as ongoing education on an annual basis and as needed should a community experience and outbreak of an infectious disease.
- The infection preventionist (IP) in conjunction with the resident service staff educator will provide in-service training for all staff on infection control policies and procedures as needed for event of an infectious outbreak including CDC and NJDOH updates and guidances.
- The Infection Preventionist (IP) will conduct competency based education on hand hygiene on all staff and donning and doffing of personal protective equipment (PPE) for all staff upon hire. The IP in conjunction with resident service staff educator will coordinate annual competency education on hand hygiene and PPE.
- The Infection Preventionist/Designee will be responsible to ensure that staff is knowledgeable of appropriate isolation precaution signage and that signage is implemented in designated areas to heighten awareness on cough etiquette, hand hygiene, and other hygiene measures in high visible areas.
- The infection Preventionist will ensure appropriate signage is visible in designated areas for newly emergent infections.
- Just in time training will be conducted by the resident service staff educator and IP as needed.
- Hand Hygiene using Alcohol -Based Hand Sanitizer (ABHS) will be done ("gel in/gel out") before and after all resident contact, contact with infectious material and before and after removal of PPE, including gloves.
- Cleaning and disinfecting room and equipment will be performed using products that have EPA approving emerging pathogens.
- If an associate is ill, they are should be instructed to stay home. If associate feels ill or exhibit symptoms during their shift, in addition to continue to wear their mask, their temperature should be taken, point of care testing and PCR should be completed and they shall be sent home.
- All staff will be screened upon entering the community. Each community will verify absence of fever and respiratory symptoms, and any exposures, close contact, group gathering of staff or travel that may put them at risk.
- Associates will continually be re- educated and the following will be reinforced:
 - Strong hand-hygiene practices
 - Cough Etiquette
 - Respiratory hygiene
 - Transmission based precautions
 - Appropriate utilization of PPE as indicated

Communications

- All communications will be centralized and coordinated through a Command Center established by the executive director within the community.
- Infection Prevention Control recommendations will be discussed, and reviewed with the infection preventionist, medical director, NHA, the executive director, director of nursing and department managers.

- Additional input from other community leaders/ staff will be solicited as needed.
- Communication will be forwarded to the designated command center office for final review and dissemination.
- Workflows and processes developed will be communicated to the staff through appropriate methods.
- Huddles will be developed in collaboration with the staff educator and may take the place of policy review depending on the prevailing circumstances.
- Zoom, Texting methods will be utilized for providing staff with just in time education, up to date information, public health advisories through links to the CDC and NJ DOH, and as a hub for internal communications.
- Zoom and email methods will be utilized to communicate with families.
- Nursing will ensure clear and consistent communication with transporter and the receiving community when transferring a resident with known, suspect, or unknown COVID-19 status to a hospital, out resident community or clinic, or other health care setting.
- Remote video conferencing will be provided and coordinated by the community life director for the residents as needed.

Resident/Family Notification

- Inform residents, their representatives, and families of those residing in facilities by 5:00 P.M. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or two or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other.
- This information must:
 - Not include personally identifiable information;
 - Include information on actions to prevent or reduce the risk of transmission, including if normal operations of the community will be altered; and
 - Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever two or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Source Control

- All residents, visitors and staff are required to wear a face mask when entering the community.
- Residents and visitors should, ideally, wear a well-fitted face mask upon arrival to and throughout their stay in the community. If they do not have a face mask, they should be offered a facemask as supplies allow.
- Residents may remove their facemask when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room.
- Facemasks should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- All associates should always wear a facemask while they are in the community, including in breakrooms or other spaces where they might encounter co-workers.
- Surgical Facemasks should NOT be worn instead of a respirator if more than source control is needed.
- To reduce the number of times associates must touch their face and potential risk for self-contamination, healthcare workers should consider continuing to wear the same respirator or facemask (extended use) throughout their entire work shift, instead of intermittently switching back to a surgical mask.

- Respirators with an exhalation valve are not recommended for source control, as they allow unfiltered exhaled breath to escape.
- N95 respirator recommended for aerosol-generating procedures for all residents/clients in communities with substantial and high transmission levels.
- Associates should wear source control PPE when they are in areas of the community where they could encounter residents (e.g., dining room, common halls/corridors).
- **N95 mask should be worn anytime there is an outbreak in a healthcare setting until the local DOH closes the outbreak.**

Infection Control Plan for Residents:

- Provide education to residents and any visitors regarding the importance of handwashing and maintaining infection control protocols (social distancing, wearing of masks, and hand hygiene). Assist residents in performing hand hygiene if they are unable to do so themselves. Education should also be provided to residents to cover their coughs and sneezes with a tissue, then throw the tissue away in the trash and wash their hands.
- Monitor community transmission rates as provided by NJDOH weekly or when available for communicable diseases.
- For COVID-19, mitigations measures such as source control, quarantine/work restrictions, and screening will be the same for all individuals in applicable circumstances, regardless of whether the individual is or is not up to date with vaccinations.
- **If there is sustained community transmission:**
Encourage residents to remain in their rooms. If there are cases in the community, restrict residents to their room except for medically necessary procedures.
- If they need to leave their rooms, residents must wear appropriate PPE, perform hand hygiene, limit their movement and practice social distancing.
- Cancel group field trips, activities, and communal dining in the affected area.
- Cohort ill residents and assign them with dedicated or consistent care givers as staffing will allow.
- Resident identified with same symptoms/confirmations may be cohorted.
- Aid individual residents who may have difficulties washing hands or using hand sanitizer.
- All residents will be continually monitored to promptly detect symptomatic residents.
- Testing of newly admitted residents for communicable disease will be done accordance with either Executive Order, CMS, NJDOH or CDC requirements and recommendations.

SOURCE CONTROL GUIDE

Community Transmission Level Very High

- **Working with residents with suspected SAR-CoV-2 infection-** Gowns, gloves, eye protection, N95
- **Working with residents WITHOUT suspected or confirmed SAR-CoV-2** – N95 respirator, eye protection (source control)

Community Transmission Level High

- **Working with residents with suspected or confirmed SAR-CoV-2-** gown, gloves, eye protection, N95 respirator
- **Working with residents WITHOUT suspected or confirmed SAR-CoV-2** – ASTM level 3 surgical mask and eye protection (source control) **with no confirmed cases in the healthcare setting.**

Community Transmission Medium

- **Working with residents with suspected or confirmed SAR-CoV-2-** gown, gloves, eye protection, N95 respirator
- **Working with residents WITHOUT suspected or confirmed SAR-CoV-2** – ASTM level 3 surgical mask and eye protection (source control) **with no confirmed cases in the healthcare setting**
Community Transmission Level Low
- **Working with residents with suspected or confirmed SAR-CoV-2-** gown, gloves, eye protection, N95 respirator
- **Working with residents WITHOUT suspected or confirmed SAR-CoV-2** – ASTM level 3 surgical mask and eye protection (source control) **with no confirmed cases in the healthcare setting.**

Aerosol -Generating Procedures(AGP) and COVID-19

- a NIOSH-approved N95, eye protection, gown, and gloves must be worn when performing an AGP on residents with known or suspected COVID-19.
- The number of associates present during the procedure should be limited to only those essential for resident care and procedure support. Visitors should not be present for the procedure.
- Procedures that may generate infectious aerosols and represent a transmission risk include but are not limited to:
 - Nebulizer administration
 - High-flow oxygen delivery
 - Upon setup of nebulizer, have associates should maintain a safe distance (6 feet or greater), possibly outside the door, if safe to do so.
 - If resident can tolerate, recommend discussion with physician of feasibility of resident to switch to metered-dose inhalers with a dedicated spacer.
- **Cardiopulmonary resuscitation (CPR) in residents with known or suspected COVID-19:**
 - Clinical staff should initiate discussions about advance care directives and goals of care with all residents (or their authorized decision-maker) on arrival to a subacute or long-term care setting or with any significant change in clinical status, such as an increase in level of care.
 - When providing CPR to residents with COVID-19, clinical staff should follow guidance from the American Heart Association (AHA) and consider the following principles: Reduce provider exposure to COVID-19 and other hazards to staff:
 - All health clinical staff involved in providing CPR should wear all appropriate PPE (N95 or higher-level respirator, eye protection, gown, and gloves).
 - Appropriate PPE should be donned BEFORE performing the components of resuscitation that are aerosol-generating.
 - Where possible, CPR should be performed in an airborne infection isolation room.
 - Close the door to the resuscitation area when possible, to minimize airborne contamination of adjacent indoor space.
 - Limit clinical staff in the room to only those essential for resident care.

SURVEILLANCE

- Establish a process to screen such as "Accushield Screen" on all who enter the community (staff, admits, readmits, contractors, volunteers, visitors, etc.)to identify and manage people with suspected or confirmed COVID-19 infection per CDC and CMS guidance. Recordkeeping should follow current industry guidance.

- Use NJ DOH line list to capture key information about each case.
- Develop a plan for testing residents and staff for COVID-19, based on CMS, CDC, and NJDOH guidance.
- Maintain a low threshold for testing, particularly for those who have been exposed to or have symptoms of COVID-19, when experiencing an outbreak, or when community transmission levels are substantial or high.

Conducting Routine and Ongoing Infectious Disease Surveillance:

- Each community will establish a daily infection control meeting or utilize their daily morning meeting to identify any issues regarding infection control and prevention.
- Community acquired infections will be tracked and reported by the infection preventionist (IP).
- Staff will report new infection in the daily meeting, identify rate of infectious diseases, and any significant increases in infection rates will be addressed.
- The Infection Preventionist will review antibiotic usage, identify trends, and areas of improvement.
- Monthly infection control analysis and QAPI of trends and infection control breeches.
- All staff are to receive annual education as to the need to report any change in resident condition to supervisory staff for follow up.
- An annual infection control risk assessment to be completed by the IP and included in annual community assessment.
- Ongoing reporting to NHSN as per state and federal guideline requirements.

POLICIES:

- Each community will continue to review and reinforce existing infection prevention control and NJDOH, CMS, and NHSN reporting policies.
- Policies will be updated as may be required to ensure any new regulatory guides have been incorporated into the infection control prevention plans.
- Each community will maintain review of, and implement procedure provided by the NJDOH, CMS, and CDC that is issued at the time of each specific infectious disease or pandemic event, regarding how, when, which activities/procedures/restrictions may be eliminated, restored, and the timing of when those changes may be executed.

RESIDENT SCREENING

- Actively monitor all residents upon admission and at least daily for fever (temperature $\geq 100.0^{\circ}\text{F}$) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry.
- If residents have fever or symptoms consistent with COVID-19, implement transmission-based precautions.
- Increase monitoring of residents to twice daily with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection.
- During a community outbreak, monitor of all residents from daily to every shift to rapidly detect those with new symptoms.
- Newly admitted and re-admitted residents will be screened and tested in accordance with NJDOH, CMS and CDC requirements and recommendations.

STAFF HEALTH SCREENS

- Implement processes for staff screening, testing, exclusion, and return to work.

- Assigned staff will conduct temperature/ screening checks at resident/ visitor entry points, applying the current screening questions.
- Associates will be screened for symptoms of the infectious disease at the beginning of their shift. Associates are to self-monitor throughout their shift and report any new or emerging signs or symptoms of the infectious disease to the designated contact.
- An associate showing signs or symptoms of the infectious disease should be removed from the workplace.
- Staff should tell their supervisors when they or other staff members have symptoms of a respiratory infection, and they should be excluded from work until illness has resolved—this is especially important during a pandemic or Flu season. The infection preventionist should be immediately made aware of call outs or staff illnesses for follow up.
- Ongoing education will be provided to staff to self-monitor for signs and symptoms of contagious or communicable diseases.
If an associate experiences symptoms before the associate arrives to work that include vomiting, diarrhea, sore throat, fever, cough, then the associate shall: Notify the manager by telephone; and not report to work until screened by the infection preventionist.
- If an associate reports symptoms at work that include vomiting, diarrhea, sore throat, fever, cough, then management shall, depending on type of illness: have the associate stop work immediately, and report illness to infection preventionist for further guidance.
- **Sick associates must stay home.** Sick staff will remain off work until cleared by the infection preventionist, following the most recent NJ DOH/CDC guidelines on discontinuation of transmission-based precautions. Specific testing for COVID-19 or Influenza will be done for sick staff as appropriate.
- Communicate to staff the importance of staying home when they are sick.
- Communicate to staff the importance of being vigilant for symptoms and staying in touch with management if or when they start to feel sick.
- Staff who work in multiple locations may pose higher risks and should be asked about exposure to communities with recognized COVID-19 cases or other communicable diseases. The risks should be weighed against the need to care for the residents.

VISITOR SCREENING

- EMS personnel responding to an emergency do not need to be screened so they can attend to an emergency without delay.
- All visitors will follow all Accushield screening procedures.
- A Facemask will be offered and provided to visitors if they do not have one or should they enter the community with a cloth facemask.

VISITATION:

- Instructions will be provided to visitors before entering the community and residents' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current community policy while in the resident's room.
- UMC communities will monitor all entrances and screen those entering as per state, and federal guidance, including staff, visitors and vendors.
- If visitation is restricted by the local DOH, CMS, or CDC or an executive order, the communities will implement various, cost-free means to keep residents and their families connected during the pandemic. This includes: Face-to-face video calls, Zoom calls
Phone calls
Outdoor visitation when allowed.

Visiting Booth and window visits

- Signage at the community's entrance discourages anyone from visiting when they have a contagious infection or sick.
- Visitors who are symptomatic of communicable diseases will be denied entrance into the community.
- The Executive Director has the authority in conjunction with NJDOH to restrict or ban visitation during an outbreak.
- Compassionate visits and essential caregiver visits is allowed for residents.

Physical Barriers

- Wherever possible, install clear dividers such as a glass or plastic window or partition that can serve to protect the receptionist face and mucous membranes from respiratory droplets that may be produced upon visitors or residents' arrival at front desk or entrance.

Hand Hygiene:

To prevent the spread of infection, associates should wash hands with soap and water for at least 20 seconds or use a hand sanitizer with at least 60% alcohol to clean hands BEFORE and AFTER:

- Touching your eyes, nose, or mouth;
- Touching your mask;
- Entering and leaving the community; and
- Touching an item or surface that may be frequently touched by other staff, such as door handles, tablets, computer screens and keyboards.
- Associates should perform hand hygiene before and after all resident contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process Hand Sanitizer.

Respiratory Etiquette

- Staff, resident and visitors will be provided ongoing education on respiratory etiquette. Infectious diseases can be spread by droplets expelled from the mouth and nose, associates, residents and visitors should exercise appropriate respiratory etiquette by covering nose and mouth when sneezing, coughing, or yawning and perform hand hygiene.

Establish administrative controls

Administrative controls can be defined as policies and work rules used to prevent exposure.

Examples include:

Increasing the space between workers;

- Disinfecting procedures
- Not shaking out soiled laundry;
- Staff education training;
- Cross-train associates as appropriate to ensure critical operations can continue during worker absence;
- Limit the use of shared workstations;
- Post signs reminding associates of respiratory etiquette, masks, handwashing;
- Provide clearly designated entrance and exits;
- Establish cohorts working on same shift

Housekeeping during a designated outbreak

- Objects that are touched repeatedly by multiple individuals, such as door handles, light switches, control buttons/levers, dials, levers, water faucet handles, computers, phones, or handrails must be cleaned frequently with an appropriate disinfectant.
- Surfaces that are handled less often, or by fewer individuals, may require less frequent disinfection. The disinfection methods and schedules selected are based on specific workplace conditions.
- Housekeeping staff may be at increased risk because they may be cleaning many potentially contaminated surfaces. Some housekeeping activities, like dry sweeping, vacuuming, and dusting, can resuspend into the air particles that are contaminated with the infectious agent. For that reason, alternative methods and/or increased levels of protection may be needed.
- Cleaning and disinfecting room and equipment will be performed using products that have EPA approving emerging viral pathogens.
- Use EPA-registered hospital disinfectants to clean most surfaces and resident care areas and educate staff on the "kill time".
- Associates should sanitize their work areas upon arrival, throughout the workday, and immediately before leaving for the day.

Shared Bathrooms

- Shared bathrooms should be cleaned regularly using EPA-registered disinfectants at least twice per day (e.g., in the morning and evening and after times of heavy use).
- Make sure bathrooms are continuously stocked with soap and paper towels or automated hand dryers. Hand sanitizer could also be made available.
- Make sure trash cans are emptied regularly.
- Provide information on how to wash hands properly. Hang hand hygiene signs in bathrooms.
- Residents should be instructed that sinks could be an infection source and should avoid placing toothbrushes directly on counter surfaces. Totes could also be used for personal items to limit their contact with other surfaces in the bathroom.

• **Social Distancing**

- Limit in-person meetings
- Promote remote work as much as possible
- Encourage and require social distancing to the greatest extent possible while in the community.
- Encourage associates to minimize ridesharing. If this cannot be avoided, while in vehicles, employees must ensure adequate ventilation and facemasks are worn.
- Discourage sharing of food utensils and food with other associates and between residents.
- In areas where associates work within 6 feet of each other, computer stations should be moved or repositioned to increase distance.
- Delivery items delivered through curbside delivery as needed.

Testing

- Testing will be performed on all residents and staff as per the current guidelines issued by NJDOH, CDC, Executive Orders, and CMS based on the specific testing criteria required for the identified communicable disease.
- Each UM community have contracted with a certified laboratory service provider to ensure

routine and stat diagnostic services are readily available to test residents and associates as needed.

Quarantine

- The protocols for isolation, quarantine, and testing will be modified in response to local and national health orders.
- Care for all in quarantine using the appropriate PPE (gowns, gloves, eye protection, and NIOSH-approved N95 or equivalent or higher-level respirator).
- Quarantine all close contacts who are not up to date with all recommended COVID-19 vaccine doses and recommended boosters, even if viral testing is negative.
- Residents can be removed from quarantine after day 10 following the exposure if they do not develop symptoms OR after day 7 following the exposure if a viral test is negative for SARS-CoV-2 and they do not develop symptoms.
- The specimen should be collected and tested within 48 hours before the time of planned discontinuation of transmission-based precautions. Continue performing contact tracing if testing reveals additional cases Note: A broad-based approach.
- **Quarantine all close contacts who are not up to date with all recommended COVID-19 vaccine doses and recommended boosters, even if viral testing is negative, until there are no new cases for 10 days.**
- For COVID-19, All residents **who are not up to date** with all recommended COVID-19 vaccine doses and are **new admissions and readmissions** should be placed in quarantine, **even if they have a negative test upon admission**, and should be tested as per guidelines- immediately and 5-7 days after their admission. **Quarantine may be discontinued after day 7 if a viral test is negative for SARS-CoV-2 and they do not develop symptoms.**
- Residents who are up to date with all recommended COVID-19 vaccine doses and residents who have recovered from SARS-CoV-2 infection in the prior 90 days **do not need to be placed in quarantine but should be tested as per guidelines.**
- Residents who are not up to date with all recommended COVID-19 vaccines and boosters that routinely leave the community less than 24 hours and do not have close contact with a suspected or known COVID-19 positive person, **do not have to quarantine.**
- In the event of ongoing transmission within a community that is not controlled with initial interventions, strong consideration should be given to use of quarantine for these residents on affected households/halls, even if they are up to date with all recommended COVID-19 vaccine doses or boosters or has had COVID-19 infection in the last 90 days.

Remove from Quarantine:

- **The length of quarantine for staff and residents will be established and followed based on the type of communicable disease generating at the time and CDC, CMS, and NJDOH recommendations**

Cohorting

- Communities should do their best to designate rooms, household/halls, or floors for cohorts when available; however, any general physical separation may be acceptable. This may include one side of a household or hall or a group of rooms in a hallway or household. See UMC cohorting policy.
- Residents **colonized with or infected with multi-drug resistant organisms**, including

Clostridioides difficile, should not be placed in a semi-private room when possible unless their potential roommate(s) is/are colonized or infected with the same organism(s).

- In Assisted Living, the community will isolate the infected individual in their apartment. Appropriate PPE set up will be placed outside the resident's room in accordance with CDC, CMS and NJDOH guidelines.
- Isolation and cohorting will continue until the outbreak is resolved.

EDUCATION

- Provide education on COVID-19 and other communicable disease basics for staff, including their role in prevention and containment. (e.g., transmission, signs, symptoms, general infection control practices). Reinforce education to maintain competencies (e.g., new hires, new products, audit results, outbreak, guidance updates).
- Encourage residents and staff to remain up to date with all recommended COVID-19 vaccine doses, and recommended boosters and other pertinent vaccines such as Pneumonia and Flu vaccines. Residents and staff should be offered resources and counseled about the importance of receiving recommended COVID-19 vaccines and boosters when eligible as well as other vaccines that can prevent the spread of communicable diseases.
- When a pandemic plan or outbreak is activated, all associates will receive training which will cover all elements of this plan and the following topics:
 - The infectious agent and the disease(s) it can cause;
 - The signs and symptoms of the disease;
 - How the disease can be spread;
 - An explanation of Exposure Prevention Plan;
 - Educate staff on when to put residents into transmission-based precautions (TBP) (e.g., contact plus droplet/enhanced respiratory precautions).
 - Define "Isolation" as to physically separates someone who is sick with a contagious disease, like COVID-19, from residents who are not sick.
 - Define "Quarantine" as to physically separate and restrict the movement of residents who were exposed to a contagious disease, like COVID-19, to see if they become sick.
- Provide ongoing re-enforcement of transmission-based precaution education as needed
- Provide competency-based education on PPE donning and doffing for all staff including what to wear and when (gowns, respirator, face mask, eye protection, gloves), standard precautions, source control, and for residents in transmission-based precautions.
- As applicable, ensure compliance with respiratory protection program, fit testing, medical evaluation, and education standards. Have references on PPE donning and doffing readily available, posted in multiple locations, and at point of care.
- Provide, reinforce, and document staff education on cleaning products, including:
 - Ready-to-use or to-be-prepared (diluted/mixed) product.
 - Effectiveness against SARS-CoV-2 virus.
 - Contact (wet) time and frequency and of cleaning and disinfecting.
- Reinforce staff education on equipment cleaning:
 - Every piece of equipment that is shared between residents should be cleaned and disinfected after each use.
 - Resident designated equipment is cleaned and disinfected when soiled and according to a

schedule set by the community (i.e., after each use, daily, weekly, etc.).

- Determine who cleans which piece of equipment: when, how, and with what product.

Hand Hygiene

- Make sure that hand hygiene supplies are readily accessible at entrances and throughout the community, especially in resident care areas, hallways, and resident rooms.
- Place alcohol-based hand sanitizer dispensers near the doorways of rooms to promote hand hygiene from entry to exit.
- Provide hand hygiene training to all staff and all volunteers (e.g., food handlers, clergy, hairdressers, pet therapists, recreation therapists and others).
- Ensure staff are trained to clean thumbs, between fingers and under fingernails—these areas are most often missed when using alcohol-based hand sanitizers
- Make sure hand hygiene supplies are always available and easy to access.
- Post signs about the importance of hand hygiene in common areas. Make sure the signs are visible.
- Provide alert and oriented residents with individual hand sanitizer bottles during outbreak.

Daily Rounds

- Conduct daily unit rounds to discuss and evaluate the status of residents with an infection or who are on antibiotics.
- This is also an opportunity to review which residents have an invasive device that could be removed (such as urinary catheters or IVs) to decrease their risk for infection.
- 24/7 Monitoring Check for signs of infection in all residents on a unit where a single resident has a fever and is potentially contagious. During influenza season remain aware that people can be contagious for days prior to symptom onset. Hospitalized Resident Rounds.
- Updates on outbreak status and staffing will be discussed in daily stand-up meeting and infection control meeting.

PPE Supplies

- Ensure adequate PPE supplies are available. Ensure there is a process for tracking the amount of PPE supplies on hand and update as needed.
- Designate staff to be responsible for checking and restocking PPE supplies and maintain burn rate of PPE.
- Supplies should be placed in a central location and directly outside resident rooms with visible signage outlining what PPE should be used when Transmission-Based Precautions are in place.
- Routinely and rigorously train all staff, including environmental staff, on how to use and select PPE. Training and practice should take place at the time of hire and annually.
- Re-evaluate and reinforce PPE best practices as needed or when there are staff members or residents with an infectious disease.
- There will be regular communication between the following departments on the stock inventory of key PPE supplies: clinical, building services, executive director/NHA, Infection Preventionist and other departments when necessary.
- The stock of N95 respirators and PPE in the care settings will be monitored and centralized in

a secured designated room and PPE burn rate will be reviewed weekly in the daily stand-up meeting to ensure adequate supply.

- Post clear signage on the doors of residents who require Transmission-Based Precautions. These signs should not reveal diagnoses, specific organisms, or resident identifiers, but should state the types of precautions required and ideally what PPE should be used
- A 30-day supply of infection control personal protective equipment and supplies will be maintained in each community.
- Each community will be responsible for immediately notifying the home office Director of Risk Management when unable to obtain infection control supplies and PPE from vendors to ensure procurement of necessary equipment timely.
- If a community is unable to obtain supplies they should reach out to their local OEM and DOH.
- Review of vendor agreements will be done as needed for food, water, medications, sanitizing agents, and other supplies.

Daily stewardship rounds

- During morning meetings, review any new and existing antibiotic prescriptions for each household or care setting. This is an opportunity to evaluate indications, culture or test results, clinical response, and appropriate duration of any treatment therapy.

RESIDENT EQUIPMENT

- Dedicate equipment to individual residents, when possible, especially items that are difficult to disinfect such as gait belts and lift slings.
- Dedicate equipment for use with residents known to have COVID-19.

Reporting/ Contact Tracing

- Infection Preventionist will comply with NJ DOH reporting requirements through the CDRSS. Healthcare associated exposures will be investigated and reported to the appropriate departments as needed.
- The feasibility and utility of performing contact tracing to identify exposed healthcare personnel and application of work restrictions depends upon the degree of community transmission and the resources available for contact tracing.
- For areas with:
 - Minimal to no community transmission of SARS-CoV-2, sufficient resources for contact tracing, and no staffing shortages, risk assessment of exposed associates and application of work restrictions may be feasible and effective.
 - Moderate to substantial community transmission of SARS-CoV-2, insufficient resources for contact tracing, or staffing shortages, risk assessment of exposed associates and application of work restrictions may not be possible.
- Contact tracing identification should begin at 48 hours prior to symptom onset, or specimen collection for asymptomatic cases. NJDOH/CDC considers close contact to be 15 minutes over 24 hours.
- Report to NJDOH within one working day any positive COVID-19 cases or other communicable diseases identified.
- Develop plans for a surge in numbers of COVID-19-positive residents or other communicable disease (e.g., plan for 10, 20, 30, or more cases) and staff. Plans should include establishment and implementation of a cohorting plan. Plans should also address strategies to mitigate staffing shortages.
- Maintain vaccine-preventable strategies. Ensure influenza and pneumococcal vaccinations

continue. Work with local public health and pharmacy to provide COVID-19 vaccine for residents and staff.

- Random rounds will be conducted monthly and as needed by the Infection Preventionist to ensure proper wearing of PPE and proper hand hygiene is being performed on the resident floors. Just in time spot education will be completed as warranted for non-compliance with formal competency and corrective action as needed to ensure compliance. Findings will be reviewed in QAPI and reported to NHSN as required.

Strategies to Mitigate Staffing Shortages

- Maintaining appropriate staffing in each community is essential to providing a safe work environment for staff and safe resident care.
- As the COVID-19 or other communicable disease pandemic progresses, staffing shortages may likely occur due to staff exposures, illness, or need to care for family members at home. Each community must be prepared for staffing shortages and plan accordingly. Considerations for creating a staffing contingency plan include (but are not limited to):
 - Not admitting new residents until staffing shortages are alleviated
 - Staffing agency and obtain new staff agency contracts as needed
 - Cross train staff to work in other areas not usually assigned should staffing be compromised
 - Management or office staff to assist with residents (within their scope of practice)
 - Implement sick leave policies that are flexible and non-punitive
 - Bonus or overtime pay
 - Pull from other UM communities for staff if feasible
 - Suspend vacation request as needed during outbreak
 - Closing the units/households (may be an option)

Recovery

- Recovery will be based on the conclusion of an outbreak and clearance by local DOH and state governing agencies.
- UM communities will conduct recovery activities in the aftermath of an infectious disease outbreak or a pandemic event.
- Recovery activities will focus on returning the community to normal operations as well as developing any QAPI Plans to improve preparedness and response capabilities.
- Establish short- and long-term goals to return community to the pre-event baseline.
- Evaluate how the outbreak plan was carried out and identify gaps that occurred during the response.
- Identify lessons learned, missed opportunities and difficulties encountered
- Determine potential solutions to the gaps identified in the outbreak plan.
- Update the community outbreak plan to reflect lessons learned and recommendations.
- Revise outbreak plan as needed.
- Replenish stocks of PPE and supplies to enable the community to maintain or restore routine infection prevention and control services.
- Educate staff on changes in the community outbreak plan.

REFERENCES

<https://www.nj.gov/health/cd/documents/topics/NCOV/Cohorting-PAC.pdf>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

Policy Administration

- A. On an annual basis, our commitment to and implementation of this policy shall be reviewed.
- B. The Executive Director/Administrator with support of Director of Nursing at each operating community is responsible for the implementation and communication of this policy.
- C. The Corporate Director of Risk Management and Corporate Director of Clinical Services are responsible for monitoring and reporting on the implementation of this policy. This responsibility includes bringing to the attention of the Executive Leadership or the Board instances where this policy is not being consistently applied.

Approval Signatures

Step Description	Approver	Date
	Mark Lenhard	11/25/2022
	DaLinda Love: Corp Dir, Clin Services	11/25/2022

