

# EGG HARBOR CARE CENTER

## Guidelines (SOG) for caring for COVID-19 residents

### Purpose

The purpose is to establish an SOG for care of residents with confirmed or suspected COVID 19

### Procedure

Facility will follow the CDC guidance for Infection Prevention and Control Recommendations for care of residents with Confirmed Coronavirus Disease 2019: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

In addition the facility will follow with infection control measures as per NJDOH guidance available at:

[https://www.nj.gov/health/cd/documents/topics/NCOV/COVID LTC Recommendations.pdf](https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_LTC_Recommendations.pdf)

Facility shall implement outbreak interventions outlined in the NJDOH Outbreak Management Checklist available at:

[https://www.nj.gov/health/cd/documents/topics/NCOV/COVID outbreak management Checklist.pdf](https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_outbreak_management_Checklist.pdf)

The following is the updated based on CDC and NJDOH guidelines to ensure appropriate care transitions are done to follow proper infection control practices and procedures for care of residents with COVID 19.

When residents are suspected of having COVID-19 infection the facility will contact the local health department. Residents infected with COVID-19 may have symptoms that vary in severity from lack of symptoms to mild or severe symptoms up to and including fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19. This will be subject to critical updates, such as updates to guidance for using PPE: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the resident does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the resident and isolate him/her in a room with the door closed.

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The following will help in caring for residents while maintaining infection control practices to prevent and control the transmission.

## Key Strategies to Prepare for COVID-19

### 1. Keep COVID -19 from entering the facility

- a. All outside personnel are restricted entering the facility, except in certain compassionate-care situations.
- b. Restrict all volunteers and non-essential healthcare personnel (employee), including consultant services (e.g., barber, hairdresser).
- c. Implement universal use of source control for everyone in the facility.
- d. Actively screen anyone entering the building (employee, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift; send ill personnel home.
- e. Cancel all field trips outside of the facility.

### 2. Identify infections early:

- a. Actively screen all residents daily for fever and symptoms of COVID-19; if symptomatic, immediately isolate and implement appropriate Transmission-Based Precautions. Active screening of residents and persons in the facility will be done for fever and other COVID-19 signs and symptoms per shift. Beware of atypical presentation in older adults. Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. Vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry
- b. Facility will notify the state and/or local health department immediately (<24 hours) if these occur:
  - i. Severe respiratory infection causing hospitalization or sudden death
  - ii. Clusters ( $\geq 3$  residents and/or employee) of respiratory infection
  - iii. Individuals with suspected or confirmed COVID-19
- c. Any resident who are admitted/readmitted to the facility will be monitored for fever and other COVID-19 symptoms for at least 14 days. The resident will be assessed prior to discharge to evaluate for COVID symptoms.

### 3. Prevent spread of COVID -19

- Stop current communal dining and all group activities. Encourage residents/residents to stay in their room.
- Utilize telemedicine and alternate means of communication to maintain social distancing orders. Telemedicine release forms to be distributed as needed.
- Facility will implement universal masking of all persons (e.g., staff members, visitors, clergy) entering the facility, with a surgical or isolation mask (not a respirator).

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- Ensure all residents wear a face mask/ cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointment including for essential procedures outside of the facility.
  - Enforce social distancing among residents and perform frequent hand hygiene.
  - Facility will follow updated CDC's Strategies to Optimize the Supply of PPE and Equipment at <https://www.cdc.gov/coronavirus/2019-ncov/employee/ppe-strategy/index.html>.
  - Facility will evaluate and bundle tasks to optimize PPE and limit exposures. Consider cross-training to conserve resources.
  - Facility will evaluate and try to dedicate staff and mobile equipment exclusively to a unit/wing to minimize exposures and transmission throughout a facility and in-between facilities.
  - When resident is suspected or diagnosed with COVID -19 the facility will follow the precautions and protocols in prevention and control of the disease in accordance with the medical practitioner's orders and CDC interim guidance.
  - When COVID-19 is identified in the facility, restrict all residents to their rooms and have employee wear all recommended PPE that is available at the time of identification for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. employee should be trained on PPE use including putting it on and taking it off.
    - i. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop.
    - ii. When a case is identified, contact public health department as they can help inform decisions about testing asymptomatic residents on the unit or in the facility.
4. **Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:**
- If facility anticipate or are experiencing PPE shortages, reach out to your state/local office of emergency management / local health department who can engage your local healthcare coalition.
  - Consider extended use of respirators, facemasks, and eye protection or prioritization of gowns for certain resident care activities.
5. **Identify and manage severe illness:**
- Designate a location to care for residents with suspected or confirmed COVID-19, separate from other residents.

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- Monitor ill residents (including documentation of temperature and oxygen saturation) at least Q shift to quickly identify residents who require transfer to a higher level of care.

### **Infection Prevention and Control Recommendations for Residents with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19)**

The key concepts in this CDC recommendation is to

- a) reduce the facility risk by cancel elective procedures, use telemedicine when possible, limit points of entry and manage visitors, screen everyone entering the facility for COVID-19 symptoms, implement source control for everyone entering the facility, regardless of symptoms.
- b) Isolate symptomatic residents as soon as possible by placing residents with suspected or confirmed COVID-19 in private rooms with the door closed and with private bathrooms (as possible).
- c) Protect healthcare personnel by emphasizing hand hygiene, cohort residents with COVID-19, limit the numbers of staff providing their care, and prioritizing respirators for aerosol generating procedures.

#### **1. Minimize Chance for Exposures**

Ensure to follow facility policies and practices are in place to minimize exposures to respiratory pathogens including SARS-CoV-2, the virus that causes COVID-19. Measures should be implemented before resident arrival, upon arrival, throughout the duration of the resident's visit, and until the resident's room is cleaned and disinfected. It is particularly important to protect individuals at increased risk for adverse outcomes from COVID-19 (e.g. older individuals with comorbid conditions), including employee who are in a recognized risk category.

- **Universal Source Control**

Continued community transmission has increased the number of individuals potentially exposed to and infectious with SARS-CoV-2. Fever and symptom screening have proven to be relatively ineffective in identifying all infected individuals, including employee. Symptom screening also will not identify individuals who are infected but otherwise asymptomatic or pre-symptomatic; additional interventions are needed to limit the unrecognized introduction of SARS-CoV-2 into healthcare settings by these individuals. As part of aggressive source control measures, everyone entering the facility will implement universal masking while in the building, regardless of symptoms.

- **Resident and Visitors**

Residents and visitors who are allowed under the guidelines should, ideally, be wearing their own cloth face covering upon arrival to the facility. If not, they should be offered a facemask or cloth face covering as supplies allow, which should be worn while they are in the facility (if tolerated). They should also be instructed that if they must touch or adjust their cloth face covering they should perform hand hygiene immediately before and after. Facemasks and cloth face coverings 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. Residents may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., employee, visitors) enter the room. Screening for symptoms and appropriate evaluation and isolation of individuals who report symptoms should still occur.

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- **Healthcare Personnel**

As part of source control efforts, employee should wear a facemask at all times while they are in the healthcare facility as they offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are anticipated shortages of facemasks, facemasks should be prioritized for employee and then for residents with symptoms of COVID-19 (as supply allows). Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required. Employee should also be instructed that if they must touch or adjust their facemask or cloth face covering, they should perform hand hygiene immediately before and after.

Employee should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination).

## **Admission of residents to the facility**

As per the guidance from CDC, the facility will evaluate and accept a resident diagnosed with COVID-19 and still under Transmission- Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If the facility cannot follow them, the facility must wait until these precautions are discontinued. CDC has released [Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19](#). Information on the duration of infectivity is limited, and the interim guidance has developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

If possible, the facility will dedicate a unit/wing / floor exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room).

If a resident with COVID-19 is discharged to the facility, AND

- Transmission-Based Precautions *are still required*, the resident should go to a facility with adequate personal protective equipment supplies and an ability to adhere to infection prevention and control recommendations for the care of COVID-19 residents. Preferably, the resident would be placed at a facility that has already cared for COVID-19 cases, in a specific unit designated to care for COVID-19 residents
- Transmission-Based Precautions *have been discontinued*, but the resident has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room,
- Transmission-Based Precautions *have been discontinued* and the resident's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

## **Cohorting and Admission based requirements**

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1. The outbreak response plan will be reviewed to determine whether it includes a cohorting plan as described below and the facility will implement a plan, to accommodate to the extent possible:
  - a. Overall separation of residents;
  - b. Dedicating staff to each cohort and;
  - c. Allowing for necessary space to do so at the onset of an outbreak.
2. The residents will be identified into a minimum of three cohort groups:
  - a. Individuals who are showing SYMPTOMS OF covid-19 or who have tested positive for COVID-19;
  - b. Individuals who have been exposed to someone who has tested positive for COVID-19 or has shown symptoms of COVID-19 (i.e, individuals who are not themselves symptomatic, but may potentially be incubating the virus); and
  - c. Individuals who are not ill and have not been exposed
3. The facility will follow up with local department of health for guidance in regards to accepting admissions or readmissions of residents if the facility has COVID-19 residents and does not have the ability to:
  - a. Cohort as 1. Above
  - b. Follow CDC guidance for infection prevention and control; and
  - c. Maintain adequate staffing
4. A facility will follow up with department of health for guidance in regards to accepting admissions or readmissions with or without COVID-19 if the facility has the ability to:
  - a. Cohort as in 1. Above
  - b. Follow CDC guidance for infection prevention and control; and
  - c. Maintain adequate staffing
5. Admissions or readmissions for persons under investigation for COVID-19 is permitted only if they can be placed in isolation.
6. Facility will evaluate and identify possibilities for separate wing/unit or floor to accept asymptomatic residents coming or returning from the hospital if possible. This may mean moving residents in facility to create a new wing/unit. Limit staff working between wing/units as much as possible.
7. Facility will evaluate and identify possibilities to separate wing/unit to accept COVID-19 (+) residents and care for those suspected or confirmed with COVID-19 if possible.

### **Before Arrival**

- The facility will accept residents that are discharged from the hospital if they are deemed appropriate for discharge to the post-acute care setting upon a determination by the hospital physician or designee that the resident is medically stable for return based on their capacity and available resources to provide adequate, safe care in the facility.
- Hospital discharge planners must confirm to the facility, by telephone, that the resident is medically stable for discharge and provide comprehensive discharge instructions prior to the transport of a resident. The facility will follow up with the hospital to ensure that the persons under investigation for COVID-19 who have undergone testing in the hospital shall not be discharged until results are available.

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- If resident is coming from the hospital, obtain clinical details and updates during the pre-admission process to ensure infection control practices are followed. The resident should wear a mask regardless of the symptoms before entering the facility.
- Before arrival, instruct them to call beforehand to inform facility personnel and provide detailed clinical report. This will allow the facility to prepare for receipt of the resident.
- If a resident is arriving via transport by emergency medical services (EMS), EMS personnel should contact the facility and follow previously agreed upon local or regional transport protocols.
- **Upon Arrival and During the Visit**
  - Limit and monitor the points of entry to the facility.
  - Take steps to ensure all persons with symptoms of COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, and hand hygiene.
  - Ensure the resident as well as the EMS transport personnel put on a face mask or cloth covering before entering the building regardless of symptoms.
  - Post visual alerts (e.g., signs, posters) and increase signage for vigilant infection prevention at the entrance of the unit and possible outside resident rooms to provide residents and employee with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use face masks for source control, and how and when to perform hand hygiene.
  - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with 60-95% alcohol, tissues, and waste bins are available.
  - Ensure appropriate PPE is worn by health care personnel including mask.
  - Residents should be provided with masks to ensure source control. Source control (putting a facemask over the mouth and nose of a symptomatic resident) can help to prevent transmission to others.
- Isolate the resident in a private room with the door closed. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
  - Incorporate questions about new onset of respiratory symptoms into daily assessments of all newly admitted residents. Monitor for and evaluate all new fevers and respiratory illnesses among residents. Place any resident with unexplained fever or respiratory symptoms on appropriate Transmission-Based Precautions and evaluate.

### **2. Adhere to Standard and Transmission-Based Precautions**

Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting.

Facility will ensure to provide supplies necessary to adhere to recommended infection prevention and control Practices

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- Hand Hygiene Supplies:
  - Place alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory Hygiene and Cough Etiquette:
  - Tissues and trash cans are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
- Personal Protective Equipment (PPE):
  - Assess current PPE supply.
    - Identify health department or health care coalition contacts for getting assistance during PPE shortages.
    - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools
  - Implement strategies to optimize current PPE supply *even before shortages occur*
    - Bundling resident care and treatment activities to minimize entries into resident room (e.g., having clinical staff clean and disinfect high-touch surfaces when in the room)
    - Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
      - Extreme care must be taken to **avoid touching the respirator, facemask or eye protection**. If this must occur, employee should perform hand hygiene immediately before and after contact to prevent contaminating themselves or others.
    - Prioritizing gowns for activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of employee.
    - Developing a process for decontamination and reuse of PPE such as face shields and goggles
  - Make necessary PPE available in areas where resident care is provided.
    - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.
    - Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit tested employee), gowns, gloves, and eye protection (i.e., face shield or goggles).

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- Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE, prior to exiting the room, or before providing care for another resident in the same room.
- Consider implementing a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
- Ensure all staff are trained on proper donning (putting on), doffing (taking off), and disposal of any PPE including use a respirator or facemask, gown, gloves, and eye protection. The employees who enter the room of a resident with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection.
- **Hand Hygiene**
  - Employee 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.
  - Employee should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water and vigorously scrubbing with soap for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
  - Hand hygiene supplies should be available to all personnel in every care location.
- **Personal Protective Equipment**

Employee must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE and limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Ensure employees follow the facility policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a resident with known or suspected COVID-19 includes:
- **Respirator or Facemask**
  - Put on a facemask before entry into the resident room.
  - N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when caring for residents with COVID 19 or suspected COVID 19 and when performing or present for an aerosol-generating procedure.
  - Perform hand hygiene according to facility policy and CDC guidelines.

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- **Eye Protection**

- Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the resident room. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- Remove eye protection before leaving the resident room or care area.
- Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.

- **Gloves**

- Put on clean, non-sterile gloves upon entry into the resident room or care area.
  - Change gloves if they become torn or heavily contaminated.
- Remove and discard gloves when leaving the resident room and immediately perform hand hygiene.

- **Gowns**

- Put on a clean isolation gown upon entry into the resident room. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the resident room. Disposable gowns should be discarded after use.
- If there are shortages of gowns, they should be prioritized for:
  - aerosol-generating procedures
  - care activities where splashes and sprays are anticipated
  - high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of employees. Examples include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care etc.

#### 4. Resident Placement

Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19

- Implement facility cohorting plan that allows for separation of residents, dedicating staff and medical equipment to each of these cohorts and allowing for necessary space to do so at the onset of an outbreak:
  - Identify three cohort groups:
    - 1.) "Ill"
    - 2.) "Exposed" (not ill, but potentially incubating) and
    - 3.) "Not ill/not exposed".
- Dedicate resident specific equipment and supplies. If not possible, restrict dedicated equipment within a specific cohort with routine cleaning and disinfection between resident use.

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- Employee assigned to affected unit(s) should not rotate to unaffected units. This restriction includes prohibiting employee from working on unaffected units after completing their usual shift on the affected unit(s).
- Close the unit to new admissions except as needed to cohort ill individuals or staff.
- Consider closing to new admissions if you are unable to appropriately cohort. This does not include readmissions back to your facility.
- During an outbreak, public health authorities can provide assistance on a case-by-case basis.
- Dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
  - Assign dedicated employee to work only in this area of the facility.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive).
  - Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them.
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected.
  - If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation.
  - All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.
- For residents with COVID-19 or other respiratory infections, evaluate need for hospitalization. If hospitalization is not medically necessary, treating the person in the facility is preferable if the individual's situation allows.
- Place the resident with known or suspected COVID-19 in a single-person room with the door closed. The resident should have a dedicated bathroom or other facilities if possible.
- As a measure to limit employee exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated employee, to care for known or suspected COVID-19 residents. Dedicated means that employees are assigned to care only for these residents during their shift.

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- Determine how staffing needs will be met as the number of residents with known or suspected COVID-19 increases and employee become ill and are excluded from work.
- It might not be possible to distinguish residents who have COVID-19 from residents with other respiratory viruses. As such, residents with different respiratory pathogens will likely be housed on the same unit. However, only residents with the same respiratory pathogen may be housed in the same room. For example, a resident with COVID-19 should not be housed in the same room as a resident with an undiagnosed respiratory infection.
- During times of limited access to respirators or facemasks, facilities could consider having employee remove only gloves and gowns (if used) and perform hand hygiene between residents with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use). Risk of transmission from eye protection and facemasks during extended use is expected to be very low.
  - Employee must take care not to touch their eye protection and respirator or facemask.
  - Eye protection and the respirator or facemask should be removed, and hand hygiene performed if they become damaged or soiled and when leaving the unit.
- Employee should strictly follow basic infection control practices between residents (e.g., hand hygiene, cleaning and disinfecting shared equipment).
- Limit transport and movement of the resident outside of the room for medically essential purposes.
  - Consider providing portable x-ray equipment in resident cohort areas to reduce the need for resident transport.
- To the extent possible, residents with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Residents should wear a facemask to contain secretions during transport. If residents cannot tolerate a facemask or one is not available, they should use tissues to cover their mouth and nose.
- Personnel entering the room should use available PPE as described above. A log will be maintained of all personnel who care for or enter the resident room.
- Whenever possible, perform procedures/tests in the resident's room.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.).
- Residents should be restricted (to the extent possible) to their rooms except for medically necessary procedures.
- When residents move out of room, they should wear face mask, perform hand hygiene, limit movement in facility and perform social distancing.

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- Perform surveillance to detect respiratory infections, including COVID-19 and report to attending physician as soon as possible for appropriate follow up.
- Report any known or suspect communicable disease outbreak, by phone to the LHD with jurisdiction over the facility.
- Once the resident has been discharged or transferred, employee including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles according to CDC guidance and housekeeping /environmental services policies (at least a minimum of 4 hours). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use per facility polices.

### 4. Evaluate and Manage Residents with Symptoms of COVID-19

- Ask residents as appropriate to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least Q shift for fever ( $T \geq 99.6^{\circ}\text{F}$ ) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, implement Transmission-Based Precautions as described below.
  - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or employee with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or  $\geq 3$  residents or employee with new-onset respiratory symptoms within 72 hours of each other.
  - Contact information for the healthcare-associated infections program in each state health department is available.
  - CDC has resources for performing respiratory infection surveillance in long-term care facilities during an outbreak.pdf icon[7 pages]
- Residents with suspected COVID-19 should be prioritized for testing.
- Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
- Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated employee (see section on Dedicating Space).
- As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.

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- Monitoring of asymptomatic residents done every shift to more rapidly detect any with new symptoms.
- If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. **Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.**
- While awaiting transfer, residents should wear a cloth face covering or facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed)
- All recommended PPE should be used by healthcare personnel when coming in contact with the resident.
- Identify care plan goals and life sustaining treatment plans for residents.
  - Review and update care plans to avoid unnecessary emergency room visits and hospitalizations in consultation with resident/physician/family/IDCP team.
  - Review symptoms, clinical progression and expected outcomes
  - Confirm residents' care preferences (e.g., home with palliative or hospice care; remain at LTCF with symptom management; hospitalization for medical intervention; allow natural death).
  - Review and complete Physician Orders for Life-Sustaining Treatment (POLST)
  - Advise residents, families, and authorized proxies to review and update Advance Directives
  - Transfer notification applies to all residents of the facility. If possible, limit transfers to medical necessity.

### 5. Take Precautions When Performing Aerosol-Generating Procedures (AGPs)

- Some procedures performed on resident with known or suspected COVID-19 could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.
- If performed, the following should occur:
  - Employee in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown.
  - The number of employee 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.
  - AGPs should ideally take place in an AIIR.
  - Clean and disinfect the area after the procedure.

### 5. Collection of Diagnostic Respiratory Specimens

- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a suspected COVID-19 resident, the following should occur:
  - Employee in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown.

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- The number of employee present during the procedure should be limited to only those essential for resident care and procedure support. Visitors should not be present for specimen collection.
- Specimen collection should be performed in a normal examination room with the door closed.
- Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

### **6. Manage Visitor Access and Movement within the Facility**

- Because of the ease of spread in a long-term care setting and the severity of illness that occurs in residents with COVID-19 restrict visitors to residents with known or suspected COVID-19. Encourage use of alternative mechanisms for resident and visitor interactions such as video-call applications on cell phones or tablets. Current situations are to restrict visitation except for end of life and exacerbating situations and they should be screened for fever and respiratory symptoms upon entry to the facility. If fever or respiratory symptoms are present, visitor should not be allowed entry into the facility.
- Communication should occur via letters or emails to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations.
- Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.
- Post signs at the entrances to the facility advising that no visitors may enter the facility.
- Facility will screen all medical professional visitors using the screening questionnaire and will restricted as per the guidelines.
  - Require the visiting essential medical professional to wear a facemask while in the facility. The facility may require the individual to use additional forms of PPE, as determined by the facility; and
  - Provide instruction, before the staff member or visiting essential medical profession enters the facility, on hand hygiene, the location of hand washing stations;
  - Limiting surfaces touched and use of PPE according to the facility policy.
  - Limit the medical professional's movement within the facility to those areas necessary to complete the professional's task;
  - Advise the medical professional to limit physical contact with anyone in the facility. For example, practice social distancing with no handshaking or hugging and remaining six feet apart;
  - Restrict the staff member or medical professional from entering the facility if he or she is unable to demonstrate the proper use of infection control techniques; and
  - Advise the medical professional to monitor for signs and symptoms of respiratory infection 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 encountered while in the facility. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on findings.

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- Facility will screen and monitor the vendors and transportation providers (e.g., when taking residents to offsite) using the screening questionnaire and will be restricted as per the guidelines.
  - require the individual to wear a facemask while in the facility,
  - provide instruction before the individual enters the facility on hand hygiene, the location of handwashing stations, limiting surfaces touched, and use of PPE according to current facility policy;
  - limit the individual's movement within the facility to those areas necessary to complete the vendor's or transportation provider's task;
  - advise the individual to limit physical contact with anyone in the facility. For example, practice social distancing with no handshaking or hugging and remaining six feet apart.
  - Restrict the individual from entering the facility if he or she is unable to demonstrate the proper use of infection control techniques; and
  - Advise the individual to monitor for signs and symptoms of respiratory infection 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 encountered while in the facility. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on findings.
- For supply vendors, it is recommended that they drop off supplies at a dedicated location, such as a loading dock, instead of entering the facility.
- Facility will follow procedures for monitoring, managing, and training all visitors, which should include:
  - All visitors should be instructed to wear a facemask or cloth face covering at all times while in the facility, perform frequent hand hygiene, and restrict their visit to the resident's room or other area designated by the facility.
  - Informing visitors about appropriate PPE use according to current facility visitor policy.
  - Decisions about visitation for compassionate care situations should be made on a case-by-case basis, which should include careful screening of the visitor for fever or symptoms consistent with COVID-19. Those with symptoms should not be permitted to enter the facility. Any visitors that are permitted must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

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- If visitation must occur, visits should be scheduled and controlled.
- Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.
- Visitors should not be present during AGPs or other specimen collection procedures.
- Visitors should be instructed to only visit the resident room. They should not go to other locations in the facility.
- The following rules shall apply to resident visitors for end-of-life situations:
  - a. The facility shall actively screen and restrict visitation for those who meet one or more of the following criteria:
    - i. Exhibit signs or symptoms of a respiratory infection, such as a fever (evidenced by a temperature check of the visitor taken by the facility), cough, shortness of breath, or sore throat;
    - ii. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with respiratory illness;
    - iii. In the last 14 days, has traveled internationally to a country with sustained community transmission. For updated information on affected countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>; or
    - iv. Resides in or travels to a community where community-based spread of COVID19 is occurring.
  - b. If, after undergoing screening, the visitor is permitted to enter the facility, the facility shall:
    - i. Ask the visitor if he or she had any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If the answer is yes, then it is recommended that the facility offer the visitor a facemask to use while onsite.
    - ii. Facilities should provide instruction, before visitors enter residents' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident's room.
    - iii. Limit the visitor's movement within the facility to the resident's room (e.g., reduce walking the halls, avoid going to dining room, etc.); and
    - iv. Advise the visitor to limit physical contact with anyone other than the resident while in the facility. For example, practice social distancing with no handshaking or hugging and remaining six feet apart.
    - v. Restrict a visitor from entering the facility if he or she is unable to demonstrate the proper use of infection control techniques; and
    - vi. Advise the visitors to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on findings.

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## 7. Implement Engineering Controls

- Design and install engineering controls to reduce or eliminate exposures by shielding employee and other residents from infected individuals. Examples of engineering controls include, physical barriers or partitions to guide residents through triage areas, curtains between residents in shared area, air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are properly installed and maintained

## 8. Monitor and Manage Healthcare Personnel

- Health care personnel who are ill with respiratory symptoms or communicable diseases should follow the HR policies that are non-punitive, flexible, and consistent with public health guidance.
- Create or review an inventory of all personnel who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed.
- Review current resident services and restrict non-essential healthcare personnel, such as elective consultations, and volunteers from entering the building.
  - Consider implementing telehealth to offer remote access to care activities
- As part of source control efforts, employees should wear a facemask or cloth face covering at all times while they are in the healthcare facility. When available, facemasks are generally preferred over cloth face coverings for employees as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are shortages of facemasks, facemasks should be prioritized for employee and then for residents with symptoms of COVID-19 (as supply allows). Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.
- All employees should be reminded to practice social distancing when in break rooms or common areas.
- As part of routine practice, employee should be asked to regularly monitor themselves for fever and symptoms of COVID-19.
  - Employee should be reminded to stay home when they are ill.
  - If employee develop fever ( $T \geq 99.6$ ) or symptoms consistent with COVID-19\* while at work they should keep their cloth face covering or facemask on, inform their supervisor, and leave the workplace.
- Screen all employees at the beginning of their shift and again prior to the end of their shift for fever and symptoms of COVID-19\*
  - Actively take their temperature\* and document absence of shortness of breath, new or change in cough, sore throat, and muscle aches. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.

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- \*Fever is either measured temperature >99.6 degrees F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<99.6 degrees F) or other symptoms (e.g., nausea, vomiting, diarrhea, abdominal pain, headache, runny nose, fatigue) based on assessment by infection Preventionist/designee.
- Employees who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.
- Facilities should develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
  - CDC has created guidance to assist facilities with mitigating staffing shortages.
  - For guidance on when employees with suspected or confirmed COVID-19 may return to work refer to Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)
- Employees with suspected COVID-19 should be prioritized for testing.
- Decisions about return to work for employee with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a test-based strategy or a symptom-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy).

### **Return to Work Criteria for employee with Confirmed or Suspected COVID-19**

**Use the *Test-based strategy* as the preferred method for determining when employee may return to work in healthcare settings:**

1. *Test-based strategy*. Exclude from work until
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens) [1]. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

**If the *Test-based strategy* cannot be used, the *Symptom-based strategy* may be used for determining when employee may return to work in healthcare settings:**

2. *Symptom-based strategy*. Exclude from work until
  - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 10 days have passed *since symptoms first appeared*

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**Employee with laboratory-confirmed COVID-19 who have not had any symptoms** should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

If employee had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

### Contingency Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. At baseline, healthcare facilities must:

- Understand their staffing needs and the minimum number of staff needed to provide a safe work environment and resident care.
- Be in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional employee (e.g., hiring additional employee, recruiting retired employee, using students or volunteers), when needed.

### Contingency capacity strategies for healthcare facilities include:

Adjusting staff schedules, hiring additional employee, and rotating employee to positions that support resident care activities.

- Cancel all non-essential procedures and visits. Shift employees who work in these areas to support other resident care activities in the facility. Facilities will need to ensure these employees have received appropriate orientation and training to work in these areas that are new to them.
- Employee will work with HR regards to any concerns to address social factors that might prevent employee from reporting to work such as transportation or housing if employee live with vulnerable individuals.
- Identify additional employee to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of employee.
- Request that employee postpone elective time off from work.

Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for residents with COVID-19.

Developing plans to allow asymptomatic employee who have had an unprotected exposure to the virus that causes COVID-19 to continue to work.

- These employees should still report temperature and absence of symptoms each day before starting work. These employees should wear a facemask (for source control) while at work for 14 days after the exposure event. A facemask instead of a cloth face covering should be used by these employees for source control during this time period while in the facility. After this time period, these employee should revert to their facility policy regarding universal source control during the pandemic.

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- A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including for the care of residents with suspected or confirmed COVID-19.
- Of note, N95 or other respirators with an exhaust valve might not provide source control. To add a layer of protection use a surgical mask over the N95 or other respirators with an exhaust valve.
- If employee develop even mild symptoms consistent with COVID-19, they must cease resident care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.

Prioritizing employee with suspected COVID-19 for testing, as testing results will impact when they may return to work and for which residents they might be permitted to provide care.

Developing criteria to determine which employee with suspected or confirmed COVID-19 (who are well enough to work) could return to work in a healthcare setting before meeting all Return to Work Criteria—if shortages continue despite other mitigation strategies.

- Considerations include:
  - The type of employee shortages that need to be addressed.
  - Where employee are in the course of their illness (e.g., viral shedding appears to be higher earlier in the course of illness).
  - The types of symptoms they are experiencing (e.g., persistent fever).
  - Their degree of interaction with residents and other employee in the facility. For example, are they working in telemedicine services, providing direct resident care, or working in a satellite unit reprocessing medical equipment?
  - The type of residents they care for (e.g., immunocompromised residents).
- As part of planning, healthcare facilities (in collaboration with risk management) should create messaging for residents and employee about actions that will be taken to protect them from exposure to SARS-CoV-2 if employee with suspected or confirmed COVID-19 are allowed to work.

### **Crisis Capacity Strategies to Mitigate Staffing Shortages**

When staffing shortages are occurring, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide resident care.

When there are no longer enough staff to provide safe resident care:

- Implement regional plans to transfer residents with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing
- If not already done, allow asymptomatic employee who have had an unprotected exposure to the virus that causes COVID-19 to continue to work.
  - These employees should still report temperature and absence of symptoms each day before starting work. These employees should wear a facemask (for source control) while at work for 14 days after the exposure event. A facemask instead of a cloth face covering should be used by these employees for source control during this time period while in the facility. After this time period, these employees should revert to their facility policy regarding universal source control during the pandemic.

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- A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including for the care of residents with suspected or confirmed COVID-19
- Of note, N95 or other respirators with an exhaust valve might not provide source control.
  - If employee develop even mild symptoms consistent with COVID-19, they must cease resident care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.
- If shortages continue despite other mitigation strategies, consider implementing criteria to allow employee with suspected or confirmed COVID-19 who are well enough to work but have not met all Return to Work Criteria to work. If employees are allowed to work before meeting all criteria, they should be restricted from contact with severely immunocompromised residents (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:
  1. If not already done, allow employee with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., residents or other employee), such as in telemedicine services.
  2. Allow employee with confirmed COVID-19 to provide direct care only for residents with confirmed COVID-19, preferably in a cohort setting.
  3. Allow employee with confirmed COVID-19 to provide direct care for residents with suspected COVID-19.
  4. As a last resort, allow employee with confirmed COVID-19 to provide direct care for residents *without* suspected or confirmed COVID-19.
- If employee are permitted to return to work before meeting all Return to Work Criteria, they should still adhere to all Return to Work Practices and Work Restrictions recommendations described in that guidance.

### **Return to Work Practices and Work Restrictions**

After returning to work, employee should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. A facemask instead of a cloth face covering should be used by these employee for source control during this time period while in the facility. After this time period, these employees should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for residents with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control.

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- Be restricted from contact with severely immunocompromised residents (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

### **Strategies to Mitigate Healthcare Personnel Staffing Shortages**

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (employee) and safe resident care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to employee exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting employee to return to work without meeting all return to work criteria above. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information.

### **9. Educate Residents, Healthcare Personnel, and Visitors about COVID-19, Current Precautions Being Taken in the Facility, and Actions They Can Take to Protect Themselves**

- Provide information about COVID-19 (including information about signs and symptoms) and strategies for managing stress and anxiety.
- Review CDC's Interim Infection Prevention and Control Recommendations for residents with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings
- Educate and train employee
  - Reinforce HR sick leave policies; remind employees not to report to work when ill
  - Educate them about new policies for source control while in the facility.
  - Reinforce adherence to standard infection prevention and control measures including hand hygiene and selection and use of personal protective equipment (PPE). Have employees demonstrate competency with putting on and removing PPE and monitor adherence by observing resident care activities.
  - Provide employees with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
  - Ensure that employees are educated, trained, and have practiced the appropriate use of PPE prior to caring for a resident, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment
- Educate both facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility. Inclusion of consultants is important, since they commonly provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.
- Educate residents and families including, information about COVID-19; actions the facility is taking to protect them and/or their loved ones, including visitor restrictions; and actions they can take to protect themselves in the facility, emphasizing the importance of social distancing, hand hygiene, respiratory hygiene and cough etiquette, and wearing a cloth face covering.
- Have a plan and mechanism to regularly communicate with residents, family members and employees, including if cases of COVID-19 are identified among residents or employees.

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### 10. Implement Environmental Infection Control

- Dedicated medical or disposable non critical resident care equipment (BP cuffs, blood glucose monitoring equipment's etc.) should be used when caring for residents with known or suspected COVID-19.
  - All non-dedicated, non-disposable medical equipment used for resident care should be cleaned and disinfected according to manufacturer's instructions using EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Environmental Cleaning and Disinfection:
  - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas;
  - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
  - 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.
  - Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
  - Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g. Bed rails, over bed table, bed side commode, lavatory surfaces in residents bath rooms) are cleaned and disinfected with and EPA registered disinfectant at least daily and when visibly soiled.
  - Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those resident-care areas in which aerosol-generating procedures are performed.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Additional information about recommended practices for terminal cleaning of rooms and PPE to be worn by environmental services personnel is available in the [Healthcare Infection Prevention and Control FAQs for COVID-19](#)

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## 11. Establish Reporting within and between Healthcare Facilities and to Public Health Authorities

- Implement mechanisms that promote inter departmental and communication with external entities about known or suspected COVID-19 residents and facility plans for response.
- Communicate and collaborate with public health authorities.
  - Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to employee.
  - Communicate information about known or suspected COVID-19 residents to appropriate personnel before transferring them to any health care facilities etc.

## 12. Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19

The decision to discontinue Transmission-Based Precautions for residents with confirmed COVID-19 should be made using either a test-based strategy or a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or time-based strategy as described below. **Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.**

**Symptomatic residents with COVID-19** should remain in Transmission-Based Precautions until **either**:

- *Symptom-based strategy*
  - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 10 days have passed *since symptoms first appeared*
- *Test-based strategy*
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens) [1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

**Residents with laboratory-confirmed COVID-19 who have not had any symptoms** should remain in Transmission-Based Precautions until **either**:

- *Time-based strategy*
  - 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

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- *Test-based strategy*
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Consider consulting with local infectious disease experts when making decisions about discontinuing Transmission-Based Precautions for residents who might remain infectious longer than 10 days (e.g., severely immunocompromised).

### **When a Testing-Based Strategy is Preferred**

CDC recommends that hospitalized residents may have longer periods of SARS-CoV-2 RNA detection compared to residents with mild or moderate disease. Severely immunocompromised residents (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV) may also have longer periods of SARS-CoV-2 RNA detection and prolonged shedding of infectious recovery. These groups may be contagious for longer than others. In addition, placing a resident in a setting where they will have close contact with individuals at risk for severe disease warrants a conservative approach.

Hence, a test-based strategy is preferred for discontinuation of transmission-based precautions for residents who are hospitalized or severely immunocompromised or being transferred to a long-term care or assisted living facility

If testing is not readily available, facilities should use the symptom-based strategy for discontinuation of Transmission-Based Precautions or extend the period of isolation beyond the symptom-based-strategy duration, on a case by case basis in consultation with local and state public health authorities.

### **Discontinuation of empiric Transmission-Based Precautions for residents suspected of having COVID-19:**

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 resident can be made based upon having negative results from at least one FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA.

- If a higher level of clinical suspicion for COVID-19 exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.
- If a resident suspected of having COVID-19 is never tested, the decision to discontinue Transmission-Based Precautions can be made based upon 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.

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### **Disposition of Residents with COVID-19:**

Residents can be discharged from the healthcare facility whenever clinically indicated.

If discharged to home:

- Isolation should be maintained at home if the resident returns home before discontinuation of Transmission-Based Precautions. The decision to send the resident home should be made in consultation with the resident's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and resident's ability to adhere to home isolation recommendations.

If discharged to another nursing home or other long-term care facility (e.g., assisted living facility), AND

- Transmission-Based Precautions *are still required*, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 residents. Preferably, the resident would be placed in a location designated to care for COVID-19 residents.
- Transmission-Based Precautions *have been discontinued*, but the resident has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline.
- Transmission-Based Precautions *have been discontinued* and the resident's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

Residents with a diagnosis of COVID-19 who are discharged to home from the facility prior to the discontinuance of transmission-based precautions should be advised to follow home isolation precautions for 10 days. Residents can be discharged from the facility whenever clinically indicated and should not be held only for the purposes of isolation.

### **Prior to Discharge:**

Assess the Suitability of the Residential Setting for Home Care. In consultation with state or local health department staff, a healthcare professional should assess whether the residential setting is appropriate for home care. Considerations for care at home include whether:

- The resident is stable enough to receive care at home.
- Appropriate caregivers are available at home.
- There is a separate bedroom where the resident can recover without sharing immediate space with others.
- Resources for access to food and other necessities are available.

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- The resident and other household members have access to appropriate, recommended personal protective equipment (at a minimum, gloves and facemask) and are capable of adhering to precautions recommended as part of home care or isolation (e.g., respiratory hygiene and cough etiquette, hand hygiene);
- There are household members who may be at increased risk of complications from COVID-19 infection (e.g., people >65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions).
- When resident is discharged, instructions will be provided to the resident/significant other to monitor for fever and other COVID-19 symptoms for at least 14 days and if symptoms occur, they are advised to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the persons they were in contact with, and the locations within the facility they visited.

### **Provide Guidance for Precautions to Implement during Home Care**

Upon discharge of the resident, the household members, intimate partners, and caregivers may have close contact with a person with symptomatic, laboratory-confirmed COVID-19 or a person under investigation. Close contacts should monitor their health; they should call their healthcare provider right away if they develop symptoms suggestive of COVID-19 (e.g., fever, cough, shortness of breath) (see Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposure in Travel-associated or Community Settings.)

A facility should provide the following:

- Provide CDC's [Interim Guidance for Preventing Coronavirus Disease 2019 \(COVID-19\) from Spreading to Others in Homes and Communities](#) to the resident, caregiver, and household members
- Contact the state or local health department to discuss criteria for discontinuing any such measures. Check available hours when contacting local health departments.
- The discharge summary should be completed based on the facility protocols.

### **Updated Guidance's:**

#### **Resident Cohorting**

**Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19. See Emergency Preparedness Plan section XXIII – Pandemic – Influenza section for general guidelines.**

- Each Center will pre-determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit.
  - Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected).

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Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19.

- Depending on the facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, cluster of rooms or separate if necessary with construction type plastic barriers or a fire doors for example.
- Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs), nurses, AND therapists assigned to care for these residents.
  - a. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility located in a Non – Covid areas (cold zone) on the unit.
  - b. To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
  - c. Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
  - d. Ensure HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).
  - e. Assign environmental services [EVS] staff to work only on the unit.
    - If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to mitigate staffing shortages, restrict their access to the unit.
    - Assign HCP dedicated to the COVID-19 care unit (e.g., NAs) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities.
    - HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N into the room and wipe down high touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.
- Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- Ensure that HCP are trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE).
  - If PPE shortages exist, implement strategies to optimize PPE supply on the unit, such as:
  - Round rooms and prioritize patients from COVID negative to COVID positive and not bounce between cohorts to preserve PPE.
  - Bundle care activities to minimize the number of HCP entries into a room.

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- Consider extended use of respirators (or facemasks if respirators are not available), eye protection, and gowns. Limited reuse of PPE may also be considered.
- Consider prioritizing gown use for high-contact resident care activities and activities where splash or spray exposures are anticipated.
- Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit.
- Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.

### **Considerations for new admissions or readmissions to the facility**

- Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions should go to the designated COVID-19 care unit however, can be housed in a private room for 14 days because of the chance of incidental exposure in the hospital or community. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
- Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit.
  - If Transmission-Based Precautions have been discontinued, but the resident with COVID-19 remains symptomatic (i.e., persistent symptoms or chronic symptoms above baseline), they can be housed on a regular unit but should remain in a private room until symptoms resolve or return to baseline.
  - These individuals should remain in their rooms to the extent possible during this time period.
  - If they must leave their rooms, facilities should reinforce adherence to universal source control policies and social distancing [e.g., perform frequent hand hygiene, have the resident wear a cloth face covering or facemask (if tolerated) and remain at least 6 feet away from others when outside of their room].
- **Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown.**
  - Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
  - All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.
  - Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit.
  - However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future.

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- Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE.
- Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home.
- New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty.

### **Response to Newly Identified SARS-CoV-2-infected HCP or Residents**

1. HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset
  - Prioritize these HCP for SARS-CoV-2 testing. Exclude HCP with COVID-19 from work until they have met all return to work criteria.
  - Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.
  - Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known.
  - If the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
  - Exposed HCP should be assessed for risk and need for work exclusion.
  - If testing is available, asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for testing (see information on testing below).
  - If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above.
  - Be in communication with local healthcare coalitions, federal, state, and local public health partners

### **Resident with new-onset suspected or confirmed COVID-19**

- Ensure the resident is isolated and cared for using all recommended COVID-19 PPE.
- Place the resident in a single room if possible pending results of SARS-CoV-2 testing.
  - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).
  - If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.

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- If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.
- Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).
  - Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.
- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
- Increase monitoring of ill residents, including assessment of symptoms.
  - Monitor vital signs, oxygen saturation via pulse oximetry, and respiratory exam, every 8 hours. Monitor every 4 hours as indicated based on symptoms or resident's confirmed COVID-19 status.
  - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
- Counsel all residents to restrict themselves to their room to the extent possible.
- HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.
  - If HCP PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated.
  - Broader testing could be utilized to prioritize PPE supplies (see section on using testing).
- Notify HCP, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning, limiting time exposure).
  - Promptly (within 12 hours) notify HCP, residents, and families about identification of COVID-19 in the facility:
  - Provide educational sessions or handouts for HCP, residents, and families
  - Maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions
  - Monitor hand hygiene and PPE use in affected areas
- Maintain all interventions while assessing for new clinical cases (symptomatic residents):
  - Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.

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- If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing
- The incubation period for COVID-19 can be up to 14 days and the identification of a new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

### Use of Testing to Inform the Response to COVID-19 in Nursing Homes

Considerations for use of COVID testing to inform cohort decisions

- If testing supplies or capacity are limited, testing of symptomatic HCP and symptomatic residents should be prioritized.
  - If unit-wide or facility-wide testing is not available in response to newly identified SARS-CoV-2 infected residents or HCP, moving any residents other than those confirmed to have COVID-19 should be done with caution given the risk of asymptomatic infection; in those situations, all recommended COVID-19 PPE should be used during care of all residents on the affected unit or facility.
- If testing capacity allows, use of facility-wide testing following identification of newly identified SARS-CoV-2 infected residents or HCP could be particularly important. Facility-wide testing can help identify asymptomatic or pre-symptomatic residents with COVID-19 to guide movement into COVID-19 designated spaces.

### Point Prevalence Testing

Pursuant to ED No. 20-013, the facility will ensure that the baseline molecular testing must be completed by or before May 30, 2020.

- The facility will supplement or amend the outbreak response plan to include facility assessment according to guidance and implement a COVID-19 testing plan (Plan) under ED No. 20-013.
- The administrator of the facility will provide the attestation of compliance to the DOH in accordance with the directive before May 19<sup>th</sup> and May 30<sup>th</sup> respectively.
- Pursuant to Section 3 of the ED, the facility will conduct testing to include:
  - Round 1: Baseline molecular testing of residents/residents completed by or before May 30, 2020;
  - Round 2: Retesting of individuals who test negative at baseline within 3-7 days after baseline testing; and
  - Round 3+: Further retesting in accordance with the NJDOH Directive referencing the CDC Guidelines.
- Those that previously tested positive are not required to be retested at this time, but proof of the positive result must be obtained and kept on file.
- Residents who test negative at baseline will be retested within 3-7 days after baseline. Residents that refuse testing or that are a person under investigation must remain in isolation for a full 14 days and staff must use full PPE.

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- For residents that refuse testing, the resident should be considered as a PUI, a note must be written in the chart, notify the family/responsible party and continue to check temperature at least twice a day. If a temperature or symptoms develop, then the resident must be moved and cohorted in accordance with the plan. The resident may rescind the refusal to be tested at any time.
- For suspect or confirmed COVID-19 case(s), resident/ family and MD notification should be done along with implementation of Standard and Transmission-based Precautions including use of a N95 respirator or higher (or facemask, if unavailable), gown, gloves, and eye protection.
- The facility will identify residents and cohort accordingly:
  - Confirmed positive residents
  - PUI's i.e. Residents who have been exposed to someone who has tested positive for COVID-19 (i.e., residents who are not themselves symptomatic, but may potentially be incubating the virus)
  - Residents who have tested negative and have not been exposed or further exposed
- **Ongoing:** New resident admissions that have tested negative previously or have not been tested will receive a baseline molecular test upon day of admission. If the baseline test is negative, the resident will be rested within 3-7 days of the baseline test. The resident must remain in isolation for the full 14 days period, or as recommended by the CDC or NJDOH or CMS.
- Further retesting will be completed as per guidance received from the NJDOH
- Any symptomatic residents will be retested at the time of clinical suspicion regardless of the testing interval.
- The Infection Control Preventionist and the Facility Administrator will conduct a review of all test results to assure that the testing schedule is appropriate to assure consistent specimen collection, interpretation of results and an infection control response.
- If there is limited access to re-testing the facility will strategize as follows:
  - a. Prioritize re-testing of any resident/resident with new symptoms and a previous negative result.
  - b. Prioritize re-testing residents/residents who frequently leave the facility for dialysis or other services.
  - c. Prioritize re-testing residents/residents with known exposures to positive residents/residents or staff, especially roommates of known positive cases.

### Employees PPS Testing

All center active staff must be tested for covid-19 in accordance with E.O. 20-013. Any staff refusing to be tested will not be permitted to work or visit the facility and is subject to discipline up to and including termination.

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- If a team member has tested positive (by another healthcare provider) the test results need to be provided to the facility.
- Employees that have already tested positive do not need to be retested.
- All other employees that have never been tested, tested negative or if test results are not on record, need to be tested and if negative, get a 2nd test within 3-7 days of the 1st test being administered.
- Testing requirements will be updated according to DOH guidelines and directives.
- All test results must be kept in the employee's confidential medical file.

### **COVID -19 REPORTING**

The facility will follow the Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Home in addition to the local/state health authorities. This includes the reporting to NHSN – CDC web site and the NJDOH site through NJHA to include i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; (ii) Total deaths and COVID-19 deaths among residents and staff; (iii) Personal protective equipment and hand hygiene supplies in the facility; (iv) Ventilator capacity and supplies in the facility; (v) Resident beds and census; (vi) Access to COVID-19 testing while the resident is in the facility; (vii) Staffing shortages; and (viii) Other information specified by the Secretary according to the specifications determined by CMS and NJDOH.

### **Removal of remains of the resident who expired of COVID 19**

The facility follows the guidance in relation to the executive order 20-010 as below:

1. When a death occurs at the facility unless the circumstances of the death are statutorily required to be investigated by the Medical Examiner's office, the facility shall contact the decedent's legal next-of-kin or the decedent's designated representative within 4 hours from the time of death and advise that the person(s) with legal authority to control the disposition of the decedent's remains must make arrangements for the removal and disposition by a licensed mortuary practitioner within 12 hours of death.
2. When a death occurs at the Facility, and there is no known legal next of-kin or designated representative for the decedent, or the remains have not been removed from the facility within 12 hours from the time of death, and the facility is unable to continue to safely store the remains, the facility may transport the remains to the designated State Temporary Morgue for the catchment area in which the facility is located, as set forth in paragraph 4 below.

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3. When a death occurs at the Facility and the identity of the decedent is unknown, unless the circumstances of the death are statutorily required to be investigated by the Medical Examiner's office, the remains shall be deemed to be unidentified.
  - a. The Health Care Facility shall, as soon as possible, but not later than 4 hours from the time of death, contact the office of the county or intercounty medical examiner in the jurisdiction where the death occurred to take custody of the remains.
  - b. If remains received as unidentified are thereafter identified, the county or intercounty medical examiner shall release the remains pursuant to the direction of any proper person willing to accept responsibility therefor and who shall state the name and last known residence of the deceased, and acknowledge receipt of the remains.
  - c. Unidentified remains shall not be transferred to or accepted by the State's temporary morgues.
  - d. Disposition of unidentified remains shall be performed pursuant to N.J.S.A. 40A:9- 54-o - 56.
4. When permitted under this Directive, Health Care Facilities and registered mortuaries may transport human remains to State Temporary Morgues as follows:
  - a. Northern Catchment Area: Hospitals, healthcare facilities, and registered mortuaries located in the counties of Bergen, Essex, Hudson, Passaic, Morris, Sussex and Warren may transport human remains to the Northern State Temporary Morgue, whose email address is: Morgue-north@gw.njsp.org and telephone number is (609) 433-4117.
  - b. Central Catchment Area: Hospitals, healthcare facilities, and registered mortuaries located in the counties of Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset and Union may transport human remains to the Central-Southern State Temporary Morgue, whose email address is Morguecentral@gw.njsp.org and telephone number is (609) 433-0641.
  - c. Southern Catchment Area: Hospitals, healthcare facilities and registered mortuaries located in the counties of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem may transport human remains to the Central-Southern State Temporary Morgue, whose email address is Morguesouth@gw.njsp.org and telephone number is (609) 433-4184.
5. The Facility or registered mortuary transferring human remains to a State temporary morgue maintains responsibility for making appropriate and timely arrangements for the removal of the remains from the State Temporary Morgue for final disposition.

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6. The Facility or registered mortuary that assumes responsibility for the transport of human remains to a State Temporary Morgue ("Transferring Entity") is required to do the following:

- a. Contact the State Temporary Morgue designated for the catchment area in which the Transferring Entity is located to make arrangements for the temporary morgue to receive the remains;
- b. Ensure that the medical professional pronouncing the death of the decedent initiates the death certificate by entering the death particulars (name, date of death, and cause of death) into the New Jersey Electronic Death Records System (EDRS) and that an EDRS number is generated prior to transport;
- c. Arrange for transportation of the remains from the Transferring Entity to the State Temporary Morgue designated for the catchment area in which the Transferring Entity is located;
1. The Department of Health, Office of the Chief State Medical Examiner, or Department of Law and Public Safety, Division of Consumer Affairs, may issue supplemental guidance on the transportation of remains during the current public health emergency.
- d. Accurately complete the State Transfer Form, which is attached hereto and incorporated herein by reference;
- e. Ensure that the remains prepared for transportation are accompanied by available information identifying the decedent, as set forth in paragraph 8 below;
- f. Ensure that the transportation provider returns a copy of the fully executed State Transfer Form to the Transferring Entity in a timely manner after the remains are transported to and received by the State temporary morgue;
- g. Maintain a copy of the fully executed State Transfer Form in the decedent's record;
- h. Provide the decedent's next of kin, if one exists, with a copy of the fully executed State Transfer Form and advise the next of kin when the remains were transferred and to which State temporary morgue; and
- i. Ensure that the appropriate arrangements are made for the removal of the remains from the State temporary morgue for disposition in a timely manner.

7. Prior to transportation from the location where death occurred or was discovered, all human remains, regardless of cause of death, shall be placed into non-porous, polyvinyl (minimum 8 mm thickness) zippered pouches designed for human remains (i.e., cadaver or "body" bags) and externally disinfected using products approved by the U.S. Environmental Protection Agency to be effective against emerging viral pathogens.

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- a. The Transferring Entity is responsible for maintaining an appropriate supply of cadaver bags to meet the demand.
  - b. Transferring Entities shall provide information on their inventories of cadaver bags to the New Jersey Department of Health, Office of the Chief State Medical Examiner, or New Jersey Office of Emergency Management.
  - c. State entities may, depending on supply, make available cadaver bags to Transferring Entities and may require reimbursement for cost.
8. Human remains prepared for transportation shall be accompanied by available information identifying the decedent.
- a. Identifying information must be recorded indelibly on the outside of the pouch, near the zipper closure, and on the body itself and shall include the decedent's name, date of death, date of birth, the name of the transferring entity and the EDRS case number for the decedent.
  - b. The Transferring Entity shall maintain a record describing any unique physical attributes of the deceased (scars, markings, tattoos) as well as retain a photograph of decedent and identifying marks, whenever possible.
  - c. When the cause of death is known or reasonably suspected to have been related to COVID-19 or other contagious disease, a completed copy of the Department of Health's Communicable Disease Alert Form must accompany the remains.
9. All persons involved in the preparation for disposition, transportation or storage of human remains, regardless of the cause of death, should wear appropriate personal protection equipment and adhere to precaution standards for the preparation and handling of human remains set forth in N.J.A.C. 8:9-1.3.
10. Mobility assistance vehicle providers and emergency medical providers, outside of the 911 system, may be used for the purposes of transporting human remains to and from the State temporary morgue sites.
- a. Providers transporting human remains shall ensure that the remains are properly secured in the vehicle for transport.
  - b. Upon completion of the transport, the emergency medical provider shall disinfect the vehicle that was used to transport the human remains with products approved by the U.S. Environmental Protection Agency to be effective against emerging viral pathogens.

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11. The facility using a State Temporary Morgue shall ensure that staff responsible for coordinating the removal of remains from the State Temporary Morgue are advised of the location of the remains and that staff immediately provide the location of the remains and a copy of the fully executed State Transfer Form to a licensed mortuary practitioner seeking to take custody of the remains for disposition.

12. The facility shall, within their staffing capabilities, afford mortuary and/or Medical Examiner staff 24-hour access to their morgues to retrieve human remains, inclusive of all holidays and for the duration of this Directive, to the best of their staffing resources.

### **UPDATES: 6-10-20**

#### **Guidelines (SOG) for outdoor visitations during COVID 19**

##### **Purpose**

The purpose is to establish an SOG for care of outdoor visitations during COVID 19 in accordance with the executive order no – 20-017

##### **Procedure**

- 1) Facilities may start scheduling appointments on the effective date of this Executive Directive, but visitation may not begin until June 21, 2020.
- 2) A resident who is suspected or confirmed to be infected with COVID-19; or quarantined for an exposure to a COVID-19 case cannot be visited except for an end of life situation.
- 3) A resident who has been diagnosed with COVID-19 may be visited only after they have met the criteria for discontinuation of isolation as defined in guidance from NJDOH and CDC.
- 4) The facility should honor each resident's right to have and choose visitors and to make preferences. The facility should consult every resident to determine who the resident would wish to visit with in person. These consultations also serve as a personalized communication with the resident to explain how visitation will work and what the resident can expect.
- 5) Clear communication of the visitation policy should be provided to residents, resident's visitors, staff and others, as needed in writing, via the methods the facility uses to convey information or policy changes.
- 6) The facility should establish a designated area for visitors to be screened that accommodates social distancing and infection control standards.
- 7) Visitors should be provided with the visitation guidelines upon check in. The facility should provide graphics to assist residents and visitors in maintaining social distancing and infection control standards.

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- 8) Visitors are not permitted entrance past the reception area of the facility, including restrooms, which will not be available to visitors at this time.
- 9) The facility should provide a visiting area with accommodations offered for those with mobility needs and designated seating for visitors.
- 10) The facility should also provide reasonable accommodations for any resident with a disability, such as hearing, vision, or cognitive impairments, and assist any resident with transport using their adaptive equipment.
- 11) Prior to transporting a resident to the designated outdoor visitation space, the facility must screen the visitor for infectious communicable diseases, including COVID-19 symptoms using the screening checklist.
- 12) Any visitors with symptoms of COVID-19 infection (subjective or objective fever equal to or greater than 99.6 F or as further restricted by facility policy, 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) will not be permitted to visit with a resident.
- 13) Transport of a resident to and from the designated outdoor visitation space must be safe and orderly. At a minimum, safe transport means that the resident cannot be transported through any space designated as COVID-19 care space or space where residents suspected or confirmed to be infected with COVID-19 are present.
- 14) Transport must be done while keeping 6 feet distance between other residents and staff.
- 15) A facility staff member familiar with the required protocols must remain with the resident at all times during the visit.
- 16) Each resident is limited to no more than two visitors at a time.
- 17) A visitor must remain at least 6 feet from the resident and attending staff member(s) at all times during the visit.
- 18) Whenever possible, visitors should wait in a vehicle prior to the visitation time. If the visitor is using public or ride share transport, the visitor(s) should wait in an outdoor space that ensures social distancing of at least six feet from other visitors.
- 19) Staff must wear at least a surgical facemask; residents must wear a face covering (surgical mask if supply is available); and visitors must wear a face covering or mask for the duration of the visit.

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- 20) Visits with a resident in a designated outdoor space must be scheduled in advance and are dependent on permissible weather conditions, availability of outdoor space, and sufficient staffing at the facility to meet resident care needs, as well as the health and well-being of the resident.
- 21) Facilities should provide appropriate protection from the weather, (e.g. sun, heat, and rain). Visits may be cancelled because of inclement or unsafe weather conditions (e.g. high humidity/heat, poor air quality).
- 22) A facility may limit the length of any visit, the days on which visits will be permitted, the hours during a day when visits will be permitted, and the number of times during a day or week a resident may be visited.
- 23) Food is not permitted during the visits. Visitors may bring items for the resident but must leave the package at reception or another location, as directed by the facility. Visitors may bring their own water which cannot be shared with the resident. The facility shall provide appropriate hydration for the resident during the visit.
- 24) At the conclusion of the visit, the residents should be transported back to their rooms by a facility staff member.
- 25) The facility will receive informed consent from the visitor and the resident in writing that they are aware of the possible dangers of exposure to COVID-19 for both the resident and the visitor and that they will follow the rules set by the facility in regard to outdoor visitation. The facility must receive a signed statement from each visitor and resident (if the resident is unable to consent then the consent needs to be signed by the authorized representative) with a copy provided to the visitor and resident, that they are aware of the risk of exposure to COVID-19 during the visit, that they will strictly comply with the facility policies during outdoor visitation, and that the visitor will notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID-19 within fourteen days of the visit.
- 26) At least 24 hours before commencing outdoor visitation, the facility must submit to the Department via email to [LTC.DiseaseOutbreakPlan@doh.nj.gov](mailto:LTC.DiseaseOutbreakPlan@doh.nj.gov) an attestation on facility letterhead from the facility administrator with the facility name and license number and “Outdoor Visitation Attestation” in the subject line, as follows:

*I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive No. 20-017 and the facility has a location designated for outdoor visitation, sufficient staff, a mechanism for appointments and sufficient PPE to permit visitation.*

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- 27) Facilities shall maintain records of all visitors to the facility including those outlined above. These records should document name, contact information, name of the resident being visited or other reason for visiting, and company or organization represented, if applicable. This information should be kept by the facility per policy, for a minimum of 30 days.

### UPDATED- 7-1-20

**Testing in Nursing Homes for** residents or healthcare personnel (HCP) who previously had COVID-19 confirmed by viral testing (e.g., reverse-transcriptase polymerase chain reaction, RT-PCR) and who have recently recovered need to be re-tested as part of facility-wide testing

Whether residents or HCP who previously had COVID-19 confirmed by viral testing need to be re-tested depends on: 1) how much time has passed since their initial illness; 2) what strategy the facility is using to determine when residents can discontinue isolation and HCP can return to work; and 3) whether the individual has developed symptoms after initial recovery.

- Most individuals who recently recovered from COVID-19 are likely no longer infectious even if they continue to have a positive viral test (e.g., persistently or recurrently detectable viral RNA). When an individual has a positive test result <6 weeks after they met criteria for [discontinuation of Transmission-Based Precautions](#) or [Home Isolation](#), it can be difficult to determine if they have been re-infected or if they still have detectable viral RNA from their previous infection.
- Residents and HCP who had a positive viral test in the past 6–8 weeks and are now asymptomatic may not need to be retested as part of facility-wide testing unless the facility is using a [test-based strategy to determine if residents can discontinue isolation](#) or [HCP can return to work](#). Residents and HCP who had a positive viral test over 8 weeks ago should be retested as part of facility-wide testing, regardless of symptoms.
- Residents and HCP who had a positive viral test at any time and become symptomatic after recovering from the initial illness should be re-tested and placed back on the appropriate [Transmission-Based Precautions](#) or excluded from work, respectively.

This guidance may be updated as we learn more information on viral persistence and risk for reinfection.

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## Updated information- Admission/Readmission- – 7-1-20

### Guidelines (SOG) new admissions or readmissions to the facility

- **Newly admitted and readmitted residents with confirmed COVID-19** who have not met criteria for discontinuation of Transmission-Based Precautions should go to the **designated COVID-19 care unit** however, can be housed in a private room for 14 days because of the chance of incidental exposure in the hospital or community. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.

These resident needs to follow the guidelines for discontinuation of transmission-based precautions using the symptom-based strategy or test-based strategy-based CDC guidelines.

- Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit, however should be quarantined for 14 days as precaution. It is recommended that they are tested on the day of admission. Testing at the end of 14 day to increase certainty is encouraged based on the availability of resources for testing. In case testing is not possible at the end of the 14-day, decision should be made under the guidance of the IPC and attending physician and this should be documented for clarity.
  - If Transmission-Based Precautions have been discontinued, but the resident with COVID-19 remains symptomatic (i.e., persistent symptoms or chronic symptoms above baseline), they can be housed on a regular unit but should remain in a private room until symptoms resolve or return to baseline.
  - These individuals should remain in their rooms to the extent possible during this time period.
  - If they must leave their rooms, facilities should reinforce adherence to universal source control policies and social distancing [e.g., perform frequent hand hygiene, have the resident wear a cloth face covering or facemask (if tolerated) and remain at least 6 feet away from others when outside of their room].
- **Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown.**
  - Options include placement in a single room or in a **separate observation area** so the resident can be monitored for evidence of COVID-19.
  - All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.
  - Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit.
  - However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future.

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- Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE.
- Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home.
- New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of 14 day to increase certainty is encouraged based on the availability of resources for testing. In case testing is not possible at the end of the 14-day, decision should be made under the guidance of the IPC and attending physician and documented for clarity.
- For residents who frequently leave the facility for dialysis or other services ( have met the criteria for discontinuation of transmission based precautions and/or has tested negative) it is recommended to place them in a private room under quarantine due to increased risk for exposure based on current guidance related to community/facility transmission of COVID 19.