Atlas Rehabilitation & Healthcare at Daughters of Miriam Response Plan for Emergent Infectious Diseases (Including COVID-19)

PURPOSE

To provide guidance to long term care providers on how to prepare for new or newly evolved Infectious diseases whose incidence in humans has increased or threatens to increase in the near future and that has the potential to pose a significant public health threat and danger of infection to the residents, families and staff of the skilled nursing center.

ASSUMPTIONS

This document contains general policy elements that are intentionally broad. It is customizable depending on the specific care center demographics, location, and current disease threats. It is not comprehensive and does not constitute medical or legal advice.

Every disease is different. The local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing center response related to a specific disease threat.

This document contains recommendations that may not be applicable to all types of long-term care facilities. Modifications should be made based upon the regulatory requirements and the structure and staffing for the specific care setting.

Definitions

Emerging Infectious disease -- Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:

i. New infections resulting from changes or evolution of existing organisms
ii. Known infections spreading to new geographic areas or populations
iii. Previously unrecognized infections appearing in areas undergoing ecologic transformation
iv. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

Pandemic - A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

Endemic Level – the usual level of given disease in a geographic area.
Isolating – process of separating sick, contagious persons from those who are not sick.
Quarantine – Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.
Cohorting -The practice of grouping patients who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other patients.
Department – Department of Health (DOH)
Long-term care facility – a nursing home, licensed pursuant to P.L. 1971, c.136 (C.26:2H – 1 et seq.).
Outbreak – any unusual occurrence of disease or any disease above background or endemic levels.

GOAL

To protect our residents, families, and staff from harm resulting from exposure to an emergent infectious disease while they are in our care center.

1. General Preparedness for Emergent Infectious Diseases (EID)

    a. The care center's emergency operation program will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza. This plan will:
        i. build on the workplace practices described in the infection prevention and control policies.
        ii. include administrative controls (screening, isolation, visitor policies and employee absentee plans.

iii. address environmental controls (isolation rooms, plastic barriers sanitation stations, and special areas for contaminated wastes).
iv. Address human resource issues such as employee leave of absence.
v. Be compatible with the care center's business continuity plan.

b. Clinical leadership will be vigilant and stay informed about EIDs around the world. They will keep administrative leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.

c. As part of the emergency operations plan, the care center will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, foot and head coverings, surgical masks, assorted sizes of disposable N95 respirators, and gloves. The amount that is stockpiled will minimally be enough for several days of center-wide care but will be determined based on storage space and costs.

d. The care center will develop plans with their vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including an EID outbreak.

e. The care center will regularly train employees and practice the EID response plan through drills and exercises as part of the center's emergency preparedness training.

f. The care center has contracted with Infectious Disease: Michael Barnish, DO, FAC or Robert E. Segal, MD, or alternate as indicated by Atlas Healthcare, LLC.

2. Local Threat

a. Once notified by the public health authorities at either the federal, state and/or local level that the EID is likely to or already has spread to the care center's community, the care center will activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities.

b. The care center's Infection Preventionist (IP) will research the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration

(OSHA), and other relevant local, state and federal public health agencies.

c. Working with advice from the care center's medical director or clinical consultant, facility laboratory, (Aculabs or alternative), safety officer, human resource director, local and state public health authorities, and others as appropriate, the IP will review and revise internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.

d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.

e. If EID is spreading through an airborne route, then the care center will activate its respiratory protection plan to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.

f. Provide residents and families with education about the disease and the care center's response strategy at a level appropriate to their interests and need for information.

g. Brief contractors and other relevant stakeholders on the care center's policies and procedures related to minimizing exposure risks to residents.

h. Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the care center along will the instruction that anyone who sick must not enter the building.

i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the care center, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work.

j. Self-screening – Staff will be educated on the care center's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:

    i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health.

ii. Precautionary removal of employees who report an actual or suspected exposure to the EID.
iii. Self-screening for symptoms prior to reporting to work.
iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.

k. Self-isolation - in the event there are confirmed cases of the EID in the local community, the care center may consider closing the care center to new admissions, and limiting visitors based on the advice of local, state and federal public health authorities.

l. Environmental cleaning - the care center will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.

m. Engineering controls – The care center will utilize appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

n. Reporting Requirements - Filing reports is important for appropriate oversight and regulation of healthcare. This includes reporting to federal and state governmental agencies, with timely and accurate information needed to make prompt and necessary decisions. The care center will comply with all reporting requirements of all applicable Governmental Guidelines & Directives including, but not limited to, reporting to the NHSN through the SAMS portal (overseen by the CDC) as required by NJDOH Executive Directive No. 20-026**.**

o. Aculabs (or alternate) will provide all laboratory testing and resulting unless otherwise directed by federal, state, and local authorities

p. The facility has the right to obtain new laboratory services if needed.

q. Visits with family members and loved ones are very much encouraged and will be conducted in accordance with the CDC's, CMS and NJDOH's guidelines for indoor and outdoor visitations. Visitation may be restricted based on recommendations from federal, state, and local public health authorities.

3. Suspected case in the care center

a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation room and notify local public health authorities.

b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible.

c. If the suspected infectious person requires care while awaiting transfer, follow care center policies for isolation procedures, including all recommended PPE for staff at risk of exposure.

d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.

e. If feasible, ask the isolated person to wear a facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless it advised otherwise by public health authorities.

f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.

g. Implement the isolation protocol in the care center (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the care center's infection prevention and control plan. Please refer to: (**Categories of Transmission Based Precautions**) and/or recommended by local, state, or federal public health authorities.

h. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

4. Employer Considerations

a. Management will consider its requirements under OSHA, (Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and other employees shall be of paramount concern. Management shall take into account:

   i. The degree of frailty of the residents in the care center.
   ii. The likelihood of the infectious disease being transmitted to the residents and employees.
   iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces)
   iv. The precautions which can be taken to prevent the spread of the infectious disease and

b. Other relevant factors Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.

c. Apply whatever action is taken uniformly to all staff in like circumstances.

d. Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.

e. Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.

f. Generally, accepted scientific procedures, whenever available, will be used to determine the level of risk posed by an employee.

g. Permit employees to use sick leave, vacation time, and FMLA where appropriate while they are out of work.

h. Permit employees to return to work when cleared by a licensed physician, however, additional precautions may be taken to protect the residents.

i. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline.

j. To notify via phone, social media, email or other electronic notification system, residents, staff, families/guardians and attempt to keep them informed of their response to the outbreak, and include any new or suspected cases COVID-19 in the facility. All communication will be sent out in compliance with the frequency and content as required by all applicable and current Governmental Guidelines and Directives.

6. Isolation and Cohorting:

a) Include the potential for transmission of infectious agents in patient placement decisions.
b) Place patients who pose risk for transmission to others (e.g., uncontained secretions, excretions, or wound drainage) in a single patient room when available.

c) Determine the patient placement based on the following principles:
    i. Route of transmission of the known or suspected infectious agent.
    ii. Risk factors for transmission in the infected patient.
    iii. Risk factors for adverse outcomes resulting from a HAI in other patients in the area or room being considered for patient placement.
    iv. Availability of single room

d) Consult infection control professionals before patient placement to determine the safety of alternative room that do not meet engineering requirements for negative pressure room, EID airborne.
e) Place together (cohort) patients who are presumed to have the same infection based on clinical presentation and diagnosis when known) in area of the facility that are away from other patients, especially patients who are at increased risk for infections (e.g., immunocompromised patients)
f) Consider using temporary portable solutions (e.g., exhaust fan) to create negative pressure environment in the converted area of the facility. Discharge air directly to the outside, away from people and air intakes, or direct all the air through HEPA filters before it is introduced to other airspaces.
g) Residents remain on appropriate precautions until Attending Physician, the Medical Director or guidance form federal, state, and local authorities to discontinue.

h) Cohorting residents for COVID-19 based on the following:

1. Individuals who are showing symptoms of COVID-19 or who have tested positive for COVID-19.
2. 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
3. Individuals who are not ill and has not been exposed.

i) Facility shall assign dedicated staff to each cohort and allow for necessary space to do so at the onset of an outbreak. Please refer to **(Cohorting and Managing Residents for COVID-19 Policy).**

6. Test Based Prevention Strategy (PPS) Point Prevalence Survey

Testing of Residents

1. If testing capacity allows, **facility-wide PPS of all residents** should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience from nursing homes with COVID-19 cases suggests that when residents with COVID-19 are identified, there are often asymptomatic residents with SARS-CoV-2 present as well.
2. PPS of all residents in the facility can identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility. If undertaking facility-wide PPS, facility leadership should be prepared for the potential to identify multiple asymptomatic residents with SARS-CoV-2 infection and make plans to cohort them.
3. If testing capacity is not sufficient for facility-wide PPS, performing PPS on **units with symptomatic residents** should be prioritized.
4. All residents will have molecular testing completed by or before May 26, 2020
5. All residents who test negative will be retested within 48 hours after baseline testing, and if negative, again after 48 hours.
6. If testing capacity is sufficient, and the COVID -19 status is unknown, new admissions and readmissions will be tested residents to determine status and may be considered a Person Under Investigation until test results received.
7. If a resident/patient **refuses** to undergo COVID-19 testing, then the facility shall:

    - Treat the individual as a Person Under Investigation
    - Make a notation in the resident's chart
    - Notify any authorized family member or legal representative of this decision
    - Continue to monitor the resident for signs/symptoms of COVID-19 at least twice per day.

8. The onset of temperature or other symptoms consistent with COVID-19 require implementation of TBP immediately and cohorting in the appropriate group (if many symptomatic residents are present).
9. At any time the resident may rescind their decision not to be treated.

When testing capacity is available and facility spacing permits, patients/residents should be organized into the following cohorts:

a) Cohort 1 – COVID-19 Positive:

This cohort consists of both symptomatic and asymptomatic patients/residents who test positive for

COVID-19, including any new or re-admissions. If feasible, care for COVID-19 positive patients/residents on a separate closed unit. Patients/residents who test positive for COVID-19 are known to shed virus, regardless of symptoms; therefore,

all positive patients/residents would be placed in this positive cohort.

b) Cohort 2 – Symptomatic Residents being evaluated for COVID-19:

This cohort consists of symptomatic patients/residents who test negative for COVID-19 with an identified exposure to someone who was positive. **All symptomatic COVID-19 negative patients/residents should be considered exposed but should also be evaluated for other causes of their symptoms.** To the best of their ability, separate symptomatic and asymptomatic patients/residents, ideally having one group housed in private rooms. Even though symptomatic COVID-19 negative patients/residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Asymptomatic patients/residents should be closely monitored for symptom development.

c) Cohort 3 – Symptomatic Residents who are also identified as having close contact with someone with who tested positive for COVID-19:

This cohort consists of patients/residents who test **negative for COVID-19 with COVID- 19 like symptoms and are thought to have no known exposures**. In situations of widespread COVID-19, all negative persons in a facility may be considered exposed. **Cohort 3 should only be created when the facility is relatively certain that patients/residents have been properly isolated from all COVID-19 positive and incubating patients/residents and staff.** Facilities may not be able to create this cohort.

d) Cohort 4 – Asymptomatic residents who have had close contact with someone positive for COVID-19 and are placed on empiric TBP:

In general room restriction for these individuals is not required; however, TBP may be considered when the resident is unable to be tested or wear source control for the recommended time period; if they are moderately to severely immunocompromised; reside on a unit with ongoing SARS-CoV-2 infection that is not controlled by initial interventions; or as directed by local or state authorities.

- **If there are multiple cases on the wing/unit and when movement would otherwise introduce COVID- 19 to another occupied wing/unit, do not relocate them. Limit the movement of all patients/residents and staff in general.**

10. If testing capacity is not sufficient for unit-wide PPS, testing should be prioritized for **symptomatic residents and other high-risk residents**, such as those who are admitted from a hospital or other facility, roommates of symptomatic residents, or those who leave the facility regularly for dialysis or other services.

Retesting Residents

After the initial testing has been performed for residents and the results have been used to implement resident cohorting, the facility may consider retesting under the following circumstances:

- Retest any resident who was negative and develops symptoms consistent with COVID-19.

- Retest all resident who previously tested negative at some frequency (every 48 hrs x 2 tests) after the initial PPS
- Consider continuing retesting until PPS do no identify new cases
- If testing capacity is not sufficient for retesting all residents, retest those who frequently leave the facility for dialysis or other services and those with known exposure to infected residents (such as roommates or HCP).

Testing of HCP

1. If testing capacity allows, PPS of **all HCP** should be considered with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well.
2. Baseline molecular testing of all direct care workers and non-direct care workers within the long-term care facility (i.e., administrative, housekeeping, dietary staff) shall be completed by or before May 26,2020.
3. Employees with initial negative results may be retested in 48 hours and if negative, again in 48 hours.
4. Negative employees shall continue to work and follow current facility infection control practices.
5. New hires will be screened and tested upon hire.
6. Unless new hires are symptomatic, will be allowed to work, following the facility current facility infection control practices.
7. Testing Consent will be obtained from each employee and placed in their medical file.

8. Further retesting in accordance with the CDC guidance, amended and supplemented. CDC recommends **HCP with COVID-19 be excluded from work**.
9. If a staff member test positive for COVID-19 (Symptomatic or Asymptomatic), the facility may permit the employee to return to work subject to the CDC/NJDOH as follows:

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

1. ***Time-based strategy.*** Exclude from work until:
    - should remain on isolation until 10 days have passed since the date of first positive SARS-CoV-2 viral diagnostic test OR 7 days have passed with a negative viral test obtained within 48 hours prior to returning to work** **AND** have **remained asymptomatic** (if symptoms appear during this time refer to symptom bases strategy).
2. ***Test-based strategy***. Exclude from work until:

- Use of a test-based strategy and consultation with an infectious disease specialist or other expert and an occupational health specialist is **recommended to determine when moderate to severely immunocompromised HCP may return to work.** This approach requires results from at least two consecutive specimens collected 48 hours apart using a viral test. When symptoms are present, there should be resolution of fever and improvement of symptoms.

3. ***Symptom-based strategy.*** Exclude from work until:
    - HCP who are not moderately to severely immunocompromised with mild to moderate illness should remain in isolation until **10 DAYS** have passed since symptoms first appeared (for severe to critical illness, a minimum of 10 days, up to 20) OR 7 days with a negative viral test obtained within 48 hours prior to returning to work** **AND** at least 24 hours have passed since the resolution of fever without the use of fever-reducing medication **AND** improvement of symptoms.

**If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later, day 7. Day 0 is the point of symptom onset or positive viral test for asymptomatic infection.

- The facility should continue to **assess the risk of exposed healthcare personnel to COVID-19** using the NJDOH Healthcare Personnel (HCP) Exposure to COVID-19 Case Risk Algorithm, which would include a 10-day furlough from work, while actively monitoring for symptoms.
- In facilities where staff attendance is strained by excessive callouts and furloughs, the facility, may **consider allowing asymptomatic HCP who have had a HIGH or MEDIUM risk exposure to a COVID-19 patient to continue to work provided the following**:
    1. HCP should **report temperature and absence of symptoms each day** prior to starting work (at least every 12 hours while at work) for the 10-day period after their exposure.
        - If HCP develop even **mild** symptoms consistent with COVID-19, they must **cease patient care activities**, **don a facemask (if not already wearing)**, and **notify their supervisor or occupational health services** prior to leaving work.
    2. **HCP wears a facemask while at work for the same 10-day period.**
- **Asymptomatic HCP who tested positive for COVID-19** should continue home isolation for 7 days after their first positive COVID-19 test AND have had no subsequent symptoms. Out of an abundance of caution they should follow masking guidance below.
- **Symptomatic HCP who have tested positive for COVID-19** may return to work 7 days after symptoms first developed AND 72 hours (3 days) after fever has resolved without the use of fever-reducing medications with a significant improvement in symptoms (whichever period is longer). HCP who have tested positive for COVID-19

shall be:

1. Masked at work until symptoms have completely resolved or until 10 days after illness onset/positive test (whichever is longer) and.
2. Restricted from caring for severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset/positive test (whichever is longer).

HCP Refusing Testing by Facility

Any employee who test positive for COVID-19, refuse to participate in COVID-19 testing, or refuse to authorize release of their testing results to the LTC will be excluded from work until such time as such staff undergoes testing and the results of such testing are disclosed to the LTC.

7. Contingency Staffing Capacity Strategies

The facility will review and adjust staff schedules, hire additional HCP, and rotate HCP to positions that support patient care activities within the facility. Additional guidance includes but is not limited to:

1. Cancel all non-essential procedures and visits.
2. Shift HCP who work in other areas to support patient care activities in the facility.
3. Administration will need to ensure these HCP have received appropriate cross- training to work in these areas that are new to them.
4. Initiate Staff Communication meetings to attempt to address social factors in that might prevent HCP from reporting to work such as transportation or housing if HCP with vulnerable individuals.
5. Identify additional HCP to work in the facility via Agency Assistance.
6. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP assistance.
7. Request that HCP postpone elective time off from work where applicable.

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Nursing Home Administrator: Yehuda Cohen

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Department of Health	Blackwood, NJ 08012	
Gloucester County Department of Health	204 E. Holly Avenue Sewell, NJ 08080	(P) 856-218-4100
NJ After-Hours Department of Health Staff		(P) 609-392-2020
NJ After Hours Infectious Disease Questions		(P) 609-826-5964

New Jersey Department of Health	P.O. Box 360 Trenton, New Jersey 08625-0360	1-800-962-1253
Burlington County Health Department	Rapheal Meadow Center 15 Pioneer Blvd Westhampton, NJ 08060	(P) 609-265-5548 (F) 609-265-3152
Camden County	512 Lakeland Rd,	(P) 856-379-6037

Resources/References:

https://www.covid19.nj.gov
https://www.nj.gov/health
https://www.cdc.gov/
https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
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https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

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