Outbreak Response Plan (as required by NJDOH Executive Directive No. 20-026)

In accordance with N.J.S.A. 2H-12.87, assisted living residences are required to have an outbreak response plan that includes the items specified in the March 6, 2020 notification issued by the New Jersey Department of Health (NJDOH) and amended by NJDOH Executive Order No. 20-026 issued August 10, 2020.

1. **Lessons learned from the response to and experience with COVID-19**
    a. Screening and monitoring of residents and staff for symptoms
    b. Implementation of isolation and cohorting plans
    c. Continuous education and training of staff on PPE and infectious disease policies and protocols
    d. Communication with staff, residents, families and resident representatives on status of new cases, policies and protocols in the event of an outbreak
2. **Communication in the event of an outbreak:**
    a. Communication with staff
        i. Method – Staff will receive notices via text, email, and/or verbal communication
        ii. Communication will describe the mitigating actions taken by the facility to prevent or reduce the risk of transmission and shall not include personally identifiable information
        iii. At least weekly
    b. Communication with residents, families or guardians
        i. Method – Residents will receive letters via email and delivery to their apartments
        ii. Method – Families or guardians will receive phone calls and/or letters via email and/or mail delivery via USPS
        iii. Communication will describe the mitigating actions taken by the facility to prevent or reduce the risk of transmission and shall not include personally identifiable information
        iv. At least weekly; or
        v. Per CMS guidance by 5 p.m. the next calendar day following the subsequent occurrence of either:
            1. Each time a single confirmed infection of COVID-19 is identified or
            2. Whenever 3 or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other

3. **Policy and Procedure for virtual communication with residents, families, and resident representatives in the event of visitation restrictions**
    a. In the event of visitation restrictions, communities will resume virtual communication between residents, families and resident representatives through Facetime, Zoom video conferencing, etc. Window visits will also resume. Staff are available to help facilitate with virtual communication, as necessary. Appointments for Facetime or Zoom calls and/or window visits can be made by calling the receptionist or designee.

4. **Strategy for securing necessary staff in the event of a new outbreak of COVID-19 or any other infectious disease or emergency among staff**
    - **a.** When a staff shortage is anticipated the facility will use contingency staffing strategies to plan and prepare for mitigating this problem:
        - i. Determine the current staffing needs to provide a safe work environment and safe resident care based on:
            1. The number of residents residing in the community and;
            2. The care needs of those residents
        - ii. Contingency capacity strategies will include:
            1. Adjusting staff schedules
            2. Hiring additional staff
                a. Utilize Vikus online recruiting platform
                b. Offer referral bonuses for existing staff to refer candidates
                c. Offer signing bonuses
                d. Utilize "hazard pay" rates
            3. Following Return to Work strategy described below
            4. Utilizing Agency staff (utilizing agency staffing does not necessarily indicate that a contingency capacity strategy has been initiated)
                a. The Facility has Staffing Agency contracts with the following:
                    i. Care Right There (856) 244-7722 (for Cardinal Village)
            5. Cancel all non-essential activities and visits to shift staff who work in these areas to support resident care with appropriate orientation and training
            6. Training managers to provide resident care
            7. As appropriate, request that employees postpone elective time off from work
                a. Consideration will be given to the mental health benefits of time off during an outbreak
            8. Allow asymptomatic staff who have had an unprotected exposure to COVID-19 but are not known to be infected to continue to work
                a. Subject to daily wellness screening before, during and after work
                b. Subject to following PPE policies and procedures, including wearing a facemask (for source control)
            9. Communicate with local public health partners to identify possible staffing resources
                a. Gloucester County Health Department 856-218-4138 or 856-218-4101
            10. Undertake Crisis Capacity Strategies to Mitigate Staffing Shortages
                a. Per CDC and NJDOH guidance.

4. Strategy for securing necessary staff in the event of a new outbreak of COVID-19 or any other infectious disease or emergency among staff (Continued)

Return to Work

When can an employee who was diagnosed with COVID-19 who is symptomatic return to work?

Healthcare workers diagnosed with COVID-19 must be isolated at home for a minimum of 10 days after symptom onset. There must be at least 24 hours that have passed since having a fever without medication and feeling well with improved respiratory symptoms before returning to work.

When can an employee who was diagnosed with COVID-19 who is asymptomatic return to work?

Healthcare workers who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since their first positive viral diagnostic test.

After returning to work, employees should:

- Wear a facemask at all times while in the healthcare facility. As of 4/2/2020, Heritage Senior Living instituted a policy that all employees must wear a mask during their entire shift.
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles).
- Self-monitor for symptoms and report to Executive Director if respiratory symptoms recur or worsen.

When can an employee return to work when the COVID-19 test is negative and the employee has had upper respiratory symptoms?

- The employee may return to work when the employee has had at least 24 hours without having a fever without medication and feeling well with improved respiratory symptoms.

Source:

https://www.cdc.gov
Criteria for return to work for healthcare personnel with SARS-CoV-2 infection (interim guidance)

5. Urgent Calls or Concerns:

a. A phone number (856) 373-6603 (Cardinal) for urgent calls and an email address Covidconcerns@cardinalvillage.com for non-urgent concerns has been prominently displayed on the facility's website and included in communications to families.

6. Testing:

a. Weekly testing of all staff was initiated beginning August 24, 2020 and will continue until guidance from NJDOH changes

6. Testing: (Continued)

b. In the event of a Covid19 outbreak, testing of residents will be initiated as follows:
   i. Repeat weekly testing of all residents until no new facility-onset of COVID-19 are identified among residents and staff and at least 14 days have elapsed since the most recent positive result and during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative
   ii. Retesting of residents who have been confirmed positive whenever required according to CDC and NJDOH guidance.

c. The Facility will continue to report testing data through the New Jersey Hospital Association. (NJHA) portal

d. Any resident or staff who is newly symptomatic consistent with COVID-19 will be retested at the onset of symptoms, regardless of the interval between the most recent negative test and the symptom onset

7. Routine Monitoring and Screening: The facility shall actively screen all persons entering the building (except EMS personnel) for signs and symptoms of COVID-19 The screening will take place in the designated screening area that accommodates social distancing and infection control standards. All Visitors (including outside health care providers, consultants and contractors) and staff are required to check-in at the front desk kiosk to receive the following screening:

a. Temperature checks including subjective and/or objective fever equal to or greater than 100.4 F

b. Completion of a screening questionnaire about symptoms and potential exposure which shall include at a minimum:
   i. Whether in the last 14 days, the visitor has had an identified exposure to someone with a confirmed diagnosis of COVID-19, someone under investigation for COVID-19, or someone suffering from a respiratory illness.
   ii. Whether the visitor has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC.
   iii. Whether in the last 14 days, the visitor has returned from a state on the designated list of states under the 14-day quarantine travel advisory, available for review at https://covid19.nj.gov/faqs/nj-information/travel- information/which-states-are-on-the-travel-advisory-list-are-there-travel- restrictions-to-or-from-new-jersey.
   iv. Determination if any signs or symptoms of COVID-19, are exhibited including, but not limited to:
      1. chills;
      2. cough;
      3. shortness of breath or difficulty breathing,
      4. sore throat;
      5. fatigue;
      6. muscle or body aches;
      7. headache;
      8. new loss of taste or smell;
      9. congestion or runny nose;

7. **Routine Monitoring and Screening: (Continued)**

10. nausea or vomiting; or
11. diarrhea

c. **Prohibited entry** Upon screening, the facility shall prohibit entry into the building for those who meet one or more of the following criteria:
   i. Exhibit signs or symptoms of an infectious communicable disease, including COVID-19, such as a subjective and/or objective fever (evidenced by a temperature check of the visitor equal to or greater than 100.4 F or as further restricted by facility), chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea
   ii. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or someone under investigation for COVID-19, or someone ill with respiratory illness;
   iii. In the last 14 days, has returned from a designated state under the 14-day quarantine travel advisory; or
   iv. Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH

https://www.state.nj.us/health/cd/topics/ncov.shtml and CDC https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html.

d. **Permitted entry**: If, after undergoing screening, the person is permitted to enter the building, the facility shall:

   i. The facility will have the visitor review and sign an informed consent. The informed consent states that they are aware of the possible risk of exposure to COVID-19 for both the resident and the visitor and that they will strictly comply with the rules set by the facility in regard to visitation. 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. The Facility must retain a copy of this 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,
   ii. Require the person to wear a cloth face covering or facemask. The facility may require the visitor to use additional forms of personal protective equipment (PPE), as determined by the facility.
   iii. Provide the visitation guidelines
   iv. Provide instruction on hand hygiene, limiting surfaces touched, the use of PPE, and inform visitors of the location of hand hygiene stations,
   v. Advise the person to limit physical contact with anyone other than the resident while in the facility. For example, practice social distancing with no handshaking, kissing or hugging and remaining six feet apart

7. Routine Monitoring and Screening: (Continued)

d. Permitted entry: (Continued)

vi. For visitors provide visitation in the resident's room, if they are in a single room. If a resident is in a shared room, the facility needs to identify a visitation location that allows for social distancing and for deep cleaning. Limit the visitor's movement within the facility to the resident's room or designated space (e.g., reduce walking the halls, avoid going to dining room, etc.)

vii. The facility will advise anyone entering the facility to monitor for signs and symptoms of COVID-19 for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. The facility will immediately screen the individuals of a reported contact, and take all necessary actions based on any findings

viii. Persons who are unable to demonstrate the proper use of infection prevention and control techniques will be restricted from entering the facility.

ix. No more than two visitors are permitted at one time per resident. The facility will use appointments in order to limit the number of visitors inside the building at one time

8. Reporting to Public Health Officials:

a. The facility shall enter information in the NHSN COVID-19 Module twice weekly
b. The facility shall report daily on the NJHA website
    i. Case count
    ii. PPE Inventory
    iii. Testing
    iv. Test results
c. The facility shall call the Gloucester County, NJ Department of Health upon the occurrence of any new positive cases of COVID-19 among residents and/or staff
    i. 856-218-4101 or 856-218-4137

9. **Environmental Services**:

    a. During COVID-19 or other infectious outbreak the facility will safeguard the cleanliness of the environment, to reduce the potential of spread of infectious pathogens. The facility is ensuring that the cleaning processes follow established CDC, Depart of Health and EPA recommendations.

        i. All cleaning solutions used are of the appropriate and registered by Environmental Protection Agency (EPA)

        ii. Cleaning supplies and equipment shall be appropriately cleaned, disinfected and stored to protect against the spread of pathogens.

        iii. All personnel are responsible for promptly reporting potentially infectious conditions.

        iv. The wellness department will notify the housekeeping department when the possibly of the spread of infectious organism exists (Resident testing positive for COVID-19).

        v. Cleaning consist of a thorough cleaning and disinfection with special emphasis on those items handled directly by the resident; furnishings, faucets handles, commodes, door knobs, etc. high touch areas.

        vi. Washing of walls where frequently touched areas.

        vii. Floor clean specific to covering; example, carpet, wood, tile, ceramic, etc.

        viii. Non-disposable, re-usable residents care items should be cleaned and appropriately disinfected before reusing.

    b. Apartment cleaning is done to establish cleanliness and consistency in the way an apartment is cleaned and disinfected during an infectious outbreak

    c. All residents' laundry will be washed and dried separately; returned to their rooms using proper infection control standards.

    d. Hand hygiene stations containing alcohol-based hand rubs are located throughout the community

Cohorting

In the event of a COVID-19 outbreak putting our residents at risk, the following plan should be implemented to slow the spread of the virus and protect those most vulnerable by addressing the need to separate residents based on their status, dedicate staff to applicable cohorts when appropriate, and create necessary space to meet these needs at the onset of the outbreak.

Resident Cohorting: This may be done by creating areas or zones using different wings, using different portions of a hall (opposite ends), and/or setting up space dividers such as privacy curtains in communal areas. The most effective measures will be building-specific, based on the building layout and the feasibility of providing care safely, with infection-control protocols always followed.

Residents should be identified in the following cohorts

Cohort 1 – COVID-19 Positive (This includes all residents who have been confirmed via testing; whether symptomatic or asymptomatic; whether new resident, readmitted resident, or current resident.) The number of rooms will be adjusted as needed based on the number of positive cases. Rooms may be shared by residents who are positive, with privacy screens or dividers to separate them.

Cohort 2 – COVID-19 Negative, but Exposed (This includes all residents who have tested negative but are identified as having been exposed or are suspected of having been exposed. These residents may be symptomatic or asymptomatic.) The number of rooms will be adjusted as needed based on the number of cases identified as negative, but exposed. Rooms may be shared by residents who are of the same cohort, with privacy screens or dividers to separate them.

Cohort 3 – COVID-19 Negative, Not Exposed (This includes all residents who have tested negative and have no symptoms. These residents are thought to have no known exposures.) This will likely include the majority of the residents in the building and would therefore require little to no movement of these residents. Rooms may be shared by residents who are of the same cohort, with no privacy screens necessary.

Cohort 4 – New or Readmission (This includes all persons being admitted or readmitted, whose status is unknown.) These residents will remain in observation, in an isolated area, for 14 days to be monitored for symptoms. It is likely these residents would be isolated in private rooms if such accommodations are available; if not, privacy screens or dividers will be used. If isolated in private rooms with no communal sharing of space, those rooms may be located within the same hallway or unit as Cohorts 2 and 3. If New or Readmissions have a recent (within 48 hours) negative test result, they will only have to remain in isolation as long as it takes to have them re-tested to confirm a second negative test. After a second negative test, their status can be changed to Cohort 3.

Cohorting

Cohort 5 – Memory Care Neighborhood (This includes all residents residing in secured memory care neighborhoods; whether new resident, readmitted resident, or current resident.) If a resident has a positive test result, they will be isolated in their room as tolerated and the entire neighborhood will be treated as COVID-19 positive, with appropriate staffing and PPE usage. If New or Readmissions have a recent (within 48 hours) negative test result, they will only have to remain in isolation as long as it takes to have them re-tested to confirm a second negative test. After a second negative test, their status can be changed to Cohort 3.

Rooms: Rooms may be shared by residents who identify of the same status, with a privacy screen, curtain, or divider between them as described above to prevent cross-contamination. Rooms may not be shared by residents who identify with different cohorts. When establishing cohorts, it is of the utmost importance to move residents only when necessary, to avoid spreading the virus throughout the building.

Medical Equipment: Though most residents obtain their own personal equipment, there may be rare occasions when the home may provide equipment that has been used for multiple people, in turn. No equipment may be shared in different cohorts, at any time. If equipment is shared within a cohort, it must be cleaned and disinfected between uses.

Staffing: When possible, staff will be assigned to work with a specific cohort, and will be assigned exclusively, to prevent movement between areas. This scheduling will be impacted by the number of residents in each cohort. In the event staff are assigned to provide care for multiple cohorts, staff would round from well/low risk (negative test results) first, to possible/medium risk (unknown), to probable/moderate risk (exposed), to ill/high risk (positive test results). Any staff who have tested positive and returned to work will only be assigned to residents who have tested positive (Cohort 1) or tested negative but have been exposed (Cohort 2). See also the Employee Exposure Guidelines, which are included at the end of this plan.

PPE: All PPE usage, storage, and disposal procedures outlined in the PPE Guidelines (included at the end of this plan) are to be implemented for all cohorts. A minimum of a face mask is required by everyone entering the building. When entering an area of minimum risk (Cohort 3), mask and gloves will be worn. When entering areas of medium or moderate risk (Cohorts 2 and), staff should use gloves, gowns, and an N95 mask. When entering an area of high risk (Cohort 1), staff should also use a face shield in addition to all other PPE. In situations when there is a facility outbreak, the entire facility would be considered Cohort 1 and 2 and therefore**, all staff** would wear gloves, gowns, N95 masks and face shields.

Cohorting

COVID-19 Personal Protective Equipment (PPE):

Our top priority is the safety of our staff and the safety of our residents. We are continuously evaluating our policies and procedures regarding the use of PPE as new information and new state and national guidelines emerge.

How should I care for my surgical mask?

- The outside of the masks should be treated as potentially infectious.
- Avoid touching the outer surface of the mask.
- Every time the mask is touched, hand hygiene must be performed.
- Masks **do** need to be replaced if soiled and after aerosol-generating procedures. (Nebulizers)
- Masks must not be touched, pulled down, mal-positioned, or worn as a necklace.
- If the mask gets torn, wet, visibly soiled, or hard to breathe through, it should be removed and discarded.

Is there a different management plan for N95 masks?

All of the above recommendations for surgical masks apply to N95 masks except that we expect N95 masks will be fitted per CDC guidelines and can be used for up to 7 days though they need to be replaced if soiled and after aerosol-generating procedures.

Do all residents have to wear face masks?

Residents are instructed to wear a facemask (for source control) at all times when outside of their apartments. Residents with symptoms consistent with COVID-19 will be provided a face mask and isolated per our existing policies. In their rooms/apartment, if symptomatic residents cannot tolerate a face mask, they no longer need to wear the face mask as long as their caregivers are wearing appropriate personal protective equipment.

Can a single face mask be worn continuously, including care of multiple residents?

Yes. A single mask can be worn to provide care of multiple residents. Masks must be changed, however, if they become wet or contaminated during a case.

Can I use my face mask between residents, including those with confirmed COVID-19, suspect COVID-19, other respiratory viruses or residents in whom none of these apply?

Yes. Your face mask must be handled carefully to prevent both self-contamination and cross-contamination. Under conditions of extended use or reuse, a face shield can be worn over the face mask when caring for residents in droplet/contact precautions as the form of eye protection and to reduce potential splatter to the mask.

Cohorting

How can I drink when I am supposed to wear a face mask (surgical or procedural)?

Drinking is only permitted in designated areas. If you need to drink, ensure you are 6 feet away from others, perform hand hygiene, remove the mask, drink, and then replace your face mask.

How do I handle the mask when I'm ready to eat/drink during a break?

In nonclinical settings, where eating and drinking is not restricted, take the following steps to remove the mask:

1. Perform hand hygiene with soap and water or an alcohol-based hand rub
2. Prepare clean surface (paper towel) or paper bag.
3. Remove the face mask by grabbing strings by ears and carefully removing mask from face.
4. Store mask carefully to avoid contamination to other surfaces and
5. Perform hand hygiene with soap and water or an alcohol-based hand rub

After you have finished eating or drinking, take the following steps to replace the mask:

1. Perform hand hygiene with soap and water or an alcohol-based hand rub
2. Remove mask carefully and don mask ensuring clean side is to your face, taking care to avoid touching face or eyes
3. Perform hand hygiene with soap and water or an alcohol-based hand rub

Can staff gather in break rooms and other places to eat and relax, and if so should they leave their masks on?

Staff should adhere to the same principles of social distancing when together in break rooms, conference rooms or other spaces. They should allow 6 feet distance from others and should take the appropriate precautions involving hand hygiene and not touching their faces. Masks can be taken off in such areas for eating and drinking. To limit the number of people in a break room, staff should consider staggering their break times.

Can non-approved PPE devices be brought from home (e.g. masks, goggles, etc.)?

For the foreseeable future, communities have adequate supplies of PPE for its employees. We are constantly looking for new suppliers for such critical items as masks, gloves and eye protection. Therefore, unless or until we reach such a critical shortage of PPE that we have no other choice, we recommend not allowing the use of PPE devices brought from home.

Cardinal Village Community - Cohorting Rooms and Staffing Plan

Cohort Rooms
Cohort 1 – 344 and 345
Cohort 2 – 343
Cohort 3 – Regular Rooms
Cohort 4 – 209, 211, and 213

Staffing
Cohort 1 – LPN (including meds)
Cohorts 2 and 4 – Dedicated Team (Med Techs or LPN will administer meds)
Cohort 3 – Regular Staff (Med Techs or LPN will administer meds)
Any staff who have tested positive will care for Cohort 1, then Cohort 2, then Cohort 4. Staff who have tested positive would care for Cohort 3 only as a last resort based on staffing shortage