Outbreak Response Plan – Addendum

Effective date and Updates – 9/23/2020, 2/21/2021, 6/15/2021

Purpose:

To protect our residents from widespread outbreaks and pursuant to New Jersey law, Monmouth Care Center (MCC) has re- developed and re-implemented an Outbreak Response Plan. The staff at MCC will be educated in outbreak prevention and how to respond to an outbreak.

Procedure: The Outbreak Plan addresses: Prevention, Assessment, and Mitigation of Infectious Diseases

The facility conducts an annual risk assessment as part of the infection control program and the emergency management plan to identify, track, trend and implement prevention techniques to prevent disease outbreaks. If an infectious disease outbreak occurs the facility has disease specific interventions that are implemented to mitigate the outbreak and prevent the spread. If the disease is a novel organism the Infection Control Preventionist works closely with the NJDOH, CDC and CMS regarding actions to be taken.

Resident Care

Staff will be informed of disease specific symptoms to monitor for and the protocol for reporting. Ongoing and intensified assessment of all residents will be done to evaluate potential spread. This nursing assessment guidance will be established by the nurse leaders, infection control preventionist, and medical director. Residents will be educated about symptoms to report to a nurse immediately should they occur. Telehealth evaluation of suspected infected residents may be considered to aide in exposure prevention. Staff will explain and provide reassurance and answer residents' questions. Care plans will be updated to reflect the current needs of each affected resident during the outbreak period.

Transmission Based Precautions Protocol- Transmission based precautions are followed based on the mode of transmission of the infectious organism. Staff receive education about standard, contact, droplet, and airborne precautions on hire and annually. The type of precautions used are specific to each disease. The facility maintains a list of common infectious diseases and the required precautions required to prevent spread. The type of precautions also affect visitation, equipment use, isolation requirements and resident, staff and family communication alerts.

Cohort Protocol

Cohorting is the practice of grouping residents who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other residents. If needed a cohorting plan will be implemented using up to four basic groupings.

a) Cohort 1 – COVID-19 Positive (second floor): This cohort consists of both symptomatic and asymptomatic patients/residents who test positive for COVID-19, including any new or re-admissions known to be positive, who have not met the discontinuation of Transmission-Based Precautions criteria. 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 – COVID-19 Negative, exposed (second floor): This cohort consists of symptomatic and asymptomatic patients/residents who test negative for COVID-19 with an identified exposure to someone who was positive. Exposed individuals should be quarantined for 14 days from last exposure, regardless of test results. All symptomatic patients/residents in this cohort should be evaluated for causes of their symptoms. Patients/residents who test negative for COVID-19 could be incubating and later test positive. To the best of their ability, long-term care facilities (LTCFs) should 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 monitored for symptom development.

c) Cohort 3 – COVID-19 Negative, Not Exposed (first floor): This cohort consists of patients/residents who test negative for COVID-19 with no COVID-19 like symptoms and are thought to have no known exposures. The index of suspicion for an exposure should be low, as COVID-19 has been seen to rapidly spread throughout the post-acute care setting. In situations of widespread COVID-19, all negative persons in a facility would 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 HCP. Facilities may not be able to create this cohort.

d) Cohort 4 – Presumptive Unit, PUI Unit, New or Re-admissions (first floor):

This cohort consists of all persons from the community or other healthcare facilities who are newly or readmitted. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be compatible with COVID-19. Testing at the beginning and end of this period could be considered to increase certainty that the person is not infected.

Residents who routinely leave the facility need to be quarantined based on based on the facility population and assessment of risk to determine if quarantine is indicated (e.g., spending at least 15 cumulative minutes of exposure at a distance of less than 6 feet to an infected person during a 24-hour period). Exposure risk may vary based on the local community transmission. The risk assessment should include factors such as community transmission; infection prevention and control compliance from transport personnel, the resident, and receiving facility HCP; and the presence of COVID-19 positive cases(s) at the sending and/or receiving facility. In general, the focus should be adherence to recommended infection prevention and control measures (e.g., audits of process monitoring) with routine monitoring for any development of symptoms. If available, these residents may be prioritized for a private room or cohort with others who frequently leave the facility.

It also may depend on how the resident goes to an outside appointment. If the resident goes via ambulance, straight to the appointment and then right back to the facility they likely do not have to quarantine. If they go with a family member, etc. then they will likely have to quarantine.

Communication Protocol

Group notification of resident's, families, visitors, vendors, contractors, physicians and staff in the event of an outbreak of a contagious disease is conducted immediately. Notification includes provision of

information regarding the type of outbreak, restrictions on visitation, educational materials, specific resident impacts, actions implemented to mitigate the spread of disease, and changes in routine daily care and services delivery.

Group notification and outbreak updates and guidance will be posted on the facility web site and 24/7 hotline number based on the disease specific requirements and guidance from regulatory authorities such as but not limited to NJDOH and CDC. The Social Service and Activity departments will coordinate telephone and or email, and or video visits during outbreaks. Individual notification of residents, families and physicians is also completed for each individual that is diagnosed with the organism. Residents and staff will be notified of any outbreak, the extent of the outbreak within the facility, actions implemented to mitigate an outbreak, notification of any restrictions, education in easy-to-understand language, and be provided with required personal protective equipment if required.

Administration recognizes the importance of open communication and will inform residents, families, significant others and guardians of the outbreak concerns and how this affects "everyday life" at the facility, e.g., visiting hours, meals, activities, and restricted or limited access to the facility. A phone tree notification will likely be established by the Administrator and the Social Service department to inform all residents' primary contacts. Additional written notification mailings will be considered. Email notifications will be done if email addresses are available. Social Media, particularly the facility's Face Book page will post notifications and updates. Facility notifications will be updated regularly verbally and/or posted, and the facilities 24/7 hotline telephone. Resident rights and privacy will be maintained with all of the above notifications.

Housekeeping & Laundry Protocols

Disease specific cleaning and disinfecting protocols are in place to ensure facility cleanliness and mitigation of spread of infectious organisms. The facility maintains a supply of cleaning products approved by EPA for cleaning and disinfecting. Housekeeping staff follow written protocols beyond general cleaning that are disease specific including increasing cleaning passes, increased cleaning of high touch surfaces, and purchasing of additional cleaning products as needed that are disease specific. Laundry will also be handled as required based on the specific disease organism.

Staffing Protocol

Staffing protocols address work restrictions, alternative plans to staff if shortages occur, and use of personal protective equipment to protect staff and residents during an outbreak to minimize the spread of infection and ensure resident care needs are met. Assigned tasks will be identified/prioritized by department directors that can be temporarily eliminated or modified during an outbreak should a staffing shortage occur. The facility will make every effort to have routine employee unit assignments.

To the extent possible, the same HCP should be responsible for the care and services provided within individual cohorts. HCP caring for the COVID-19 Positive (cohort 1), should continue to only care for patients/residents in cohort 1. All efforts should be made to keep HCP working in their assigned cohort. If staffing resources become strained, every effort should be made to prevent HCP with high- and medium- level exposures to COVID-19 from working with cohort 3 (and cohort 4, if applicable). When crisis level staffing is in place, ensure HCP are prioritizing rounding in a "well to ill" flow to minimize risk

of cross-contamination (i.e., beginning with Standard Precaution care areas and working toward Transmission-Based Precaution, then finally outbreak areas).

Employee Monitoring Protocol

All employees are monitored for signs of symptoms when they report to work. Employees are required to notify their supervisor or director if they develop symptoms at work or prior to work. Employees are required to notify their supervisor or director of any potential exposure. Employees that become symptomatic at work will be removed from duties and given guidance according to the most current regulatory directives and on appropriate medical follow up. Sick leave policies will be followed but may be modified to allow flexibility and consistency with public health guidance. Return to work will be determined by standards set at the NJDOH and CDC and are disease specific. The Medical Director, Director of Nursing, Infection Preventionist, and Administrator will enforce these guidelines.

Staff Education

Employees will receive outbreak disease education to dispel concerns and prevent unwarranted call outs. Re-education will be given to all employees specific and related to infection control practices including but not limited to handwashing, personal hygiene, donning and removing PPE, and disease specific infection control information.

Laboratory Protocols

Disease specific testing protocols are implemented to quickly identify all affected individuals, initiate infection control actions and implement treatments. Lab testing are disease specific and these decisions are guided by medical orders, CDC, and NJDOH directives, guidance, and best practices.

Public Health Reporting Protocol

All infectious disease outbreaks are reported to public health officials in accordance with applicable executive directives and regulatory guidance. Public health officials also provide the facility with directives and guidance during an outbreak. They can and are expected to provide support, guidance, access to testing, and specific PPE if needed. Facility administration monitors updates from regulatory agencies including but not limited to NJDOH, NJHA, CDC, CMS, WHO, and OSHA. Communication with public health agencies is conducted as required and may include reporting outbreak statistics, line listing of affected individuals if required, PPE inventory, testing, testing results, staffing, essential supplies, other. The Administrator, Director of Nursing, Infection Preventionist and department directors will meet regularly and review to ensure implementation as required. MCC abides by all laws and regulations.

Resident Quality of Life Protocol

Prevention of Social Isolation Protocol

The facility recognizes the importance of filling the resident's lives with person centered activities and socialization. We attempt to prevent loneliness and know that humor, fun and mental activity are treatments and kindness that can heal. Maintaining quality of life and preventing social isolation are very important during a restriction or limited visitation during imposed communal activity, dinning, and

visitation restrictions. Keeping up morale and using distraction to reduce stress is equally important during a crisis. Alternate visitation protocols will be implemented consistent with type of outbreak and NJDOH requirements to initiate phased LTCF reopening, visitation, and services resumption guidelines. Whenever possible virtual visits, outside visitation, phone calls will be used to encourage family and friends contact with residents. Activity programs will be tailored to any restrictions required to contain the spread of infection. Meals may be required to be served in rooms instead of in a communal dining area, for example.

Supply Inventory Protocol

PAR levels are maintained and reviewed by the Administrator, Director of Nursing, and Infection Control Preventionist in the event of an outbreak. A 60-day emergency PPE supply (CDC Burn Rate Calculator and/or the NJDOH LTC Stockpile Benchmark Calculator), required emergency food and water supply, disinfection products, resident care products, and equipment needs are monitored and replaced based on established levels. In the event of a communicable disease outbreak, supply inventory needs may be revised and will be purchased from our established vendors or shared between existing common facilities. If any supply needs cannot be met, then administration will inform our management company, communicate with our Local DOH for guidance, report on NHSN and NJHA websites.

Signage Protocol

Signs that may be posted at all entrance doors would be about seeing the receptionist, visitation, safety rules, protocols, and prevention. Precautionary signage would be before entering facility, PUI and Covid-19 secure units. Visitation will be based on current guidance, status of the building, and based on community spread via NJDOH/CDS CLAI Scores. Completion of a health screening questionnaire, real time temp check, and if available Point-of-Care test may be required before being allowed to visit. Compassionate care, essential caregiver, and end of life visits may be permitted during outbreaks in compliance with CDC and NJ Department of Health guidance if approved by administration. Visitors will be escorted to their loved one, provided with needed PPE and instructed in use, education, reporting symptoms post visit, and proper isolation requirements will be maintained.

Lessons Learned from COVID19

The following changes have been made to facility infection control protocols, protocols, and/or operations as a result of the COVID19 pandemic:

- Instituted a respiratory protection program in compliance with revised OSHA regulations. This program includes fit testing staff for the use of N95 respirator masks.
- Creation of a 60-day emergency PPE supply, in addition to normal operating PPE supply in the event adequate supplies cannot be purchased based on supply chain problems.
- PPE use and burn rates and importance of point in time calculations
- Educational materials to reflect new guidance
- Modification of protocols
- Modification of resident activities and meals locations to ensure safety and minimize the risk of infection while maintaining safe social interactions.

- Facility-wide cohort plan that required creation of specific units to contain and prevent the spread of infection.
- Creation of Infection Control Preventionist to assist and be responsible for the infection control program and assist with outbreak prevention and management

Limited Resource List:

- ED 20-013: LTC Staff Testing Requirements for COVID-19
- ED 20-017 Standards and Protocols for Visitors and Facility Staff
- ED 20-026 (revised) Resumption of Services in all Long-Term Care Facilities ("Reopening Directive")
- 4/13/2020 Emergency Curtailment of Admissions Order
- CMS Guidance for Infection Control and Prevention in Nursing Homes
- CMS FAQ on Nursing Home Visitation
- 8/26/2020 CMS guidance on testing requirements in nursing homes
- CMS Memo Nursing Home Reopening Recommendations for State and Local Officials
- CMS Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes
- CDC Resources for Healthcare Professionals
- CDC Infection Control Guidelines
- CDC Clinical Care Guidance for Healthcare Professionals
- CDC Criteria for Return to Work for Healthcare Personnel
- NHSN COVID 19 Reporting Module
- NJDOH May 12, 2021 Memo: THIS MEMORANDUM REGARDING MANDATORY GUIDELINES FOPROVISION OF SERVICES, VISITATION, GROUP ACTIVITIES AND TESTING, AMENDS AND SUPPLEMENTS E.D. 20-026, REISSUED ON JANUARY 6, 2021, E.D. 20-025, REVISED ON AUGUST 31, 2020 AND E.D. 21-001, AND IS MEANT TO BE USED IN CONJUNCTION WITH E.D. 20-025, E.D. 21-001 AND E.D. 20-026.