SOMERSET WOODS
Rehabilitation and Nursing Center

Topic: Infectious Disease COVID 19 Outbreak Response Plan

Policy: It is the Policy of the facility to follow CDC, CMS, State and Local Health Department's guidance regarding Covid 19 Infection Prevention and Control Recommendations.

Guidance:

A. Infection prevention and control (IPC) practices:
   - **a.** Encourage everyone to remain **up to date** with all recommended COVID-19 vaccine doses.
   - **b.** You are **up to date** with your COVID-19 vaccines if you have completed a COVID-19 vaccine primary series and received the most recent booster dose recommended for you by CDC.
     - **i.** COVID-19 vaccine recommendations are based on three things:
       1. Your age
       2. The vaccine you first received, and
       3. The length of time since your last dose
   - **c.** Staff, residents and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.
   - **d.** Ensure everyone is aware of recommended IPC practices in the facility.
     - **i.** Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene).
     - **ii.** Post visual signs to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
       1. a positive viral test for SARS-CoV-2
       2. symptoms of COVID-19, or
       3. close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure for staff)).
     - iii. Instruct staff to report any of the 3 above criteria to Infection Preventionist (IP).
     - iv. Provide guidance about recommended actions for patients and visitors who have any of the above three criteria.
       1. Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation.
       2. For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact.

e. Source Control Measures
    i. Refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.
    ii. Facility may choose to offer well-fitting facemasks as a source control option for visitors but should allow the use of a mask or respirator with higher-level protection that is not visibly soiled by people who chose that option based on their individual preference.
    iii. Source control options for staff include:
        1. A NIOSH-approved particulate respirator with N95 filters or higher;
        2. A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated);
        3. A well-fitting facemask.
    iv. NIOSH-approved N95 is indicated for personal protective equipment (PPE) during the care of a patient with SARS-CoV-2 infection
    v. N95 respirators should be removed and discarded after the patient care encounter and a new one should be donned.
    vi. When SARS-CoV-2 Community Transmission levels are high, source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients.
    vii. When SARS-CoV-2 Community Transmission levels are **not** high, universal source control is not mandatory.
    viii. SARS-CoV-2 Community Transmission levels will be monitored indicia of community spread as reflected by the statewide weekly Variant Weekly Surveillance Reports and the CDC Community Levels, and adjust facility practices in a manner consistent with CDC, CMS and NJDOH recommendations based on the level of community spread.

f. **Universal Use of Personal Protective Equipment for HCP**
    i. If facility is in county with high transmission, facility may consider implementing universal use of NIOSH-approved particulate respirators with N95 filters or higher for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.
    ii. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) may be considered to be worn during all patient care encounters when county has High transmission.

g. **Viral Testing**
    i. Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test for SARS-CoV-2 as soon as possible.
    ii. Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. ***Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.***
    iii. Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be

considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended.

h. **Process to Respond to SARS-CoV-2 Exposures Among Staff and Others**
    i. If healthcare-associated transmission is suspected or identified, facility may consider expanded testing of staff and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts.
    ii. If testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.

B. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection
    a. Suspected patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.
    b. **Duration of Empiric Transmission-Based Precautions for Symptomatic Patients being Evaluated for SARS-CoV-2 infection**
        i. The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test.
        ii. If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
        iii. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.
    c. **Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection**
        i. Asymptomatic patients do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These patients should still wear source control and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.
            1. Examples of when empiric Transmission-Based Precautions following close contact may be considered include:
                a. Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
                b. Patient is moderately to severely immunocompromised
                c. Patient is residing on a unit with others who are moderately to severely immunocompromised
                d. Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions
            2. Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

a. Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
b. If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

d. **Patient Placement**
   i. Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom.
      1. If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
   ii. Facility could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.
   iii. Limit transport and movement of the patient outside of the room to medically essential purposes.
   iv. Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

e. **Personal Protective Equipment**
   i. Staff who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
   ii. Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard.

f. **Visitation**
   i. Patients should be encouraged to limit in-person visitation while they are infectious.
      1. Counsel patients and their visitor(s) about the risks of an in-person visit.
      2. Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
   ii. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.

iii. Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.

g. **Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection**
   i. ***Patients who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for patients with severe to critical illness.***
   ii. Patients should self-monitor and seek re-evaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these patients should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.
   iii. Patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation

h. **Patients with mild to moderate illness who are *not* moderately to severely immunocompromised:**
   i. At least 10 days have passed *since symptoms first appeared* **and**
   ii. At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
   iii. Symptoms (e.g., cough, shortness of breath) have improved

i. **Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:**
   i. At least 10 days have passed since the date of their first positive viral test.

j. **Patients with severe to critical illness and who are *not* moderately to severely immunocompromised:**
   i. At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
   ii. At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
   iii. Symptoms (e.g., cough, shortness of breath) have improved
   iv. The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

k. **Patients who are moderately to severely immunocompromised**
   i. may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.
   ii. Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.
   iii. **The criteria for the test-based strategy are:**
      1. **Patients who are symptomatic:**
         a. Resolution of fever without the use of fever-reducing medications **and**
         b. Symptoms (e.g., cough, shortness of breath) have improved, **and**

c. Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

2. **Patients who are not symptomatic:**
    a. Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

l. **Environmental Infection Control**
    i. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
    ii. All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
    iii. 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 patient-care areas in which AGPs are performed.
    iv. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
    v. Once the patient has been discharged or transferred, staff, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles.

C. Setting-specific considerations
    a. Assign one or more individuals with training in IPC to provide on-site management of the IPC program
    b. This should be a full-time role for at least one person in facilities that have more than 100 residents.
    c. Managing admissions and residents who leave the facility:
        i. Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. In general, admissions in counties where Community Transmission levels are high should be tested upon admission; admission testing at lower levels of Community Transmission is at the discretion of the facility.
        ii. They should also be advised to wear source control for the 10 days following their admission. Residents who leave the facility for 24 hours or longer should generally be managed as an admission.
    d. ***Empiric use of Transmission-Based Precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours*** (e.g., for medical appointments, community outings).
    e. Placement of residents with suspected or confirmed SARS-CoV-2 infection
        i. Ideally, residents should be placed in a single-person room as described in Section 2.
        ii. If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.

f. Responding to a newly identified SARS-CoV-2-infected HCP or resident
    i. When performing an outbreak response to a known case, facility should always defer to the recommendations of the jurisdiction's public health authority.
    ii. A single new case of SARS-CoV-2 infection in any staff or resident should be evaluated to determine if others in the facility could have been exposed.
    iii. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
    iv. Perform testing for all residents and staff identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
        1. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
        2. Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
    v. Empiric use of Transmission-Based Precautions for residents and work restriction for staff are not generally necessary unless residents meet the criteria or staff meet criteria in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. However, source control should be worn by all individuals being tested.
        1. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of staff with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
        2. If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for staff who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively.
        3. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.

a. If antigen testing is used, more frequent testing (every 3 days), should be considered.

g. **Indoor visitation during an outbreak response:**
   i. Facility should follow guidance from CMS about visitation.
   ii. Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility.
   iii. If indoor visitation is occurring in areas of the facility experiencing transmission, it should ideally occur in the resident's room. The resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit.