BRIDGEWAY CARE AND REHABILITATION CENTER AT HILLSBOROUGH

Infection Prevention and Outbreak Response Plan

Residents in long-term care facilities are at greater risk of developing illness when exposed to communicable diseases. Bridgeway Senior Healthcare has developed a comprehensive infection prevention and outbreak response plan for early detection of an outbreak and implementation of control measures to reduce further transmission.

An outbreak is defined as an increase in the incidence of a disease which is greater than what would be expected to occur within a single unit, wing or throughout the facility during a defined time. Criteria to declare an outbreak are disease-specific and are defined by the New Jersey Department of Health (NJDOH).

The purpose of the Outbreak Response plan is to guide the facility to handle confirmed or suspected outbreaks of disease. Response is customized according to the type of outbreak, such as respiratory or gastrointestinal. Due to the scope of the COVID-19 pandemic, a separate COVOD-19 Outbreak Response Plan has been developed, however the basic process for managing an outbreak is described below.

A key piece of an effective Infection Control Program is an Infection Preventionist, who oversees the surveillance process and identifies the presence of infections in the facility. Surveillance includes daily review of the electronic medical record, review of the nursing report, utilization of antibiotics, and monitoring residents for signs and symptoms of infectious disease.

When a resident exhibits symptoms of a contagious disease, we:

- ❧ Notify the resident's physician who will order pertinent lab tests;
- ❧ Initiate transmission-based precautions
- ❧ Increase surveillance for signs and symptoms of other residents and staff to identify cases.

If the case(s) meet the criteria for an outbreak, the resident, family, Director of Nursing, Administrator, Medical Director, and local health department will be notified. The residents, families and staff will receive periodic updates via phone, text, email, or printed materials.

If more than one resident is affected:

- ❧ Residents, staff, equipment, and supplies will be restricted to one of three cohorts:
    1) Ill
    2) Exposed (not ill, but potentially incubating)
    3) Not ill/not exposed (new admission)
- ❧ Residents on the affected units will be isolated to their rooms.
- ❧ Staff assigned to affected units should not rotate to unaffected units.

- Environmental Services will ensure that resident rooms are cleaned with EPA-approved disinfecting agents and will focus on frequently touched areas in the resident room and the common areas in the vicinity of the room.
- Hand hygiene practices will be reinforced for residents, visitors, and staff.
- In-service education will be provided to all staff regarding the disease process, preventative infection prevention practices, and transmission-based precautions.
- Visitation of family, friends, and volunteers may be restricted or discouraged.

An outbreak is generally considered to be over when two incubation periods have passed without the identification of any new cases. The local health department will make the final determination of the end of the outbreak.

The outbreak plan will be reviewed annually and as necessary and will be revised in accordance with CDC, NJDOH and the Association of Professional in Infection Control and Epidemiology (APIC) guidelines.

For additional information on our COVID-19 Outbreak Plan, continue reading.

COVID-19

Lessons Learned – COVID-19 Wave #1

Bridgeway conducted a debriefing of the incident on August 19, 2020 and developed an After-Action Report (AAR). The content of the AAR is privileged and confidential and for quality improvement purposes only; however, the lessons learned in the following key areas have been incorporated into this plan:

- Communication/Notification: use of the Incident Command Structure, notification of staff, notification of residents/families, and notification of external sources.
- Resources and Assets: staffing, PPE, supplies, equipment, transportation and evacuation, and testing.
- Safety and Security: patient/staff/visitor Access.
- Patient Management: clinical needs, resident rights, support activities, cohorts, and physician visits.
- Facilities: ventilation, sanitation/disinfection, and regulated medical waste and storage.
- Mandatory Reporting Compliance: NHSN, NJHA, OEM and DOH.

Definition of an Outbreak

A COVID-19 outbreak in a LTC facility is defined as ≥1 facility-acquired COVID-19 case in a resident or ≥ 1 laboratory confirmed COVID-19 case among staff.

Signs and Symptoms

COVID-19 may be difficult to differentiate from other illnesses due to common signs and symptoms. The most common signs and symptoms associated with COVID-19 include: cough, new shortness of breath, sore throat, URI symptoms, fever, chills with or without shaking, new fatigue, new body aches, nausea, vomiting, diarrhea or new loss of sense of taste or smell.

Testing

The facility has entered into agreements with several labs to mitigate overwhelming the testing capacity of any individual lab.

Bridgeway completed initial point prevalence testing and subsequent testing requirements in accordance with Executive Directive 20-013 and submitted the required attestation of compliance to the NJ DOH. Ongoing testing and retesting will be in accordance with CDC and NJ DOH guidance, as amended and supplemented.

On October 20, 2020, the NJ DOH issued Executive Directive 20-026 (Revised) to allow antigen testing as an alternative to molecular diagnostic PCR tests. According to the CDC, COVID-19 antigen tests can augment other testing efforts, especially in settings where PCR testing capacity is limited, or testing results are delayed (e.g., > 48 hours). Click here for the Testing Plan.

COMMUNICATION PLAN

Bridgeway Care and Rehabilitation has developed a communication plan to assure that, in an emergency or infectious disease outbreak, the necessary resources are in place to ensure:

1. Facility staff have updated phone lists to contact other staff, physicians, residents, families/responsible parties, and other necessary people and/or agencies in a timely manner;
2. Residents and their families/responsible parties have a means to stay in touch with residents and facility staff; and
3. Facility staff have resources to guide thought processes in the event of a primary telephone system failure.

When the Incident Command Center is operating, the Communications Coordinator is responsible for implementing the Communication Plan. When the Incident Command Center is not operating, any individual with access to our electronic medical record may be designated to implement this plan.

Personnel Contacts

The following table lists the various phone lists that may be needed in the event of an emergency, the process owner responsible for updating each list, and the updating frequency. All these lists are part of this Communication Plan.

Phone List	Process Owner	Updated
Emergency Phone List	Receptionist	Quarterly
Employee Phone List	Human Resources/ Payroll	Quarterly
Physician Phone List	Medical Records	Quarterly
Internal Phone Extensions	Receptionist	Quarterly
Resident Emergency Contact List	Point Click Care User	Run as needed

Emergency Notification

Bridgeway shall notify the residents and their families/responsible parties of situations which effect routine operations; for example, infectious disease outbreaks and emergency preparedness measures such as utility failure, evacuation, etc.

The primary means of communication may include contact by phone, email, and or cell phone text blasts. Resident contact information is available in our electronic medical record.
Specific to COVID-19:

- General communication will be at least weekly and by way of memo to residents and by way of email/text blast to resident families and staff. These general communications may include up to date statistics, mitigation efforts, changes to normal operations, and a point of contact (e.g., Administrator) for any questions or concerns. Each update will contain a boilerplate passage reminding recipients that they can stay in touch via Facebook, Bridgeway's webpage, and by scheduling virtual visits and will also include links to these sources.
- If the facility receives a positive test result for a resident or staff (an outbreak), or if three or more residents or staff with new-onset respiratory symptoms occur within 72 hours of each other, the facility shall notify all residents, the resident's representative (one), and all staff by 1700 hours on the calendar day after the date the result is received by the facility.
- During an outbreak, positive test results for individual residents shall be reported directly (in person or by phone) to the resident, the resident's representative, the Infection Prevention Nurse, the Director of Nursing, the Administrator, and the Medical Director.
- During an outbreak, positive test results for staff shall be reported directly (in person or by phone) to the individual staff member, his/her manager, the Infection Prevention Nurse, the Employee Health Nurse, the Director of Human Resources, the Administrator, and the Medical Director.
- The facility shall use a line list to document test results and will submit the line list to the local and State Departments of Health as required and/or instructed.

Alternate Means of Communication

In the event of a telephone system failure, the Communications Coordinator or designee is responsible for assuring, among other things, that alternate communication equipment is available, distributed, and tracked. The priority action items are:

1. Gather portable radios.

2. Confirm presence of facility-owned cell phones.
3. Complete a Radio/Phone Distribution Log.
4. Distribute copies of the Radio/Phone Distribution Log to key areas.
5. Run a Resident Emergency Contact List.
6. Notify residents and their families/responsible parties of alternate ways to contact the facility which may include any of the following:
   - Facility owned cell phones
   - Copy/Fax Machines
   - By email to askbridgewayhb@bshcare.com.
   - During circumstances where in-person visitation is restricted, virtual visitation through Skype may be scheduled at www.bshcare.com/skype.

Urgent Communications

Bridgeway has established a mechanism for residents and their families to contact the facility with urgent questions or concerns that are not being responded to via normal communication methods. These mechanisms are posted on our website and are monitored by the Administrator and other key personnel. Contact may be made:

- By calling the Urgent Communications Hotline at (908) 315-5933. When prompted, press "2" for Bridgeway at Hillsborough.
- By email to askbridgewayhb@bshcare.com.

RESIDENT PROTOCOL

Monitoring Residents for COVID-19

Current Residents

When not in an outbreak, monitor for signs and symptoms of COVID-19 and vital signs at least once daily and notify clinician if resident develops corresponding signs or symptoms. When in an outbreak, monitor for signs and symptoms and vital signs every shift.

New Admissions and Re-admissions

All new admissions and re-admissions will be screened for COVID-19, including vaccination status, prior diagnosis of COVID-19, current signs and symptoms, and test results, prior to acceptance and upon admission into the facility. If the resident was tested at a facility prior to admission, the sending facility must provide lab results to the receiving facility.

To be considered fully vaccinated, at least two weeks must have passed since the receipt of the second dose of a 2-dose series or at least two weeks have passed since the receipt of

one dose of a single dose vaccine. A fully vaccinated resident can be placed in a room with an unvaccinated or partially vaccinated resident if both residents have not had close contact with a suspected or confirmed case of COVID-19 and/or have not traveled to a restricted area during the 14 days prior to admission or room placement.

Management of Residents

Cohorts

Residents will be placed in cohorts based upon their COVID-19 vaccination status, prior diagnosis of COVID-19, signs and symptoms, exposure to COVID-19, and test results. The facility will designate areas for each cohort as needed.

Cohort 1 – COVID-19 Positive

This cohort consists of both symptomatic and asymptomatic residents who test positive for COVID-19, regardless of vaccination status, including any new or re-admissions who are COVID-19 positive and have not met criteria for discontinuation of isolation. If feasible, care for COVID-19 positive residents on a separate closed unit. Residents who test positive for COVID-19 are known to shed virus, regardless of symptoms; therefore, all positive residents would be placed in this positive cohort.

- COVID-19 area will be clearly marked with signage.
- Only employees who are providing direct care to the residents in the designated rooms should be in the COVID-19 area.
- Isolation will be discontinued based on signs and symptoms per the CDC and NJDOH recommendations
- Requires use of full PPE – gown, gloves, face shield, and N95 mask.

Cohort 2 – COVID-19 Negative, Exposed

This cohort consists of symptomatic and asymptomatic residents, regardless of vaccination status, who test negative for COVID-19 but have had an identified exposure (close contact) in the past 14 days to someone who was positive. Exposed individuals should be quarantined for 14 days from last exposure, regardless of negative test results or vaccination status.

Symptomatic COVID-19 negative residents should be considered exposed but should also be evaluated for other causes of their symptoms. If feasible, symptomatic and asymptomatic residents should be separated, ideally having symptomatic residents placed in private rooms.

Asymptomatic residents should be closely monitored for symptom development and consideration should be given to other illnesses such as influenza.

Testing at the end of this period could be considered to increase certainty that the person is not infected.

- Isolation will be discontinued based on signs and symptoms per the CDC and NJDOH recommendations.
- Requires use of full PPE – gown, gloves, face shield, and N95 mask.

Cohort 3 – COVID-19 Negative, Not Exposed

This cohort consists of residents who:

- Test negative for COVID-19, who have no COVID-19-like symptoms, and are thought to have no known exposures.
- Have clinically recovered from COVID-19 and are within 90 days of symptom onset or positive test.
- Are fully vaccinated and who have not been in close contact with a suspected or confirmed case of COVID-19 including newly or readmitted residents.

In situations of widespread COVID-19 transmission within the facility, all negative persons the facility would be considered exposed. Cohort 3 should only be created when the facility is relatively certain that residents have been properly isolated from all COVID-19 positive and incubating residents and staff.

- Requires standard precautions with universal source control measures

Cohort 4 – New or Re-admissions

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

- Remain on 14-day isolation for observation of symptoms.
- Requires use of full PPE – gown, gloves, face shield, and N95 mask.

Transmission Based Precautions

Residents who are newly admitted and not vaccinated, and residents who are COVID-19 positive or were exposed to someone who tested COVID-19 positive, will be placed on transmission-based precautions with the use of full PPE until the resident meets criteria for discontinuation of transmission-based precautions.

When a fully vaccinated resident is admitted or re-admitted and has not been in close contact with a suspected or confirmed case of COVID-19 within the last 14 days, the

resident may be placed in either a private room or a semi-private room with another fully vaccinated individual. Quarantine and transmission-based precautions are not required.

Residents who go on medical or non-medical outings may be at increased risk for exposure to COVID-19. When a resident is out of the facility for less than 24 hours, an exposure risk assessment using the NJDOH Risk Assessment Decision Tree may be completed upon the return to the facility. If a resident is at an increased risk of exposure, the resident will be placed on 14-day quarantine. Residents who are out of the facility for more than 24 hours, will be treated as a re-admission.

Residents who attend outings will be routinely monitored for the development of any signs or symptoms.

Transfer to an Acute Care Facility

If a resident who is confirmed to be COVID-19 positive or is under investigation for COVID-19 requires transfer to an acute care facility, staff will notify the transferring EMS/ambulance agency of the resident's COVID status when placing the call to arrange transport, document the COVID status on the Universal Transfer Form and contact the receiving facility and inform them of the resident's COVID status.

Death

If a resident who is confirmed to be COVID-19 positive or is under investigation for COVID-19 dies, inform the funeral home of the resident's COVID status.

STAFF PROTOCOL

As long as COVID-19 is present in the surrounding community, there exists a risk of it entering the facility. To mitigate the risk of this occurrence by staff, the following staff-specific interventions are in place:

- Staff receives education specific to COVID-19.
- Staff are provided with PPE.
- Staff are primarily assigned to a designated unit or department and are rotated only when necessary to meet the needs of the residents.
- Staff are directed not to report work if they feel ill.

Screening

Prior to entering the facility, all staff are screened for COVID-19. Staff who do not pass the screening process will be evaluated by a nurse who will determine if they can work.

Staff who develop signs and symptoms during their shift must inform their supervisor or manager on duty and be tested for COVID-19 prior to leaving the facility. They will be restricted from work while test results are pending.

Staff Testing

All staff will undergo testing in accordance with current CDC and/or NJ DOH guidelines. For employees who work at more than one facility, Bridgeway will accept the results from another facility, provided that the testing is compliant with Bridgeway's current testing process and the employee consents to have the test results made available to Bridgeway simultaneously with the facility where the employee was tested.

Management of COVID-19 Negative Staff

If staff test negative for COVID-19 they may still be restricted from work based upon self-reporting of either exposure to a confirmed COVID-19 case or symptoms that *could* be associated with COVID-19 or another illness. The Employee Health Nurse or designee must be informed of the exposure and/or complaint of symptoms. The risk of exposure and need for work restrictions will be determined by using the *Revised NJDOH Exposure to Confirmed COVID-19 Case Risk Algorithm* and the following table:

	Symptomatic	**Asymptomatic**
Exposed	Employees who test negative AND have symptoms, will be restricted from work for 14 days from the date of exposure and instructed to quarantine.	Unvaccinated employees who test negative and have NO symptoms will be restricted from work for 14 days from the date of exposure and will be instructed to self-isolate and monitor for symptoms. Vaccinated employees (not immunocompromised) who test negative and have NO symptoms will not be restricted from work.
Not Exposed	Employees who report COVID-like symptoms but have not been exposed and test negative will contact the Employee Health Nurse for further evaluation and determination of work restriction, as the symptoms are likely related to another illness.	Continue to work

Management of COVID-19 Positive Staff

Staff who test positive for COVID-19 will be restricted from work until they meet the CDC criteria to return.

The Infection Prevention Employee Health Nurses or their designee will initiate contact tracing, notify the local Health Department, notify staff, residents, resident representatives

and others per the facility's communication plan, and report the case in the mandated NJDOH and CMS reporting systems.

Return to Work Criteria

Staff who have been restricted from will not be allowed to return until they meet CDC return to work criteria.

Crisis Staffing

Crisis staffing will be implemented during times of potential or actual staffing shortages to ensure continuity of operations and the ability to meet the needs of the residents. All departments will work collaboratively to implement the initiatives.

1. Each department director will document the minimum staffing requirements for their area, based on census and resident acuity where appropriate.
2. All current full-time, part-time, and per diem employees will be notified when a staffing emergency is in effect and requested to provide additional availability to work.
3. Department directors may implement any/all the following initiatives with currently working staff: change shift length (from 8- to 10- or 12-hour shifts), adjust the start and/or end times for existing staff, implement mandatory overtime in accordance with state regulation and facility policy.
4. Additional initiatives may include:
   a. Use of staff from other Bridgeway or Avalon locations.
   b. Use temporary staff through contracted agencies.
   c. Recruit temporary employees who could assist with tasks that can be performed by unlicensed and non-certified staff.
   d. Use physical therapists, occupational therapists, and speech therapists for resident care tasks as appropriate to their discipline.
   e. When approved through CMS and NJ DOH waivers, recruit Certified Homemaker Home Health Aides and other health care workers to assist with resident care.
   f. When approved through CMS and NJ DOH waivers, implement a dining assistant training program consistent with regulatory requirements.
   g. Communicate the need among staff to postpone elective time off from work.
   h. Reassign health care personnel (e.g., nursing administrative and MDS staff) to support essential patient care activities in the facility.

i. Address social factors that might prevent health care personnel for reporting to work such as transportation and housing.

j. Determine the priority of nursing care and services during staffing shortages and consider initiatives to modify the workload of staff.

5. Communicate with local healthcare coalitions, federal, state, and local health partners to identify additional healthcare personnel.
6. As a last resort, and in collaboration with the Administrator, transfer residents to healthcare facilities or alternate care sites with adequate staffing to provide safe patient care.

VISITATION PROTOCOL

Limiting Entry

Due to the vulnerability of our residents, and to reduce the risk of introduction of COVID-19 into the facility as community transmission becomes widespread, the facility will restrict the access of visitors. Visitors include all individuals who are not residents and who do not meet the definition of facility staff, which includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility. The following actions may be implemented to control access into and within the facility:

- Screen visitors upon arrival and anyone who has a temperature, is exhibiting or has recently exhibited signs and symptoms of COVID-19, was diagnosed with COVID-19 with the past 14 days or had traveled to a travel restricted area will not be allowed to visit.
- Entry to the facility will be limited to designated entrances and signage will be posted to indicate an outbreak and deter entry.
- Virtual visitation will be available to residents and families to stay in touch.
- An area will be designated for families to drop off and pick-up resident supplies.
- Physicians and other clinicians will be encouraged to use telemedicine. When in-person visitation is necessary, physicians and other clinicians will be asked to visit less frequently and bundle their visits.
- Vendors will drop off supplies at a designated area and will not transport the supplies within the facility.

Resident Visitation

Visitation can be conducted based upon the facility's structure and resident's needs but will be restricted to assigned indoor visitation spaces or designated outdoors. Considering the ongoing risk of COVID-19 transmissions, residents and visitors must adhere to the core

principles of COVID-19 infection control, including maintaining physical distancing and conducting outdoor visits whenever possible.

Visits for compassionate care, such as end-of-life situations or when a resident has a decline, needs encouragement to eat or drink, has weight loss or is experiencing emotional distress should be allowed for residents regardless of vaccination status.

The resident or their designee and the visitor will complete a consent form indicating the procedures for visitation, associated risks of the visit, and the need to notify the facility if they test positive or exhibit signs and symptoms of COVID-19 within 14 days of their visit. The resident will be consulted to determine who may visit them.

All outdoor and non-compassionate care indoor visits will be limited at the facility's discretion to ensure adequate time to sanitize the visitation space with an EPA approved product.

All visits will be scheduled through the facility website at https://www.bshcare.com/visitation.html. Confirmation of the visit will be sent via email. For all visits:

- Well-fitting face masks must be worn by visitors as source control after leaving the screening area and when walking to the visitation area.
  - When **BOTH** the visitor and resident are fully vaccinated:
    - While alone in the resident's room or visitation area, residents and their visitors may choose to have close contact, including touch, and to remove their face masks.
    - While in the facility, visitors should wear facemasks and physically distance from healthcare personnel and other residents and visitors who are not part of their group.

    Fully vaccinated means at least 14 days have passed since an individual received the single-shot vaccine (J&J), or the 2nd dose of a 2-shot vaccine (Pfizer or Moderna).
  - When **EITHER** the visitor or resident is not fully vaccinated:
    - While in the facility, visitors should wear facemasks and physically distance from healthcare personnel and other residents and visitors who are not part of their group.
    - While alone in the resident's room or visitation area, the safest approach is for everyone to maintain physical distancing and wear well-fitting facemasks.

    - ❧ Fully vaccinated residents may choose to have close contact, including touch, with their unvaccinated visitors; however, residents and visitors must wear well-fitting face masks.
- ❧ Visitor must perform hand hygiene prior to the initiation and at the end of the visit.
- ❧ No more than two visitors are allowed at a time. Residents and visitors should exercise good judgement regarding visiting with small children.
- ❧ Social distancing (6 feet) must be maintained for all unvaccinated residents.
- ❧ If the resident is fully vaccinated, the resident and visitor may have close contact (including touch) for a limited amount of time if both are wearing a well-fitting face mask and perform hand hygiene before and after the contact. The visitor shall maintain physical distance from staff members.
- ❧ To limit movement throughout the facility, visitors will be guided to the designated location for the visit.
- ❧ Visits will be monitored by staff to ensure there is compliance with infection control measures.
- ❧ When practicable, Visitors will be escorted out of the visitation area at the completion of the visit. They cannot enter any other area in the facility.
- ❧ The visitation area will be cleaned and disinfected with an EPA-approved product between visits.

Indoor Visitation not During an Outbreak

Indoor visitation is allowed for all residents with following exceptions:

- If the regional CALI score is high or very high (3 or 4) and < 70% of the residents in the facility are fully vaccinated (≥ than 2 weeks following the receipt of the second dose in a 2-dose series, or ≥ 2 weeks following the receipt of a single dose vaccine).
- Indoor visitation should be limited for residents vaccinated or unvaccinated who:
    - Are confirmed positive.
    - Are on 14-day quarantine due to exposure to COVID-19.
    - Are on 14-day isolation because they were recently admitted/readmitted from the hospital or at high risk for exposure after an out-of-facility appointment.

  For these residents, virtual visits may be schedule through our website.

Visitation During an Outbreak

When a new case of COVID-19 among residents or staff is identified, the facility should begin outbreak testing of all residents who have not had a positive test within the past 90 days, and suspend all visitation until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

- If the first round of outbreak testing (day 3 to 7) reveals no additional COVID-19 cases in other units of the facility visitation can resume for residents in units with no COVID-19 cases. Visitation will be suspended on the affected unit until criteria for discontinuation for outbreak testing is met.
- If the first round of testing reveals one or more additional COVID-19 cases on other units, visitation will be suspended for all residents (vaccinated or unvaccinated) until the facility meets criteria for discontinuation of outbreak testing.

Visitor Policies and Procedures

Please read our visitation policies click here. Visitors who are unable or unwilling to comply with our policies will be restricted from visiting.

Agency Staff/Essential Medical Provider

Physicians and other clinicians will be encouraged to use telemedicine. When in-person appointments are necessary, physicians and other clinicians will be asked to bundle their visits.

MANDATORY REPORTING

During a COVID-19 pandemic the facility will complete mandatory reporting to the following agencies: CDC (NHSN portal), NJDOH, NJHA.