BRIDGEWAY CARE AND REHABILITATION CENTER AT HILLSBOROUGH

Infection Prevention and Outbreak Response Plan (updated 10/7/22)

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 symptom 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) Symptomatic
    2) Exposed (vaccination status, and/or symptoms depending on infection)
    3) PUI (Person Under Investigation depending on symptoms)
- 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 Environmental Protection Agency (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 as well as other frequently touched surfaces.
- 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 discouraged but will be accommodated with proper personal protective equipment (PPE) and education.

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.

TIMELINE OF KEY EVENTS

On January 7, 2020 Chinese health authorities confirmed that a cluster of cases of pneumonia, reported just one week earlier, was associated with a novel coronavirus. Two weeks later, on January 20th, the CDC confirmed the first case of COVID-19 in the U.S.; a resident of Washington State who had travelled to Wuhan, China. This case ultimately led to a skilled nursing facility in Kirkland, Washington becoming the first COVID-19 epicenter in the U.S. by the end of February. Following is a timeline of key events of the outbreak and response:

- March 4th: The first positive case was announced in Bergen County, New Jersey.
- March 5th: Bridgeway initiated screening of all employees, visitors and vendors.
- March 9th: New Jersey reported its first COVID-19 death. Governor Murphy issued Executive Order #103, declaring both a State of Emergency and a Public Health Emergency.
- March 10th: Bridgeway initiated Incident Command.
- March 11th: The World Health Organization officially characterized COVID-19 as a pandemic.
- March 12th: Bridgeway closed its doors to family and non-essential visitors.
- March 21st: Bridgeway initiated universal source control, requiring all staff to wear a surgical mask throughout their shift.
- March 23rd: Bridgeway initiated a single point of entry into the facility.
- March 24th: Bridgeway was notified by a per diem employee, whose last day worked in the facility was March 12th, that they developed symptoms and were tested for COVID-19. The result was confirmed positive on March 28th.
- March 30th: Bridgeway had its first two cases of residents with COVID-19. Both were admitted from hospitals, neither had a diagnosis of COVID-19 on admission, and both developed symptoms two days after admission.
- April 10th: Bridgeway had its first in-house employee case of COVID-19.
- April 15th: On the very day that both residents above were declared recovered, our first long-term care resident (facility-acquired) was confirmed positive.
- April 25th: Bridgeway had its first COVID-19 related death.
- May 10th: Bridgeway had its last facility-acquired resident case of COVID-19.
- May 12th: Bridgeway had its last COVID-19 related death. In all, eight residents succumbed to COVID-19.

- May 19th: The Administrator submitted an Attestation of Compliance with NJDOH Commissioner Persichilli's Executive Directive 20-013; Amendment of Outbreak Plan for COVID-19.
- May 29th: The Administrator submitted an Attestation of Compliance with NJDOH Commissioner Persichilli's Executive Directive 20-013; Implementation of a COVID-19 Testing Plan.
- May 29th: Bridgeway had its last COVID-19 positive employee; an asymptomatic positive.
- June 20th: The Administrator submitted an Attestation of Compliance with NJDOH Commissioner Persichilli's Executive Directive 20-017; Outdoor Visitation.
- June 22nd: In response to Executive Directive 20-017, Bridgeway opened to outdoor visitation.
- June 22nd: The NJ Department of Health conducted a COVID-19-focused Infection Control Survey and found the facility "to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19."
- July 8th: Bridgeway's COVID-19 Outbreak (E2020-15527) was officially closed by the NJ Department of Health.

LESSONS LEARNED

Bridgeway conducted debriefings on August 19, 2020, and December 27, 2021, and developed After-Action Reports (AARs). The content of the AARs is privileged and confidential and for quality improvement purposes only; however, the lessons learned 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 A COVID-19 OUTBREAK

An 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. Facility-acquired COVID-19 infection in a long-term care resident is defined as a confirmed diagnosis 14 days or more after admission for a non-COVID condition, without an exposure during the previous 14 days to another setting where an outbreak was known or suspected to be occurring unless there is confirmation of possible transmission or exposure through a breach in PPE.

- Whenever ≥ 3 residents or staff develop new onset respiratory symptoms that occur within 72 hours of each other.

SIGNS AND SYMPTOMS OF COVID-19

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
- Shortness of breath or difficulty breathing
- Sore throat
- Headache
- Congestion or runny nose
- Fever
- Chills with or without shaking
- New fatigue
- New muscle or body aches
- Nausea
- Vomiting
- Diarrhea
- New loss of sense of taste or smell

TESTING

Bridgeway follows NJ DOH and CDC guidance for testing of staff, residents, and visitors (see detailed Testing Plan).

COMMUNICATION PLAN

BRIDGEWAY CARE AND REHABILITATION CENTER AT HILLSBOROUGH

Infection Prevention and Outbreak Response Plan (updated 10/7/22)

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.

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, or if three or more residents or staff with new-onset respiratory symptoms occur within 72 hours of each other, the facility shall notify the 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 Director of Nursing, 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 PROTOCOLS

Monitoring Residents for COVID-19

Resident monitoring is based on the facility's outbreak status:

- Non-Outbreak: monitor for fever, decreased oxygen saturation and new or worsening signs and symptoms of COVID-19 daily.
- Outbreak: obtain full set of vital signs, including oxygen saturation, and monitor for fever and new or worsening signs/symptoms of COVID-19 every shift.

If a resident develops new or worsening signs and symptoms of COVID-19, staff will perform point-of-care antigen testing and contact the clinician.

Pre-admission Screening

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 a single dose vaccine. To be considered up to date, newly admitted residents must either:

- Be fully vaccinated and not yet eligible for a booster dose, or
- Have received a booster dose when clinically eligible.

In general, residents who are up to date with all recommended COVID-19 vaccine doses and residents who have recovered from COVID-19 in the past 90 days do not need to be placed in quarantine. Quarantine is recommended for all other residents. Residents who are up to date with vaccination 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 during the 14 days prior to admission or room placement.

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.

Management of COVID-19 Positive Residents

The following procedure will be followed when a resident has tested positive for COVID-19:

1. Move the resident to the COVID-19 designated area for Cohort 1 and maintain transmission-based precautions until they meet current criteria for discontinuation. If a resident becomes positive within 14 days of admission, the facility is responsible to notify the sending facility of the results to allow for the appropriate response and investigation and alert the local health department.
2. If there are multiple cases of COVID on the unit/wing, and when relocation of the residents may introduce COVID to another unit, do not relocate the residents.
4. Notify the DON, Administrator, Attending Clinician, Medical Director, resident and family representative.
5. The Infection Preventionist or designee will contact the local health department and initiate a line listing.
    a. *Hillsborough Health Department – 908-369-5652*
    b. *Bridgewater Health Department – 908-725-5720*
6. Initiate testing of residents and staff in accordance with our COVID-19 testing plan.
7. Monitor all residents at least once each shift for signs and symptoms of COVID-19. If signs or symptoms develop, follow the procedure for suspected COVID-19 listed above.
8. Conduct contact tracing to determine exposure of staff and residents who had close contact (within six feet for at least 15 minutes over a 24-hour period) with the resident within 48 hours of the date of the test. Testing will be performed on the identified close contacts.
9. Notify residents, their families/representatives, and staff per facility communication plan.
10. Consider curtailing admissions.
11. Include cases in the COVID -19 reporting requirements as required by the NJ Department of Health and CMS.
12. The resident will be considered recovered upon meeting the CDC criteria for discontinuation of transmission-based isolation precautions.
13. Upon discharge, terminally clean and disinfect the room using EPA-approved products.

Residents Returning from Outings

Residents who go on medical or non-medical outings may be at increased risk for exposure to COVID-19. Residents who leave the facility will be educated about the potential risk associated with the public setting, and infection prevention measures they can take, including avoiding crowded and poorly ventilated spaces, wearing a mask in these areas, practicing social distancing and hand hygiene.

When a resident leaves the facility, he/she will be assessed and monitored for COVID-like signs and symptoms.

- In most circumstances, quarantine is not recommended for patients/residents who leave the facility for <24 hours and do not have close contact with a suspected or known COVID-19 positive person. Residents who attend outings will be routinely monitored for the development of any signs or symptoms.

- Residents who are out of the facility for more than 24 hours, will be treated as a re-admission. When a resident leaves the facility for more than 24 hours, an exposure risk assessment using the NJDOH Risk Assessment Decision Tree will be completed upon their return to determine the need for testing and/or isolation.

Transfer to an Acute Care Facility

The following procedure should be used when a resident who is confirmed to be COVID-19 positive or is under investigation for COIVD-19 requires transfer to an acute care facility:

1. Notify the transferring EMS/ambulance agency of the resident's COVID status when placing the call to arrange transport.
2. Apply a face well-fitting face mask on resident.
3. Ensure that the COVID status is documented on the Universal Transfer Form.
4. When the responding transport personnel arrive:
    a. Ensure they are wearing proper PPE.
    b. Notify them of the COVID status of the resident.
5. Contact the receiving facility and inform them of the resident's COVID status.
6. Following discharge, perform terminal room cleaning disinfection using an EPA-approved product.

STAFF PROTOCOL

Mitigation of Risk

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, including signs and symptoms of COVID-19, cough and respiratory etiquette, and infection control practices such as hand hygiene, universal source control, transmission-based precautions, and proper use of personal protective equipment (PPE).
- Staff are provided with PPE. Each staff member is issued a well-fitting face mask daily for universal source control. Staff who enter the room of a resident who is on

transmission-based isolation precautions is provided a gown, gloves, well-fitting face mask or N95 mask and face shield.

- Universal eye protection should be instituted for staff who are resident-facing or who cannot maintain physical distancing when the CDC Community Transmission Level for Healthcare Settings is either substantial or high (this is NOT the COVID-19 Community Level).
- Staff are primarily assigned to a designated unit or department. Staff 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 and at the start of every shift, all staff are screened for COVID-19. Screening will include:

1. Completion of a questionnaire to identify:
    a. The presence of signs and symptoms;
    b. Contact with anyone who was recently diagnosed with or exposed to COVID-19; and
2. Vaccination status.
3. Temperature monitoring for fever > 99.6°F.

Staff who do not pass the screening process will be evaluated by a nurse who will determine the need for testing and 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. The Employee Health Nurse or designee must be informed as well.

Staff Testing

As a condition of continued employment, all staff will undergo testing in accordance with current CDC and/or NJ DOH guidelines (see Testing Plan).

Management of Symptomatic or Exposed 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 guided by CDC and NJDOH recommendations.

Management of COVID-19 Positive Staff

Staff who test positive for COVID-19 will be restricted from work until they meet the CDC and NJDOH criteria to return. While out of work, they are instructed to self-isolate, practice distancing, and to contact their clinician if their signs or symptoms worsen.

The Infection Prevention Employee Health Nurses or their designee will:

1. Initiate contact tracing to determine which residents, staff, vendors and visitors may have been exposed to the staff member within 48 hours prior to the collection of the test.
2. Initiate COVID-19 testing for staff and residents who may have been exposed.
3. Start a line listing.
4. Notify the local Health Department:
    a. Hillsborough Health Department: 908-369-5652
    b. Bridgewater Health Department: 908-725-5720
5. Notify staff, residents, resident representatives and others per the facility's communication plan.
6. Report the case in the mandated NJDOH and CMS reporting systems.

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. Consider allowing staff who have been restricted from work to return to work according to the CDC Strategies to Mitigate Healthcare Personnel Shortages.
5. Volunteers who are up to date with COVID-19 vaccination may be used to supplement staffing when necessary.
6. 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. Implement the most current Return to Work Criteria developed and approved by CDC and CMS;

h. Communicate the need among staff to postpone elective time off from work;

i. Reassign health care personnel (e.g., nursing administrative and MDS staff) to support essential patient care activities in the facility;

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

k. Provide and communicate resources available to health care personnel to assist with anxiety and stress.

l. Determine the priority of nursing care and services during staffing shortages and consider initiative to modify the workload of staff; for example, change medication administration times, hold non-essential medications, bathing schedules, etc.

7. Consider use of exposed/asymptomatic positive staff in accordance with current CDC and NJ DOH guidelines
8. Communicate with local healthcare coalitions, federal, state and local health partners to identify additional healthcare personnel.
9. 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.

VISITOR PROTOCOL

Screening

In accordance with CMS Memo QSO-20-39-NH and NJ Executive Directive 21-012, visitation must be allowed for all residents, at all times. Visitation may be restricted by the Department of Health.
Due to the vulnerability of our residents, and to reduce the risk of introduction of COVID-19 into the facility, the facility will screen all 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. Visitor will be screened for the following:

- Temperature
- The presence of signs and symptoms of COVID-19
- A diagnosis of COVID-19 with the past 14 days
- Exposure to someone who was diagnosed with COVID-19 in the past 14 days.

Visitors who "screen out" will not be allowed to visit inside the building and will be offered alternate ways to visit; for example, outdoor visits, window visits, or virtual visits.

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.

Core Principles of COVID-19 Infection Prevention

Visitors will be guided to adhere to the Core Principles of COIVD-19 Infection Prevention during their visit. The Core Principles include:

- Perform hand hygiene. This may be done with alcohol-based hand rub or handwashing and should be done frequently.
- Use a well-fitting face mask.
- Physically distance from others.

Types of Visits/Minimizing Risk

Outdoor visits generally pose a lower risk of transmission due to increased space and airflow, and are preferred when possible.

Indoor visits are allowed at all times and for all residents, subject to the following:

- When a resident is in a private room, visits may occur in the resident's room or in a designated visitation area.
- When a resident is in a semi-private room, visits should occur in a designated visitation area. When this is not practical (e.g., resident is bed-confined), efforts should be made to decrease the risk of transmission to the resident's roommate; for example, offer to take the roommate to another location or draw the privacy curtain.
    - Due to difficulty in maintaining physical distancing, no more than two visitors may visit at a time.

- 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 up to date with COVID-19 vaccination:
        - 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.
    - 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.
- During an outbreak investigation visitors will be made aware of the outbreak and potential risks of visiting.
- Visitors who are visiting a resident who is under transmission-based isolation precautions must see the nursing staff for assistance donning PPE prior to entering the resident's room.

MANDATORY REPORTING

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