To health!
NJHA
New Jersey Hospital Association

COVID-19

UPDATED TOOLKIT OF RESOURCES FOR LONG TERM CARE FACILITIES

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Table of Contents

XV. Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel (Updated Oct. 30, 2020)

XVI. OSHA's Rule Relaxation For ANNUAL Fit Testing and Use of Expired Respirators

XVII. Respiratory Protection Program Requirements

XVIII. Infection Prevention & Control Resources for COVID-19 Competency-Based Training (May 6, 2020)

XIX. How to Properly Don and Doff Personal Protective Equipment

XX. Clean Hands Count CDC

XXI. New Jersey Hospital Association LTC PPE Data Collection Portal Overview

XXII. Useful COVID-19 websites for LTC facilities

XXIII. COVID educational resources for LTC staff

XXIV. Information on Temporary Nurse Aide Free Training and Competency Checklist

This resource was created with funding from the Assistant Secretary for Preparedness and Response and the New Jersey Department of Health.

Updated NJDOH Recommendations for Long-Term Care Facilities during COVID-19 Pandemic Guidance Overview

The New Jersey Department of Health (NJDOH) has developed this guidance to assist long term and residential care facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. Given the congregate nature of long-term care facilities (LTCF) and residents served (e.g., older adults often with underlying chronic medical conditions), this population is at an increased risk of serious illness when infected with COVID-19. LTCF have experience managing respiratory infections and outbreaks among residents and healthcare personnel (HCP[1]) and should apply those outbreak management principles, in addition to heightened measures within, to COVID-19. **Please note this is a rapidly evolving situation and as more data become available this guidance may change.** Additional resources on how LTCF can prepare for and manage COVID-19 can be found here: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html.

IDENTIFY PLAN AND RESOURCES

Review and update your CMS "all -hazards emergency preparedness program and plan" which includes emergent infectious diseases.

- If you do not have a plan, a template can be found at https://www.ahcancal.org/Survey-Regulatory-Legal/Emergency-Preparedness/Pages/default.aspx
- Review CDC's COVID-19 Preparedness Checklist for Nursing Homes and other LTCF at https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf
- Review the Occupational Safety and Health Administration (OSHA) Guidance on Preparing Workplaces for COVID-19 at https://www.osha.gov/Publications/OSHA3990.pdf.

Identify public health and professional resources.

- Locate a local health department (LHD) contact using the NJDOH – Local Public Health Directory at http://www.local-health.nj.gov/
- Contact NJDOH at https://www.nj.gov/health/cd/topics/covid2019_questions.shtml or via phone during regular business hours at (609) 826-5964 for questions, and after hours/weekends at (609) 392-2020 for emergencies.
- Connect with state long-term care professional/trade association resources.
- Assign one person to monitor public health updates from federal, local, and state entities.

Identify contacts at local hospitals in preparation for the potential need to hospitalize facility residents or to receive discharged patients from the hospital.

- If a resident is referred to a hospital, coordinate transport with the hospital, LHD, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the facility.
- **Opening and/or maintaining bed capacity in hospitals is vitally important.**
- A list of New Jersey state hospitals can be found at https://healthapps.state.nj.us/facilities/acFacilityList.aspx.

PROTECTING RESIDENTS, VISITORS, AND HCP

Provide education about respiratory infections, including COVID-19.

- Educate on potential harm from respiratory illnesses to nursing home residents, and basic prevention and control measures for respiratory infections such as influenza and COVID-19.
- Include the following topics in education:
  - Hand hygiene: https://www.cdc.gov/handhygiene/providers/index.html
  - Respiratory hygiene and cough etiquette: https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
  - Personal Protective Equipment (PPE): https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
- CDC COVID-19 Print Resources: https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html

Develop criteria and protocols for screening and/or restricting entrance to the facility.

- Ill individuals are the most likely sources of introduction of COVID-19 into a facility. **CDC recommends aggressive screening and enforcing sick leave policies for ill HCP.**
- Individuals (e.g., vendors, visitors, essential caregivers) should be screened for fever and other symptoms of COVID-192. Those with symptoms or unable to demonstrate proper infection control techniques should not be permitted to enter or stay at the facility. **Any individuals that are permitted and screened should practice source control, social distancing, perform frequent hand hygiene, and restrict their visit to a designated area.**
- **Use of a facemask for source control is recommended for HCP if not otherwise wearing a respirator.**
- Facilities located in areas with **moderate to substantial community transmission** are more likely to encounter asymptomatic or pre-symptomatic individuals with COVID-19 incubation or infection. Community transmission levels can be assessed by referring to the NJDOH COVID-19 Activity Level Index (CALI) Score at https://www.nj.gov/health/cd/statistics/covid/index.shtml. Universal eye protection in addition to source control and other infection prevention and control measures, should be instituted to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions, for all HCP and for all individuals who are unable to maintain social distancing.
- Advise any persons who entered the facility to **monitor for fever and other COVID-19 symptoms**[2] for at least 14 days after exiting the facility. If symptoms occur advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the persons they were in contact with, and the locations within the facility they visited.

Review, implement, and reinforce an infection control plan for preventing communicable disease among residents, visitors, and HCP. The plan should include: ▪

- **Transparent communication** to staff and families regarding identification of a COVID-19 case and/or outbreak and actions taken.
  - Communicate with families to advise them of visitor restrictions and alternative methods for visitation (e.g., video conferencing) during an outbreak. A sample communication letter can be found at https://www.cdc.gov/coronavirus/2019-ncov/downloads/healthcare-facilities/Long-Term-Care-letter.pdf.
  - Consider creating list serve communication to update families, assigning staff as primary contacts for families for inbound calls and conducting regular outbound calls to keep families up-to-date, offering a phone line with a voice recording updated at set times each day with the facilities general operating.
- Enact a policy defining what PPE should be used by visitors and essential caregivers.
- Before visitors enter the designated area, staff will provide instructions to visitors on hand hygiene, limiting surfaces touched, and appropriate use of PPE. Designated visitation areas should be cleaned and disinfected after each visit.
- Ensure visitor movement is limited within the facility (e.g., avoid the cafeteria and other gathering areas).

- Review the CMS Quality, Safety & Oversight (QSO) Group memo Ref: QSO-20-39-NH at https://www.cms.gov/files/document/qso-20-39-nh.pdf and the NJDOH COVID-19 Temporary Operational Waivers and Guidelines at https://www.nj.gov/health/legal/covid19/ for expanded recommendations.
- A policy for when HCP should use Standard, Droplet, and Contact Precautions for residents with symptoms of respiratory infection unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
  - **For suspect or confirmed COVID-19 case(s) Standard and Transmission-Based Precautions including use of a N95 respirator or higher (or facemask, if unavailable), gown, gloves, and eye protection is recommended.**
  - CDC guidance states that **facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. When available, respirators (instead of facemasks) are preferred**; they should be prioritized for situations where respiratory protection is most important (i.e., procedures **that are likely to generate respiratory aerosols**) and for the care of residents with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella).
- Use respiratory protection as part of a **comprehensive respiratory protection program** that meets the requirements of OSHA's Respiratory Protection standard (29 CFR 1910.134) and includes medical exams, fit testing, and training. **Implement this program, if not in place.**
- Employers must demonstrate and document good-faith efforts to comply with OSHA standards, as outlined in the *Respiratory Protection Guidance for the Employers of Those Working in Nursing Homes, Assisted Living, and Other Long-Term Care Facilities During the COVID-19 Pandemic* (https://www.osha.gov/sites/default/files/respiratory-protection-covid19-long-term-care.pdf) and summarized in *Understanding Compliance with OSHA's Respiratory Standard During the Coronavirus Disease (COVID-19) Pandemic* (https://www.osha.gov/sites/default/files/respiratory-protection-covid19-compliance.pdf). OSHA's temporary enforcement memoranda are time-limited to the current COVID-19 crisis and are aligned with CDC's Strategies for Optimizing the Supply of N95 Respirators. LTCF employers should periodically refer to OSHA's COVID-19 webpage for the most up-to-date interim/temporary enforcement discretion memoranda and guidance.
- In the event of shortages or exhaustion of supplies, refer to the CDC *Optimizing Supply of PPE and Other Equipment during Shortages* at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.
- Implementing and/or maintaining a respiratory hygiene program throughout the facility.
- Utilize telemedicine and alternative means of communication (e.g., telephones, video chat, call bell system, intercoms) to maintain social distancing.
- Cohorting residents and staff.
- Collection of specimens.

Identify care plan goals and life sustaining treatment plans for residents.

- Review and update care plans to avoid unnecessary emergency room visits and hospitalizations.
- Review National Hospice and Palliative Care Organizations' COVID-19 Shared Decision Making Tool with residents, families, and authorized proxies, available at https://www.nhpco.org/wp-content/uploads/COVID-19-Shared-Decision-Making-Tool.pdf.
  - Review symptoms, clinical progression and expected outcomes (e.g., Acute Respiratory Distress Syndrome; mechanical ventilation).
  - Confirm residents' care preferences (e.g., home with palliative or hospice care; remain at LTCF with symptom management; hospitalization for medical intervention; allow natural death).
  - Review and complete Physician Orders for Life-Sustaining Treatment (POLST), available at http://www.njha.com/polst/.
  - Advise residents, families, and authorized proxies to review and update Advance Directives at https://www.state.nj.us/health/advancedirective/.
- Transfer notification applies to all residents of the facility. If possible, limit transfers to medical necessity.

SURVEILLANCE AND TRACKING

Perform surveillance to detect respiratory infections, including COVID-19.

- Maintain and/or implement protocol(s) for daily monitoring of residents and HCP for fever and other symptoms of COVID-19[2].
  - For tracking residents and staff, refer to the NJDOH Facility Line List Template at https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-19%20_Facility_Line_List_Template.xlsx.
  - **Note: Your LHD will provide instructions to report COVID-19 cases to public health authorities electronically.**
- Remember that older adults may manifest symptoms of infection differently and that other symptomology should also be assessed. Vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry.
- For incoming residents, if possible, dedicate a unit/wing exclusively for those coming or returning from the community or other healthcare facilities. This can serve as an observation area where they remain for 14 days to monitor for symptoms that may be compatible with COVID-192 (instead of integrating as usual on short-term rehab floor or returning to long-stay original room). **Testing at the end of this period could be considered to increase certainty that the person is not infected.** Refer to NJDOH Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml.
- If symptoms are detected, clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza. Verify the diagnosis using clinical, epidemiological and lab test information, considering seasonal disease occurrence. Co-infection with COVID-19 is possible and should be considered; refer to CDC's Clinical Tips at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-tips-for-healthcare-providers.html. Refer to CDC for more information about COVID-19 symptoms[2].

Report any known or suspect communicable disease outbreak, by phone to the LHD with jurisdiction over the facility.

- Refer to NJDOH Guidelines for the Control of Respiratory Virus Outbreaks in LTCF and Other Institutional Settings at https://www.nj.gov/health/cd/documents/flu/outbreak_prevention.pdf
- Your LHD will help assess the situation and provide guidance for further actions, including laboratory testing.

RESIDENT MANAGEMENT

Determine appropriate placement of new- and re-admissions, positive COVID-19 case(s).

- Review the NJDOH Outbreak Management Checklist at https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Outbreak_Management_Checklist.pdf.
- For suspect or confirmed COVID-19 case(s), Standard and Transmission-based Precautions including use of a N95 respirator or higher (or facemask, if unavailable), gown, gloves, and eye protection is recommended.
- Implement the **facility cohorting plan** that allows for separation of residents, dedicating staff and medical equipment to each of these cohorts and allowing for necessary space to do so at the onset of an outbreak:
  - Dedicate resident specific equipment and supplies. If not possible, restrict dedicated equipment within a specific cohort with routine cleaning and disinfection between resident use.

- HCP assigned to the COVID-19 Positive cohort should not rotate to unaffected units. This restriction includes prohibiting HCP from working on unaffected units after completing their usual shift in the COVID-19 Positive cohort.
- Close the unit to new admissions except as needed to cohort ill individuals or staff.
- Close to new admissions if you are unable to comply with the Emergency Conditional Curtailment of Admissions order at https://www.nj.gov/health/legal/covid19/4-13-20_EmergencyCurtailmentOfAdmissions.pdf.
- If there are multiple cases on the wing/unit and when movement would otherwise introduce COVID-19 to another occupied wing/unit, do not relocate them.
- Refer to the NJDOH Cohorting in Post-Acute Care Facilities document at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml.

Implement environmental infection control measures.

- Conduct routine cleaning and disinfection of frequently touched surfaces and shared medical equipment using an EPA-registered, hospital-grade disinfectant on List N (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2). Adhere to the manufacturer's instructions for use and review internal environmental cleaning protocols to ensure appropriate measures are being taken to clean and disinfect throughout the facility. Consider increasing the frequency of routine cleaning and disinfection.
- Dedicated medical equipment should be used when caring for a resident with known or suspected COVID-19, when possible.
  - All non-dedicated, non-disposable medical equipment used for resident care should be **cleaned and disinfected** according to manufacturer's instructions and facility policies.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Consider implementing engineering controls such as curtains or partitions between patients/residents to reduce or eliminate exposures from infected individuals. This is especially important when semi-private rooms must be used. Ensure there is a policy and procedure for routine cleaning and disinfection.

Enhance active surveillance.

- When a confirmed COVID-19 case is identified at the facility, monitor residents **at minimum, during every shift**, with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs (heart rate, blood pressure, temperature, and pulse oximetry).
- Clinicians should use their judgment to determine if a resident has signs and symptoms compatible with COVID-192 and whether they should be tested.
- Seek out additional cases of respiratory illness among residents and HCP. Be alert for new onset of illness among exposed persons, and review resident and HCP histories to identify previous onsets of illness that may not have been correctly recognized as being part of the outbreak.
- **Continue to perform ongoing weekly testing of all staff** until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community (ED 20-026).
  - Staff who have previously tested positive must be re-tested according to CDC and CDS guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html.
  - Refer to the NJDOH Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml.

STAFF MANAGEMENT AND CONTINGENCY PLANNING

Implement procedure for monitoring HCP working within the facility.

- Screen and log all persons entering the facility and all HCP at the beginning of each shift. Advise any persons who enter the facility to monitor for fever and other COVID-19 symptoms2 for at least 14 days after exiting the facility. If symptoms occur advise them to self-isolate at home, contact their healthcare provider and immediately notify the facility of the date they were in the facility, the persons they were in contact with and the locations within the facility they visited. Screen all HCP at the beginning of their shift for fever and other symptoms of COVID-19. Actively take their temperature and document absence of symptoms.
- Ensure compliance with source control and social distancing requirements.
- Facilities must ensure that essential caregiving visits comply with existing directives and are conducted as safely as possible and must require infection prevention and control practices, hand hygiene and PPE.
- HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.
- Identify HCP who may be at higher risk for severe COVID-19 disease and attempt to assign to unaffected unit.
- **Evaluate and manage HCP with symptoms of illness.**
- Implement sick leave policies that are non-punitive, flexible, and consistent with public health measures that allow ill HCP to stay home.
- As part of routine practice, ask HCP (including consultant and contracted personnel) to regularly monitor themselves for fever and symptoms of COVID-192. Remind HCP to stay home when they are ill.
- If HCP develop fever or symptoms of COVID-19 while at work, they must cease resident care activities, keep their mask on, and notify their supervisor or occupational health services prior to leaving work.

Perform HCP exposure risk assessment for staff who cared for or had close contact with a COVID-19 case(s).

- To help facilities document and assess HCP risk and exposure, NJDOH has developed the below series of tools and check-lists based on CDC guidance, available at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml:
  - Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel
  - NJDOH HCP Exposure to Confirmed COVID-19 Case Risk Algorithm
  - Retrospective Assessment Tool for HCP Potentially Exposed to COVID-19
  - NJDOH COVID-19 Fever and Symptom Monitoring Log for HCP
  - HCP Exposure Line List

Develop contingency staffing and resident placement plans.

- Identify minimum staffing needs and prioritize critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.
- When transmission in the community is identified, LTCFs may face staffing shortages. Facilities should develop (or review existing) plans to mitigate staffing shortages. Staffing shortages may be addressed by reviewing the COVID-19 Temporary Operational Waivers and Guidelines at https://www.nj.gov/health/legal/covid19/ for potential solutions.
- Communicate with local healthcare coalitions, federal, state, and local public health partners to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed. Be aware of emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
- Contact your healthcare coalition for guidance on altered standards of care in case residents need acute care and hospital beds are not available.

- Strategize about how your facility can help increase hospital bed capacity in the community.
- Establish memoranda of agreement with local hospitals for admission to the LTCF of lower acuity residents to facilitate utilization of acute care resources for those more seriously ill.

Develop strategies for optimizing the supply of PPE.

- Facilities are required to have an adequate emergency stockpile of PPE, essential cleaning and disinfection supplies so that staff, residents and visitors can adhere to recommended infection prevention and control practices.
- Use the CDC's PPE Burn Rate Calculator to estimate the amount of PPE needed for the facility's required supply. The calculator can be found at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/PPE-Burn-Rate-Calculator.xlsx.
- Facilities should calculate the quantity of PPE to fulfill this requirement at a burn rate based on the highest use of PPE during the COVID-19 surge in their facilities.
- Review protocols for optimization of PPE supplies. Review CDC's Strategies to Optimize PPE Supplies at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.
- Bundle tasks to optimize PPE and limit exposures. Consider cross-training to conserve resources.
- Review CDC's FAQ about PPE at https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html.

[1] For this guidance, CDC defines HCP as all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. This may include, but is not limited to contracted staff, licensed independent practitioners, nursing students, etc.

[2] Symptoms of COVID-19 may include gastrointestinal upset, fatigue, sore throat, dry cough and shortness of breath; visit https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html for more information.

COVID-19 Infection Prevention and Control Assessment Tool (Tele-ICAR) for Long-Term Care and Assisted Living Facilities

The New Jersey Department of Health (NJDOH) Infection Control and Assessment and Response (ICAR) team recognizes the rapidly changing recommendations and guidelines during these unprecedented times. We extend our sincere gratitude to each and every healthcare team member for the dedication, sacrifice, and determination to provide the best care possible for our New Jersey (NJ) residents during this global pandemic. We hope this will be an opportunity to pause and consider the accomplishments to date in protecting the health and safety of NJ residents.

This tele-ICAR tool is developed by the Centers for Disease Control and Prevention (CDC) and is intended to help long term care (LTC) and assisted living facilities (ALF) to prepare to respond effectively to COVID-19 by evaluating the status of their current response activities.

The tele-ICAR tool focuses on the following key strategies and prevention activities for COVID-19 response:

- Keep COVID-19 out of the facility.
- Identify infections, as early as possible.
- Prevent spread of COVID-19 in the facility.
- Assess and optimize personal protective equipment (PPE) supplies.
- Identify and manage severe illness in patients/residents.
- Educate, monitor, and screen healthcare personnel (HCP) and patients/residents.
- Ensure adherence to recommended infection prevention and control (IPC) practices.
- Communicate with local and state health departments and other healthcare facilities.

Findings from the assessment can be used to target facility-specific IPC preparedness and/or containment activities that healthcare facilities can immediately focus on while continuing to keep their patients/residents and HCP safe. Please complete this tool and submit it to the NJ ICAR team at CDS.ICAR@doh.nj.gov or via fax at 609-292-5811, at your earliest convenience.

The NJDOH ICAR team is available for virtual consultations to support IPC activities. If you are interested in a consultative appointment, please complete the tele-ICAR assessment and check the box indicating such. A member of the ICAR team will follow-up to coordinate a **one-hour scheduled virtual appointment with the NJ ICAR team**. We appreciate your partnership and look forward to continually improving the health and well-being of NJ residents.

INFECTION CONTROL ASSESSMENT & RESPONSE
NEW JERSEY DEPARTMENT OF HEALTH

INTERESTED IN VIRTUAL TELE-ICAR CONSULTATION: YES ☐ NO ☐

SEND COMPLETED FORMS TO CDS.ICAR@DOH.NJ.GOV OR VIA FAX TO 609- 292-5811

Instructions: Please answer the questions in the space provided. If additional information is needed, please review the guidance available on the CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes at https://www.cdc.govcoronavirus/2019-ncov/hcp/long-term-care.html. Any additional questions can be directed to the NJ ICAR team at CDS.ICAR@doh.nj.gov.

DEMOGRAPHICS

Facility Point of Contact (POC) Name: _____

Facility POC Title: _____

POC Phone: _____ **POC E-mail Address:** _____

Facility Name: _____ **Date:** _____

- Number of beds in the facility: _____
- Total number of staff in the facility: _____
- Total number of patients/residents in the facility: _____
- Total number of units: _____

Specialty Units (check all that apply)

☐ Vent/trach ☐ Dialysis ☐ Dementia/Memory ☐ Skilled Nursing ☐ Subacute Rehab ☐ Psychiatric care

Which of the following situations apply to the facility? (check all that apply)

☐ No cases of COVID-19 currently reported in the surrounding community
☐ Cases reported in the surrounding community
☐ Sustained transmission reported in the surrounding community
☐ Cases identified in their facility (either among HCP and/or patients/residents)
☐ Cluster of ILI in facility (either among HCP and/or patients/residents)

Have you received any prior information specific to prevention transmission of COVID-19? (check all that apply)

☐ No
☐ Yes, from the state health department
☐ Yes, from the local health department
☐ Yes, from Centers for Disease Control and Prevention (CDC)
☐ Yes, from Centers for Medicare and Medicaid Services (CMS)
☐ Yes, from another source: _____

Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities

Note: This document does not supersede any existing state and federal regulation. Facilities shall comply with any applicable existing regulatory requirements.

Testing for COVID-19, the infection caused by SARS-CoV-2, is an epidemiologic tool to assess the number of people in a facility with the disease. Generally, viral testing for SARS-CoV-2 is considered to be diagnostic when conducted among individuals with symptoms consistent with COVID-19 or among asymptomatic individuals with known or suspected recent exposure to SARS-CoV-2 to control transmission, or to determine resolution of infection.

VIRAL TESTING

Viral testing is considered screening when conducted among asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification and considered surveillance when conducted among asymptomatic individuals to detect transmission hot spots or characterize disease trends. **Authorized assays for viral testing include those that detect COVID-19 nucleic acid or antigen.** The first two SARS-CoV-2 antigen tests to receive FDA Emergency Use Authorization or EUA are authorized for testing symptomatic persons within 5 days of symptom onset and **there are limited data on antigen test performance in asymptomatic persons**. However, given the transmission of COVID-19 from asymptomatic and pre-symptomatic nursing home residents and healthcare personnel (HCP)* with COVID-19 infection, CDC is providing considerations for the use of antigen tests in asymptomatic persons during this public health emergency. Refer to the CDC Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html and the accompanying Considerations for Interpreting Antigen Test Results in Nursing Homes table in the Appendix.

VISITORS AND ESSENTIAL CAREGIVERS

Facilities that have antigen testing available may use it to supplement their visitor and essential caregiver screening process. The facility's policies and procedures should address testing arrangements, including who pays for any testing, reporting of results, and notification to local public health. **Visitors and essential caregivers who test positive are not permitted to enter the facility.** Facilities should operate in accordance with applicable NJDOH COVID-19 Temporary Operational Waivers and Guidelines at https://www.nj.gov/health/legal/covid19/.

TESTING A PREVIOUSLY POSITIVE COVID-19 CASE

For persons previously diagnosed with COVID-19 who remain asymptomatic after recovery, retesting is not recommended **within 3 months** after the date of symptom onset or first positive test. If re-testing is performed within 3 months, re-isolation would not be indicated, and quarantine would not be recommended in the event of close contact with an infected person. For persons who develop new symptoms consistent with COVID-19 <3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant re-testing; consultation with infectious disease or infection control experts is recommended. Isolation may be considered during this evaluation based on consultation with an infection control expert.

Testing should be considered again for residents or HCP who were positive >3 months after the date of initial onset of the prior infection or exposure (e.g., in response to an exposure or serial testing). Currently, NJDOH and CDC recommend that if an individual test positive with viral test (e.g., reverse-transcriptase polymerase chain reaction [RT-PCR] or antigen test) **more than 3 months** after an initial positive test, it should be managed as new infection or re-infection. Until public health can collect more data about the infectivity of individuals who test positive >90 days (3 months) after their first infection, NJDOH and CDC are recommending a conservative approach to act on these results. **These timeframes and recommendations may change as more information becomes available.**

TEST-BASED METHODS FOR DISCONTINUATION OF TRANSMISSION-BASED PRECAUTIONS (TBP) AND HCP RETURN TO WORK GUIDANCE

In general, a test-based method to discontinue TBP or return HCP to work is not recommended. However, in some instances, a test-based strategy could be considered to allow for return to work or discontinuation of TBP earlier than if the symptom-based strategy were used. Many individuals will have prolonged viral shedding, which may limit the utility of this approach. A test-based strategy could also be considered for some HCP or residents (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the HCP or residents being infectious for more than 20 days.

Antigen tests should NOT be utilized to determine the duration of TBP nor when HCP can return to work. If a long-term care facility (LTCF) needs to use a test-based method, they should use only RT-PCR.

IDENTIFICATION OF A COVID-19 CASE IN LTCFS

When a new case of COVID-19 is identified in a LTCF, facility-level testing is an important tool to assist with containment and response. Routine testing may identify cases in HCP, new- or re-admitted residents and/or in residents who have been at the facility longer than 14 days. Upon identification of a confirmed case of COVID-19 within a LTCF, **there are critical priority actions facilities should take regardless of where the transmission event occurred**.

Regardless of attribution of the case, all facilities should take the following steps when a new case of COVID-19 (e.g., residents, HCP, essential caregivers) is identified in their facility:

- Perform a risk assessment to determine any potential exposures and/or infection control breaches at the facility.
- Determine any possible exposures the new case of COVID-19 (e.g., resident, HCP, essential caregiver) may have had prior to diagnosis including contact with other known COVID-19 positive persons or those who later developed symptoms consistent with COVID-19.
- Alert the local health department to the newly identified case.
- Identify close contacts including 48 hours prior to symptom onset/date of specimen collection of associated case, if applicable.
  - Close contact is identified as being within approximately 6 feet of a COVID-19 case for a prolonged period of time, a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic residents, 2 days prior to test specimen collection) until the time the resident is isolated; or
  - Having direct contact with infectious secretions from an individual with COVID-19. Infectious secretions may include sputum, serum, blood, and respiratory droplets (e.g., being coughed or sneezed on).
- Quarantine close contacts for 14 days from last exposure and provide care using all COVID-19 recommended personal protective equipment (PPE).
- Any newly positive residents should be cohorted appropriately.
- Any newly positive HCP should be provided information on duration of isolation and when they can return to work. Refer to NJDOH *Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel* at https://www.nj.gov/health/cd/topics/covid19_healthcare.shtml.

NOTE: Any identification of COVID-19 in the LTCF should be reported to the local health department and will prompt an investigation. During an investigation the LTCF will work with the LHD to implement additional infection prevention and control measures. Refer to the NJDOH COVID-19 Communicable Disease Investigation Chapter (Table 1) at https://www.nj.gov/health/cd/topics/covid2019_professionals.shtml.

NEWLY POSITIVE FACILITY-ONSET COVID-19 CASE IN A RESIDENT

Facility-onset COVID-19 infection in a LTCF 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. This does not apply to residents who were positive for COVID-19 on admission to the facility and were placed into appropriate TBP OR residents who were placed into TBP on admission and developed SARS-CoV-2 infection within 14 days after admission, unless there is confirmation of possible transmission or exposure through a breach in PPE.

Upon identification of a facility-onset COVID-19 case in their facility, and in addition to the steps outlined above, the facility should:

- Perform weekly testing of all residents until no new facility-onset cases of COVID-19 are identified among residents and positive cases in HCP and at least 14 days have elapsed since the most recent positive result and during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative.
- Continue weekly HCP testing in accordance with applicable NJDOH COVID-19 Temporary Operational Waivers and Guidelines at https://www.nj.gov/health/legal/covid19/.
- Refer to NJDOH Outbreak Management Checklist and COVID-19 Disease Chapter for full outbreak recommendations.

If the newly identified COVID-19 positive resident does not meet the facility-onset COVID-19 case criteria, the facility should take the following additional actions:

- Upon identification of a case of COVID-19 in a resident who was recently admitted (within 14 days), the receiving facility must provide these results back to the sending facility to allow for the appropriate response and investigation.
- Alert the local health department to a new case and identify the facility that the resident was transferred from (if applicable).
- Conduct a risk assessment to determine if the resident had been cohorted appropriately, cared for in full TBP, if any breaches in PPE occurred, and if there are any resident, HCP, or essential caregiver exposures that may have occurred.

NEWLY POSITIVE HCP

During the course of weekly surveillance testing, HCP may test positive. Given the local community transmission of SARS-CoV-2, it is difficult for public health to attribute an isolated positive case of

COVID-19 in HCP to a specific facility, particularly if there are limited epidemiologic linkages that could support exposure or transmission. However, regardless of attribution, LTCFs should take immediate action to ensure that further transmission does not occur. This is particularly relevant for facilities without an active outbreak.

Upon identification of a new COVID-19 case in HCP, and in addition to the steps outlined above the facility should:

- Alert their local health department to possible COVID-19 outbreak in their facility, if not currently experiencing an outbreak. If the facility was experiencing an outbreak, report the new test result as a newly confirmed case.
- Conduct a risk assessment to determine if the HCP may have exposed any residents or other HCP. Facilities should take into account the role of the HCP, level of resident contact, use of appropriate PPE, and use of source control (e.g., facemask/face covering) when in the healthcare facility.
- **Perform facility-wide testing of residents**, as described above, if the facility is not already conducting routine testing of all residents. Results of testing will guide further response activities and recommendations.
- Encourage transparent communication. If the newly positive HCP works at other healthcare facilities, strongly encourage the HCP to alert those facilities immediately.
- **Continue routine HCP testing** in accordance with applicable NJDOH COVID-19 Temporary Operational Waivers and Guidelines at https://www.nj.gov/health/legal/covid19/.

**Healthcare personnel (HCP): HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, feeding assistants, students and trainees, contractual HCP not employed by the healthcare facility, and persons not directly involved in resident care but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.*

See next page for Appendix: Considerations for Interpreting Antigen Test Results in Nursing Homes. The interpretation of antigen testing results is subject to change as more information becomes available.

Appendix: **Considerations for Interpreting Antigen Test Results in Nursing Homes**

Non-outbreak/investigation facilities			
Person	**Antigen Result**	**Confirmatory Molecular Testing**	**Return to Work Criteria and Transmission-Based Precautions (TBP) Recommendations**
Asymptomatic Resident or Healthcare Personnel (HCP)	Antigen Positive	Perform RT-PCR within 48 hours	• Resident should be isolated and placed on appropriate TBP. • HCP should be excluded from work. • Initiate facility-wide testing of all residents per NJDOH guidance. • Refer to NJDOH Outbreak Management Checklist and COVID-19 Disease Chapter for full outbreak and investigation recommendations. **Note: If confirmatory RT-PCR is positive, then this is a confirmed case. If the confirmatory RT-PCR is negative, the antigen test might be a false positive. Obtain a second RT-PCR at least 24 hours after the first RT-PCR. If the second RT-PCR is also negative, this is not a case. If the second RT-PCR test is positive, this is a confirmed case.**
	Antigen Presumptive Negative	Not Recommended	• Allow HCP to continue to work or resident to remain out of isolation. • Continue serial testing per NJDOH guidance.
Symptomatic Resident or HCP	Antigen Positive	Not Recommended	• Resident should be isolated and placed on appropriate TBP. • HCP should be excluded from work. • Initiate facility-wide testing of all residents per NJDOH guidance. • Refer to NJDOH Outbreak Management Checklist and COVID-19 Disease Chapter for full outbreak and investigation recommendations.
	Antigen Presumptive Negative	Perform RT-PCR within 48 hours	• Residents should be kept on TBP and HCP excluded from work until RT-PCR results return. Discontinuation of TBP and return to work criteria for symptomatic individuals should be based on the alternate diagnosis, if available, and existing policies and procedures. **Note: If confirmatory RT-PCR is positive, then this is a confirmed case. If the confirmatory RT-PCR is negative, this is not a case.** **Note: If an individual has recovered from SARS-CoV-2 infection in the past 3 months and develops new symptoms suggestive of COVID-19, alternative diagnoses should be considered.**

Facilities with an active outbreak or investigation			
Person	**Antigen Result**	**Confirmatory Molecular Testing**	**Return to Work Criteria and Transmission-Based Precautions (TBP) Recommendations**
Asymptomatic Resident or HCP	Antigen Positive	No confirmatory test is necessary **	• Resident should be isolated and placed on appropriate TBP. • HCP should be excluded from work. • Continue serial testing per NJDOH guidance. • Refer to NJDOH Outbreak Management Checklist and COVID-19 Disease Chapter for full outbreak and investigation recommendations.
	Antigen Presumptive Negative	Not Recommended	• Resident should continue to be placed on the appropriate TBP for the duration of the investigation or outbreak testing. • Allow HCP to continue to work. • Continue serial testing per NJDOH guidance.
Symptomatic Resident or HCP	Antigen Positive	Not Recommended	• Resident should be isolated and placed on appropriate TBP. • HCP should be excluded from work. • Refer to NJDOH Outbreak Management Checklist and COVID-19 Disease Chapter for full outbreak and investigation recommendations.
	Antigen Presumptive Negative	Perform RT-PCR within 48 hours	• Residents should be kept on TBP and HCP excluded from work until RT-PCR results return. Discontinuation of TBP and return to work criteria for symptomatic individuals should be based on the alternate diagnosis, if available, and existing policies and procedures. **Note: If confirmatory RT-PCR is positive, then this is a confirmed case. If the confirmatory RT-PCR is negative, this is not a case.** **Note: If an individual has recovered from SARS-CoV-2 infection in the past 3 months and develops new symptoms suggestive of COVID-19, alternative diagnoses should be considered.**

** No confirmatory test is necessary. But if pre-test probability is thought to be low (e.g. isolated cases with no known facility exposures), the facility may perform confirmatory RT-PCR tests. If confirmatory RT-PCR is positive, then this is a confirmed case. If the confirmatory RT-PCR is negative, the antigen test might be a false positive. Obtain a second RT-PCR at least 24 hours after the first RT-PCR. If the second RT-PCR is also negative, this can be interpreted as a false positive or resolved infection. If the second RT-PCR test is positive, this is a confirmed case.

Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities

COVID-19 has had a major impact in healthcare facilities, especially in the post-acute care setting. COVID-19 has a broad clinical presentation, long incubation period, and is transmissible through asymptomatic or pre-symptomatic people, including patients/residents and healthcare personnel (HCP). Therefore, cohorting using traditional symptom-based screening alone should be avoided if possible but when necessary, done with caution given the risk of asymptomatic or pre-symptomatic infection. Cohorting is most effective when resources permit for rapid identification and isolation and when there are dedicated HCP and equipment per cohort. **Please note this document is intended to help guide decisions in consultation with the clinical team and facility specific resources. This is a rapidly evolving situation and as more data become available related to COVID-19, this information may change. For up-to-date information refer to the "Resources" section at the end of this document.**

Cohorting is only one element of infection prevention and control measures used for outbreak control. The facility should review or develop a cohorting plan **before** the identification of the first case. This plan should consider resources including the availability of testing, personal protective equipment (PPE) and staffing. When testing capacity is available and facility spacing permits, patients/residents should be organized into the following cohorts:

A. Cohort 1 – COVID-19 Positive

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

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 closely monitored for symptom development.

C. Cohort 3 – COVID-19 Negative, Not Exposed

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 – New or Re-admissions

This cohort consists of all persons from the community or other healthcare facilities who are newly or re-admitted. 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 end of this period could be considered to increase certainty that the person is not infected.** COVID-19 positive persons who have not met the discontinuation of Transmission-Based Precautions should be placed in Cohort 1 – COVID-19 Positive. Individuals who have cleared Transmission-Based Precautions and it has been <3 months after the date of symptom onset or positive viral test (for asymptomatic) of prior infection can go to cohort 3.

OUTBREAK CRISIS RECOMMENDATIONS

In the event of widespread identified cases, focus should be placed on cohorts 1-2. New admissions should stop until control measures are effectively instituted. Depending on a variety of factors (e.g., facility layout, private room availability, testing results) LTCFs may not be able to effectively cohort, as described above. In situations where COVID-19 positive persons are located on multiple units/wings, the facility should follow the below recommendations:

- Implement **universal Transmission-Based Precautions using COVID-19 recommended PPE (i.e., N95 respirator or higher [or facemask if unavailable], eye protection, gloves, and isolation gown) for the care of all patients/residents**, regardless of presence of symptoms or COVID-19 status.
- Refer to CDC Optimizing Supply of PPE and Other Equipment during Shortages at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.
- Consider **repurposing unused space** such as therapy gyms, activity and dining rooms during this time to cohort patients/residents.
- **If there are multiple cases on the wing/unit and when movement would otherwise introduce COVID-19 to another occupied wing/unit, do not relocate them.** Limit the movement of all patients/residents and HCP in general.
- Ensure appropriate use of **engineering controls** such as curtains between patients/residents to reduce or eliminate exposures from infected individuals. This is especially important when **semi-private rooms** must be used. Allocate private rooms to maintain separation between patients/residents, based on test results and clinical presentation. For example:
  - COVID-19 positive persons may share a semi-private room to keep them grouped together.
    - Patients/residents who are colonized with or infected with multidrug-resistant organisms (MDROs), including *Clostridium difficile*, should not be placed in a semi-private room or group area when possible, unless their potential roommate(s) is/are colonized or infected with the same organism(s).
  - Private rooms may be allocated to isolate symptomatic persons or quarantine asymptomatic persons, based on availability.
- Shift focus to maintaining dedicated HCP to a wing/unit with a heightened focus on infection prevention and control audits (e.g., hand hygiene and PPE use) and providing feedback to HCP on performance.

FREQUENTLY ASKED QUESTIONS

What if space in our facility doesn't allow us to create a "separate wing/unit" for these cohorts?

Facilities should do their best to designate separate wings/units or floors for cohorts when available; however, any general physical separation may be acceptable. This **may include one side of a wing/unit; a group of rooms at the end of a wing/hallway; or a repurposed group area** such as a gym, cafeteria or other large communal space. Patients/residents who are colonized with or infected with MDROs, including Clostridium difficile, should not be placed in a semi-private room or group area when possible, unless their potential roommate(s) is/are colonized or infected with the same organism(s).

What does it mean to dedicate HCP to these cohorts?

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).

Can medical equipment be used across cohorts?

Dedicate medical equipment to the COVID-19 Positive (cohort 1) area. Medical equipment should not be shared across cohorts. If this is not possible, equipment should be used by rounding in a "well to ill" flow to minimize risk of cross-contamination. All equipment should be **appropriately cleaned and disinfected** according the manufacturer's instructions between patient/resident use.

When can patients/residents be removed from isolation and the COVID-19 Positive (cohort 1) area?

Decisions to extend or remove persons from Transmission-Based Precautions should be made in consultation with a healthcare provider and/or public health professional and is subject to differences in disease course, symptoms, living situation, available resources and clinical management. Refer to the NJDOH *Quick Reference: Discontinuation of Transmission-Based Precautions and Home Isolation for Persons Diagnosed with COVID-19* at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml for recommended strategies.

CDC recommends patients/residents diagnosed with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can be removed from the COVID-19 Positive (cohort 1) area. If symptoms are still present, and they have been moved off of the COVID-19 Positive (cohort 1) area, they should be placed in a private room until all symptoms resolve or are at their baseline. Once all symptoms have resolved, or returned to baseline, they do not require further restrictions, based upon their history of COVID-19. **Routine infection prevention and control measures should remain in place, which may include maintaining Transmission-Based Precautions when unit or facility wide precautions are in place despite meeting the discontinuation criteria.**

How do we determine patient/resident exposures?

The index of suspicion for an exposure should be low, as COVID-19 has been seen to rapidly progress throughout the post-acute care setting. Exposures may include shared HCP; shared equipment; or being housed on the same wing/unit with a COVID-19 positive person. Facilities should identify patients/residents who were cared for by HCP who are COVID-19 positive and staff suspected of having COVID-19. Exposures should be traced back to 48 hours prior to symptom onset or positive test for asymptomatic positive HCP, as the exposed patient/resident may later develop symptoms of COVID-19 or test positive. Patients/residents who are identified as a close contact (e.g., cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of the HCP COVID-19 testing are known. If the HCP is diagnosed with COVID-19, patients/residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms. **Lab confirmed COVID-19 positive patients/residents should be relocated to the COVID-19 Positive (cohort 1) area.**

Rapid isolation is key. Once there are multiple cases or exposures on a wing/unit, transition the wing/unit to the appropriate cohort and focus efforts on rapid implementation of control measures for unaffected wings/units (i.e., containment efforts). If there are multiple cases on the wing/unit and when movement would otherwise introduce COVID-19 to another occupied wing/unit, do not relocate them. Ensure appropriate use of engineering controls such as curtains to reduce or eliminate exposures from infected individuals.

Do patients/residents who routinely leave the facility need to be quarantined?

The facility should defer to the established policy and procedures based on their 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 cohorted with others who frequently leave the facility.

What should we do about roommates of patients/residents who are symptomatic or COVID-19 positive?

Roommates may already be exposed; it is generally not recommended to separate them given spatial limitations. Ensure **appropriate use of engineering controls** such as curtains to reduce or eliminate exposures between roommates.

Roommates of a laboratory confirmed **COVID-19 positive case should be considered exposed but may be kept isolated in their room after the COVID-19 positive is transitioned to the COVID-19 Positive area (cohort 1). Note: When movement would otherwise introduce COVID-19 to another occupied wing/unit, do not relocate them.** The exposed roommate should be cared for using all COVID-19 recommended PPE and monitored for 14 days from last exposure to the known COVID-19 case, for development of symptoms. Testing should be performed, if available.

What types of precautions should be used in each cohort?

Regardless of cohort, all HCP should adhere to Standard Precautions and any necessary Transmission-Based Precautions according to clinical presentation and diagnosis, when caring for any patients/residents.[1] F**ull Transmission-Based Precautions and all recommended COVID-19 PPE should be used for all patients/residents who are:**

- **COVID-19 positive**
- **Suspected of having COVID-19**
- **New and re-admissions**
- **Exposed to any COVID-19 positive person (e.g., HCP, visitor, roommate)**
- **On a wing/unit (or facility wide), regardless of presence of symptoms, when transmission is suspected or identified[2]**

Facilities should Implement protocols for extended use of PPE, if resources are limited. **HCP should wear eye protection and an N95 respirator or higher (or facemask if unavailable) at all times while in the COVID-19 Positive (cohort 1)** area with gown and gloves added when entering patient/resident rooms. Facilities should consider this same approach for designated patient/resident care areas of persons who are **exposed** (and potentially incubating). **As part of source control efforts, staff should wear a facemask at all times while they are in the healthcare facility.** There should be emphasis on patients/residents practicing basic infection prevention and control measures including source control, especially during direct care.

Resources

[1] CDC, Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings – Recommendations of the Healthcare Infection Control Practices Advisory Committee
https://www.cdc.gov/hicpac/pdf/core-practices.pdf

[2] CDC, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

CDC Strategies to Optimize the Supply of PPE and Equipment
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

CDC Responding to Coronavirus (COVID-19) in Nursing Homes
https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

NJDOH, COVID-19: Information for Healthcare Professionals
https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml

COVID-19 Exposure Risk Assessment Template for Patients in Post-Acute Care Settings

This tool may be used to assess the need for quarantine of patients/residents who leave the facility for periodic medical-related or non-medical outings. Facilities are strongly encouraged to establish ongoing communication to notify of known or suspected exposures. This risk assessment should be adapted as appropriate depending on settings, resource availability, and level of community disease burden (e.g., NJDOH COVID-19 Activity Level Index [CALI] Score). **This should NOT be used to assess new or re-admissions.** As a reminder, individuals may not test out of COVID-19 quarantine. Refer to the NJDOH *Why You Can't Test Out of COVID-19 Quarantine* at https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-Cannot-Test-Out-of-Quarantine.pdf.

Risk assessments should be well documented to include the reasons for a placement decision and considerations should, at minimum, include evaluation of:

- Frequency of potential exposures.
- Transportation mode and potential for exposures during transportation.
- Adherence to social distancing and source control of others who interacted with the patient/resident.
- Degree to which the patient/resident can maintain/adhere to adequate social distancing, hand hygiene, and source control (if applicable).
- Degree to which the immune system of the patient/resident might be compromised.
- Risks and benefits of physically moving the patient/resident.

For any patient/resident taking a trip outside of the facility, the facility should:

- Provide the patient/resident with any items needed to follow infection prevention recommendations (e.g., hand sanitizer, face covering).
- Educate the patient/resident and others (e.g., transport personnel, friends, family) of appropriate infection prevention precautions.
- Continue symptom screening of patient/resident on their return to the facility.
- Follow internal protocol (which may include a 14-day quarantine upon returning to the facility) regarding management of patient/resident who take trips outside of the facility, based on their risk assessment, re-opening phase, and NJDOH COVID-19 CALI Score.
- If possible, cohort patients/residents who make frequent trips outside the facility.

Additional information on management of new or re-admissions and assessing exposure risk for patients/residents who routinely leave the facility is available at NJDOH *Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities* at https://www.state.nj.us/health/cd/topics/covid2019_healthcare.shtml.

Directions: Answer the questions below by placing a check mark in the appropriate column. If the patient/resident is unable to provide the necessary information, staff may need to contact the family of the patient/resident, transport services or any other contact to confirm exposure risk. This should be used for patients/residents who frequently leave the facility; asymptomatic, COVID-19 negative patients/residents; or those who have tested positive (and been removed from isolation) more than 3 months ago. **This should NOT be used to assess new or re-admissions.**

Date of assessment: _____ Facility name: _____

Patient/resident name: _____ Unit/room: _____

POC Phone:_____ POC E-mail Address: _____

Hemodialysis (Y/N):_____ Destination: _____

Staff member initials: _____ Total time outside the facility: _____

Dates out of the facility: _____

If you answer yes to any of the questions, the patient/resident may be considered at increased risk for COVID-19 incubation. The facility should consider additional assessment if needed and/or continue to quarantine the individual for 14 days from the last date of known or suspected exposure.

Current COVID-19 activity	**Yes**	**No**
Did the patient/resident travel to an area with increasing community transmission of COVID-19? *Refer to the NJDOH CALI Weekly Reports at https://www.nj.gov/health/cd/statistics/covid/.*	☐	☐
General risk assessment	**Yes**	**No**
If yes, did the patient/resident have close contact[1] with someone with known COVID-19 or who had symptoms[2] consistent with COVID-19 while away from the facility?	☐	☐
Did the patient/resident fail to practice source control (wear a cloth or disposable mask) at all times (except for eating or drinking) and social distancing while away from the facility?	☐	☐
Aside from healthcare interactions, did the patient/resident spend time (≥ 15 cumulative minutes within 24-hours) indoors in a public place or business within 6 feet of persons who were not using cloth or disposable masks for source control?	☐	☐
Did the patient/resident fail to practice social distancing (e.g., 6 feet separation, use of partition) at all times while away from the facility (except when receiving medical care or transfer assistance)?	☐	☐
Did the patient/resident spend time in an enclosed space (e.g., place of worship, house gathering) with persons who were not practicing source control and social distancing?	☐	☐
Was the patient/resident transported in a vehicle, including family-member's vehicle, with occupants who were not practicing source control and social distancing (e.g. one rider per row, use of partition)	☐	☐
Additional risk assessment specific to medical appointments	**Yes**	**No**
Does the outside healthcare facility treat patients with known or suspected COVID-19?	☐	☐
Does the outside healthcare facility have an outbreak of COVID-19 within the past 28 days or documented transmission among its staff or patients?	☐	☐
Did transport services and/or the outside facility fail to adhere to source control, social distancing, and infection prevention measures while the patient/resident was in their care?	☐	☐
Did the patient/resident have close contact1 with anyone who was not practicing source control and/or social distancing?	☐	☐

[1] Being within less than 6 feet of a COVID-19 case for a prolonged period of time (≥ 15 minutes within 24-hours)

[2] These symptoms can include but are not limited to: Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion, nausea or vomiting, diarrhea.

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PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

EXECUTIVE DIRECTIVE NO. 20-026[1]

Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37

WHEREAS, Coronavirus disease 2019 ("COVID-19") is a contagious, and at times fatal, respiratory disease caused by the respiratory illness caused by the SARS-CoV-2 virus; and

WHEREAS, symptoms of the COVID-19 illness include fever, cough and shortness of breath, which may appear in as few as two or as long as 14 days after exposure, and can spread from person to person via respiratory droplets produced when an infected person coughs or sneezes; and

WHEREAS, on March 9, 2020, Governor Philip D. Murphy issued Executive Order 103, declaring the existence of a Public Health Emergency, pursuant to the Emergency Health Powers Act, N.J.S.A. 26:13-1 et seq., and a State of Emergency, pursuant to the Disaster Control Act, N.J.S.A. App A:9-33 et seq., in the State of New Jersey for COVID-19; and

WHEREAS, the Public Health Emergency was extended by Governor Murphy under Executive Order Nos. 119, 138, 151, 162,171, 180 and 186; and

WHEREAS, Executive Directive 20-013 issued May 20, 2020, instituted a testing requirement for COVID-19 in New Jersey licensed Long-Term Care Facilities, Assisted Living Residences, Comprehensive Personal Care Homes, Residential Health Care Facilities, and Dementia Care Homes (collectively "LTCFs" or "facilities"); and

WHEREAS, LTCFs have been heavily impacted by COVID-19. The New Jersey Department of Health (NJDOH) has taken an aggressive approach to detection of and response to the virus in these vulnerable populations; and

WHEREAS, New Jersey has created a guide, *The Road Back: Restoring Economic Health Through Public Health*, which outlines six key principles and benchmarks to guide the process

[1] This revised Executive Directive amends and supersedes Executive Directive 20-026 issued on August 10, 2020.

for restoring New Jersey's economic health by ensuring public health and how activities are going to be restarted in stages; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has also proposed similar phased recommendations for state and local officials to begin reopening long-term care facilities. Additionally, the Centers for Disease Control and Prevention (CDC) has addressed reopening considerations for LTCFs in their nursing home COVID-19 guidance; and

WHEREAS, resumption of services for LTCFs requires a phased in approach, based on each facility's outbreak status and ability to meet the outlined criteria. Such criteria include the case status in the facility; access to testing; adequate staffing; and adequate personal protective equipment (PPE) and infection control protocols, among others.

NOW, THEREFORE, I, JUDITH PERSICHILLI, Commissioner of the Department of Health, pursuant to the powers afforded to me under the Emergency Health Powers Act, hereby ORDER and DIRECT the following:

The provisions in this Directive apply to all residential healthcare facilities Long-Term Care Facilities, Assisted Living Residences, Comprehensive Personal Care Homes, Residential Health Care Facilities, and Dementia Care Homes (collectively "LTCFs" or "facilities"); as defined in N.J.S.A. 26:2H-12.87[2]; and N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37.

The provisions for LTCFs reopening are subject to the State of New Jersey remaining out of the "maximum restrictions Stage" described in *The Road Back: Restoring Economic Health through Public Health* (http://d31hzlhk6di2h5.cloudfront.net/20200518/ff/c9/8c/41/1917eaf623c02595b9225209/Strategic_Restart_Plan.jpg) reopening plan. If at any point during the public health response the state returns to the "maximum restrictions Stage," **all facilities** covered by this Directive must return to the maximum restrictions of Phase zero (0), as described herein.

Phases per this Directive:

> **Phase 0:** Any facility with an active outbreak of COVID-19, as defined by the Communicable Disease Service (CDS), per the COVID-19 Communicable Disease Manual Chapter, any facility that cannot attest to criteria to advance phases, and all facilities if New Jersey is in maximum restrictions per the *Road Back to Recovery*: https://covid19.nj.gov/faqs/nj-information/reopening-guidance/when-and-how-is-new-jersey-lifting-restrictions-what-does-a-responsible-and-strategic-restart-of-new-jerseys-economy-look-like

[2] As defined in N.J.S.A. 26:2H-12.87, long-term care facility means a nursing home, assisted living residence, comprehensive personal care home, residential health care facility, or dementia care home licensed pursuant to P.L. 1971, c. 136 (C.26:2H-1 et seq.).

Phase 1: Facilities that never had an outbreak or that concluded an outbreak per section (II)(5) below, and 14 days have passed since New Jersey moved to Stage 1 (May 2, 2020) of the Road Back to Recovery and the facility has submitted all the attestations required in this Directive.

Phase 2: Facilities that never had an outbreak or that concluded an outbreak per section (II)(5) below, and 14 days have passed since New Jersey moved to Stage 2 (June 15, 2020) of the Road Back to Recovery and the facility has submitted all the attestations required in this Directive.

Phase 3: Facilities that never had an outbreak or that concluded an outbreak per section (II)(5) below, and 14 days have passed since New Jersey moved to Stage 3 (DATE TBD) of the Road Back to Recovery and the facility has submitted all the attestations required in this Directive.

I. Requirements for Initiating a Phased Reopening of Long-Term Care Facilities, Assisted Living Residences, Comprehensive Personal Care Homes, Residential Health Care Facilities, and Dementia Care Homes.

1. A facility can initially advance phases in conjunction with the State's reopening stages, with a 14-day delay (one incubation period). This delay is intended to protect residents and staff of LTCFs in the event of a rebound in COVID-19 community transmission while New Jersey moves from stage to stage in lifting restrictions. For example, New Jersey entered Stage 2 on June 15, 2020; LTCFs who meet the criteria outlined within would be able to enter Phase 2, no sooner than June 29, 2020. If at any time during the State's reopening stage, the State moves back or pauses a Stage, facilities must implement the requirements for that stage and phase as outlined within this Directive.

2. In addition to complying with the requirements otherwise outlined in this Directive, all LTCFs in New Jersey must attest to meeting the criteria below prior to advancing from Phase 0 to any new "Phase" in their reopening process. Facilities that cannot meet these criteria will remain in "Phase 0", a heightened state of maximum restrictions. Facilities that have submitted attestations but can no longer meet the attestation requirements, must notify the Department's Division of Certificate of Need and Licensing that they cannot meet the requirements and will be required to re-submit an attestation once the facility is able to meet the requirements for the attestation.

3. Facilities are required to have a documented "Outbreak Plan" as required by N.J.S.A. 26:2H-12.87. The plan must include but not be limited to lessons learned from the response to and experience with COVID-19. Further, the plan must include a strategy for effective and clear communication with staff, patients/residents, their families or guardians about any infectious disease outbreaks as required by N.J.S.A. 26:2H-12.87. The "Outbreak Plan" must also include:

i. Methods to communicate information on mitigating actions implemented by the facility to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered. Notifications shall not include personally identifiable information.

ii. Methods to provide cumulative updates for residents, their representatives, and families of those residing in the facilities at least once weekly, in particular during a curtailed visitation period.

iii. Written standards, policies and procedures that provide for virtual communication (e.g. phone, video-communication, Facetime, etc.) with residents, families and resident representatives, in the event of visitation restrictions due to an outbreak of infectious disease or in the event of an emergency**.**

iv. A documented strategy for securing more staff in the event of a new outbreak of COVID-19 or any other infectious disease or emergency among staff.

4. The outbreak plan must be posted on the facility's website for public view by **October 30, 2020.**

5. In addition to the requirements above, CMS certified facilities are also required to comply with CMS rule: 42 CFR §483.80(g) and with CMS guidance at https://www.cms.gov/files/document/qso-20-29-nh.pdf. This rule requires facilities have a documented communication plan to inform residents, their representatives, and families of the residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other.

6. All facilities must prominently display on their website and/or social media platforms and include in communications to families, guardians and the public, a phone number or method of communication for urgent calls or complaints.

7. All facilities, even those not certified by CMS are encouraged to follow CMS recommendations at https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf, for communication when facilities cannot permit in-person visits as follows:

i. Offer alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.);

ii. Create or increase email listserv communications to update families;

iii. Assign staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date (e.g., a "virtual visitation coordinator");

offer a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits;

iv. Host conference calls, webinars, or virtual "office hours" at set times, but at minimum on a weekly basis, when families can call in, or log on to a conference line, and facility staff can share the status of activities or happenings in the facility and family members can ask questions or make suggestions; and

v. Update the facility's website, at minimum on a weekly basis, to share the status of the facility and include information that helps families know what is happening in the loved one's environment, such as food menus and any scheduled activities.

8. In order for a facility to advance from one phase to another, the facility must not be experiencing a staffing shortage or currently operating under a contingency or crisis staffing plan as defined by the CDC, Strategies to Mitigate Healthcare Personnel Staffing Shortages at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.ttml#.

9. Facilities must conduct testing in accordance with this directive. Facilities may execute a contract or enter into an agreement with a laboratory or other vendor for prioritization of test results and to ensure testing capacity for repeat facility-wide testing. Facilities may use on-site laboratories or other arrangements for testing provided testing requirements herein are met. All facilities must test residents and staff as follows:

Continued testing of residents:

i. Repeat weekly testing of all residents until no new facility-onset cases* of COVID-19 are identified among residents and positive cases in staff **and** at least 14 days have elapsed since the most recent positive result **and** during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative.

ii. Retesting of residents who have been confirmed positive whenever required according to CDS and CDC guidance.

Continued testing of staff as follows:

i. Ongoing weekly testing of all staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community.

ii. Retesting staff who have previously tested positive according to CDC and NJDOH guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

*Facility onset SARS-CoV-2 infections refer to SARS-CoV-2 infections that originated in the facility. It does not refer to the following:

- Residents who were known to have C*OVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.*

- *Residents who were placed into Transmission-Based Precautions on admission and developed SARS-CoV-2 infection within 14 days after admission*.

Use of Antigen Testing

Antigen testing may be used as an alternative to molecular diagnostic PCR tests subject to the following parameters:

i. Antigen testing may be used to fulfill the weekly employee testing requirements set forth in this directive and also may be used on asymptomatic individuals at the facility's discretion. If antigen testing is used, please refer to CDS: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-19_Antigen_Testing_in_LTCF.pdf and CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html guidance for testing interpretation.

ii. Only antigen tests that have received an **Emergency Use Authorization or approval from the United States Food and Drug Administration (FDA)** may be used to fulfill the requirements of this directive.

iii. All facilities that perform COVID-19 point of care tests (such as antigen tests) in their facilities must possess a federal Clinical Laboratory Improvement Amendment (CLIA) Certificate. Additional information and application instructions for a CLIA Certificate can be found at https://www.nj.gov/health/phel/clinical-lab-imp-services/federal_clia.shtml.

10. Facilities must continue to report testing data through the New Jersey Hospital Association (NJHA) portal here: https://ppe.njha.com Data entered in this portal is not cumulative.

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

12. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, and no later than October 30, 2020, if the facility does not attempt to advance to another phase during that time, the facility must submit to the Department via email to LTC.PhasedReopening@doh.nj.gov a Phased Reopening attestation on facility**

letterhead from the facility administrator with the facility name and license number as follows:

Email Subject Line to LTC.PhasedReopening@doh.nj.gov:
[Facility Name] – [Facility License #] – Phased Reopening Attestation – Entering Phase #

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; I attest that the facility has implemented and will continue to adhere to all the requirements set forth in Section (I) (3) to (11) of Executive Directive No. 20-026[1] to advance to [PHASE #] and [NAME OF THE FACILITY] currently:

a. Has an "Outbreak Plan," as required by N.J.S.A. 26:2H-12.87, and the plan is posted on the facility's website for public view. The plan includes effective communication methods to notify patients/residents, their families or guardians and staff about any infectious disease outbreaks and includes strategies and methods for virtual communications in the case of visitation restrictions, at a minimum on a weekly basis;

b. Is not experiencing a staffing shortage, is not under a contingency or crisis staffing plan and has a documented plan for securing additional staff in case of a COVID-19 outbreak among staff as part of the facility's "Outbreak Plan;"

c. (CMS certified facilities only) has a documented communication plan and is informing residents, their representatives, and families of the residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other, in accordance with CMS rule 42 CFR §483.80(g);

d. Is prominently displaying on their website and/or social media platforms and including in communications to families, guardians and the public, a phone number or method of communication for urgent calls or complaints; and

e. Is meeting testing and data reporting requirements of residents and staff as outlined in NJDOH E.D. 20-026[1].

II. Required Core Practices for Infection Prevention and Control.

1. Regardless of a facility's current reopening phase, core infection prevention and control practices must be in place at all times. Maintaining core infection prevention and control practices is key to preventing and containing outbreaks and is crucial in ensuring the delivery of quality, safe care. In addition to the requirements in N.J.A.C. 8:39-20, the following practices shall remain in place even as LTCF's resume normal activities, regardless of the facility's current reopening phase:

   Review the *Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings – Recommendations of the Healthcare Infection Control Practices Advisory Committee* at https://www.cdc.gov/hicpac/pdf/core-practices.pdf, and implement any guidance applicable to the facility.

   i. Facilities must educate residents, staff, and visitors about COVID-19, current precautions being taken in the facility, and protective actions. Facilities must encourage social distancing with physical separation.

   ii. All facilities, except for facilities with ventilator-dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by:

      a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2;

      b. A physician who has completed an infectious disease fellowship;

      c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience.

   * The requirements in this section do not modify or supersede requirements for facilities providing care to ventilator-dependent residents pursuant to N.J.S.A. 26:2H-12.87(1)(c).

   iii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPC program by conducting internal quality improvement audits. Additional information is available at the NJDOH Healthcare Associated Infections page at https://www.nj.gov/health/cd/topics/hai.shtml, the NJDOH COVID-19 page at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml, and CDC's

Infection Control Assessment Tools page at:
https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html.

iv. **Facilities with No Ventilator Beds**

a. Facilities with 100 or more beds or on-site hemodialysis services must:

1) Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021.

2) Prior to the hiring of an employee for the IPC program, facilities **have until October 30, 2020** to enter into a contract for infection control services. Facilities must have, at a minimum, executed a contract, by October 30, 2020 in preparation for the start of the flu season in the fall of 2020. Facilities may terminate the contract once they hire or staff their IPC program and submit an attestation to the NJDOH, as required within this Directive.

3) Responsibilities of this position must include, at a minimum, developing infection prevention and control policies and procedures, performing infection surveillance, providing competency-based training of staff and auditing adherence to recommended infection prevention and control practices.

b. Facilities with less than 100 beds, or no on-site hemodialysis services must**:**

1) Staff their IPC program based on the resident population and facility service needs identified in the facility risk assessment available at: https://www.cdc.gov/longtermcare/excel/IPC-RiskAssessment.xlsx.

2) Prior to the hiring of any staff for their IPC program identified in section b. 1) above facilities will have **until October 30, 2020** to enter into a contract for infection control services. Facilities must have at a minimum a contract, by October 30, 2020, in preparation for the start of the flu season in the fall of 2020. Facilities may terminate the contract once they hire or staff their IPC program and submit an attestation to the NJDOH, as required within this Directive.

3) Responsibilities of this position must include, at a minimum, developing infection prevention and control policies and procedures, performing infection surveillance, providing competency-based training of staff and auditing adherence to recommended infection prevention and control practices.

v. **Facilities with on-site ventilator beds** must follow the requirements under N.J.S.A. 26:2H-12.87 (a) to (d), and must attest to compliance with N.J.S.A. 26:2H-12.87 (a) to (d); including but not limited to, the requirement that facilities as part of their outbreak response plan and part of their infectious disease committee, must on a full-time or part-time basis, or contracting with on a consultative basis, retain or hire the following individuals:

   a. An individual certified by the Certification Board of Infection Control and Epidemiology; and

   b. A physician who has completed an infectious disease fellowship.

vi. **In order for the facility to meet the requirements of this Directive and no later than October 30, 2020, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an Infection Control Contract attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
   [Facility Name] – [Facility License #] – Infection Control Contract

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF FACILITY] and to bind [NAME OF FACILITY] thereto; that [NAME OF FACILITY] is in compliance with all requirements for Contracting Infection Control Services in Executive Directive 20-026[1] and I attest that [NAME OF FACILITY] has:

   a. One hundred (100) or more beds or on-site hemodialysis services and has contracted with an infection control service pursuant to the requirements of E.D. 20-026[1].

   b. Less than 100 beds or no on-site hemodialysis services and has contracted with an infection control service based on the resident population and facility service needs identified in the facility risk assessment per E.D. 20-026[1].

vii. **In order for the facility to meet the requirements of this Directive and no later than August 10, 2021 for facilities without ventilators beds or immediately for facilities with ventilator beds, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an Infection Control Employee attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
[Facility Name] – [Facility License #] – Infection Control Employee

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF FACILITY] and to bind [NAME OF FACILITY] thereto; that [NAME OF FACILITY] is in compliance with all requirements in Executive Directive 20-026[1] and has hired an Infection Control Employee and I attest that [NAME OF FACILITY] has:

a. Less than 100 beds or no on-site hemodialysis services has staffed the IPC program based on the resident population and facility service needs identified in the facility risk assessment per E.D. 20-026[1].

b. One hundred (100) or more beds or on-site hemodialysis services and has hired an infection control employee pursuant to the requirements of E.D. 20-026[1].

c. Facilities with ventilator beds must attest having hired or contracted pursuant to the requirements of N.J.S.A. 26:2H-12.87(a) to (d).

2. Facilities must develop and implement a Respiratory Protection Program (RPP) that complies with the Occupational Safety and Health Administration (OSHA) respiratory protection standards for employees, if such program is not already in place as of the date of enactment of this Directive. The program must include medical evaluations, training and fit testing. Refer to OSHA's Respiratory Protection Page at: https://www.osha.gov/sltc/respiratoryprotection/. Facilities will have **until May 30, 2021** to create and implement the plan.

    i. Facilities may contract with a consultant or vendor to fulfill the requirements of this section and must attest to the implementation of a RPP no later than May 30, 2021.

    ii. **In order for the facility to meet the requirements of this Directive and no later than May 30, 2021, the facility must create and implement a RPP and must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov a Respiratory Protection Program Implementation attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
[Facility Name] – [Facility License #] – Respiratory Protection Program Implementation

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] has implemented a Respiratory Protection Program in compliance with Executive Directive 20-026[1] and I attest that [NAME OF THE FACILITY]:

a. Has implemented a respiratory protection program that complies with the OSHA respiratory protection standard for employees.

3. Facilities are required to have an adequate emergency stockpile of PPE, essential cleaning and disinfection supplies so that staff, residents and visitors can adhere to recommended infection prevention and control practices as outlined here:

   i. Facilities that belong to a system that has eight (8) or more facilities will be required to have **one (1) month of PPE in stock**. Facilities that do not belong to a system with eight (8) or more facilities will be required to have **two (2) months of PPE in stock**. Facilities must acquire the PPE to fulfill the requirements outlined herein by October 30, 2020.

      a. Facilities should use the CDC's PPE Burn Rate Calculator in order to estimate the amount of PPE needed for their required supply under this Directive. This tutorial video guides users on how to use the PPE Burn Rate Calculator: https://youtu.be/E_mhrROqJh0. The calculator can be found at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/PPE-Burn-Rate-Calculator.xlsx.

      b. Facilities should calculate the quantity of PPE to fulfill this requirement at a burn rate based on the highest use of PPE during the COVID-19 surge in their facilities.

      c. If, after using the calculator, facilities determine they already have the stock they need, they are permitted to submit the required attestation immediately.

      d. The PPE in stock is only to be used in the event of an emergency and not for daily use.

ii. All facilities must have essential cleaning and disinfection supplies on hand in the event of a supply chain disruption.

iii. If at any time the facility is forced to use their PPE stockpile due to an emergency, the facility is required to re-stock and resubmit the attestation below indicating the re-stocking.

iv. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase but no later than October 30, 2020, if the facility does not attempt to advance to another phase during that time, the facility must submit to the Department via email to LTC.PPEStockpile@doh.nj.gov a PPE Stockpile attestation on facility letterhead from the facility administrator with the facility name and license number, as follows:**

Email Subject Line to LTC.PPEStockpile@doh.nj.gov:
[Facility Name] – [Facility License #] – PPE Stockpile

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] is in compliance with PPE in stock as required in Executive Directive 20-026[1]and I attest that [NAME OF THE FACILITY]:

a. Is a standalone or is not part of a system with eight (8) or more facilities, has used the CDC PPE Burn Rate Calculator and has two (2) months of PPE on hand in accordance with Executive Directive 20-026[1]; or

b. Is part of a system of eight (8) or more facilities and has used the CDC PPE Burn Rate Calculator and has one (1) month of PPE on hand in accordance with Executive Directive 20-026[1].

c. Has re-stocked PPE and is in compliance with Executive Directive 20-026[1].

4. Starting on October 30, 2020, all LTCFs are required to report, at a minimum twice per week, COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-Term Care Facility COVID-19 Module: https://www.cdc.gov/nhsn/ltc/covid19/index.html. Facilities not currently enrolled must enroll and submit data by October 30, 2020. The module requires the following information to be submitted:

   - Counts of residents and facility personnel with suspected and laboratory positive COVID-19;
   - Counts of suspected and laboratory positive COVID-19 related deaths among residents and facility personnel;
   - Resident beds and census;
   - Staffing shortages;
   - Status of personal protective equipment (PPE) and hand hygiene supplies; and
   - Ventilator capacity and supplies for facilities with ventilator dependent units.

   i. CMS certified facilities should submit data in accordance with 42 CFR §483.80(g) and CMS guidance in QSO-20-29, available at: https://www.cms.gov/files/document/qso-20-29-nh.pdf, but not less than two times per week.

   ii. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, and no later than October 30, 2020, if the facility does not attempt to advance to another phase during that time, the facility must submit to the Department via email to LTC.DataReporting@doh.nj.gov a Data Reporting attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DataReporting@doh.nj.gov:
   [Facility Name] – [Facility License #] – Data Reporting

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] has registered and is

submitting data to the National Health safety Network as required by Executive Directive 20-026[1] and I attest that [NAME OF THE FACILITY]:

a. Has registered, authorized NJDOH to access data and is entering information in the NHSN COVID-19 Module twice weekly.

5. A facility with a COVID-19 outbreak will remain in Phase 0 (maximum restrictions) until their outbreak of COVID-19 has concluded.

i. A facility **may allow** indoor visitation if no new facility-onset of COVID-19 cases in the last 14 days have been detected, in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html AND the facility is not currently conducting outbreak testing in accordance with CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html, CMS facility testing requirements: https://www.cms.gov/files/document/qso-20-38-nh.pdf and/or CDS/Local health Department guidance: https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2.

ii. The detection of a NEW COVID-19 outbreak returns the facility to Phase 0, including restricting indoor visitation, regardless of the facility's current Phase. In order to leave Phase 0, facilities must re-submit an attestation upon conclusion of the outbreak, as directed within this directive.

iii. An outbreak of COVID-19 is defined by the Communicable Disease Service, COVID-19 Communicable Disease Manual Chapter available at: https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf.

iv. Outbreaks are considered concluded when there are no symptomatic/asymptomatic probable or confirmed COVID-19 cases among employees or residents after 28 days (two incubation periods) have passed since the last case's onset date or specimen collection date (whichever is later), as defined and updated per the COVID-19 Communicable Disease Manual Chapter. For CMS certified facilities, the facility must receive a survey by the NJDOH. The determination of an outbreak's conclusion will be made by either NJDOH or local health officers, pursuant to N.J.A.C. 8:57-1.10.

v. Upon conclusion of an outbreak, the facility may directly advance to the applicable Phase based on the criteria in this Directive. For example, if a facility was at Phase 3 but has a new outbreak of COVID-19, they would return to Phase 0. If the facility can still attest to the criteria for Phase 3 and the State is still in Stage 3 of reopening when the outbreak is concluded, the facility could directly return to Phase 3.

vi. For the purposes of this Directive, management of a COVID-19 outbreak, infection prevention and control recommendations for COVID-19, or laboratory testing

guidance issued by a local health department (LHD) or NJDOH should be followed in addition to the requirements set herein.

vii. **In order for the facility to meet the requirements of this Directive and before advancing from Phase 0 or to any other phase, the facility must submit to the Department via email to LTC.OutbreakEnd@doh.nj.gov an End of Outbreak attestation following the end of a COVID-19 outbreak or, if the facility never experienced a COVID-19 outbreak, a No Outbreak Experienced attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Following the end of a COVID-19 outbreak at the facility:

Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
[Facility Name] – [Facility License #] – End of Outbreak

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

a. I attest that the facility has received determination of COVID-19 outbreak conclusion by the LHD or NJDOH on [INSERT DATE], as defined by the Communicable Disease Service COVID-19 Disease Chapter on [INSERT DATE]. If the facility is CMS certified, the facility has received a survey from the NJDOH on [INSERT DATE].

If the facility has never experienced a COVID-19 outbreak:

Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
[Facility Name] – [Facility License #] – No Outbreak Experienced

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

a. I attest that the facility has never experienced a COVID-19 outbreak.

III. Required standards for visitation and service during each reopening "Phase."

1. **Exceptions to visitation restrictions in any phase:**

   i. In emergency situations EMS personnel shall be permitted to go directly to the resident.

   ii. Sections 1819(c)(3)(A) and 1919(c)(3)(A) of the Social Security Act (the Act) and implementing regulations at 42 CFR 483.10(f)(4)(i)(C), require that a Medicare and Medicaid certified nursing home provide representatives of the State Long-Term Care Ombudsman with immediate access to any resident, however during this Public Health Emergency (PHE) in-person access may be restricted. If in-person access is not advisable due to infection control concerns and transmission of COVID-19, facilities must facilitate resident communication (e.g., by phone or through use of other technology) with the ombudsman. The CARES Act states the State Long-Term Care Ombudsman shall have continued direct access (or other access through the use of technology) to residents of long-term care facilities during any portion of the public health emergency relating to coronavirus.

   iii. The CARES Act does not repeal or amend CMS requirements under sections 1819 or 1919 of the Act or implementing regulations. Nor does it place a time limit or expiration date (e.g., until September 30, 2020) on the CMS requirements providing for resident access to the Ombudsman program, but instead affirms that the current pandemic requires the Ombudsman program and long term care facilities to support resident access and communication in a variety of methods. For additional information regarding resident access to the Ombudsman please see Frequently Asked Questions (FAQ) on Nursing Home Visitation at: https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf.

   iv. Section 483.10(f)(4)(i)(E) and (F) requires facilities to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). Protection and Advocacy (P&A) programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported or if there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in

person." 42 CFR 51.42(c); 45 CFR 1326.27. Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention.

v. Facilities shall coordinate with Medicaid Managed Care Organizations (MCOs) consistent with the requirements of the MCO contract, including supporting communication by representatives of the MCO with their enrollees, either in-person or using alternative means (e.g., by phone or through use of other technology) as necessary for infection control. When a resident is unable to communicate independently with the MCO representative, either temporarily or permanently, the facility will provide timely updates to the MCO regarding the health status of the individual.

2. **Requirements for Visitation and/or Entry in Any Phase:**

i. Facilities shall screen and log all persons entering the facility and all staff at the beginning of each shift. Facilities that have antigen testing available are encouraged to use it as part of their visitor screening process. Visitors who test positive are not permitted to enter the facility. If antigen testing is used, please refer to CDS: (https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2) and CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html), guidance for testing interpretation.

ii. Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened.

iii. Facilities must actively screen all persons entering the building (except EMS personnel) for signs and symptoms of COVID-19. Screening is to include:

a. Temperature checks including subjective and/or objective fever equal to or greater than 100.4 F or as further restricted by facility.

b. Completion of a questionnaire about symptoms and potential exposure which shall include at a minimum:

1) Whether in the last 14 days, the visitor has had an identified exposure to someone with a confirmed diagnosis of COVID-19, someone under investigation for COVID-19, or someone suffering from a respiratory illness.

2) Whether the visitor has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC.

3) Whether in the last 14 days, the visitor has returned from a state on the designated list of states under the 14-day quarantine travel advisory, available for review at: https://covid19.nj.gov/faqs/nj-information/travel-information/which-states-are-on-the-travel-advisory-list-are-there-travel-restrictions-to-or-from-new-jersey.

iv. Facilities must observe anyone entering the facility for any signs or symptoms of COVID-19, including, but not limited to:

1) chills;
2) cough;
3) shortness of breath or difficulty breathing,
4) sore throat;
5) fatigue;
6) muscle or body aches;
7) headache;
8) new loss of taste or smell;
9) congestion or runny nose;
10) nausea or vomiting; or
11) diarrhea.

v. Upon screening, facilities must prohibit entry into the building for those who meet one or more of the following criteria:

a. Exhibit signs or symptoms of an infectious communicable disease, including COVID-19, such as a subjective and/or objective fever (evidenced by a temperature check of the visitor equal to or greater than 100.4 F or as further restricted by facility), chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea;

b. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or someone under investigation for COVID-19, or someone ill with respiratory illness;

c. In the last 14 days, has returned from a designated state under the 14-day quarantine travel advisory; or

d. Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH https://www.state.nj.us/health/cd/topics/ncov.shtml and CDC https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html.

e. If testing (i.e. antigen or PCR) is used, tests positive.

vi. The facility must establish a designated area for visitors to be screened that accommodates social distancing and infection control standards. Visitors should be provided with the visitation guidelines upon check in. The facility should provide graphics to assist residents and visitors in maintaining social distancing and infection control standards.

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

viii. If, after undergoing screening, the person is permitted to enter the building, the facility shall:

a. Require the person to wear a cloth face covering or facemask (covering both mouth and nose at all times). The facility may require the visitor to use additional forms of personal protective equipment (PPE), as determined by the facility.

b. Provide instruction on hand hygiene, provide instruction on limiting surfaces touched, provide instruction on the use of PPE, and inform visitors of the location of hand hygiene stations, before the visitor enters the facility and resident's room.

c. Advise the person to limit physical contact with anyone other than the resident while in the facility. For example, practice social distancing with no handshaking, kissing or hugging and remaining six feet apart.

d. For visitors, provide visitation in the resident’s room, if they are in a single room. If a resident is in a shared room, the facility needs to identify a

visitation location that allows for social distancing and for deep cleaning. Limit the visitor's movement within the facility to the resident's room or designated space (e.g., reduce walking the halls, avoid going to dining room, etc.). For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

e. Restrict a person from entering the facility if they are unable to demonstrate the proper use of infection prevention and control techniques.

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

x. <u>The facility must receive informed consent from the visitor(s) and the resident in writing that they are aware of the possible dangers of exposure to COVID-19 for both the resident and the visitor and that they will follow the rules set by the facility in regard to visitation. The facility must receive a signed statement from each visitor and resident (if the resident is unable to consent then the consent needs to be signed by the authorized representative) with a copy provided to the visitor and resident, that they are aware of the risk of exposure to COVID-19 during the visit, that they will strictly comply with the facility policies during visitation, and that the visitor will notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID-19 within fourteen days of the visit.</u>

3. **Cohorting, PPE and Training Requirements in Every Phase:**

i. Facilities shall train and provide staff with all recommended COVID-19 PPE, to the extent PPE is available, and consistent with CDC guidance on optimization of PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html), if applicable. All staff must wear all appropriate PPE when indicated. Staff may wear cloth face coverings if facemask is not indicated, such as for administrative staff or while in non-patient care areas (e.g. breakroom).

ii. Facilities shall implement universal source control for everyone in the facility. All residents, whether they have COVID-19 symptoms or not, must practice source control when around others (surgical mask if supply is available) in accordance with CDC guidance at: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-

sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Source control may be provided with cloth face coverings or facemasks.

iii. Facilities shall separate COVID-19 positive and negative residents in accordance with NJDOH guidance at: https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml. A resident is considered recovered from COVID-19 only after they have met the criteria for discontinuation of isolation as defined by the NJDOH at: https://www.state.nj.us/health/cd/topics/ncov.shtml, and CDC guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html.

iv. Facilities must continue to follow current NJDOH orders, guidance and directives on admissions and readmissions. Facilities may receive residents who were tested prior to admission/transfer or shortly thereafter, in accordance with NJDOH Guidance: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Cohorting_PAC.pdf, Orders: https://www.state.nj.us/health/legal/covid19/4-13-20_EmergencyCurtailmentOfAdmissions.pdf and Directives. Facilities shall take appropriate action on the results including, but not limited to, the guidance below:

a. Sending Facility: COVID-19 diagnostic test results must be provided (in addition to other pertinent clinical information) to the receiving facilities for any transferred residents upon receipt of lab results.

b. Receiving Facility: Upon identification of a case of COVID-19 in a resident who was recently admitted (within 14 days), the receiving facility must provide these results back to the sending facility to allow for the appropriate response and investigation.

4. **Indoor End-of-Life**, **Compassionate Care**, and **Essential Caregiver** visitation is allowed for all residents, including pediatric and those covered by the Americans with Disabilities Act (ADA) or the Law Against Discrimination (LAD), in all phases pursuant to the following requirements, NJDOH directives and section (III)(2)(i) to (xx) of this directive**:**

i. All residents can be visited in all phases in **limited** situations as follows:

a. **End-of-life** situations pursuant to the requirements of this Directive and NJDOH Executive Directive No. 20-017 at:

https://nj.gov/health/legal/covid19/6-19-20_ExecutiveDirectiveNo20-017_StandardsProtocolsVisitorsFacilityStaff.pdf .

b. **Compassionate Care** situations visits are allowed with transmission-based precautions, pursuant to the requirements of this Directive and NJDOH Executive Directive No. 20-017 at: https://nj.gov/health/legal/covid19/6-19-20_ExecutiveDirectiveNo20-017_StandardsProtocolsVisitorsFacilityStaff.pdf. The term "compassionate care situation" does not exclusively refer to end-of-life situations. CMS gives the following examples:

1) A resident who was living with their family before recently being admitted to a nursing home, the change in their environment and sudden lack of family can be a traumatic experience. Allowing a visit from a family member in this situation would be consistent with the intent of the term "compassionate care situations." Similarly, allowing someone to visit a resident whose friend or family member recently passed away, would also be consistent with the intent of these situations. (https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf).

2) A resident receiving hospice care whose health status is sharply declining, or when a resident is not enrolled in hospice, but their health status has sharply declined (https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf).

3) A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.

4) A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past). (https://www.cms.gov/files/document/qso-20-39-nh.pdf).

5) Facilities must work with residents, healthcare providers (e.g. hospice providers), families or guardians to determine when visits for compassionate care situations are appropriate and can be safely conducted.

6) While compassionate care visits are allowed in all phases, compassionate care visits when facilities are in Phase 0, should not be routine and allowed only on a limited basis as an exception to restricting visitation. Facilities must ensure that these visits are conducted as safely as possible and must require infection control practices, hand hygiene:

https://www.cdc.gov/handhygiene/pdfs/Provider-Factsheet-508.pdf and appropriate PPE in accordance with guidance from the CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html) and CMS: (https://www.cms.gov/files/document/qso-20-39-nh.pdf.)

c. **Indoor Essential Caregiver Visitation Pursuant to the Requirements of This Directive:**

1) All residents may receive indoor essential caregiver visitation in facilities where there has been no new facility-onset COVID-19 cases in the last 14 days AND the facility is not currently conducting outbreak testing per the CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html), CMS: https://www.cms.gov/files/document/qso-20-38-nh.pdf and CDS guidance : https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-19_Antigen_Testing_in_LTCF.pdf.

2) Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for end-of-life, compassionate care situations in accordance with NJDOH Executive Directive No. 20-017, as outlined in this directive and in accordance with CMS guidance: https://www.cms.gov/files/document/qso-20-39-nh.pdf, with adherence to transmission-based precautions.

3) An essential caregiver could be an individual who was previously actively engaged with the resident or is committed to providing assistance with activities of daily living.

4) Facilities must establish policies and procedures for how to designate and utilize an essential caregiver.

5) Consult the facility's Administrator, Director of Nursing, Social Services Director, or other designated facility staff to help determine who meets the criteria of an essential caregiver.

6) The resident must be consulted about their wishes to determine whom to designate as the essential caregiver. Consider persons such as a family member, outside caregiver, or friend who provided regular care to the resident prior to the pandemic.

7) Residents may express a desire to designate more than one essential caregiver based on their past involvement and needs (e.g., more than one family member previously split time to provide care for the resident). In these unique situations, facility staff should work cooperatively with the resident and family to work out a schedule to accommodate the essential caregivers.

8) Work with the resident and essential caregiver to identify a schedule of up to two (2) hours per visit, one (1) time per week, for the essential caregiver to be in the facility, if the facility is in phase 0. Facilities in Phases one (1) or two (2) may allow for two visits per week not to exceed a total of four (4) hours per week. Facilities in phase three (3) may allow essential caregiving visitation under their regular procedures and per this directive.

9) Ensure that scheduling of essential caregiver visits takes into account the number of essential caregivers in the building at the same time. The facility may establish time limits as needed to keep residents safe.

10) Utilize the essential caregiver to provide care in the same manner as prior to the pandemic.

11) Facilities must ensure that essential caregiving visits are conducted as safely as possible and must require infection control practices, hand washing and PPE.

12) Facilities that have antigen testing available are encouraged to use it as part of their visitor screening process. Visitors who test positive are not permitted to enter the facility. If antigen testing is used, please refer to CDS: (https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2) and CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html), guidance for testing interpretation.

5. **Indoor visitation for pediatric residents and residents with intellectual and/or developmental disabilities** covered under the Americans with Disabilities Act (ADA) or state Law Against Discrimination (LAD) is allowed in phases 1, 2 and 3 pursuant to the requirements in this Directive and NJDOH Executive Directive No. 20-025: https://www.state.nj.us/health/legal/covid19/ED20-025VisitationDD.pdf.

   i. Nothing in this directive shall be interpreted to prevent pediatric residents currently negative or asymptomatic and not on transmission-based precautions from attending educational institutions or medical appointments (e.g. physical therapy) provided protocols are in place to protect the resident and the facility.

6. **Outdoor visitation** is allowed for negative and asymptomatic, or COVID-19 recovered residents in all Phases, as per NJDOH Executive Directive 20-017:

https://nj.gov/health/legal/covid19/6-19-20_ExecutiveDirectiveNo20-017_StandardsProtocolsVisitorsFacilityStaff.pdf and this directive. The Directive requires facilities to attest to their visitation plan and capabilities, receive informed consent from visitors and residents and safeguard residents, staff and visitors among others.

i. In accordance with CMS guidance: (https://www.cms.gov/files/document/qso-20-39-nh.pdf), outdoor visitation is preferred over indoor visitation and should be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Outdoor visitation should be facilitated routinely, except during periods of unsuitable weather conditions (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), when an individual resident's health status prevents visitation (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status prevents visitation..

7. **Indoor Visitation by Appointment in Accordance with CMS QSO-20-39**

i. Indoor visitation by appointment is allowed in every phase per CMS visitation guidance: (https://www.cms.gov/files/document/qso-20-39-nh.pdf) released on September 17, 2020, pursuant to the requirements in this directive as follows:

a. A facility **may allow** indoor visitation after no new facility-onset of COVID-19 cases in the last 14 days have been detected, in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html AND the facility is not currently conducting outbreak testing in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html, CMS facility testing requirements: https://www.cms.gov/files/document/qso-20-38-nh.pdf and/or CDS/Local health Department guidance: https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2.

b. Indoor visitation can only occur in facilities where there has been NO NEW facility-onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing and has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

c. Facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). For example, if a facility has had no facility-onset COVID-19 cases in the last 14 days and its county positivity rate is low or medium, as determined by NJDOH, a nursing home **must** facilitate in-person visitation consistent with regulations, CMS guidance and the requirements outlined in this directive.

1. Facilities in medium or high-positivity counties are encouraged to test visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test.

d. As stated in section (III)(2)(i) to (x), facilities must have a mechanism to collect informed consent from the residents and visitors, have a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

e. Indoor visitation permitted in this section should be socially distanced at least six (6) feet between persons at all times. The risk of transmission can be further reduced through the use of physical barriers (e.g. Plexiglas dividers, curtains).

f. Visitors **must be screened and logged** in accordance with section (III)(2)(i) to (x) of this Directive.

g. Except for on-going use of virtual visits, facilities may still restrict visitation (beyond end-of-life, compassionate care and essential caregiver) due to the COVID-19 county positivity rate per CMS guidance: https://www.cms.gov/files/document/qso-20-39-nh.pdf, the facility's COVID-19 status, a resident's COVID-19 status except as outlined in section 4(i) above, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 public health emergency. However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v).

1. Facilities should use the NJDOH COVID-19 Activity Level Index (CALI) Score here: https://www.nj.gov/health/cd/statistics/covid/index.shtml as additional information to determine how to facilitate indoor visitation. The CALI Score takes into account three factors for the region: (1) case rate (per 100,000) is calculated as a proportion of the population; (2) percent of COVID-like illness; and (3) the percent positivity. The CALI Score should be used to facilitate indoor visitation:

   - **CALI Score Low** = Visitation should occur according to the core principles of COVID-19 infection prevention, NJDOH guidance and directives (beyond compassionate care, end-of-life and essential caregiver visits).

- **CALI Score Medium =** Consider limiting indoor visitation, although visitation may occur according to the core principles of COVID-19 infection prevention and NJDOH guidance and directives (beyond compassionate care, end-of-life and essential caregiver visits).

- **CALI Score High or Very High =** Visitation should only occur for compassionate care, end-of-life and essential caregiver situations according to the core principles of COVID-19 infection prevention, NJDOH guidance and directives

- County positivity rate does not need to be considered for outdoor visitation.

h. Before commencing indoor visitation facilities must attest to their visitation plan and capabilities, receive informed consent from visitors and residents and safeguard residents, staff and visitors among others.

ii. **In order for the facility to meet the requirements of this Directive and at least 3 business days before commencing indoor visitation, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov an Indoor Visitation During Phase 0 or Phase 1 attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
[Facility Name] – [Facility License #] – Indoor Visitation Attestation

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026[1], not experienced any new facility-onset of COVID-19 cases in 14 days, has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

IV. Required standards for services during each phase.

1. **Phase 0**

   i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

   ii. Screen and log all persons entering the facility and all staff at the beginning of each shift in accordance with section (III)(2)(i) to (x) of this Directive.

   iii. Entry of non-essential personnel is prohibited. Those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers, are prohibited from entering the building.

   iv. Facilities shall screen all residents, at minimum during every shift, with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure, temperature, and pulse oximetry.

   v. When facilities are experiencing an outbreak, communal dining and all group activities should be limited. Residents shall stay in their rooms as much as possible and cohort in accordance with CDS: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Cohorting_PAC.pdf and CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

   vi. Avoid non-medically necessary trips outside the building. For medically necessary trips away from the facility the resident must wear a cloth face covering or facemask
   (surgical mask if supply is available) in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

   vii. Perform ongoing weekly testing of all staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive must be re-tested according to CDC and CDS guidance at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

2. **Phase 1**

   i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

   ii. Screen and log all persons entering the facility and all staff at the beginning of each shift in accordance with section (III)(2)(i) to (x) of this Directive.

   iii. Entry of non-essential personnel is prohibited. Those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers, are prohibited from entering the building.

   iv. Restrict communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.

      a. Residents may eat in the same room while practicing infection prevention and control precautions including social distancing measures. This includes limiting the number of people at tables and using barriers and/or maintaining separation of space by at least 6 feet, as deemed appropriate based on facility risk assessment.

      b. When feasible, seat the same small group of residents together each day, so that each resident is in contact with the same small group. There should be no mixing of residents across these groups.

      c. When feasible, staff should be assigned to specific tables in order to minimize the number of residents they interact with and remain with that group each day, whenever possible.

      d. The sharing of condiments and serving utensils is prohibited. Sanitize/clean high-touch surfaces (e.g. chairs, tables) between seating/meals. The facility should use disposable utensils and cups when possible.

      e. The facility must ensure that processes are in place to maintain infection control protocols such as preventing staff from cleaning used tableware (e.g. plates and cups) and immediately serving food without proper handwashing. When feasible disposable cups and utensils are preferred.

         1) Consider the following steps: refrain from removing used plates and tableware from the table until all residents have finished eating or utilize specific staff to serve residents and refill drinks during the meal and a separate group of staff to clear plates and tableware of those who are finished.

v. Restrict group activities in general. Limited activities may be conducted for COVID-19 negative and asymptomatic or COVID-19 recovered residents only in their small groups. Facilities that permit group activities shall:

a. Maintain infection prevention and control precautions including social distancing and source control measures, and limit the numbers of residents who participate, as deemed appropriate based on facility risk assessment and as permissible pursuant to statewide indoor and outdoor gatherings limitations.

b. As much as possible, keep the same residents in the same group each day so that each resident is in contact with the same group, including the same staff, in order to minimize multiple interactions and remain with that group daily. Group size should not exceed more than 10 individuals.

c. Activity items that cannot be appropriately cleaned and disinfected should not be shared between residents. For example, residents should be given their own personal bingo cards and tiles.

vi. Avoid non-medically necessary trips outside the building. For medically necessary trips away from the facility, the resident must wear a cloth face covering or facemask
(surgical mask if supply is available) in accordance with CDC guidance at: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

vii. Screen all residents, at a minimum daily**,** with temperature checks, questions and observations for other signs or symptoms of COVID-19.

viii. Continue to perform ongoing weekly testing of all staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive should be re-tested according to CDC and CDS guidance at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

3. **Phase 2**

i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

ii. Screen and log all persons entering the facility and all staff at the beginning of each shift in accordance with section (III)(2)(i) to (x) of this Directive

iii. **In order for the facility to meet the requirements of this Directive and at least 48 hours before commencing indoor visitation in Phase 2, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov a Phase 2 Indoor Visitation attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
[Facility Name] – [Facility License #] – Phase 2 Indoor Visitation Attestation

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026[1], the facility has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments and sufficient PPE to permit visitation.

iv. For medically necessary trips away from the facility, the resident must wear a cloth face covering or facemask (surgical mask if supply is available) in accordance with CDC guidance:https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

v. Entry of non-essential personnel/contractors into the building is permitted. Personnel /contractors must be logged and screened in accordance with section (III)(2)(i) to (x) of this Directive. This includes personnel providing elective consultations and non-essential services (e.g., barber, hair stylist) as determined necessary by the facility. Such personnel are permitted access only to COVID-19 negative and asymptomatic or COVID-19 recovered residents. Entry of volunteers is not permitted in Phase 2.

vi. Requirements for infection prevention and control precautions, including social distancing, cloth face coverings or facemasks continue to apply for indoor visitation/entry of non-essential personnel/contractors in Phase 2. When possible, facilities should restrict movement of person entering the facility to a designated area (e.g., medical consults provided in designated treatment room).

vii. Limit communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.

a. Residents may eat in the same room while practicing infection prevention and control precautions including social distancing measures whenever possible. This includes limiting the number of people at tables and using barriers and/or maintaining separation of space by at least 6 feet, as deemed appropriate based on facility risk assessment.

b. When feasible, a small group of residents should be seated together each day, so that each resident is in contact with the same small group. There should be no mixing of residents across these groups.

c. When feasible, staff should be assigned to specific tables in order to minimize the number of residents they interact with and remain with that group each day, whenever possible.

d. The sharing of condiments and serving utensils is prohibited. Sanitize/clean high-touch surfaces (e.g. chairs, tables) between seating/meals.

e. The facility must ensure that processes are in place to maintain infection control protocols such as preventing staff from cleaning used tableware (e.g. plates and cups) and immediately serving food without proper handwashing. When feasible disposable cups and utensils are preferred.

1) Consider the following steps: refrain from removing used plates and tableware from the table until all residents have finished eating or utilize specific staff to serve residents and refill drinks during the meal and a separate group of staff to clear plates and tableware of those who are finished.

viii. Limit group activities to no more than 10 people, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only, as deemed appropriate based on facility risk assessment.

ix. Maintain infection prevention and control measures including social distancing and source control measures.

x. Continue to perform ongoing weekly testing of all staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive should be re-tested according to CDC and CDS guidance at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

xi. Screen all residents, at minimum daily, with temperature checks, questions and observations for other signs or symptoms of COVID-19.

4. **Phase 3**

i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

ii. Allow entry of non-essential healthcare personnel/contractors as determined necessary by the facility, based on screening and including infection prevention and control precautions, social distancing, hand hygiene, and cloth face coverings or facemasks.

iii. Allow entry of volunteers, based on screening and including infection prevention and control precautions, social distancing, hand hygiene, and cloth face coverings or facemasks.

iv. Screen all residents, at minimum daily, with temperature checks, questions and observations for other signs or symptoms of COVID-19 and test if symptomatic.

v. Limit communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.

a. Residents may eat in the same room while practicing infection prevention and control precautions including social distancing measures whenever possible. This includes limiting the number of people at tables and using barriers and/or maintaining separation of space by at least six (6) feet, as deemed appropriate based on facility risk assessment.

b. When feasible, a small group of residents should be seated together each day, so that each resident is in contact with the same small group. There should be no mixing of residents across these groups.

c. When feasible, staff should be assigned to specific tables in order to minimize the number of residents they interact with and remain with that group each day, whenever possible.

d. The sharing of condiments and serving utensils is prohibited. Sanitize/clean high-touch surfaces (e.g. chairs, tables) between seating/meals.

e. The facility must ensure that processes are in place to maintain infection control protocols such as preventing staff from cleaning used tableware (e.g. plates and cups) and immediately serving food without proper handwashing. When feasible disposable cups and utensils are preferred.

1) Consider the following steps: refrain from removing used plates and tableware from the table until all residents have finished eating or utilize specific staff to serve residents and refill drinks during the meal and a separate group of staff to clear plates and tableware of those who are finished.

vi. Resume Group activities, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only, as deemed appropriate based on facility risk assessment.

vii. Maintain infection prevention and control measures including social distancing and source control measures.

viii. For medically necessary trips away from the facility the resident must wear a cloth face covering or facemask (surgical mask if supply is available) in accordance with CDC guidance, available at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance

ix. Continue to perform ongoing weekly testing of all staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive must be re-tested according to CDC and CDS guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html.

This Directive shall take effect immediately. The provisions of this Directive shall remain in force and effect for the duration of the public health emergency originally declared in Executive Order No. 103 (2020), and as extended by Executive Order, unless otherwise modified, supplemented and/or rescinded.

Dated: October 20, 2020

Judith M. Persichilli, RN, BSN, MA
Commissioner

Resources

CDC Preparing for COVID-19 in Nursing Homes
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

CMS Memo Nursing Home Reopening Recommendations for State and Local Officials
https://www.cms.gov/files/document/qso-20-30-nh.pdf

New Jersey COVID-19 Information Hub, FAQ
https://covid19.nj.gov/faqs/nj-information/general-public/when-and-how-is-new-jersey-lifting-restrictions-what-does-a-responsible-and-strategic-restart-of-new-jerseys-economy-look-like

NJDOH Revised Executive Order 20-013 (Testing in Post-Acute Settings)
https://www.nj.gov/health/legal/covid19/05-20-2020_ExecutiveDirectiveNo20-013_LTC_planCOVID19testing_revised.pdf

NJDOH COVID-19, Communicable Disease Manual Chapter
https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf

NJDOH COVID-19: Information for Healthcare Professionals
https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml

The Road Back: Restoring Economic Health Through Public Health
http://d31hzlhk6di2h5.cloudfront.net/20200518/ff/c9/8c/41/1917eaf623c02595b9225209/Strategic_Restart_Plan.jpg

Appendix

A. E.D. 20-026[1] Attestations

APPENDIX A

1. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, and no later than October 30, 2020, if the facility does not attempt to advance to another phase during that time, the facility must submit to the Department via email to LTC.PhasedReopening@doh.nj.gov a Phased Reopening attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.PhasedReopening@doh.nj.gov:
   [Facility Name] – [Facility License #] – Phased Reopening Attestation – Entering Phase #

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; I attest that the facility has implemented and will continue to adhere to all the requirements set forth in Section (I) (3) to (11) of Executive Directive No. 20-026[1] to advance to [PHASE #] and [NAME OF THE FACILITY] currently:

   a. Has an "Outbreak Plan," as required by N.J.S.A. 26:2H-12.87, and the plan is posted on the facility's website for public view. The plan includes effective communication methods to notify patients/residents, their families or guardians and staff about any infectious disease outbreaks and includes strategies and methods for virtual communications in the case of visitation restrictions, at a minimum on a weekly basis;

   b. Is not experiencing a staffing shortage, is not under a contingency or crisis staffing plan and has a documented plan for securing additional staff in case of a COVID-19 outbreak among staff as part of the facility's "Outbreak Plan;"

   c. (CMS certified facilities only) has a documented communication plan and is informing residents, their representatives, and families of the residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other, in accordance with CMS rule 42 CFR §483.80(g);

   d. Is prominently displaying on their website and/or social media platforms and including in communications to families, guardians and the public, a phone number or method of communication for urgent calls or complaints; and

e. Is meeting testing and data reporting requirements of residents and staff as outlined in NJDOH E.D. 20-026[1].

2. **In order for the facility to meet the requirements of this Directive and no later than October 30, 2020, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an Infection Control Contract attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
   [Facility Name] – [Facility License #] – Infection Control Contract

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF FACILITY] and to bind [NAME OF FACILITY] thereto; that [NAME OF FACILITY] is in compliance with all requirements for Contracting Infection Control Services in Executive Directive 20-026[1] and I attest that [NAME OF FACILITY] has:

   a. One hundred (100) or more beds or on-site hemodialysis services and has contracted with an infection control service pursuant to the requirements of E.D. 20-026[1].

   b. Less than 100 beds or no on-site hemodialysis services and has contracted with an infection control service based on the resident population and facility service needs identified in the facility risk assessment per E.D. 20-026[1].

3. **In order for the facility to meet the requirements of this Directive and no later than May 30, 2021, the facility must create and implement a RPP and must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov a Respiratory Protection Program Implementation attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
   [Facility Name] – [Facility License #] – Respiratory Protection Program Implementation

   Attestation Text:

I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] has implemented a Respiratory Protection Program in compliance with Executive Directive 20-026[1] and I attest that [NAME OF THE FACILITY]:

a. Has implemented a respiratory protection program that complies with the OSHA respiratory protection standard for employees.

4. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase but no later than October 30, 2020, if the facility does not attempt to advance to another phase during that time, the facility must submit to the Department via email to LTC.PPEStockpile@doh.nj.gov a PPE Stockpile attestation on facility letterhead from the facility administrator with the facility name and license number, as follows:**

Email Subject Line to LTC.PPEStockpile@doh.nj.gov:
[Facility Name] – [Facility License #] – PPE Stockpile

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] is in compliance with PPE in stock as required in Executive Directive 20-026[1] and I attest that [NAME OF THE FACILITY]:

a. Is a standalone or is not part of a system with eight (8) or more facilities, has used the CDC PPE Burn Rate Calculator and has two (2) months of PPE on hand in accordance with Executive Directive 20-026[1]; or

b. Is part of a system of eight (8) or more facilities and has used the CDC PPE Burn Rate Calculator and has one (1) month of PPE on hand in accordance with Executive Directive 20-026[1].

c. Has re-stocked PPE and is in compliance with Executive Directive 20-026[1].

5. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, and no later than October 30, 2020, if the facility does not attempt to advance to another phase during that time, the facility must submit to the Department via email to LTC.DataReporting@doh.nj.gov a Data Reporting attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DataReporting@doh.nj.gov:
   [Facility Name] – [Facility License #] – Data Reporting

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] has registered and is submitting data to the National Health safety Network as required by Executive Directive 20-026[1] and I attest that [NAME OF THE FACILITY]:

   a. Has registered, authorized NJDOH to access data and is entering information in the NHSN COVID-19 Module twice weekly.

6. **In order for the facility to meet the requirements of this Directive and before advancing from Phase 0 or to any other phase, the facility must submit to the Department via email to LTC.OutbreakEnd@doh.nj.gov an End of Outbreak attestation following the end of a COVID-19 outbreak or, if the facility never experienced a COVID-19 outbreak, a No Outbreak Experienced attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Following the end of a COVID-19 outbreak at the facility:

   Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
   [Facility Name] – [Facility License #] – End of Outbreak

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

a. I attest that the facility has received determination of COVID-19 outbreak conclusion by the LHD or NJDOH on [INSERT DATE], as defined by the Communicable Disease Service COVID-19 Disease Chapter on [INSERT DATE]. If the facility is CMS certified, the facility has received a survey from the NJDOH on [INSERT DATE].

If the facility has never experienced a COVID-19 outbreak:

Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
[Facility Name] – [Facility License #] – No Outbreak Experienced

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

a. I attest that the facility has never experienced a COVID-19 outbreak.

7. **In order for the facility to meet the requirements of this Directive and at least 3 business days before commencing indoor visitation, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov an Indoor Visitation During Phase 0 or Phase 1 attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
[Facility Name] – [Facility License #] – Indoor Visitation Attestation

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026[1], not experienced any new facility-onset of COVID-19 cases in 14 days, has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

8. **In order for the facility to meet the requirements of this Directive and at least 48 hours before commencing indoor visitation in Phase 2, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov a Phase 2 Indoor Visitation attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

   Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
   [Facility Name] – [Facility License #] – Phase 2 Indoor Visitation Attestation

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026[1], the facility has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments and sufficient PPE to permit visitation.

Quick Reference: Executive Directive No. 20-026 Resumption of Services Guidance in all Long-Term Care Facilities – Infection Prevention & Control

Note: This document does not supersede any existing state and federal regulation. Facilities shall comply with any applicable existing regulatory requirements.

CRITERIA FOR PHASED RESUMPTION OF SERVICES

Facilities may directly advance to the applicable Phase based on criteria within Executive Directive (ED) No. 20-026 https://www.nj.gov/health/legal/covid19/.

Phase 0	Phase 1	Phase 2	Phase 3
■ Any facility regardless of outbreak status, when New Jersey is in maximum restrictions of Road to Reopening OR ■ Any facility identified with an active outbreak[1] of COVID-19 OR ■ Any facility that cannot complete COVID-19 testing in accordance with reopening plans as outlined in ED No. 20-026 AND/OR ■ Any facility that cannot attest to adequate staff; testing capacity for repeat facility-wide testing; PPE; cleaning and disinfection supplies; "Phased Reopening Attestation;" "Data Reporting;" "PPE Stockpile;" and "Infection Control Contract/Employee."	■ Facilities that conclude an outbreak of COVID-19 OR never had a case of COVID-19 at their facility AND ■ 14 days have passed since New Jersey moved to Stage 1 of Road to Reopening AND ■ Can attest to adequate staff; testing capacity for repeat facility-wide testing; adequate PPE; cleaning and disinfection supplies; "End of Outbreak" or "No Outbreak Experienced;" "Data Reporting;" "PPE Stockpile;" and "Infection Control Contract/Employee." AND ■ Performs continued testing of all staff per ED No. 20-026	■ Facilities that conclude an outbreak of COVID-19 OR never had a case of COVID-19 at their facility AND ■ 14 days have passed since New Jersey moved to Stage 2 of Road to Reopening AND ■ Can attest to adequate staff; testing capacity for repeat facility-wide testing; adequate PPE; cleaning and disinfection supplies; "End of Outbreak" (if applicable); "Date Reporting;" "PPE Stockpile;" "Infection Control Contract/Employee;" and "Phase 2 Indoor Visitation Attestation." AND ■ Performs continued testing of all staff per ED No. 20-026	■ Facilities that conclude an outbreak of COVID-19 OR never had a case of COVID-19 at their facility AND ■ 14 days have passed since New Jersey moved to Stage 3 of Road to Reopening AND ■ Can attest to adequate staff; testing capacity for repeat facility-wide testing; adequate PPE; cleaning and disinfection supplies; "End of Outbreak" (if applicable); "Reporting and PPE Stockpile;" "Infection Control Contract/Employee;" and "Phase 2 Indoor Visitation Attestation." AND ■ Performs continued testing of all staff per ED No. 20-026

[1] This guidance does not replace previous guidance issued by NJDOH for management of a COVID-19 outbreak, infection prevention and control recommendations for COVID-19, or laboratory testing guidance. Guidance may be subject to change as new information becomes available. For guidance related to COVID-19 in post-acute facilities, please visit the NJDOH COVID-19 information for healthcare professionals at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml.

CRITERIA FOR PHASED RESUMPTION OF SERVICES

Facilities may directly advance to the applicable Phase based on criteria within Executive Directive (ED) No. 20-026 https://www.nj.gov/health/legal/covid19/.

<table>
<tr><th>CATEGORY</th><th>Phase 0</th><th>Phase 1</th><th>Phase 2</th><th>Phase 3</th></tr>
<tr><td>Outdoor visitation</td><td colspan="4">Refer to ED No. 20-026 for information on outdoor visitation at https://www.nj.gov/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf.</td></tr>
<tr><td rowspan="2">Indoor visitation
Visitors should practice routine infection prevention and control precautions including social distancing, hand hygiene, and wearing a cloth face covering or facemask
Facilities may still restrict visitation due to the COVID-19 county positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 public health emergency. However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v).</td><td colspan="4">Indoor visitation can only occur in facilities where:
■ No new facility-onset COVID-19 cases are identified in the last 14 days;
■ The facility is not currently conducting outbreak testing;
■ There is a mechanism to collect informed consent from the residents and visitors;
■ There is a designated location for indoor visitation;
■ The facility has sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit safe visitation.
Facilities should use the NJDOH COVID-19 Activity Level Index (CALI) Score to facilitate indoor visitation https://www.nj.gov/health/cd/statistics/covid/index.shtml.</td></tr>
<tr><td>Limit visitation, in general. Indoor visitation by (appointment only) to COVID-19 negative, asymptomatic and COVID-19 recovered residents only. Facilities should have a plan to limit visitation hours and the number of visitors permitted. Visitors should be permitted based on screening[2] criteria and restricted to a designated area.</td><td>Limit scheduled visitation (appointment only) to COVID-19 negative, asymptomatic and COVID-19 recovered residents only. Facilities should have a plan to limit visitation hours and the number of visitors permitted. Visitors should be permitted based on screening[2] criteria and restricted to a designated area.</td><td>Resume full indoor visitation. Visitors should be permitted based on screening[2] criteria.</td></tr>
</table>

[2] Screening includes monitoring temperature to identify fever and inquiring about other COVID-19 symptoms or known or suspected exposures. Source control should be in place prior to entry, as appropriate.

CATEGORY	Phase 0	Phase 1	Phase 2	Phase 3
Visitation for pediatric, developmentally disabled, and intellectually disabled residents	Refer to ED No. 20-026 for information on visitation for pediatric, developmentally disabled, and intellectually disabled residents at https://www.nj.gov/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf.			
Visitation for indoor end-of-life, compassionate care, and essential caregivers	Refer to ED No. 20-026 for information on visitation for indoor end-of-life and compassionate care at https://www.nj.gov/health/legal/covid19/8-20_ExecutiveDirective-No20-026_LTCResumption_of_Svcs.pdf.			
Entry of volunteers Volunteers should practice routine infection prevention and control precautions including social distancing, hand hygiene, and wearing a cloth face covering or facemask.	**Prohibit entry** of volunteers into the building.			**Allow entry of volunteers** based on screening[2] criteria.
Entry of non-essential personnel/contractors like those providing elective consultations, non-essential services (e.g., barber). Non-essential personnel/ contractors should practice routine infection prevention and control precautions including social distancing, hand hygiene, and wearing a cloth face covering or facemask.	**Prohibit entry** of non-essential personnel into the building.		**Limit entry of non-essential personnel/ contractors** into the building based on screening[2] criteria. When possible, restrict their movement to a designated area (e.g., medical consults provided in designated treatment room). **Non-essential personnel are permitted access to COVID-19 negative and asymptomatic or COVID-19 rcovered residents only**.	**Allow entry of non-essential personnel/ contractors, as determined necessary by the facility** based on screening[2] criteria.

[2] Screening includes monitoring temperature to identify fever and inquiring about other COVID-19 symptoms or known or suspected exposures. Source control should be in place prior to entry, as appropriate.

CATEGORY	Phase 0	Phase 1	Phase 2	Phase 3
Communal dining	**Limit communal dining**, encourage residents to stay in their room and/or cohort.	**Limit communal dining to COVID-19 negative, asymptomatic and COVID-19 recovered residents only.** Residents may eat in the same room while practicing infection prevention and control precautions including social distancing measures. This includes limiting the number of people at tables, keeping residents in the same small dining group, and using barriers and/or maintaining separation of space by at least 6 feet, as deemed appropriate based on facility risk assessment.		
Group activities Resumption of group activities should include routine infection prevention and control precautions including social distancing, hand hygiene, and wearing a cloth face covering or facemask.	**Limit group activities**, encourage residents to stay in their room and/or cohort.	**Restrict group activities in general**. Limited activities may be conducted for COVID-19 negative, asymptomatic and COVID-19 recovered residents only in their small groups. Group size should not exceed more than 10 individuals.	**Limit group activities to no more than 10 people**, including outings, for COVID-19 negative, asymptomatic and COVID-19 recovered residents only, as deemed appropriate based on facility risk assessment.	**Resume Group activities**, including outings, for COVID-19 negative, asymptomatic and COVID-19 recovered residents only, as deemed appropriate based on facility risk assessment.
Trips outside of the building Any trip outside of the building during the public health emergency should be carefully considered on a case-by-case basis. If residents partake in these trips/outings they should be advised to follow all infection prevention and control measures, and be prepared to quarantine upon return, based on assessment of risk.	**Avoid non-medically necessary trips outside the building.** For medically necessary trips away from the facility the resident must wear a cloth face covering or facemask (as tolerated) and the resident's COVID-19 status must be shared with the transportation service and entity with whom the resident has the appointment.		***Refer to the appropriate Phase "Group Activities" (above) for guidance related to non-medical outings.** For medical trips away from of the facility the resident must wear a cloth face covering or facemask (as tolerated) and the resident's COVID-19 status must be shared with the transportation service and entity with whom the resident has the appointment.	
	Pediatric residents: ED No. 20-026 shall not be interpreted to prevent **pediatric residents** currently negative or asymptomatic (and not on Transmission-Based Precautions) from attending educational institutions or medical appointments (e.g. physical therapy) provided protocols are in place to protect the resident and the facility.			

[2] Screening includes monitoring temperature to identify fever and inquiring about other COVID-19 symptoms or known or suspected exposures. Source control should be in place prior to entry, as appropriate.

CATEGORY	Phase 0	Phase 1	Phase 2	Phase 3
Resident screening	**Screen[2] all residents, at minimum every shift** with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs should include heart rate, blood pressure temperature, and pulse oximetry. Perform COVID-19 testing if indicated.	**Screen[2] all residents, at minimum daily**, with temperature checks, questions and observations for other signs or symptoms of COVID-19 and test if indicated.		
Staff and other persons screening (e.g., essential caregivers)	**Screen[2] and log all persons entering the facility and all staff at the beginning of each shift**. Advise any persons who enter the facility to monitor for fever and other COVID-19 symptoms for at least 14 days after exiting the facility. If symptoms occur advise them to self-isolate at home, contact their healthcare provider and immediately notify the facility of the date they were in the facility, the persons they were in contact with and the locations within the facility they visited. **Facilities that have antigen testing available are encouraged to use it as part of their visitor screening process.** Visitors who test positive are not permitted to enter the facility. If antigen testing is used, please refer to NJDOH Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities (https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml) and CDC guidance for testing interpretation (https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html).			
Resident SARS-CoV-2 molecular testing Re-testing individuals who previously tested positive should be done in accordance with CDC and CDS guidance (e.g., >3 months after the date of onset of the prior infection).	**Test any resident** showing new signs or symptoms consistent with COVID-19. **Test all previously negative residents weekly** until no new facility-onset cases of COVID-19 are identified.	Test any resident showing **new signs or symptoms** consistent with COVID-19 and in accordance with public health recommendations.		

[2] Screening includes monitoring temperature to identify fever and inquiring about other COVID-19 symptoms or known or suspected exposures. Source control should be in place prior to entry, as appropriate.

CATEGORY	Phase 0	Phase 1	Phase 2	Phase 3
Resident SARS-CoV-2 molecular testing (cont'd)	among **residents and positive cases in staff *and*** at least 14 days have elapsed since the most recent positive result ***and*** during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative; test any resident showing new signs or symptoms consistent with COVID-19.			
Staff SARS-CoV-2 testing Re-testing individuals who previously tested positive should be done in accordance with CDC and CDS guidance (e.g., >3 months after the date of onset of the prior infection).	**Test all COVID-19 negative staff weekly.** Prioritize testing of staff showing new signs or symptoms consistent with COVID-19. Antigen testing may be used to fulfill the weekly employee testing requirements set forth in ED No. 20-026 and may be used on asymptomatic individuals at the facility's discretion. Refer to *NJDOH COVID-19: Information for Healthcare Professionals* page for testing considerations at https://www.state.nj.us/health/cd/topics/covid2019_healthcare.shtml.			
Cohorting	Maintain separation of COVID-19 positive and negative residents in accordance with NJDOH Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities at https://www.state.nj.us/health/cd/topics/covid2019_healthcare.shtml.			

[2] Screening includes monitoring temperature to identify fever and inquiring about other COVID-19 symptoms or known or suspected exposures. Source control should be in place prior to entry, as appropriate.

Resources

CDC Preparing for COVID-19 in Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

CMS Memo Nursing Home Reopening Recommendations for State and Local Officials https://www.cms.gov/files/document/qso-20-30-nh.pdf

CMS Memo Nursing Home Visitation - COVID-19 https://www.cms.gov/files/document/qso-20-39-nh.pdf

New Jersey COVID-19 Information Hub, FAQ https://covid19.nj.gov/faqs/nj-information/general-public/when-and-how-is-new-jersey-lifting-restrictions-what-does-a-responsible-and-strategic-restart-of-new-jerseys-economy-look-like

NJDOH Revised Executive Directive No. 20-013 (Testing in Post-Acute Settings) https://www.nj.gov/health/legal/covid19/

NJDOH COVID-19, Communicable Disease Manual Chapter https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf

NJDOH COVID-19: Information for Healthcare Professionals https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml

The Road Back: Restoring Economic Health Through Public Health http://d31hzlhk6di2h5.cloudfront.net/20200518/ff/c9/8c/41/1917eaf-623c02595b9225209/Strategic_Restart_Plan.jpg

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Commissioner

EXECUTIVE DIRECTIVE NO. 20-017

STANDARDS AND PROTOCOLS FOR VISITORS AND FACILITY STAFF PURSUANT TO EXECUTIVE ORDER NO. 103 SUPERSEDING THE MARCH 16, 2020 VISITATION GUIDANCE MEMORANDUM

WHEREAS, Coronavirus disease 2019 ("COVID-19") is a contagious, and at times fatal, respiratory disease caused by the respiratory illness caused by the SARS-CoV-2 virus; and

WHEREAS, symptoms of the COVID-19 illness include fever, cough and shortness of breath, which may appear in as few as two or as long as 14 days after exposure, and can spread from person to person via respiratory droplets produced when an infected person coughs or sneezes; and

WHEREAS, the CDC and the New Jersey Department of Health (DOH) have identified key strategies to address COVID-19 in long-term care facilities and congregate settings, including but not limited to identifying infection early; taking measures to prevent the spread of COVID-19 through asymptomatic, pre-symptomatic, and symptomatic transmission; and dedicating areas of a facility to care for residents with suspected or confirmed COVID-19; and

WHEREAS, given the congregate nature and resident populations typically served in long-term care facilities (e.g., older adults often with underlying chronic medical conditions), the long-term care population are at the highest risk of being affected by COVID-19 and, if infected, are at risk of serious illness; and

WHEREAS, because healthcare providers and support staff are a source of introduction of COVID-19 into long-term care facilities, the CDC and the DOH recommend actively screening every person entering the facilities for fever and symptoms of COVID-19;

WHEREAS, long-term care facilities are required to comply with the COVID-19 baseline testing requirements in Executive Directive 20-013;

WHEREAS, according to the CDC, and as reflected in the State, experience with outbreaks in long-term care facilities has shown that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms and some may not

report any symptoms, yet unrecognized asymptomatic and pre-symptomatic infections contribute to transmission in these settings; and

WHEREAS, on March 9, 2020, Governor Murphy issued Executive Order 103, declaring the existence of a Public Health Emergency, pursuant to the Emergency Health Powers Act, N.J.S.A. 26:13-1 et seq., and a State of Emergency, pursuant to the Disaster Control Act, N.J.S.A. App A:9-33 et seq., in the State of New Jersey for COVID-19; and

WHEREAS, the Public Health Emergency was extended by Governor Murphy under Executive Order Nos. 119,138, and 151; and

WHEREAS, the state is in Phase 2 of the reopening process; and

WHEREAS, mandatory guidelines for visitors and staff were put into place via a memorandum issued by the Department of Health dated March 13, 2020, and superseded by a revised memorandum on March 16, 2020, for dementia care facilities, long-term facilities, pediatric transitional care homes, assisted living residences, comprehensive personal care homes, and assisted living programs; and

WHEREAS, under the declared Public Health Emergency, the Commissioner of the Department of Health is empowered, pursuant to N.J.S.A. 26: 13-12, to take all reasonable and necessary measures to prevent the transmission of infectious disease and apply proper prevention measures and controls for infectious disease; and

NOW, THEREFORE, I, JUDITH PERSICHILLI, Commissioner of the Department of Health, pursuant to the powers afforded to me under the Emergency Health Powers Act, hereby **ORDER** and **DIRECT** the following:

Effective June 19, 2020 and until lifted by the Department of Health (Department), the following screening and restriction requirements for all visitors to dementia care homes, long-term care facilities, pediatric transitional care homes, assisted living residences, comprehensive personal care homes, and assisted living programs shall be implemented by these facilities:

1. **Definitions.** For the purposes of this Executive Directive, “Restricting” means the individual should not be allowed in the facility at all; and “Limiting” means the individual should not be allowed in the facility, except for end-of-life situations.
2. **Limiting Resident Visitation.** No resident visitors shall be permitted in the facility except for end-of-life situations, and except as provided in Section 4 below, until further notice. The following rules shall apply to resident visitors for end-of-life situations:
    a) The facility shall actively screen and restrict visitation for those who meet one or more of the following criteria:
        i. Exhibit signs or symptoms of an infectious communicable disease, including COVID-19, such as a subjective and/or objective fever (evidenced by a temperature check of the visitor taken by the facility),

chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea;

ii. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or someone under investigation for COVID-19, or someone ill with respiratory illness; or

iii. Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC.

b) If, after undergoing screening, the visitor is permitted to enter the facility, the facility shall:

i. Require the visitor to wear a cloth face covering or facemask. The facility may require the visitor to use additional forms of personal protective equipment (PPE), as determined by the facility;

ii. Provide instruction on hand hygiene, provide instruction on limiting surfaces touched, provide instruction on the use of PPE, and inform visitors of the location of handwashing stations, before the visitor enters the facility and resident's room;

iii. Limit the visitor's movement within the facility to the resident's room or designated space (e.g., reduce walking the halls, avoid going to dining room, etc.), but permit the visitor to use a designated restroom, as necessary;

iv. Advise the visitor to restrict physical contact with anyone other than the resident while in the facility. For example, practice social distancing (remain six feet apart) with no handshaking or hugging;

v. Restrict a visitor from entering the facility if he or she is unable to demonstrate the proper use of infection prevention and control techniques; and

vi. Advise visitors to monitor for signs and symptoms of COVID-19 for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals

of reported contact, and take all necessary actions based on any findings.

c) Facilities are required to provide notification in compliance with 42 C.F.R. 483.10(g)(14)(i)(B) when a resident experiences a change of condition. Facilities should not limit compassionate care visits when the resident has been determined to be at end of life.

3. **Alternatives to Resident Visits.** In lieu of visits, the Department strongly suggests facilities continue:

a) Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).

b) Creating/increasing listserv communication to update resident on outdoor visitation availability.

c) Assigning staff as primary contact to the resident's visitors for inbound calls and conducting regular outbound calls to keep them informed.

d) Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.

4. **Designated Outdoor Visitation Space by appointment only.** Beginning on June 21, 2020, facilities may allow in-person visitation in a designated outdoor visitation space, provided that the facility implements all of the following safety, care, and infection prevention and control measures:

a) Facilities may start scheduling appointments on the effective date of this Executive Directive, but visitation may not begin until June 21, 2020.

b) A resident who is suspected or confirmed to be infected with COVID-19; or quarantined for an exposure to a COVID-19 case cannot be visited except for an end of life situation. A resident who has been diagnosed with COVID-19 may be visited only after they have met the criteria for discontinuation of isolation as defined in guidance from NJDOH and CDC.

c) The facility should honor each resident's right to have and choose visitors and to make preferences. The facility should consult every resident to determine who the resident would wish to visit with in person. These consultations also serve as a personalized communication with the resident to explain how visitation will work and what the resident can expect.

d) Clear communication of the visitation policy should be provided to residents, resident's visitors, staff and others, as needed in writing, via the methods the facility uses to convey information or policy changes. Facilities should consider providing the visitation guidelines in various languages as needed.

e) The facility should establish a designated area for visitors to be screened that accommodates social distancing and infection control standards. Visitors should be provided with the visitation guidelines upon check in. The facility should provide graphics to assist residents and visitors in maintaining social distancing and infection control standards. Visitors are not permitted entrance past the reception area of the facility, including restrooms, which will not be available to visitors at this time.

f) The facility should provide a visiting area with accommodations offered for those with mobility needs and designated seating for visitors. The facility should also provide reasonable accommodations for any resident with a disability, such as hearing, vision, or cognitive impairments, and assist any resident with transport using their adaptive equipment.

g) Prior to transporting a resident to the designated outdoor visitation space, the long-term care facility must screen the visitor for infectious communicable diseases, including COVID-19 symptoms. Any visitors with symptoms of COVID-19 infection (subjective or objective fever equal to or greater than 100.4 F or as further restricted by facility policy, chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea) will not be permitted to visit with a resident.

h) Transport of a resident to and from the designated outdoor visitation space must be safe and orderly. At a minimum, safe transport means that the resident cannot be transported through any space designated as COVID-19 care space or space where residents suspected or confirmed to be infected with COVID-19 are present. Transport must be done while keeping 6 feet distance between other residents and staff.

i) A long-term care facility staff member familiar with the required protocols must remain with the resident at all times during the visit.

j) Each resident is limited to no more than two visitors at a time. A visitor must remain at least 6 feet from the resident and attending staff member(s) at all times during the visit. Whenever possible, visitors should

wait in a vehicle prior to the visitation time. If the visitor is using public or ride share transport, the visitor(s) should wait in an outdoor space that ensures social distancing of at least six feet from other visitors.

k) Staff must wear a surgical facemask; residents must wear a face covering (surgical mask if supply is available); and visitors must wear a face covering or mask for the duration of the visit. Visits with a resident in a designated outdoor space must be scheduled in advance and are dependent on permissible weather conditions, availability of outdoor space, and sufficient staffing at the facility to meet resident care needs, as well as the health and well-being of the resident. Facilities should provide appropriate protection from the weather, (e.g. sun, heat, and rain). Visits may be cancelled because of inclement or unsafe weather conditions (e.g. high humidity/heat, poor air quality).

l) A long-term care facility may limit the length of any visit, the days on which visits will be permitted, the hours during a day when visits will be permitted, and the number of times during a day or week a resident may be visited.

m) Food is not permitted during the visits. Visitors may bring items for the resident but must leave the package at reception or another location, as directed by the facility. Visitors may bring their own water which cannot be shared with the resident. The facility shall provide appropriate hydration for the resident during the visit.

n) At the conclusion of the visit, the residents should be transported back to their rooms by a facility staff member.

o) The facility must receive informed consent from the visitor and the resident in writing that they are aware of the possible dangers of exposure to COVID-19 for both the resident and the visitor and that they will follow the rules set by the facility in regard to outdoor visitation. The facility must receive a signed statement from each visitor and resident (if the resident is unable to consent then the consent needs to be signed by the authorized representative) with a copy provided to the visitor and resident, that they are aware of the risk of exposure to COVID-19 during the visit, that they will strictly comply with the facility policies during outdoor visitation, and that the visitor will notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID-19 within fourteen days of the visit.

p) At least 24 hours before commencing outdoor visitation, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an attestation on facility letterhead

from the facility administrator with the facility name and license number and “Outdoor Visitation Attestation” in the subject line, as follows:

> *I, [**NAME**], of full age, hereby certify that I am employed with the Facility in the capacity of [**INSERT TITLE**]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive No. 20-017 and the facility has a location designated for outdoor visitation, sufficient staff, a mechanism for appointments and sufficient PPE to permit visitation.*

5. **Vendors.** For vendors and transportation providers (e.g., when taking residents to offsite appointments, etc.), the facility shall actively screen and restrict those individuals from entering the facility if they meet one or more of the following criteria:

    a) Exhibit signs or symptoms of COVID-19, such as a fever (evidenced by a temperature check of the individual taken by the facility), chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea;

    b) In the last 14 days, has had close contact with someone with a confirmed diagnosis of COVID- 19, or with someone under investigation for COVID-19, or someone ill with respiratory illness;

    c) Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC;

    d) If, after undergoing screening, the vendor or transportation provider is permitted to enter the facility, the facility shall:

        i. Require the individual to wear a cloth face covering or facemask while in the facility. The facility may require the individual to use additional forms of personal protective equipment (PPE), as determined by the facility;

        ii. Provide instruction on hand hygiene, provide instruction on limiting surfaces touched, provide instruction on the use of PPE, and inform the vendor/transportation provider of the location of handwashing stations, before they enter the facility;

iii. Limit the individual's movement within the facility to those areas necessary to complete the vendor's or transportation provider's task;

iv. Advise the individual to limit physical contact and practice social distancing with anyone in the facility;

v. Restrict the individual from entering the facility if he or she is unable to demonstrate the proper use of infection prevention and control techniques, such as use of a facemask or proper hand hygiene; and

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

e) For supply vendors, it is recommended that they drop off supplies at a dedicated location, such as a loading dock, instead of entering the facility.

f) Transport providers should not be permitted to render services if they meet the criteria outlined in a) through c), above.

6. **Volunteers.** Until further notice of the Department, non-healthcare volunteers shall be restricted from the facility, except if the individual is a volunteer advocate for the resident.

7. **Monitoring and Restricting Health Care Facility Staff and Non-essential Medical Professional Visitors**. The facility shall restrict non-essential medical professionals (except for end-of life situations) from entering the facility, until further notice by the Department. Essential medical professionals and non-essential medical professionals visiting the facility for end-of-life situations may enter the facility pursuant to the below requirements. The facility shall actively screen all health care facility staff (including regional, agency and corporate staff), essential medical professional visitors and non-essential medical professional end-of-life visitors and restrict access to anyone who meets any of the following criteria:

a) Exhibits signs or symptoms of an infectious communicable disease, including COVID-19 symptoms. Symptoms of COVID-19 infection include subjective or objective fever equal to or greater than 100.4 F or as further restricted by facility policy, chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss

of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea. For facility staff and visiting essential medical professionals, the facility shall document the temperature of the staff member, for the absence of COVID-19 symptoms.

b) In the last 14 days, has had an identified exposure to someone with a confirmed diagnosis of COVID- 19, or someone under investigation for COVID-19.

c) Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC.

d) If, after undergoing screening, the staff member or visiting essential or non-essential medical professional is permitted to enter the facility, the facility shall:

   i. Require the staff member and visiting essential or non-essential medical professional to wear a cloth face covering or facemask while in the facility. The facility may require the individual to use additional forms of PPE, as determined by the facility;

   ii. Provide instruction, before the staff member or visiting essential or non-essential medical profession enters the facility, on hand hygiene, the location of handwashing stations, limiting surfaces touched, and the use of PPE;

   iii. Limit the staff member or visiting essential or non-essential medical professional's movement within the facility to those areas necessary to complete the professional's task;

   iv. Advise the staff member or visiting essential or non-essential medical professional to limit physical contact and practice social distancing with anyone in the facility, except when needed for patient care purposes;

   v. Restrict the staff member or visiting essential or non-essential medical professional from entering the facility if he or she is unable to demonstrate the proper use of infection prevention and control techniques; and

   vi. Advise the staff member or visiting essential or non-essential medical professional to monitor for signs and symptoms of COVID-19 for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the

individuals they were in contact with, and the locations within the facility they encountered while in the facility. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on any findings.

e) Health care facility staff, visiting essential or non-essential medical professionals who have signs and symptoms of an infectious communicable disease, including COVID-19 should not report to work.

f) Any health care staff and visiting essential or non-essential medical professional that develops signs or symptoms of COVID-19 while on-the job, are required to:

i. Immediately stop work, replace or keep on their facemask, and self-isolate at home.

ii. Inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with, and

iii. Contact their health care provider.

g) Refer to the CDC guidance for exposures that might warrant restricting health care personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)

8. **Documentation of Resident Visitors, Health Care Facility Staff and Non-essential Medical Professional Visitors, and Vendors.** Facilities shall maintain records of all visitors to the facility including those outlined above. These records should document name, contact information, name of the resident being visited or other reason for visiting, and company or organization represented, if applicable. This information should be kept by the facility per policy, for a minimum of 30 days.

9. **Notification of Restricted and Limited Visits**. Facilities shall communicate through multiple means to inform individuals, including non-essential health care personnel, of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls. Facilities should contact their local health department for questions and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html) and the New Jersey Department of Health Website for COVID-19: https://www.nj.gov/health/cd/topics/ncov.shtml.

10. **Exceptions to Visitor Limitations and Restrictions**. In emergency situations EMS personnel shall be permitted to go directly to the resident**.**

    Please note that residents still have the right to access the Ombudsman program. Their access should be restricted per the guidance above (except in compassionate care situations); however, facilities may review this on a case-by-case basis. If in-person access is not available due to infection prevention and control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or any other entity listed in 42 CFR § 483.1 O(f)(4)(i).

This Directive shall take effect immediately. The provisions of this Directive shall remain in force and effect for the duration of the public health emergency originally declared in Executive Order No. 103 (2020), and as extended by Executive Orders 119, 138, and 151, unless otherwise amended, superseded, or lifted.

Dated: June 19, 2020

Judith Persichilli, RN, BSN, MA
Commissioner

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JUDITH M. PERSICHILLI, RN, BSN, MA
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EXECUTIVE DIRECTIVE NO. 20-025 (REVISED)[1]

PROTOCOLS AND CONDITIONS FOR VISITATION OF PEDIATRIC, DEVELOPMENTALLY DISABLED, INTELLECTUALLY DISABLED RESIDENTS AND RESIDENTS WITH MAJOR NEUROCOGNITIVE DISORDER OR SERIOUS MENTAL ILLNESS IN LONG-TERM CARE FACILITIES LICENSED PURSUANT TO N.J.A.C. 8:39

WHEREAS, Coronavirus disease 2019 ("COVID-19") is a contagious, and at times fatal, respiratory disease caused by the SARS-CoV-2 virus; and

WHEREAS, symptoms of the COVID-19 illness include fever, cough and shortness of breath, which may appear in as few as two or as long as 14 days after exposure, and can spread from person to person via respiratory droplets produced when an infected person coughs or sneezes; and

WHEREAS, COVID-19 can be spread by people who do not show any symptoms; and

WHEREAS, on March 9, 2020, Governor Philip D. Murphy issued Executive Order 103, declaring the existence of a Public Health Emergency, pursuant to the Emergency Health Powers Act, N.J.S.A. 26:13-1 et seq., and a State of Emergency, pursuant to the Disaster Control Act, N.J.S.A. App A:9-33 et seq., in the State of New Jersey for COVID-19; and

WHEREAS, the Public Health Emergency was extended by Governor Murphy under Executive Order Nos. 119, 138, 151, 162 and 171; and

WHEREAS, on March 13, 2020 the Department of Health issued guidelines restricting visitation in Long-Term Care Facilities to end-of-life situations, which were revised and reissued on March 16, 2020 and supplemented on June 19, 2020; and

WHEREAS, those restrictions on visitation were necessary to impede the spread of COVID-19 in long-term care facilities; and

[1] This revised Executive Directive amends and supersedes Executive Directive No. 20-2025 dated July 15, 2020.

WHEREAS, the State of New Jersey has flattened the curve of COVID-19 cases and transmission in the State and has entered the reopening phase and is lifting certain COVID-19 restrictions;

NOW, THEREFORE, I, JUDITH PERSICHILLI, Commissioner of the Department of Health, pursuant to the powers afforded to me under the Emergency Health Powers Act, hereby ORDER and DIRECT the following:

I. Long-term care facilities licensed pursuant to N.J.A.C. 8:39 are required to permit indoor visitation by parents, family, guardians or support persons (visitors) of pediatric, developmentally disabled, intellectually disabled residents and residents with major neurocognitive disorder [2] or serious mental illness pursuant to this directive.[3] When determining whether a support person is needed, facilities are reminded that they must comply with federal and state laws, such as the Americans with Disabilities Act (ADA) 42 U.S.C. §12101 and the New Jersey Law Against Discrimination (LAD) N.J.S.A. 10:5-1, et seq.

II. Outdoor visitation is to continue to occur under the provisions of NJDOH Executive Directive 20-017.

III. Indoor visitation is to occur under the following conditions:

1. The State of New Jersey must remain out of the *maximum restrictions Stage* described in *The Road Back: Restoring Economic Health through Public Health* (http://d31hzlhk6di2h5.cloudfront.net/20200518/ff/c9/8c/41/1917eaf623c02595b9 225209/Strategic_Restart_Plan.jpg) reopening plan. If at any point during the public health response the State returns to the *maximum restrictions Stage,* visitation permitted under this Executive Directive must stop.

2. In order to permit visitors, the facility is required to have achieved a "post-outbreak" COVID-19 status, pursuant to the following standards:

   i. An outbreak of COVID-19 is An outbreak of COVID-19 is defined by the Communicable Disease Service, per the COVID-19 Communicable Disease Manual Chapter at https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf.

   ii. Outbreaks are considered concluded when there are no symptomatic/asymptomatic probable or confirmed COVID-19 cases after 28 days (2 incubation periods) have passed since the last case's onset date or specimen collection date, whichever is later, as defined and updated per the COVID-19 Communicable Disease Manual Chapter:

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[2] As used in this directive "major neurocognitive disorder" requires substantial impairment to be present in one or (usually) more cognitive domains. The impairment must be sufficient to interfere with independence in everyday activities. See: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Publisher

[3] As used in this directive "serious mental illness" is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. See: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Publisher

https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf.

3. Facilities shall adhere to the following protocols and develop written guidelines for visitors.
    i. The facility shall actively screen all visitors for signs and symptoms of COVID-19. Screening is to include:
        a. Temperature checks;
        b. Completion of a questionnaire about symptoms and potential exposure. The questionnaire shall include at a minimum:
            1) Whether in the last 14 days, the visitor has had an identified exposure to someone with a confirmed diagnosis of COVID-19, someone under investigation for COVID-19, or someone suffering from a respiratory illness;
            2) Whether the visitor has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC; and
            3) Whether in the last 14 days, the visitor has returned from a state on the designated list of states under the 14-day quarantine travel advisory; and
        c. Observation of any signs or symptoms of COVID-19, including, but not limited to:
            1) Coughing;
            2) Sneezing;
            3) Congestion; or
            4) Runny nose.
        d. Upon screening, facilities must prohibit visitation for those who meet one or more of the following criteria:
            1) Exhibit signs or symptoms of an infectious communicable disease, including COVID-19, such as a subjective and/or objective fever (evidenced by a temperature check of the visitor equal to or greater than 100.4 F or as further restricted by facility), chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea;
            2) In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or someone under investigation for COVID-19, or someone ill with respiratory illness;
            3) In the last 14 days, has returned from a designated state under the 14- day quarantine travel advisory; or

4) Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC.

e. The facility should establish a designated area for visitors to be screened that accommodates social distancing and infection control standards. Visitors should be provided with the visitation guidelines upon check in. The facility should provide graphics to assist residents and visitors in maintaining social distancing and infection control standards.

f. No more than two visitors are permitted at one time per resident.

g. If, after undergoing screening, the visitor is permitted to enter the facility, the facility shall:

1) Require the visitor to wear a facemask. The facility may require the visitor to use additional forms of personal protective equipment (PPE), as determined by the facility.

2) Provide instruction on hand hygiene, provide instruction on limiting surfaces touched, provide instruction on the use of PPE, and inform visitors of the location of handwashing stations, before the visitor enters the facility and resident's room.

3) Limit the visitor's movement within the facility to the resident's room or designated space (e.g., reduce walking the halls, avoid going to dining room, etc.).

4) Advise the visitor to limit physical contact with anyone other than the resident while in the facility. For example, practice social distancing with no handshaking or hugging and remaining six feet apart.

5) Restrict a visitor from entering the facility if he or she is unable to demonstrate the proper use of infection prevention and control techniques.

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

h. The facility must receive informed consent from the visitor(s) and the resident in writing that they are aware of the possible dangers of exposure to COVID-19 for both the resident and the visitor and that they will follow the rules set by the facility in regard to visitation. The facility must receive a signed statement from each visitor and resident

(if the resident is unable to consent then the consent needs to be signed by the authorized representative) with a copy provided to the visitor and resident, that they are aware of the risk of exposure to COVID-19 during the visit, that they will strictly comply with the facility policies during visitation, and that the visitor will notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID-19 within fourteen days of the visit.

i. Visitors shall be restricted to a designated area during each visit.

4. Indoor visitation must occur under the following conditions:

   i. All visitors' access to the facility will be limited to a designated visitation area, as well as the designated screening area, in order to limit the access of a visitor to the facility.

   ii. Facilities may allow visitation in a resident's room, if the resident is in a single room. If a resident is in a shared room, the facility must identify a visitation location that allows for social distancing and deep cleaning.

   iii. Transport of a resident to and from the designated visitation space must be safe and orderly. At a minimum, safe transport means that the resident cannot be transported through any space designated as COVID-19 care space or space where residents suspected or confirmed to be infected with COVID-19 are present. Transport must be done while keeping 6 feet distance between other residents and staff.

   iv. Residents and visitors must wear a face covering (surgical mask if supply is available) for the duration of the visit, in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/prevent- getting-sick/cloth-face-cover-guidance.html. A face covering should NOT be worn by children under the age of 2 or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

   v. Food is not permitted during the visits. Visitors may bring items for the resident but must leave the package at reception or another location, as directed by the facility. Visitors may bring their own water which cannot be shared with the resident. The facility shall provide appropriate hydration for the resident during the visit.

   vi. At the conclusion of the visit, the residents should be transported back to their rooms by a facility staff member.

5. Visitation shall occur via appointment only. A long-term care facility may limit the length of any visit, the days on which visits will be permitted, the hours during a day when visits will be permitted, and the number of times during a day or week a resident may be visited.

6. At least 48 hours before commencing indoor visitation, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an attestation on facility letterhead

from the facility administrator with the facility name and license number and "Visitation Attestation" in the subject line, as follows:

> *I, **[NAME]**, of full age, hereby certify that I am employed with the Facility in the capacity of **[INSERT TITLE]**; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive No. 20-025 and the facility is not experiencing an outbreak, has locations designated for visitation, sufficient staff, a mechanism for appointments and sufficient PPE to permit visitation.*

7. Please note that residents still have the right to access the Ombudsman program. Their access should be restricted per the guidance above (except in compassionate care situations); however, facilities may review this on a case-by- case basis. If in-person access is not available due to infection prevention and control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or any other entity listed in 42 CFR § 483.10(f)(4)(i).
8. This Directive shall take effect immediately. The provisions of this Directive shall remain in force and effect for the duration of the public health emergency originally declared in Executive Order No. 103 (2020), and as extended by Executive Orders 119, 138, 151, 162 and 171, unless otherwise amended, superseded, or lifted.

Dated: August 31, 2020

Judith Persichilli, RN, BSN, MA
Commissioner

State of New Jersey
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PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

November 16, 2020

TO: Administrators
Long-term Care Facilities Licensed Pursuant to N.J.A.C. 8:39
Assisted Living Residences Licensed Pursuant to N.J.A.C. 8:36
Comprehensive Personal Care Homes Licensed Pursuant to N.J.A.C. 8:36
Residential Health Care Facilities Licensed Pursuant to N.J.A.C. 8:42
Dementia Care Homes Licensed Pursuant to N.J.A.C. 8:37

FROM: Judith M. Persichilli, R.N., B.S.N., M.A.
Commissioner

SUBJECT: Holiday Visitation Guidance

THIS GUIDANCE REGARDING HOLIDAY VISITATION IS MEANT TO BE USED IN CONJUNCTION WITH GUIDANCE ISSUED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) AND COMMUNICABLE DISEASE SERVICE (CDS), AND CURRENT DEPARTMENT OF HEALTH DIRECTIVES AND ORDERS.

The virus that causes Coronavirus 2019 Disease ("COVID-19") is easily transmitted, especially in group settings. Many residents of health care facilities are being treated for health conditions that make them particularly vulnerable to suffering the most serious complications of COVID-19 infection, including death. The State of New Jersey is currently experiencing a rise in COVID-19 cases and community spread. As the upcoming holiday season will include family visitation, it is imperative for the residents of congregate living facilities that their families and facility staff take precautions in order to provide a safe environment for everyone.

Because of the risk of the rapid spread of the virus, and the need to protect all members of the community, especially residents of health care facilities who are at increased risk of serious complications and death from COVID-19, the Department of Health (DOH) is providing the following guidance regarding visitation during the upcoming holiday season.

1. The April 13, 2020 Emergency Curtailment of Admission Order is still in effect. Facilities that cannot implement proper infection control protocols, cannot cohort, or do not have enough staff, PPE and cleaning supplies to properly care for all residents, may not admit or readmit residents into their facility. 4/13/2020 Order: https://www.state.nj.us/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf

2. The DOH strongly recommends against families taking residents out of facilities for holiday celebration events or gatherings. The Centers for Disease Control and Prevention (CDC) has reported that a significant driver of the recent case increases is small family gatherings. The CDC and the DOH recommend that individuals at increased risk of severe illness from COVID-19 avoid in-person gatherings with individuals with whom they do not live.

3. Instead of family visits outside of the facility, the DOH recommends visitation outdoors, or possibly indoors in facilities that meet the requirements for indoor visitation in accordance with DOH Executive Directive 20-026[1]. Increased virtual communications in lieu of visitation should be used by facilities during the holidays.

4. Facilities should enourage families that decide to bring residents to gatherings outside of the facility to follow CDC guidance for celebrating the holidays: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/holidays.html. Facilities should remind residents to follow all recommended infection prevention and control measures when gathering during the holidays, including social distancing, hand hygiene and wearing a cloth face covering or face mask.

5. Families that decide to take their family members out of their facilities should plan in advance of the event. Residents that leave their facilities for family celebrations must be quarantined upon their return to the facility in accordance with CDC guidance as follows:

    a. Require all individuals who leave the facility for holiday gatherings/visits to quarantine for 14 days upon return to the facility.

    b. If the resident lives in a private residence or room, the resident may be quarantined in their private residence or room. These residents should still be separated from others in the facility for 14 days upon their return.

    c. If the resident has a roommate, the resident should be quarantined in an observation room in the facility's new or re-admissions cohort, if one is available, for 14 days upon their return.

[1] Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37

d. If an observation room is not available, the facility should notify the family that the resident will not be permitted to return to the facility until a room is available or until the facility is otherwise able to cohort returning residents in compliance with current CDC and DOH guidance and directives, which are available here: Recommendations for Long-Term Care Facilities during COVID-19 Pandemic **UPDATED** 11/3/20
Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities **REVISED** 10/29/20
Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities **UPDATED** 10/22/20

e. ***Facilities should develop and implement a plan in preparation for the return of residents leaving the facility for holiday visits/gatherings that includes the following:***

   i. Estimate how many residents can be cohorted, dependent on the facility's available space, for a 14-day quarantine period based on current census and projected census from Nov. 25 through Dec. 31, 2020, as well as available PPE and staff.

   ii. Establish a sign-up process for residents and families to make reservations before taking a resident out of the facility. Reservations should be available up to the number of people the facility can accommodate for a 14-day quarantine period. Require the number of days requested for leave to be confirmed 36 hours before the resident leaves the facility.

   iii. Create a waiting list for those residents who request a reservation after the established limit has been reached. Residents that leave without a reservation or on a waiting list may not be guaranteed readmittance to the facility at the end of their visit outside of the facility; please plan in advance for such situations. Residents/families should be informed of this possibility.

   iv. Require 36 hours' notice of cancellation/change in plans before a resident is taken out of the facility for a family visit.

   v. Require the resident and family/friend to certify that:

      1. They are aware of the possible dangers of exposure to COVID-19 for both the resident and family/friend;

      2. They will follow masking, social distancing and hand hygiene practices pursuant to CDC and DOH directives; and

3. They will notify the facility if anyone present at the holiday gatherings tests positive for COVID-19 or exhibits symptoms of COVID-19 within 14 days of the resident's visit/stay outside the facility.

vi. The facility should obtain a signed certification from each family/friend and resident (if the resident is unable to consent, then consent needs to be signed by the authorized representative) with a copy provided to the family/friend and resident.

f. ***Prior to taking a resident out of the facility, family members should contact the facility's administration to make sure that an observation room will be available upon the return of the resident or they can make a reservation as delineated above. Facilities may require that families care for their loved ones until there is a room available to quarantine the resident. Families should work with the facility's administration to have a plan for quarantining the resident and for the resident's return.***

6. Facilities should use the CDS risk assessment tool to help inform their planning for the leave of residents from their facility's during the holiday celebrations. The guidance can be found here: https://www.nj.gov/health/cd/documents/topics/NCOV/INFCONT_exp_risk_assess_template_patients_postacute.pdf

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PHILIP D. MURPHY
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Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

IN RE: New Jersey Nursing Homes and Assisted Living Facilities	EMERGENCY CONDITIONAL CURTAILMENT OF ADMISSIONS ORDER

TO: All Administrators

Pursuant to Executive Order 103, Governor Philip D. Murphy declared that the spread of COVID-19, which is a novel coronavirus, within New Jersey constitutes an imminent public health hazard that threatens and presently endangers the health, safety, and welfare of the residents of one or more municipalities or counties of the State. As such, Governor Murphy declared the existence of a Public Health Emergency, pursuant to the Emergency Health Powers Act, N.J.S.A. 26:13-1 to -31, and a State of Emergency, pursuant to the Disaster Control Act, N.J.S.A. App.A:9-45 & App. A:9-47. These emergency declarations were thereafter continued by Executive Order No. 119.

Under the declared health emergency, the Commissioner is empowered, pursuant to N.J.S.A. 26:13-12, to "[t]ake all reasonable and necessary measures to prevent the transmission of infectious disease or exposure to toxins or chemicals and apply proper controls and treatment for infectious disease or exposure to toxins or chemicals." Pursuant to this authority, the Department of Health (Department), hereby directs all nursing homes and assisted living facilities that fail to adhere to the below directives to curtail all admissions and readmissions in accordance with this Order.

I. EMERGENCY CONDITIONAL CURTAILMENT OF ADMISSIONS ORDER

A. Pursuant to the above-referenced authority, in order to slow the spread of COVID-19 in the community and protect vulnerable populations from contracting the virus, the Commissioner of the Department of Health hereby ORDERS that any facility unable to effectively cohort its residents in accordance with the minimum requirements set forth below shall immediately curtail admissions as follows:

1. The facility shall review its outbreak response plan to determine whether it includes a cohorting plan as described below. If it does not, the facility is directed to implement such a plan, specifically allowing for:
    a. Overall separation of residents;
    b. Dedicating staff to each cohort; and
    c. Allowing for necessary space to do so at the onset of an outbreak.

2. The facility shall identify a minimum of three cohort groups:
    a. Individuals who are showing symptoms of COVID-19 or who have tested positive for COVID-19;
    b. Individuals who have been exposed to someone who has tested positive for COVID-19 or has shown symptoms of COVID-19 (i.e., individuals who are not themselves symptomatic, but may potentially be incubating the virus); and
    c. Individuals who are not ill and have not been exposed

3. The facility shall be prohibited from accepting admissions or readmissions of individuals if the facility has COVID-19 residents and does not have the ability to:
    a. Cohort as in 1. above;
    b. Follow CDC guidance for infection prevention and control; and
    c. Maintain adequate staffing.

4. The facility shall be permitted to accept admissions or readmissions of individuals if the facility has COVID-19 residents and the facility can:
    a. Cohort as in 1. above;
    b. Follow CDC guidance for infection prevention and control; and
    c. Maintain adequate staffing.

5. A facility without any COVID-19 positive residents shall be permitted to accept admissions or readmissions of individuals with or without COVID-19 if the facility has the ability to:
    a. Cohort as in 1b. above;
    b. Follow CDC guidance for infection prevention and control; and
    c. Maintain adequate staffing.
6. Admissions or readmissions for persons under investigation for COVID-19 is permitted only if they can be placed in isolation.

7. The facility shall comply with infection control measures as per the Department's guidance available at: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_LTC_Recommendations.pdf

8. The facility shall implement outbreak interventions outlined in the Department's Outbreak Management Checklist available at: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Outbreak_Management_Checklist.pdf

B. This Order is effective immediately upon your notification by email.

This emergency order shall remain in effect until the Department lifts the order. Please confer with your local health officer for further actions that may be necessary.

Failure to comply with this Emergency Order may result in the imposition of penalties and/or other applicable remedies.

Thank you for your attention to this important matter and for your anticipated cooperation. If you have any questions regarding this Emergency Curtailment of Admissions Order, please contact Lisa King in the Office of Program Compliance at (609) 376-7890. For other questions, please contact the New Jersey Coronavirus and Poison Center Hotline at (800) 222-1222. For COVID-19 updates, please continue to check the Department's website for routinely updated information at https://www.nj.gov/health/cd/topics/ncov.shtml.

Lisa King, Regulatory Officer
Office of Program Compliance
Division of Certificate of Need and Licensing

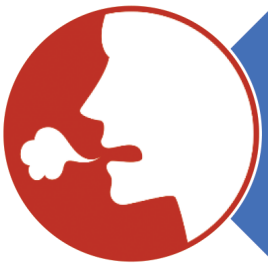
LK:jlm:dj

DATE: April 13, 2020
Control X20030
Via E-MAIL

Quick Reference: Discontinuation of Transmission-Based Precautions and Home Isolation for Persons Diagnosed with COVID-19

This guidance is provided to assist healthcare facilities, healthcare providers and local public health officials in determining when to discontinue Transmission-Based Precautions and/or home isolation for persons with confirmed COVID-19. This document is intended to serve as a general resource. For the complete guidance, refer to the COVID-19 Communicable Disease Manual Chapter (see section 7A. Isolation) at https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf.

SYMPTOM-BASED STRATEGY

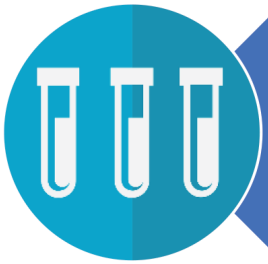


Non severely immunocompromised[1] patients with mild[2] to moderate[3] illness should remain on isolation **≥10 DAYS** have passed since symptoms first appeared (up to 20 days for severe[4] or critical[5] illness or those who are severely immunocompromised) **AND** at least 24 hours have passed since **r**esolution of fever, without use of fever-reducing medication **AND** **i**mprovement in symptoms.

TIME-BASED STRATEGY

Asymptomatic persons should remain on isolation **≥10 DAYS** have passed since the date of first positive COVID-19 viral diagnostic test (up to 20 days for those who are severely immunocompromised) **AND** have **remained asymptomatic** (if symptoms appear during this time refer to above).

TEST-BASED STRATEGY



Generally not recommended. Could be considered for persons who are **severely immunocompromised** in consultation with an infectious disease expert,if concerns exist for the patient being infectious for more than 20 days.

UPDATE: A test-based strategy for discontinuation of Transmission-Based Precautions is no longer recommended because, in most cases, it results in prolonged isolation of persons who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. In some instances, a test-based strategy could be considered if needing to discontinue Transmission-Based Precautions earlier than the time- or symptom-based strategies allow. Additionally, criteria for discontinuation of Transmission-Based Precautions are now determined by illness severity (see below). For individuals with severe or critical illness or those who are severely immunocompromised the recommended duration for isolation is at least 10 days and up to 20 days after symptom onset or date of their first positive viral diagnostic test (if asymptomatic). For more information regarding the latest evidence behind these changes visit https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html.

Decisions to extend Transmission-Based Precautions or home isolation should be made in consultation with a healthcare provider and/or public health professional and is subject to differences in disease course, symptoms, living situation, available resources and clinical management. It is important to note that it is possible that a person known to be infected with COVID-19 could discontinue isolation earlier than a person who is quarantined because of the possibility they are infected.

Resources

CDC Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

CDC Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings
https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html

Illness severity definitions

[1] The degree of immunocompromise in the individual is determined by the treating provider however some conditions such as being on chemotherapy for cancer, being within one year out from receiving hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.

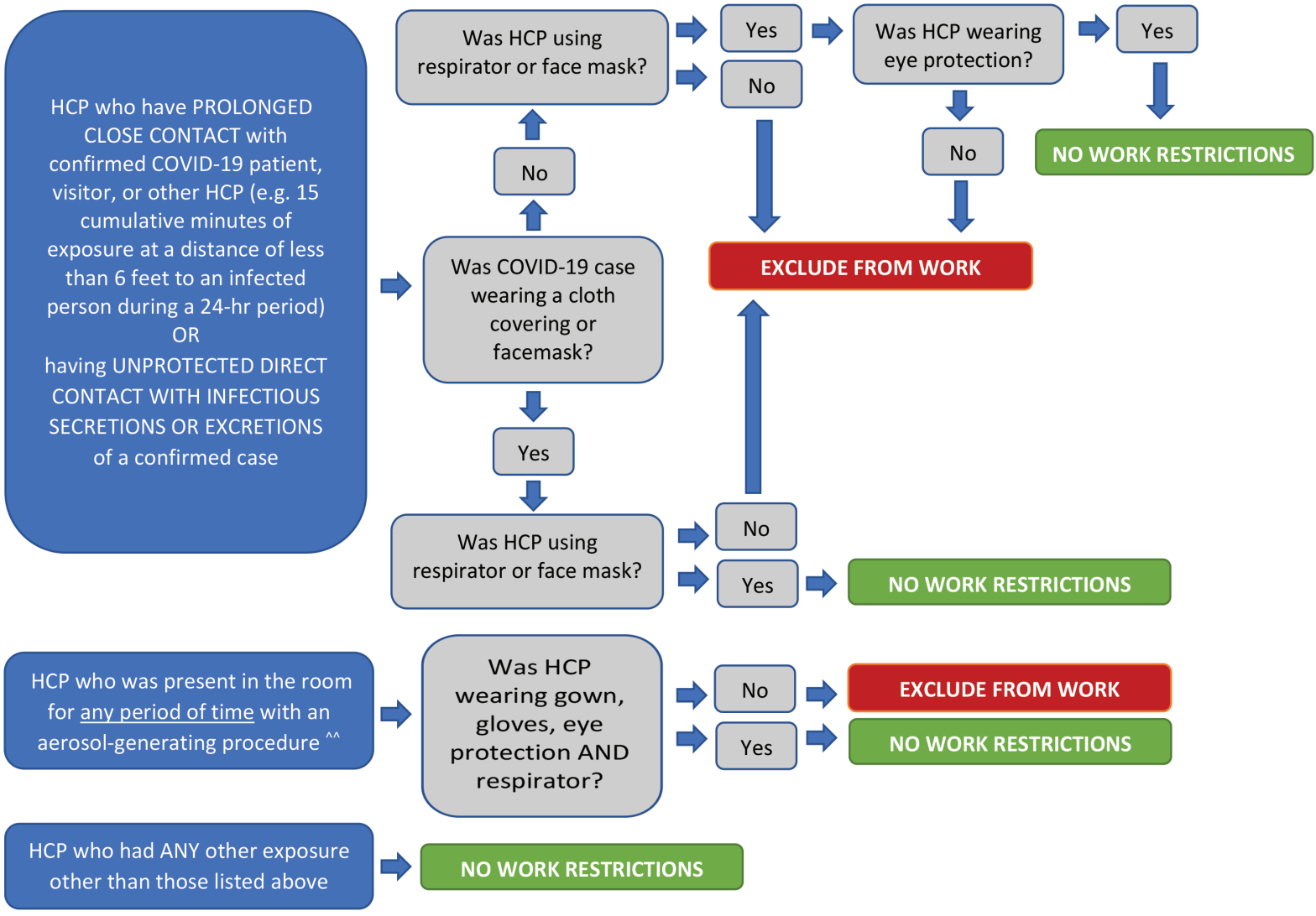
[2] Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

[3] Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

[4] Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

5Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

NJDOH Healthcare Personnel (HCP)^ EXPOSURE to Confirmed COVID-19 Case Risk Algorithm



See next page for additional recommendations.

CATEGORY*	ADDITIONAL RECOMMENDATIONS**
Exclude from work	■ Exclude from work for 14 days from most recent exposure to COVID-19. Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19. Any HCP who develop fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
No work restrictions	Follow all recommended infection prevention and control practices, including wearing a facemask for source control while at work, monitoring themselves for fever or symptoms consistent with COVID-19 and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19 at the beginning of their shift. ■ Any HCP who develop fever or symptoms consistent with COVID-19 should cease patient care activities, keep their facemask on, immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

^ For this guidance, CDC defines HCP as all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

^^ Procedures likely to generate aerosols include but are not limited to cardiopulmonary resuscitation; endotracheal intubation and extubation; bronchoscopy; sputum induction; manual ventilation; suctioning of airways; high flow oxygen delivery; and nebulizer administration. It is uncertain whether aerosols generated during high flow oxygen delivery and nebulizer administration are infectious. Until additional data are available, full Transmission Based Precautions should be used for these procedures in patients with COVID-19.

* If staffing shortages occur, it might not be possible to exclude exposed HCP from work. For additional information and considerations refer to CDC's Strategies to Mitigating HCP Staffing Shortages.

** Healthcare facilities should determine close contact(s) within the facility for all laboratory confirmed COVID-19 cases. Identification should begin at 48 hours prior to symptom onset, or specimen collection for asymptomatic cases. NJDOH considers close contact to be 15 cumulative minutes of exposure at a distance of less than 6 feet to an infected person during a 24-hour period.

NOTE: This document is meant to be a supplement to the CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. Guidance may be subject to change as new information becomes available. For more information please visit the New Jersey Department of Health COVID-19 page (https://www.nj.gov/health/cd/topics/ncov.shtml) or CDC's website for healthcare professionals (https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html).

Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel

HEALTHCARE PERSONNEL EXPOSURE RISK ASSESSMENT GUIDANCE

As resources permit, healthcare facilities should promptly resume formal healthcare personnel^ (HCP) risk assessments for exposure to COVID-19 using the updated NJDOH Risk Assessment Algorithm located at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, a conservative approach to HCP monitoring and applying work restrictions is recommended to prevent transmission from potentially contagious HCP to patients/residents, other HCP and visitors. Occupational health programs should have a low threshold for evaluating symptoms and testing HCP.

The feasibility and utility of performing contact tracing to identify exposed HCP and application of work restrictions depends upon the degree of community transmission of SARS-CoV-2 and the resources available for contact tracing. For areas with:

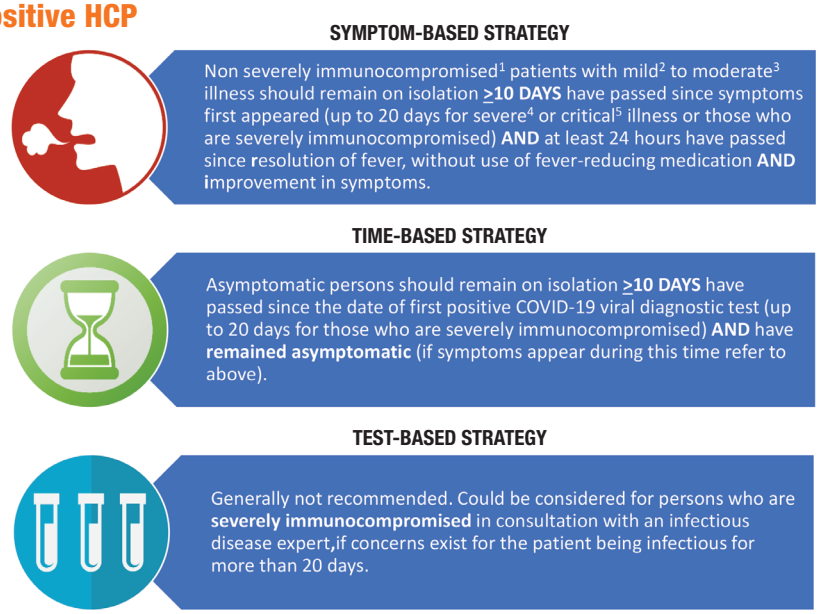
- Minimal to no community transmission of SARS-CoV-2, sufficient resources for contact tracing, and no staffing shortages, risk assessment of exposed HCP and application of work restrictions may be feasible and effective.
- Moderate to substantial community transmission of SARS-CoV-2, insufficient resources for contact tracing, or staffing shortages, risk assessment of exposed HCP and application of work restrictions may not be possible.

If staffing shortages occur, it might not be possible to exclude exposed HCP from work. Healthcare facilities should include their occupational health program, if applicable, in the assessment and management of risk. **Refer to the Strategies to mitigate HCP staffing shortages section**, below.

HCP TESTING RESULTS GUIDANCE (molecular detection and rapid antigen testing only, not serology)

UPDATE: A test-based strategy is no longer recommended for discontinuation of isolation because, in most cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are most likely no longer infectious. In some instances, a test-based strategy could be considered if needing to discontinue Transmission-Based Precautions earlier than the time- or symptom-based strategies allow. For more information regarding the evidence behind this change and test-based strategy criteria, visit https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html.

1. COVID-19 Positive HCP



The highest level of illness severity (see below) experienced by the HCP at any point in their clinical course should be used when determining mild, moderate, severe or critical illness and subsequent decisions on when they may return to work. For HCP with severe or critical illness or those who are severely immunocompromised the recommended duration for work exclusion is at least 10 days and up to 20 days after symptom onset or date of their first positive viral diagnostic test (if asymptomatic). Upon meeting the return to work criteria, all HCP who have tested positive or diagnosed with COVID-19 should adhere to the following guidance:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19. Of note, N95 or other respirators with an exhaust valve might not provide source control.
- After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
- Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms of COVID-19 (re)occur or worsen.

2. COVID-19 Negative HCP

a. Asymptomatic HCP tested negative: No restrictions based on COVID-19 test results. HCP should continue to report recognized exposures, regularly monitor themselves for fever and symptoms of COVID-19, practice source control and should not report to work when ill.

b. Symptomatic HCP tested negative: Symptomatic HCP who test negative for COVID-19 may have another respiratory virus. Similar guidance on infection prevention and control should be followed (e.g., isolate from others, practice good hand hygiene, clean and disinfect environmental surfaces, etc.). If HCP have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. At minimum HCP should be excluded from work for at least 24 hours after symptoms resolve including fever, if applicable. Consult your facilities occupational health policy for return to work after illness criteria.

Note: These are current recommendations based on available data and CDC guidelines. Facilities who wish to use an extended time frame for return to work, given the needs of their unique patient populations and available resources, may do so at their discretion.

3. Contact tracing

Healthcare facilities should have a process for notifying the health department about known or suspected cases of COVID-19, and should establish a plan, in consultation with local public health authorities, for how exposures in a healthcare facility will be investigated and how contact tracing will be performed. The plan should address the following:

- Who is responsible for identifying contacts and notifying potentially exposed individuals?
- How will such notifications occur?
- What actions and follow-up are recommended for those who were exposed?

Contact tracing should be carried out in a way that protects the confidentiality of affected individuals to the extent possible and is consistent with applicable laws and regulations. **HCP and patients who are currently admitted to the facility or were transferred to another healthcare facility should be prioritized for notification.** These groups, if infected, have the potential to expose a large number of individuals at higher risk for severe disease, or in the situation of admitted patients, be at higher risk for severe illness themselves. Long-term care facilities (LTCFs) should refer to the NJDOH Testing in Response to a Newly Identified COVID-19 Case in LTCFs at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml.

When HCP are positive for COVID-19, facilities should do their due diligence and work with their local health department to identify and notify close contacts. HCP who had prolonged close contact (15 cumulative minutes of exposure at a distance of less than 6 feet to an infected person during a 24-hr period) or had direct contact with infectious secretions with inadequate PPE should be considered potentially exposed. **Prolonged close contact should be determined by taking the cumulative contact the potentially exposed individual had with the infected case over any 24 hour period within the period from 2 days before symptom onset (or positive test collection date in an asymptomatic infected individual) until the positive case has been effectively isolated.**

Contact tracing is generally recommended for anyone (e.g., HCP, patient, visitor) who had prolonged close contact with the COVID-19 case. **The following actions are also recommended if the potentially infectious individual is a patient or visitor. Recommended actions for HCP, patients, and visitors:**

- Perform a risk assessment and apply work restrictions for other HCP who were exposed to the infected provider based on whether these HCP had prolonged, close contact and what PPE they were wearing. Refer to the NJDOH HCP Exposure to Confirmed COVID-19 Case Risk Algorithm located at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml.
- Patients who are identified as a close contact of a positive HCP should be assessed and quarantined using CDC Public Health Guidance for Community-Related Exposures at https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html. Place exposed patients who are currently admitted to the healthcare facility in appropriate Transmission-Based Precautions and monitor them for onset of COVID-19 until 14 days after their last exposure.
- Local health departments should work with the healthcare facility to identify and perform contact tracing of exposed patients who are not currently admitted to the healthcare facility and for visitors.

For additional resources, tips and guidance for contact tracing see https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/overview.html.

4. Strategies to mitigate HCP staffing shortages

Facilities experiencing severe staffing shortages due to work exclusions related to COVID-19, may consider alternative strategies to mitigate those shortages. The CDC provides guidance for contingency and crisis capacity strategies at https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html. Facilities considering implementing these strategies should consult CDC guidance and public health authorities to assure appropriate implementation. Additional considerations include:

- Maintain staffing internally (e.g., extra shifts, extra pay, contact staffing agencies).
- Review and implement applicable executive directives, waivers and guidance available on the *COVID-19 Temporary Operational Waivers and Guidelines* page at https://www.nj.gov/health/legal/covid19/.
- Partner with other facilities within the area or corporation.
- Review existing pandemic influenza and disaster preparedness plans for resource allocation references.
- Utilize the Medical Reserve Corps (contact the local health department and Office of Emergency Management in your jurisdiction).

Resources

CDC Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

^ HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Illness severity definitions

[1] The degree of immunocompromise in the HCP is ultimately determined by the treating provider however some conditions such as being on chemotherapy for cancer, being within one year out from receiving hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and require actions such as lengthening the duration of HCP work restrictions. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect occupational health actions to prevent disease transmission.

[2] Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

[3] Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

[4] Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

[5] Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

OSHA's Rule Relaxation for Fit Testing and Use of Expired Respirators

FREQUENTLY ASKED QUESTIONS

Q: Are expired N95 masks that are not part of the SNS stockpile suitable for use?

A: Some U.S. stockpiles include N95 filtering facepiece respirators (N95s) that have exceeded their manufacturer-designated shelf life. U.S. Government decision makers are considering whether these products should be released for use during the COVID-19 response. Information is provided below that may be used to inform these product release decisions. In times of respiratory protective device shortage, such as during the COVID-19 response, supplies must be managed so that protection against exposure is adequate. For more information please visit: https://www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.html

CDC recommends that N95s that have exceeded their manufacturer-designated shelf life should be used only as outlined in the Strategies for Optimizing the Supply of N95 Respirators.

Q: Where can I find more information about use of expired respirators when supplies are low?

A: More information can be found in this link:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/crisis-alternate-strategies.html.

Per CDC guidance, use of additional N95 respirators beyond the manufacturer-designated shelf life for care of patients with COVID-19, tuberculosis, measles, and varicella can be considered. However, respirators beyond the manufacturer-designated shelf life may not perform to the requirements for which they were certified. Over time, components such as the straps and nose bridge material may degrade, which can affect the quality of the fit and seal. Some models have been found NOT to perform in accordance with NIOSH performances standards, and consideration may be given to use these respirators as identified in Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response. In addition, consideration can be given to use N95 respirators beyond the manufacturer-designated shelf life that have not been evaluated by NIOSH. It is optimal to use these respirators in the context of a respiratory protection program that includes medical evaluation, training, and fit testing. It is particularly important that HCP perform the expected seal check, prior to entering a patient care area.

Q: What should be checked to make sure they are still good?

A: More information can be found in this link below:
https://www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.html

Per CDC guidance, users should take the following precautionary measures prior to using the respirator in the workplace:

- Visually inspect the N95 to determine if its integrity has been compromised.
- Check that components such as the straps, nose bridge, and nose foam material did not degrade, which can affect the quality of the fit, and seal and therefore the effectiveness of the respirator.
- If the integrity of any part of the respirator is compromised, or if a successful user seal check cannot be performed, discard the respirator and try another respirator.
- Users should perform a **user seal check** immediately after they don each respirator and should not use a respirator on which they cannot perform a successful user seal check.

Accordingly, CDC/NIOSH believes the following products, despite being past their manufacturer-designated shelf life, should provide the expected level of protection to the user if the stockpile conditions have generally been in accordance with the manufacturer-recommended storage conditions and an OSHA-compliant respiratory protection program is used by employers. In alphabetical order, these models are:

- 3M 1860
- 3M 1870
- 3M 8210
- 3M 9010
- 3M 8000
- Gerson 1730
- Medline/Alpha Protech NON27501
- Moldex 1512
- Moldex 2201

Q: What measures are being taken by OSHA regarding fit testing requirements during the COVID-19 response?

A: On March 14th, the Occupational Safety and Health Administration (OSHA) released Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak. The guidance can be found here: https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit.

A fit test is required for anyone wearing a respirator to protect against COVID-19. Annual fit test can be temporarily suspended if the employee has already been fit tested to that respirator.

In summary:

- Perform initial fit tests for each HCP with the same model, style, and size respirator that the worker will be required to wear for protection against COVID-19 (initial fit testing is essential to determine if the respirator properly fits the worker and is capable of providing the expected level of protection);
- Inform workers that the employer is temporarily suspending the annual fit testing of N95 filtering facepiece respirators to preserve and prioritize the supply of respirators for use in situations where they are required to be worn.

RESPIRATORY PROTECTION GUIDANCE for the Employers of Those Working in Nursing Homes, Assisted Living, and Other Long-Term Care Facilities During the COVID-19 Pandemic

OSHA® Occupational Safety and Health Administration

OSHA is committed to protecting the health and safety

of America's workers. This guidance is designed specifically for nursing homes, assisted living, and other long-term care facilities (LTCFs) (e.g., skilled nursing facilities, inpatient hospice, convalescent homes, and group homes with nursing care). LTCFs are different than other healthcare settings because they assist residents and clients with tasks of daily living in addition to providing skilled nursing care.

While this guidance focuses on protecting workers from occupational exposure to SARS-CoV-2 (the virus that causes COVID-19 disease) by the use of respirators, primary reliance on engineering and administrative controls for controlling exposure is consistent with good industrial hygiene practice and with OSHA's traditional adherence to a "hierarchy of controls."[1] Under this hierarchy, engineering and administrative controls are preferred to personal protective equipment (PPE). Therefore, employers should always reassess their engineering controls (e.g., ventilation) and administrative controls (e.g., hand hygiene, physical distancing, cleaning/disinfection of surfaces) to identify any changes they can make to avoid over-reliance on respirators and other PPE (see CDC's COVID-19 webpage on *Nursing Homes and Long-Term Care Facilities*). This is especially vital considering the current supply chain demand for N95 filtering facepiece respirators (FFRs). Additional control strategies for preventing exposure to SARS-CoV-2 in LTCFs can be found in OSHA's *COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers* and CDC's *Nursing Homes and Long-Term Care Facilities*.

Even when control strategies are in place, PPE, including respirators, will be needed for workers when close contact with someone who is known or suspected of having COVID-19 cannot be avoided. **Whenever respirators are required, employers must implement a written, worksite-specific respiratory protection program (RPP), including medical evaluation, fit testing,[2] training, and other elements, as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134).** OSHA requirements for other PPE (e.g., eye protection, protective clothing) can be found in OSHA's General PPE standard (29 CFR 1910.132) and Eye and Face Protection standard (29 CFR 1910.133).

[1] More information about the hierarchy of controls can be found at: https://www.osha.gov/shpguidelines/hazard-prevention.html.

[2] Note: In its March 14, 2020, memo (https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit), OSHA has articulated a temporary policy under which OSHA will exercise enforcement discretion with respect to the annual fit testing requirements in paragraph (f)(2) of 29 CFR § 1910.134 for FFRs used in healthcare, as long as the employer conducts initial fit tests for each healthcare professional with the same model, style, and size respirator that the worker will be required to wear for protection against SARS-CoV-2. Initial fit testing is essential to determine if the respirator properly fits the worker and is capable of providing the expected level of protection.

Face Coverings, Facemasks Authorized for Use as Source Control by the FDA, FDA-cleared or Authorized Surgical Masks, and Respirators

There are multiple products/devices that can be used during the COVID-19 pandemic to cover a wearer's mouth and nose, and it is important to select the right one for the situation. These products/devices can provide source control, and some of them are also considered PPE that will protect the wearer as well. Source control refers to the use of a product/device to cover a person's mouth and nose to reduce the spread of respiratory secretions and aerosols when that person is breathing, talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are currently recommended for everyone in healthcare facilities, including in LTCFs, even if they do not have symptoms of COVID-19. Healthcare providers should wear source control products/devices at all times while they are in a LTCF, including in breakrooms or other spaces where they might encounter other people, including co-workers. The source control product/device should be appropriate for the anticipated exposure(s). These products/devices include:

- **Cloth Face Coverings:** These are homemade or commercially available products made of cloth that cover the nose and mouth. Cloth face coverings should NOT be worn instead of an FDA-cleared or authorized surgical mask if protection against exposure to splashes and sprays of infectious material from others is needed. Cloth face coverings do not provide effective respiratory protection for workers when protection against airborne hazards is needed, and do not fall under OSHA's Respiratory Protection standard. They are not considered PPE for the wearer, but can assist in source control. LTCF patients and visitors should wear their own cloth face covering upon arrival at and throughout their stay in a LTCF for source control.3 If they do not have a cloth face covering, they should be offered a facemask, surgical mask, or cloth face covering by the LTCF, as supplies allow.
- **Facemasks:** These products look similar to, and are often mistaken for, surgical masks, but do not provide fluid resistance. They do not provide effective respiratory protection for workers when protection against airborne hazards is needed, and do not fall under OSHA's Respiratory Protection standard. They are not considered PPE for the wearer, but can assist in source control. The FDA has authorized the emergency use of facemasks, including cloth face coverings, that meet certain criteria for use as source control by the general public and healthcare personnel in accordance with CDC recommendations during the COVID-19 public health emergency. An example of this type of product would be a KN95 respirator with ear loops instead of head straps and that has not undergone rigorous fit testing to demonstrate a proper fit/effective seal to the wearer's face.
- **FDA-cleared or authorized surgical masks:** Surgical masks are cleared, or are authorized for emergency use, by the FDA and are jointly regulated by OSHA under the PPE standard (29 CFR 1910.132) and the Bloodborne Pathogens standard (29 CFR 1910.1030). When available, FDA-cleared or authorized surgical masks are preferred over cloth face coverings for healthcare workers, as they offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. They are loose-fitting devices that do not provide effective respiratory protection for workers when the wearer might be exposed to airborne hazards, and do not fall under OSHA's Respiratory Protection standard.

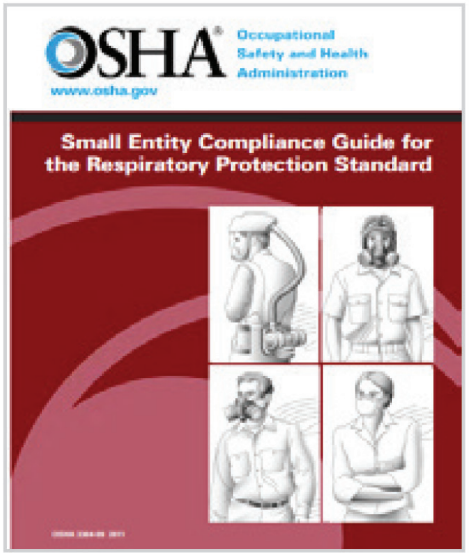
N95 respirators and surgical masks

- **Respirators (including FDA-cleared or authorized surgical N95 FFRs):** Healthcare providers who are in close contact with an LTCF resident with suspected or confirmed SARS-CoV-2 infection must use a NIOSH-approved N95 FFR or equivalent or higher-level respirator (29 CFR 1910.134). When protection against exposure to splashes and sprays of infectious material from others is also needed, an FDA-cleared or authorized surgical N95 FFR must be worn by healthcare workers (29 CFR 1910.134 and 29 CFR 1910.1030). Surgical N95 respirators provide the same level of respiratory protection as a N95 respirator; however, a surgical N95 respirator meets the FDA requirements for fluid penetration, flammability, and biocompatibility (see 21 CFR 878.4040(b)(1)). OSHA regulates respirators under the Respiratory Protection standard (29 CFR 1910.134). In order for a respirator to provide the expected level of protection, it must be used in the context of a respiratory protection program (29 CFR 1910.134).

For additional information see CDC's *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic*.

[3] CDC's most up-to-date recommendations for the general public (vs. healthcare workers) on how to select, wear, and clean a face covering can be found at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html).

Respiratory Protection Program (RPP)



Employers can refer to OSHA's *Small Entity Compliance Guide for the Respiratory Protection Standard* for a better understanding of OSHA's Respiratory Protection standard. The guide includes step-by-step instructions for compliance with the standard, checklists, and commonly-asked questions, as well as a sample written RPP. The key elements of an RPP that employers must implement when any of their staff are required to wear respirators include the following:

- Assign a suitably trained program administrator to oversee all elements of the RPP. This can be an infection prevention and control practitioner or a nurse administrator. If there are no staff members suitably trained to be the program administrator, consider hiring a local industrial hygiene consulting service to help establish a RPP or contact OSHA's *On-Site Consultation Program*.[4]
- Implement and maintain a written RPP that details worksite-specific procedures and elements for required respirator use (e.g., medical evaluation, fit testing, training, maintenance, etc.). Certain program elements may also be required by OSHA for voluntary respirator use in order to prevent potential hazards associated with the use of a respirator.
- Conduct a risk assessment to identify which workers are at risk of exposure to any airborne hazards (e.g., SARS-CoV-2, tuberculosis [TB], Legionella, certain hazardous chemicals). Such workers could include: any staff (whether clinical or not) in close contact (less than 6 feet) with residents with confirmed or suspected COVID-19 (e.g., during bathing, dressing, toileting, and direct clinical care); clinical staff performing aerosol-generating procedures[5] (e.g., respiratory therapy, open suctioning of airways, BiPaP and CPAP); cleaning staff; maintenance staff; and visiting practitioners (e.g., physicians or physical therapists who do not normally work at that facility). Note: For classifying exposure risk to SARS-CoV-2, OSHA has divided job tasks into four risk exposure levels, as depicted in the occupational risk pyramid for COVID-19.
- Implement procedures for selecting the appropriate type of respirator(s) for the hazard, whether it be an infectious agent (e.g., SARS-CoV-2) and/or a hazardous chemical. The program administrator is responsible for identifying which type(s) of respirator is suitable based on the hazard(s), workplace factors, and user factors. OSHA's *Small Entity Compliance Guide for the Respiratory Protection Standard* can be a useful tool for assisting in general respirator selection.
- Select from NIOSH-approved respirators and be cautious of counterfeit respirators, which often come to the commercial market during pandemics. Employers can access *NIOSH's NIOSH-Approved N95 Particulate Filtering Facepiece Respirators and Counterfeit Respirators / Misrepresentation of NIOSH-Approval* to determine if the respirator model they are considering is NIOSH-approved.
- During times like the present pandemic, when there are increased demands on the supply chain for N95 FFRs, consider alternatives to N95 FFRs, including other FFRs (e.g., P100s, N99s), reusable elastomeric (rubber) respirators, and powered air purifying respirators (PAPRs). While the initial investment for elastomeric respirators and PAPRs may be greater than for N95 FFRs, purchasing these types of respirators can often lead to cost savings over the long-term since they are reusable and can also help reduce the impact of supply chain disruptions. In addition, loose-fitting PAPRs do not require fit testing, which can lead to further cost and time savings for employers. For additional information on the advantages and limitations of using elastomeric respirators and PAPRs during COVID-19, refer to CDC's *Elastomeric Respirators: Strategies During Conventional and Surge Demand Situations* and CDC's *Considerations for Optimizing the Supply of Powered Air-Purifying Respirators (PAPRs)*.

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[4] OSHA's On-Site Consultation Program offers no-cost and confidential occupational safety and health services to small- and medium-sized businesses in all 50 states, the District of Columbia, and several U.S. territories, with priority given to high-hazard worksites. On-Site Consultation services are separate from enforcement and do not result in penalties or citations. Consultants from state agencies or universities work with employers to identify workplace hazards, provide advice for compliance with OSHA standards, and assist in establishing and improving safety and health programs.

[5] See "*Which Procedures Are Considered Aerosol Generating Procedures in Healthcare Settings?*" at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html

- Choose eye and face protection that can be worn safely together with the type of respirator being used, meaning that care must be taken to ensure that the eye or face protection will not interfere with the seal of the respirator.
- Implement procedures for performing medical evaluations of workers required to use respirators to determine their ability to safely wear a respirator prior to needing to wear one in the workplace. Identify a physician or other licensed healthcare professional to conduct the medical evaluations and maintain confidentiality.
- Ensure that any worker using a tight-fitting respirator (e.g., N95 FFR) is fit-tested prior to initial use of the respirator, whenever a different respirator size, style, model or make is used, and at least annually thereafter. Passing a fit-test is important because it ensures that the size, make, and model of the respirator can provide a proper facial seal to offer the expected level of protection to the wearer.
- Ensure that only OSHA-approved fit test protocols (which can be found in 29 CFR 1910.134, Appendix A) are used for fit testing.[2] If you are having difficulty obtaining commercially available fit-testing solutions required for some qualitative fit tests due to limited commercial supplies, refer to OSHA's/NIOSH's guidance for Preparing Solutions for Qualitative Fit Testing from Available Chemicals, or consider switching to a quantitative fit test protocol or contracting with a reputable occupational health clinic that provides fit-testing services.

- Establish procedures and schedules for the maintenance and storage of any respirators used for more than a single use (e.g., procedures for cleaning, disinfecting, storing, repairing, discarding). Note that while N95 FFRs are meant to be discarded after each use, CDC has developed contingency and crisis strategies, including reuse and decontamination of N95 FFRs, to help healthcare facilities conserve their supplies in the face of shortages. For additional information, refer to CDC's *Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators and CDC's Elastomeric Respirators: Strategies During Conventional and Surge Demand Situations*.
- Provide effective training to workers required to wear respirators. Training must be conducted in a manner that is understandable to workers, meaning that your training program should be tailored to the education level and language background of your workers.
- Train workers who wear respirators on: how to properly put them on and take them off; how to conduct proper user seal checks; how to recognize respiratory hazards in their workplace; the limitations and capabilities of respirators; and how to recognize the medical signs and symptoms that may prevent or limit effective respirator use. Ensure that they can demonstrate the knowledge to safely and correctly use their respirators.
- Conduct periodic evaluations of the workplace to ensure that your written RPP is being properly implemented and is up-to-date, and to ensure that workers are using their respirators properly. Solicit input from workers (and union representatives, if applicable) to provide feedback on the program.

Temporary Enforcement Discretion Related to the Respiratory Protection Standard During COVID-19

- In light of the essential need for adequate supplies of respirators during the COVID-19 pandemic, OSHA has temporarily allowed for some enforcement flexibility regarding respirators - including certain fit testing provisions,2 the use of respirators that are beyond their manufacturer's recommended shelf life, extended use and reuse of respirators, the use of alternative respirators certified under standards of certain other countries and jurisdictions, and decontamination of respirators - as is described in detail in various temporary enforcement memoranda, which can be found on *OSHA's COVID-19 webpage*. **In order for OSHA to exercise enforcement discretion, employers must demonstrate and document good-faith**

efforts to comply with OSHA standards, as outlined in the same memoranda and summarized in *Understanding Compliance with OSHA's Respiratory Standard During the Coronavirus Disease (COVID-19) Pandemic*. OSHA's temporary enforcement memoranda are time-limited to the current COVID-19 crisis and are aligned with CDC's *Strategies for Optimizing the Supply of N95 Respirators*, which recommend a variety of conventional, contingency, and crisis capacity control strategies. Enforcement discretion applies only after an employer has considered and taken all possible steps to comply with measures in a particular control strategy. LTCF employers should periodically refer to *OSHA's COVID- 19 webpage* for the most up-to-date interim/temporary enforcement discretion memoranda and guidance.

Resources

OSHA's Guidance on Preparing Workplaces for COVID-19
https://www.osha.gov/Publications/OSHA3990.pdf

OSHA's Respiratory Protection Training Videos
https://www.osha.gov/respiratory-protection/training

NIOSH's Healthcare Respiratory Protection Resources
https://www.cdc.gov/niosh/npptl/hospresptoolkit/default.html

NIOSH's & OSHA's Hospital Respiratory Protection Program Toolkit
https://www.cdc.gov/niosh/docs/2015-117/default.html

OSHA's Inspection Procedures for the Respiratory Protection Standard
https://www.osha.gov/sites/default/files/enforcement/directives/CPL_02-00-158.pdf

FDA's Decontamination Systems for Personal Protective Equipment EUAs
https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/decontamination-systems-personal-protective-equipment-euas

The Joint Commission's Implementing Hospital Respiratory Protection Programs: Strategies from the Field
https://www.jointcommission.org/resources/patient-safety-topics/infection-prevention-and-control/respiratory-protection/

NIOSH's Respirator Trusted-Source Information
https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3surgicaln95.html

NIOSH's National Personal Protective Technology Laboratory
https://www.cdc.gov/niosh/npptl/default.html

NIOSH's Education and Research Centers
https://www.cdc.gov/niosh/oep/ercportfolio.html

National Institute for Environmental Health Sciences' Worker Training Program
https://www.niehs.nih.gov/careers/hazmat/awardees/index.cfm

Professional industrial hygiene and occupational health associations (e.g., AIHA)

Certified industrial hygienists/health and safety consultants

Local or state Departments of Health/Public Health

Respirator manufacturers

This document does not have the force and effect of law and is not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

DOL-OSHA-OOC-2020-103

Infection Prevention & Control Resources for COVID-19 Competency-Based Training

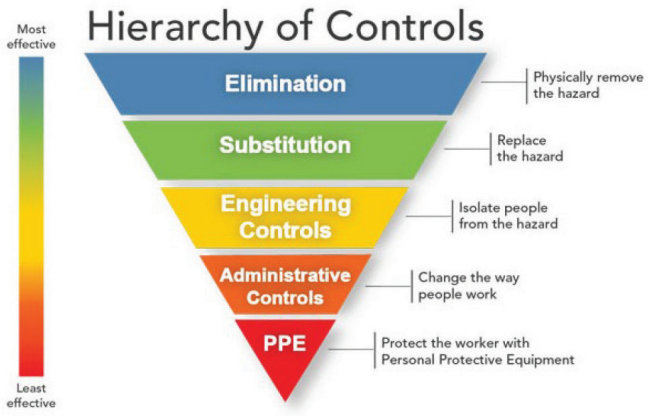
The following resources have been compiled to assist in the rapid control of the global COVID-19 pandemic. Please review these resources with key staff members and volunteers. As a reminder, existing infection prevention and control (IPC) programs should include evidence-based policies and procedures which are reviewed and updated regularly. The Centers for Disease Control and Prevention (CDC) developed definitions to assist with the implementation of competency-based training, auditing, and feedback elements for IPC programs at https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html. In addition to the CDC Training for Healthcare Professionals website (https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html) consider the follow resources:

HAND HYGIENE	
CDC	
Hand Hygiene in Healthcare Settings – Education Courses	https://www.cdc.gov/handhygiene/providers/training/index.html
New Jersey Department of Health (NJDOH)	
Caught Red Handed	https://www.nj.gov/health/cd/documents/topics/hai/caught_red_handed_hai.pdf
World Health Organization	
Your 5 Moments for Hand Hygiene	https://www.who.int/gpsc/5may/Your_5_Moments_For_Hand_Hygiene_Poster.pdf?ua=1
TRANSMISSION BASED PRECAUTIONS & PERSONAL PROTECTIVE EQUIPMENT (PPE)	
Association for Professionals in Infection Control & Epidemiology (APIC)	
PPE Do's and Don'ts	http://professionals.site.apic.org/infographic/ppe-dos-and-donts/
CDC	
Using PPE	https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
States Targeting Reduction in Infections via Engagement (STRIVE) – PPE	https://www.cdc.gov/infectioncontrol/training/strive.html#anchor_1565264877
Emory University School of Medicine	
COVID-19: Conserving PPE (videos)	https://med.emory.edu/departments/medicine/divisions/infectious-diseases/serious-communicable-diseases-program/covid-19-resources/conserving-ppe.html

National Ebola Training and Education Center	
PPE for COVID-19 (video)	https://www.youtube.com/channel/UCDpHc1LkcEpiWR0q7Il5eZQ
COVID PPE Guidance	https://repository.netecweb.org/exhibits/show/ncov/item/697
Occupational Safety and Health Administration (OSHA)	
Respiratory Protection Training Videos	https://www.osha.gov/SLTC/respiratoryprotection/training_videos.html
ENVIRONMENTAL CLEANING	
CDC & APIC	
STRIVE Program – Environmental Services	https://apic.org/resources/topic-specific-infection-prevention/environmental-services/
Nebraska Medicine – Infection Control Assessment & Promotion Program	
Environmental Cleaning in Healthcare Training Video Series	https://icap.nebraskamed.com/practice-tools/educational-and-training-videos/draft-environmental-cleaning-in-healthcare/

EXTENDED USE OF PPE

Surge capacity refers to the ability to maintain a sudden, unexpected increase in demand that would otherwise severely challenge or exceed the present capacity of a facility. Three general strata have been used to describe surge capacity: conventional; contingency; and crisis; these should be used to prioritize measures to conserve PPE supplies during the COVID-19 pandemic. CDC recommends that all U.S. healthcare facilities begin using PPE contingency strategies now1. Personal protection must be a multifaceted approach addressing the National Institute for Occupational Safety and Health (NIOSH) hierarchy of control measures2. Additional engineering and administrative control measures must be implemented before introducing contingency or crises protocols for the extended use of PPE.



Resources

[1]CDC, Strategies to Optimize the Supply of PPE and Equipment
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Centers for Medicare and Medicaid Services, Policy & Memos to States and Regions
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions

[2]NIOSH, Hierarchy of Controls
https://www.cdc.gov/niosh/topics/hierarchy/default.html

New Jersey Hospital Association, N95 Respirator Resource Guide V1
http://www.njha.com/media/597544/NJHA-COVID-19-N95-Respirator-Resource-Guide-V1.pdf

NJDOH, COVID-19: Information for Healthcare Professionals
https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml

NJDOH, Healthcare Associated Infections, ICAR Resources
https://www.nj.gov/health/cd/topics/hai.shtml

OSHA, COVID-19
https://www.osha.gov/SLTC/covid-19/standards.html

U.S. Environmental Protection Agency, Coronavirus (COVID-19)
https://www.epa.gov/coronavirus

U.S. Food and Drug Administration, Coronavirus Disease 2019 (COVID-19)
https://www.fda.gov/emergency-preparedness-and-response/counter-terrorism-and-emerging-threats/coronavirus-disease-2019-covid-19

- Letters to Health Care Providers 2020
https://www.fda.gov/medical-devices/medical-device-safety/letters-health-care-providers

Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

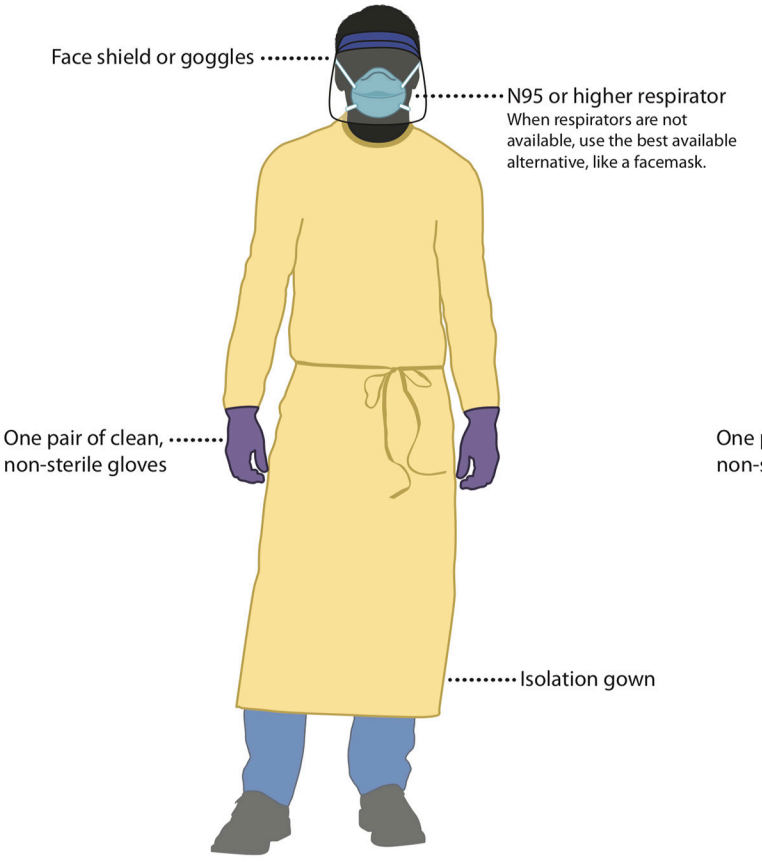
BEFORE CARING FOR PATIENTS WITH CONFIRMED OR SUSPECTED COVID-19, HEALTHCARE PERSONNEL (HCP) MUST:

- **Receive comprehensive training** on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- **Demonstrate competency** in performing appropriate infection control practices and procedures.

Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator



Acceptable Alternative PPE – Use Facemask

Donning (putting on the gear):

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. **Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
   - **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
   - **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. **Put on face shield or goggles.** When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **HCP may now enter patient room.**

Doffing (taking off the gear):

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
3. **HCP may now exit patient room.**
4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).*** Do not touch the front of the respirator or facemask.
   - **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
   - **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
7. **Perform hand hygiene after removing the respirator/facemask** and before putting it on again if your workplace is practicing reuse.

* Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices.

CLEAN HANDS COUNT

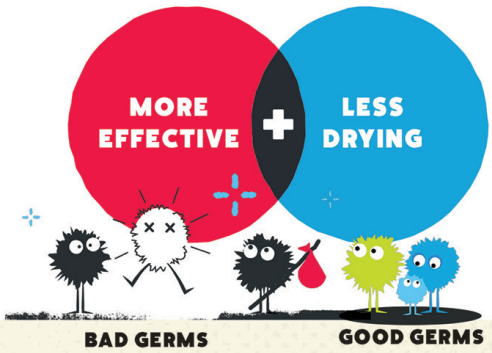
FOR HEALTHCARE PROVIDERS

KNOW THE TRUTH TO PROTECT YOURSELF AND PROTECT YOUR PATIENTS

TRUTH:

Alcohol-based hand sanitizer is more effective and less drying than using soap and water.

THE NITTY GRITTY:
Compared to soap and water, alcohol-based hand sanitizers are better at reducing bacterial counts on hands and are effective against multidrug-resistant organisms (e.g., MRSA). Additionally, alcohol-based hand sanitizers cause less skin irritation than frequent use of soap and water.



TRUTH:

Using alcohol-based hand sanitizer does NOT cause antibiotic resistance.

THE NITTY GRITTY:
Alcohol-based hand sanitizers kill germs quickly and in a different way than antibiotics. There is no chance for the germs to adapt or develop resistance.

TRUTH:

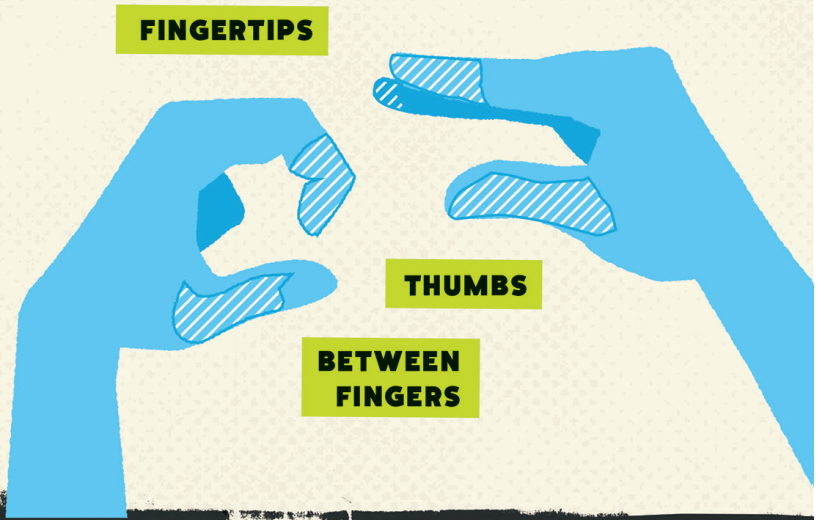
Alcohol-based hand sanitizer does not kill *C. difficile*, but it is still the overall recommended method for hand hygiene practice.

THE NITTY GRITTY:
Always use gloves when caring for patients with *C. difficile*. In addition, when there is an outbreak of *C. difficile* in your facility, wash your hands with soap and water after removing your gloves.

TRUTH:

Some healthcare providers miss certain areas when cleaning their hands.

THE NITTY GRITTY:
Using alcohol-based hand sanitizer becomes a habit and sometimes healthcare providers miss certain areas:



Clean Hands Count 100% of the Time

PROTECT YOURSELF AND PROTECT YOUR PATIENTS FROM POTENTIALLY DEADLY GERMS

TRUTH:

The amount of product you use matters.

THE NITTY GRITTY :
Use enough alcohol-based hand sanitizer to cover all surfaces of your hands. Rub your hands together until they are dry. Your hands should stay wet for around 20 seconds if you used the right amount.

TRUTH:

Glove use is not a substitute for cleaning your hands. Dirty gloves can soil your hands.

THE NITTY GRITTY :
Clean your hands after removing gloves to protect yourself and your patients from infection.

TRUTH:

On average, healthcare providers perform hand hygiene less than half of the times they should.

THE NITTY GRITTY :
When healthcare providers do not perform hand hygiene 100% of the times they should, they put themselves and their patients at risk for serious infections.

CLEAN HANDS COUNT

www.cdc.gov/HandHygiene

This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and GOJO.

New Jersey Hospital Association LTC PPE Data Collection Portal Overview

LTC - Case Count		
# of Vacant Bed	# of Vacant Bed	The number of beds that are not currently occupied by patients/residents
# of New Admissions (in the past 24 hours)	# of New Admissions (in the past 24 hours)	The number of new patients/residents admitted in the past 24 hours
Total census	Total census	**Total number of patients/residents today**
Taking New Admissions	Taking New Admissions	YES if accepting new patients/residents; NO if not
COVID-19 Positive Patients	COVID-19 Positive Patients	The number of current patients/residents with confirmed case of COVID-19
COVID-19 Suspected Patients	COVID-19 Suspected Patients	The number of current patients/residents with a presumptive positive case of COVID-19
# COVID+/ PUI who were COVID+/PUI before admission	# COVID+/ PUI who were COVID+/PUI before admission	**# of cases today**
Total # COVID+/PUI patients who have expired	Total # COVID+/PUI patients who have expired	**Cumulative deaths as of this date**
Of the total deaths, # who were COVID+/PUI before admission	# who were COVID+/PUI before admission among the total deaths	**Cumulative deaths for this subset of patients as of this date**
Total # patients recovered from COVID-19	Total # patients recovered from COVID-19	**Cumulative # of recovered patients who meet the CDC criteria** – a non-test-based strategy: At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); and, at least 7 days have passed ***since symptoms first appeared.*** CDC & NJDOH d/c isolation guidance was updated and the period was extended from 7 days to 10 days. The NJODH Quick Reference: Discontinuation of Transmission-Based Precautions and Home Isolation for Persons Diagnosed with COVID-19 is available at https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-QuickRef_Discont_Isolation_and_TBP.pdf
# staff COVID+	# staff COVID+	**Staff cases as of today**
COVID-19 Suspected Patients	COVID-19 Suspected Patients	**Staff PUI as of today**

LTC - Case Count (cont'd)		
# staff COVID+/PUI who have expired	# staff COVID+/PUI who have expired	**Cumulative deaths for staff as of today**
Total # staff recovered from COVID-19 and returned to work	Total # staff recovered from COVID-19 and returned to work	**Cumulative # of recovered staff who meet the CDC criteria**

LTC - Retesting Results June 15 & Forward		
Staff Test Result Reporting		As defined by Executive Directive No. 20-013, staff includes all direct care workers and non-direct care workers within the LTC including administrative, janitorial, and kitchen staff. This includes individuals who are full-time, part-time, or per diem, and other personnel. Vendors who enter the facility are not considered staff.
Total # staff	Total_staff	The total number of people – full-time, part-time, per diem personnel all categories, including agency personnel.
# of staff requiring testing	Staff_Requiring_Testing	This is the total # of staff requiring testing on each day, which excludes those on leave of absence and those who previously tested positive within the last 90 days. Any staff person who tested positive more than 90 days ago should be included in the # of staff requiring testing.
# of staff awaiting PCR test results at time of this daily report, if applicable	Staff_Awaiting_PCR_Test_Results	The total number of staff who were administered a test but for whom a result has not yet been received.

Useful COVID-19 Websites for LTC Facilities

NJDOH COVID-19 Vaccination page:
https://www.state.nj.us/health/cd/topics/covid2019_vaccination.shtml

NJDOH COVID-19 Regional Statistics page:
https://www.nj.gov/health/cd/statistics/covid/

CMS COVID-19 Nursing Home Data:
https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

NJDOH Communicable Disease Service Investigation Manual:
https://www.state.nj.us/health/cd/documents/topics/NCOV/NCOV_chapter.pdf updated Sept. 7, 2020

New Jersey Hospital Association COVID-19 Resource page:
http://www.njha.com/coronavirus

NJDOH: General COVID-19 Information:
https://www.nj.gov/health/cd/topics/ncov.shtml

CMS Nursing Home Resource Center:
https://www.cms.gov/nursing-homes

CMS: Sept. 28, 2020 | Nursing Home Reopening Recommendations for State and Local Officials (REVISED)
https://www.cms.gov/files/document/qso-20-30-nh.pdf

CMS: Sept. 28, 2020 | Guidance related to the Emergency Preparedness Testing Exercise Requirements- Coronavirus Disease 2019 (COVID-19)
https://www.cms.gov/files/document/qso-20-41-all.pdf

CMS: Updated, Sept. 28, 2020 | July 9, 2020, Nursing Home Five Star Quality Rating System updates, Nursing Home Staff Counts, Frequently Asked Questions, and Access to Ombudsman (REVISED):
https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf

CMS: Updated Sept. 28, 2020 | Issued May 18, 2020, Nursing Home Reopening Recommendations for State and Local Officials:
https://www.cms.gov/files/document/qso-20-30-nh.pdf-0

CMS: Updated, Sept. 28, 2020; issued March 13, 2020 | Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED):
https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

CMS: Updated, Sept. 28,. 2020, issued March 23, 2020 | Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum including guidance Prioritization of Survey Activities for LTC and COVID-19 Focused Survey for Nursing Homes:
https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0

CMS: Sept. 25, 2020 | Categorical Waiver – Corrugated Medical Tubing:
https://www.cms.gov/files/document/qso-20-40-lsc.pdf

CMS: Sept. 17, 2020 | Nursing Home Visitation:
https://www.cms.gov/files/document/qso-20-39-nh.pdf

CMS: Aug. 26, 2020 | Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID19 Focused Survey Tool,
https://www.cms.gov/files/document/qso-20-38-nh.pdf

CMS: Aug. 26, 2020 | Interim Final Rule (IFC), CMS-3401-IFC, Updating Requirements for Reporting of SARS-CoV-2 Test Results by Clinical Laboratory Improvement Amendments of 1988 (CLIA) Laboratories, and Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency
https://www.cms.gov/files/document/qso-20-37-clianh.pdf

CMS: June 25, 2020 | Changes to Staffing Information and Quality Measures Posted on the Nursing Home Compare Website and Five Star Quality Rating System due to the COVID-19 Public Health Emergency,
https://www.cms.gov/files/document/qso-20-34-nh.pdf

CMS: June 4, 2020 | Posting of Nursing Home Inspections,
https://www.cms.gov/files/document/qso-20-33-nh.pdf

CMS: June 1, 2020 | COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes,
https://www.cms.gov/files/document/qso-20-31-all.pdf

CMS: May 6, 2020 | Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes,
https://www.cms.gov/files/document/qso-20-29-nh.pdf

CMS: April 24, 2020 | Nursing Home Five Star Quality Rating System updates, Nursing Home Staff Counts, and Frequently Asked Questions,
https://www.cms.gov/files/document/qso-20-28-nh.pdf

CMS: April 13, 2020 | 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios,
https://www.cms.gov/files/document/qso-20-25-nh.pdf

CMS: March 10, 2020, Guidance for use of Certain Industrial Respirators by Health Care Personnel,
https://www.cms.gov/files/document/qso-20-17-all.pdf

CMS, March 4, 2020 | Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes,
https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf

CDC: LTC Preparing for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-carefacilities.html

NJDOH- Employee Exposure Tools and COVID-19: Information for Healthcare Professionals:
https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml

Strategies for Optimizing the Supply of PPE based on CDC Guidance:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes

Using Personal Protective Equipment (PPE)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

COVID-19 Educational Resources for LTC Staff

CDC Project Firstline

Project Firstline is a CDC national training collaborative offering timely infection control training to front line health care workers and the public health workforce in the fight against infectious disease threats.
https://www.cdc.gov/infectioncontrol/projectfirstline/index.html

https://www.cdc.gov/handhygiene/training/InteractiveEducation/

https://emergency.cdc.gov/coca/calls/2020/callinfo_061620.asp

https://www.youtube.com/watch?v=t7OH8ORr5Ig&feature=emb_logo

https://www.youtube.com/watch?v=1ZbT1Njv6xA&feature=emb_logo

https://www.youtube.com/watch?v=7srwrF9MGdw&feature=emb_logo

https://www.youtube.com/watch?v=YYTATw9yav4&feature=emb_logo

AHRQ ECHO National Nursing Home COVID-19 Action Network

https://rwjms.rutgers.edu/community_health/other/project-echo/nursing-home-can

CDC Online Infection Control Training for LTC

https://www.cdc.gov/longtermcare/training.html

CMS Online Infection Control Training for LTC

https://qsep.cms.gov/COVID-Training-Instructions.aspx

QIO Program - Fundamentals of Infection Prevention in Nursing Homes

https://qioprogram.org/cms-cdc-fundamentals-covid-19-prevention-nursing-home-management

STATE OF NEW JERSEY

DEPARTMENT OF HEALTH

NOTICE OF RULE WAIVER/MODIFICATION/SUSPENSION

PURSUANT TO EXECUTIVE ORDER NO. 103 (MURPHY) (MARCH 9, 2020)

AND EXECUTIVE ORDER 119 (MURPHY) (APRIL 7, 2020)

COVID-19 STATE OF EMERGENCY

Temporary Rule **WAIVER/MODIFICATION OF N.J.A.C. 8:39-43.2 - REQUIREMENTS FOR NURSE AIDE CERTIFICATION, adopted by THE COMMISSIONER OF THE DEPARTMENT OF HEALTH**

Date: **April 14, 2020**

Authority: N.J.S.A. App.A:9-45 & App. A:9-47; Executive Order No. 103 (Murphy)("EO 103"), Executive Order No. 119 (Murphy) ("EO 119")

Effective Date: **April 14, 2020**

Expiration Date: Concurrent with end of EO 103, as extended by EO 119

This is an emergency adoption of a temporary rule waiver/modification of N.J.A.C. 8:39-43.2, which sets forth the requirements for applicants to receive certification as a nurse aide in long-term care facilities. Section 6 of EO 103, issued in response to the COVID-19 pandemic, authorizes agency heads to waive/suspend/modify any existing rule, where the enforcement of the rule would be detrimental to the public welfare during the emergency, notwithstanding the provisions of the Administrative Procedure Act or any law to the contrary. Pursuant to that authority, as well as the Emergency Health Powers Act, N.J.S.A. 26:13-1 to -31, and N.J.A.C. 8:36-2.7(a), and with the approval of the Governor and in consultation with the State Director of Emergency Management, the Commissioner of the Department of Health is waiving its rules as follows:

COVID-19 is a contagious, and at times fatal, respiratory disease that is responsible for the 2019 novel coronavirus outbreak. The Centers for Disease Control and Prevention (CDC) expects that additional cases of COVID-19 will be identified in the coming days, including more cases in the United States, and that person-to-person spread is likely to continue to occur. As of April 12, 2020, there were at least 61,850 positive cases of COVID-19 in New Jersey, with at least 2,350 of those cases having resulted in death. If COVID-19 continues to spread in New Jersey at a rate comparable to the rate of spread in other affected areas, it will greatly strain the health care professionals charged with caring for patients ill with COVID-19 and may become too large in scope to be handled by New Jersey's currently certified health care professionals. Staffing

shortages have already been reported at long-term care facilities, assisted living facilities, assisted living programs and comprehensive personal care homes throughout New Jersey.

N.J.A.C. 8:39-43.2 sets forth the requirements for applicants to receive certification as a nurse aide in long-term care facilities. Under the rule, applicants must (1) successfully complete a nurse aide in long-term care facilities training program that has been approved by the Department; (2) provide evidence that he or she is of good moral character, including, but not limited to, compliance with the requirements of the Criminal Background Investigation Program in accordance with N.J.A.C. 8:43I; and (3) pass both the Department's clinical skills competency exam and written/oral exam.

In order to effectively respond to the shortage of staff in long-term care facilities, assisted living facilities, assisted living programs and comprehensive personal care homes, it is necessary to expand N.J.A.C. 8:39-43.2, which requires that applicants for certification as a nurse aide in long-term care facilities pass both the Department's clinical skills competency exam and written/oral exam. Pursuant to this rule waiver/modification, the Department adds N.J.A.C. 8:39-43.2(c), which permits long-term care facilities, assisted living facilities, assisted living programs and comprehensive personal care homes to temporarily employ individuals who complete and pass the 8-hour Temporary Nurse Aide Training Program sponsored by the American Health Care Association and the National Center for Assisted Living and who have demonstrated competency using the program's skills competency checklist. All individuals seeking to work as a nurse aide pursuant to this waiver/modification must comply with the requirements for a criminal background check pursuant to N.J.A.C. 8:43I, and the time delineated in N.J.S.A. 26:2H-84(d) will be extended for a period of 90 days. This rule waiver/modification will allow the Department to effectively respond to the immediate shortage of staff in long-term care facilities while still ensuring that individuals who are hired as nurse aides receive the adequate training.

Facilities that hire one or more nurse aides under the modified requirements created by this waiver/modification must retain records detailing which, if any, of the above actions were implemented, including a list of the names, Social Security numbers and birth dates of the individuals temporarily hired pursuant to this waiver/modification, the training records and completed competency checklists, the duration of the implementation, and must document and immediately report to the Department any incidents involving the abuse, neglect or misappropriation of property of a resident of the facility, which are attributable to the nurse aides hired under this waiver/modification.

Facilities that hire one or more nurse aides under the modified requirements created by this waiver/modification must, within one week of the hiring of one or more nurse aides, provide the Department with the names, Social Security numbers and birth dates of the individuals temporarily hired pursuant to this waiver/modification by sending the information to:

Garlina Finn, Education Program Development Specialist
Certification Program
New Jersey Department of Health
P.O. Box 358
Trenton, New Jersey 08625-0358

This waiver/modification is effective only during the period of Public Health Emergency declared by Governor Philip D. Murphy in Executive Order No. 103 issued on March 9, 2020 and extended by Executive Order No. 119 issued on April 7, 2020, and so long as the Public Health Emergency exists pursuant to a Governor's Executive Order. When the Public Health Emergency is lifted, facilities will be required to return to operation in accordance with all licensure standards. Nurse aides employed pursuant to this waiver/modification will no longer be eligible to work as certified nurse aides and will have to fulfill the regulatory requirements to become a certified nurse aide.

Full Text of the modified rule follows (additions indicated in boldface **thus**):

8:39-43.2 – Requirements for Nurse Aide Certification

(a) An applicant for certification as a nurse aide in long-term care facilities shall:

1. Successfully complete a nurse aide in long-term care facilities training program that has been approved by the Department;

2. Provide evidence that he or she is of good moral character, including, but not limited to, compliance with the requirements of the Criminal Background Investigation Program in accordance with N.J.A.C. 8:43I; and

3. Pass both the Department's clinical skills competency exam and written/oral exam.

(b) An applicant shall fulfill the requirements in (a) above in order to be listed on the New Jersey Nurse Aide Registry.

The above-referenced rule is hereby waived/modified subject to the following additional terms and conditions:

(c) During the period of Public Health Emergency declared by Governor Philip D. Murphy in Executive Order No. 103 issued on March 9, 2020, and extended by Executive Order No. 119 issued on April 7, 2020, and so long as the Public Health Emergency exists pursuant to a Governor's Executive Order, the following individuals, although not certified, may be employed as nurse aides:

1. Individuals who complete and pass the 8-hour Temporary Nurse Aide Training Program sponsored by the American Health Care Association and the National Center for Assisted Living program and have demonstrated competency using the program's skills competency checklist.

2. All individuals seeking to work as a nurse aide pursuant to this waiver/modification must comply with the requirements for a criminal background check pursuant to N.J.A.C. 8:43I, and the time delineated in N.J.S.A. 26:2H-84(d) (60 days for the Division of State Police in the Department of Law and Public Safety background check and an additional 60 days for the federal authorities' background check) will be extended for a period of 90 days.

3. Long-term care facilities, assisted living facilities, assisted living programs and comprehensive personal care homes may temporarily employ

individuals who qualify under N.J.A.C. 8:39-43.2(c)(1) and (2). Facilities that hire one or more nurse aides under the modified requirements created by this waiver/modification must:

a. **retain records detailing which, if any, of the above actions were implemented, including a list of the names, Social Security numbers and birth dates of the individuals temporarily hired pursuant to this waiver/modification, the training records and completed competency checklists, the duration of the implementation, and must document and immediately report to the Department any incidents involving the abuse, neglect or misappropriation of property of a resident of the facility, which are attributable to the nurse aides hired under this waiver/modification.**

b. **within one week of the hiring of one or more nurse aides, provide the Department with the names, Social Security numbers and birth dates of the individuals temporarily hired pursuant to this waiver/modification by sending the information to:**

Garlina Finn, Education Program Development Specialist
Certification Program
New Jersey Department of Health
P.O. Box 358
Trenton, New Jersey 08625-0358

4. **When the Public Health Emergency is lifted, facilities will be required to return to operation in accordance with all licensure standards. Nurse aides employed pursuant to this waiver/modification will no longer be eligible to work as nurse aides and will have to fulfill the regulatory requirements to become a certified nurse aide.**

I find that waiver/modification of the rules above is necessary because enforcement of the existing rules would be detrimental to the public welfare during this emergency.

4/14/20
DATE

Judith M. Persichilli

JUDITH M. PERSICHILLI, RN, BSN, MA
COMMISSIONER
DEPARTMENT OF HEALTH

AHCA Temporary Nurse Aide 8-hour Training Course

Available **free of charge** here:
https://educate.ahcancal.org/products/temporary-nurse-aide

Temporary Nurse Aide Skills Competency Checklist

To be used for new employees who complete AHCA/NCAL's Temporary Nurse Aide Training Program

ADAPT AS NEEDED FOR FACILITY PROCESSES

CMS DEFINITION §483.35 "Competency" is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

Many factors must be considered when determining whether or not facility staff have the specific competencies and skill sets necessary to care for residents' needs, as identified through the facility assessment, resident-specific assessments, and described in their plan of care.

All nursing staff must also meet the specific competency requirements as part of their license and certification requirements defined under State law or regulations.

Demonstration of Competency

Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas.

Examples for evaluating competencies may include but are not limited to:

- Lecture with return demonstration for physical activities;
- A pre- and post-test for documentation issues;
- Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents;
- Reviewing adverse events that occurred as an indication of gaps in competency; or
- Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.

Continue on the next two pages

Temporary Nurse Aide Skills Competency Checklist

To be used for new employees who complete AHCA/NCAL's Temporary Nurse Aide Training Program

PREVENTING INFECTION WHILE PROVIDING PERSONAL CARE		
Skill	**Competency Date**	**Observed By**
Standard Precautions		
Handwashing		
Using Barriers (Gloves, Gowns, Mask, etc.)		
Isolation/Transmission Based Precautions		
Cleaning, Disinfection, Sterilization		
Personal Care Routines (bathing)		
Shampooing		
Oral Hygiene		
Denture Care		
Grooming		
Shaving		
Nail Care		

PERSONAL SAFETY AND EMERGENCY CARE		
Skill	**Competency Date**	**Observed By**
Dressing/Undressing		
Bloodborne Pathogens		
Body Mechanics		
Choking		
Injury Prevention		

DOCUMENTATION AND CORE NURSING SKILLS		
Skill	**Competency Date**	**Observed By**
Documentation		
Bedmaking		
Making an Occupied Bed		
Transferring a Resident		

Continue on the next page

POSITIONING, MOVING, AND RESTORATIVE CARE		
Skill	**Competency Date**	**Observed By**
Positioning		
Moving Up in Bed When Resident Unable		
Moving a Resident		
Stand, Pivot, Transfer		
Assisting with Walking (ambulation)		

NUTRITION AND ELIMINATION		
Skill	**Competency Date**	**Observed By**
Assisting with Meals		
Assisting with Elimination (toileting)		
Assisting with Ostomy		

ADVANCED AND SPECIALTY CARE ENVIRONMENTS		
Skill	**Competency Date**	**Observed By**
Oxygen Therapy		
Motivate Resident/Stop when Resists		
Specific Behavioral Symptoms		
Specific Techniques for ADLs		

COMFORT CARE AND END OF LIFE		
Skill	**Competency Date**	**Observed By**
Pain Management		
Promoting Comfort and Sleep		
End of Life Care		

ETHICS AND THE LAW IN LTC		
Skill	**Competency Date**	**Observed By**
Physical Care of Body After Death		

Temporary NA Name: _____ Date of Hire: _____