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| Administrative P & P Manual<br>Nursing P & P Manual | JEWISH HOME AT ROCKLEIGH<br>JEWISH HOME ASSISTED LIVING |
| **Subject: Outbreak Response Plan including But Not Limited to Coronavirus** | **Date: February 2020, Rev. March, April, May, August, December 2020, January, May, June, July, December 2021, May 2022, November 2022, January 2023, April 2023, May 2023** |

**Goal**

To protect our elders, staff, families and visitors from harm resulting from disasters and exposure to an emergent infectious disease while they are in our Home.

**Purpose**

The purpose of this document is to provide guidance for the Jewish Home at Rockleigh and Jewish Home Assisted Living's outbreak response plan. This plan is reviewed and updated annually and as needed.

An outbreak is defined as an increase of disease among a specific population in a geographic area during a specific period of time. The types of situations this document addresses include individual cases and/or clusters of:

- Organisms with clinically significant resistance
- Organisms not previously or recently detected
- New/rare clinical presentations of diseases

This policy provides guidance on how to prepare for new or newly evolved infectious diseases whose incidence in humans has increased or threatens to increase in the near future and that has the potential to pose a significant public health threat and danger of infection to the residents, staff and families of the Home.

This Plan also encompasses information from the following Jewish Home policies, procedures and documents which encompass outbreak preparedness:

- Annual Facility Assessment
- Infection Prevention:
    - Epidemiology and Surveillance- This information is monitored by the Jewish Home's Medical Director, Nursing management team, which includes the DON, ADON and Infection Control Preventionist.
    - Surveillance Flow Chart- provides routine monitoring of residents and staff to quickly identify signs of a communicable disease that could develop into an outbreak
    - Facility-Acquired Infections
    - Criteria for Determining Infections- Evidence based outbreak response measures are in place by using the internet (e.g., CDC guidance) for latest research and protocols on containing and eliminating outbreaks. Consulting specialists are conferred with as necessary.

    - Infection Prevention Reporting (including tracking)
    - Monthly Infection Prevention Report
    - Resident and Staff Line Listing (data collection)
    - Outbreak Investigation
    - Reportable Diseases- outbreaks are reported to public health officials in accordance with applicable laws and regulations
    - Bloodborne Pathogen Exposure Control Plan
    - Outbreak Surveillance
    - Infection Prevention and Control for Suspected or Confirmed Coronavirus (COVID-19)
    - COVID-19 Diagnosed and/or Exposed Staff Member
    - Residents Discharged from COVID-19 Wing
    - COVID-19 Point Prevalence Testing
    - PPE Supply: Strategies for Optimizing and Stockpiling
- Personnel Policies:
    - Emergency Contact Lists
    - Chain of Command
    - Emergency Staffing Policy
    - Leave Share/Donation Policy
- Communication Plan- Clear policies for the notification of residents, resident's families, visitors and staff in the event of an outbreak of a contagious disease at the Jewish Home.
- HIPAA/Confidentiality Compliance
- Incident Command Center
- Emergency Response Planning
- Reportable Events to the Department of Health/Local Agency
- Evacuation Plan and Agreements
- Visitors- Signs are posted on the front desk to alert visitors of an outbreak and to ensure those visiting are not ill. In certain times, visitation is canceled as dictated by regulatory officials.
- Employee Health Protocols- Staff are instructed by the Employee Health department that they are not permitted to work when sick unless cleared by their physician/medical personnel or they wait the required period of time for clearance.

Other applicable parts of this Plan include:

- Workplace practices described in the infection prevention and control program
- Administrative controls (screening, isolation, visitor policies and employee absentee plans)
- Environmental controls (isolation wings, plastic barriers, alcohol based hand sanitizers/dispensers and special areas for contaminated wastes)
- Human resource issues such as employee leave and vaccination mandates

The local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and response related to a specific disease threat.

**Definitions:**

**Case definition:** a set of uniformly applied criteria such as clinical, laboratory, and other diagnostic modalities for identifying a particular infectious disease, but in the context of outbreak investigation, there may be added limitation on time and place to reflect the unique scope of the suspected event.

**Close contact** – refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period.

**Cluster:** an aggregation of cases grouped by time and place that may be greater than the expected number, whether the expected number is known or not; also referred to as a small outbreak.

**Colonization:** the presence, growth, and multiplication of a microorganism(s) in a host, but without clinical response or damage to the host; often found to be a precursor to infection.

**Common source:** an outbreak transmission mode that involves intermittent or continuous exposure to a common harmful source. May be referred to as a point source outbreak when the exposure is limited to a single group in a brief period of time.

**Control measures:** various actions deployed in order to interrupt and reduce or eliminate the occurrence of a communicable disease or infection. Measures are tailored to the event and may include patient isolation and cohorting, enhanced cleaning and disinfection, enhanced hand hygiene (e.g., soap and water vs. alcohol-based sanitizer), targeted staff education, and targeted or expanded surveillance and other modalities.

**Environmental sampling:** involves collection and testing of samples taken from the environment (i.e., surface, air, water) or healthcare personnel (e.g., nasal swabs), and interpreting the data in order to assist in determining the potential source of an outbreak.

**Epidemic curve:** a histogram that shows the distribution pattern of an outbreak event over time, which may assist in revealing the mode of transmission.

**Fully vaccinated**: individual are considered fully vaccinated if it has been two weeks after receiving the second dose COVID-19 vaccine series or one single dose COVID-19 vaccine recommended by the CDC.

**Line list:** a list established to assist and guide an outbreak investigation by documenting and organizing demographic data, clinical risk factors, and host or other contributing factors.

**Outbreak:** an increase in the occurrence of cases of infection or disease over what is expected in a defined setting or group in a specified time period; synonym of epidemic but used more often when limiting the geographic area.

**Propagated source:** an outbreak transmission mode that involves the spread from person to person; may last longer in event of secondary or tertiary waves of exposure.

**Pseudo-outbreak:** an increase in positive culture results without evidence of disease, frequently attributed to contaminated specimen collection, lab reporting inaccuracies, and bias.

**"Up-to-date"** - those who received a primary series (either a 2-dose primary series or a single-dose primary series) and the first booster dose for which they are eligible

**Procedure**

Activation of the outbreak plan:

- The policies above outline protocols for isolating and cohorting infected and at-risk patients in the event of an outbreak of a contagious disease until the cessation of the outbreak
- Lab testing through Acculabs and Capstone is available as needed.
- The Home has ABBOTT BINAX tests in stock to use as needed.

Thresholds include:

- Reports from disease intervention specialists (DIS) or clinical providers.
- Whenever disease levels exceed what is expected in a given community (either at the Jewish Home or in our immediate community area).

Roles and responsibilities:
In preparation thereof or once the existence of an outbreak has been confirmed, the Outbreak/Infection Prevention Response Team should be activated. This will include the President/CEO, Administrator, DON, Infection Preventionist (IP), ADON, Director of Medicine, VP of HR, Communications Director and individuals from the Jewish Home Assisted Living. Representatives on the team may include the Director of Environmental Services, Director of Social Work and individuals from the contracted laboratory, pharmacy and respiratory therapy team. The team would also include representatives from the local Bergen County DOH and OEM who provide input as necessary. The Home will contract with an APIC Certified Infection Control Consultant as needed.

The Infection Preventionist works together with the Response Team and Director of Nursing. The IP is designated as the Workplace Safety Officer. She/he is knowledgeable in infection control, has the authority to implement, monitor and ensure compliance, works with the team to develop plans and monitor effectiveness, conducts workplace specific hazard assessments, gains input from non-management staff regarding the plan and reviews policies and procedures.

Roles and responsibilities of the individual team members include:

- Leadership, management, and oversight of outbreak activities (Administrator/DON).
- Surveillance activities (IP).
- Epidemiologic activities and investigation. (IP)
- Data management and security. (IP and IT)
- Contact investigation and partner services. (IP, Employee Health)
- Oversight of laboratory specimen collection, transport, and testing. (DON)

- Risk communication and communication with media. (CEO)
- Control and prevention measures. (IP)
- Coordination with external partners and agencies. (Administrator)
- Provider and public education and outreach. (IP and CEO)
- Support activities such as logistics and budgetary management. (Administrator)
- Rounding on units to ensure compliance with infection control standards. This includes on-the-spot education, compilation of results and recommendations for changes to be made to improve compliance. Specific areas of focus include handwashing/hand hygiene, handling of PPE and ensuring social distancing. (IP and coaching leaders)
- Review of current practices and recommendations (IP)

Considerations for the team include:

- Review of educational needs
- Review of staffing, resources, supplies and support available
- Review of testing protocols and treatments.
- Reviewing transfer agreements with other facilities
- Review of protocols
- Review of regulations

Discussion topics may include

- Review of available information, including successes and barriers that are impeding progress.
- Case definition.
- Purpose and scope of investigation.
- Available and needed resources.
- Roles of each group involved in the outbreak response.
- Schedule of regular updates.
- Discussion of any political sensitivities pertaining to the outbreak and investigation.
- Development of initial media and ongoing awareness strategy.
- Informing local, state and federal (as/if mandated) staff of outbreak initiation.

**Emergency Staffing**

Administration will consider its requirements under OSHA, Center for Medicare and Medicaid Services (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and other employees shall be of paramount concern. Management shall take into account:

i. The degree of frailty of the residents in the Home;
ii. The likelihood of the infectious disease being transmitted to the residents and employees;
iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces)
iv. The precautions which can be taken to prevent the spread of the infectious disease and
v. Other relevant factors. Once these factors are considered, the Home will weigh its options and determine the extent to which exposed employees, or those who are

showing signs of the infectious disease, must be precluded from contact with residents or other employees.

vi. Apply whatever action is taken uniformly to all staff in like circumstances. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline including not being allowed to work.

In an emergency situation, the Administrator, VP of Human Resources and key staff (as designated by the facility's Incident Command System) shall meet for briefing on staffing needs and to implement the strategy to secure staff if an outbreak takes place. This will include reviewing:

a. On-duty staff and scheduled staff. During an emergency, staff currently on duty will be required to stay on duty until they are relieved by other staff.
b. Off-duty staff and on-call staff, including department managers.
c. Staff from sister facility, and non-medical volunteers (if permitted) who are already on file with the facility.
d. Healthcare professional volunteers who present to the facility to provide assistance (pending criminal background checks), non-medical staff and volunteers if permissible will only be assigned to and perform non-medical tasks.
e. Every effort shall be made to ensure that no staff work greater than 16 consecutive hours.

Job orientation shall be provided for all emergency staff and volunteers to acquaint them with the immediate needs of residents, the physical facility, disaster plan, and specific duties and responsibilities.

Staff who have multiple capabilities can be used in case of emergency. For example, certified nursing assistants who work in the recreation department can work as certified nursing assistants. Occupational therapists can help with activities of daily living.

As census changes, the Home may move elders (within the building) so that staffing can be consolidated.

Staff in departments not typically on the units may be considered for different positions including, but not limited to, working in the kitchen, housekeeping, etc.

The Human Resources department will reach out to area nursing schools, staffing agencies, recruiters, other health care facilities and the local and state health departments to recruit additional temporary staff. In addition, prior staff who are no longer employed by the home and are considered to be in good standing will be contacted.

For additional information, refer to the Home's Administrative Emergency Staffing Policy.

**Investigation:**

Recognition of a potential outbreak is critical in order to initiate the outbreak investigation. Both clusters and outbreaks may require recognition and surveillance as necessary.

The Centers for Disease Control and Prevention's primary components of the initial investigation include:

1) Confirming the presence of an outbreak by reviewing the following:
    a. Retrospective surveillance records
    b. Elder medical records
    c. Microbiology records
        i. Contact Medical Director and review collected information for final decision.
            1. If confirmed, continue to the following steps.
            2. If not a cluster or an outbreak, document evaluation and decision.

2) Identifying investigation team and resources
    a. Notify Infection Prevention Response team
    b. Assess local, state, and federal resources
    c. Determine subject matter expert(s)

3) Verifying the diagnosis of all cases must be validated to define the problem and validate appropriate resources using:
    a. clinical and
    b. laboratory diagnosis

4) Establishing a preliminary case definition
    a. Definition needs to be narrow enough to focus investigation but broad enough to capture the majority of cases (typically driven by pathogen).
    b. Careful consideration should be taken when deciding if specific organism is required verses symptomology.
    c. Consider the following factors:
        i. The agent (virus, bacterium, parasite, or other microbe)
        ii. The host (refers to human who can get the disease)
        iii. The environment (refers to extrinsic factors that affect the agent and opportunity for exposure)

5) Alerting administration and key healthcare partners about the investigation:
    a. Administration, if not already alerted
    b. Federal, state and local agencies as appropriate
    c. Laboratory should be asked to alert IP immediately if new results meet case definition

6) Performing a detailed literature review with efforts will help identify possible sources which merit further investigation and insight into investigative methodology. Sources include:
    a. Center for Disease Control and Prevention (CDC)
    b. Communicable disease Manual
    c. American Journal of Infection Control (AJIC)
    d. Infection Control and Hospital Epidemiology (ICHE)

7) Developing a methodology for case finding by defining which of the following sources will be used:
    a. Laboratory records
    b. Surveillance records
    c. Interview staff on unit
    d. Validate if colonization could be a factor

8) Preparing an initial line list in accordance with local or state DOH guidance/forms which may include:
    a. Clinical information such as:
        i. patient signs or symptoms,
        ii. medications,
        iii. procedures,
        iv. consults,
        v. elder locations,
        vi. contact with healthcare providers, and
        vii. host factors
    b. Development requires review of a variety of different sources of information including:
        i. Case definition
        ii. medical records,
        iii. patient location information (admission, discharge, and transfer data), and
        iv. staff interviews.
    c. Data from the line list should also be used to create an epidemic curve.
        i. The shape of the epidemic curve will provide information that may help identify the mode of transmission. Keep in mind:
            1. Elders may become colonized with organisms well before they develop clinical infections, and some elders will not develop infections at all.
            2. Include the incubation period
            3. Exposure(s) are often ongoing and organisms may be transmitted from elder to elder, in addition to coming from a common, contaminated source.
            4. The shape of the curve in a "point-source" healthcare-associated outbreak might look very different from that seen in a point-source outbreak of a foodborne disease.

9) Observing and reviewing potentially implicated patient care activities
    a. Based upon line list, observations of clinical practices may assist in identifying the cause of the outbreak.
    b. The type and location of observations will be based upon the line list.
    c. Focus should be on practice patterns and workflows that deviate from good infection prevention and control practices and facility or unit policies.

d. Observations should also review adherence to general infection prevention practices, such as hand hygiene, use of PPE and compliance with transmission-based precautions.
e. Validate how practices differ among healthcare providers.
    i. Interview staff regarding practices with open dialogue and transparency of information in order to determine:
        1. Root cause
        2. System failures
        3. Lapses in patient safety
f. To help delineate the potential causes of outbreaks, these observations can also provide "teachable moments" in infection prevention and control.

10) Considering whether environmental sampling or HCP sampling should be performed
    a. Environmental or healthcare provider cultures should never be the first step in an outbreak investigation.
    b. Environmental culturing or sampling of healthcare providers during outbreak investigations:
        i. Perform these cultures only after line list and observations are complete so that it can focus on items that seem the most likely to be implicated.
        ii. Before obtaining any environmental cultures, collaborate with the state epidemiologist, key leadership and/or laboratory personnel to determine whether they are able to process the cultures that will be obtained and discuss the optimal methods of obtaining them.
        iii. Culture only items that are possibly implicated in the investigation.
        iv. Culture the items that make the most sense as the likely reservoir for the organism.
    c. If the decision is to proceed, define appropriate actions in the event of both negative and positive cultures.

11) Implementing initial control measures with the ultimate goal of halting adverse events.
    a. Consider a variety of measures driven from:
        i. Line listing
        ii. Observations
        iii. Best practice recommendations
        iv. Study outcomes
    b. It is always appropriate to reinforce education on compliance with general infection prevention and control recommendations.

12) Components of the Follow-Up Investigation:
    a. Defining and refining the case definition based upon new information to make it as focused as possible either by being narrowed or expanded.
    b. Continuing case finding and surveillance to monitor the progress of outbreak and ensure it has ended.

c. Review control measures regularly with compliance evaluation to ensure recommendations are being carried out. If suboptimal, consideration on how to best increase compliance must be made. As the outbreak begins to subside, control measures should be critically assessed to determine if and when these activities can be discontinued.
d. Maintaining surveillance activities to validate the outbreak is ultimately over by the investigative team. Generally, if active surveillance has been in place and no new cases have been identified during a period of twice as long as the incubation period, measures can be discontinued.

13) Write Final Outbreak Investigation Report
   a. The final report should be clear and concise, outlining the key problem and interventions.
   b. Although the steps may not occur sequentially, the report helps to guide the Infection Preventionist in meeting the following goals:
      i. Identify the source and ultimately eliminate transmission of the pathogen.
      ii. Implement infection prevention and control strategies.
      iii. Develop plans to prevent outbreaks in the future.
      iv. Address the concerns and educational needs of healthcare providers, elders, and visitors.
      v. Consult with local health agencies to validate reporting requirements and take advantage of resources available to assist in the investigation.

**Debrief/After-Action Meeting:**

After every outbreak investigation and response, a debrief or after-action meeting, including representatives from all areas of the Jewish Home, Health Department and partner organizations, may be held to discuss the response and how to improve for next time. Notes taken from the meeting can inform improvements for the outbreak investigation and response plan. Preparedness counterparts may be helpful in providing tools and technical assistance on evaluating a response.

An evaluation of the outbreak response would focus on effectiveness of the response, cost of the response, efficient use of resources, productivity of interventions, and relationships with providers, as well as organization and leadership of the response effort. Also reviewed would be the successes, challenges and recommendations for improvement.

This information is shared with the QAPI Committee.

**Regarding Corona virus:**

It is the policy of the Jewish Home to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Standard, Contact and Airborne Precautions. Staff will be correctly trained and capable of implementing infection control procedures and adhere to requirements.

Clinical leadership will be vigilant and stay informed about emerging infectious diseases (EIDs) around the world. They will keep administrative leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.

As part of the emergency operations plan, the Home will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, goggles, surgical masks, assorted sizes of disposable N95 respirators, and gloves. The amount that is maintained in storage will minimally be for 90-days (3 months) worth of use. The daily burn rate is monitored.

All staff will be continuously educated in the use of PPE.

The Home contracts with a consultant to provide fit testing for staff for N95 use. In addition, designated staff have been trained to fit test. Their competency was checked by the outside consultant.

The Home has agreements in place with vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including an EID outbreak.

The Home will regularly train employees and practice the EID response plan through drills and exercises as part of the Home's emergency preparedness training

Local Threat

a. Once notified by the public health authorities at the federal, state and/or local level that the EID is likely to or already has spread to the community, the Home will activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities.
b. The Home's designated Infection Preventionist (IP) will research the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies.
c. Working with advice from the Home's medical director, administrative leadership, human resource director, local and state public health authorities, and others as appropriate, the IP will review and revise internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.
d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Special emphasis will be placed on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.
e. If the EID is spreading through an airborne route, the Home will activate its respiratory protection plan to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.
f. Residents and families will receive education about the disease and the Home's response strategy at a level appropriate to their interests and need for information.

g. Vendors, medical staff and visitors will be briefed on the Home's policies and procedures related to minimizing exposure risks to residents.
h. Signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection will be posted at the entry of the Home and around the building along with the instruction that anyone who is sick must not enter the building.
i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the care center, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work as well as ongoing.
j. Staff will be educated on the Home's plan to control exposure of the residents. This plan may include:
    a. Reporting any suspected exposure to the EID while off duty to their supervisor.
    b. Precautionary removal of employees who report an actual or suspected exposure to the EID.
    c. Self-screening for symptoms prior to reporting to work.
    d. Prohibiting staff from reporting to work if they are sick until cleared to do so by the employee health team
k. Self-isolation - in the event there are confirmed cases of the EID in the local community, the Home may consider closing the Home to new admissions, and limiting visitors based on the advice of local public health authorities.
l. Environmental cleaning - the Home will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
m. Engineering controls – All rooms are private rooms which allow for separating of residents.
n. The Home will utilize appropriate physical plant alterations as necessary including plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

Suspected case in the Home:

a. Test resident who exhibits symptoms of the EID and depending on test results, place in a cohorted wing and notify local public health authorities through line listing. Any staff exhibiting symptoms will be tested and depending on test results would be sent home and/or receive a follow up PCR test.

b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services if necessary.

c. If the suspected infectious person requires care while awaiting transfer, follow Home policies for isolation procedures, including all recommended PPE for staff at risk of exposure.

d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially designated, trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.

e. The isolated person will need to wear a facemask if possible while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless advised otherwise by public health authorities. During times of COVID outbreak, all residents will be encouraged to wear face masks unless medically contraindicated. Staff will care plan on any residents unable to wear face masks and enhance infection control precautions (e.g. assist with hand hygiene, social distancing, standard precaution practices)

f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.

g. Implement isolation protocols in the Home (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the center's infection prevention and control plan and/or recommended by local, state, or federal public health authorities. (See Isolation and Cohorting section of this policy below.)

h. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

**Ethical Considerations:**

1. In the event that a public health emergency creates demand that minimizes resources such as reduces staffing levels to critical levels, the Home may take a number of approaches to ensure safe care including suspending admissions, cross-training of staff and/or discharging to other levels of care.
2. If the Home is operating under a crisis standard of care and the Home is at critical care capacity, or will be overwhelmed despite taking all appropriate steps to increase the surge capacity to care for critically ill patients, and a regional authority has declared a public health emergency, in conformance with the NJ DOH Allocations of Critical Care Resources During a Public Health Emergency policy, the Home may triage critically ill patients. This will be done with the guidance of a triage team that includes members from medical and nursing leadership. The separation of the triage role from the clinical role is intended to promote objectivity, avoid conflicts of commitments, and minimize moral distress. The triage team will also be involved in resident or family appeals of triage decisions, and in collaborating with the attending physician to disclose triage decisions to residents and families.
3. Any allocation system would be equitable (fair) and serve to maximize lives and life years saved (utility).
4. The Jewish Home shall provide ongoing training to its leadership team regarding these ethical questions and circumstances.
5. Residents who are not triaged to receive critical care will receive medical care that includes intensive symptom management and psychosocial support. They should be reassessed daily to determine if changes in resource availability or their clinical status warrant provision of critical care services. Where available, specialist palliative care teams will be available for consultation.

**COVID Testing Plan:**

When it is determined either by the facility Response Team or as dictated by local, state or the federal government agencies that all testing must be completed, then the following steps are taken:

1. Staff and resident who are tested by the Jewish Home are done so by dedicated staff whose competency is checked to ensure they are performing testing properly. Testing will be completed in a dedicated space in time controlled increments. Staff will be appropriately spaced apart while the testing is completed.
2. Prior to testing, all staff and resident will be educated on the reasons for the testing.
3. Staff or resident with signs and symptoms of COVID-19, regardless of vaccination status must be tested immediately. Symptomatic staff or resident 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.). Staff and resident must wear facemasks for source control until symptoms improved. If staff have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. At minimum staff should be excluded from work for at least 24 hours after symptoms resolve including fever, if applicable.
4. For staff who are found to be positive for COVID-19, will be sent home until criteria to return to work is met. The Home will actively identify staff with close contact and residents who were cared for. The Home will investigate to determine if others in the facility could have been exposed. Exposures should be traced back 48 hours prior to symptom onset or positive test for asymptomatic positive staff.
5. The Home will perform testing for all resident and staff identified as 'close contact' or use broad-based testing approach (e.g unit, floor, or department) if potential close contacts cannot be identified or managed or if contact tracing fails to halt transmission. Testing for all staff and residents shall begin immediately (but not earlier than 24hours after the exposure) and, if negative again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. When performing broad-based approach and additional cases are identified after 3 series of testing, testing should continue on the affected units every 3-7 days until there are no new cases for 14 days. Close contact staff and elder must mask for 10 days.
6. For asymptomatic close contact staff who test negative, no restrictions are placed on working based on COVID-19 results but the staff should continue to report recognized exposures, regularly monitor themselves for fever and symptoms of COVID-19, and should not report to work when ill.
7. If an employee is tested and determined to be positive, they are not to return to work for at least 10 days have passed since symptoms first appeared or first positive test; OR 7 days with 2 negative results from antigen and/or NAAT PCR (obtained on day 5 and again 48 hours later, day 7) AND at least 24 hours have passed since the resolution of fever and symptoms improved.
8. Staff and resident who recovered from COVID-19 within the last 30 days do not need to get tested if remain asymptomatic. If testing is necessary, use antigen test instead of NAAT PCR test. Consult with the Home's Infectious Disease specialist as needed.

9. Upon return to work, the staff member will be reassessed by the Home's staff to ensure they are asymptomatic or symptoms improved. This individual must continue to be masked when they return to work, even in non-patient areas. They will be reminded that they may be exposing residents. If they remove their facemasks, e.g. to eat, they need to separate themselves from others. They need to continue to monitor for symptoms and seek reevaluation by the Home's Employee Health team if symptoms recur or worsen.
10. Any staff member who refuses to be tested will be considered as a Person Under Investigation and will not be allowed to work at the Jewish Home until they undergo testing and results of such testing are disclosed to the Home.
11. As part of our protocol, staff must provide permission for lab results to be released to the Home.
12. Staff must provide information to the Home's Employee Health department regarding their prior testing results.
13. Any residents testing positive for COVID-19 will be moved to the COVID unit wing or may stay at their own room/apartment for at least 10 days and as outlined in cohorting below.
14. Families of residents are notified by the social worker or nurse of the testing. Residents are also educated by the nursing staff about the testing and the reasons for the testing.
15. If a resident refuses to undergo COVID-19 testing, the Home shall treat the person as a Person Under Investigation, make a notation in the resident's chart, notify any authorized family member of such and continue to check temperature of the resident at least twice a day. Onset of temperature or other symptoms consistent with COVID-19 will require immediate cohorting in accordance with the section below on Isolation and Cohorting. At any time, the resident may rescind their decision not to be tested.
16. Retesting is implemented to detect any newly developed infections and to inform decisions as necessary.
17. During an outbreak, the Home continues to assess every elder, staff member and visitor daily for signs and symptoms of the illness.
18. Any staff not appropriately using PPE will be in serviced and subject to progressive disciplinary action up to and including termination.
19. As of July 1, 2021, a condition of employment (unless a medical or religious exemption has been granted by the Home) is to be up-to-date with vaccine against COVID-19 this includes having received a primary series (either a 2-dose primary series or a single-dose primary series) and the first booster dose for which they are eligible according to New Jersey Executive Order No. 294.
20. The Jewish Home arranges for vaccination clinic to occur onsite for elders and staff. Staff are permitted paid time off to receive the vaccination and are paid if they have symptoms related to the vaccine. They may also receive paid time off to accompany a family member to receive the vaccine. This includes receiving the booster shot.
21. All positive tests results are reported to the Department of Health, National Healthcare Safety Network (NHSN) and SimpleReport.gov.

**Isolation and Cohorting:**

1. Every room at the Jewish Home is a private room or apartment and has a private bathroom.
2. All staff, residents, and visitors will use source control (surgical mask, KN95 or N95) on unit or area of the facility during Outbreak status or when recommended by the local Department of Health. Masking can be discontinued to these areas if no new cases have been identified for 14 days. The Home may consider implementing use of NIOSH-approved N95 or respirator to affected units if ongoing transmission is not controlled.
3. The Jewish Home has dedicated areas of the Home that can be used as a series of isolation rooms as needed.
4. Determination of isolation is made with the clinical team based on clinical testing of the elder and positive results.
5. COVID-19 Positive cohorts consists of both symptomatic and asymptomatic patients/residents who test positive for COVID-19. These isolation areas are defined with tarps, closed doors and droplet/airborne precaution signs. There are dedicated separate staff for the isolation/cohort unit. Staff use additional PPE (including but not limited to face shields, face masks, N95, gloves, gowns) when working on the Cohort unit. This unit also has its own assigned equipment. On some situations, resident may confine in their own single person room/apartment with own bathroom and equipment. Doors will be kept close at all times (if safe to do so).
6. Exposed/close contact resident, empiric Transmission Base Precaution (TBP) may be considered for those who are moderately to severely immunocompromised, unable to be tested or wear source control. Resident may be placed on PUI (Person under investigation) for 7 days (count day of exposure as day 0) with all negative tests after the exposure if remain without symptoms and afebrile. If viral testing is not performed, resident can be removed from TBP after day 10 following exposure. The degree of immunocompromised for the resident is determined by the treating provider, and preventive actions are tailored to each individual and situation.
7. COVID-19 Negative, Person Under Investigation (PUI) observation: symptomatic patients/residents who test negative for rapid COVID-19 and awaiting for reverse transcription polymerase chain reaction (RT-PCR) test results. All symptomatic COVID-19 negative patients/residents should be evaluated for other causes of their symptoms. Even though asymptomatic COVID-19 negative patients/residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Resident may stay in their private single room or apartment, these individuals may possibly not be moved and doors are kept closed at all times. Resident must wear facemasks (if able to) for source control until symptoms improved.
8. New or Re-admissions: Any new or re-admissions will be tested as soon as they are admitted regardless of vaccination status unless tested positive for COVID-19 in the past 30 days. All new or re-admit will be advised to wear source control for the 10 days (if able to) following their admission if source control is not already in place. Asymptomatic

new admission or those who leave the facility >24 hours do not require to be placed on Transmission Base Precaution.

9. If staff are working in both well and ill units, they first provide care for those on the well unit and then go to those on the ill unit.
10. Adequate receptacles are placed in these areas including but not limited to extra garbage cans, hand sanitizers and other EPA approved cleaning products are placed throughout the area.
11. In the isolation areas, there is separate designated medication carts, lifts and other related patient equipment.
12. Isolation areas have increased routine cleaning and disinfection processes conducted.
13. As part of this Response Plan, the Home may close to new admissions as needed to cohort.

**Communication Plan: Notification and Reporting:**

It is the policy of the Jewish Home Family to provide appropriate and ongoing communication in the event of an emergency situation. Knowing how important it is to keep key government agencies, staff, residents, family members, board members and the community informed, this policy defines the process and methods to be used in an emergency situation. The Home's CEO/President, Executive VP/Administrator, VP of Human Resources, Director of Nursing and Director of Communications work closely together to ensure communication is effective, timely and comprehensive.

Methods of communication include but are not limited to e-mails, written notices, discussions in person and via phone and ZOOM meetings. The Home's Information Technology and Social Work team consistently review the list of e-mail addresses to ensure it is up to date and comprehensive.

The Home provides any cumulative updates for residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: a confirmed infection of COVID-19 is identified (including new admissions), or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

**Communication with Government/Health Agencies:**

Based on the situation at hand, the Administrator or designee is responsible for notifying the County and/or State Health Department and any other relevant agencies.

As necessary, the Administrator will reach out to other healthcare organizations including hospitals as well as emergency medical personnel, medical staff, Ombudsman's office, medical transport companies, vendors as needed, insurance companies as required and the Office of Emergency Management.

The Administrator/designee reports the required information (including line lists) into the NJHA and NHSN systems and via e-mail daily as required by CMS, the NJ Department of Health and the Bergen County Health Department.

**Communication with Residents:**
The administrator, in conjunction with the President/CEO, will define the messages and communication strategies that will be employed. These may include but are not limited to:

- In person meeting with residents
- Meetings via closed circuit broadcast into resident rooms (e.g., Zoom)
- Individual meetings
- Written communication

When notifying residents, resident representatives, and families, the Home follows these guidelines:

- Informs residents and their families if they are positive and to be moved or if they were tested and determined to be negative.
- Includes information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered,
- Not include any personally identifiable information.
- Document this notification in the electronic medical record.

Reasonable accommodations are made so that residents, resident representatives and families can access information. These include but are not limited to telephone calls, in person discussions, written communications, information on the in-house channel and e-mail communications.

**Communication with Families:**
The President/CEO, in conjunction with the administrator and key members of the management staff, will define the messages and communication strategies that will be employed. These may include but are not limited to:

- Emails and text messages
- Telephone communication
- Meetings facilitated by video conferencing
- Written communication

**Communication with Staff:**
The Vice President of Human Resources will serve as the coordinator of all communication with staff. The VP of HR or designee, in conjunction with the President/CEO and appropriate administrator will define the messages and communication strategies that will be employed. These may include but are not limited to:

- Emails and text messages
- Meetings of staff in small and large groups conducted by department heads or administration
- Telephone communication

**Communication with Board Members:**

The President/CEO, in conjunction with the administrator and key members of the management staff, will define the messages and communication strategies that will be employed. These may include but are not limited to:

- Emails and text messages
- Telephone communication
- Meetings facilitated by video conferencing
- Written communication

**Communication with Media:**
The President/CEO, in conjunction with the administrator and key members of the management staff, will define the messages that will be shared. Only the President/CEO or Director, Marketing and Technology is authorized to speak to the media and only the President/CEO or designee is authorized to make a statement or answer media questions.

**Website Information:**
As necessary, the Jewish Home's website (www.jewishhomefamily.org) includes a copy of this Outbreak Plan, update on facility status and ways to communicate with loved ones and staff.

**Lessons Learned from Prior Outbreaks Including but not Limited to COVID-19**

- Ensure Response Team in place to provide direction on overall Outbreak Response Plan.
- Ensure clear comprehensive protocol in place for assessing, testing, cohorting and treating outbreak. Ensure protocol is a collaborative effort with members of the medical staff including local acute care hospitals and is based on national guidelines such as CDC guidance.
- Review all advance directives and have a conversation before a crisis happens.
- Ensure there are specific staff, equipment and unit space available to cohort and care for residents who are both symptomatic and asymptomatic.
- Ensure there are clear lines of communication with local and state health departments. Integrate Home into regional response.
- Ensure there are connections in place with critical vendors including but not limited to access to PPE, medications, testing, food, nursing supplies, fuel, transportation, mortuary services, emergency services.
- Ensure up-to-date phone numbers and e-mail addresses for staff and resident families.
- Ensure clear communication methods are in place with key partners including residents, staff and family members. Educate families on what is and what is not a crisis. Talking to individuals directly vs. e-mails is helpful.
- Ensure partnership agreements in place with staffing agencies to allow for adequate staffing.
- Ensure technology resources available such as Zoom capabilities.
- It is critical to move quickly but deliberately to ensure outbreak is contained.
- Ensure handwashing and other sanitation procedures are done correctly. Ensure staff have appropriate PPE and the knowledge to properly don and doff equipment.

- Ensure regular in-servicing of staff and residents takes place to review infection control and other protocols. Reviewing competency of staff, including for cleaning procedures, is critical.
- Ensure constant review of best practices, access to latest research and implementation of protocols.
- Ensure methods in place to enhance resident and staff morale and to address mental health issues/concerns.
- Provide opportunities for compassionate care visits, especially at the end-of-life.
- Ensure method in place for admissions if possible, especially if families do not have access to help orient their loved one to the Home.
- Ensure chain of command and replacement staff are designated in case of staff vacancies.
- Ensure plans in place to address future possible outbreaks. Ongoing vigilance is critical.

**Challenges from Prior Outbreaks Including but not limited to COVID-19**

- Lack of information about a new emerging outbreak makes responding more difficult.
- Lack of involvement of visitors, volunteers and other 'non-essential' providers intensifies pressure on staff.
- Dependence on others for PPE is not possible. The Home had to secure items itself from non-traditional sources.
- Fear of the known and unknown by staff, elders was very challenging.
- Replacing the many staff who became ill very quickly was challenging.
- There was a staffing shortage in the region and it became difficult to find replacement staff.
- Constant time-consuming reporting requirements as well as required changes to policies and protocols were challenging.
- Long term physical and mental effects from COVID outbreak.
- Identifying COVID-fatigue amongst staff, elders and families. Addressing it is critical and difficult.

**Successes from COVID-19 Outbreak**

- Ability of the JH team to bond strongly, work tightly together and be resourceful.
- Readiness of JH team to figure out how best to strategically plan and care for those during the outbreak was critical to success.
- Organization strengthened by going through the experience- each staff member and elder came out stronger.
- Development of the COVID protocol including but not limited to medical interventions, COVID diet and hydration program
- Open communication is critical to allaying fears and building trust
- Staff emerge in new roles and took responsibility for working as a team.
- Focus on infection control and improving systems.