

| HAYM SALOMON HOME FOR NURSING & REHABILITATION | | | |
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| Section: Infection Control | | Policy# | |
| Issue Date: 03/13/2020 | Revision Date: 12/21,1/22,10/22,3/23,11/2312/20/2023,1/24,2/24,7/24,/9/24, | Review Date: | Prepared by: Administration |
| Policy Subject: Pandemic Emergency Plan – Coronavirus Disease (COVID–19), Comprehensive | | | |
| Approved by: Administrator, Medical Director, Director of Nursing, Infection Preventionist, QAA Committee | | | |

BACKGROUND

SARS-CoV-2, commonly known as COVID-19, is primarily a viral respiratory infection. It is most commonly spread between people who are in close proximity of each other (within 6 feet). It spreads through respiratory droplets or small particles produced when an infected person coughs, sneezes, sings, talks or breathes. These particles can be inhaled into the nose and mouth, and eventually into the lungs, causing an infection. Droplets can also land on surfaces and inanimate objects and spread when dirty hands touch the eyes, nose and mouth. The incubation period is between 3-7 days. Symptoms of the virus include fever, cough, shortness of breath, severe lower respiratory infection/acute respiratory distress syndrome and may also include nasal congestion, sore throat, diarrhea, and nausea.

POLICY STATEMENT

Haym Salomon will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of COVID-19. The facility will follow and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the New York State Department of Health (NYSDOH), to identify and prevent the spread of the **SARS-CoV-2 virus**. Haym Salomon Infection Preventionist will ensure that the Infection Prevention and Control Program, including the COVID-19 response, is implemented and based on current federal and state regulations and guidelines.

During an officially declared national emergency, or state or municipal emergency declared pursuant to article two-B the executive law, related to contagious or infectious disease outbreak, the nursing home shall have screening requirements for every individual entering the facility, including staff, for symptoms associated with the infectious disease outbreak. This will include temperature monitoring. Symptom's check, and any other screening as stipulated by federal or state government.

DEFINITIONS

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.

Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Up to Date: a person has received all recommended Covid-19 vaccines.

PROCEDURE

GENERAL/CORE PRINCIPLES OF COVID-19 PREVENTION

- The facility will provide education to staff to address:
 - Staying home from work when sick
 - Identifying signs/symptoms of Covid-19 in resident and reporting same to appropriate personnel
 - Reviewing standard and transmission-based precautions; review appropriate identifiers (e.g., signage)
 - Reviewing appropriate use of personal protective equipment (donning and doffing)
 - Hand hygiene
 - Reviewing respiratory etiquette
- The facility will provide education to visitors by the following means:
 - Posting visual alerts (e.g., signs and posters) at entrances and in strategic places (e.g., lobby, elevators, cafeterias, that include instructions about current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene)
 - Posting visual alerts of recommended actions (e.g., stay home of sick) to prevent transmission to others if they have any of the following:
 - A positive viral test for SARS-CoV-2
 - Symptoms of Covid-19, or
 - A close contact with someone with SARS-CoV-2 infection
- The facility may choose to actively screen staff and visitors for symptoms of Covid-19
- The facility will reinforce cleaning and disinfection procedures to include:

The facility will maintain adequate products and equipment to prevent the spread of infections, including but not limited to, gloves, isolation gowns, procedure masks, N95 masks, eye protection, hand hygiene products, and EPA-registered cleaning and disinfection products.

- Cleaning/disinfecting multiple-use equipment in between use for each resident (e.g., blood pressure cuffs, glucometer, stethoscopes, etc.)
- Increasing cleaning and disinfection of high-touch surfaces (both inside and outside of resident care areas) including contact/dwell times for products used for disinfection.

MONITORING AND EVALUATION OF FACILITY RESIDENTS

- Routinely monitor all residents upon admission and at least daily for fever x 72 hours for signs and symptoms consistent with Covid-19 infection as well as any change in condition.

- Ask residents to immediately report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection.
- Identification, early work-up, including testing as indicated, and treatment will be initiated by clinical staff for all residents with suspected or confirmed COVID-19.

MANAGEMENT OF NEW and RE-ADMISSIONS and RESIDENTS OOP <24 HOURS

- Empiric transmission-based precautions is not necessary for new or re-admission or residents who leave the facility for <24 hours (e.g., for medical appointments, community outings).
- Patients/Residents who leave the facility for longer than 24 hours will be managed as an admission.
- Testing of a patient/resident on admission or re-admission is at the discretion of the facility, or as advised by the local health department.
 - Facility may utilize local metrics (e.g., increase in Covid-19 related hospital admissions or increase in ICU beds occupied by Covid-19 patients) that could

reflect increasing community respiratory viral activity to determine if testing is warranted.

MANAGEMENT OF RESIDENTS WITH KNOWN COVID-19 INFECTION

- Place resident in a single-person room. If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for Covid-19, residents should remain in their current location.
 - The door should be kept closed if safe to do so.
 - Ideally, the resident should have a dedicated bathroom.

- Initiate contact and droplet precautions and place signage by room door to reflect same.

The facility will make every attempt to promote consistent staff and staff assignment on each unit:

- The DON/RNS will make every effort to have residents that have been confirmed with COVID-19 infection to be grouped into the same assignment's
- To the extent possible, staff working on the affected units will not be assigned to other units during the outbreak of an infectious communicable disease.
- Clinical and other staff who have direct resident contact will be limited to specific areas of the facility and not rotating staff between various areas of the facility during the period they are working each day during periods of recognized outbreaks.
- Staff to utilize full PPE (gown, fit-tested N95 mask, eye protection, and gloves) when entering room.
- Dedicated or disposable patient care equipment will be utilized when feasible.
- Shared equipment will be cleaned and disinfected using an appropriate EPA-registered disinfectant.
- Monitor resident for worsening/change in condition.

- Document assessment of symptoms, vital signs, and oxygen saturation via pulse oximetry at least Q shift to quickly identify residents who require transfer to a higher level of care
- Encourage residents to wear face mask (as tolerated) for source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation.
- Limit transport and movement of the patient/resident outside of the room to medically essential purposes.

DURATION OF TBP FOR RESIDENTS WITH COVID-19 INFECTION

- In general, patients/residents who are hospitalized for Covid-19 infection will be maintained on TBP for the time period described for patients with severe to critical illness.
- Facility may use symptom-based or test-based strategy to discontinue TBPs

Symptom-based strategy:

- Patients with mild to moderate illness who are not moderately to severely immunocompromised:
 - At least 10 days have passed since symptoms first appeared and
 - At least 24 hours have passed since last fever without the use of fever-reducing medications and
 - Symptoms (e.g., cough, shortness of breath) have improved
- Patients/residents who were asymptomatic throughout the infection and are not moderately to severely immunocompromised:
 - At least 10 days have passed since the date of their first positive viral test
- Patients with severe to critical illness and who are not moderately to severely immunocompromised:
 - At least 10 days and up to 20 days have passed since symptoms first appeared and
 - At least 24 hours have passed since last fever without the use of fever-reducing medications and
 - Symptoms (e.g., cough, shortness of breath) have improved
 - Patients/residents who are moderately to severely immunocompromised:
 - Use of a test-based strategy and, if available, consultation with an infectious disease specialist to determine when TBP can be discontinued for these residents.

Test-based strategy

- Patients/residents who are symptomatic
- Resolution of fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved, and
- Results are negative from at least 2 consecutive respiratory specimens collected 48 hours apart using an antigen or molecular test
- If symptoms recur (e.g., rebound), patients/residents will be placed back into isolation until they again meet the symptom-based criteria to discontinue TBP

MANAGEMENT OF RESIDENTS SUSPECTED OF COVID-19 INFECTION OR WITH CLOSE-CONTACT EXPOSURE

- Place resident in a single-person room
- If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for Covid-19, residents should remain in their current location.
- The door should be kept closed if safe to do so.
- Ideally, the resident should have a dedicated bathroom.

If symptomatic:

- Initiate empiric transmission-based precautions (TBP)
- Perform viral tests for Covid-19
- If using NAAT or PCR test, a single negative test is sufficient. If a higher level of clinical suspicion exists, confirm with a second NAAT or PCR
- If using an antigen (rapid) test, a negative result should be confirmed by either a negative NAAT/PCR test or second antigen test taken 48 hours after the first negative test.

If asymptomatic:

- Empiric use of TBP is not necessary while being evaluated for SARS-CoV-2 following close contact with someone with SAR-CoV-2 infection, unless
- Patient/resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Patient/resident is moderately to severely immunocompromised
- Patient/resident is resident on a unit with others who are moderately to severely immunocompromised
- Patient/resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.
- Perform a series of 3 viral tests for Covid-19
- Test immediately (but not earlier than 24 hours after the exposure), on day 3 if previous test negative, and on day 5 after the 2nd negative test
- Encourage patients/ residents to wear face mask, as tolerated, for source control.

TESTING and REPORTING

- A single case of Covid-19 is considered an outbreak. In the event of an outbreak, the facility will conduct testing in accordance with the most current CDC recommendations.
- When testing is initiated due to potential/known close contact or higher-risk exposure, test all exposed residents on day 1, day 3 and day 5.
- If all results are negative during any round of testing, no further action is necessary.
- If results indicate any positive cases during any round of testing, initiate outbreak testing every 3-7 days x14 days until there are no new positives.
- If using antigen tests, may consider testing every 3 days.
- *When SARS-CoV-2, influenza virus, and respiratory syncytial virus are co-circulating in the community, test for all 3 viruses.

- Testing is not required for residents and staff who are asymptomatic and have recovered from Covid-19 infection within the prior 30 days. Testing will be considered for those who have recovered in the prior 31-90 days.
- Use an antigen test instead of a molecular test.
- Residents who are symptomatic and/or had a close-contact COVID exposure and refuse COVID 19 testing will receive education and will be placed on transmission-based precaution (TBPs) until the criteria for discontinuation of isolation precautions have been met in accordance with 42CFR&483.109c) (6)
- Staff who have signs or symptoms of COVID-19 and refuse testing may be prohibited from entering the building until the return-to-work criteria are met.
- If outbreak testing has been triggered and a staff member may be restricted from the building until the procedures for outbreak testing have been completed.
- Testing of visitors is at the discretion of the facility.
- Visitors may continue to use either PCR testing or antigen testing.
- Facility cannot deny visitor the right to visit if they do not have a Covid-negative test.
- Point of Care Antigen tests that have resulted positive will be reported to NYSDOH ECLRS as directed by NYSDOH by 1:00PM of the day following receipt of the results.
- All staff and residents testing positive shall be documented on respective line lists and the results will be reported on all required submissions to the CDC via NHSN (at least weekly) and NYSDOH via HERDS (daily reporting Mon through Friday)
- Facility to complete a Nosocomial Outbreak Report (NORA) via the NYS Health Commerce System (HCS) at the time of the identification of any new case.

Communication/Notification of COVID-Positive Cases

- The nurse will notify the physician, resident, and/or resident representative(s) when a resident is suspected of or has confirmed Covid-19 infection. The nurse and/or physician will discuss with the resident and/or resident representative(s) the treatment/management plan.
- Inform residents, their representatives, and families of those residing in facilities by 5PM the next calendar day following the occurrence of either a single confirmed infection of Covid-19, or 3 or more residents or staff with new-onset respiratory symptoms occurring within 72 hours of each other.

*Per CMS 23-13-ALL, as of 5/12/2023, CMS will no longer enforce the above notification requirement even though this reporting is expected.

EMPLOYEE RETURN TO WORK CRITERIA

- The facility's sick leave policy will be reviewed with the staff who are exhibiting symptoms or test positive for symptoms for an infection for an infectious disease.
- The facility will not penalize any staff member for absenteeism due to communicable illness and will implement all applicable sick leave policies.
- HCP with even mild symptoms will be prioritized for viral testing with NAAT (nucleic acid) or Antigen test
- If using NAAT, a single negative test is sufficient.

- If using an antigen test, a negative result should be confirmed by either a negative NAAT or second negative antigen test taken 48 hours after the first negative test.

HCP with Covid-19 Infection:

- HCP with mild to moderate illness who are not moderately to severely immunocompromised may return to work after the following criteria has been met:
 - At least 5- 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work OR 10 days if testing is not performed or if a positive test at day 5-7, AND
 - At least 24 hours have passed since last fever without the use of fever-reducing medications, AND

Symptoms (e.g., cough, shortness of breath) have improved.

*Either a NAAT or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later. · HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised may return to work after the following criteria have been met:

- At least 5-7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).
- *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later · HCP with severe to critical illness who are not moderately to severely immunocompromised may return to work after the following criteria have been met:

At least 10 days and up to 20 days have passed since symptoms first appeared, and

- At least 24 hours have passed since last fever without the use of fever-reducing medications, and
- Symptoms (e.g., cough, shortness of breath) have improved.
- The test-based strategy may be used to inform the duration of work restriction.

Symptomatic:

- Resolution of fever without the use of fever-reducing medications, and
- Improvement in symptoms (e.g., cough, shortness of breath), and
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Asymptomatic

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

HCP with Covid-19 Exposure

- Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include:

- HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure.
- HCP is moderately to severely immunocompromised.
- HCP cares for or works on a unit with patients who are moderately to severely immunocompromised.
- HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

- If work restriction is recommended, HCP may return to work after either of the following time periods:

- HCP can return to work after day 5- 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following a higher-risk exposure is negative.
- If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.
- Following a higher-risk exposure, HCP should:

Have a series of three viral tests for SARS-CoV-2 infection.

- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
- Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develops fever or symptoms consistent with COVID-19 should immediately self-isolate and contact employee health or immediate supervisor to notify and arrange for medical evaluation and testing.

HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with

SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

Facility QA Committee will assess staffing needs to determine if needs are at the conventional, contingency or crisis levels to implement emergency staffing plans.

- If employees must return to work under the contingency or crisis staffing plans, follow the CDC's mitigation strategies for return-to-work criteria.
- Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
- *In NYS, facilities must complete the DOH Checklist and Attestation for HCP Return to Work Waiver (found here) for review by the Commissioner of Health before staff can return to work under the crisis strategy.

MASK AS UNIVERSAL SOURCE CONTROL

Masks as universal source control is at the discretion of the facility or as advised by the local health department.

- As directed by NYSDOH guidance, facility may utilize local metrics (e.g., increase in Covid-19 related hospital admissions or increase in ICU beds occupied by Covid-19 patients) that could reflect increasing community respiratory viral activity to determine if testing is warranted.

The facility may allow individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

- If using N95 respirators as source control, fit testing is not required. Refer to facility's Respiratory Protection Program and OSHA's guidelines Appendix D.

Mask as PPE will be utilized for individuals who have suspected or confirmed Covid-19 or other respiratory infection as well as for those individuals who had a close contact exposure

- (resident and visitors) or a higher-risk exposure (healthcare personnel) with someone with SARS-CoV-2 infection for 10 days after the exposure.
- NIOSH-approved fit-tested N95 masks are required when caring for patients/residents with suspected or confirmed Covid-19 infection.

Refer to facility's Respiratory Protection program Policy.

- Masks as source control will be utilized in areas/units experiencing a Covid-19 outbreak until no new cases have been identified for a period of 14 days.
- When used solely for source control, masks may be used for an entire shift unless they become soiled, damaged, or hard to breathe through.
- *If masks (e.g., N95) are used as PPE during the care of a patient/resident with Covid-19 infection (or droplet precautions), they should be removed and discarded after the patient/resident care encounter and a new one should be donned.

VISITATION

- Facility will utilize the core principles of infection prevention to promote safe visitation and decrease the risk of Covid-19 spread.
- The facility will allow the number of visitors based on the ability to adhere to infection control principles, including the ability to maintain physical distancing between residents and visitors, as applicable.
- Facility visitation may be conducted through a variety of means - in resident rooms, outdoors (weather permitting), designated visitation spaces, and virtually.
- The facility will post signage in highly visible areas (e.g., entrances, exits, elevator banks, etc.) with instructions for infection prevention, including Covid-19 (example, hand hygiene, cough etiquette, physical distancing, immunizations, etc.).
- Residents on transmission-based precautions may still receive visitors. Visitors will be cautioned of the potential risks associated with visiting.

In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated).

Visitors who have had close contact with someone with Covid-19 infection or those with confirmed Covid-19 infection or compatible symptoms will be advised to defer non-urgent in-person visits until they meet the CDC criteria for healthcare settings to end isolation.

- To limit movement in the facility during visitation while there is an outbreak investigation, the following guidelines will be followed:
- Visitor(s) will go directly to the resident's room or designated area.
- If a resident shares a room, the facility will attempt to facilitate in-room visitation while adhering to the core principles of infection prevention as related to Covid-19.
- Visitors will be encouraged to wear a mask and physically distance themselves from other residents and staff, when possible

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