

Hudson Park Rehabilitation and Nursing Center COVID-19 Action Plan

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PURPOSE: To provide guidelines for the prompt detection and effective triage and isolation of potentially infectious patients to prevent unnecessary exposures among patients and healthcare personnel at the facility.

How COVID-19 Spreads:

COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus. These droplets and particles can be breathed in by other people or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. People who are closer than 6 feet from the infected person are most likely to get infected.

COVID-19 is spread in three main ways:

- Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus.
- Having these small droplets and particles that contain virus land on the eyes, nose, or mouth, especially through splashes and sprays like a cough or sneeze.
- Touching eyes, nose, or mouth with hands that have the virus on them.

Symptoms of COVID-19:

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus**. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19:

- 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 or runny nose
- Nausea or vomiting
- Diarrhea

Prevention:

The best way to prevent illness is to avoid being exposed to this virus.

The CDC recommends everyday preventive actions to help prevent the spread of respiratory diseases, including:

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
 - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

Vaccination:

There are currently vaccines to prevent coronavirus disease 2019 (COVID-19). The facility will participate in the vaccination clinics through the contracted pharmacy and/or designated health department.

The facility will post signage, including at points of entry and exit and each residential hallway, reminding residents that the facility offers COVID-19 vaccination.

Resident Vaccination:

The facility will educate all residents and resident’s designated representatives on the benefits of the COVID-19 vaccine, and risks.

All new residents and resident readmitted to the facility have an opportunity to receive the first or any required next dose of the COVID-19 vaccine within fourteen days of having been admitted or readmitted to the facility.

Informed consent will be obtained from residents and/or designated representatives and for the vaccine. All residents who decline to be vaccinated will sign a declination, which indicates that they were offered the opportunity for a COVID-19 vaccination but declined. The declination includes that if they later decide to be vaccinated for COVID-19, it is their responsibility to request vaccination from the facility. Vaccination consent or declination will be maintained in the resident’s medical record.

The facility will schedule the second clinic with the contracted pharmacy and/or health department and ensure the residents are scheduled for the second vaccination. A record of the vaccination will be maintained in the resident’s medical record.

Employee Vaccination:

All employees, agency staff, affiliated parties, contracted staff, medical, nursing, students, and volunteers be fully vaccinated against COVID-19 in accordance with the New York State

Department of Health under Public Health Law Sections 225, 2800, 2803, 3612, and 4010, as well as Social Services Law Sections 461 and 461(e), Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York.

Medical exemptions will be considered based on the CDC guidance for contraindications for COVID-19 vaccine. Employees requesting a religious exemption are required to provide a written and signed statement objecting to immunization due to sincere and genuine religious belief which prohibits immunization.

Staff that has an approved medical or religious exemption are required to wear a N95 mask at all times and these employees shall be socially distanced from all staff during their breaks and meals to prevent transmission of virus.

COVID-19 Booster Vaccines:

Residents and staff who received a Pfizer-BioNTech or Moderna COVID-19 vaccine are eligible for a booster shot at 6 months or more after their initial series.

Residents and staff who received the Johnson & Johnson COVID-19 vaccine, booster shots are also recommended for those who were vaccinated two or more months ago.

Eligible individuals may choose which vaccine they receive as a booster dose.

Treatment:

The Food and Drug Administration (FDA) has approved one drug, remdesivir (Veklury), to treat COVID-19.

People with COVID-19 should receive supportive care to help relieve symptoms. For severe cases, treatment should include care to support vital organ functions.

People who think they may have been exposed to COVID-19 should contact their healthcare provider immediately.

DEFINITIONS

- **Healthcare Personnel (HCP)** – HCP refers to all persons, paid and unpaid, working in healthcare settings engaged in patient care activities, including: patient assessment for triage, entering examination rooms or patient rooms to provide care or clean and disinfect the environment, obtaining clinical specimens, handling soiled medical supplies or equipment, and coming in contact with potentially contaminated environmental surfaces.

POLICY:

1. Monitoring of Residents:
 - a. **Prior to Entry:**

- i. Residents will be screened by the Corporate Admissions Team for the presence of 1 negative COVID-19 test result during hospitalization prior to admission.

b. After Admission

- i. All new admissions/re-admissions will be screened/monitored **every shift** for **14 days** by obtaining Vital Signs and Respiratory Monitoring:
 - a. Temperature, Pulse, Respirations, Blood Pressure, Pulse Oximetry
 - b. Cough, SOB, Sore Throat
- ii. After 14-days residents will be screened/monitored **Daily** by obtaining Vital Signs and Respiratory Monitoring:
 1. Temperature, Pulse, Respirations, Blood Pressure and Pulse Oximetry
 2. Cough, SOB, or Sore Throat
- iii. New admissions/re-admissions with no previous positive COVID test within 90 days will be tested via antigen testing on day of admission. They will then have an Antigen COVID-19 test performed on day 4 of admission/re-admission.
- iv. Quarantine is no longer recommended for residents who are being admitted if they are fully vaccinated and have **not** had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days.

c. Outside Appointments

- i. All appointments should be restricted to those only that are medically necessary.
 1. Obtain baseline temperature before leaving and VS and respiratory monitoring every shift x 14 days upon return from appointment.
- ii. All residents receiving dialysis will need VS and Respiratory Monitoring every shift.
- iii. All residents receiving dialysis will be tested for COVID-19 weekly or with any symptoms.
- iv. Quarantine is not recommended for fully vaccinated residents who leave the facility for less than 24 hours (e.g., for medical appointments) and do not have close contact with someone with SARS-CoV-2 infection unless uncertainty exists about their adherence or the adherence of those around them to recommended IPC measures.
- v. Residents who leave the facility should be reminded to follow all recommended IPC practices including source control, physical distancing, and hand hygiene and to encourage those around them to do the same.
- vi. Individuals accompanying residents (e.g., transport personnel, family members) should also be educated about these IPC practices and should assist the resident with adherence.
- vii. For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is

essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.

- viii. In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with SARS-CoV-2 infection.
 - ix. Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.
 - x. Facilities might consider quarantining residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended IPC measures.
 - xi. Residents who leave the facility for 24 hours or longer should generally be managed as described in the New Admission and Readmission section
2. All HCP and other facility staff shall wear a facemask while within 6 feet of residents. The Face mask must completely cover both the nose and mouth. Extended wear of facemasks is allowed; facemasks should be changed when soiled or wet and when HCP go on breaks. The facility will attempt to bundle care and minimize the number of HCP and other staff who enter rooms to reduce the number of personnel requiring facemasks.
 3. If there are suspected cases of COVID-19 in the facility:
 - a. Residents suspected of infection with COVID-19 should be given a facemask to wear, and the facility must immediately contact the NYSDOH.
 - b. The resident must be isolated in a separate room with the door closed.
 - c. Staff attending the resident if and until they are transferred should wear gowns, gloves, eye protection (face shield), and facemasks and should maintain social distancing of at least six (6) feet from the resident except for brief, necessary interactions.
 - d. The facility will bundle care and minimize the number of HCP and other staff who enter rooms to reduce the number of personnel requiring facemasks.
 4. If there are confirmed cases of COVID-19 in the facility:
 - a. Notify the local health department and NYSDOH if not already involved.
 - b. Actively monitor all residents on affected units once per shift.
 - i. This monitoring must include a symptom check, vitals, lung auscultation, and pulse oximetry.
 - c. Assure that all residents in affected units remain in their rooms. Cancel group activities and communal dining. Offer other activities for residents in their rooms to the extent possible, such as video calls.
 - d. Residents must wear facemasks when HCP or other direct care providers enter their rooms unless such is not tolerable.
 - e. Do not float staff between units.

- f. Cohort residents with COVID-19 with dedicated HCP and other direct care providers if possible. It might not be possible to have completely separate staffing teams. In this situation, staffing assignments should be made to maintain separate teams to the greatest extent possible, and facilities should make every effort possible to reduce the number of staff caring for residents in different cohorts.
- g. All residents on affected units should be placed on droplet and contact precautions, regardless of the presence of symptoms and regardless of COVID-19 status.
- h. HCP and other direct care providers should wear gown, gloves, eye protection (a face shield), and N95 respirators (or equivalent) if the facility has a respiratory program with fit tested staff and N95s. Otherwise, HCP and other direct care providers should wear gown, gloves, eye protection, and facemasks. Facilities may implement extended use of eye protection and facemasks/N95s when moving from resident to resident (i.e. do not change between residents) unless other medical conditions which necessitate droplet precautions are present. However, gloves and gowns must be changed, and hand hygiene must be performed.
- i. For residents who initially test negative, re-testing should be performed immediately if they develop symptoms consistent with COVID-19.

Discontinuation of Precautions of Residents with COVID-19:

The non-test based strategy is the preferred method used by this facility for the discontinuation of precautions.

1. Non-test-based strategy:
 - a. At least 3 days (72 hours) have passed since recovery, defined as resolution of fever (greater than or equal to 100.0) without the use of fever-reducing medications; **AND**
 - b. Improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**
 - c. At least **10 days** have passed since symptoms attributed to COVID-19 first appeared.
 - i. For patients who were asymptomatic at the time of their first positive test and remain asymptomatic, at least 10 days have passed since the first positive test.
2. Symptom-based strategy for persons with severe-to-critical illness¹ who are NOT severely immunocompromised:
 - a. At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
 - b. Symptoms have improved; **AND**
 - c. At least 10 days and up to 20 days have passed since symptoms attributed to COVID-19 first appeared.
 - d. Consider consultation with infection control or infectious disease experts, especially if fewer than 15 days have passed since symptom onset.

3. Symptom-based strategy for persons who are severely immunocompromised
 - a. Persons who are severely immunocompromised can remain SARS-CoV-2 culture-positive more than 20 days after symptom onset or first positive test. Consultation with infectious diseases specialists is recommended; use of a test-based strategy (defined below) for determining when to discontinue transmission-based precautions should be considered.
 - b. At a minimum, when the symptom-based strategy is determined to be appropriate after specialist consultation, persons who are severely immunocompromised should remain on transmission-based precautions until:
 - i. At least 24 hours have passed since last fever without the use of fever-reducing medications; AND
 - ii. Symptoms (if present) have improved; AND
 - iii. At least 10 days and up to 20 days have passed since symptoms attributed to COVID-19 first appeared.
 1. For severely immunocompromised persons who were asymptomatic at the time of their first positive test and who remain asymptomatic, at least 10 days and up to 20 days have passed since the date of collection of their first positive test.
 2. For severely immunocompromised patients who were asymptomatic at the time of their first positive test and subsequently developed symptoms attributed to COVID 19, at least 10 days and up to 20 days have passed since symptom onset in addition to the clinical criteria above. The test-based strategy is strongly preferred for severely immunocompromised patients (e.g. treated with immunosuppressive drugs, stem cell or solid organ transplant recipients, inherited immunodeficiency, or poorly controlled HIV). If the test strategy is not used for individuals severely immunocompromised, the case should be discussed with the local health department or with NYSDOH.
4. The test-based strategy is not recommended except:
 - a. for severely immunocompromised individuals if concern exists that they might remain infectious more than 20 days.
 - b. in other circumstances when the symptom-based strategy might lead to clinically inappropriate use of transmission-based precautions; however, due to the frequency of prolonged test positivity, the utility of this approach is limited.
5. All of the following are required to discontinue transmission-based precautions using the test based strategy:
 - a. At least 24 hours have passed since last fever, without fever-reducing medications; AND
 - b. Symptoms (if present) have improved; AND
 - c. Results are negative from at least two consecutive respiratory specimens collected greater than or equal to 24 hours apart and tested using an FDA-authorized

molecular viral assay for detection of SARS-CoV-2 RNA. Antigen tests are not molecular viral assays and should not be used for this purpose.

Testing Requirements:

Routine Testing of Staff

Fully vaccinated staff does not have to be routinely tested.

Routine testing of newly hired staff not yet fully vaccinated (fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2-dose series or receipt of one dose of a single-dose vaccine) and employees with an approved medical or religious exemption should be based on the extent of the virus in the community.

The facility will use their county positivity rate in the prior week as the trigger for staff testing frequency. Reports of COVID-19 county-level positivity rates are available on the following website (see section titled, “COVID 19 Testing”): <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg>

Community COVID-19 Activity	County Positivity Rate in the past week	Minimum Testing Frequency of Unvaccinated Staff*
Low	< 5%	Once a month
Medium	5% - 10%	Once a week*
High	>10%	Twice a week*

*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

Testing of Staff and Residents with COVID-19 Signs or Symptoms

Staff with signs or symptoms of COVID-19 must receive a COVID-19 test immediately, along with any other medically-appropriate testing (e.g. viral respiratory pathogens), and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, facilities and staff must follow CDC return to work requirements for facility staff working in nursing homes. See “Protocols for Personnel to Return to Work Following Suspected or Confirmed Positive for the COVID-19 Virus” below. Staff who do not test positive for COVID-19 but have symptoms should follow facility policies to determine when they can return to work.

Residents who have signs or symptoms of COVID-19, whether fully vaccinated or not, must be tested immediately. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance. Once test results are obtained, the facility must take the appropriate actions based on the results.

Any positive test result must continue to be reported to the Department by 1:00 p.m. of the day following receipt of such test results, in accordance with existing reporting protocols and mechanisms.

Testing of Staff and Residents with an Exposure

Asymptomatic HCP with a higher-risk exposure and residents with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5–7 days after exposure.

People with SARS-CoV-2 infection in the last 90 days do not need to be tested if they remain asymptomatic, including those with a known contact.

Testing of Staff and Residents in Response to an Outbreak

An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak.

Upon identification of a single new case of COVID-19 infection in any HCP or residents, all HCP and residents, regardless of vaccination status, should be tested immediately, and all HCP and residents who test negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among HCP or residents for a period of at least 14 days since the most recent positive result.

For individuals who test positive for COVID-19, repeat testing is not recommended. A symptom-based strategy is intended to replace the need for repeated testing.

Other Testing Considerations

In keeping with current CDC recommendations residents who have recovered from COVID-19 and are asymptomatic do not need to be retested for COVID-19 within 3 months after symptom onset.

Routine Testing of Residents

Routine testing of asymptomatic residents is not recommended unless prompted by a change in circumstances, such as the identification of a confirmed COVID-19 case in the facility. Facilities may consider testing asymptomatic residents who leave the facility frequently, such as for dialysis or chemotherapy.

Refusal of Testing

Staff that have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return-to-work criteria are met.

If outbreak testing has been triggered and a staff member refuses testing, the staff member will be prohibited from entering the building until the procedures for outbreak testing have been completed.

Staff who refuses routine testing will be prohibited from entering the building.

Residents (or resident representatives) may exercise their right to decline COVID-19 testing. If a resident has symptoms consistent with COVID-19, or has been exposed to COVID-19, or if there is a facility outbreak and the resident declines testing, he or she should be placed on or remain on TBP until he or she meets the symptom-based criteria for discontinuation.

COVID-19 and Influenza Confirmatory Testing

1. Any resident who is known to have been exposed to COVID-19 or influenza or has symptoms consistent with COVID-19 or influenza shall be tested for both such diseases.
2. Whenever a person expires while in a nursing home, where in the professional judgment of the nursing home clinician there is a clinical suspicion that COVID-19 or influenza was a cause of death, but no such tests were performed in the 14 days before death, the nursing home shall administer both a COVID-19 and influenza test within 48 hours after death.
3. Such tests shall be performed using rapid testing (Antigen) methodologies. The facility shall report the death to the Department immediately after and only upon receipt of both such test results through the Health Emergency Response Data System (HERDS). Notwithstanding the foregoing, no test shall be administered if the next of kin objects to such testing.

Communal Dining

Communal dining may occur for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status while adhering to the core principles of COVID-19 infection prevention.

Communal dining may occur without the use of face coverings or physical distancing, if all residents are fully vaccinated. If there are unvaccinated residents also dining in the communal dining area, all residents must wear face coverings when not eating and unvaccinated residents should physically distance from others.

Staff members who are assisting more than one resident simultaneously must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents

A full disinfection of the dining room will occur after each meal.

Activities

Group activities may be facilitated for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status with social distancing among residents, appropriate hand hygiene, and use of a face covering (except while eating).

Group activities may occur without the use of face coverings or social distancing if all residents participating are fully vaccinated. If any residents that are not fully vaccinated are participating,

all residents must wear a face covering and unvaccinated residents should physically distance from others.

All equipment/supplies used during the activity will be disinfected after each use. A full disinfection of the activity room will occur after each activity has concluded.

Manage Visitor Access and Movement within the Facility

Visitation can be conducted in the facility under the following conditions:

1. Visitors must be able to adhere to the core principles, including infection prevention and control policies.
2. Adherence to screening protocols for all visitors.
3. All visitations will be supervised by facility staff to ensure all core principles of infection control and prevention are adhered to.

Visitation Guidelines:

1. All visits will be held outdoors whenever practicable.
 - a. Outdoor visitation is preferred even when the resident and visitor are fully vaccinated against COVID-19. Fully vaccinated refers to a person who is ≥ 2 weeks following receipt of the second dose in a 2- dose series, or ≥ 2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.
2. Indoor visitation will be accommodated for weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) and an individual resident's health status (e.g., medical condition)
 - a. Indoor visitation will occur in a well-ventilated space
 - b. Visitors will not be allowed to walk around the facility or enter resident care areas unless it is for an end of life visit or the health status of the resident prevents them from leaving their room.
3. Visitation areas (both outdoor and indoor) will be set up by the facility allowing for 6ft of social distancing. There will be markings to cue social distancing delineations.
4. All visitations will take place by appointment only. The facility will have designated days and time slots allowing for a 30 minute visitation. The time slot will allow for appropriate disinfection between visits.
 - a. Each resident is only allowed two (2) visitors during the 30-minute time slot.
 - b. Visitors under the age of 18 years old must be accompanied by an adult.
5. Upon arrival to the facility and prior to resident access, the visitor(s) must go through a screening process to include:
 - a. screening for signs and symptoms of COVID-19;
 - b. a temperature check; and

- c. screening for potential exposure to COVID-19, which shall include questions regarding international travel.
6. Visitor Testing and Vaccination
 - a. The facility will encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days).
 - b. The facility along with the DOH encourages visitors to become vaccinated when eligible.
 - c. Indoor Visitation – if the visitor does not have a negative test within 2-3 days prior to the visit, the facility will request that the visitor be tested via a rapid antigen test in the designated area prior to access to the facility/resident.
 7. Documentation of the screening will be maintained onsite in an electronic format and will include the following for each visitor:
 - a. First and last name of the visitor;
 - b. Physical (street) address of the visitor;
 - c. Daytime and Evening telephone number;
 - d. Date and time of visit; and
 - e. Email address if available
 8. Visitors will be provided with proper PPE; face mask/covering if they do not have one (it is advised all visitors arrive with their own face covering). The face mask must cover both the nose and mouth at all times while on facility grounds.
 9. Staff will provide both the resident and visitor(s) with an alcohol-based hand rub, consisting of at least 60% alcohol for hand hygiene prior to the visit.
 10. Residents may have close contact (including touch) with their visitor if the resident is fully vaccinated. A well-fitting face mask (covering both the nose and mouth) must be worn by the resident and hand-hygiene must be performed before and after. Visitors must physically distance from other residents and staff in the facility.
 11. Upon the conclusion of the 30-minute visitation period, all objects will be properly sanitized with an approved EPA disinfectant.

Visitation Exclusions:

1. Visitation will not be allowed (except for end-of-life and compassionate care visits) regardless of vaccination status for:
 - a. Unvaccinated residents if the nursing home’s COVID-19 county positivity rate is >10% **AND** <70% of residents in the facility are fully vaccinated;
 - b. Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; **OR**

- c. Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

Visitation During an Outbreak

1. Visitation can still occur when there is an outbreak (an outbreak exists when a new nursing home onset of COVID-19 occurs [i.e., a new COVID-19 case among residents or staff]), but there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility.
2. When a new case of COVID-19 among residents or staff is identified, the facility will immediately begin outbreak testing and suspend all visitation (except end-of-life and compassionate care visits) until at least one round of testing is completed. Visitation can resume based on the following criteria:
 - a. If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility will suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.
 - b. If the first round of outbreak testing **reveals one or more additional COVID-19 cases in other areas/units of the facility**, then the facility will suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.
3. The facility will post appropriate signage regarding any current outbreak to notify visitors about the potential for COVID-19 exposure in the facility.

Visit Related Exposures

If a visitor to the facility tests positive for SARS-CoV-2 by a diagnostic test and the visit occurred from two days before the visitor's symptom onset (or in the 2 days before the date of collection of the positive sample for visitors who remained asymptomatic) to the end of the visitor's isolation period, there is a potential for exposure.

Exposures among visitors and residents should be evaluated using community contact tracing guidelines, meaning exposure is defined by the proximity of the individuals and duration of the visit (contact within 6 feet and duration 10 minutes or more) regardless of personal protective equipment (PPE) or face covering used by the visitor or the resident.

The following will be evaluated to determine the appropriate follow-up when there is identification of a visitor who tests positive for COVID-19.

1. The visit was supervised by an appropriate facility staff member; and
2. the visit was conducted in a common area or outdoor area that does not require the visitor to enter a resident unit; and
3. the visitor complied with all COVID-19 precautions including hand hygiene and appropriate use of a face mask or face covering, and
4. the visitor and the resident maintained at least 6 feet of distance from each other for the entire duration of the visit; and
5. the visitor maintained at least 6 feet of distance from all other visitors, residents, and staff for the entire duration of the visit.

If all of the above criteria are confirmed as occurring during the visit, then the following action will be taken with the specific resident that had the visit:

1. The resident who received the visit will be placed on 14- day quarantine in a single room in the designated observation area using Contact plus Droplet precautions and eye protection.
2. The resident will be monitored for symptoms and have temperature checks every shift
3. The resident will be tested for SARS-CoV-2 every 3 to 7 days for at least 14 days.

If all of the above criteria cannot be confirmed, the facility will proceed with contact tracing to determine the extent of the exposure within the facility. Any affected unit (or the entire facility, depending on the amount of contact) will initiate the following:

1. Initiate testing every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result
2. Initiate transmission based precautions
3. Initiate testing for influenza (as per 10 NYCRR 415.33).
4. Facility staff that is exposed according to CDC HCP exposure guidance should be furloughed. See: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.
5. If contacts include other visitors, those visitors should be considered exposed if contact was within 6 feet for more than 10 minutes to the COVID -19 positive visitor, regardless of PPE or face covering worn.
6. Facility staff or visitors who are identified as exposed at the facility will be reported by the facility to the local health department where the individual resides.

Personal Caregiving Visitation

The following policies regarding Personal Caregiving Visitation will only be implemented when there is a declared State or local public health emergency. At this time, there is no declared public health emergency.

Definitions:

A “personal caregiving visitor” means a family member, close friend, or legal guardian of a resident designated by such resident, or such resident’s lawful representative, to assist with personal caregiving or compassionate caregiving for the resident.

Personal caregiving is defined as care and support of a resident to benefit such resident’s mental, physical, or social well-being,

Compassionate caregiving is defined as personal caregiving provided in anticipation of the end of the resident’s life or in the instance of significant mental, physical or social decline or crisis.

Designating a Personal Caregiver:

The facility shall ask residents or their designated representatives in the event the resident lacks capacity, at time of admission or readmission, which individuals the resident elects to serve as their personal caregiving visitor.

A resident shall be entitled to designate at least two personal caregiving visitors at one time. The facility shall maintain a written record of the resident’s designated personal caregiving visitors in the resident’s individualized comprehensive plan of care, and shall document when personal caregiving and compassionate caregiving is provided in the resident’s individualized comprehensive plan of care.

Review of Personal Caregivers:

The facility shall ask all current residents or their designated representative if the resident lacks capacity, whether the facility’s current record of designated personal caregiving visitors remains accurate, or whether the resident, or their designated representative if the resident lacks capacity, wishes to make any changes to their personal caregiving visitor designations. Such inquiries shall be made no less frequently than quarterly and upon a change in the resident’s condition and upon review of a facility’s visitation policies and procedures.

The facility shall update the resident’s individualized comprehensive plan of care with the date the facility sought updates from the resident and indicate on the plan of care any changes to the resident’s personal caregiving visitor.

Access to Personal Caregivers:

If the facility has reasonable cause to believe that a resident will not benefit from accessing their designated personal caregiving visitors, such reasoning will be documented in the resident’s individualized comprehensive plan of care.

- a. The facility will require a NYS licensed or certified health or mental health professional (including but not limited to a physician, registered nurse, licensed clinical social worker, psychologist, or psychiatrist) and not associated with the nursing home, to provide a written statement that the personal caregiving will substantially benefit the resident’s quality of life, including a statement from such medical provider that the personal caregiving visitation will enhance the resident’s mental, physical, or psychosocial well-

being. Such written statements from the medical provider shall be maintained in the resident's individualized comprehensive plan of care.

The facility may prohibit a personal caregiving visitor from entering if the facility has reasonable cause to believe that permitting the personal caregiving visitor to meet with the resident is likely to pose a threat of serious physical, mental, or psychological harm to such resident.

- a. In the event the facility determines that denying such personal caregiving visitor access to the resident is in the resident's best interests, the facility will document the date of and reason for visitation refusal in the resident's individualized comprehensive plan of care, and on the same date of the refusal the facility shall communicate its decision to the resident and their designated representative.

Further, the facility may refuse access to or remove from the premises any personal caregiving visitor who is causing or reasonably likely to cause physical injury to any facility resident or personnel.

Personal Caregiver Visitation Guidelines:

All personal caregiving visitors must adhere to infection control measures established by the facility and with any guidelines from the NYS DOH, or in the absence of applicable Department guidance, consistent with long term care facility infection control guidelines from the U.S. Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services.

Such infection control measures include, but need not be limited to:

- a. testing all personal caregiving visitors for any communicable disease, which includes rapid on-site testing or requiring the visitor to present a negative test result dated no more than seven days prior to the visit;
- b. checking the personal caregiving visitor's body temperature upon entry to the facility, and denying access to any visitor with a temperature above 100 degrees Fahrenheit;
- c. conducting health screenings of all personal caregiving visitors upon entry to the facility, including screenings for signs and symptoms of COVID-19 or any other communicable disease which is prevalent in the facility's geographic area, and recording the results of such screenings;
- d. requiring all personal caregiving visitors to don all necessary personal protective equipment appropriately, and providing such personal protective equipment to all personal caregiving visitors, including a face mask at all times in the facility and a face mask and face shield if providing direct care; and
- e. enforcing social distancing between persons during visitation, including personal caregiving visitation, except as necessary to provide personal caregiving by the personal caregiving visitor for the resident.

Frequency and Duration of Personal Caregiving Visits:

Residents are able to receive their designated personal caregiving visitors for the resident's desired frequency and length of time.

The facility may limit the frequency and length of visit due to the following:

- a. for the resident's clinical or personal care needs;
- b. to ensure the resident's roommate has adequate privacy and space to receive their own designated personal caregiving visitors; or
- c. because the desired visitation frequency or duration would impair the effective implementation of applicable infection control measures, including social distancing of at least six feet between the visitors and others in the facility, having sufficient staff to effectively screen all personal caregiving visitors and monitor visits to ensure infection control protocols are being followed throughout, and having a sufficient supply of necessary personal protective equipment for all personal caregiving visitors.

Personal Caregiver Visitation Limitation or Suspension:

The facility may limit or temporarily suspend personal caregiving visitation to protect the health, safety and welfare of residents if:

- a. Local infection rates are at a level that presents a serious risk of transmission of COVID-19 within the facility;
- b. The facility is experiencing temporary inadequate staffing and has reported such staffing shortage to the Department of Health; or
- c. An acute emergency situation exists at the facility, including loss of heat, loss of elevator service, or other temporary loss of an essential service.

In the event the facility suspends or limits personal caregiving visitation, the facility will notify residents, all designated personal caregiving visitors, and the NYS DOH regional office and the duration of the suspension within twenty-four hours of implementing the visitation suspension or limitation.

Additionally, for each day of the suspension or limitation, the facility will document the specific reason for the suspension or limitation in their administrative records.

The facility will provide a means for all residents to engage in remote visitation with their designated personal caregiving visitor(s), including but not limited to phone or video calls, until such time that the suspension or limitation on personal caregiving visitation has ended.

Compassionate Caregiving Visitation

Eligibility:

Situations in which a resident is eligible for a compassionate caregiving visitor include but are not limited to the following:

- a. end of life;
- b. the resident, who was living with their family before recently being admitted to the facility, is struggling with the change in environment and lack of physical family support;
- c. the resident is grieving after a friend or family member recently passed away;
- d. the resident needs cueing and encouragement with eating or drinking, and such cueing was previously provided by family and/or caregiver(s), and the resident is now experiencing weight loss or dehydration; and
- e. the 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).

Compassionate caregiving visitation shall be permitted at all times, regardless of any general visitation restrictions or personal caregiving visitation restrictions in effect in the facility.

All compassionate care visitors must adhere to infection control measures established by the facility.

Such infection control measures include, but need not be limited to:

- a. checking the visitor's body temperature upon entry to the facility, and denying access to any visitor with a temperature above 100 degrees Fahrenheit;
- b. conducting health screenings of the visitor upon entry to the facility, including screenings for signs and symptoms of COVID-19 or any other communicable disease which is prevalent in the facility's geographic area, and recording the results of such screenings;
- c. requiring all visitors to don all necessary personal protective equipment appropriately, and providing such personal protective equipment to all visitors, including a face mask at all times in the facility and a face mask and face shield if providing direct care; and
- d. enforcing social distancing between persons during visitation; if, however, personal contact would be beneficial for the resident's mental or psychosocial well-being, the visitor will use appropriate personal protective equipment and adhere to hand hygiene protocols before and after resident contact.

Monitor and Manage Ill and Exposed Healthcare Personnel

1. Health checks for all HCP and other facility staff will be completed at the beginning of each shift. This includes all personnel entering the facility regardless of whether they are providing direct patient care (See attached Staff Monitoring Log).'
2. Facility staff performing health checks must wear a facemask.

3. HCP and other facility staff with symptoms or with $T \geq 100.0$ F will be sent home, and HCP and other facility staff who develop symptoms or fever while in the facility will immediately be sent home.

Health Care Personnel and COVID-19 Paid Sick Leave Law

1. HCPs who are furloughed due to contact with a known positive case, or because they do not meet the above conditions for returning to work, may qualify for paid sick leave benefits, and their employers can provide them with a letter confirming this, which can be used to demonstrate eligibility for the benefit.

Asymptomatic Fully Vaccinated HCP Exposed to COVID-19

Asymptomatic HCP who have been fully vaccinated against COVID-19 do **not** need to quarantine or furlough after exposure to COVID-19. Fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2-dose series or receipt of one dose of a single-dose vaccine.

Protocols for Personnel (Not Fully Vaccinated) to Return to Work Following COVID-19 Exposure

Asymptomatic HCP who have had exposure to, or been in contact with, a confirmed or suspected case of COVID-19 (e.g. had prolonged close contact in a healthcare setting with a patient, visitor, or HCP with confirmed or suspected COVID-19 while not wearing recommended personal protective equipment per CDC guidelines; had close community contact within 6 feet of a confirmed or suspected case for 10 minutes or more; or was deemed to have had an exposure [including proximate contact] by a local health department), may be released from quarantine after a 10-day quarantine period without testing if no symptoms have been reported during the quarantine period, may return to work after 14-days, providing the following conditions have been met:

- a. HCP must continue daily symptom monitoring through day 14.
 - b. HCP must be counseled to continue strict adherence to all recommended non-pharmaceutical interventions, including hand hygiene and the use of appropriate face coverings.
 - c. HCP must be advised that if any symptoms develop, they should immediately self-isolate and contact the local public health authority or their healthcare provider to report this change in clinical status and determine if they should seek testing.
2. If staff who are asymptomatic contacts working under these conditions develop symptoms consistent with COVID-19, they should immediately stop work and isolate at home. Testing should be prioritized for hospitalized health care workers. All staff with symptoms consistent with COVID-19 should be dealt with as if they have this infection regardless of the availability of test results.

Protocols for Personnel to Return to Work Following Suspected or Confirmed Positive for the COVID-19 Virus:

A test-based strategy is not recommended because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Symptom-based strategy for return to work:

HCP with mild to moderate illness who are *not* 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

HCP who were asymptomatic throughout their infection and are *not* severely immunocompromised:

- At least 10 days have passed since the date of their first positive viral diagnostic test.

HCP with severe to critical illness or who are 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
- Consider consultation with infection control experts

Severely immunocompromised definition:

- Some conditions, such as being on chemotherapy for cancer, hematologic malignancies, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and taking immunosuppressive medications (e.g., drugs to suppress rejection of transplanted organs or to treat rheumatologic conditions such as mycophenolate and rituximab, 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.

Train and Educate Healthcare Personnel

1. Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
2. HCP must be medically cleared, trained, and fit tested for respiratory protection device use (e.g., N95 filtering face piece respirators).
3. Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

Implement Environmental Infection Control

1. Dedicated medical equipment should be used for patient care.
2. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
3. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
4. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19.

Establish Reporting within Healthcare Facilities and to Public Health Authorities

1. Communicate and collaborate with public health authorities.
2. Promptly notify state or local public health authorities of patients with known or suspected COVID-19 (i.e., PUI). The Infection Control Preventionist is responsible for communication with public health officials and dissemination of information to HCP.

References:

[Updated NH Visitation Guidance 7-8-2021 Final 1625790076595 0.pdf \(ny.gov\)](#)

[DAL 21-17 \(state.ny.us\)](#)

[QSO-20-38-NH REVISED \(cms.gov\)](#)

[Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination | CDC](#)

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

[Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC](#)

<https://commerce.health.state.ny.us/HCSRestServices/HCSCContentServices/docs?docPath=/hes/Documents/Source/hpn/hpnSrc/C46E97FA6DE4BEAFE0530547A8C06F28.pdf>

https://regs.health.ny.gov/sites/default/files/pdf/emergency_regulations/Personal%20Caregiving%20and%20Compassionate%20Caregiving%20Visitors%20in%20Nursing%20Homes%20and%20Adult%20Care%20Facilities.pdf

<https://www.leadingagency.org/linkservid/92DC334B-B35E-9709-1C2343E6CF8C398F/showMeta/0/>

https://coronavirus.health.ny.gov/system/files/documents/2021/04/updated_travel_advisory_april_10_2021a.pdf

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html>

NYS DAL 20-26-12

NYS DAL NH-20-16

https://apps.health.ny.gov/pub/ctrldocs/alrtview/postings/Nursing_Home_Guidance_3_1583593822992_0.6.20_with_signage.pdf

https://commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/COVID19_LTFC_guidance_2_0200312_1584137320257_0.pdf

<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>

<https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html>

<https://www.cms.gov/medicareprovider-enrollment-and-certificationsurvey/certificationgeninfopolicy-and-memos-states-and/interim-final-rule-ifc-cms-3401-ifc-additional-policy-and-regulatory-revisions-response-covid-19>

<https://commerce.health.state.ny.us/HCSRestServices/HCSCContentServices/docs?docPath=/hes/Documents/Source/hpn/hpnSrc/AF881A149551979AE0530547A8C0AB96.pdf>