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.

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.

Possible symptoms include:

- 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:

- Handwashing
- Staying Up to Date with COVID-19 Vaccines
- Improving Ventilation and Spending Time Outdoors
- Getting Tested for COVID-19 if needed
- Following Recommendations for What to Do If You Have Been Exposed
- Staying Home If You Have Suspected or Confirmed COVID-19

- Seeking Treatment If You Have COVID-19 and Are at High Risk of Getting Very Sick
- Avoiding Contact with People Who Have Suspected or Confirmed COVID-19

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.

- **"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.

- **"Level of community transmission"** refers to facility's county level of COVID-19 transmission. This metric uses two indicators for categorization (1. Total number of new cases per 100,000 persons within the last 7 days and 2. Percentage of positive diagnostic and screening nucleic acid amplification tests (NAAT) during the last 7 days), which can be found on the Centers for Disease Control and Prevention (CDC) COVID-19 Integrated County View site at https://covid.cdc.gov/covid-data-tracker/#county-view.

- **"Higher-risk exposure"** refers to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff do not wear adequate personal protective equipment during care or interaction with an individual. For more information, see CDC's "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2."

- **"Up-to-Date"** means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.

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 (14) 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 the 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.

All new employees during the pre-employment screening process, the facility shall illicit information from the prospective personnel regarding their vaccination status, including whether any first doses of the vaccine were previously administered, and whether the prospective personnel are interested in obtaining the COVID-19 vaccine. Such information must be documented with the personnel's pre-employment screening information and, if hired, retained in the personnel file.

Within 14-days of having been hired the facility will make a diligent effort to schedule all consenting and eligible personnel for the COVID-19 vaccination. All signed written consents with the administration information must be filed at the facility.

Any declination of the COVID-19 vaccine Booster within the series must have a signed written declination that they were offered the vaccine but declined and this must be filed at the facility and be available for the review by the DOH at their request.

Medical exemptions and or religious exemptions will be considered based on the CDC guidance for contraindications for COVID-19 vaccine.

Staff that has an approved medical exemption or are not fully vaccinated 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.

Up to Date Vaccination Status:
You are **up to date** with your COVID-19 vaccines if you have completed a COVID-19 vaccine primary series and received the most recent booster dose recommended for you by CDC.

COVID-19 vaccine recommendations are based on three things:
1. Your age

2. The vaccine you first received, and
3. The length of time since your last dose

People who are moderately or severely immunocompromised have different recommendations for COVID-19 vaccines.

COVID-19 Vaccination Schedule Primary Series and Booster Vaccines:

Adults Who Are Moderately or Severely Immunocompromised – 18 years or older:

Pfizer-BioNTech:

1st Dose PRIMARY SERIES	**2nd Dose** PRIMARY SERIES 3 weeks after 1st dose	**3rd Dose** PRIMARY SERIES At least 4 weeks after 2nd dose
4th Dose UPDATED BOOSTER At least 2 months after 3rd dose or last booster, and can be Pfizer-BioNTech or Moderna		

Moderna:

1st Dose PRIMARY SERIES	**2nd Dose** PRIMARY SERIES 4 weeks after 1st dose	**3rd Dose** PRIMARY SERIES At least 4 weeks after 2nd dose
4th Dose UPDATED BOOSTER At least 2 months after 3rd dose or last booster, and can be Pfizer-BioNTech or Moderna		

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1st Dose PRIMARY SERIES	**2nd Dose** ADDITIONAL DOSE At least 4 weeks after 1st dose and should be Pfizer-BioNTech or Moderna	**3rd Dose** UPDATED BOOSTER At least 2 months after 2nd dose or last booster, and can be Pfizer-BioNTech or Moderna

Examples of Moderately or Severely Immunocompromised:

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system

- Received chimeric antigen receptor (CAR)-T-cell therapy (a treatment to help your immune system attach to and kill cancer cells) or received a stem cell transplant (within the last 2 years)
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress their immune response

Adults ages 18 years and older (Not Considered Moderately or Severely Immunocompromised):

Pfizer-BioNTech:

1st Dose PRIMARY SERIES	**2nd Dose** PRIMARY SERIES 3-8 weeks* after 1st dose	**3rd Dose** UPDATED (BIVALENT) BOOSTER At least 2 months after 2nd primary series dose or last booster, and can be Pfizer-BioNTech or Moderna

Moderna:

1st Dose PRIMARY SERIES	**2nd Dose** PRIMARY SERIES 4-8 weeks* after 1st dose	**3rd Dose** UPDATED (BIVALENT) BOOSTER At least 2 months after 2nd primary series dose or last booster, and can be Pfizer-BioNTech or Moderna

* Talk to your healthcare or vaccine provider about the timing for the 2nd dose in your primary series.

- People ages 6 months through 64 years, and especially males ages 12 through 39 years, may consider getting the 2nd primary Pfizer-BioNTech or Moderna 8 weeks after the 1st dose.
    - A longer time between the 1st and 2nd primary doses may increase how much protection the vaccines offer, and further minimize the rare risk of myocarditis and pericarditis.
- Anyone wanting protection due to high levels of community transmission, people ages 65 years and older, or people who are more likely to get very sick from COVID-19, should get the second dose of:
    - Pfizer-BioNTech COVID-19 vaccine 3 weeks (or 21 days) after the first dose.
    - Moderna COVID-19 vaccine 4 weeks (or 28 days) after the first dose.

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1st Dose PRIMARY SERIES	**Pfizer-BioNTech or Moderna** UPDATED (BIVALENT) BOOSTER At least 2 months after 1st dose or last booster, and can be Pfizer-BioNTech or Moderna

Up to Date: Immediately after the most recent booster recommended for you

If you have completed your primary series, but are not yet eligible for a booster, you are also considered up to date.

Medical Exemptions:

Process: Medical exemptions will be considered based on the CDC guidance for contraindications for COVID-19 vaccine.

Due to the frequently changing guidelines, current CDC recommendations will be reviewed prior to granting an exemption. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.

Staff requesting an exemption will be required to obtain documentation from their provider which includes:

- A statement certifying that immunization with COVID-19 vaccine is detrimental to the person based on a specific pre-existing health condition.
- The nature and duration of the medical condition which is consistent with generally accepted medical standards.
- The request will be reviewed by Human Resources and reviewed by the facility's medical director regarding the medical information.

Accommodations will be documented in employee personnel records

Staff that has an approved medical exemption are required to wear a N95 or KN95 mask at all times and these employees shall be socially distanced from all staff during their breaks and meals to prevent transmission of virus. They are tested weekly. See contingency plans.

Religious Exemptions
While the NYS Health Department does not accept religious exemptions, the facility has the obligation to accommodate an employee's sincerely held religious belief under Title VII of the Civil Rights Act (Title VII), unless the accommodation creates an undue hardship.

Mere personal preferences are not religious beliefs protected by Title VII. And neither are social, political, or economic philosophies, no matter how deeply held. See Religious Exemption to COVID-19 Policy and Procedure.

Treatment:
The FDA has authorized certain antiviral medications and monoclonal antibodies to treat mild to moderate COVID-19 in people who are more likely to get very sick.

- **Antiviral treatments** target specific parts of the virus to stop it from multiplying in the body, helping to prevent severe illness and death.
- **Monoclonal antibodies** help the immune system recognize and respond more effectively to the virus.

.Treatment	Who	When	How
Nirmatrelvir with Ritonavi (Paxlovid) *Antiviral*	Adults; children ages 12 years and older	Start as soon as possible; must begin within 5 days of when symptoms start	Taken by mouth (orally)
Molnupiravir (Lagevrio) *Antiviral*	Adults	Start as soon as possible; must begin within 5 days of when symptoms start	Taken by mouth (orally)
Remdesivir (Veklury) *Antiviral*	Adults and children	Start as soon as possible; must begin within 7 days of when symptoms start	Intravenous (IV) infusions at a healthcare facility for 3 consecutive days
Bebtelovimab *Monoclonal antibody*	Adults; children ages 12 years and older	Start as soon as possible; must begin within 7 days of when symptoms start	Single IV injection

Monitoring of Residents:

1. Monitoring of Residents **Prior to Entry**:
    a. 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. Based on the expiration of the State Disaster Emergency, declared pursuant to Executive Order 202, the facility may accept a COVID-19 positive resident if they are capable of providing appropriate and necessary care.

2. Monitoring of Residents **After Admission:**
    a. All new admissions/re-admissions will be screened/monitored **every shift** for **14 days** by obtaining Vital Signs and Respiratory Monitoring:
        i. Temperature, Pulse, Respirations, Blood Pressure, Pulse Oximetry
        ii. Cough, SOB, Sore Throat
    b. After 14-days residents will be screened/monitored **Daily** by obtaining Vital Signs and Respiratory Monitoring:
        i. Temperature, Pulse, Respirations, Blood Pressure and Pulse Oximetry
        ii. Cough, SOB, or Sore Throat
    c. 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.
    d. 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.

3. Monitoring of Residents following an **Outside Appointment:**
    a. All appointments should be restricted to those only that are medically necessary.
    b. All residents receiving dialysis will need VS and Respiratory Monitoring daily.
    c. 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. 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.
    d. 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.
    e. Individuals accompanying residents (e.g., transport personnel, family members) should also be educated about these IPC practices and should assist the resident with adherence.
    f. 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.
    g. Residents who leave the facility for 24 hours or longer should generally be managed as described in the New Admission and Readmission section.

4. Monitoring of Residents following a **Resident Outing:**
    a. Residents will be permitted to leave the facility as they choose.
    b. Residents and any individual accompanying the resident will be reminded to follow all recommended infection prevention practices include use of face coverings or mask, physical distancing, and hand hygiene.
    c. Quarantine is not recommended for fully vaccinated residents who leave the facility for less than 24 hours 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. 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.

d. Residents who leave the facility for 24 hours or longer should be managed as a new admission or readmission.

Routine PPE:

1. All HCP and other facility staff shall wear a facemask while in the facility. 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.

Confirmed Cases of COVID-19 in the facility:

1. Actively monitor all residents on affected units once per shift.
    a. This monitoring must include a symptom check, vital signs and pulse oximetry.
2. Consider quarantining all residents in the affected unit. Cancel group activities and communal dining on the affected unit. Offer other activities for residents in their rooms to the extent possible, such as video calls.
3. Residents must wear facemasks when HCP or other direct care providers enter their rooms unless such is not tolerable.
4. Limit floating of staff between units.
5. 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.
6. The Negative asymptomatic roommate of a positive resident should be on Transmission Based Precautions/Quarantine in a private room for 14-days regardless of their vaccination status.
7. HCP and other direct care providers should wear gown, gloves, eye protection (a face shield), and N95 respirators (or equivalent) when caring for a positive resident.
    a. 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.
8. For residents who initially test negative, re-testing should be performed immediately if they develop symptoms consistent with COVID-19.
9. Notify the NYSDOH.

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

Routine testing of staff that are not fully vaccinated, should be based on the extent of the virus in the community. Staff 50 years and older require the 2nd booster 4 months after the 1st to be considered fully vaccinated and up to date. Staff that are up-to date, do not have to be routinely tested.

For HCP who work in the facility infrequently, they should ideally be tested within the 3 days before their shift (including the day of the shift).

Facilities should use their community transmission level as the trigger for staff testing frequency. Reports of COVID-19 level of community transmission are available on the CDC COVID-19 Integrated County View site: https://covid.cdc.gov/covid-data-tracker/#county-view.

Routine Testing Intervals by County COVID-19 Level of Community Transmission

Level of COVID-19 Community Transmission	**Minimum Testing Frequency of Staff who are not fully vaccinated**
Low (Blue)	Not Recommended
Moderate (Yellow)	Once a week*
Substantial (Orange)	Twice a week*
High (Red)	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.

If the level of community transmission decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the level of community transmission has remained at the lower activity level for at least two weeks before reducing testing frequency.

In accordance with CMS and CDC guidance, in general, testing is not necessary for asymptomatic people who have recovered from SARS- CoV-2 infection in the prior 90 days; however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

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 are to have a PCR test done and 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 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 accordance with CMS and CDC guidance, in general, testing is not necessary for asymptomatic people who have recovered from SARS- CoV-2 infection in the prior 90 days; however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

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 and Activities
Communal activities and dining may occur while adhering to the core principles of COVID-19 infection prevention.

The safest approach is for everyone, regardless of vaccination status, to wear a face covering or mask while in communal areas of the facility.

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.
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.

Visitation

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. Regardless of how visits are conducted, core infection control principles and best practices reduce the risk of COVID-19 transmission.

Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave.

Outdoor visitation is preferred when the resident and/or visitor are not fully vaccinated with all recommended COVID-19 vaccine doses. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, and poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, and quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor Visitation

Although there is no limit on the number of visitors that a resident can have at one time, visits will be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents.

Large gatherings (e.g., parties, events) where large numbers of visitors are in the same space at the same time and physical distancing cannot be maintained will not be allowed.

During indoor visitation, visitor movement in the facility will be limited. Visitors will not be allowed to walk around different halls of the facility. They shall go directly to the resident's room or designated visitation area.

If a resident's roommate is not fully vaccinated or immunocompromised (regardless of vaccination status), visits will not be conducted in the resident's room. Immunocompromised is defined as: people who have:

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

Upon arrival to the facility and prior to resident access, the visitor(s) must go through a screening process to include:

- screening for signs and symptoms of COVID-19;
- a temperature check; and

- screening for potential exposure to COVID-19, which shall include questions regarding international travel.

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

Mask, Personal Protective Equipment, and Physical Distancing Requirements for Visitors:
All visitors must:

- Wear a well-fitting non-surgical paper mask or a mask of higher quality (i.e., surgical mask, KN95 or N95) at all times during any visitation at the facility. If the visitor wishes, a cloth mask may be placed over the paper mask. The masks must cover both the nose and the mouth; and
- Physically distance from facility personnel and other patients/residents/visitors that are not directly associated with the specific resident(s) being visited by that individual.

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.

Testing for Visitors:
Visitors must have received a negative SARS-CoV-2 test result one day prior to visitation for antigen tests and two days prior to visitation for NAAT (e.g. PCR) tests. All visitors may use either NAAT testing or antigen testing.

Facilities can offer to conduct onsite testing of visitors, if practical.

- Testing will be conducted in an area near the entrance. It will not be conducted in a resident care area.
- Staff performing the testing must maintain proper infection control and use recommended personal protective equipment, which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens.
- Any visitor with a positive test result will not be allowed to visit the resident and must leave the facility. The facility will notify the local health department where the individual resides.
- All positive test results will be entered onto the ASCII Format sheet for conversion and submission to the DOH via the Electronic Clinical Laboratory Reporting System (ECLRS) on the Health Commerce System.

For visitors who visit for multiple days, including a visitor who comes every day, proof of negative testing is required as often as feasible, at a minimum every third day (meaning at a minimum testing is required on day one, day 4, day 7, and so on).

Visitation Exclusions:

Visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or currently meet the criteria for quarantine should not enter the facility until they meet the criteria used for residents to discontinue transmission-based precautions.

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.
    ii. For visitors 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.

Visitation During an Outbreak

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors may still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room.

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.

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 ≥ 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.

Return to Work Criteria for HCP Who Were Exposed to Individuals with Confirmed SARS-CoV-2 Infection

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):

- **HCP who have received all COVID-19 vaccine and booster:**
  - No work restrictions unless HCP moderately to severely immunocompromised
  - Perform SARS-CoV-2 testing immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure.
  - Follow all recommended infection prevention and control practices, including wearing well-fitting source control (respirator or well-fitted face mask), 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 develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
- **HCP who have not received all COVID-19 vaccine and booster doses:**

  Option 1:
  - Exclude from work.
  - HCP can return to work after day 7 following the exposure (day 0) if a viral test (either an antigen test or NAAT can be used) is negative for SARS-CoV-2 and HCP do not develop symptoms. The specimen can be collected and tested within 48 hours before the time of planned return to work (e.g., in anticipation of testing delays).

  Option 2:
  - Exclude from work.
  - HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.
  - Although the residual risk of infection is low, healthcare facilities could consider testing for SARS-CoV-2 within 48 hours before the time of planned return.

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

The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.

Either an antigen test or nucleic acid amplification test (NAAT) can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

HCP with mild to moderate illness who are *not* moderately to severely immunocompromised:

- At least 7 days if a negative antigen or NAAT 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) 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* moderately to severely immunocompromised:

- At least 7 days if a negative antigen or NAAT is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or a positive test at day 5-7) have passed since the date of their first positive viral test.

HCP with severe to critical illness and are *not* moderately to severely immunocompromised:

- In general, when 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.

HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

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.

Guidance for return-to-work for fully vaccinated healthcare workers where there is a critical staffing shortage (Contingency Plan)

In limited circumstances where there is a critical staffing shortage, employers may allow a person to return to work after day 5 of their isolation period (where day zero is defined as either date of symptom onset if symptomatic, or date of collection of first positive test if asymptomatic) if they meet all the following criteria:

- The individual is fully vaccinated (e.g. completed 1 dose of Janssen or 2 doses of an mRNA vaccine at least 2 weeks before the day they become symptomatic or, if asymptomatic, the day of collection of the first positive specimen).
- The individual is asymptomatic, or, if they had mild symptoms, when they return to work they must:
    - Not have a fever for at least 72 hours without fever-reducing medication
    - Have resolution of symptoms or, if still with residual symptoms, then all are improving
    - Not have rhinorrhea (runny nose)
    - Have no more than minimal, non-productive cough (i.e., not disruptive to work and does not stop the person from wearing their mask continuously, not coughing up phlegm)
- The individual is able to consistently and correctly wear a well-fitting face mask, a higher-level mask such as a KN95, or a fit-tested N95 respirator while at work. The mask should fit with no air gaps around the edges.
    - A higher-level mask or respirator should be worn even when the individual is in non-patient care areas such as breakrooms or offices.
- Individuals who are moderately to severely immunocompromised are not eligible to return to work under this guidance.
- The individual should be restricted from contact with severely immunocompromised residents/patients (e.g., transplant, hematology-oncology).
- Testing is not required.
- Workers participating in this program will be instructed that:
    - They should practice social distancing from coworkers at all times except when job duties do not permit such distancing.
    - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
    - They should self-monitor for symptoms and seek re-evaluation from occupational health or their personal healthcare provider if symptoms recur or worsen.

Travel

As of June 25, 2021, the New York State Travel Advisory is no longer in effect. As such, travelers arriving in New York are no longer required to submit traveler health forms.

All travelers, domestic and international, should continue to follow all Federal, State and CDC travel requirements.

Domestic Travel

- Get up to date with your COVID-19 vaccines before you travel.
- Consider getting tested before travel.
- **After travel:**

- Get tested with a viral test if your travel involved situations with greater risk of exposure such as being in crowded places while not wearing a high-quality mask or respirator.
- Self-monitor for COVID-19 symptoms; isolate and get tested if you develop symptoms.

International Travel

- Get up to date with your COVID-19 vaccines before you travel.
- Consider getting tested before travel.
- **After travel:**
  - Get tested with a COVID-19 viral test 3-5 days after travel.
  - Self-monitor for COVID-19 symptoms; isolate and get tested if you develop symptoms.

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.

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