Hudson Park Rehabilitation and Nuring 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.

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

- **"Cloth mask"** Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal protective equipment (PPE) appropriate for use by healthcare personnel.**

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 seven (7) 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 7-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 up to date on vaccination status 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.

.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

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. Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

b. Residents will be advised to wear source control (i.e., a well-fitting facemask) for the 10 days following their admission.
c. Testing is not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended.
d. Empiric use of Transmission-Based Precautions is not necessary for admissions unless they meet the criteria of when empiric Transmission-Based Precautions may be considered:
    i. Patient is unable to be tested or wear source control as recommended for the 10 days following their admission
    ii. Patient is moderately to severely immunocompromised
    iii. Patient is residing on a unit with others who are moderately to severely immunocompromised
    iv. Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

4. Monitoring of Residents who leave the facility **for greater than 24 hours**:
    a. Residents who leave the facility for 24 hours or longer should be managed as an admission.

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

Healthcare facilities may choose to offer well-fitting facemasks as a source control option for visitors but should allow the use of a mask or respirator with higher-level protection that is not visibly soiled by people who chose that option based on their individual preference.

Source control options for HCP include:

- A NIOSH-approved particulate respirator with N95 filters or higher;
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated);
- A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; OR
- A well-fitting facemask.

When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through.

If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned.

When SARS-CoV-2 Community Transmission levels are **not** high, universal source control is not required. However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who:

- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure; or
- Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or
- Have otherwise had source control recommended by public health authorities

Individuals might also choose to continue using source control based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease.

This source control policy for SARS-CoV-2 does not effect the requirements under the *Regulation for Prevention of Influenza Transmission by Healthcare and Residential Facility and Agency Personnel*. At this time, influenza is prevalent in NYS. And Section 2.59 of the New York State Sanitary Code (10 NYCRR § 2.59) requires all health care and residential facilities and agencies regulated pursuant to Article 28, 36, or 40 of the Public Health Law to ensure that all personnel, as defined in the regulation, not vaccinated against influenza for the current influenza season wear a surgical or procedure mask while in areas where patients or residents are typically present.

When SARS-CoV-2 Community Transmission levels **are high**, source control is required for everyone in the facility when they are in areas of the healthcare facility where they could encounter patients.

The facility will post a notice regarding face masks and Community Transmission level for all visitors and HCP upon entry into the facility.

Universal Use of Personal Protective Equipment for HCP

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

As community transmission levels increase, the facility may implement a broader use of respirators and eye protection by HCP as described below:

- All aerosol-generating procedures; and
- If healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place.

Placement of residents with suspected or confirmed SARS-CoV-2 infection:

- Residents should be placed in a single-person room if available. The door should be kept closed (if safe to do so). Ideally, the resident should have a dedicated bathroom.
    - If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
- If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.
    - The facility may consider designating an entire unit(s) within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.
- The resident(s) will be placed on Transmission Based precautions.

Personal Protective Equipment with suspected or confirmed SARS-CoV-2 infection:

- HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
- Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard

Responding to a newly identified SARS-CoV-2-infected HCP or resident

- The facility will follow the below recommendations unless directed otherwise by the NYS health department or local health department.
- A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.
- The approach to an outbreak investigation could involve either contact tracing or a broad-based approach.
    - A broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
- Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
    - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.

    - Testing is not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended.
- Empiric use of Transmission-Based Precautions for residents are not necessary unless residents meet the following criteria:
    - Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
    - Patient is moderately to severely immunocompromised
    - Patient is residing on a unit with others who are moderately to severely immunocompromised
    - Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions
- In the event of ongoing transmission within the facility that is not controlled with initial interventions, the use of Transmission-Based Precautions for residents will be implemented. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
- If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. If empiric use of Transmission-Based Precautions for residents were implemented as described above, they can be discontinued.
- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
    - If antigen testing is used, more frequent testing (every 3 days), should be considered.

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

Exposures that might require testing and/or restriction from work can occur both while at work and in the community.

Higher-risk exposures are classified as HCP who had prolonged* close contact** with a patient, visitor or HCP with confirmed SARS-CoV-2 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)[4]
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

Following a higher-risk exposure, HCP should:

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

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

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

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

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

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

In addition to above:

- HCP should follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

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

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

*An exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, **any duration** should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.

**Close contact is defined as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

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.

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 asymptomatic staff is no longer recommended but may be performed at the discretion of the facility.

Testing of Staff and Residents with COVID-19 Symptoms or Signs
Staff with even mild symptoms of COVID-19, regardless of vaccination status, must be tested as soon as possible and are expected to be restricted from the facility pending the results of COVID-19 testing.

When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.

- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses.

If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidance "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2."

Residents who have signs or symptoms of COVID-19, regardless of vaccination status, must be tested as soon as possible. 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.

Testing of Staff and Residents in Response to an Outbreak
An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP are discontinued. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission.
Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing.

If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). See "Responding to a newly identified SARS-CoV-2-infected HCP or resident."

Other Testing Considerations
In general, testing is not necessary for asymptomatic people who have recovered from SARSCoV-2 infection in the prior 30 days; testing should be considered for those who have recovered in the prior 31-90 days however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended.

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.

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
Nursing homes are advised that all staff and visitors should continue to adhere to the core principles of COVID-19 infection prevention. Those principles include:

- Although COVID-19 testing is no longer required (See Visitor Testing and Vaccination below for further guidance), facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. If the visitor is aware that they are positive or had a recent exposure they should defer non-urgent, in-person visitation until they meet Centers for Disease Control and Prevention (CDC) criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent, in-person visitation until 10 days after their close contact, if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
- Hand hygiene. Use of alcohol-based hand rub is preferred when hands are not visibly soiled. Otherwise, soap and water hand washing should be performed.
- Face covering or mask (covering mouth and nose) in accordance with the most up-to-date CDC recommendations.
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask; specified entries, exits and routes to designated areas; and hand hygiene).
- Frequent cleaning and disinfection of high-touch surfaces in the facility and designated visitation areas after each visit.
- Appropriate staff use of personal protective equipment (PPE).
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care).
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO- 20-38-NH).
- The risk of COVID transmission can be further reduced using physical barriers (e.g., clear Plexiglass dividers, curtains).
- Also, nursing homes should enable visits to be conducted with an adequate degree of privacy.

Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. For outdoor visits, the facility will create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor Visitation
Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations.

Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. During peak times of visitation and large gatherings (e.g., parties, events) facilities should encourage physical distancing.

Face Coverings and Masks During Visits
If the nursing home's county COVID-19 community transmission is high, everyone in a healthcare setting should wear face coverings or masks.

If the nursing home's county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks.

Regardless of the community transmission level, residents and their visitors when alone in the resident's room or in a designated visitation area, may choose not to wear face coverings or masks and may choose to have close contact (including touch). Residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit.

If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.

While not recommended, residents who are on transmission-based precautions (TBP) or quarantine can still receive visitors. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated). Before visiting residents, who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention. Facilities may offer well-fitting facemasks or other appropriate PPE, if available; however, facilities are not required to provide PPE for visitors.

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.

Visitor Testing and Vaccination
Facilities in counties with high levels of community transmission will offer testing to visitors. If facilities do not offer testing, they should encourage visitors to be tested on their own before coming to the facility (e.g., within 2–3 days).

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.
- All testing will be documented on the Visitor Rapid Antigen Testing Log.
- 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.

CMS strongly encourages all visitors to become vaccinated and facilities should educate and also encourage visitors to become vaccinated. Visitor testing and vaccination can help prevent the spread of COVID-19 and facilities may ask about a visitors' vaccination status, however, visitors are not required to be tested or vaccinated (or show proof of such) as a condition of visitation.

If the visitor declines to disclose their vaccination status, the visitor should wear a face covering or mask at all times. This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems.

Visitation Exclusions:
Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation.

For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).

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.
2. 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.

Return to Work Criteria for HCP with SARS-CoV-2 Infection
The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions.

After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP

should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

- **HCP with mild to moderate illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
    - At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7)*,* **and**
    - At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
    - Symptoms (e.g., cough, shortness of breath) have improved.

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

- **HCP who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
    - At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

- **HCP with severe to critical illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
    - At least 10 days and up to 20 days have passed *since symptoms first appeared,* **and**
    - At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
    - Symptoms (e.g., cough, shortness of breath) have improved.

The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

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.

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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