BRIDGEWAY CARE AND REHABILITATION CENTER

Infection Prevention and Outbreak Response Plan

COVID-19

LESSONS LEARNED – COVID-19 WAVE #1

Bridgeway conducted a debriefing of the incident on August 19, 2020 and developed an After-Action Report (AAR). The content of the AAR is privileged and confidential and for quality improvement purposes only; however, the lessons learned in the following key areas have been incorporated into this plan:

- Communication/Notification: use of the Incident Command Structure, notification of staff, notification of residents/families, and notification of external sources.
- Resources and Assets: staffing, PPE, supplies, equipment, transportation and evacuation, and testing.
- Safety and Security: patient/staff/visitor Access.
- Patient Management: clinical needs, resident rights, support activities, cohorts, and physician visits.
- Facilities: ventilation, sanitation/disinfection, and regulated medical waste and storage.
- Mandatory Reporting Compliance: NHSN, NJHA, OEM and DOH.

DEFINITION OF AN OUTBREAK

A COVID-19 outbreak in a LTC facility is defined as ≥1 facility-acquired COVID-19 case in a resident or ≥ 1 laboratory confirmed COVID-19 case among staff.

SIGNS AND SYMPTOMS

COVID-19 may be difficult to differentiate from other illnesses due to common signs and symptoms. The most common signs and symptoms associated with COVID-19 include: cough, new shortness of breath, sore throat, URI symptoms, fever, chills with or without shaking, new fatigue, new body aches, nausea, vomiting, diarrhea or new loss of sense of taste or smell.

TESTING

The facility has entered into agreements with several labs to mitigate overwhelming the testing capacity of any individual lab.

Bridgeway completed initial point prevalence testing and subsequent testing requirements in accordance with Executive Directive 20-013 and submitted the required attestation of compliance to the NJ DOH. Ongoing testing and retesting will be in accordance with CDC and NJ DOH guidance, as amended and supplemented.

COMMUNICATION PLAN

Bridgeway Care and Rehabilitation has developed a communication plan to assure that, in an emergency or infectious disease outbreak, the necessary resources are in place to ensure:

1. Facility staff have updated phone lists to contact other staff, physicians, residents, families/responsible parties, and other necessary people and/or agencies in a timely manner;
2. Residents and their families/responsible parties have a means to stay in touch with residents and facility staff; and
3. Facility staff have resources to guide thought processes in the event of a primary telephone system failure.

When the Incident Command Center is operating, the Communications Coordinator is responsible for implementing the Communication Plan. When the Incident Command Center is not operating, any individual with access to our electronic medical record may be designated to implement this plan.

Personnel Contacts

The following table lists the various phone lists that may be needed in the event of an emergency, the process owner responsible for updating each list, and the updating frequency. All these lists are part of this Communication Plan.

Phone List	Process Owner	Updated
Emergency Phone List	Receptionist	Quarterly
Employee Phone List	Human Resources/ Payroll	Quarterly
Physician Phone List	Medical Records	Quarterly
Internal Phone Extensions	Receptionist	Quarterly
Resident Emergency Contact List	Point Click Care User	Run as needed

Emergency Notification

Bridgeway shall notify the residents and their families/responsible parties of situations which effect routine operations; for example, infectious disease outbreaks and emergency preparedness measures such as utility failure, evacuation, etc.

The primary means of communication may include contact by phone, email, and or cell phone text blasts. Resident contact information is available in our electronic medical record.
Specific to COVID-19:

- General communication will be at least weekly and by way of memo to residents and by way of email/text blast to resident families and staff. These general communications may include up to date statistics, mitigation efforts, changes to normal operations, and a point of contact (e.g., Administrator) for any questions or concerns. Each update will contain a boilerplate passage reminding recipients that they can stay in touch via Facebook, Bridgeway's webpage, and by scheduling virtual visits and will also include links to these sources.
- If the facility receives a positive test result for a resident or staff (an outbreak), or if three or more residents or staff with new-onset respiratory symptoms occur within 72 hours of each other, the facility shall notify all residents, the resident's representative (one), and all staff by 1700 hours on the calendar day after the date the result is received by the facility.
- During an outbreak, positive test results for individual residents shall be reported directly (in person or by phone) to the resident, the resident's representative, the Infection Prevention Nurse, the Director of Nursing, the Administrator, and the Medical Director.
- During an outbreak, positive test results for staff shall be reported directly (in person or by phone) to the individual staff member, his/her manager, the Infection Prevention Nurse, the Employee Health Nurse, the Director of Human Resources, the Administrator, and the Medical Director.
- The facility shall use a line list to document test results and will submit the line list to the local and State Departments of Health as required and/or instructed.

Alternate Means of Communication

In the event of a telephone system failure, the Communications Coordinator or designee is responsible for assuring, among other things, that alternate communication equipment is available, distributed, and tracked. The priority action items are:

1. Gather portable radios.
2. Confirm presence of facility-owned cell phones.

3. Complete a Radio/Phone Distribution Log.
4. Distribute copies of the Radio/Phone Distribution Log to key areas.
5. Run a Resident Emergency Contact List.
6. Notify residents and their families/responsible parties of alternate ways to contact the facility which may include any of the following:
    - Facility owned cell phones
    - Copy/Fax Machines
    - By email to askbridgewayhb@bshcare.com.
    - During circumstances where in-person visitation is restricted, virtual visitation through Skype may be scheduled at www.bshcare.com/skype.

Urgent Communications

Bridgeway has established a mechanism for residents and their families to contact the facility with urgent questions or concerns that are not being responded to via normal communication methods. These mechanisms are posted on our website and are monitored by the Administrator and other key personnel. Contact may be made:

- By calling the Urgent Communications Hotline at (908) 315-5933. When prompted, press "2" for Bridgeway at Hillsborough.
- By email to askbridgewayhb@bshcare.com.

RESIDENT PROTOCOL

Monitoring Residents for COVID-19

Current Residents

Monitor for sign and symptoms of COVID-19 at least once daily and notify clinician if resident develops corresponding signs or symptoms.

New Admissions and Re-admissions from the Community or Hospital

All new admissions and re-admissions will be screened for COVID-19 prior to acceptance into the facility and upon admission. If the resident was tested at a facility prior to admission, the sending facility must provide lab results to the receiving facility. The resident will be placed in a cohort based upon their COVID-19 status.

Transfers Between Bridgeway Senior Healthcare Facilities

Unless determined otherwise by Nursing, residents who transfer between Bridgeway Senior Healthcare facilities during their initial 14-day observation period will only require

isolation with transmission-based precautions for the remainder of the 14-day period. All other residents will not need to be isolated upon transfer.

Management of Residents

Cohorts

Residents will be placed in cohorts based upon their COVID-19 test results, symptoms and exposure to COVID-19. The facility will designate an area for each cohort.

Cohort 1 – COVID-19 Positive

This cohort consists of both symptomatic and asymptomatic residents who test positive for COVID-19, including any new or re-admissions who are COVID-19 positive and have not met criteria for discontinuation of isolation. If feasible, care for COVID-19 positive residents on a separate closed unit. Residents who test positive for COVID-19 are known to shed virus, regardless of symptoms; therefore, all positive residents would be placed in this positive cohort.

Cohort 2 – COVID-19 Negative, Exposed

This cohort consists of symptomatic and asymptomatic residents who test negative for COVID-19 with an identified exposure to someone who was positive.

Cohort 3 – COVID-19 Negative, Not Exposed

This cohort consists of residents who test negative for COVID-19 with no COVID-19-like symptoms and are thought to have no known exposures. In situations of widespread COVID-19, all negative persons in a facility would be considered exposed. Cohort 3 should only be created when the facility is relatively certain that residents have been properly isolated from all COVID-19 positive and incubating residents and staff. The facility may not be able to create this cohort.

Cohort 4 – New or Re-admissions

This cohort consists of all persons from the community or other healthcare facilities whose COVID-19 status is unknown. This cohort serves as an observation area where residents remain for 14 days to monitor for symptoms that may be compatible with COVID-19. Testing at the end of this period could be considered to increase certainty that the person is not infected.

Transmission Based Precautions

Residents who are newly admitted and residents who are COVID-19 positive or were exposed to someone who tested COVID-19 positive, will be placed on transmission-based precautions with the use of full PPE until the resident meets criteria for discontinuation of transmission-based precautions.

Transfer to an Acute Care Facility

If a resident who is confirmed to be COVID-19 positive or is under investigation for COVID-19 requires transfer to an acute care facility, staff will notify the transferring EMS/ambulance agency of the resident's COVID status when placing the call to arrange transport, document the COVID status on the Universal Transfer Form and contact the receiving facility and inform them of the resident's COVID status.

Death

If a resident who is confirmed to be COVID-19 positive or is under investigation for COVID-19 dies, inform the funeral home of the resident's COVID status.

STAFF PROTOCOL

As long as COVID-19 is present in the surrounding community, there exists a risk of it entering the facility. To mitigate the risk of this occurrence by staff, the following staff-specific interventions are in place:

- Staff receives education specific to COVID-19.
- Staff are provided with PPE.
- Staff are primarily assigned to a designated unit or department and are rotated only when necessary to meet the needs of the residents.
- Staff are directed not to report work if they feel ill.

Screening

Prior to entering the facility, all staff are screened for COVID-19. Staff who do not pass the screening process will be evaluated by a nurse who will determine if they can work.

Staff who develop signs and symptoms during their shift must inform their supervisor or manager on duty and be tested for COVID-19 prior to leaving the facility. They will be restricted from work while test results are pending.

Staff Testing

All staff will undergo testing in accordance with current CDC and/or NJ DOH guidelines. For employees who work at more than one facility, Bridgeway will accept the results from another facility, provided that the testing is compliant with Bridgeway's current testing process and the employee consents to have the test results made available to Bridgeway simultaneously with the facility where the employee was tested.

Management of COVID-19 Negative Staff

If staff test negative for COVID-19 they may still be restricted from work based upon self-reporting of either exposure to a confirmed COVID-19 case or symptoms that *could* be associated with COVID-19 or another illness. The Employee Health Nurse or designee must be informed of the exposure and/or complaint of symptoms. The risk of exposure and need for work restrictions will be determined by using the *Revised NJDOH Exposure to Confirmed COVID-19 Case Risk Algorithm* and the following table:

	Symptomatic	**Asymptomatic**
Exposed	Employees who, after a negative test, report an exposure AND symptoms, will be restricted from work for 14 days from the date of exposure and instructed to self-isolate.	Employees who, after a negative test, report an exposure and NO symptoms, will be restricted from work for 14 days from the date of exposure, and instructed to self-isolate and monitor for symptoms.
Not Exposed	Employees who report COVID-like symptoms but have not been exposed and test negative will contact the Employee Health Nurse for further evaluation and determination of work restriction, as the symptoms are likely related to another illness.	Continue to work

Management of COVID-19 Positive Staff

Staff who test positive for COVID-19 will be restricted from work until they meet the CDC criteria to return.

The Infection Prevention Employee Health Nurses or their designee will initiate contact tracing, notify the local Health Department, notify staff, residents, resident representatives and others per the facility's communication plan, and report the case in the mandated NJDOH and CMS reporting systems.

Return to Work Criteria

Staff who have been restricted from will not be allowed to return until they meet CDC return to work criteria.

Crisis Staffing

Crisis staffing will be implemented during times of potential or actual staffing shortages to ensure continuity of operations and the ability to meet the needs of the residents. All departments will work collaboratively to implement the initiatives.

1. Each department director will document the minimum staffing requirements for their area, based on census and resident acuity where appropriate.
2. All current full-time, part-time, and per diem employees will be notified when a staffing emergency is in effect and requested to provide additional availability to work.
3. Department directors may implement any/all the following initiatives with currently working staff: change shift length (from 8- to 10- or 12-hour shifts), adjust the start and/or end times for existing staff, implement mandatory overtime in accordance with state regulation and facility policy.
4. Additional initiatives may include:
    a. Use of staff from other Bridgeway or Avalon locations.
    b. Use temporary staff through contracted agencies.
    c. Recruit temporary employees who could assist with tasks that can be performed by unlicensed and non-certified staff.
    d. Use physical therapists, occupational therapists, and speech therapists for resident care tasks as appropriate to their discipline.
    e. When approved through CMS and NJ DOH waivers, recruit Certified Homemaker Home Health Aides and other health care workers to assist with resident care.
    f. When approved through CMS and NJ DOH waivers, implement a dining assistant training program consistent with regulatory requirements.
    g. Communicate the need among staff to postpone elective time off from work.
    h. Reassign health care personnel (e.g., nursing administrative and MDS staff) to support essential patient care activities in the facility.
    i. Address social factors that might prevent health care personnel for reporting to work such as transportation and housing.
    j. Determine the priority of nursing care and services during staffing shortages and consider initiatives to modify the workload of staff.
5. Communicate with local healthcare coalitions, federal, state, and local health partners to identify additional healthcare personnel.
6. As a last resort, and in collaboration with the Administrator, transfer residents to healthcare facilities or alternate care sites with adequate staffing to provide safe patient care.

VISITATION PROTOCOL

Due to the vulnerability of our residents, and to reduce the risk of introduction of COVID-19 into the facility as community transmission becomes widespread, the facility will restrict

access of visitors and non-essential personnel in accordance with NJ Department of Health (NJDOH) guidelines and Executive Directive 20-026 for the resumption of services in LTC facilities, which details four phases. Visitor access depends upon a combination of whether the visitor is essential or non-essential and which phase the facility is in.

Category	PHASE 0	PHASE 1	PHASE 2	PHASE 3
Outdoor visitation	Refer to Executive Directive No. 20-026 for information on outdoor visitation at https://www.nj.gov/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf.			
Indoor visitation Visitors should practice routine infection prevention and control precautions including social distancing, hand hygiene, and wearing a cloth face covering or facemask	**Prohibit visitation**, in general.		**Limit scheduled visitation (appointment only) to COVID-19 negative, asymptomatic and COVID-19 recovered residents only.** Facilities should have a plan to limit visitation hours and the number of visitors permitted. Visitors should be permitted based on screening[2] criteria and restricted to a designated area.	**Resume indoor visitation.** Visitors should be permitted based on screening[2] criteria.
Visitation for pediatric, developmentally disabled, and intellectually disabled residents	Refer to Executive Directive No. 20-026 for information on visitation for pediatric, developmentally disabled, and intellectually disabled residents at https://www.nj.gov/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf.			
Visitation for indoor end-of-life, compassionate care, and essential caregivers	Refer to Executive Directive No. 20-026 for information on visitation for indoor end-of-life and compassionate care at https://www.nj.gov/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf.			

When resident visitation is restricted, virtual visitation will be available to residents and families to stay in touch. Families will be able to schedule visits on the facility's website.

Outdoor visitation will be permitted in accordance with NJ DOH guidelines, subject to facility policies and procedures. Visit www.bshcare.com/visitation for details.

End-of-life, compassionate care, and essential caregiver visits (defined below) will be allowed in all phases but will be limited and must be coordinated with the Unit Manager or designee and/or Social Worker as follows:

- **End-of-Life** includes those residents who are experiencing a significant clinical decline and, based on the judgement of the clinical team, may have a limited life expectancy and/or whose death appears imminent; for example, a resident who has been on hospice for six months and has stopped eating and drinking, or a resident who has had a positive COVID-19 test, is experiencing symptoms and has not yet met the CDC criteria for discontinuation of isolation precautions.
    - All Phases: 10am – 8pm, two visitors in the room at any given time, no "waiting" inside the facility.
- **Compassionate care** visits include those situations which may not be end-of-life but, based on the judgement of the clinical team, may be beneficial when a resident may be physically declining or needs emotional support; for example, a significant change in condition or dealing with an emotional trauma such as difficulty adjusting to the facility or dealing with the recent death of a family member or friend.

- Phase 0: Two hours per visit, one visit per week
- Phases 1 and 2: Two hours per visit, two visits per week
- Phase 3: Per the facility's regular visitation policy

- An **essential caregiver** is a person who was actively engaged with the resident by providing assistance with activities of daily living prior to the onset of the COVID-19 pandemic. The facility will schedule essential caregivers and consider the number of essential caregivers who will be in the facility at a time.
  - All residents are eligible except those who are in a 14-day quarantine period, or positive for COVID-19 and have not yet met the criteria for the discontinuation of isolation.
  - The facility will determine who meets the definition of an essential caregiver and may limit the number of caregivers in the facility at any given time.
  - Phase 0: Two hours per visit, one visit per week
  - Phases 1 and 2: Two hours per visit, two visits per week
  - Phase 3: Per the facility's regular visitation policy

Visitor Policies and Procedures

Please read our general policies for routine ***outdoor visits, end-of-life visits, compassionate care visits and essential caregiver visits*** when the facility is in any phase click here. Visitors who are unable or unwilling to comply with our policies will be restricted from visiting.

The following policies apply to end-of-life, compassionate care, and essential caregiver visits (collectively, "visitors") and are in addition to the general visitation policies:

1. Visitors will be required to undergo COVID testing in accordance with the facility's Health Care Professional testing (e.g., weekly, twice weekly).
2. Visitors who test positive will not permitted to enter the facility until they meet the CDC criteria for discontinuation of isolation. They will be directed to self-isolate at home and follow up with their personal physician.
3. Visitors are strongly requested to receive an annual flu vaccination prior to visiting.
4. A designated staff member will escort the visitor to the designated visitation area.
   a. For residents in a private room, visitation may take place in the resident's room.
   b. For residents in a semi-private room, visitation may take place in a common area or the resident's room at the discretion of the nursing team.
5. A designated staff member will observe the visitor performing hand hygiene and will assist with donning the necessary PPE prior to entering the visitation area.

6. The designated staff member will advise the visitor to remain in the room and instruct them on the use of the call bell for assistance and when they are ready to leave.
7. The designated staff member will assist the visitor with doffing PPE and observe the visitor performing hand hygiene.
8. A designated staff member will escort the visitor off unit and to the facility exit.

The following policies apply to all other **indoor visits** and are in addition to the general visitation policies:

1. In Phase 2, indoor visitation is allowed by appointment only and only in a common area which allows for social distancing and sanitizing of surfaces after the visit;
2. In Phase 3, indoor visitation may occur in a residents' room, but only if it is a private room. For residents in semi-private rooms, visits must occur in a designated space which allows for social distancing and sanitizing of surfaces after the visit.

Agency Staff/Essential Medical Provider

Physicians and other clinicians will be encouraged to use telemedicine. When in-person appointments are necessary, physicians and other clinicians will be asked to bundle their visits.

MANDATORY REPORTING

During a COVID-19 pandemic the facility will complete mandatory reporting to the following agencies: CDC (NHSN portal), NJDOH, NJHA, OEM.