Administrative P & P Manual Nursing P & P Manual	JEWISH HOME AT ROCKLEIGH JEWISH HOME ASSISTED LIVING
Subject: Outbreak Response Plan including But Not Limited to Coronavirus	**Date: February 2020, Rev. March, April, May, August 2020**

Goal

To protect our elders, staff, families and visitors from harm resulting from disasters and exposure to an emergent infectious disease while they are in our Home.

Purpose

The purpose of this document is to provide guidance for the Jewish Home at Rockleigh and Jewish Home Assisted Living's outbreak response plan. This plan is reviewed and updated annually and as needed.

An outbreak is defined as an increase of disease among a specific population in a geographic area during a specific period of time. The types of situations this document addresses include individual cases and/or clusters of:

- Organisms with clinically significant resistance
- Organisms not previously or recently detected
- New/rare clinical presentations of diseases

This policy provides guidance on how to prepare for new or newly evolved infectious diseases whose incidence in humans has increased or threatens to increase in the near future and that has the potential to pose a significant public health threat and danger of infection to the residents, staff and families of the Home.

This Plan also encompasses information from the following Jewish Home policies, procedures and documents which encompass outbreak preparedness:

- Annual Facility Assessment
- Infection Prevention:
    - Epidemiology and Surveillance- This information is monitored by the Jewish Home's Medical Director, Nursing management team, which includes the DON, ADON and Infection Control Preventionist.
    - Surveillance Flow Chart- provides routine monitoring of residents and staff to quickly identify signs of a communicable disease that could develop into an outbreak
    - Facility-Acquired Infections
    - Criteria for Determining Infections- Evidence based outbreak response measures are in place by using the internet (e.g., CDC guidance) for latest research and protocols on containing and eliminating outbreaks. Consulting specialists are conferred with as necessary.
    - Infection Prevention Reporting (including tracking)
    - Monthly Infection Prevention Report
    - Resident and Staff Line Listing (data collection)

    - Outbreak Investigation
    - Reportable Diseases- outbreaks are reported to public health officials in accordance with applicable laws and regulations
    - Bloodbourne Pathogen Exposure Control Plan
    - Outbreak Surveillance
    - Infection Prevention and Control for Suspected or Confirmed Coronavirus (COVID-19)
    - COVID-19 Diagnosed and/or Exposed Staff Member
    - Residents Discharged from COVID-19 Wing
    - COVID-19 Point Prevalence Testing
    - PPE Supply: Strategies for Optimizing and Stockpiling
- Personnel Policies:
    - Emergency Contact Lists
    - Chain of Command
    - Emergency Staffing Policy
    - Leave Share/Donation Policy
- Communication Plan- Clear policies for the notification of residents, resident's families, visitors and staff in the event of an outbreak of a contagious disease at the Jewish Home.
- HIPAA/Confidentiality Compliance
- Incident Command Center
- Emergency Response Planning
- Reportable Events to the Department of Health/Local Agency
- Evacuation Plan and Agreements
- Visitors- Signs are posted on the front desk to alert visitors of the outbreak and to ensure those visiting are not ill. In certain times, visitation is canceled as dictated by regulatory officials.
- Employee Health Protocols- Staff are instructed by the Employee Health department that they are not permitted to work when sick unless cleared by their physician/medical personnel or they wait the required period of time for clearance.

Other applicable parts of this include:

- Workplace practices described in the infection prevention and control program
- Administrative controls (screening, isolation, visitor policies and employee absentee plans)
- Environmental controls (isolation wings, plastic barriers, alcohol based hand sanitizers/dispensers and special areas for contaminated wastes)
- Human resource issues such as employee leave

The local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing center response related to a specific disease threat.

Procedure

Activation of the outbreak plan:

- The policies above outline protocols for isolating and cohorting infected and at-risk patients in the event of an outbreak of a contagious disease until the cessation of the outbreak
- Lab testing through Acculabs and Capstone is available as needed.

Thresholds include:

- Reports from disease intervention specialists (DIS) or clinical providers.
- Whenever disease levels exceed what is expected in a given community (either at the Jewish Home or in our immediate community area).

Roles and responsibilities:

In preparation thereof or once the existence of an outbreak has been confirmed, the Outbreak Response Team should be activated. This will include the President/CEO, Administrator, DON, ADON, Director of Medicine, Infection Control Preventionist, VP of HR, Communications Director and individuals from the Jewish Home Assisted Living. Representatives on the team may include the Director of Environmental Services, Director of Social Work and individuals from the contracted laboratory, pharmacy and respiratory therapy team. The team would also include representatives from the local Bergen County DOH and OEM who provide input as necessary.

Roles and responsibilities of the Team members include:

- Leadership, management, and oversight of outbreak activities.
- Surveillance activities.
- Epidemiologic activities and investigation.
- Data management and security.
- Contact investigation and partner services.
- Oversight of laboratory specimen collection, transport, and testing.
- Risk communication and communication with media.
- Control and prevention measures.
- Coordination with external partners and agencies.
- Provider and public education and outreach.
- Support activities such as logistics and budgetary management.

Considerations for the team include:

- Review of educational needs
- Review of staffing, resources, supplies and support available
- Review of testing protocols and treatments.
- Reviewing transfer agreements with other facilities
- Review of protocols
- Review of regulations

Discussion topics may include

- Review of available information, including successes and barriers that are impeding progress.

- Case definition.
- Purpose and scope of investigation.
- Available and needed resources.
- Roles of each group involved in the outbreak response.
- Schedule of regular updates.
- Discussion of any political sensitivities pertaining to the outbreak and investigation.
- Development of initial media and ongoing awareness strategy.
- Informing local, state and federal (as/if mandated) staff of outbreak initiation.

Emergency Staffing

Administration will consider its requirements under OSHA, (Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and other employees shall be of paramount concern. Management shall take into account:

i. The degree of frailty of the residents in the Home;
ii. The likelihood of the infectious disease being transmitted to the residents and employees;
iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces)
iv. The precautions which can be taken to prevent the spread of the infectious disease and
v. Other relevant factors. Once these factors are considered, the Home will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.
vi. Apply whatever action is taken uniformly to all staff in like circumstances. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline including not being allowed to work.

In an emergency situation, the Administrator, VP of Human Resources and key staff (as designated by the facility's Incident Command System) shall meet for briefing on staffing needs and to implement the strategy to secure staff if an outbreak takes place. This will include reviewing:

a. On-duty staff and scheduled staff. During an emergency, staff currently on duty will be required to stay on duty until they are relieved by other staff.
b. Off-duty staff and on-call staff, including department managers.
c. Staff from sister facility, and non-medical volunteers (if permitted) who are already on file with the facility.
d. Healthcare professional volunteers who present to the facility to provide assistance (pending criminal background checks). Non-medical staff and (volunteers if permissible) will only be assigned to and perform non-medical tasks.
e. Every effort shall be made to ensure that no staff work greater than 16 consecutive hours.

Job orientation shall be provided for all emergency staff and volunteers to acquaint them with the immediate needs of residents, the physical facility, disaster plan, and specific duties and responsibilities.

Staff who have multiple capabilities can be used in case of emergency. For example, certified nursing assistants who work in the recreation and adult day health departments can work as certified nursing assistants. Occupational therapists can help with activities of daily living.

As census changes, the Home may move elders (within the building) so that staffing can be consolidated.

Staff in departments not typically on the units may be considered for different positions including, but not limited to, working in the kitchen, housekeeping, etc.

The Human Resources department will reach out to area nursing schools, staffing agencies, recruiters, other health care facilities and the local and state health departments to recruit additional temporary staff. In addition, prior staff who are no longer employed by the home and are considered to be in good standing will be contacted.

For additional information, refer to the Home's Administrative Emergency Staffing Policy.

Investigation:

An outbreak investigation identifies the characteristics of affected persons in the outbreak and the characteristics of the underlying risk network. This information can guide intervention efforts to improve health outcomes, prevent additional infections, and ultimately control the outbreak. An outbreak investigation includes the examination of current data and potentially the collection of new data to identify factors associated with transmission. The following are the goals of an outbreak investigation:

- Determine the size and scope of the outbreak and the risk network (e.g., undiagnosed cases, diagnosed cases not previously linked to the outbreak, and/or persons at risk of infection).
- Identify factors associated with transmission.
- Understand connections between cases.
- Assess risk for ongoing transmission.
- Determine the interventions that might stop the outbreak.

Determine who is at risk of becoming ill: The team will collect additional information, including potential review of medical records or interviews, as needed.

Debrief/After-Action Meeting:

After every outbreak investigation and response, a debrief or after-action meeting, including representatives from all areas of the Jewish Home, Health Department and partner organizations, may be held to discuss the response and how to improve for next time. Notes taken from the meeting can inform improvements for the outbreak investigation and response plan. Preparedness counterparts may be helpful in providing tools and technical assistance on evaluating a response.

An evaluation of the outbreak response would focus on effectiveness of the response, cost of the response, efficient use of resources, productivity of interventions, and relationships with providers, as well as organization and leadership of the response effort. Also reviewed would be the successes, challenges and recommendations for improvement.

Regarding Coronavirus:

It is the policy of the Jewish Home to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Standard, Contact and Airborne Precautions. Staff will be correctly trained and capable of implementing infection control procedures and adhere to requirements.

Clinical leadership will be vigilant and stay informed about emerging infectious diseases (EIDs) around the world. They will keep administrative leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.

As part of the emergency operations plan, the Home will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, surgical masks, assorted sizes of disposable N95 respirators, and gloves. The amount that is maintained in storage will minimally be for 60-days (2 months) worth of use. The daily burn rate is monitored.

The Home has agreements in place with vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including an EID outbreak.

The Home will regularly train employees and practice the EID response plan through drills and exercises as part of the Home's emergency preparedness training

Local Threat

a. Once notified by the public health authorities at the federal, state and/or local level that the EID is likely to or already has spread to the community, the Home will activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities.
b. The Home's designated Infection Preventionist (IP) will research the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies.
c. Working with advice from the Home's medical director, administrative leadership, human resource director, local and state public health authorities, and others as appropriate, the IP will review and revise internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.
d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Special emphasis will be placed on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.

e. If the EID is spreading through an airborne route, the Home will activate its respiratory protection plan to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.
f. Residents and families will receive education about the disease and the Home's response strategy at a level appropriate to their interests and need for information.
g. Vendors, medical staff and visitors will be briefed on the Home's policies and procedures related to minimizing exposure risks to residents.
h. Signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection will be posted at the entry of the Home and around the building along with the instruction that anyone who is sick must not enter the building.
i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the care center, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work as well as ongoing.
j. Staff will be educated on the Home's plan to control exposure of the residents. This plan may include:
    a. Reporting any suspected exposure to the EID while off duty to their supervisor.
    b. Precautionary removal of employees who report an actual or suspected exposure to the EID.
    c. Self-screening for symptoms prior to reporting to work.
    d. Prohibiting staff from reporting to work if they are sick until cleared to do so by the employee health team
k. Self-isolation - in the event there are confirmed cases of the EID in the local community, the Home may consider closing the Home to new admissions, and limiting visitors based on the advice of local public health authorities.
l. Environmental cleaning - the Home will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
m. Engineering controls – All rooms are private rooms which allow for separating of residents.
n. The Home will utilize appropriate physical plant alterations as necessary including plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

Suspected case in the Home:

a. Place a resident who exhibits symptoms of the EID in a cohorted wing and notify local public health authorities through line listing. Any staff exhibiting symptoms would be sent home.

b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services if necessary.

c. If the suspected infectious person requires care while awaiting transfer, follow Home policies for isolation procedures, including all recommended PPE for staff at risk of exposure.

d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically

cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional "just in time" training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.
e. The isolated person will need to wear a facemask if possible while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless it advised otherwise by public health authorities. During times of COVID outbreak, all residents will be wearing face masks.
f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.
g. Implement isolation protocols in the Home (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the center's infection prevention and control plan and/or recommended by local, state, or federal public health authorities. (See Isolation and Cohorting section of this policy below.)
h. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

Ethical Considerations:

1. In the event that a public health emergency creates demand that minimizes resources such as reduces staffing levels to critical levels, the Home may take a number of approaches to ensure safe care including suspending admissions, cross-training of staff and/or discharging to other levels of care.
2. If the Home is operating under a crisis standard of care and the Home is at critical care capacity, or will be overwhelmed despite taking all appropriate steps to increase the surge capacity to care for critically ill patients, and a regional authority has declared a public health emergency, in conformance with the NJ DOH Allocations of Critical Care Resources During a Public Health Emergency policy, the Home may triage critically ill patients. This will be done with the guidance of a triage team that includes members from medical and nursing leadership. The separation of the triage role from the clinical role is intended to promote objectivity, avoid conflicts of commitments, and minimize moral distress. The triage team will also be involved in resident or family appeals of triage decisions, and in collaborating with the attending physician to disclose triage decisions to residents and families.
3. Any allocation system would be equitable (fair) and serve to maximize lives and life years saved (utility).
4. The Jewish Home shall provide ongoing training to its leadership team regarding these ethical questions and circumstances.
5. Residents who are not triaged to receive critical care will receive medical care that includes intensive symptom management and psychosocial support. They should be reassessed daily to determine if changes in resource availability or their clinical status warrant provision of critical care services. Where available, specialist palliative care teams will be available for consultation.

COVID Testing Plan:

When it is determined either by the facility Response Team or as dictated by local, state or the federal government agencies that all testing must be completed, for example, prior to May 26, 2020, all Jewish Home staff and all residents were tested using baseline molecular testing to determine their COVID status, then the following steps are taken:

1. Staff who are tested by the Jewish Home are done so by dedicated staff whose competency is checked to ensure they are performing testing properly. Testing will be completed in a dedicated space in time controlled increments. Staff will be appropriately spaced apart while the testing is completed.
2. Prior to testing, all staff will be educated on the reasons for the testing.
3. In accordance with CDC guidelines, the Home will perform a second test within 3-7 days after the first negative result if this is the baseline.
4. If an employee is tested and determined to be positive, they are not to return to work for 10 days after they were tested AND have had no subsequent symptoms. If they had symptoms, they need to wait the 10 days AND 3 days (72 hours) after fever has resolved without the use of fever reducing medications with a significant improvement of respiratory symptoms (whichever period is longer).
5. For staff who are found to be positive for COVID-19 or PUI, the Home will actively identify residents who were cared for by the staff. Exposures should be traced back 48 hours prior to symptom onset or positive test for asymptomatic positive staff, as the exposed resident may later develop symptoms of COVID-19 or test positive. Residents with close contact who were cared for by these staff should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of the HCP COVID-19 testing are known. If the staff member is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
6. Upon return to work, the staff member will be reassessed by the Home's staff to ensure they are asymptomatic. This individual must continue to be masked when they return to work, even in non-patient areas.
7. They will be reminded that they may be exposing residents. If they remove their facemasks, e.g. to eat, they need to separate themselves from others. They need to continue to monitor for symptoms and seek reevaluation by the Home's Employee Health team if symptoms recur or worsen.
8. Symptomatic staff who test negative for COVID-19 may have another respiratory virus. Similar guidance on infection prevention and control should be followed (e.g., isolate from others, practice good hand hygiene, clean and disinfect environmental surfaces, etc.). If staff have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. At minimum staff should be excluded from work for at least 24 hours after symptoms resolve including fever, if applicable.
9. For asymptomatic staff who test negative, no restrictions are placed on working based on COVID results but the staff should continue to report recognized exposures, regularly monitor themselves for fever and symptoms of COVID-19, use facemasks for source control, and should not report to work when ill.
10. Testing continues weekly for staff and residents. For residents, testing takes place every other week if 14 days of negative results take place.

11. Any staff member who refuses to be tested will be considered as a Person Under Investigation and will not be allowed to work at the Jewish Home until they undergo testing and results of such testing are disclosed to the Home.
12. As part of our protocol, staff must provide permission for lab results to be released to the Home.
13. Staff must provide information to the Home's Employee Health department regarding their prior testing results.
14. Any residents testing positive are moved to the isolation unit for at least 10 days and as outlined below.
15. Families of residents are notified by the social worker/nurse of the testing. Residents are also educated about the testing and the reasons for the testing.
16. If a resident refuses to undergo COVID-19 testing, the Home shall treat the person as a Person Under Investigation, make a notation in the resident's chart, notify any authorized family member of such and continue to check temperature of the resident at least twice a day. Onset of temperature or other symptoms consistent with COVID-19 will require immediate cohorting in accordance with the section below on Isolation and Cohorting. At any time, the resident may rescind their decision not to be tested.
17. Retesting is implemented to detect any newly developed infections and to inform decisions as necessary.
18. During an outbreak, the Home continues to assess every elder, staff member and visitor daily for signs and symptoms of the illness.

Isolation and Cohorting:

Cohorting is effective as they allow for dedicated staff and equipment per cohort.

1. Every room at the Jewish Home is a private room or apartment and has a private bathroom.
2. The Jewish Home has dedicated areas of the Home that can be used as a series of isolation rooms.
3. Determination of isolation is made with the clinical team based on clinical testing of the elder and positive results.
4. COVID-19 Positive cohorts consists of both symptomatic and asymptomatic patients/residents who test positive for COVID-19. These isolation areas are defined with tarps, closed doors and droplet/airborne precaution red signs. There are dedicated separate staff for the isolation/cohort unit. Staff use additional PPE (including but not limited to face shields, face masks, gloves, gowns, hair nets) when working on the Cohort unit. This unit also has its own assigned equipment.
5. If staff are working in both well and ill units, they first provide care for those on the well unit and then go to those on the ill unit.
6. COVID-19 Negative, Exposed: This cohort consists of symptomatic and asymptomatic patients/residents who test negative for COVID-19 with an identified exposure to someone who was positive. All symptomatic COVID-19 negative patients/residents should be considered exposed but should also be evaluated for other causes of their symptoms. Even though symptomatic COVID-19 negative patients/residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Asymptomatic patients/residents should be closely monitored for symptom development. Since every resident is in a private room or apartment, these individuals may possibly not be moved

7. COVID-19 Negative, Not Exposed: This cohort consists of patients/residents who test negative for COVID-19 with no COVID-19 like symptoms and are thought to have no known exposures. The index of suspicion for an exposure should be low, as COVID-19 has been seen to rapidly spread throughout the post-acute care setting. In situations of widespread COVID-19, all negative persons in a facility would be considered exposed.
8. New or Re-admissions: Any new or re-admissions will be tested immediately prior to admission to help determine where the new admission should be placed (isolation for positive COVID-19 vs new admissions in quarantine for 14 days). 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 individuals remain for 14 days to monitor for symptoms that may be consistent with COVID-19. Each of these rooms has a sign which lists the day of admission into the room as well as the expected date of discharge from the room or quarantine. In the Jewish Home Assisted Living, the new admission/readmission is quarantined in their own apartment for 14 days.
9. Newly admitted or readmitted residents are monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended PPE.
10. Adequate receptacles are placed in these areas including but not limited to extra garbage cans, Purrell and other alcohol based cleaning products are placed throughout the area.
11. In the isolation areas, there is separate designated medication carts, lifts and other related patient equipment.
12. Isolation areas have increased routine cleaning and disinfection processes conducted.
13. As part of this Response Plan, the Home may close to new admissions as needed to cohort.

Communication Plan: Notification and Reporting:

It is the policy of the Jewish Home Family to provide appropriate and ongoing communication in the event of an emergency situation. Knowing how important it is to keep key government agencies, staff, residents, family members, board members and the community informed, this policy defines the process and methods to be used in an emergency situation. The Home's CEO/President, Executive VP/Administrator, VP of Human Resources, Director of Nursing and Director of Communications work closely together to ensure communication is effective, timely and comprehensive.

Methods of communication include but are not limited to e-mails, written notices, discussions in person and via phone and ZOOM meetings. The Home's Information Technology and Social Work team consistently review the list of e-mail addresses to ensure it is up to date and comprehensive.

The Home provides any cumulative updates for residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: a confirmed infection of COVID-19 is identified (including new admissions), or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Communication with Government/Health Agencies:

Based on the situation at hand, the Administrator or designee is responsible for notifying the County and/or State Health Department and any other relevant agencies.
As necessary, the Administrator will reach out to other healthcare organizations including hospitals as well as emergency medical personnel, medical staff, Ombudsman's office, medical transport companies, vendors as needed, insurance companies as required and the Office of Emergency Management.

The Administrator/designee reports the required information (including line lists) into the NJHA and NHSN systems and via e-mail daily as required by CMS, the NJ Department of Health and the Bergen County Health Department.

Communication with Residents:
The administrator, in conjunction with the President/CEO, will define the messages and communication strategies that will be employed. These may include but are not limited to:

- In person meeting with residents
- Meetings via closed circuit broadcast into resident rooms (e.g., Zoom)
- Individual meetings
- Written communication

When notifying residents, resident representatives, and families, the Home follows these guidelines:

- Informs residents and their families if they are positive and to be moved or if they were tested and determined to be negative.
- Includes information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered,
- Not include any personally identifiable information.
- Document this notification in the electronic medical record.

Reasonable accommodations are made so that residents, resident representatives and families can access information. These include but are not limited to telephone calls, in person discussions, written communications, information on the in-house channel and e-mail communications.

Communication with Families:
The President/CEO, in conjunction with the administrator and key members of the management staff, will define the messages and communication strategies that will be employed. These may include but are not limited to:

- Emails and text messages
- Telephone communication
- Meetings facilitated by video conferencing
- Telephone communication
- Written communication

Communication with Staff:
The Vice President of Human Resources will serve as the coordinator of all communication with staff. The VP of HR or designee, in conjunction with the President/CEO and appropriate administrator will define the messages and communication strategies that will be employed. These may include but are not limited to:

- Emails and text messages
- Meetings of staff in small and large groups conducted by department heads or administration
- Telephone communication

Communication with Board Members:
The President/CEO, in conjunction with the administrator and key members of the management staff, will define the messages and communication strategies that will be employed. These may include but are not limited to:

- Emails and text messages
- Telephone communication
- Meetings facilitated by video conferencing
- Telephone communication
- Written communication

Communication with Media:
The President/CEO, in conjunction with the administrator and key members of the management staff, will define the messages that will be shared. Only the President/CEO or Director, Marketing and Technology is authorized to speak to the media and only the President/CEO or designee is authorized to make a statement or answer media questions.

Website Information:
As necessary, the Jewish Home's website (www.jewishhomefamily.org) includes a copy of this Outbreak Plan, update on facility status and ways to communicate with loved ones and staff.

Lessons Learned from Prior Outbreaks Including but not Limited to COVID-19

- Ensure Response Team in place to provide direction on overall Outbreak Response Plan.
- Ensure clear comprehensive protocol in place for assessing, testing, cohorting and treating outbreak. Ensure protocol is a collaborative effort with members of the medical staff including local acute care hospitals and is based on national guidelines such as CDC guidance.
- Review all advance directives and have a conversation before a crisis happens.
- Ensure there are specific staff, equipment and unit space available to cohort and care for residents who are both symptomatic and asymptomatic.
- Ensure there are clear lines of communication with local and state health departments. Integrate Home into regional response.
- Ensure there are connections in place with critical vendors including but not limited to access to PPE, medications, testing, food, nursing supplies, fuel, transportation, emergency services.
- Ensure up-to-date phone numbers and e-mail addresses for staff and resident families.
- Ensure clear communication methods are in place with key partners including residents, staff and family members. Educate families on what is and what is not a crisis. Talking to individuals directly vs. e-mails is helpful.

- Ensure partnership agreements in place with staffing agencies to allow for adequate staffing.
- Ensure technology resources available such as Zoom capabilities.
- It is critical to move quickly but deliberately to ensure outbreak is contained.
- Ensure handwashing and other sanitation procedures are done correctly. Ensure staff have appropriate PPE and the knowledge to properly don and doff equipment.
- Ensure regular inservicing of staff and residents takes place to review infection control and other protocols. Reviewing competency of staff, including for cleaning procedures, is critical.
- Ensure constant review of best practices, access to latest research and implementation of protocols.
- Ensure methods in place to enhance resident and staff morale and to address mental health issues/concerns.
- Provide opportunities for compassionate care visits, especially at the end-of-life.
- Ensure method in place for admissions if possible, especially if families do not have access to help orient their loved one to the Home.
- Ensure plans in place to address future possible outbreaks. Ongoing vigilance is critical.

Challenges from Prior Outbreaks Including but not Limited to COVID-19

- Lack of information about a new emerging outbreak makes responding more difficult.
- Lack of involvement of visitors, volunteers and other 'non-essential' providers intensifies pressure on staff.
- Dependence on others for PPE is not possible. The Home had to secure items itself from non-traditional sources.
- Fear of the known and unknown by staff, elders was very challenging.
- Replacing the many staff who became ill very quickly was challenging.
- There was a staffing shortage in the region and it became difficult to find replacement staff.
- Constant time-consuming reporting requirements as well as required changes to policies and protocols were challenging.
- Long term physical and mental effects from COVID outbreak.

Successes from COVID-19 Outbreak

- Ability of the JH team to bond strongly, work tightly together and be resourcesful.
- Readiness of JH team to figure out how best to strategically plan and care for those during the outbreak was critical to success.
- Organization strengthened by going through the experience- each staff member and elder came out stronger.