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Governor

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JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

EXECUTIVE DIRECTIVE NO. 20-026[1]

Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37

WHEREAS, Coronavirus disease 2019 ("COVID-19") is a contagious, and at times fatal, respiratory disease caused by the respiratory illness caused by the SARS-CoV-2 virus; and

WHEREAS, symptoms of the COVID-19 illness include fever, cough and shortness of breath, which may appear in as few as two or as long as 14 days after exposure, and can spread from person to person via respiratory droplets produced when an infected person coughs or sneezes; and

WHEREAS, on March 9, 2020, Governor Philip D. Murphy issued Executive Order 103, declaring the existence of a Public Health Emergency, pursuant to the Emergency Health Powers Act, N.J.S.A. 26:13-1 et seq., and a State of Emergency, pursuant to the Disaster Control Act, N.J.S.A. App A:9-33 et seq., in the State of New Jersey for COVID-19; and

WHEREAS, the Public Health Emergency was extended by Governor Murphy under Executive Order Nos. 119, 138, 151, 162,171, 180, 191, 200 and 210; and

WHEREAS, Executive Directive 20-013 issued May 20, 2020, instituted a testing requirement for COVID-19 in New Jersey licensed Long-Term Care Facilities, Assisted Living Residences, Comprehensive Personal Care Homes, Residential Health Care Facilities, and Dementia Care Homes (collectively "LTCFs" or "facilities"); and

WHEREAS, LTCFs have been heavily impacted by COVID-19. The New Jersey Department of Health (NJDOH) has taken an aggressive approach to detection of and response to the virus in these vulnerable populations; and

[1] This revised Executive Directive amends and supersedes Executive Directive 20-026 issued on October 20, 2020.

WHEREAS, New Jersey has created a guide, *The Road Back: Restoring Economic Health Through Public Health*, which outlines six key principles and benchmarks to guide the process for restoring New Jersey's economic healthby ensuring public health and how activities are going to be restarted in stages; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has also proposed similar phased recommendations for state and local officials to begin reopening long-term care facilities. Additionally, the Centers for Disease Control and Prevention (CDC) has addressed reopening considerations for LTCFs in their nursing home COVID-19 guidance; and

WHEREAS, resumption of services for LTCFs requires a phased in approach, based on each facility's outbreak status and ability to meet the outlined criteria. Such criteria include the case status in the facility; access to testing; adequate staffing; and adequate personal protective equipment (PPE) and infection control protocols, among others.

NOW, THEREFORE, I, JUDITH PERSICHILLI, Commissioner of the Department of Health, pursuant to the powers afforded to me under the Emergency Health Powers Act, hereby ORDER and DIRECT the following:

The provisions in this Directive apply to all residential healthcare facilities Long-Term Care Facilities, Assisted Living Residences, Comprehensive Personal Care Homes, Residential Health Care Facilities, and Dementia Care Homes (collectively "LTCFs" or "facilities"); as defined in N.J.S.A. 26:2H-12.87[2]; and N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37.

The provisions for LTCFs reopening are subject to the State of New Jersey remaining out of the "maximum restrictions Stage" described in *The Road Back: Restoring Economic Health through Public Health* (http://d31hzlhk6di2h5.cloudfront.net/20200518/ff/c9/8c/41/1917eaf623c02595b9225209/Strategic_Restart_Plan.jpg) reopening plan. If at any point during the public health response the state returns to the "maximum restrictions Stage," **all facilities** covered by this Directive must return to the maximum restrictions of Phase zero (0), as described herein.

Phases per this Directive:

> **Phase 0:** Any facility with an active outbreak of COVID-19, as defined by the Communicable Disease Service (CDS), per the COVID-19 Communicable Disease Manual Chapter, any facility that cannot attest to criteria to advance phases, and all facilities if New Jersey is in maximum restrictions per the *Road Back to Recovery*: https://covid19.nj.gov/faqs/nj-information/reopening-guidance/when-and-how-is-new-

[2] As defined in N.J.S.A. 26:2H-12.87, long-term care facility means a nursing home, assisted living residence, comprehensive personal care home, residential health care facility, or dementia care home licensed pursuant to P.L. 1971, c. 136 (C.26:2H-1 et seq.).

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Phase 1: Facilities that never had an outbreak or that concluded an outbreak per section (II)(5) below, and 14 days have passed since New Jersey moved to Stage 1 (May 2, 2020) of the Road Back to Recovery and the facility has submitted all the attestations required in this Directive.

Phase 2: Facilities that never had an outbreak or that concluded an outbreak per section (II)(5) below, and 14 days have passed since New Jersey moved to Stage 2 (June 15, 2020) of the Road Back to Recovery and the facility has submitted all the attestations required in this Directive.

Phase 3: Facilities that never had an outbreak or that concluded an outbreak per section (II)(5) below, and 14 days have passed since New Jersey moved to Stage 3 (DATE TBD) of the Road Back to Recovery and the facility has submitted all the attestations required in this Directive.

I. Requirements for Initiating a Phased Reopening of Long-Term Care Facilities, Assisted Living Residences, Comprehensive Personal Care Homes, Residential Health Care Facilities, and Dementia Care Homes.

1. A facility can initially advance phases in conjunction with the State's reopening stages, with a 14-day delay (one incubation period). This delay is intended to protect residents and staff of LTCFs in the event of a rebound in COVID-19 community transmission while New Jersey moves from stage to stage in lifting restrictions. For example, New Jersey entered Stage 2 on June 15, 2020; LTCFs who meet the criteria outlined within would be able to enter Phase 2, no sooner than June 29, 2020. If at any time during the State's reopening stage, the State moves back or pauses a Stage, facilities must implement the requirements for that stage and phase as outlined within this Directive.

2. In addition to complying with the requirements otherwise outlined in this Directive, all LTCFs in New Jersey must attest to meeting the criteria below prior to advancing from Phase 0 to any new "Phase" in their reopening process. Facilities that cannot meet these criteria will remain in "Phase 0", a heightened state of maximum restrictions. Facilities that have submitted attestations but can no longer meet the attestation requirements, must notify the Department's Division of Certificate of Need and Licensing that they cannot meet the requirements and will be required to re-submit an attestation once the facility is able to meet the requirements for the attestation.

3. Facilities are required to have a documented "Outbreak Plan" as required by N.J.S.A. 26:2H-12.87. The plan must include but not be limited to lessons learned from the response to and experience with COVID-19. Further, the plan must include a strategy for effective and clear communication with staff, patients/residents, their families or

guardians about any infectious disease outbreaks as required by N.J.S.A. 26:2H-12.87. The "Outbreak Plan" must also include:

i. Methods to communicate information on mitigating actions implemented by the facility to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered. Notifications shall not include personally identifiable information.

ii. Methods to provide cumulative updates for residents, their representatives, and families of those residing in the facilities at least once weekly, in particular during a curtailed visitation period.

iii. Written standards, policies and procedures that provide for virtual communication (e.g. phone, video-communication, Facetime, etc.) with residents, families and resident representatives, in the event of visitation restrictions due to an outbreak of infectious disease or in the event of an emergency**.**

iv. A documented strategy for securing more staff in the event of a new outbreak of COVID-19 or any other infectious disease or emergency among staff.

4. The outbreak plan must be posted on the facility's website for public viewing order to meet the requirements of this directive.

5. In addition to the requirements above, CMS certified facilities are also required to comply with CMS rule: 42 CFR §483.80(g) and with CMS guidance at https://www.cms.gov/files/document/qso-20-29-nh.pdf. This rule requires facilities have a documented communication plan to inform residents, their representatives, and families of the residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other.

6. All facilities must prominently display on their website and/or social media platforms and include in communications to families, guardians and the public, a phone number or method of communication for urgent calls or complaints.

7. All facilities, even those not certified by CMS are encouraged to follow CMS recommendations at https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf, for communication when facilities cannot permit in-person visits as follows:

i. Offer alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.);

ii. Create or increase email listserv communications to update families;

iii. Assign staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date (e.g., a "virtual visitation coordinator"); offer a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits;

iv. Host conference calls, webinars, or virtual "office hours" at set times, but at minimum on a weekly basis, when families can call in, or log on to a conference line, and facility staff can share the status of activities or happenings in the facility and family members can ask questions or make suggestions; and

v. Update the facility's website, at minimum on a weekly basis, to share the status of the facility and include information that helps families know what is happening in the loved one's environment, such as food menus and any scheduled activities.

8. In order for a facility to advance from one phase to another, the facility must not be experiencing a staffing shortage or currently operating under a contingency or crisis staffing plan as defined by the CDC, Strategies to Mitigate Healthcare Personnel Staffing Shortages at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.ttml#.

9. Facilities must conduct testing in accordance with this directive. Facilities may execute a contract or enter into an agreement with a laboratory or other vendor for prioritization of test results and to ensure testing capacity for repeat facility-wide testing. Facilities may use on-site laboratories or other arrangements for testing provided testing requirements herein are met. All facilities must test residents and staff as follows:

Testing of residents:

i. Initiate testing of all residents (every 3 to 7 days) until no new facility-onset cases* of COVID-19 are identified among residents and positive cases in staff **and** at least 14 days have elapsed since the most recent positive result **and** during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative.

ii. Retest residents who have previously tested positive according to CDC and NJDOH guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Testing,-Isolation,-and-Quarantine-for-Persons-Who-Have-Recovered-from-Previous-SARS-CoV-2-Infection

iii. Any resident who is newly symptomatic consistent with COVID-19 must be retested at the onset of symptoms, regardless of the interval between the most recent negative test and symptom onset, in accordance with public health recommendations.

*Facility onset SARS-CoV-2 infections refer to SARS-CoV-2 infections that originated in the facility. It does not refer to the following:

- Residents who were known to have C*OVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.*

- *Residents who were placed into Transmission-Based Precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.*

Continued testing of staff as follows:

i. Ongoing testing of all facility staff in accordance with QSO-20-38, https://www.cms.gov/files/document/qso-20-38-nh.pdf, and this directive until otherwise directed by the NJDOH.

- "Facility staff" includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions.

  NOTE: A facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source (e.g., their employer or on their own). If the facility needs to prioritize resources, testing might be most impactful when conducted on healthcare personnel who have regular close contact (within 6 feet) with large numbers of residents or who regularly care for persons with risk factors or medical conditions that increase the risk of severe illness.

  a. Routine testing should be based on the extent of the virus in the community, therefore facilities should use the regional positivity rate reported in the COVID-19 Activity Level Index (CALI) Weekly Report: https://www.nj.gov/health/cd/statistics/covid/, in the prior week, as the trigger for staff testing frequency as follows:

Regional CALI Level	Regional Percent Positivity Rate in the past week	Minimum testing frequency
Low	<3%	Once a Week*
Moderate	3-10%	Once a Week*
High/Very High	>10%	Twice a Week**

*Testing at this frequency until the NJDOH changes testing cadence based on epidemiology and data about the circulation of virus in the community or new CMS guidance.
**This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

b. If the 48-hour turn-around time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments.

c. Facilities should begin testing all staff at the frequency prescribed in the testing table above, based on the regional positivity rate reported in the past week.

d. Facilities should monitor their regional CALI level every week and adjust the frequency of staff testing according to the table above.

- If the regional CALI level increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met.

- If the regional CALI level decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency.

ii. Retest staff who have previously tested positive according to CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Testing,-Isolation,-and-Quarantine-for-Persons-Who-Have-Recovered-from-Previous-SARS-CoV-2-Infection

iii. Any staff who is newly symptomatic consistent with COVID-19 must be retested at the onset of symptoms, regardless of the interval between the most recent negative test and symptom onset.

Use of Antigen Testing

Antigen testing is a form of viral testing and may be used as an alternative to molecular diagnostic PCR tests subject to the following parameters:

i. Antigen testing may be used to fulfill any testing requirements set forth in this directive and also may be used on asymptomatic individuals at the facility's discretion. If antigen testing is used, please refer to CDS: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-19_Antigen_Testing_in_LTCF.pdf and CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html guidance for test interpretation and to determine when RT-PCR confirmation testing is necessary.

ii. Only antigen tests that have received an **Emergency Use Authorization or approval from the United States Food and Drug Administration (FDA)** may be used to fulfill the requirements of this directive.

iii. All facilities that perform COVID-19 point of care (POC) tests such as antigen tests, in their facilities must possess a federal Clinical Laboratory Improvement Amendment (CLIA) Certificate. Additional information and application instructions for a CLIA Certificate can be found at https://www.nj.gov/health/phel/clinical-lab-imp-services/federal_clia.shtml. CMS is temporarily exercising enforcement discretion under CLIA for SARS-CoV-2 POC testing for a facility that has submitted a CMS-116 application for a CLIA Certificate of Waiver (CoW), but has not yet been assigned a CLIA number. Specifically, facilities that have applied for a CLIA CoW to perform waived, FDA approved or authorized SARS-CoV-2 POC testing (as indicated on section VI of the submitted CMS-116), can begin SARS-CoV-2 POC testing and reporting patient-specific results as soon as they have submitted their application to their State Agency (SA). A non-certified facility will be treated as operating under CoW while their application is being processed. https://www.cms.gov/files/document/covid-sars-cov-2-point-care-testing-and-clia-certificate-wavier-applications.pdf

10. Facilities must continue to report testing data through the New Jersey Hospital Association (NJHA) portal here: https://ppe.njha.com. Data entered in this portal is not cumulative. Facilities that are entering data in the NHSN Antigen Module do not need to enter testing data into the NJHA portal. All facilities performing POC tests should gain access to the antigen module on NHSN.

11. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, the facility must submit to the Department via email to LTC.PhasedReopening@doh.nj.gov a Phased Reopening attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

    Email Subject Line to LTC.PhasedReopening@doh.nj.gov:
    [Facility Name] – [Facility License #] – Phased Reopening Attestation – Entering Phase #

    Attestation Text:
    I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; I attest that the facility has implemented and will continue to adhere to all the requirements set forth in Section (I) (3) to (11) of Executive Directive No. 20-026 to advance to [PHASE #] and [NAME OF THE FACILITY] currently:

    a. Has an "Outbreak Plan," as required by N.J.S.A. 26:2H-12.87, and the plan is posted on the facility's website for public view. The plan includes effective communication methods to notify patients/residents, their families or

guardians and staff about any infectious disease outbreaks and includes strategies and methods for virtual communications in the case of visitation restrictions, at a minimum on a weekly basis;

b. Is not experiencing a staffing shortage, is not under a contingency or crisis staffing plan and has a documented plan for securing additional staff in case of a COVID-19 outbreak among staff as part of the facility's "Outbreak Plan;"

c. (CMS certified facilities only) has a documented communication plan and is informing residents, their representatives, and families of the residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other, in accordance with CMS rule 42 CFR §483.80(g);

d. Is prominently displaying on their website and/or social media platforms and including in communications to families, guardians and the public, a phone number or method of communication for urgent calls or complaints; and

e. Is meeting testing and data reporting requirements of residents and staff as outlined in NJDOH E.D. 20-026.

II. Required Core Practices for Infection Prevention and Control.

1. Regardless of a facility's current reopening phase, core infection prevention and control practices must be in place at all times. Maintaining core infection prevention and control practices is key to preventing and containing outbreaks and is crucial in ensuring the delivery of quality, safe care. In addition to the requirements in N.J.A.C. 8:39-20, the following practices shall remain in place even as LTCF's resume normal activities, regardless of the facility's current reopening phase:

   Review the *Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings – Recommendations of the Healthcare Infection Control Practices Advisory Committee* at https://www.cdc.gov/hicpac/pdf/core-practices.pdf, and implement any guidance applicable to the facility.

   i. Facilities must educate residents, staff, and visitors about COVID-19, current precautions being taken in the facility, and protective actions. Facilities must encourage social distancing with physical separation.

   ii. All facilities, except for facilities with ventilator-dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site

management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by:

a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2;

b. A physician who has completed an infectious disease fellowship;

c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience.

* The requirements in this section do not modify or supersede requirements for facilities providing care to ventilator-dependent residents pursuant to N.J.S.A. 26:2H-12.87(1)(c).

iii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPC program by conducting internal quality improvement audits. Additional information is available at the NJDOH Healthcare Associated Infections page at https://www.nj.gov/health/cd/topics/hai.shtml, the NJDOH COVID-19 page at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml, and CDC's Infection Control Assessment Tools page at: https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html.

iv. **Facilities with No Ventilator Beds**

a. Facilities with 100 or more beds or on-site hemodialysis services must:

1) Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021.

2) Prior to the hiring of an employee for the IPC program, facilities **must** enter into a contract for infection control services. Facilities may terminate the contract once they hire or staff their IPC program and submit an attestation to the NJDOH, as required within this Directive.

3) Responsibilities of this position must include, at a minimum, developing infection prevention and control policies and procedures, performing infection surveillance, providing competency-based training of staff and auditing adherence to recommended infection prevention and control practices.

b. Facilities with less than 100 beds, or no on-site hemodialysis services must**:**

1) Staff their IPC program based on the resident population and facility service needs identified in the facility risk assessment available at: https://www.cdc.gov/longtermcare/excel/IPC-RiskAssessment.xlsx.

2) Prior to the hiring of any staff for their IPC program identified in section b. 1) above facilities will must enter into a contract for infection control services. Facilities may terminate the contract once they hire or staff their IPC program and submit an attestation to the NJDOH, as required within this Directive.

3) Responsibilities of this position must include, at a minimum, developing infection prevention and control policies and procedures, performing infection surveillance, providing competency-based training of staff and auditing adherence to recommended infection prevention and control practices.

v. **Facilities with on-site ventilator beds** must follow the requirements under N.J.S.A. 26:2H-12.87 (a) to (d), and must attest to compliance with N.J.S.A. 26:2H-12.87 (a) to (d); including but not limited to, the requirement that facilities as part of their outbreak response plan and part of their infectious disease committee, must on a full-time or part-time basis, or contracting with on a consultative basis, retain or hire the following individuals:

a. An individual certified by the Certification Board of Infection Control and Epidemiology; and

b. A physician who has completed an infectious disease fellowship.

vi. **In order for the facility to meet the requirements of this Directive, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an Infection Control Contract attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
[Facility Name] – [Facility License #] – Infection Control Contract

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF FACILITY] and to bind [NAME OF FACILITY] thereto; that

[NAME OF FACILITY] is in compliance with all requirements for Contracting Infection Control Services in Executive Directive 20-026 and I attest that [NAME OF FACILITY] has:

a. One hundred (100) or more beds or on-site hemodialysis services and has contracted with an infection control service pursuant to the requirements of E.D. 20-026.

b. Less than 100 beds or no on-site hemodialysis services and has contracted with an infection control service based on the resident population and facility service needs identified in the facility risk assessment per E.D. 20-026.

vii. **In order for the facility to meet the requirements of this Directive and no later than August 10, 2021 for facilities without ventilators beds or immediately for facilities with ventilator beds, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an Infection Control Employee attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
[Facility Name] – [Facility License #] – Infection Control Employee

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF FACILITY] and to bind [NAME OF FACILITY] thereto; that [NAME OF FACILITY] is in compliance with all requirements in Executive Directive 20-026 and has hired an Infection Control Employee and I attest that [NAME OF FACILITY] has:

a. Less than 100 beds or no on-site hemodialysis services has staffed the IPC program based on the resident population and facility service needs identified in the facility risk assessment per E.D. 20-026.

b. One hundred (100) or more beds or on-site hemodialysis services and has hired an infection control employee pursuant to the requirements of E.D. 20-026.

c. Facilities with ventilator beds must attest having hired or contracted pursuant to the requirements of N.J.S.A. 26:2H-12.87(a) to (d).

2. Facilities must develop and implement a Respiratory Protection Program (RPP) that complies with the Occupational Safety and Health Administration (OSHA) respiratory

protection standards for employees, if such program is not already in place as of the date of enactment of this Directive. The program must include medical evaluations, training and fit testing. Refer to OSHA's Respiratory Protection Page at: https://www.osha.gov/sltc/respiratoryprotection/. Facilities will have until May 30, 2021 to submit an attestation to the Department regarding the plan. This requirement does not modify or otherwise affect facilities' existing obligations under federal law to comply at all times with all applicable requirements of OSHA's respiratory protection standards found at 29 C.F.R. 1910.134.

i. Facilities may contract with a consultant or vendor to fulfill the requirements of this section and must submit an attestation regarding the implementation of a RPP no later than May 30, 2021.

ii. Facilities may contract with a consultant or vendor to fulfill the requirements of this section and must attest to the implementation of a RPP.

iii. **In order for the facility to meet the requirements of this Directive and no later than May 30, 2021, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov a Respiratory Protection Program Implementation attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
[Facility Name] – [Facility License #] – Respiratory Protection Program Implementation

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] has implemented a Respiratory Protection Program in compliance with Executive Directive 20-026 and I attest that [NAME OF THE FACILITY]:

a. Has implemented a respiratory protection program that complies with the OSHA respiratory protection standard for employees.

3. Facilities are required to have an adequate emergency stockpile of PPE, essential cleaning and disinfection supplies so that staff, residents and visitors can adhere to recommended infection prevention and control practices as outlined here:

i. Facilities that belong to a system that has eight (8) or more facilities will be required to have **one (1) month of PPE in stock**. Facilities that do not belong to a system with eight (8) or more facilities will be required to have **two (2) months of**

PPE in stock. Facilities must acquire the PPE to fulfill the requirements outlined herein.

a. Facilities should use the CDC's PPE Burn Rate Calculator in order to estimate the amount of PPE needed for their required supply under this Directive. This tutorial video guides users on how to use the PPE Burn Rate Calculator: https://youtu.be/E_mhrROgJh0. The calculator can be found at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/PPE-Burn-Rate-Calculator.xlsx.

b. Facilities should calculate the quantity of PPE to fulfill this requirement at a burn rate based on the highest use of PPE during the COVID-19 surge in their facilities.

c. If, after using the calculator, facilities determine they already have the stock they need, they are permitted to submit the required attestation immediately.

d. The PPE in stock is only to be used in the event of an emergency and not for daily use.

e. All facilities must have essential cleaning and disinfection supplies on hand in the event of a supply chain disruption.

ii. If at any time the facility is forced to use their PPE stockpile due to an emergency, the facility is required to re-stock and resubmit the attestation below indicating the re-stocking.

iii. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase the facility must submit to the Department via email to LTC.PPEStockpile@doh.nj.gov a PPE Stockpile attestation on facility letterhead from the facility administrator with the facility name and license number, as follows:**

Email Subject Line to LTC.PPEStockpile@doh.nj.gov:
[Facility Name] – [Facility License #] – PPE Stockpile

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] is in compliance with PPE in stock as required in Executive Directive 20-026 and I attest that [NAME OF THE FACILITY]:

a. Is a standalone or is not part of a system with eight (8) or more facilities, has used the CDC PPE Burn Rate Calculator and has two (2) months of PPE on hand in accordance with Executive Directive 20-026; or

b. Is part of a system of eight (8) or more facilities and has used the CDC PPE Burn Rate Calculator and has one (1) month of PPE on hand in accordance with Executive Directive 20-026.

c. Has re-stocked PPE and is in compliance with Executive Directive 20-026.

4. All LTCFs are required to report, at a minimum twice per week, COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-Term Care Facility COVID-19 Module: https://www.cdc.gov/nhsn/ltc/covid19/index.html. And the Antigen testing module.The module requires the following information to be submitted:

- Counts of residents and facility personnel with suspected and laboratory positive COVID-19;
- Counts of suspected and laboratory positive COVID-19 related deaths among residents and facility personnel;
- Resident beds and census;
- Staffing shortages;
- Status of personal protective equipment (PPE) and hand hygiene supplies; and
- Ventilator capacity and supplies for facilities with ventilator dependent units.

i. CMS certified facilities should submit data in accordance with 42 CFR §483.80(g) and CMS guidance in QSO-20-29, available at: https://www.cms.gov/files/document/qso-20-29-nh.pdf, but not less than **two** times per week.

ii. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, the facility must submit to the Department via email to LTC.DataReporting@doh.nj.gov a Data Reporting attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Email Subject Line to LTC.DataReporting@doh.nj.gov:
[Facility Name] – [Facility License #] – Data Reporting

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] has registered and is submitting data to the National Health safety Network as required by Executive Directive 20-026 and I attest that [NAME OF THE FACILITY]:

a. Has registered, authorized NJDOH to access data and is entering information in the NHSN COVID-19 Module twice weekly.

5. A facility with a COVID-19 outbreak will remain in Phase 0 (maximum restrictions) until their outbreak of COVID-19 has concluded.

i. A facility **may allow** indoor visitation if no new facility-onset of COVID-19 cases in the last 14 days have been detected, in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html AND the facility is not currently conducting outbreak testing in accordance with CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html, CMS facility testing requirements: https://www.cms.gov/files/document/qso-20-38-nh.pdf and/or CDS/Local health Department guidance: https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2.

ii. The detection of a NEW COVID-19 outbreak returns the facility to Phase 0, including restricting indoor visitation, regardless of the facility's current Phase. In order to leave Phase 0, facilities must re-submit an attestation upon conclusion of the outbreak, as directed within this directive.

iii. An outbreak of COVID-19 is defined by the Communicable Disease Service, COVID-19 Communicable Disease Manual Chapter available at: https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf.

iv. Outbreaks are considered concluded when there are no symptomatic/asymptomatic probable or confirmed COVID-19 cases among employees or residents after 28 days (two incubation periods) have passed since the last case's onset date or specimen collection date (whichever is later), as defined and updated per the COVID-19 Communicable Disease Manual Chapter. For CMS certified facilities, the facility must receive a survey by the NJDOH. The determination of an outbreak's conclusion will be made by either NJDOH or local

health officers, pursuant to N.J.A.C. 8:57-1.10.

v. Upon conclusion of an outbreak, the facility may directly advance to the applicable Phase based on the criteria in this Directive. For example, if a facility was at Phase 3 but has a new outbreak of COVID-19, they would return to Phase 0. If the facility can still attest to the criteria for Phase 3 and the State is still in Stage 3 of reopening when the outbreak is concluded, the facility could directly return to Phase 3.

vi. For the purposes of this Directive, management of a COVID-19 outbreak, infection prevention and control recommendations for COVID-19, or laboratory testing guidance issued by a local health department (LHD) or NJDOH should be followed in addition to the requirements set herein.

vii. **In order for the facility to meet the requirements of this Directive and before advancing from Phase 0 or to any other phase, the facility must submit to the Department via email to LTC.OutbreakEnd@doh.nj.gov an End of Outbreak attestation following the end of a COVID-19 outbreak or, if the facility never experienced a COVID-19 outbreak, a No Outbreak Experienced attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

Following the end of a COVID-19 outbreak at the facility:

Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
[Facility Name] – [Facility License #] – End of Outbreak

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

a. I attest that the facility has received determination of COVID-19 outbreak conclusion by the LHD or NJDOH on [INSERT DATE], as defined by the Communicable Disease Service COVID-19 Disease Chapter on [INSERT DATE]. If the facility is CMS certified, the facility has received a survey from the NJDOH on [INSERT DATE].

If the facility has never experienced a COVID-19 outbreak:

Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
[Facility Name] – [Facility License #] – No Outbreak Experienced

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

a. I attest that the facility has never experienced a COVID-19 outbreak.

III. Required standards for visitation and service during each reopening "Phase."

1. Exceptions to visitation restrictions in any phase:

i. In emergency situations EMS personnel shall be permitted to go directly to the resident.

ii. Sections 1819(c)(3)(A) and 1919(c)(3)(A) of the Social Security Act (the Act) and implementing regulations at 42 CFR 483.10(f)(4)(i)(C), require that a Medicare and Medicaid certified nursing home provide representatives of the State Long-Term Care Ombudsman with immediate access to any resident, however during this Public Health Emergency (PHE) in-person access may be restricted. If in-person access is not advisable due to infection control concerns and transmission of COVID-19, facilities must facilitate resident communication (e.g., by phone or through use of other technology) with the ombudsman. The CARES Act states the State Long-Term Care Ombudsman shall have continued direct access (or other access through the use of technology) to residents of long-term care facilities during any portion of the public health emergency relating to coronavirus.

iii. The CARES Act does not repeal or amend CMS requirements under sections 1819 or 1919 of the Act or implementing regulations. Nor does it place a time limit or expiration date (e.g., until September 30, 2020) on the CMS requirements providing for resident access to the Ombudsman program, but instead affirms that the current pandemic requires the Ombudsman program and long term care facilities to support resident access and communication in a variety of methods. For additional information regarding resident access to the Ombudsman please see Frequently Asked Questions (FAQ) on Nursing Home Visitation at: https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf.

iv. Section 483.10(f)(4)(i)(E) and (F) requires facilities to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). Protection and Advocacy (P&A) programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with

developmental disabilities if the incidents are reported or if there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person." 42 CFR 51.42(c); 45 CFR 1326.27. Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention.

v. Facilities shall coordinate with Medicaid Managed Care Organizations (MCOs) consistent with the requirements of the MCO contract, including supporting communication by representatives of the MCO with their enrollees, either in-person or using alternative means (e.g., by phone or through use of other technology) as necessary for infection control. When a resident is unable to communicate independently with the MCO representative, either temporarily or permanently, the facility will provide timely updates to the MCO regarding the health status of the individual.

2. **Requirements for Visitation and/or Entry in Any Phase:**

i. Facilities shall screen and log all persons entering the facility and all staff at the beginning of each shift. Facilities that have POC testing available are encouraged to use it as part of their visitor screening process, in particular during high/very high CALI scores in the region. Visitors who test positive are not permitted to enter the facility. If antigen testing is used, please refer to CDS: (https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2) and CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html) guidance for testing interpretation.

a. During moderate and high CALI scores, facilities may request but not require, visitors to be tested on their own prior to coming to the facility. Facilities with POC tests and ability to test visitors, should prioritize regular visitors (e.g., weekly visitors), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test. The visitor can provide proof of a negative FDA approved or authorized point-of-care test collected and performed in the past 24 hours or PCR test collected and resulted no more than 3 days prior to the visit.

ii. Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19, show signs or symptoms of COVID-19 or fail any criteria after being screened in accordance with section (iv) below.

iii. Any EMS-regulated transport personnel who have donned appropriate PPE in advance of entering the facility to transport a resident **should NOT be required to doff PPE and take a POC test** but should be screened in accordance with section (iv) below.

   a. Non-emergency medical transport personnel – such as taxi, Lyft, Uber, non-MAV or non-BLS – should be screened in accordance with section (iv) and may be tested prior to entering the facility to transport a resident. Drivers and transport personnel can provide proof of a negative FDA approved or authorized point-of-care test collected and performed in the past 24 hours or PCR test collected and resulted no more than 3 days prior to the visit in order to fulfill testing requirements under this section.

iv. Facilities must actively screen all persons entering the building (except EMS personnel during an emergency) for signs and symptoms of COVID-19. Screening is to include:

   a. Temperature checks including subjective and/or objective fever equal to or greater than 100.4 F or as further restricted by facility.

   b. Completion of a questionnaire about symptoms and potential exposure which shall include at a minimum:

      1) Whether in the last 14 days, the visitor has had an identified exposure to someone with a confirmed diagnosis of COVID-19, someone under investigation for COVID-19, or someone suffering from a respiratory illness.

      2) Whether the visitor has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH and CDC.

      3) Whether in the last 14 days, the visitor has returned from a state on the designated list of states under the 14-day quarantine travel advisory, available for review at: https://covid19.nj.gov/faqs/nj-information/travel-information/which-states-are-on-the-travel-advisory-list-are-there-travel-restrictions-to-or-from-new-jersey.

v. Facilities must observe anyone entering the facility for any signs or symptoms of COVID-19, including, but not limited to:

1) chills;
2) cough;
3) shortness of breath or difficulty breathing,
4) sore throat;
5) fatigue;
6) muscle or body aches;
7) headache;
8) new loss of taste or smell;
9) congestion or runny nose;
10) nausea or vomiting; or
11) diarrhea.

vi. Upon screening, facilities must prohibit entry into the building for those who meet one or more of the following criteria:

a. Exhibit signs or symptoms of an infectious communicable disease, including COVID-19, such as a subjective and/or objective fever (evidenced by a temperature check of the visitor equal to or greater than 100.4 F or as further restricted by facility), chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea;

b. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or someone under investigation for COVID-19, or someone ill with respiratory illness;

c. In the last 14 days, has returned from a designated state under the 14-day quarantine travel advisory; or

d. Has been diagnosed with COVID-19 and has not yet met criteria for the discontinuation of isolation per guidance issued by NJDOH https://www.state.nj.us/health/cd/topics/ncov.shtml and CDC https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html.

e. If testing (i.e. antigen or PCR) is used, tests positive.

vii. The facility must establish a designated area for visitors to be screened that accommodates social distancing and infection control standards. Visitors should be provided with the visitation guidelines upon check in. The facility should provide graphics to assist residents and visitors in maintaining social distancing and infection control standards.

viii. No more than two visitors are permitted at one time per resident. The facility must use appointments in order to limit the number of visitors inside the building at one time.

ix. If, after undergoing screening, the person is permitted to enter the building, the facility shall:

a. Require the person to wear a cloth face covering or facemask (covering both mouth and nose at all times). The facility may require the visitor to use additional forms of personal protective equipment (PPE), as determined by the facility.

b. Provide instruction on hand hygiene, provide instruction on limiting surfaces touched, provide instruction on the use of PPE, and inform visitors of the location of hand hygiene stations, before the visitor enters the facility and resident's room.

c. Advise the person to limit physical contact with anyone other than the resident while in the facility. For example, practice social distancing with no handshaking, kissing or hugging and remaining six feet apart.

d. For visitors, provide visitation in the resident's room, if they are in a single room. If a resident is in a shared room, the facility needs to identify a visitation location that allows for social distancing and for deep cleaning. Limit the visitor's movement within the facility to the resident's room or designated space (e.g., reduce walking the halls, avoid going to dining room, etc.). For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

e. Restrict a person from entering the facility if they are unable to demonstrate the proper use of infection prevention and control techniques.

x. The facility must advise anyone entering the facility to monitor for signs and symptoms of COVID-19 for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals of a reported contact, and take all necessary actions based on any findings.

xi. **The facility must receive informed consent from the visitor(s) and the resident in writing that they are aware of the possible dangers of exposure to COVID-19 for both the resident and the visitor and that they will follow the**

rules set by the facility in regard to visitation. The facility must receive a signed statement from each visitor and resident (if the resident is unable to consent then the consent needs to be signed by the authorized representative) with a copy provided to the visitor and resident, that they are aware of the risk of exposure to COVID-19 during the visit, that they will strictly comply with the facility policies during visitation, and that the visitor will notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID-19 within fourteen days of the visit.

3. **Cohorting, PPE and Training Requirements in Every Phase:**

   i. Facilities shall train and provide staff with all recommended COVID-19 PPE, to the extent PPE is available, and consistent with CDC guidance on optimization of PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html), if applicable. All staff must wear all appropriate PPE when indicated. Staff may wear cloth face coverings if facemask is not indicated, such as for administrative staff or while in non-patient care areas (e.g. breakroom).

   ii. Facilities shall implement universal source control for everyone in the facility. All residents, whether they have COVID-19 symptoms or not, must practice source control when around others (surgical mask if supply is available) in accordance with CDC guidance at: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Source control may be provided with cloth face coverings or facemasks.

   iii. Facilities shall implement universal eye protection, in addition to source control and other infection prevention and control measures, for all staff and for compassionate care or essential caregiver visitors unable to maintain social distancing when the NJDOH CALI Level is Very High/High or Moderate.

   iv. Facilities shall separate COVID-19 positive and negative residents in accordance with NJDOH guidance at: https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml. A resident is considered recovered from COVID-19 only after they have met the criteria for discontinuation of isolation as defined by the NJDOH at: https://www.state.nj.us/health/cd/topics/ncov.shtml, and CDC guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html.

   v. Facilities must continue to follow current NJDOH orders, guidance and directives on admissions and readmissions. Facilities may receive residents who were tested

prior to admission/transfer or shortly thereafter, in accordance with NJDOH Guidance: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Cohorting_PAC.pdf, Orders: https://www.state.nj.us/health/legal/covid19/4-13-20_EmergencyCurtailmentOfAdmissions.pdf and Directives. Facilities shall take appropriate action on the results including, but not limited to, the guidance below:

a. Sending Facility: COVID-19 diagnostic test results must be provided (in addition to other pertinent clinical information) to the receiving facilities for any transferred residents upon receipt of lab results.

b. Receiving Facility: Upon identification of a case of COVID-19 in a resident who was recently admitted (within 14 days), the receiving facility must provide these results back to the sending facility to allow for the appropriate response and investigation.

4. **Indoor End-of-Life**, **Compassionate Care**, and **Essential Caregiver** visitation is allowed for all residents, including pediatric and those covered by the Americans with Disabilities Act (ADA) or the Law Against Discrimination (LAD), in all phases pursuant to the following requirements, NJDOH directives and section (III)(2)(i) to (xi) of this directive**:**

i. All residents can be visited in all phases in **limited** situations as follows:

a. **End-of-life** situations pursuant to the requirements of this Directive and NJDOH Executive Directive No. 20-017 at: https://nj.gov/health/legal/covid19/6-19-20_ExecutiveDirectiveNo20-017_StandardsProtocolsVisitorsFacilityStaff.pdf .

b. **Compassionate Care** situations visits are allowed with transmission-based precautions, pursuant to the requirements of this Directive and NJDOH Executive Directive No. 20-017 at: https://nj.gov/health/legal/covid19/6-19-20_ExecutiveDirectiveNo20-017_StandardsProtocolsVisitorsFacilityStaff.pdf. The term “compassionate care situation” does not exclusively refer to end-of-life situations. CMS gives the following examples:

1) A resident who was living with their family before recently being admitted to a nursing home, the change in their environment and sudden lack of family can be a traumatic experience. Allowing a visit from a family member in this situation would be consistent with the intent of the term “compassionate care situations.” Similarly, allowing someone to visit a resident whose friend or family member recently passed away, would also be consistent with the intent of these situations.

(https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf).

2) A resident receiving hospice care whose health status is sharply declining, or when a resident is not enrolled in hospice, but their health status has sharply declined (https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf).

3) A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.

4) A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past). (https://www.cms.gov/files/document/qso-20-39-nh.pdf).

5) Facilities must work with residents, healthcare providers (e.g. hospice providers), families or guardians to determine when visits for compassionate care situations are appropriate and can be safely conducted.

6) While compassionate care visits are allowed in all phases, compassionate care visits when facilities are in Phase 0, should not be routine and allowed only on a limited basis as an exception to restricting visitation. Facilities must ensure that these visits are conducted as safely as possible and must require infection control practices, hand hygiene: https://www.cdc.gov/handhygiene/pdfs/Provider-Factsheet-508.pdf and appropriate PPE in accordance with guidance from the CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html) and CMS: (https://www.cms.gov/files/document/qso-20-39-nh.pdf.)

c. **Indoor Essential Caregiver Visitation Pursuant to the Requirements of This Directive:**

1) All residents may receive indoor essential caregiver visitation in facilities where there has been no new facility-onset COVID-19 cases in the last 14 days AND the facility is not currently conducting outbreak testing per the CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html), CMS: https://www.cms.gov/files/document/qso-20-38-nh.pdf and CDS guidance :

https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-19_Antigen_Testing_in_LTCF.pdf.

2) Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for end-of-life, compassionate care situations in accordance with NJDOH Executive Directive No. 20-017, as outlined in this directive and in accordance with CMS guidance: https://www.cms.gov/files/document/qso-20-39-nh.pdf, with adherence to transmission-based precautions.

3) An essential caregiver could be an individual who was previously actively engaged with the resident or is committed to providing assistance with activities of daily living.

4) Facilities must establish policies and procedures for how to designate and utilize an essential caregiver.

5) Consult the facility's Administrator, Director of Nursing, Social Services Director, or other designated facility staff to help determine who meets the criteria of an essential caregiver.

6) The resident must be consulted about their wishes to determine whom to designate as the essential caregiver. Consider persons such as a family member, outside caregiver, or friend who provided regular care to the resident prior to the pandemic.

7) Residents may express a desire to designate more than one essential caregiver based on their past involvement and needs (e.g., more than one family member previously split time to provide care for the resident). In these unique situations, facility staff should work cooperatively with the resident and family to work out a schedule to accommodate the essential caregivers.

8) Work with the resident and essential caregiver to identify a schedule of up to two (2) hours per visit, one (1) time per week, for the essential caregiver to be in the facility, if the facility is in phase 0. Facilities in Phases one (1) or two (2) may allow for two visits per week not to exceed a total of four (4) hours per week. Facilities in phase three (3) may allow essential caregiving visitation under their regular procedures and per this directive.

9) Ensure that scheduling of essential caregiver visits takes into account the number of essential caregivers in the building at the same time. The facility may establish time limits as needed to keep residents safe.

10) Utilize the essential caregiver to provide care in the same manner as prior to the pandemic.

11) Facilities must ensure that essential caregiving visits are conducted as safely as possible and must require infection control practices, hand hygiene and PPE.

12) Facilities that have POC testing available are encouraged to use it as part of their visitor screening process. Visitors who test positive are not permitted to enter the facility. If antigen testing is used, please refer to CDS: (https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2) and CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html), guidance for testing interpretation.

    a) During moderate and high CALI scores, facilities may request but not require, visitors to be tested on their own prior to coming to the facility. Facilities with POC tests and ability to test visitors, should prioritize regular visitors (e.g., weekly visitors), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test. The visitor can provide proof of a negative FDA approved or authorized point-of-care test collected and performed in the past 24 hours or PCR test collected and resulted no more than 3 days prior to the visit.NOTE: Facilities may test essential caregivers in accordance with section (I)(9), of this Executive Directive.

5. **Indoor visitation for pediatric residents and residents with intellectual and/or developmental disabilities** covered under the Americans with Disabilities Act (ADA) or state Law Against Discrimination (LAD) is allowed in phases 1, 2 and 3 pursuant to the requirements in this Directive and NJDOH Executive Directive No. 20-025: https://www.state.nj.us/health/legal/covid19/ED20-025VisitationDD.pdf.

    i. Nothing in this directive shall be interpreted to prevent pediatric residents currently negative or asymptomatic and not on transmission-based precautions from attending educational institutions or medical appointments (e.g. physical therapy) provided protocols are in place to protect the resident and the facility.

6. **Outdoor visitation** is allowed for negative and asymptomatic, or COVID-19 recovered residents in all Phases, as per NJDOH Executive Directive 20-017: https://nj.gov/health/legal/covid19/6-19-20_ExecutiveDirectiveNo20-017_StandardsProtocolsVisitorsFacilityStaff.pdf and this directive. The Directive requires facilities to attest to their visitation plan and capabilities, receive informed consent from visitors and residents and safeguard residents, staff and visitors among others.

i. In accordance with CMS guidance: (https://www.cms.gov/files/document/qso-20-39-nh.pdf), outdoor visitation is preferred over indoor visitation and should be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Outdoor visitation should be facilitated routinely, except during periods of unsuitable weather conditions (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), when an individual resident's health status prevents visitation (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status prevents visitation..

7. **Indoor Visitation by Appointment in Accordance with CMS QSO-20-39**

i. Indoor visitation by appointment is allowed in every phase per CMS visitation guidance: (https://www.cms.gov/files/document/qso-20-39-nh.pdf) released on September 17, 2020, pursuant to the requirements in this directive as follows:

a. A facility **may allow** indoor visitation after no new facility-onset of COVID-19 cases in the last 14 days have been detected, in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html AND the facility is not currently conducting outbreak testing in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html, CMS facility testing requirements: https://www.cms.gov/files/document/qso-20-38-nh.pdf and/or CDS/Local health Department guidance: https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#2.

b. Indoor visitation can only occur in facilities where there has been NO NEW facility-onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing and has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

c. Facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). For example, if a facility has had no facility-onset COVID-19 cases in the last 14 days and its county positivity rate is low or medium, as determined by NJDOH, a nursing home **must** facilitate in-person visitation consistent with regulations, CMS guidance and the requirements outlined in this directive.

1) Facilities in moderate or high-positivity counties are encouraged to test visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the

facility (e.g., within 2–3 days) with proof of negative test results and date of test.

d. As stated in section (III)(2)(i) to (xi), facilities must have a mechanism to collect informed consent from the residents and visitors, have a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

e. Indoor visitation permitted in this section should be socially distanced at least six (6) feet between persons at all times. The risk of transmission can be further reduced through the use of physical barriers (e.g. Plexiglas dividers, curtains).

f. Visitors must be screened and logged in accordance with section (III)(2)(i) to (xi) of this Directive.

g. Except for on-going use of virtual visits, facilities may still restrict visitation (beyond end-of-life, compassionate care and essential caregiver) due to the COVID-19 county positivity rate per CMS guidance: https://www.cms.gov/files/document/qso-20-39-nh.pdf, the facility's COVID-19 status, a resident's COVID-19 status except as outlined in section 4(i) above, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 public health emergency. However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v).

1) Facilities should use the NJDOH CALI Level here: https://www.nj.gov/health/cd/statistics/covid/index.shtml as additional information to determine how to facilitate indoor visitation. The CALI Level takes into account three factors for the region: (1) case rate (per 100,000) is calculated as a proportion of the population; (2) percent of COVID-like illness; and (3) the percent positivity. The CALI Level should be used to facilitate indoor visitation:

- CALI Level Low = Visitation should occur according to the core principles of COVID-19 infection prevention, NJDOH guidance and directives (beyond compassionate care, end-of-life and essential caregiver visits).

- CALI Level Moderate = Consider limiting indoor visitation, although visitation may occur according to the core principles of COVID-19 infection prevention and NJDOH guidance and directives (beyond compassionate care, end-of-life and essential caregiver visits).

- CALI Level High or Very High = Visitation should only occur for compassionate care, end-of-life and essential caregiver situations according to the core principles of COVID-19 infection prevention, NJDOH guidance and directives. Facilities should check CALI scores on a weekly basis, every Thursday and are to cease all indoor visitation, except for compassionate care, end-of-life and essential caregiving if their region has entered into a High/Very High until the CALI score in the region returns to yellow/moderate or green/low for a minimum of two weeks.

- County positivity rate or CALI score does not need to be considered for outdoor visitation.

h. Before commencing indoor visitation facilities must attest to their visitation plan and capabilities, receive informed consent from visitors and residents and safeguard residents, staff and visitors among others.

ii. **In order for the facility to meet the requirements of this Directive and at least 3 business days before commencing indoor visitation, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov an Indoor Visitation During Phase 0 or Phase 1 attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
[Facility Name] – [Facility License #] – Indoor Visitation Attestation

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026, not experienced any new facility-onset of COVID-19 cases in 14 days, has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

IV. Required standards for services during each phase.

1. **Phase 0**

   i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

   ii. Screen and log all persons entering the facility and all staff at the beginning of each shift in accordance with section (III)(2)(i) to (xi) of this Directive.

   iii. Entry of non-essential personnel is prohibited. Those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers, are prohibited from entering the building.

   iv. Facilities shall screen all residents, at minimum during every shift, with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure, temperature, and pulse oximetry.

   v. When facilities are experiencing an outbreak, communal dining and all group activities should be limited. Residents shall stay in their rooms as much as possible and cohort in accordance with CDS: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Cohorting_PAC.pdf and CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

   vi. Avoid non-medically necessary trips outside the building. For medically necessary trips away from the facility the resident must wear a cloth face covering or facemask (surgical mask if supply is available) in accordance with CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Upon return perform a risk assessment focused on contact tracing and adherence to recommended infection prevention and control measures. Refer to NJDOH *COVID-19 Exposure Risk Assessment Template for Patients in Post-Acute Settings* at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#4.

   vii. Perform ongoing testing of all staff per section (I)(9),until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive must be re-tested according to CDC and CDS guidance at: https://www.cdc.gov/coronavirus/2019-

ncov/hcp/testing-healthcare-personnel.html

2. **Phase 1**

   i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

   ii. Screen and log all persons entering the facility and all staff at the beginning of each shift in accordance with section (III)(2)(i) to (xi) of this Directive.

   iii. Entry of non-essential personnel is prohibited. Those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers, are prohibited from entering the building.

   iv. Restrict communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.

      a. Residents may eat in the same room while practicing infection prevention and control precautions including social distancing measures. This includes limiting the number of people at tables and using barriers and/or maintaining separation of space by at least 6 feet, as deemed appropriate based on facility risk assessment.

      b. When feasible, seat the same small group of residents together each day, so that each resident is in contact with the same small group. There should be no mixing of residents across these groups.

      c. When feasible, staff should be assigned to specific tables in order to minimize the number of residents they interact with and remain with that group each day, whenever possible.

      d. The sharing of condiments and serving utensils is prohibited. Sanitize/clean high-touch surfaces (e.g. chairs, tables) between seating/meals. The facility should use disposable utensils and cups when possible.

      e. The facility must ensure that processes are in place to maintain infection control protocols such as preventing staff from cleaning used tableware (e.g. plates and cups) and immediately serving food without proper handwashing. When feasible disposable cups and utensils are preferred.

         1) Consider the following steps: refrain from removing used plates and tableware from the table until all residents have finished eating or utilize specific staff to serve residents and refill drinks during the meal and a

separate group of staff to clear plates and tableware of those who are finished.

v. Restrict group activities in general. Limited activities may be conducted for COVID-19 negative and asymptomatic or COVID-19 recovered residents only in their small groups. Facilities that permit group activities shall:

   a. Maintain infection prevention and control precautions including social distancing and source control measures, and limit the numbers of residents who participate, as deemed appropriate based on facility risk assessment and as permissible pursuant to statewide indoor and outdoor gatherings limitations.

   b. As much as possible, keep the same residents in the same group each day so that each resident is in contact with the same group, including the same staff, in order to minimize multiple interactions and remain with that group daily. Group size should not exceed more than 10 individuals.

   c. Activity items that cannot be appropriately cleaned and disinfected should not be shared between residents. For example, residents should be given their own personal bingo cards and tiles.

vi. Avoid non-medically necessary trips outside the building. For medically necessary trips away from the facility, the resident must wear a cloth face covering or facemask
(surgical mask if supply is available) in accordance with CDC guidance at: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Upon return perform a risk assessment focused on contact tracing and adherence to recommended infection prevention and control measures. Refer to NJDOH *COVID-19 Exposure Risk Assessment Template for Patients in Post-Acute Settings* at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#4.

   Screen all residents, at a minimum daily**,** with temperature checks, questions and observations for other signs or symptoms of COVID-19. NOTE: When the NJDOH CALI Level is Very High/High screen residents at minimum every shift. When the CALI Level is Moderate screen residents at minimum twice a day.

vii. Continue to perform ongoing testing of all staff per section (I)(9), until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive should be re-

tested according to CDC and CDS guidance at:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

3. **Phase 2**

   i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

   ii. Screen and log all persons entering the facility and all staff at the beginning of each shift in accordance with section (III)(2)(i) to (xi) of this Directive

   iii. **In order for the facility to meet the requirements of this Directive and at least 48 hours before commencing indoor visitation in Phase 2, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov a Phase 2 Indoor Visitation attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

      Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
      [Facility Name] – [Facility License #] – Phase 2 Indoor Visitation Attestation

      Attestation Text:
      I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026, the facility has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments and sufficient PPE to permit visitation.

   iv. For medically necessary trips away from the facility, the resident must wear a cloth face covering or facemask (surgical mask if supply is available) in accordance with CDC guidance:https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Upon return perform a risk assessment focused on contact tracing and adherence to ivrecommended infection prevention and control measures. Refer to NJDOH *COVID-19 Exposure Risk Assessment Template for Patients in Post-Acute Settings* at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#4.

v. Entry of non-essential personnel/contractors into the building is permitted. Personnel/contractors must be logged and screened in accordance with section (III)(2)(i) to (xi) of this Directive. This includes personnel providing elective consultations and non-essential services (e.g., barber, hair stylist) as determined necessary by the facility. Such personnel are permitted access only to COVID-19 negative and asymptomatic or COVID-19 recovered residents. Entry of volunteers is not permitted in Phase 2.

vi. Requirements for infection prevention and control precautions, including social distancing, cloth face coverings or facemasks continue to apply for indoor visitation/entry of non-essential personnel/contractors in Phase 2. When possible, facilities should restrict movement of person entering the facility to a designated area (e.g., medical consults provided in designated treatment room).

vii. Limit communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only**.**

a. Residents may eat in the same room while practicing infection prevention and control precautions including social distancing measures whenever possible. This includes limiting the number of people at tables and using barriers and/or maintaining separation of space by at least 6 feet, as deemed appropriate based on facility risk assessment.

b. When feasible, a small group of residents should be seated together each day, so that each resident is in contact with the same small group. There should be no mixing of residents across these groups.

c. When feasible, staff should be assigned to specific tables in order to minimize the number of residents they interact with and remain with that group each day, whenever possible.

d. The sharing of condiments and serving utensils is prohibited. Sanitize/clean high-touch surfaces (e.g. chairs, tables) between seating/meals.

e. The facility must ensure that processes are in place to maintain infection control protocols such as preventing staff from cleaning used tableware (e.g. plates and cups) and immediately serving food without proper handwashing. When feasible disposable cups and utensils are preferred.

1) Consider the following steps: refrain from removing used plates and tableware from the table until all residents have finished eating or utilize specific staff to serve residents and refill drinks during the meal and a separate group of staff to clear plates and tableware of those who are finished.

viii. Limit group activities to no more than 10 people, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only, as deemed appropriate based on facility risk assessment.

ix. Maintain infection prevention and control measures including social distancing and source control measures.

x. Continue to perform ongoing testing of all staff per section (I)(9), until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive should be re-tested according to CDC and CDS guidance at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

xi. Screen all residents, at minimum daily, with temperature checks, questions and observations for other signs or symptoms of COVID-19.

NOTE: When the NJDOH CALI Level is Very High/High screen residents every shift. When the CALI Level is Moderate screen residents twice a day.

4. **Phase 3**

i. Indoor visitation in accordance with section (III)(7)(i) to (ii) and the requirements in this directive is allowed.

ii. Allow entry of non-essential healthcare personnel/contractors as determined necessary by the facility, based on screening and including infection prevention and control precautions, social distancing, hand hygiene, and cloth face coverings or facemasks.

iii. Allow entry of volunteers, based on screening and including infection prevention and control precautions, social distancing, hand hygiene, and cloth face coverings or facemasks.

iv. Screen all residents, at minimum daily, with temperature checks, questions and observations for other signs or symptoms of COVID-19 and test if symptomatic.

NOTE: When the NJDOH CALI Level is Very High/High screen residents every shift. When the CALI Level is Moderate screen residents twice a day.

v. Limit communal dining to COVID-19 negative and asymptomatic or COVID-19 recovered residents only.

a. Residents may eat in the same room while practicing infection prevention and control precautions including social distancing measures whenever possible.

This includes limiting the number of people at tables and using barriers and/or maintaining separation of space by at least six (6) feet, as deemed appropriate based on facility risk assessment.

b. When feasible, a small group of residents should be seated together each day, so that each resident is in contact with the same small group. There should be no mixing of residents across these groups.

c. When feasible, staff should be assigned to specific tables in order to minimize the number of residents they interact with and remain with that group each day, whenever possible.

d. The sharing of condiments and serving utensils is prohibited. Sanitize/clean high-touch surfaces (e.g. chairs, tables) between seating/meals.

e. The facility must ensure that processes are in place to maintain infection control protocols such as preventing staff from cleaning used tableware (e.g. plates and cups) and immediately serving food without proper handwashing. When feasible disposable cups and utensils are preferred.

1) Consider the following steps: refrain from removing used plates and tableware from the table until all residents have finished eating or utilize specific staff to serve residents and refill drinks during the meal and a separate group of staff to clear plates and tableware of those who are finished.

vi. Resume Group activities, including outings, for COVID-19 negative and asymptomatic or COVID-19 recovered residents only, as deemed appropriate based on facility risk assessment.

vii. Maintain infection prevention and control measures including social distancing and source control measures.

viii. For medically necessary trips away from the facility the resident must wear a cloth face covering or facemask (surgical mask if supply is available) in accordance with CDC guidance, available at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html. A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Upon return perform a risk assessment focused on contact tracing and adherence to recommended infection prevention and control measures. Refer to NJDOH *COVID-19 Exposure Risk Assessment Template for Patients in Post-Acute Settings* at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml#4.

ix. Continue to perform ongoing testing of all staff per section (I)(9),until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community. Staff who have previously tested positive must be re-tested according to CDC and CDS guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html.

This Directive shall take effect immediately. The provisions of this Directive shall remain in force and effect for the duration of the public health emergency originally declared in Executive Order No. 103 (2020), and as extended by Executive Order, unless otherwise modified, supplemented and/or rescinded.

Dated: January 6, 2021

Judith M. Persichilli, RN, BSN, MA
Commissioner

Resources

CDC Preparing for COVID-19 in Nursing Homes
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

CMS Memo Nursing Home Reopening Recommendations for State and Local Officials
https://www.cms.gov/files/document/qso-20-30-nh.pdf

New Jersey COVID-19 Information Hub, FAQ
https://covid19.nj.gov/faqs/nj-information/general-public/when-and-how-is-new-jersey-lifting-restrictions-what-does-a-responsible-and-strategic-restart-of-new-jerseys-economy-look-like

NJDOH Revised Executive Order 20-013 (Testing in Post-Acute Settings)
https://www.nj.gov/health/legal/covid19/05-20-2020_ExecutiveDirectiveNo20-013_LTC_planCOVID19testing_revised.pdf

NJDOH COVID-19, Communicable Disease Manual Chapter
https://www.nj.gov/health/cd/documents/topics/NCOV/NCOV_chapter.pdf

NJDOH COVID-19: Information for Healthcare Professionals
https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml

The Road Back: Restoring Economic Health Through Public Health

http://d31hzlhk6di2h5.cloudfront.net/20200518/ff/c9/8c/41/1917eaf623c02595b9225209/Strategic_Restart_Plan.jpg

Appendix

A. E.D. 20-026 Attestations

APPENDIX A

1. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, the facility must submit to the Department via email to LTC.PhasedReopening@doh.nj.gov a Phased Reopening attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.PhasedReopening@doh.nj.gov:
   [Facility Name] – [Facility License #] – Phased Reopening Attestation – Entering Phase #

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; I attest that the facility has implemented and will continue to adhere to all the requirements set forth in Section (I) (3) to (11) of Executive Directive No. 20-026 to advance to [PHASE #] and [NAME OF THE FACILITY] currently:

   a. Has an "Outbreak Plan," as required by N.J.S.A. 26:2H-12.87, and the plan is posted on the facility's website for public view. The plan includes effective communication methods to notify patients/residents, their families or guardians and staff about any infectious disease outbreaks and includes strategies and methods for virtual communications in the case of visitation restrictions, at a minimum on a weekly basis;

   b. Is not experiencing a staffing shortage, is not under a contingency or crisis staffing plan and has a documented plan for securing additional staff in case of a COVID-19 outbreak among staff as part of the facility's "Outbreak Plan;"

   c. (CMS certified facilities only) has a documented communication plan and is informing residents, their representatives, and families of the residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new-onset of respiratory symptoms occur within 72 hours of each other, in accordance with CMS rule 42 CFR §483.80(g);

   d. Is prominently displaying on their website and/or social media platforms and including in communications to families, guardians and the public, a phone number or method of communication for urgent calls or complaints; and

Is meeting testing and data reporting requirements of residents and staff as outlined in NJDOH E.D. 20-026.

2. **In order for the facility to meet the requirements of this Directive, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an Infection Control Contract attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
   [Facility Name] – [Facility License #] – Infection Control Contract

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF FACILITY] and to bind [NAME OF FACILITY] thereto; that [NAME OF FACILITY] is in compliance with all requirements for Contracting Infection Control Services in Executive Directive 20-026 and I attest that [NAME OF FACILITY] has:

   a. One hundred (100) or more beds or on-site hemodialysis services and has contracted with an infection control service pursuant to the requirements of E.D. 20-026.

   b. Less than 100 beds or no on-site hemodialysis services and has contracted with an infection control service based on the resident population and facility service needs identified in the facility risk assessment per E.D. 20-026.

3. **In order for the facility to meet the requirements of this Directive and no later than August 10, 2021 for facilities without ventilators beds or immediately for facilities with ventilator beds, the facility must submit to the Department via email to LTC.DiseaseOutbreakPlan@doh.nj.gov an Infection Control Employee attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DiseaseOutbreakPlan@doh.nj.gov:
   [Facility Name] – [Facility License #] – Infection Control Employee

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF FACILITY] and to bind [NAME OF FACILITY] thereto; that [NAME OF FACILITY] is in compliance with all requirements in Executive

Directive 20-026 and has hired an Infection Control Employee and I attest that [NAME OF FACILITY] has:

a. Less than 100 beds or no on-site hemodialysis services has staffed the IPC program based on the resident population and facility service needs identified in the facility risk assessment per E.D. 20-026.

b. One hundred (100) or more beds or on-site hemodialysis services and has hired an infection control employee pursuant to the requirements of E.D. 20-026.

c. Facilities with ventilator beds must attest having hired or contracted pursuant to the requirements of N.J.S.A. 26:2H-12.87(a) to (d).

4. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase the facility must submit to the Department via email to LTC.PPEStockpile@doh.nj.gov a PPE Stockpile attestation on facility letterhead from the facility administrator with the facility name and license number, as follows:**

Email Subject Line to LTC.PPEStockpile@doh.nj.gov:
[Facility Name] – [Facility License #] – PPE Stockpile

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] is in compliance with PPE in stock as required in Executive Directive 20-026and I attest that [NAME OF THE FACILITY]:

a. Is a standalone or is not part of a system with eight (8) or more facilities, has used the CDC PPE Burn Rate Calculator and has two (2) months of PPE on hand in accordance with Executive Directive 20-026; or

b. Is part of a system of eight (8) or more facilities and has used the CDC PPE Burn Rate Calculator and has one (1) month of PPE on hand in accordance with Executive Directive 20-026.

c. Has re-stocked PPE and is in compliance with Executive Directive 20-026.

5. **In order for the facility to meet the requirements of this Directive, before advancing from Phase 0 or to any other phase, and no later than October 30, 2020, if the facility does not attempt to advance to another phase during that time, the facility must submit to the Department via email to LTC.DataReporting@doh.nj.gov a Data Reporting attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Email Subject Line to LTC.DataReporting@doh.nj.gov:
   [Facility Name] – [Facility License #] – Data Reporting

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with [NAME OF THE FACILITY] in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of [NAME OF THE FACILITY] and to bind [NAME OF THE FACILITY] thereto; that [NAME OF THE FACILITY] has registered and is submitting data to the National Health safety Network as required by Executive Directive 20-026 and I attest that [NAME OF THE FACILITY]:

   a. Has registered, authorized NJDOH to access data and is entering information in the NHSN COVID-19 Module twice weekly.

6. **In order for the facility to meet the requirements of this Directive and before advancing from Phase 0 or to any other phase, the facility must submit to the Department via email to LTC.OutbreakEnd@doh.nj.gov an End of Outbreak attestation following the end of a COVID-19 outbreak or, if the facility never experienced a COVID-19 outbreak, a No Outbreak Experienced attestation on facility letterhead from the facility administrator with the facility name and license number as follows:**

   Following the end of a COVID-19 outbreak at the facility:

   Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
   [Facility Name] – [Facility License #] – End of Outbreak

   Attestation Text:
   I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

   a. I attest that the facility has received determination of COVID-19 outbreak conclusion by the LHD or NJDOH on [INSERT DATE], as

defined by the Communicable Disease Service COVID-19 Disease Chapter on [INSERT DATE]. If the facility is CMS certified, the facility has received a survey from the NJDOH on [INSERT DATE].

If the facility has never experienced a COVID-19 outbreak:

Email Subject Line to LTC.OutbreakEnd@doh.nj.gov:
[Facility Name] – [Facility License #] – No Outbreak Experienced

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto:

a. I attest that the facility has never experienced a COVID-19 outbreak.

7. **In order for the facility to meet the requirements of this Directive and at least 3 business days before commencing indoor visitation, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov an Indoor Visitation During Phase 0 or Phase 1 attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
[Facility Name] – [Facility License #] – Indoor Visitation Attestation

Attestation Text:
I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026, not experienced any new facility-onset of COVID-19 cases in 14 days, has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments, and sufficient PPE and cleaning and disinfection supplies to permit visitation.

8. **In order for the facility to meet the requirements of this Directive and at least 48 hours before commencing indoor visitation in Phase 2, the facility must submit to the Department via email to LTC.Phase2IndoorVisits@doh.nj.gov a Phase 2 Indoor Visitation attestation on facility letterhead from the facility administrator with the facility name and license number as follows**:

    Email Subject Line to LTC.Phase2IndoorVisits@doh.nj.gov:
    [Facility Name] – [Facility License #] – Phase 2 Indoor Visitation Attestation

    Attestation Text:
    I, [NAME], of full age, hereby certify that I am employed with the Facility in the capacity of [INSERT TITLE]; that I am duly authorized to the make the representations contained within this attestation on behalf of the Facility and to bind the Facility thereto; I attest that the facility has implemented all the requirements set forth in Executive Directive 20-026, the facility has a mechanism to collect informed consent from the residents and visitors, has a location designated for indoor visitation, sufficient staff, a mechanism for appointments and sufficient PPE to permit visitation.