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PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

EXECUTIVE DIRECTIVE NO. 20-026

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 and 171; 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

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 health by 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[1]; 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-jersey-lifting-restrictions-what-does-a-responsible-and-strategic-restart-of-new-jerseys-economy-look-like

[1] 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.).

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. As of the effective date of this Directive, all facilities are considered to be in Phase 0. 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.

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 view no later than **two (2) months** from the enactment date 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.html#.

9. Testing as described herein must be initiated within two (2) weeks from the effective date of 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:

Continued testing of residents:

i. Repeat weekly testing of all residents 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. Retesting of residents who have been confirmed positive whenever required according to CDS and CDC guidance.

Continued testing of staff as follows:

i. Ongoing weekly testing of all staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community.

ii. Retesting staff who have previously tested positive according to CDC and NJDOH guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html.

*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*.

10. Facilities must continue to report testing data through the New Jersey Hospital Association (NJHA) portal here: www.ppe.njha.com. Data entered in this portal is not cumulative.

11. Any resident or 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.

12. **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 two (2) months from the enactment of this Directive, 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.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 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. Facilities 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; or

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

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.

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 more than 100 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 one (1) year from the date of enactment of this Directive.

2) Prior to the hiring of an employee for the IPC program, facilities have **two (2) months** from the date of enactment of this Directive to enter into a contract for infection control services. Facilities must have, at a minimum, executed a contract, within two (2) months of enactment, in preparation for the start of the flu season in the fall of 2020. 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 have **two (2) months** from the date of enactment of this Directive to enter into a contract for infection control services. Facilities must have at a minimum a contract, within two (2) months of enactment, in

preparation for the start of the flu season in the fall of 2020. 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 will have at a maximum one (1) month from the date of enactment of this Directive to 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; or

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

vi. **In order for the facility to meet the requirements of this Directive and no later than two (2) months from the enactment 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. More than 100 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 one (1) year for facilities without ventilators beds or no later than one (1) month for facilities with ventilator* beds from the enactment of this Directive, 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. More than 100 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 **have one (1) month** to submit the attestation.) Has ventilator beds and has 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 **nine (9) months** from the date of enactment of this Directive to create and implement the plan.

i. Facilities may contract with a consultant or vendor to fulfill the requirements of this section and must attest to the implementation of a RPP no later than nine (9) months

from the enactment of this Directive.

ii. **In order for the facility to meet the requirements of this Directive and no later than nine (9) months from the enactment of this Directive, the facility must create and implement a RPP and 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 have **two (2) months**, from the date of enactment of this Directive, to 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_mhrROqJh0. 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.

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

iii. 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.

iv. **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 two (2) months from the enactment of this Directive 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.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 for in accordance with Executive Directive 20-026.

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

4. Starting on the effective date of this Directive, 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. Facilities not currently enrolled must enroll and submit data within two (2) months from the date of enactment of this Directive. 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 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, and no later than two (2) months from the enactment of this Directive, 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.

5. A facility with a COVID-19 outbreak will remain in Phase 0 (maximum restrictions) until their outbreak of COVID-19 has concluded. The detection of a NEW COVID-19 outbreak returns the facility to Phase 0 regardless of the facility's current Phase. In order to leave phase 0, facilities must re-submit an attestation upon conclusion as directed within this directive.

i. 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.

ii. 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.

iii. 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, it could directly return to Phase 3.

iv. 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.

v. **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 until September 30, 2020.

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. 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.

ii. Facilities must actively screen all persons entering the building (except EMS personnel) 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.

iii. 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.

iv. 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.

v. 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.

vi. 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.

vii. 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. 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.).

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

viii. 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.

ix. 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 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.

iv. 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 (ix) of this directive**:**

i. All Residents can be visited 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 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) 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.

4) 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 washing and appropriate PPE in accordance with CDC guidance.

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

1) All residents may receive essential caregiver visitation, except for those that are in a 14-day quarantine period, positive for COVID-19 and have not yet met the criteria for the discontinuation of isolation or symptomatic.

2) 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.

3) Facilities must establish policies and procedures for how to designate and utilize an Essential Caregiver.

4) 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.

5) 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.

6) 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.

7) 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 caregiving visitation under their regular procedures and per this directive.

8) 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.

9) Utilize the Essential Caregiver to provide care in the same manner as prior to the pandemic.

10) Facilities must ensure that Essential Caregiving visits are conducted as safely as possible and must require infection control practices, hand washing and PPE.

5. **Limited 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.

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. 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.

IV. Required standards for services during each phase.

1. **Phase 0**

i. 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 (ix) of this Directive.

ii. 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.

iii. 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.

iv. 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

v. 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.

vi. Perform ongoing weekly testing of all staff 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. 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 (ix) of this Directive.

ii. 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.

iii. 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.

iv. 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.

v. 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: . 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.

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

vii. Continue to perform ongoing weekly testing of all staff 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. 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 (ix) of this Directive.

ii. Indoor visitation by appointment is allowed. Visitation in this section is based on CMS guidance at: https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf. Visitors must be screened and logged in accordance with section (III)(2)(i) to (ix) of this Directive.

iii. 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.

iv. **In order for the facility to meet the requirements of this Directive and at least 48 hours before commencing indoor visitation, 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.

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 (ix) 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 weekly testing of all staff 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.

4. **Phase 3**

i. Resume indoor visitation. 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 (ix) of this Directive.

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.

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

ix. Continue to perform ongoing weekly testing of all staff 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.

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
B. E.D. 20-026 Infographic - Phase Requirements

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: August 10, 2020

Judith M. Persichilli

Judith M. Persichilli, RN, BSN, MA
Commissioner

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, and no later than two (2) months from the enactment of this Directive, 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.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 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.

2. **In order for the facility to meet the requirements of this Directive and no later than two (2) months from the enactment 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. More than 100 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 one (1) year for facilities without ventilators beds or no later than one (1) month for facilities with ventilator* beds from the enactment of this Directive, 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. More than 100 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 have **one (1) month** to submit the attestation) Has ventilator beds and has 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 and no later than nine (9) months from the enactment of this Directive, the facility must create and implement a RPP and 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.

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 two (2) months from the enactment of this Directive, 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.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 for in accordance with Executive Directive 20-026.

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

6. **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 two (2) months from the enactment of this Directive, 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.

7. **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:

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

8. **In order for the facility to meet the requirements of this Directive and at least 48 hours before commencing indoor visitation, 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.

APPENDIX B

Requirements to Initiate Phased LTCF Reopening, Visitation and Service Resumption

State Reopening	The Road Back: Verification that the State of New Jersey remains out of the "maximum restrictions" Stage.	✓
	The Road Back: 14 days have elapsed since NJ entered the Reopening Stage corresponding with the LTC Phase.	✓
Outbreak Prevention/ Management E.D. 20-026 N.J.S.A. 26:2H-12.87 42 CFR § 483.80(g)	Plan: Outbreak Plan is maintained and revised if necessary. (Required by N.J.S.A. 26:2H-12.87)	✓
	Plan: Outbreak communications for patients/residents, representatives, families, and staff. (Required by CMS rule 42 CFR §483.80(g) and guidance for CMS certified facilities and required by N.J.S.A. 26:2H-12.87)	✓
	Posting: Publicly post the "Outbreak Plan" on facility website. (Required within two months of this Directive's effective date)	✓
Other Communications E.D. 20-026	Posting: Publicly post—on facility website, on social media platforms, and in communications to families, guardians, and the public—a phone number or other communication method for urgent calls or complaints.	✓
	Plan: Virtual communications for residents, families, and representatives in the event of visitation restrictions. (Required by NJDOH E.D. 20-026.)	✓
Staffing E.D. 20-026	Staff capacity: No shortage and not operating under a contingency nor crisis staffing plan. (Required by NJDOH E.D. 20-026)	✓
	Plan: Securing of additional staff in event of a new COVID-19 or other infectious disease outbreak.	✓
Testing E.D. 20-026	Laboratory capacity: Agreement or contract with laboratory to ensure capacity for repeat facility-wide testing and result prioritization.	✓
	Practice: Resident testing per guidance	✓
	Practice: Staff testing per guidance	✓
Compliance	Compliance: NJDOH COVID-19 Temporary Operational Waivers and Guidelines	✓
Outbreak Status E.D. 20-026	Status: No current outbreaks. (If prior outbreak, end of outbreak as determined by NJDOH or local health officers under N.J.A.C. 8:57-1.10)	✓

Attestations Required to Initiate or Continue Phased LTCF Reopening

Attestation (Subject Line for Email)	Email Address to Submit	Deadline
Reopening Attestation – Entering Phase # [Facility Name] – [Facility License #]	LTC.PhasedReopening@doh.nj.gov	≥48 hours before advancing between Phases.
Infection Control Contract [Facility Name] – [Facility License #]	LTC.DiseaseOutbreakPlan@doh.nj.gov	≤2 months after NJDOH ED No. 20-026 enacted.
Infection Control Employee [Facility Name] – [Facility License #]	LTC.DiseaseOutbreakPlan@doh.nj.gov	≤1 year after NJDOH ED No. 20-026 enacted. ≤1month facilities with ventilator beds must attest compliance with N.J.S.A. 26:2H-12.87 (a) to (d) after NJDOH ED No. 20-026 enacted.
Respiratory Protection Program Implementation [Facility Name] – [Facility License #]	LTC.DiseaseOutbreakPlan@doh.nj.gov	≤9 months after NJDOH ED No. 20-026 enacted.
PPE Stockpile [Facility Name] – [Facility License #]	LTC.PPEStockpile@doh.nj.gov	Before advancing between Phases and ≤2 months after NJDOH ED No. 20-026 enacted. Must submit within 2 months, even if facility remains in Phase 0.
National Health Safety Network - Data Reporting [Facility Name] – [Facility License #]	LTC.Datareporting@doh.nj.gov	Before advancing between Phases and ≤2 months after ED No. 20-026 enacted.
End of Outbreak [Facility Name] – [Facility License #]	LTC.OutbreakEnd@doh.nj.gov	Facilities that have experienced a prior outbreak. Due before leaving Phase 0. NJDOH or local health officers determine end of outbreak under N.J.A.C. 8:57-1.10
No Outbreak Experienced [Facility Name] – [Facility License #]	LTC.OutbreakEnd@doh.nj.gov	Only applicable to facilities that have never experienced a prior outbreak. Due before leaving Phase 0.
Phase 2 Indoor Visitation Attestation [Facility Name] – [Facility License #]	LTC.Phase2IndoorVisits@doh.nj.gov	≥48 hours before commencing indoor visitation.

ACTIVITIES ALLOWED DURING EACH PHASE OF REOPENING, VISITATION & SERVICE RESUMPTION

	STAGES OF STATE REOPENING	MAXIMUM RESTRICTIONS	STAGE 1 (+14 DAYS)	STAGE 2 (+14 DAYS)	STAGE 3 (+14 DAYS)
	PHASES OF LTC REOPENING	**PHASE 0**	**PHASE 1**	**PHASE 2**	**PHASE 3**
VISITATION	Virtual visitation (see CMS recommendations)	✓	✓	✓	✓
	EMS personnel in emergency situations	✓	✓	✓	✓
	State Long-Term Care Ombudsman (direct or through use of technology pursuant to SSA sections 1819(c)(3)(A) and 1919(c)(3)(A), 42 CFR 483.10(f)(4)(i)(C), and the CARES Act)	✓	✓	✓	✓
	Indoor end-of-life visitation	✓	✓	✓	✓
	Indoor compassionate care visitation	✓ * **(Not Routine)**	✓	✓	✓
	Indoor Essential Caregiver visitation	✓	✓	✓	✓
	Outdoor visitation of COVID-19 recovered and COVID-19 negative+asymptomatic residents	✓	✓	✓	✓
	Indoor visitation of pediatric residents	**X**	✓	✓	✓
	Indoor visitation of residents with intellectual and/or developmental disabilities	**X**	✓	✓	✓
	Indoor visitation by appointment only, except visitors prohibited upon screening or symptoms	**X**	**X**	✓	**Visitation per LTC**
	Indoor visitation per facility procedures	**X**	**X**	**X**	✓
COMMUNAL DINING	COVID-19 negative, asymptomatic residents and COVID-19 recovered residents	**Limited***	✓	✓	✓
GROUP ACTIVITIES	COVID-19 negative, asymptomatic residents and COVID-19 recovered residents	**Limited***	✓	✓	✓
TRIPS OUTSIDE FACILITY	Medically necessary trips (with face mask/covering)	✓	✓	✓	✓
	Outings for COVID-19 negative, asymptomatic residents and COVID-19 recovered residents	**X**		✓	✓
NON-ESSENTIAL PERSONNEL /CONTRACTORS	Volunteers allowed entry	**X**	**X**	**X**	✓
	Limited entry allowed as determined necessary by facility for COVID-19 negative, asymptomatic residents and COVID-19 recovered residents	✓	✓	✓	✓
	As determined necessary by facility	**X**	**X**	✓	✓

**Limitations, precautions, and restrictions may apply per guidance and directives.*

Key Precautions Required For each Phase of LTC Service Resumption

	PHASES OF LTC SERVICE RESUMPTION	MAXIMUM RESTRICTIONS	STAGE 1 (+14 DAYS)	STAGE 2 (+14 DAYS)	STAGE 3 (+14 DAYS)
	STAGES OF STATE REOPENING	PHASE 0	PHASE 1	PHASE 2	PHASE 3
RESIDENT TESTING	All tested weekly until conditions met	✓	✓	✓	✓
	Previously positive retested per guidance	✓	✓	✓	✓
	If newly symptomatic, retest at symptom onset	✓	✓	✓	✓
STAFF TESTING	All tested weekly until NJDOH guidance changes	✓	✓	✓	✓
	Previously positive retested per guidance	✓	✓	✓	✓
	If newly symptomatic, retest at symptom onset	✓	✓	✓	✓
INFECTION CONTROL	1+ individuals trained, assigned to on-site management of Infection Prevention and Control Program (IPC) and compliance N.J.A.C 8:39	✓	✓	✓	✓
	Internal quality improvement audits	✓	✓	✓	✓
	Policies and procedures	✓	✓	✓	✓
	Staffed Infection Prevention and Control Program (IPC) (If facility has ventilator beds, this must include requirements under N.J.S.A. 26:2H-12.87(a) to (d).)	✓	✓	✓	✓
	Respiratory protection program, including medical evaluations, training, and fit testing	✓	✓	✓	✓
	Social distancing with physical separation	✓	✓	✓	✓
	Education of residents, staff, visitors	✓	✓	✓	✓
	Essential cleaning and disinfection supplies	✓	✓	✓	✓
REPORTING VIA NATIONAL HEALTHCARE SAFETY NETWORK AT LEAST TWICE WEEKLY	COVID-19 cases: residents and facility personnel	✓	✓	✓	✓
	COVID-19 deaths: residents and facility personnel	✓	✓	✓	✓
	Resident beds and census	✓	✓	✓	✓
	Staffing shortages	✓	✓	✓	✓
	PPE and hand hygiene supplies status	✓	✓	✓	✓
	Ventilator capacity and supplies for units	✓	✓	✓	✓

Key Precautions Required for Each Phase of LTC Service Resumption

	PHASES OF LTC SERVICE RESUMPTION	MAXIMUM RESTRICTIONS	STAGE 1 (+14 DAYS)	STAGE 2 (+14 DAYS)	STAGE 3 (+14 DAYS)
	STAGES OF STATE REOPENING	PHASE 0	PHASE 1	PHASE 2	PHASE 3
SYMPTOM SCREENING	All Persons: before entry to the facility	✓	✓	✓	✓
	Staff: Beginning of each shift	✓	✓	✓	✓
	All persons: For 14+ days after exiting facility	✓	✓	✓	✓
	Residents: During every shift (at minimum)	✓			
	Residents: Daily (at minimum)		✓	✓	✓
VISITATION	Require use of cloth face coverings/masks	✓	✓	✓	✓
	Require visitors to practice social distancing	✓	✓	✓	✓
	Limit hours and number of visitors	✓	✓	✓	✓
	Informed consent from visitors and residents	✓	✓	✓	✓
	Identify visitation location	✓	✓	✓	✓
	Prohibit visitation upon COVID-19 screening and/or if visitor has not discontinued isolation per NJDOH and CDC guidance	✓	✓	✓	✓
	Instruction on hand hygiene, PPE, limiting surfaces touched, limiting physical contact, etc.	✓	✓	✓	✓
	Prohibit visitation upon inability to demonstrate proper infection prevention and control	✓	✓	✓	✓
	Restrict movement within indoors of facility	✓	✓	✓	✓
	Prohibit visitation by persons subject to 14-day quarantine travel advisory	✓	✓	✓	✓
PPE	Adequate emergency stockpile of PPE	✓	✓	✓	✓
	Staff trained and provided PPE per CDC guidance	✓	✓	✓	✓
	Staff should wear cloth face covering or PPE, as indicated	✓	✓	✓	✓
	Universal source control implemented	✓	✓	✓	✓
Resident Cohorting	Separate COVID-19 positive and negative residents (Following NJDOH and CDC criteria for COVID-19 recovered residents)	✓	✓	✓	✓
Personnel Restriction	Prohibit entry of non-essential service personnel	✓	✓	*Limited	X
	Prohibit entry of volunteers	✓	✓	✓	X

What Long-Term Care Facility Visitation Is Allowed?

According to NJDOH Executive Directive No. 20-026 (Issued August 10, 2020)

Stages of State Reopening	Maximum Restrictions	Stage 1 (+14 days)	Stage 2 (+14 days)	Stage 3 (+14 days)
Phases of LTC Reopening*	LTC Phase 0**	LTC Phase 1	LTC Phase 2	LTC Phase 3
End-of-life visitation	✓	✓	✓	✓
Compassionate care visitation[1]	✓ (Not routine)	✓	✓	✓
Essential Caregiver visitation, except of COVID-19 quarantined/isolated and or COVID-19 symptomatic residents[2]	✓	✓	✓	✓
EMS personnel in emergency situations	✓	✓	✓	✓
State Long-Term Care Ombudsman[3]	✓	✓	✓	✓
Virtual, remote, and "window" visitation	✓	✓	✓	✓
Outdoor visitation of COVID-19 recovered residents and of COVID-19 negative, asymptomatic residents	✓	✓	✓	✓
Indoor visitation of pediatric residents	X	✓	✓	✓
Indoor visitation of residents with intellectual and/or developmental disabilities	X	✓	✓	✓
Limited indoor visitation by appointment only	X	X	✓	✓[4]
Indoor visitation following facility procedures	X	X	X	✓

* Facilities are not permitted to initiate a Phased Reopening until requirements specified in NJDOH Executive Directive No. 20-026 are met.

** LTC Phase 0 includes all facilities with current outbreaks of COVID-19 among residents/patients and/or staff.

[1] "Compassionate care situation" does not exclusively refer to "end-of-life situations."

[2] 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. Facilities must establish policies and procedures for how to designate and utilize an Essential Caregiver.

[3] Visitation by the State Long-Term Care Ombudsman may occur through direct or via technology in accordance with state and federal regulations.

[4] Indoor visitation is allowed per the facility plans and procedures.

NJ Health
New Jersey Department of Health