Guidelines for Coronavirus Disease 2019 (COVID-19) Outbreaks in Long-Term Care Facilities

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These guidelines represent current guidance from the West Virginia Bureau for Public Health. They are premised upon guidelines issued by the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid (CMS), experience with facility investigations in West Virginia, discussions with long term care facility administrative and medical leadership as well as local health officers, and evolving science around the transmissibility of COVID19. As more is learned about COVID19 in the long-term care setting, this guidance could change. Facilities are encouraged to maintain up to date with evolving recommendations for management at both state and federal levels.

Updates to this document are in **red** to highlight the changes.

Outbreak Definition

Because of the ease of spread in a long-term care setting and the severity of illness that occurs in residents with COVID-19, **two laboratory-confirmed COVID-19 cases detected within 14 days of each other in a long-term care facility is defined as an outbreak.** Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), LTCF populations are at the highest risk of being affected by COVID-19. If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness.

Preventing an Outbreak

- Complete the COVID-19 Preparedness Checklist for Nursing Homes and Other Long-Term Care Settings: Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings.
- Educate residents, families, and visitors. Include:
  - Information about COVID-19.
  - Actions the facility is taking to protect them and their loved ones.
  - Actions residents and family can take to protect themselves and the facility.
  - Educate and train healthcare personnel, including facility-based and consultant personnel (hospice, wound care, podiatry, etc.).
- Review Interim Infection Prevention and Control Recommendations: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings.
- Review recommendations for LTCFs: Preparing for COVID-19: Long-term Care Facilities, Nursing Homes
- Dedicate an area of the facility to care for residents with suspected or confirmed COVID-19; consider creating a staffing plan for that specific location.
- Cleaning and disinfecting: Cleaning and Disinfection for Households.
  - Increase monitoring for compliance to cleaning practices (Centers for Disease Control and Prevention (CDC) Environmental Checklist for Monitoring Terminal Cleaning).
- Educate staff on hand hygiene, respiratory etiquette, social distancing, and Personal Protective Equipment (PPE) use: Using Personal Protective Equipment (PPE).
- Ensure PPE supplies are readily available: Strategies to Optimize the Supply of PPE and Equipment. **All LTCF personnel should wear a facemask while in the facility.**
- Establish partnership between and strong communications among the facility, the local health department and local hospital. Close coordination and communications among this triad supports better outbreak management, appropriate patient management and flow, coordinates PPE supply lines, etc. Enforce social distancing for residents and staff: Communities, Schools, and Workplaces.
- Screen residents for COVID-19 symptoms and fever, at least daily.
  - Residents with a temp ≥100.0 F or repeated low-grade temps (1° above patients baseline) or COVID-19 symptoms should be placed in a single room if possible, and cared for using recommended PPE including N95 respirator (or facemask if a respirator is not available), gown, gloves, and eye protection (goggles or face shield), pending further evaluation . These residents should be prioritized for testing.

  - Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- Screen healthcare personnel (HCP) at the beginning of **every shift** for fever and respiratory symptoms. Temperature should be taken. See health screening tool below.
  - HCP with a temp ≥100.0 or COVID-19 symptoms should be sent home immediately and prioritized for COVID-19 testing.
- Consult with the West Virginia Division of Infectious Disease Epidemiology within the West Virginia Department of Health and Human Resources (DHHR), Bureau for Public Health to schedule a Tele-Infection Control Assessment: (304) 558 5358, ext.1. This is a non-punitive free technical assistance service to facilities that will help identify gaps in infection control and help them prepare if COVID-19 is introduced into the facility.
- Restrict all visitation to the facility except for end of life situations. See visitor screening tool below.
  - Keep our Residents Safe Letter: Help Keep our Residents Safe from COVID-19.
  - WV Stay at Home Order: Governor Issues Stay-at-Home Order.
- Review sick leave and occupational health policies.
- Develop contingency and surge staffing plans.
- Develop a plan for family, media, and community communications.

What to Do When a Case of COVID-19 is Detected in Your Facility

- Report all suspected or confirmed COVID-19 outbreaks to your local health department (LHD) **immediately** and maintain regular contact throughout the outbreak.
- Notify WV Office of Health Facility Licensure & Certification of all confirmed cases of COVID-19 in your facility.
- Implement appropriate control measures **immediately** (see below) and continue until outbreak closure.
- Full PPE should be worn per CDC guidelines for the resident with known or suspected COVID-19.
  - N95 respirator (or facemask if a respirator is not available), gown, gloves, and eye protection (goggles or face shield)
- When a case of COVID-19 is detected in the facility, work with the LHD to identify the infected individual's contacts from 48 hours prior to symptom onset to present time and to evaluate each contact's level of risk: Public Health Recommendations for Community-Related Exposure.
  - Maintain a line list provided by the LHD of ill residents and staff and submit to the LHD daily.
- Screen residents for COVID-19 symptoms and fever, at least daily.
  - Residents with a temp ≥100.0 F or repeated low-grade temps (>99 F or 1° above resident baseline) or COVID-19 symptoms should be placed in a single-room if possible, and cared for using recommended PPE including gown, gloves, N95 or higher-level respirator (or facemask if respirator is not available) and eye protection (goggles or face shield) pending further evaluation. These residents should be prioritized for testing.
  - Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- Screen HCP at beginning of **every shift** for fever and respiratory symptoms. Temperature should be taken. See employee health screening tool below.
  - HCP with a temp ≥100.0 or symptoms should be sent home immediately and prioritized for COVID-19 testing.
- Cohort staff to minimize movement and maintain consistent staff within the facility. Assign staff to specific residents or areas of the facility. Minimize interactions between staff assigned, to different residents or areas of the facility to the full extent possible.
- Start and maintain a line list of ill residents and staff.

- Facilitate communication between LTCF, dispatch and transport services, and hospitals during transfer so that appropriate precautions can be taken. See Nursing Facility Transfer Verbal Hand-Off Communication below.
- Develop or review plans to mitigate staffing shortages. It may be helpful to create and maintain a map of the facility to include patient locations and staff assignments to visually see cases and movement among staff and cases.
- Communicate clearly and regularly with residents, families, and the broader community.

Measures to Control an Outbreak

Transmission Based Precautions

- **HCP should adhere to standard precautions and use a N95 respirator (or facemask if a respirator is not available), gown, gloves, and eye protection (goggles or face shield) for all residents irrespective of COVID-19 diagnosis or symptoms until no new cases are identified for at least 2 incubation periods (28 days) since the most recent case onset.**
- When PPE supply is limited, facilities should use strategies to optimize the supply of PPE and equipment: Strategies to Optimize the Supply of PPE and Equipment.
- If HCP PPE supply is limited, consider extended use of facemasks and eye protection and limit gown use to positive cases or high contact situations (e.g., bathing, transferring patient, etc.). Change gloves and perform hand hygiene between residents.

Resident Placement

- Designate a location to care for residents with suspected or confirmed COVID-19, separate from other residents. Do not cohort residents with suspected COVID-19 with those who have confirmed disease, if possible.
- Place ill residents in a private room. If a private room is not available, place (cohort) residents who have COVID-19 with one another.
  - Roommates of COVID-19 patients should be considered potentially infected and not share rooms with other residents unless they remain asymptomatic and/or have tested negative for COVID-19 at least 14 days after their last exposure.
  - Precautions for patients with a history of multi-drug resistant organisms should remain in place and should be taken into consideration when cohorting residents.
- Limit resident movement outside of the room to medically essential purposes as much as possible/feasible with geriatric and dementia populations.
- Limit the number HCPs entering rooms to minimize possible exposures.

Staffing Assignments

- Assign dedicated staff to work on affected units to minimize staff movement throughout the facility. Keep a record of patient assignments.
- Discontinue non-essential therapy and ensure essential therapy staff wear a N95 respirator (or facemask if a respirator is not available), gown, gloves, and eye protection (goggles or face shield) while working with all residents irrespective of COVID-19 diagnosis or symptoms.

Monitoring and Caring for Residents

- Increase vitals/assessments of COVID-19 residents to detect clinically deteriorating residents more rapidly.
  - Monitor ill residents (including documentation of temperature and pulse oximetry) every eight hours to quickly identify residents who require transfer to a higher level of care.

- Provide treatment according to standard protocols with the following considerations included:
  - Use caution when performing aerosol-generating procedures (e.g., intubation or nebulizer treatment). Where possible, use metered dose inhalers as an alternative.
  - Limit the number of HCP encounters where practical to minimize possible exposures.
  - HCP should wear a N95 mask or higher, gown, gloves, and eye protection (goggles or face shield).

Additional Considerations

- Consider temporarily halting admissions, at least until the situation can be clarified and interventions can be implemented.
- Cancel all group activities and dining.
- Facility should keep in mind that the incubation period can be up to 14 days and the identification of new cases within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions to control transmission.
- Increase monitoring of appropriate hand hygiene and PPE use to at least 10 observations per shift. (Contact Precautions Observation Tool and Hand Hygiene Observation Tool).
- Maintain ongoing, frequent communication with residents, HCPs and families with updates on the situation and facility actions.
- Communicate clearly on the same with the broader community in conjunction with your local health department.
- Remain in close communications with and regularly report status to public health via established mechanisms in order to maintain shared awareness, assist in public communications, and help anticipate supports needed.
- Within one week of implementing control measures, consider a repeat (or if not done previously, initial) Tele-Infection Control Assessment through the WVDHHR, Bureau for Public Health, Division of Infectious Disease Epidemiology: (304) 558 5358, ext.1. This is a free service to facilities that can help identify gaps in infection control.

Laboratory Testing

The following are typical supplies needed to collect specimens for testing. Check with your laboratory on specimen collection supplies and acceptable specimens. If possible, acquire supplies in advance of an outbreak so you will be ready to collect and submit specimens when an outbreak is first identified. The local health department or laboratory processing your specimens will provide more detailed instructions on the collection and submission of specimens in the event of an outbreak.

- Nasopharyngeal (NP) swabs.
- Viral transport media (VTM).
- Transport materials that allow specimens to be kept cool, such as a styrofoam cooler and ice packs.
- Determine who will perform the testing. Testing may be done through a facility's usual laboratory or through a combination of public and/or private commercial laboratories.
- Identify method to transport specimens from the facility to the testing laboratory.

Note: WVDHHR encourages all facilities to contract with laboratories who can undertake electronic laboratory reporting to the state to facilitate rapid sharing of results between facilities and public health.

Testing Strategy

- Testing of symptomatic HCP and residents in addition to close contacts, those cared for by the same HCP and others deemed highest risk through the epidemiological investigation (be they symptomatic or asymptomatic) should be prioritized.
- Testing arrangements should be initiated for all employees and residents at the time of the initial outbreak investigation.

- This point in time testing will identify individuals with asymptomatic or pre-symptomatic infection at the time of the outbreak identification.
  - It is important to note that residents or staff with a negative test result could still be incubating disease (incubation period of 2 – 14 days) and subsequently turn positive (having either asymptomatic infection or COVID-19 disease).
- Testing should not delay immediate implementation of transmission-based precautions for all residents irrespective of COVID-19 diagnosis or symptoms. All exposed residents and staff should continue to be monitored for symptoms, PPE used for all resident care (protecting both patients and staff) and movement within the facility limited.
- Any resident or staff person developing symptoms should be tested, along with their close contacts, if indicated. It is not necessary to retest all residents and all staff with each new identified case during an outbreak.
- On rare occasions, point prevalence testing strategies of parts of the facility or of selected patients may be useful.
- Once a full incubation period (at least 14 days) has passed with no identification of disease, consider new cases to be part of a newly identified outbreak.

Healthcare Personnel Exposures

- HCP exposures should be evaluated based on type of exposure and PPE worn at the time of exposure. Based on the risk category, HCP may be excluded from work for 14 days. Additional information can be found at Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).
- Facilities may consider allowing asymptomatic HCP exposed to COVID-19 patients to continue to work in times of staffing shortages. These workers should continue to wear a facemask at work.
- If HCP develop symptoms, they must cease work and notify their supervisor prior to leaving work.

Management of Residents Returning from Hospitalization or New Admissions

- Given the long incubation period for COVID-19 infection and the need for facility transfer, **more important than a negative test result is a facility's ability to provide care for patients of unknown COVID-19 status**. If testing is required through a facility policy, results of the COVID-19 test should not delay admission.
- To reduce spread of COVID-19 in the event residents were exposed to COVID-19, facilities should:
  - Place all incoming residents in private room under isolation and monitor for respiratory symptoms daily (regardless of admission from a hospital, other facility, or home) for 14 days before they enter the facility's general population.
  - Facilities may designate a unit or wing exclusive for residents returning from hospitalization or new admissions.
  - Cohort HCP working in this area.
- Residents who have been treated for COVID-19-related illness should be placed in private rooms under isolation until they meet the criteria for removing from isolation (see below). Preferably, the resident would be placed in a location designated to care for COVID-19 residents.

Criteria for Removing Residents from Isolation:

- For persons with symptoms consistent with COVID-19 illness and who have no known exposure, isolation may be discontinued once a negative test result has been received.
- For persons who have been exposed to a confirmed case, quarantine and monitoring for symptoms should continue for 14 days regardless of negative testing results.
- For confirmed cases and symptomatic persons with a known exposure, isolation should be continued until:
  - At least 10 days have passed since symptom onset **AND**
  - Individual is fever free for 72 hours without the use of fever reducing medications **AND**
  - Respiratory symptoms have completely resolved.

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- Persons with laboratory-confirmed COVID-19 who have not had any symptoms may discontinue isolation when at least 10 days have passed since the date of their first positive COVID-19 test and have had no subsequent illness provided they remain asymptomatic.

Criteria for Return to Work for Exposed Healthcare Personnel:

- Exposed HCP as defined by initial epidemiological investigation should be restricted from working in any healthcare setting and undergo monitoring until 14 days after their last exposure. Once the monitoring period is complete, HCP can return to work with no further restrictions.
- When staffing shortages occur, exposed HCP may continue to work as follows if they are asymptomatic.
  - HCP must wear a facemask at all times in the facility while they are at work.
  - Ensure HCP does not take breaks that may require removal of mask (e.g., for eating, drinking, or smoking) in the presence of any resident or any other staff member.
  - HCP should not visit any location in the community other than their home and work, to minimize the potential for community spread.
  - HCP should be screened daily for symptoms and fever before starting work. If they develop any fever or respiratory symptoms consistent with COVID-19, they should immediately notify their supervisor and leave work. The facility should notify the local health department if any exposed HCP develops symptoms.
  - Further information can be found at: Strategies to Mitigate Healthcare Personnel Staffing Shortages

Criteria for Return to Work for Confirmed or Suspected Healthcare Personnel:

- Although a testing-based strategy for HCP returning to work is reassuring; technical limitations of interpreting sustained positive PCR test results and viral shedding studies support use of a non-testing-based strategy instead. This is especially the case when staffing shortages are at play and further exclusions could seriously impact resident care quality.
- Healthcare personnel (HCP) who were symptomatic may return to work in a healthcare setting when the following is met:
  - At least 10 days have passed since symptom onset **AND**
  - Fever free for 72 hours without the use of fever reducing medications **AND**
  - Respiratory symptoms have completely resolved.
- HCP with laboratory confirmed COVID-19 who have not had any symptoms should be excluded from work until 10 days have passed since the date of their first positive COVID-19 test assuming they have not subsequently developed symptoms since their positive test.
- After returning to work, HCP should continue to wear a mask in the healthcare facility and be restricted from contact with severely immunocompromised patients until 14 days after illness onset.
  - Adhere to hand hygiene, respiratory hygiene, and cough etiquette.
  - Self-monitor for symptoms and seek re-evaluation if respiratory symptoms recur or worsen.
- Facilities may consider strategies to mitigate staffing shortages by allowing asymptomatic positive staff to return to work earlier under crisis staffing shortages. This should be considered only after contingency staffing measures are in place: Strategies to Mitigate Healthcare Personnel Staffing Shortages.
  - If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others.
  - Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
  - As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients without suspected or confirmed COVID-19.

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Health Care Provider Family Supports

- Healthcare personnel who test positive for COVID19 and their families will need information and supports.
- Employees who are positive for COVID19 should be reported to public health for contact tracing, case management, and educational supports.
- Educational resources include:
  - What to Do if You are Sick with COVID19 (Handout version)
  - Caring for Someone at Home
  - Other resources at www.coronavirus.wv.gov or www.cdc.gov

Environmental Cleaning and Disinfection:

- Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas.
- Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2. (List N: Disinfectants for Use Against SARS-CoV-2)
  From: Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, Things Facilities Should Do Now. Preparing for COVID-19: Long-term Care Facilities, Nursing Homes .

Implement Environmental Infection Control:

- Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19.
  - All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Additional information about recommended practices for terminal cleaning of rooms and PPE to be worn by environmental services personnel is available in the (Healthcare Infection Prevention and Control FAQs for COVID-19)
- Also see: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. (Update April 13, 2020)

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COVID-19 Health Screening Tool

Do you currently have any of the following symptoms:

☐A new fever (100.4°F or higher), or a sense of having a fever?

☐A new cough that you cannot attribute to another health condition?

☐New shortness of breath that you cannot attribute to another health condition?

☐A new sore throat that you cannot attribute to another health condition?

☐New muscle aches (myalgias) that you cannot attribute to another health condition, or that may have been caused by a specific activity (such as physical exercise)?

☐Have you or anyone in your home had contact within the last fourteen days with any person under screening/testing for COVID-19, or with anyone with known or suspected COVID-19

If an individual answers **YES** to any of the screening questions, immediately activate your agency's emergency protocol for COVID-19. The designated screener should consider:

A review of the screening results

Recommendations for possible exclusion of the individual from the facility

Recommendations for medical follow-up

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Visitor Screening Tool

Because of the ease of spread in a long-term care setting and the severity of illness that occurs in residents with COVID-19, facilities should restrict all visitation except certain compassionate care situations, such as end of life situations. Decisions about visitation during an end of life situation should be made on a case by case basis, and should include careful screening of the visitor for fever or respiratory symptoms. Those with symptoms should not be permitted to enter the facility. Those visitors that are permitted must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

This screening tool should be completed on ALL individuals entering the facility and maintained for contact tracing.

Resident Name:	Date and Time of Visit:
Visitor Name:	Visitor Phone Number:

1. Do you currently have any of the following symptoms:

☐A new fever (100.4°F or higher), or a sense of having a fever?

☐A new cough that you cannot attribute to another health condition?

☐New shortness of breath that you cannot attribute to another health condition?

☐A new sore throat that you cannot attribute to another health condition?

☐New muscle aches (myalgias) that you cannot attribute to another health condition, or that may have been caused by a specific activity (such as physical exercise)?

☐Have you or anyone in your home had contact within the last fourteen days with any person under screening/testing for COVID-19, or with anyone with known or suspected COVID-19

If an individual answers **YES** to any of the screening questions, do not allow the visitor to enter the building. If you answered "NO," to all questions, proceed to number 2.

2. Before proceeding with visitation and upon entry to the facility, remind the visitor:
   - To perform hand hygiene.
   - Not to shake hands, touch, or hug individuals during visit, remain 6 feet apart. (except for end of life situations)
   - Don appropriate PPE, if indicated.
   - Stay in designated area (no walking the halls, avoid the dining room, etc.).
   - Avoid touching surfaces.

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Nursing Facility Transfer Verbal Hand-Off Communication

This document is to be used for medical status related to COVID-19 to help facilitate communication between long-term care facilities and hospitals during transfer. It is extremely important that all healthcare personnel (including EMS) involved in the transfer of a suspected or confirmed COVID-19 patient receive verbal notification **PRIOR** to caring for the resident so appropriate precautions can be taken. This form is a complement to the regular transfer form.

Date/Time of Report: _____
Agency Performing Transport: _____

Patient Name:	DOB:
Transferring Facility:	Receiving Facility:
Person Giving Report:	Person Receiving Report:

Date of symptom onset: _____

The patient has been tested for COVID-19? ☐ Yes ☐ No Date of testing_____

The patient tested positive for COVID-19? ☐ Yes ☐ No Date of result_____

Does the patient have:
☐ Fever ☐ Cough ☐ Sore throat ☐ Shortness of breath ☐ Close contact with an individual confirmed to have COVID-19 and date of last known contact: **___/___/___**
☐ Travel history from or living in areas with widespread community transmission

Where: _____ Dates of Travel: **___/___/___ to ___/___/___**

Respiratory Testing Complete

Test	**Positive**	**Negative**	**Pending**	**Not Tested**
Rapid Influenza ☐ A ☐ B	☐	☐	☐	☐
Rapid Strep	☐	☐	☐	☐
Viral Respiratory Panel for: _____	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐
Other, Specify: _____	☐	☐	☐	☐

Chest X-Ray ☐ Not Done ☐ Pending ☐ Normal ☐ Abnormal findings_____