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

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Guidelines for COVID-19 Outbreaks in Long-Term Care Facilities
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These guidelines represent current guidance from the West Virginia Department of Health and Human Resources, 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 transmission of COVID-19. As more is learned about COVID-19 in the long-term care setting, this guidance could change. Facilities are encouraged to stay 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, a single laboratory-confirmed COVID-19 case identified in a resident or staff member is defined as an outbreak. Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), Long-Term Care Facility (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. An index infection in a resident should include SARS-CoV-2 infections that originated in the nursing home and should not include:

- Residents who were known to have COVID-19 on admission to the facility and were placed into transmission-based precautions.
- Residents who were placed into transmission-based precautions on admission and developed SARS-CoV-2 infection within the 14-day period after admission.

Preventing an Outbreak

- Assign one or more individuals with training in infection control to provide management of the Infection Prevention and Control (IPC) program. For facilities that have more than 100 residents, this should be a full-time role.
- 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.
  - Visitation restrictions.
- Educate and train healthcare personnel (HCP), including facility-based and consultant personnel (hospice, wound care, podiatry, etc.).
  - Reinforce sick leave policies reminding staff not to report to work when they are ill and to notify their supervisor if they develop illness while at work.
  - Educate actions HCP can take to protect themselves outside of work and while in the facility.
  - Hand hygiene.
  - Selection and appropriate use of Personal Protective Equipment (PPE): Using Personal Protective Equipment (PPE)
  - Any new policies or procedures.
  - Respiratory etiquette.
  - Social distancing.
- 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 and develop a staffing plan for that specific location. (See Resident Placement Using Zones page 13)

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- Cleaning and disinfecting: Cleaning and Disinfection for Households.
  - Increase monitoring for compliance to cleaning practices (CDC Environmental Checklist for Monitoring Terminal Cleaning).
- 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 (LHD) 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 patient 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 HCP at the beginning of **every shift** for fever and symptoms consistent with COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. See health screening tool below.
  - HCP with a temperature of ≥100.0 or COVID-19 symptoms should be sent home immediately and prioritized for COVID-19 testing.
- Consult with the West Virginia Department of Health and Human Resources' (DHHR) Division of Infectious Disease Epidemiology 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.
- In lieu of a statewide order by the Governor, visitation guidance is issued by the Office of Health Facility Licensure and Certification and is located at www.coronavirus.wv.gov or https://dhhr.wv.gov/COVID-19/Documents/Nursing-Home-COVID19-Reopening-Plan-Revised-August-2020.pdf. This guidance follows the requirements and recommendations of the Centers for Medicare and Medicaid Services (CMS) and the CDC.
- Considerations for visitation include:
  - Screen visitors for fever (≥100.0oF), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility.
  - Facilitate alternative options for visitation: Supporting Your Loved One in a Long-Term Care Facility.
  - Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).
  - Schedule visitation in advance to enable continued social distancing.
  - Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).
  - 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 DHHR's Office of Health Facility Licensure and 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 interactions with the resident with known or suspected COVID-19.

  - Full PPE includes 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 temperature of ≥100.0 F or repeated low-grade temperature (>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 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 symptoms consistent with COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. See employee health screening tool below.
  - HCP with a temperature of ≥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 two 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.
  - Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several different patients, without removing the respirator between patient encounters. Extended use is well suited to situations wherein multiple patients with the same infectious disease diagnosis, whose care requires use of a respirator, are cohorted (e.g., housed on the same hospital unit). When practicing extended use of N95 respirators, the maximum recommended extended use period is 8–12 hours. Respirators should not be worn for multiple work shifts and should not be reused after extended use. N95 respirators should be removed (doffed) and discarded before activities such as meals and restroom breaks.

- Re-use refers to the practice of using the same N95 respirator by one HCP for multiple encounters with different patients but removing it (i.e., doffing) after each encounter. This practice is often referred to as "limited reuse" because restrictions are in place to limit the number of times the same respirator is reused. It is important to consult with the respirator manufacturer regarding the maximum number of donnings or uses they recommend for the N95 respirator model. If no manufacturer guidance is available, data suggest limiting the number of reuses to no more than five uses per device to ensure an adequate safety margin. N95 and other disposable respirators should not be shared by multiple HCP.
- For additional and more detailed guidance for extended use and reuse programs, please visit: https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html

Resident Placement

- Designate a location to care for residents with suspected or confirmed COVID-19. Ideally, this area/unit should be physically separate from other residents. (See Resident Placement Using Zones page 13)
- Place ill residents who have tested positive for COVID-19 in a private room. If a private room is not available, place (cohort) residents who have COVID-19 with one another.
- If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.
- Do not place or cohort residents who are *suspected* COVID-19 in the same area/unit of those who have been confirmed positive.
- If a resident becomes symptomatic or is suspected of having COVID-19:
  - Leave the resident and their roommate (if applicable) in their current room assignment.
  - Immediately implement transmission-based precautions.
  - Conduct testing on the symptomatic resident and the roommate (consider using point-of-care antigen test).
  - Testing should be completed, and results obtained before moving *symptomatic or suspected* residents.
  - Upon receiving results, move any COVID-19 positive resident to the COVID-19 positive dedicated area.
- If a resident tests positive and the roommate tests negative, the roommate should be considered exposed and should be placed in a private room on isolation precautions and not share rooms with other residents while monitoring for symptoms of COVID-19 for 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.
- The COVID-19 area/unit should ideally have a restroom, breakroom, and work area that are separate from other working areas.
- 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 (see page for best practices for COVID-19 medical treatment)

- Increase vitals/assessments of COVID-19 residents to detect clinically deteriorating residents more rapidly.
  - Monitor ill residents (including documentation of temperature and pulse oximetry) at a minimum of 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 N95 respirator (or facemask if a respirator is not available), 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.
- To the extent possible, restrict access of ancillary personnel on the unit.
- Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected. Facilities are encouraged to conduct audits of this practice.
- Cancel all group activities and communal 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.
- Provide educational sessions or handouts for HCP, residents, and families regarding basic infection control.
- 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 LHD.
- Remain in close communication with and regularly report (weekly at a minimum) status to the local health department 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 DHHR's 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.

Outbreak Testing Strategy

- **When one case is detected in a LTCF, outbreak testing should be initiated immediately. Performing viral testing of all residents and staff will identify infected residents quickly, in order to assist in their clinical management and allow for rapid implementation infection prevention control interventions (transmission-based precautions, cohorting staff, managing patient placement) to prevent transmission.**
- Testing support for outbreaks is available from DHHR and can be coordinated through the LHD upon notification of the outbreak.
- After initially performing testing of all residents and staff in response to an outbreak, repeat testing should occur to ensure there are no new infections among residents and staff. Repeat viral testing should occur every 3-7 days until the testing identifies no new cases of COVID-19 infection among residents or HCP for a period of at least 14 days since the most recent positive result.
- 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.

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- 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.
- Once someone has tested positive for COVID-19 they do not need to be re-tested as part of facility wide testing unless it has been greater than 90 days from their last infection or unless they are symptomatic and another etiology cannot be determined.

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).
- On December 2, 2020, the Centers for Disease Control and Prevention released guidance for acceptable alternatives to the 14-day quarantine period for individuals who might have been exposed to COVID-19. These shortened options may be used as a strategy to allow HCP to return to work sooner, however they do carry a greater post-quarantine transmission risk. Facilities may continue to 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.
- Options for releasing HCP from quarantine following an exposure:
  - Option 1: quarantine period can end after day 14 without testing.
  - Option 2: quarantine period can end after day 10 without testing and if no symptoms have been identified during daily self-monitoring (post-quarantine transmission risk is 1%-10%).
  - Option 3: quarantine period can end after day 7 if HCP tests negative (PCR or antigen) and if no symptoms have been identified during daily self-monitoring (post-quarantine transmission risk is 5%-12%).
- If HCP are brought back to work before the 14-day quarantine period, self-monitoring and mask wearing should be continued through day 14. If an HCP develops symptoms within the 14-day quarantine period, immediately isolate and contact the local health department to report change in clinical status.

Management of Residents Returning from Hospitalization, New Admissions, or Outpatient Visits (including dialysis, physician appointments, emergency department visit returns, etc.)

- 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 a 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 hospitalizations, new admissions, outpatient visits such as physician appointments, dialysis, emergency department visits return, and others where the resident leaves and returns to the facility.
  - 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.

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Criteria for Removing Residents from Isolation:

Patients with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed since symptoms first appeared, and
- At least 24 hours have passed since last fever without the use of fever-reducing medications, and
- Symptoms (e.g., cough, shortness of breath) have improved.

Note: For patients who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Patients with severe to critical illness or who are severely immunocompromised:

- At least 10 days and up to 20 days have passed since symptoms first appeared, and
- At least 24 hours have passed since last fever without the use of fever-reducing medications, and
- Symptoms (e.g., cough, shortness of breath) have improved.
- Note: for severely immunocompromised patients who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

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 until 14 days after their last exposure. Shortened quarantine options are available to HCP to allow them to return to work sooner (see healthcare personnel exposures page 7)
- 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 do 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 LHD 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

- A test-based strategy is no longer recommended to determine when to discontinue home isolation, except in certain circumstances.
- Accumulating evidence supports ending isolation and precautions for persons with COVID-19 using a symptom-based strategy. Specifically, people with mild to moderate COVID-19 remain infectious no longer than 10 days after their symptoms began, and those with more severe illness or those who are severely immunocompromised remain infectious no longer than 20 days after their symptoms began.

HCP with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed since symptoms first appeared, and
- At least 24 hours have passed since last fever without the use of fever-reducing medications, and
- Symptoms (e.g., cough, shortness of breath) have improved.

Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

HCP with severe to critical illness or who are severely immunocompromised:

- At least 10 days and up to 20 days have passed since symptoms first appeared, and
- At least 24 hours have passed since last fever without the use of fever-reducing medications, and
- Symptoms (e.g., cough, shortness of breath) have improved.
- Consider consultation with infection control experts.

Note: HCP who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

- After returning to work, HCP should continue to wear a mask in the healthcare facility.
  - 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.

Healthcare Provider Family Supports

- HCP who test positive for COVID-19 and their families will need information and supports.
- Employees who are positive for COVID-19 should be reported to the local health department for contact tracing, case management, and educational supports.
- Educational resources include:
  - What to Do if You Are Sick With COVID-19 (Handout version)
  - Caring for Someone at Home
  - Other resources: 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.

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.

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COVID-19 Health Screening Tool

Do you currently have any of the following symptoms (check if the answer is "yes"):

☐ A new fever (100.0°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 loss of taste or smell?

☐ Nausea, vomiting, diarrhea?

☐ 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 checks (answers **YES**) 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 printed and completed on ALL individuals entering the facility and maintained for contact tracing.

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

Do you currently have any of the following symptoms (check if the answer is "yes"):

1. ☐ A new fever (100.0°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 loss of taste or smell?

☐ Nausea, vomiting, diarrhea?

☐ 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 checks (answers **YES**) any of the screening questions, do not allow the visitor to enter the building. If an individual 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, and to 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 Emergency Medical Services) 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: _____

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

Has 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_____

Guidelines for COVID-19 Outbreaks in Long-Term Care Facilities

Resident Placement Using Zones

When considering resident place within the facility, think in terms of the facility being in three different zones. The term "zone" could be an area, hall, partial unit or entire unit.

Zone One: This zone is the COVID-19 positive unit. Only those residents who are COVID-19 positive can be placed on this unit. This unit should have dedicated staff designated only to unit if staffing allows. The unit should have its own entrance to prevent staff from moving to other parts of the facility. Residents will remain on this unit until they meet criteria for remove of isolation.

Zone Two: This zone is the "unknown" zone. This unit may be referred to as the "observation" unit. This zone will be those residents who have left the facility and returned, or are in and out of the facility for outpatient visits such as physician appointments, dialysis, emergency department visits where they return to the facility, re-admissions from hospitalizations, and new admissions.

- Ideally, these would be private rooms to avoid potentially exposing roommates if a resident becomes positive.
- Residents would remain in this zone until they have completed their 14-day observation period if asymptomatic.
- If the resident receives a positive test result while in this area, they should be transferred to the COVID-19 positive unit (Zone One). If possible, the resident should wear a mask while being moved, and it would be preferred to move the resident outside (weather permitting) and into Zone One through the separate entrance to that unit to avoid potentially exposing others.
- If the roommate of a COVID-19 positive resident tests negative, the roommate 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.

Zone Three: This zone is considered the general population or "well" zone.

(Photo adapted from Applying *COVID-19 Infection Prevention and Control Strategies in Nursing Homes;* Clinician Outreach and Communication Activity (COCA) Webinar; Tuesday, June 16, 2020).