CDC Care Mapping for Coronavirus in LTC facilities (Last Updated 5/30/2020)

This summary includes the more important elements for addressing COVID-19 in nursing facilities as developed by the CDC. Some earlier guidance is disregarded when it coincides with routine nursing home procedures or seems no longer relevant considering the current phase of transition. This is intended to be any easy resource document to help identify the location of key requirements and can be used as a reminder for basics in infection control and safety.

Evaluating and Testing

- **Updated Priorities for Testing**
- **Recommendations for Testing/Reporting**

Actions for Exposure to, Suspicion of, and Confirmed COVID in Employees

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Evaluating and Testing Persons for Coronavirus Disease: CDC guidance for COVID-19 may be adapted by state and local health departments as needed. (March 24, 2020)

I. Providers should immediately notify their local or state health department when a person is suspected of having COVID-19.

II. Criteria to guide Evaluation and Testing/Coordinate with local health department
   - **a.** Clinicians should use judgment if there are symptoms of COVID and consider testing anyone with symptoms of respiratory illness
   - b. Consider the local community transmission

III. Priorities for Testing (5/3/2020)
   - a. **High Priority**: hospitalized patients, symptomatic healthcare workers and workers in congregate living settings, first responders, Residents in long term care facilities or other congregate living settings including prisons and shelters – all with symptoms
   - b. **Priority**: persons with symptoms of potential COVID infection, including fever, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, vomiting or diarrhea, and/or sore throat. Persons without symptoms who are prioritized by health departments or clinicians, for any reason, including but not limited to public health monitoring, sentinel surveillance, or screening of asymptomatic individuals according to state and local plans

IV. Recommendations for Reporting, Testing, and Specimen Collection (5/3/2020)
   - a. Immediately implement recommended infection prevention and control practices for suspected patients (summary included below). (Updated 5/18/2020)
   - b. Notify infection control personnel, local/state health department
   - c. Consider designating specific persons to be responsible for communication with public health officials and dissemination of information to facility leadership.
   - d. Collect specimen as soon as possible – see Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens (May 5 guidance added on handling bulk swabs) from Patients under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
   - e. Healthcare personnel should be tested for even mild symptoms if potentially exposed while not wearing recommended PPE

Actions for Exposure to, Suspicion of, and Confirmed COVID-19 in Employees

I. 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). (March 7, 2020) (Updated 5/29/2020)

a. Healthcare facilities should consider forgoing contact tracing for exposures in favor of universal source control and personnel screening each shift

Update: *The interim guidance was updated on May 29, 2020. Updates include:*

- **Any duration** of exposure should be considered prolonged if the exposure occurred during performance an aerosol-generating procedure.
- The time period that should be used for contact tracing after *exposure to asymptomatic* individuals who test positive for SARS-CoV-2 was shortened.
    - The time period was changed **from 10 days** before obtaining the specimen that tested positive for COVID-19 **to 2 days** to accommodate pragmatic and operational considerations for the implementation of case investigation and contact tracing programs.
    - Recent data suggest that asymptomatic persons may have a lower viral burden at diagnosis than symptomatic persons. Thus, the longer contact elicitation window (10 days) may have limited impact in identifying new COVID-19 cases.
    - The recommendation for the shorter contact elicitation window (2 days) will help focus case investigation and contact tracing resources toward activities most likely to interrupt ongoing transmission.
    - This time period is also now in alignment with recommendations from the World Health Organization, European CDC, and Public Health Canada.

The interim guidance was updated on May 23, 2020 to clarify the definition of exposure for HCP not wearing eye protection.

This interim guidance was updated on May 19, 2020. Updates include:

- Simplifying exposures warranting work restrictions for healthcare personnel.
- Changing the definition of prolonged exposure to more closely align with the definition used for community exposures and contact tracing (15 minutes or longer).
- Providing flexibility in approaches for healthcare facilities depending on the degree of community transmission and availability of resources to perform contact tracing.

b. Take a conservative approach since staff will have extensive and close contact with vulnerable persons. Facilities should have a LOW threshold for evaluating symptoms and testing.

c. **5/29/2020:** prolonged close contact with anyone with confirmed COVID and not wearing facemask or respirator, not wearing eye protection when COVID affected person was not wearing a face covering or mask, or not wearing all recommended PPE while performing an aerosol generating procedure. Exclude from work for 14 days after last exposure, self-monitor, report symptoms immediately.

d. **5/29/2020:** staff with any other exposure risk other than above: Now work restrictions, follow all recommended practices for self-monitoring and at beginning of shift daily. Self-isolate immediately for any symptoms and contact authorities.

e. **Self-monitoring**: monitor self by taking temperature twice per day and be alert for symptoms; have a plan on whom to contact.
f. **Active monitoring:** state or local public health authority assumes responsibility for regular communication with potentially exposed persons. This can be delegated to the health care facility.
g. **Self- monitoring with delegated supervision**: oversight by facility in coordination with health department

Staff in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work. Risk categories should be raised by one level if staff present for procedures likely to generate high concentrations of respiratory secretions.

1. ***No Identifiable risk*** **Exposure Category:** Do not require monitoring or restriction from work.

2. **Community or travel-associated exposures**
HCP with potential exposures to COVID-19 in community settings, should have their exposure risk assessed according to CDC guidance. HCP should inform their facility's occupational health program that they have had a community or travel-associated exposure. HCP who have a community or travel-associated exposure should undergo monitoring as defined by that guidance. Those who fall into the *high-* or *medium- risk* category described there should be excluded from work in a healthcare setting until 14 days after their exposure. HCP who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

3. **Additional Considerations** – Contact tracing while still the standard, may not be achievable in all situations. In areas of community transmission, all staff are at some risk whether in the community or at work. Facilities should emphasize asking staff to report exposures and regularly monitor selves, use facemasks or cloth masks for source control and not report to work when ill. CDC has additional guidance on mitigating staffing shortages.

Manage Ill and Exposed Health Care Staff

I. *Implement sick leave policies consistent with public health guidance*
II. If symptoms develop while working (all staff should already be wearing masks) they should immediately inform supervisor and leave workplace.
III. Screen all HCP at the beginning of their shift for fever and respiratory symptoms.
    a. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and leave the workplace.
    b. HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.
IV. 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)

Criteria for Return to Work for Health Care Personnel with Confirmed or Suspected COVID-19 (Interim Guidance) – updated 4/30/2020

Use one of the below strategies to determine when HCP may return to work in healthcare settings. Test based strategies are no longer the preference

1. **Symptom based strategy**
   - At least 72 hours passed since recovery, defined as resolution of fever with use of fever reducing medications and improvement in respiratory symptoms (cough, shortness of breath) AND
   - At least ten days have passed since symptoms first appeared

2. **Test Based strategy**
   - Resolution of fever without the use of fever reducing medications AND
   - Improvement in respiratory symptoms (cough, shortness of breath) AND
   - Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). (May 22)

3. **Staff with Laboratory confirmed COVID but no symptoms**
   - Time based – 10 days since first positive test – assuming no symptoms ever developed
   - Test based: two negative tests as defined above

If HCP were never tested for COVID-19 but have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Crisis Strategies to Mitigate Staffing Shortages

Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information. As part of this, asymptomatic HCP with a recognized COVID-19 exposure might be permitted to work in a crisis capacity strategy to address staffing shortages if they wear a facemask for source control for 14 days after the exposure. This time period is based on the current incubation period for COVID-19 which is 14 days.

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WHO guidance on clinical management of severe acute respiratory infection when COVID-19 is suspected

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Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID – 19 – Updated 4/13/2020

I. Implement source control for everyone entering the building to address asymptomatic and pre-symptomatic transmission
   a. Cloth face coverings are not PPE – facemasks should be reserved for healthcare personnel
   b. For visitors, cloth coverings may be appropriate. A facemask may be used if they are not using a cloth covering when entering the facility.
   c. Actively screen for fever and symptoms before visitors enter
   d. Consider forgoing contact tracing for exposures in a health care setting in favor of universal source control for staff and screening for fever and symptoms every shift

Immediately implement <u>recommended infection prevention and control practices</u> for suspected patients

I. Limit how germs can enter the facility
   a. Isolate symptomatic patients as soon as possible
   b. Protect healthcare personnel – implement PPE optimization strategies
   c. Minimize chance for exposure – updated 5/18/2020
      i. Updates – removal recommendation that all elective procedures be postponed.
      ii. Policies should reflect that measures should be implemented to minimize exposures before patient arrival, upon arrival, throughout stay, and until room is cleaned and disinfected:
      iii. CMS and state guidance require that all persons wear masks while in the facility – required in Michigan- universal source control
      iv. *Patients and visitors should be wearing their own cloth face covering on arrival and hygiene discussed. Patients may remove face coverings only in rooms*
      v. Staff should wear facemasks at all times; cloth face coverings should not be worn instead of a respirator or face mask if more than source control is required. Non – direct care staff may wear cloth coverings if not engaged in contact.
      vi. N95 respirators with an exhaust valve may not provide source control. Staff should remove masks and put on cloth coverings when leaving the facility.
      vii. Hand hygiene is required whenever the covering or mask is touched – before and after.
      viii. Staff training for the above.
      ix. *Consider full PPE use for all care if there is COVID-19 in the facility or sustained community transmission –* ***optional and based on conservation needs***
      x. Encourage residents to remain in room, especially if there are cases in the facility.
      xi. All residents should wear a facemask when leaving their room, and use a mask or cover nose and mouth with tissues while staff or others are in their room
      xii. Ensure policy and practices are in place upon arrival of new admission of COVID positive patient, through duration of patient stay and until room is cleaned and disinfected
      xiii. Limit points of entry to the facility
      xiv. Ensure all persons with symptoms adhere to respiratory hygiene, cough etiquette, hand hygiene
      xv. Post signs and posters/ install triage stations outside the facility to screen
      xvi. Provide supplies
      xvii. Adhere to Standard and Transmission based precautions: <u>Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings</u>.

xviii. Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19 (see summary above) updated 4/30/2020 to symptom based and test based strategies

xix. Select appropriate PPE in accordance with OSHA PPE standards (29 CFR 1910 Subpart I). For COVID positive or suspected patients:
   1. Put on a respirator or mask if respirator not available BEFORE entry
   2. Disposable masks should be removed and discarded AFTER exiting and closing the door in a donning/doffing area. Perform hand hygiene after discarding.
   3. Strategies to Optimize the Current Supply of N95 Respirators - also review the 4/9/2020 CDC guidance on decontaminating/reusing respirators here and strategies for optimizing the supply of N95 respirators here.
   4. Place eye protection (goggles or shield) upon entry. Eyeglasses are not eye protection; remove eye protection before leaving the room
   5. Don clean, non-sterile gloves upon entry and change if become torn or contaminated. Discard on leaving/hand hygiene
   6. Use a clean isolation gown upon entry/change if soiled. Remove before leaving room – if there are shortages, prioritize gowns for aerosol generating procedures, splashes, high contact activity – dressing, bathing, transferring, hygiene, toileting, linen changes, wound care

xx. Patient placement
   1. Single room or cohort with others who have the same infectious agent/dedicated bathroom/consider designated units
   2. Only persons with the same respiratory pathogen can be housed in the same room. Do not place a COVID+ patient with an undiagnosed respiratory patient
   3. Reserve airborne infection isolation rooms if available for persons with aerosol generating procedures
   4. Consider having health care personnel remove only gloves and gowns and perform hand hygiene between persons with same diagnosis to optimize PPE use
   5. Staff should NOT touch eye protection or masks; these items should be removed and hand hygiene performed if they become damaged or soiled and when leaving unit
   6. Staff should strictly follow basic infection control practices between patients
   7. Limit transport and movement of confirmed patients/and avoid room transfers
   8. Patients should wear a facemask/tissues during transport out of room
   9. Terminal cleaning should be delayed until time elapse for air exchanges - see clearance rates under differing ventilation conditions)

xxi. Take precautions when performing aerosol generation procedures – requires N95 or higher level respirator, gloves, gown, and eye protection
   1. Allow only necessary personnel
   2. Ideally should take place in an AIRR
   3. Clean and disinfect room surfaces promptly

xxii. Collection of Respiratory Symptoms
   1. Conduct specimen collection in a normal exam room
   2. Use aerosol generating precautions as noted above
   3. Clean and disinfect room

Managing Visitor Access and Movement in the Facility

I. *Currently all visitors are restricted except for EOL or medical necessity, guardians and DPOAs, and*
II. *Restrict access for non-essential personnel and screen personnel daily for symptoms and especially fever (taking temperature)*
III. Establish written procedures for monitoring, managing, and educating visitors
IV. *Strictly* limit points of entry
V. Screen all visitors for respiratory symptoms upon entry – do not allow entry if fever or symptoms
VI. All visitors should perform frequent hand hygiene and follow respiratory hygiene
VII. Passively screen allowable visitors for symptoms of respiratory illness before entering
VIII. Post visual alerts
IX. Educate about use of appropriate PPE for individual situations
X. *Cancel all communal activities including dining*
XI. Limit visitors to patients with known or suspected COVID
XII. Encourage electronic or telephonic visiting
XIII. Screen residents daily for symptoms including temperature
XIV. Implement universal source control across the facility

Mitigating Healthcare Personnel Staffing Shortages – Updated 4/30/2020 to align with new Return to Work Criteria

I. Aligns with recommendations for universal source control for everyone in a healthcare facility during the pandemic.
II. Facilities should be prepared for potential staffing shortages and plans to mitigate – authorities may determine that personnel with suspected or confirmed COVID 19 could return to work before full criteria are met. There are contingency and crisis strategies.
    a. Contingency – understand your staffing needs and be in communication with authorities and coalitions/ Consider adjusting criteria to work if staffing shortages are problematic
        i. Adjust staff schedules/hire/shift and rotate positions
        ii. Address social factors that prevent staff from coming to work/transportation
        iii. Engage additional staff as allowed through emergency waivers
        iv. Postpone elective time off work
        v. Work with stakeholders to develop a regional plan
        vi. Allow exposed persons who are asymptomatic to work (allowed in Michigan)
        vii. Exposed staff should wear a facemask rather than cloth/universal source control
        viii. Staff who develop symptoms must leave work
        ix. Continue to screen all staff
        x. Prioritize staff with suspected COVID for testing
        xi. Review return to work criteria and consider the type of staff shortage being addressed, where person is in course of illness (viral shedding), any symptoms, degree of resident interaction, and types of residents cared for.

b. Crisis capacity – when there are no longer enough staff to provide safe care
    i. Implement regional plans to relocate if needed
    ii. Allow asymptomatic staff with unprotected exposure back to work (they can already work in Michigan). Facemasks must be used rather than cloth – revert to universal source control after 14 day period. Facemasks for source control does not replace the need to wear an N95 or higher masks when indicated for care of persons with COVID. N95 masks with exhaust valve may not provide source control.
    iii. Screen daily
    iv. Persons with symptoms still must leave work/prioritize for testing
    v. Apply all the above interventions under contingency plans
    vi. Infected persons should be excluded from work until they meet all Return to Work criteria unless severe staffing shortages make it necessary - - - see options below
        1. As a last resort, allow staff with confirmed COVID to care for patients without suspected or confirmed COVID 19 as long as they are well enough to work
        2. Restrict from contact with immunocompromised
        3. Allow to work where they do not interact with patients or other staff
        4. Allow to provide direct care only for COVID patients in a cohort setting
        5. Only as a last resort allow them to provide direct care to persons without COVID
        6. Must wear a facemask at all times while in the facility until they meet return to work criteria – using other PPE as needed for direct care
        7. Facemasks should be worn in all areas including breakrooms – social distancing when eating, drinking, etc.

Train Healthcare Personnel

I. Provide job/task specific training and refresher training on preventing infections
II. Ensure staff are trained to meet the needs of individual patients, including the appropriate use of PPE and guarding against contamination factsheet 8.5×11pdf icon and poster 11×17pdf icon for PPE donning and doffing methods.
III. Reinforce adherence to infection prevention and control including hand hygiene and use of PPE.
IV. Train staff to regularly monitor for symptoms and fever, and staff must stay home when ill. Educate all persons entering the facility about safe practices
V. Educate residents and families about COVID-19, actions being taken, and expectations for residents and visitors while in the facility
VI. Consider implementing a respiratory protection program for staff that is compliant with OSHA respiratory protection standard for employees, including medical evaluations, training, and fit testing. https://www.osha.gov/SLTC/respiratoryprotection/index.html

Resident Cohorting

- Before affected residents or staff are identified develop a plan and determine the location of the COVID-19 care unit and create a staffing plan.
- Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the majority of residents in the facility are already infected.

- Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19.
- Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
    - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
    - Assign environmental services [EVS] staff to work only on the unit/or use nurse assistants
    - Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
    - Ensure HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).
- Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- Ensure that HCP have been trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE).
- If PPE shortages exist, implement strategies to optimize PPE supply
- Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.

Considerations for new admissions or readmissions to the facility

- Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions (4/30) should go to the designated COVID-19 care unit.
- Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit.
    - If Transmission-Based Precautions have been discontinued, but the resident with COVID-19 remains symptomatic (i.e., persistent symptoms or chronic symptoms above baseline), they can be housed on a regular unit but should remain in a private room until symptoms resolve or return to baseline. These individuals should remain in their rooms to the extent possible during this time period. If they must leave their rooms, facilities should reinforce adherence to universal source control policies and social distancing [e.g., perform frequent hand hygiene, have the resident wear a cloth face covering or facemask (if tolerated) and remain at least 6 feet away from others when outside of their room].
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
    - All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.

    - Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. **Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home**.
- New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty.

Response to Newly Identified Staff or Residents

HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset

- Prioritize these staff for testing. Exclude staff with COVID-19 from work until they have met all return to work criteria.(4/30)
- Determine which residents received direct care from and which staff had unprotected exposure to other staff who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.
    - Residents who were cared for by these staff should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
    - Exposed staff should be assessed for risk and need for work exclusion.
- If testing is available, asymptomatic residents and staff who were exposed to other staff with COVID-19 should be considered for testing (see information on testing below). If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above.

Resident with new-onset suspected or confirmed COVID-19

- Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible. Alternatively, if an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room on that unit pending results of SARS-CoV-2 testing.
    - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).
    - If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.
- If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.
- Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).
    - Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.

- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections.
    - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
- Counsel all residents to restrict themselves to their room to the extent possible.
- HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.
    - If HCP PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated. Point prevalence surveys (PPS) could be utilized to prioritize PPE supplies (see section on use of PPS).
- Notify HCP, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning).
    - Promptly (within 12 hours) notify HCP, residents, and families about identification of COVID-19 in the facility pdf icon[164 KB, 3 pages]external icon:
        - Provide educational sessions or handouts for HCP, residents, and families
        - Maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions
    - Monitor hand hygiene and PPE use in affected areas
- Maintain all interventions while assessing for new clinical cases (symptomatic residents):
    - Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.
    - If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing
    - The incubation period for COVID-19 can be up to 14 days and the identification of a new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.
- Considerations for use of COVID testing to inform cohort decisions
    - If testing supplies or capacity are limited, testing of symptomatic HCP and symptomatic residents should be prioritized.
        - If unit-wide or facility-wide testing is not available in response to newly identified SARS-CoV-2 infected residents or HCP, moving any residents other than those confirmed to have COVID-19 should be done with caution given the risk of asymptomatic infection; in those situations, all recommended COVID-19 PPE should be used during care of all residents on the affected unit or facility.
    - If testing capacity allows, use of point prevalence surveys (PPSs) following identification of newly identified SARS-CoV-2 infected residents or HCP could be particularly important. PPSs can help identify asymptomatic or pre-symptomatic residents with COVID-19 to guide movement into COVID-19 designated spaces.

For additional information on testing in response to COVID-19 in nursing homes please refer to Considerations for Use of Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes.

Environmental Infection Control

I. Dedicate medical equipment for those with known or suspected COVID
II. Non-disposable equipment should be dedicated for the time being and cleaned according to manufacturer instructions and facility policy
III. Ensure procedures are followed consistently – this is a frequent citation area
IV. Use EPA-registered hospital grade disinfectant for routine cleaning of frequently touched surfaces - 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.
V. Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
VI. 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

CDC/CMS Required Nursing Facility Reporting

CMS has provided information and training regarding its requirements for nursing facility COVID reporting to the CDC. The NHSN LTCF Component consists of four pathways: Resident Impact and Facility Capacity, Staff and Personnel Impact, Supplies and PPE, Ventilator Capacity and Supplies.

Specifically, NFs are required to report counts of residents and staff with SUSPECTED and Positive COVID – 19, counts of deaths with SUSPECTED and Positive COVID -19 related deaths, staffing shortages, status of PPE supplies, and ventilator capacity and supplies. The module does not collect staff or resident-level personal information.

NFs are required to be actively enrolled in NHSN but CMS warns against re-enrolling a previously enrolled facility. When completing the enrollment process, facilities will gain same-day access. Daily reporting is encouraged, but retrospective reporting of the prior day is acceptable. At a minimum, reporting is expected once per week on the same day. Facilities can submit information manually, or upload CSV files. This data will be available to CMS and state authorities.

The first training on Enrollment Steps was held today following yesterday's Overview Training. Members have reported difficulty in accessing the trainings but they will be repeated next week as well. Required data elements include:

Resident Impact and Facility Capacity (Instructions)

- Admissions admitted or readmitted who were previously hospitalized and treated for COVID-19
- Residents with new laboratory positive COVID-19
- Residents with new suspected COVID-19
- Total Deaths – residents who have died in the facility or another location

- Suspected or confirmed COVID – 19 deaths who died in the facility or another location
- Bed Capacity
- Current Census
- Access to COVID testing while resident is in the facility and type of laboratory used

LTCF: Staff and Personnel Impact (Instructions)

- Staff and facility personnel with new laboratory positive COVID-19
- Staff and facility personnel with new suspected COVID-19 who are being managed as if they have it
- Staff and facility personnel with new suspected or laboratory positive COVID-19 who died
- YES/NO responses to whether there is a staffing shortage of nursing staff, clinical staff, nursing aides, or other staff.

Supplies and Personal Protective Equipment (Instructions)

- Whether there is 1) any supply and 2) enough for one week of N95 masks, surgical masks, eye protection, gowns, gloves, alcohol based hand sanitizer

Ventilator Capacity (Instructions)

- Number of mechanical ventilators in facility
- Number of mechanical ventilators in used for residents with suspected or positive COVID-19
- Ventilator supplies – if any, and if enough for one week

Other Resources

- Facility Guide to Module
- Uploading Files
- Excel Templates
    - Resident Impact and Facility Capacity Template excel icon[CSV – 1 KB]
    - Staff and Personnel Impact Template excel icon[CSV – 1 KB]
    - Supplies and Personal Protective Equipment Template excel icon[CSV – 1 KB]
    - Ventilator Capacity and Supplies Template excel icon[CSV – 1 KB]
- **Group Guides (for more than one facility)**
    - Group Guide to Using the COVID-19 Module pdf icon[PDF – 450 KB]
    - Groups and Supergroups – Viewing and Uploading COVID-19 CSV Data Files pdf icon[PDF – 850 KB]
    - Group Level CSV File Templates
        - Resident Impact and Facility Capacity Template excel icon[CSV – 1 KB]
        - Staff and Personnel Impact Template excel icon[CSV – 1 KB]
        - Supplies and Personal Protective Equipment Template excel icon[CSV – 1 KB]
        - Ventilator Capacity and Supplies Template excel icon[CSV – 1 KB]

All healthcare facilities should review and consider using:

COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings pdf icon[PDF – 1 MB]

Donning and Doffing Protective Gear
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html