Updated March 23, 2020

Frequently Asked Questions Regarding COVID-19 and PALTC

When COVID-19 Is Currently In Your Regional Community (i.e., Community Spread)

COVID-19 is the abbreviated name for novel Coronavirus Disease 19 that first emerged in Wuhan, Hubei Province, China and has spread globally and in many regions in the United States. Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person.

The situation with this outbreak is evolving rapidly with new information being learned daily. The CDC is monitoring the outbreak and working closely with federal, state, and local health departments. Because of this, healthcare personnel working in post-acute and long-term care (PALTC) settings should refer to the CDC website for the latest updates.

General Information
Strategies to Prevent the Spread of Infection in Long-Term Care Facilities

What's New (updated March 23, 2020)

AMDA's Resolution on COVID-19, dated March 19, 2020, states that a COVID-19 naïve facility should not accept an admission with clinical or lab evidence of active disease. Instead, care of these patients should be provided in alternate care sites and specialized COVID-19 facilities.

Minimizing Spread:

Dialysis patients are at high risk for acquiring the COVID-19 virus. We recommend:

- Placing these residents in a single room with standard, contact, and droplet precautions.
- Residents should wear a facemask for the entire time they are out of the LTC facility.
- Staff should assist the resident with thorough hand washing and changing of clothes upon return to the facility.
- Staff should give special attention to surveillance for influenza-like illness and should have high level of suspicion for COVID-19 in these residents.

- The LTC facility should communicate with the dialysis facility if one of its patients is suspected or tested positive for SARS-Cov-2. There should be a preemptive communication of the plans for how dialysis centers are handling the COVID-19 patients from the community.

Restrict procedures that involve manipulation of mucosal cavity, e.g., dental cleaning, denture fitting, fiberoptic evaluation of swallowing. If the study is thought to be urgent, the need should be weighed against the elevated risk of transmission due to these procedures.

Cohorting COVID-10 patients:

- Nursing facilities should identify units that can be effectively used to cohort COVID-19 patients who test positive while they are in the facility.
    - COVID-19 patients should be cohorted in a single unit.
    - There should be dedicated nursing staff to care for COVID-19 patients. They should not work on other units.
    - Equipment should not be shared between units.
    - Staff providing care to multiple patients should minimize contact with test positive or suspected COVID-19 patients and should provide care to these residents last.

Contingency planning for PPE: Nursing facilities should do contingency planning for PPE as outlined in the CDC guidance, including the reuse of masks, eye protection and washable gowns.

Admission assessment:

- We recommend that all facilities follow a robust admission process using the screening tool (also see page 4) to assess for common and uncommon COVID-19 symptoms. If COVID-19 is suspected on chart review, staff should communicate with the discharging team and request a test prior to admission.
- We recommend that staff follow standard, contact, and droplet precautions during admission assessment to minimize staff exposure.
- Residents admitted to the facility should be put on standard contact and droplet precaution for observation.

We have the first positive COVID-19 case in PALTC. How do we approach this?

The facility has two goals in caring for a COVID 19 resident:

1. Facility-specific goal: Minimize spread of infection to other residents and staff:

- Strict cohorting of COVID-19 patients in a separate unit.
- All residents on the unit should be carefully screened for common and uncommon symptoms of COVID-19.
- If a resident is diagnosed with COVID-19 on a unit, there should be a low threshold for testing other symptomatic residents on the affected unit.
- If there are multiple cases positive on the unit for COVID-19, diagnosis can be made based on symptoms.
- No movement of staff between units.
- No sharing of equipment, including medicine carts and wound care supplies, between the units.
- Practice strict adherence to infection control practices.
- Rehabilitation services should be suspended for the COVID-19 unit to avoid staff-based transmission.
- Facilities should only cohort COVID-19 confirmed residents and not cohort suspected cases on respiratory isolation pending testing results.
- Patients who are COVID-19 positive and negative for flu or other respiratory viruses can be in the same room.

2. COVID-19 patient-specific goal: Close monitoring and supportive care

Nursing home residents who are COVID-19 positive can deteriorate very quickly. These patients need a higher level of nursing and clinical care than typical nursing home residents.

- Goals of care should be reestablished, including the decision to hospitalize and placement on ventilator/life support, in an informed discussion in light of COVID 19.
- Decision to treat in place should be based on care goals and medical necessity.
- COVID 19 patients should be frequently monitored with pulse oximetry.
- Staff should be vigilant for signs that signal quick deterioration; this includes respiratory distress. This could present as a drop in the patient's oxygen saturation being the only clue.
- Staff should provide supportive care with supplemental oxygen (often at high concentrations), with IV fluids as needed.
- There is currently no clear evidence of effective treatment or prophylaxis although several studies are ongoing.
- Palliative care should be considered as appropriate.

Staff Issues:

LTC should follow the CDC interim guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19.

CDC recommends that staff with suspected or positive COVID-19 should be excluded from work until at least 3 days (72 hours) have passed *since recovery,* defined as:

- Resolution of fever without the use of fever-reducing medications
- Improvement in respiratory symptoms (e.g., cough, shortness of breath)
- At least 7 days have passed *since symptoms first appeared*.

All staff returning to work must wear a mask for 14 days after the onset of illness; practice hand hygiene and cough etiquette and self-monitor for recurrence of symptoms. If there is a recurrence, they should immediately stop working and report to the supervisor for guidance.

Active Screening of Residents Evaluate residents for the following every 12 hours
Common Signs and Symptoms
Fever ≥ 37.2°C (99.0°F)
Cough
Shortness of breath. *Increased oxygen requirements or increased frequency of nebulizer treatments may be surrogate symptoms of shortness of breath*
Less Common Signs and Symptoms
Confusion or change in mental status. *If noted, check pulse oximetry to determine if increased oxygen requirements*
Muscle aches, headache
Sore throat, runny nose
Chest pain
Diarrhea, nausea and vomiting
Probable case: any two of the common signs/symptoms *Initiate contact and droplet precautions* *Check at room air pulse-oximetry* *Increase frequency of vital signs, including pulse oximetry to every 8 hours* *Screen for influenza. **If negative, screen for COVID-19 (in areas of community outbreak may consider concomitant testing based on clinicians assessment)*** *Possible case: any one of the common signs/symptoms and 2-3 of the less common signs/symptoms* *Initiate contact and droplet precautions* *Check at room air pulse-oximetry*

The Center for Medicare & Medicaid Services (CMS) recommended on March 13, 2020 to restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life. Additional new recommendations include:

- **Cancel communal dining and all group activities, such as internal and external group activities.**
- **Implement active screening of residents and staff for fever and respiratory symptoms.**

- **Remind residents to practice social distancing and perform frequent hand hygiene.**

Per CDC guidance dated March 13, sample collection NOW includes only a nasal (nasopharyngeal) swab. **We recommend that facilities conduct emergency preparedness for COVID-19 to anticipate and prepare for increased resources needs and change in care patterns. The CDC has a preparedness checklist.**

Early identification of patients with acute respiratory illness including COVID-19 is crucial.

- We recommend surveillance of all residents and staff for clinical signs and symptoms of respiratory illness or fever.
- If you identify a ***cluster*** of acute respiratory illness ***in residents or staff*** irrespective of etiology you should contact your local public health department immediately for further guidance.
- We recommend that residents with respiratory illness be immediately isolated pending testing. **Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (REVISED)**

VISITORS AND VOLUNTEERS

What should we tell our visitors and volunteers?
CMS recommends that all facilities should restrict visitors and non-essential health care personnel, except for certain compassionate care situations, such as end-of-life. Furthermore, CMS completely restricts certain visitors regardless of the situation.

This visitation restriction should be thoughtfully communicated with families, friends, and volunteers. Restricting visitors and volunteers, especially during periods of community spread is important to reduce the risk of transmission to other residents, families, staff members, as well as the larger community.

We recommend that activity staff should proactively offer scheduled telephone or electronic face-to-face visits for residents and their families as visitor restriction and cancellation of communal dining can lead to isolation.

Facilities may have many entrances which pose a challenge when trying to screen for ill visitors. Facilities should identify all potential entrances used by the public and limit access to just a few entrances where screening can be performed.

Post large warning signs at all entrances, which include instructions regarding visits.

Visitors that are allowed to enter the facility should be screened for:

1. Clinical symptoms of respiratory illness and fever. If visitors are found to have respiratory illness, then we strongly recommend that they should not visit nursing home residents.
2. Whether they've traveled internationally within the last 14 days to the restricted countries. **Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States**
3. Whether they've had contact with an individual with confirmed or suspected COVID-19 in the prior 14 days.
4. If they reside in a community where community-based spread of COVID-19 is occurring.

In addition, facilities should ask visitors if they took any recent trips (within the last 14 days) on cruise ships. If so, facilities should suggest deferring their visit to a later date. If the visitor's entry is necessary, they should use mask while onsite and should wash hands prior to entry and at exit. Visitors who are unable to follow infection control precautions guidelines (washing hands, wearing mask, following cough etiquette) should be restricted from visitation.

Visitors:

If allowed to visit, visitors should limit contact to the residents' room or a place the facility has specifically dedicated for visits rather than common area. Visitor should be directed to frequently perform hand hygiene, follow proper cough etiquette, avoid touching surfaces, and use a mask. Staff may need to specifically instruct visitors on the use of alcohol hand rub, proper hand washing techniques and proper use of mask. All visitors should use a mask for the duration of the visit

If a visitor is exposed to a resident with COVID-19, they should monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and, if ill, should self-isolate at home and contact their healthcare provider.

If a visitor develops acute respiratory illness or COVID-19 within 14 days of visiting a facility they should report that to the facility.

Volunteers should suspend visits.

Students and trainees should also suspend visits. Some facilities have come to rely on the efforts of trainees to help reduce the burden on their licensed staff. However, students and trainees represent another possible source of individuals with asymptomatic COVID-19. This

risk is compounded if they participate in classes or other social gatherings that put them at risk for acquiring COVID-19.

Please regularly review the CMS Guidance for Infection Control and Prevention of Coronavirus Disease for updates.

What if a family member who may be ill also has a need to visit a resident?
Any family member who is ill should not be allowed to enter the facility until the illness is resolved and they are no longer considered infected with the respiratory illness or COVID-19 by their primary care physician.

We recommend use of technology such as Skype, FaceTime, or similar phone and videoconference applications when possible to avoid an unnecessary exposure.

What do we tell the families and friends of our residents?
In addition to large warning signs ("stop signs") at entrances, we also suggest sending emails and letters to family members of residents. Consider asking the resident and family council to assist with these efforts. Templates for letters may be found on the AMDA website. We recommend that the administrator plan for frequent communications with family. One example is assigning the activities staff to schedule phone or video conferencing between the residents and families especially as group activities decrease. It is important for the director of nursing (DON) or administrator to be available to talk to resident's families if needed.

What about other people who access the building—like vendors delivering medications from the pharmacy, linens, food, and other supplies?
These individuals should not enter the building if possible. Instead, as part of social distancing, they should be instructed to leave their delivery at an appropriate location well away from residents and, if possible, staff. Post signs at the doors and entrances used by vendors that remind individuals about cough etiquette. Provide alcohol hand rub and direct vendors that must enter the building access to sinks with soap and water if needed. Facilities should identify and plan for such situations.

STAFF

Should we screen our staff for COVID-19?
The DON is accountable for ensuring that staff does not work while they have signs or symptoms of a respiratory illness.

All nursing home staff, including both direct care workers (e.g., nurses, CNAs, therapists, activities staff, hospice staff, and dietary staff) AND non-direct patient care staff (e.g. environmental service or maintenance staff) should be assessed at the start of a shift through a tiered accountability approach. Diligent logs should be maintained of the staff working in the facility. This is helpful to determine staff and resident exposure patterns.

Direct patient care staff should be actively assessed for respiratory illness or fever by nurse managers of the units and supervisory staff prior to provision of patient care duties.

What should we do when a staff member is exposed to a resident with possible COVID-19.
If a staff member was exposed to individuals with known or suspected COVID-19, the staff member needs to immediately alert the DON or designated staff, regularly monitor themselves for fever and symptoms of respiratory infection, and not report to work when ill. These individuals should not continue to participate in direct resident care until further details about the exposure are known. **Asymptomatic** staff members with a COVID-19 exposure should be assessed by a designated employee, either the DON or the infection preventionist (IP), as per CDC guidance. Based on these guidelines, if the exposed staff is allowed to work they should wear a facemask while at work for 14 days post exposure and practice hand hygiene and monitor for respiratory symptoms and fever prior to coming to work.

What if a staff member develops respiratory symptoms?
Any ill staff should not be allowed to provide patient care. Sick leave policies should be non-punitive, flexible and consist with public health guidance. Encourage the Human Resources Department to review and consider revising policies given current circumstances.

Any staff that develops signs and symptoms of a respiratory infection while on the job should:

- Immediately stop work, put on a facemask, and self-isolate at home
- Inform the facility's infection preventionist of contacts with individuals, equipment, and locations
- Contact and follow the local health department recommendations for next steps (e.g., testing).

Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work.
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 (COVID-19)

Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for healthcare professionals.

When should someone who had a respiratory viral illness be allowed to return to work?
The DON is accountable for ensuring that staff does not work while they have signs or symptoms of a respiratory illness. Facilities should define a process for determining when and under what conditions an ill staff member may return to work. This process should include input by the DON, IP, or other designee with a clinical background. In addition, the facility should consult with the medical director as needed.

Typically for most respiratory viral infections, the amount of virus shed by a person decreases as symptoms resolve. Staff members who have a respiratory viral infection ***not caused by COVID-19*** should be excluded from work until at least 24 hours after they are no longer febrile (without the use of fever-reducing medications such as acetaminophen, ibuprofen, or naproxen) and after respiratory symptoms have improved, typically 4-5 days from the onset of symptoms. Frequently, people may have a lingering cough after a respiratory viral illness.

The length of time that people shed COVID-19 is not yet known. Experience with similar viruses indicates people may shed virus for at least 12 days after illness onset. People with more severe disease shed higher amounts of virus. ***Return to work of staff diagnosed with COVID-19 should be decided on a case-by-case basis and discussed with the public health department.*** **We have physicians and nurse practitioners that care for residents in more than one building. What can we do to minimize the risk of one of them introducing COVID-19?**

If the clinicians are providing outpatient care in addition to nursing home rounding, we recommend asking clinicians to visit the building first thing the morning rather than at the end of the day. Also, if staffing permits, have clinicians limit their visits to one building. If this is not possible, then ask clinicians to only visit one building each day. The rational for rounding in the morning is that the clinicians will have had overnight to know if they are starting to feel ill and can self-quarantine if needed.

As indicated above, clinicians should also practice universal masking and gloving while seeing residents.

RESPIRATORY ILLNESS IN NURSING HOME RESIDENTS

What should we do to identify the disease early?
Staff should conduct active surveillance of residents for signs and symptoms of acute respiratory illness including fever. Staff should be cognizant that some residents may have atypical symptoms. They should be systematically marked on the facility map for identification

of clusters of respiratory illness. They should also be recorded in a log of respiratory surveillance. **Instructions for the Long-Term Care (LTC) Respiratory Surveillance Line List**

Community transmission is widespread in many regions in the United States. Although COVID-19 common symptoms include fever, cough and shortness of breath, **some older adults may not show these symptoms early during their infection**. Similar to influenza illness, residents could present with exacerbation of underlying cardiac or respiratory condition such as COPD. A lower threshold should be set to evaluate these residents. **Active Screening of Residents** (also see below)

We recommend that residents with respiratory illness be immediately isolated pending testing. **Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (REVISED)**

Residents with acute respiratory symptoms should be placed on an active monitoring protocol. Active monitoring includes checking vital signs, measuring pulse oximetry, and assessing for common and less common signs and symptoms of COVID-19 every 6 to 8 hours.

One of our residents has a fever, cough, and shortness of breath. What should we do?
These symptoms could be caused by several different respiratory viral illnesses including influenza, respiratory syncytial virus (RSV), and COVID-19.

- **Isolate** the resident and initiate testing for influenza and other potential respiratory viruses. If initial tests are negative, evaluate the need for SARS-CoV-2 testing in consultation with your local and/or state public health department. The rate of virus co-infection currently reported is ~2%. Clinicians should use their clinical judgment while making a determination on whether to test concomitantly.
  The decision to test for COVID-19 is based on clinician's judgment as per the Criteria for evaluating and testing persons for COVID-19 updated on March 4, 2020.
- Use the **COVID-19 Persons under Investigation and Care Report Form** to collect information requested by the CDC as well as state and local health departments. Refer to the CDC guidance for reporting a person under investigation (PUI) or confirmed case: Reporting a PUI or Confirmed Case
- A**ssess the resident carefully for severity of illness** and need for hospitalization in conjunction with goals of care.
- **Implement standard, contact, droplet precaution and eye protection**. Use an N-95 or higher-level respirator for aerosol generating procedures.

How do we collect a sample to test for SARS-CoV-2 and where do we send it?
Sample collection NOW includes only a nasal (nasopharyngeal) swab. The individual collecting the sample should wear an N-95 respirator or facemask if a N-95 is not available), eye protection, gloves, and a gown as there is risk of the resident coughing or sneezing.

Use a swab with synthetic fibers and plastic shafts; these are the same swabs used for collecting samples to test for influenza (dacron/nylon). Place swabs into sterile tubes with 2-3 mL of viral transport media (pink liquid). If old kits with two vials are available in the same bag, they can be separated to use as two testing kits. Refrigerate specimens (2-8°C) for up to 72 hours after collection. The CDC has guidelines for the collection of clinical specimens. There are short videos for nasopharyngeal specimen collection on the AMDA website (under Other Resources).

Contact your state or local health department to determine where to send the test. The CDC has contact information and further details: Reporting a PUI or Confirmed Case.

Some local labs may be able to perform Flu/RSV testing and then send the same material off to testing for COVID-19. Contact your lab to develop strategies to conserve swabs and viral transport media.

What about the roommate and other contacts?
If the ill resident is confirmed to have COVID-19, any roommates or other contacts should be placed under surveillance for development of respiratory illness. If moved, the roommate should be placed in a private room to minimize ongoing exposure to other residents and staff. Management of other contacts should be coordinated with the local or state health department.

What about the healthcare workers?
If the ill resident is confirmed to have COVID-19, the exposed and be referred to occupational health for assessment of the degree of exposure and the need to furlough. In many nursing homes, the function of occupational health is performed by infection preventionist. We recommend that nursing facilities create interim small teams who perform the occupational health function. This is in anticipation of increased need for such function, to cover all shifts and to allow IP to perform other functions related to Infection control and prevention.
Interim US 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)

We have a diagnosed case of COVID-19 in our nursing home. What do I do?

If there is a new diagnosis of COVID-19 in the LTC facility:

- ➢ Immediately notify your local and state health department for further guidance.
- ➢ We recommend that facilities follow standard practices during a respiratory illness outbreak as they would for an influenza outbreak.
    - Have symptomatic residents stay in their own rooms, including restricting them from common activities, and have their meals served in their rooms.
    - Continue to restrict all large group activities including dining in the facility and consider serving all meals in resident rooms when the outbreak is widespread (involving multiple units of the facility).
    - Avoid new admissions or transfers to wards with symptomatic residents.
    - Continue to restrict visitation via posted notices.
    - Monitor healthcare personnel absenteeism due to respiratory symptoms and exclude those who are ill from work.
    - Restrict healthcare personnel movement between affected and unaffected areas/units of the facility.

    Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post- Acute Care Facilities

- ➢ A decision to stop new admissions to the facility should be made in conjunction with the local and state health department.
- ➢ Facilities should have a communication plan with families. Communications may be provided through a variety of means such as phone call, letter, email, website postings, etc.

We have two residents with new onset respiratory symptoms. Should they be in the same room?

If two or more residents have acute respiratory symptoms suggestive of influenza, RSV or COVID-19, we suggest implementing facility-wide precautions as detailed in the question above. Until there is a confirmed diagnosis for the involved residents, they should not be cohorted. Once it is known that there are two individuals with the same infection, then those individuals may be cohorted if necessary.

We recommend, if possible, dedicating one hallway or unit to the care of individuals with respiratory viral syndromes. There should be consistent staffing of this unit as well (*i.e.*, the same staff members work in this area, including staff that works on evening and night shift). If other staff need to come into this area to perform specialized care, such as hospice care, this should be the last group of residents to receive care before that person goes home. Prioritize the use of PPE in this area of the building. If possible several nursing functions (e.g., wound

care) should be performed by the assigned staff to limit staff caring across the facility. If this is done consideration should be given to the increased intensity of work during staff assignments.

INFECTION CONTROL AND PREVENTION IN NURSING HOMES

What kind of personal protective equipment (PPE) should we use when caring for someone with a respiratory viral illness?

We recommend standard, contact, and droplet precautions with eye protection. This means wearing a gown and gloves, together with a facemask and goggles or a face shield. In case of PPE shortages, eye protection should be prioritized to staff administering any respiratory treatment that may result in aerosolization of viral particles. Examples of respiratory treatments that may lead to aerosolization of viral particles include use of nebulizers, suctioning, tracheostomy care and application or adjustment of oxygen masks. Collecting samples to test for influenza, RSV, and COVID-19 also carry the risk as there may be droplet exposure at very close range when residents cough or sneeze.

We further recommend that the resident should remain in their room, with the door. We also recommend engineering controls such as pulling curtains and using consistent staffing assignments to limit the number of individuals to whom residents and healthcare staff have exposure. Personnel should not move from unit to unit during their assignments. This may include flexible staffing and roles to minimize movement of staff throughout the building.

Are the recommendations different for someone with COVID-19?

SARS-CoV-2 mainly spreads from person to person through respiratory droplets. Out of an abundance of caution, the CDC recommends that healthcare facilities use **airborne precautions and eye protection** in addition to standard and contact precautions for the care of suspected or confirmed COVID-19 patients. In light of shortages of PPE and the lack of a respiratory program (i.e. N-95 fit test) in LTCF, CDC has updated the infection prevention and control recommendations on March 10.

The new guidance is consistent with World Health Organization (WHO) recommendations and similar to AMDA's previous guidance.

Interim Infection Prevention and Control Recommendations (CDC)
Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected (WHO)
Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies (CDC)

- *We recommend staff use surgical masks and eye protection or face shield before administering any respiratory treatment that may result in aerosolization of viral particles to individuals not suspected of having COVID-19, but who appear to have another respiratory viral infection. Examples of respiratory treatments that may lead to aerosolization of viral particles includes use of nebulizers, suctioning, tracheostomy care. and application or adjustment of oxygen masks.*
- *If N-95 masks are in limited supply to PALTC providers, we recommend staff prioritize use of N-95 masks during respiratory procedures used in the care of residents with a possible respiratory viral infection that likely to result in aerosolization of viral particles. During all other lower-risk care, surgical masks should be utilized.*
- *We recommend that staff use N-95 mask (or facemask if a respirator is not available) and eye protection in addition to other PPE when obtaining respiratory samples in individuals with suspected COVID-19.*

Do we need to use PPE for all of our residents who get respiratory care? Some of them have a tracheostomy and need pulmonary toilet every shift.

For residents who require routine respiratory care such as daily nebulizers or who have a tracheostomy, continue to use the same infection control measures previously in place for those individuals. Should they manifest a change in symptoms, such as fever, increased sputum production, or increased oxygen requirements, this may indicate the development of an acute respiratory illness. Assess the resident for influenza, RSV and, working with state and local healthcare authorities, for COVID-19. Have a high index of suspicion. Early detection is crucial.

<u>We recommend that the continued need for nebulizer therapy in all residents be periodically reassessed; if no longer required, it should be discontinued.</u>

We recommend that staff close bedside curtains when performing respiratory procedures in semiprivate rooms.

We do not have any COVID-19 in our building but it is in our community. I am concerned about asymptomatic shedding by our staff. What are some options?

We strongly recommend active surveillance for respiratory illness and fever of both residents and staff members when there is evidence of community- wide transmission

To reduce the risk of asymptomatic staff infecting their residents, we recommend universal facemasks and glove use as a precaution.

Transmission of COVID-19 across long-term care facilities through staff working at multiple facilities has been reported. Facilities should keep a log of names of all other health care

settings where staff members are working. They should continually assess and attempt to mitigate the cross exposure risk for COVID-19 through staff transmission.

In communities with local transmission, we recommend that facilities limit residents' interactions only to clinical staff. Clinical staff should wear masks while providing direct patient care to all residents. For residents with acute respiratory illness, staff should observe transmission-based precautions.

We recommend that facilities adopt stewardship practices for PPE in accordance with CDC guidance on strategies to optimize PPE supply.

We recommend that clinicians minimize face-to-face visits with residents for routine matters. Further, we recommend that clinicians also, for now, limit routine visits and laboratory studies. Clinical staff should also consider limiting the frequency of other processes that involve direct interactions with residents, such as point-of-care capillary blood sugars, nebulizer treatments, etc.

We recommend that nursing facilities should offer telehealth whenever possible. They should encourage telehealth visits in lieu of outside appointments with specialists and other necessary clinical evaluations.

Facemask may be worn throughout an entire shift and do not need to be changed when going from resident to resident. If a facemask becomes soiled, wet, torn or no longer covers the nose and mouth, it should be discarded.

How do I know if I am using PPE correctly?
We recommend training and practicing proper use of PPE with your staff. Use a buddy system to help catch common errors. In a training scenario, it is okay to reuse gowns.

The CDC has posters that show how to put on and take off (don and doff) PPE:
Sequence for Putting on Personal Protective Equipment (PPE)

There are also videos available through the University of Nebraska:
Hospital PPE - Infection Control: Donning and Doffing

What else can we do to help our staff use PPE correctly?
Post signs on the door about the type of precautions needed with the required PPE.

Ensure that PPE is readily accessible. Ideally, supplies should be made available immediately outside the resident's room. Assign someone to check and restock supplies each shift.

Staff should be trained to don and doff their PPE at the entrance to the resident's room. A trash can should be placed near the door of the room to discard the PPE. Alcohol-based hand wash should be accessible for use after doffing the PPE.
Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

What other precaution can the staff take to minimize potential spread?
In addition to following standard infection control practices on cleaning common equipment to assess residents, e.g. thermometers, staff should be asked to clean personal equipment, e.g. stethoscopes between each use and also personal devices like cellphones frequently.

We are running low on PPE. What can we do?
Nursing homes that are part of a larger network may share the same supply resources as hospitals within their network. Individuals responsible for allocating supplies at a systems level may attempt to prioritize hospitals. We recommend working with these individuals and with senior level administrators to advocate for a supply of PPE for nursing homes as well. Stress the risk of outbreak among vulnerable elders living in a communal setting as well as the increased risk of death due to COVID-19 among adults aged ≥70 years (8% mortality for those aged 70-79; 15% for those ≥80 years).

Allow personnel caring for several people with the same respiratory illnesses to use the same face mask or N-95 as they move between residents. We recommend a new gown and gloves when moving between residents. If this is not possible due to a critical shortage of PPE supplies and there is an outbreak of possible COVID-19 in your building, healthcare personnel can also use the same gown when caring for several individuals with the same illness. Should those individuals require contact precautions for other reasons, such as a drug-resistant bacteria, we suggest starting with the residents with the least burden of potential pathogens first and working with those with the most potential pathogens last. Further, use hand hygiene and don new gloves between individuals to reduce the risk of disease transmission. Should even gloves need to be rationed, alcohol hand rub may be applied to gloves between tasks and activities for the same resident, rather than changing gloves as is recommended when going from dirty to clean tasks, such as during dressing changes. Gloves should not be used in the care of more than one resident. Check the links for measures to rationalize the use of PPE and N-95:
Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19)
Strategies for Optimizing the Supply of N95 Respirators: COVID-19

TRANSFER TO ACUTE CARE

Should I transfer my resident with a respiratory viral illness to the hospital in order to help reduce the spread of disease?

We recommend transferring residents based on their medical needs, not as a means to reduce the spread of infection. Before transferring, determine if hospital transfer is part of the resident's goals of care. If the resident is sick enough that hospital transfer is indicated, alert the personnel transporting the resident as well as the receiving hospital that the resident has a suspected viral respiratory illness. Share the results of influenza and or RSV testing as well.

We recommend that the nursing home staff review all residents' goals of care.

Guidance from the CDC dating from 3/10/20 states that residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.

Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.

We have a resident who needs to be transferred to acute care for suspected COVID-19. The hospital has resources to care for the individual and has accepted them. How do we approach this?

Transferring a resident with suspected or confirmed COVID-19 to the hospital requires consultation and communication with the local/state health department, receiving institution, and EMS services.

While making the arrangements for transfer, the individual will still require care from staff, who should continue to use standard, contact, droplet precautions and eye protection as described above. Keep the door to the resident's room closed as much as possible. Pull curtains and limit the number of staff going in and out of the room and the unit.

Alert the transport crew of the concern for COVID-19 so they can be prepared with their own respiratory protection. The hospital should be aware and have plans to minimize the risk of transmission once the individual arrives at the building.

During the physical transfer of the resident into a gurney for transport, personnel should continue to wear gloves, gown, and a face shield or facemask with goggles. The resident should have a facemask if tolerated. Once the individual is on the gurney, with clean sheets and blankets, staff should remove their PPE and gloves and perform thorough hand hygiene.

Transfer from Acute Care:

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?

As per the recent AMDA Resolution on COVID-19, a COVID 19 naïve nursing facility should not accept a COVID 19 patient who is considered a transmission risk.

If a nursing home cannot effectively implement transmission-based precautions, it must wait until the resident does not require these precautions. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room).

We have accepted a patient diagnosed with COVID-19 in our facility. When can we discontinue transmission-based precautions?

CDC states that decisions to discontinue transmission-based precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials.

Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

LEAVING THE FACILITY FOR OTHER (NON-URGENT) MEDICAL CARE

One of our residents has an appointment scheduled with a specialist they saw in the hospital. Should we send her to that appointment?

We recommend that the staff call the outside consultants and delay non-urgent visits or procedures. If there is a pressing medical need for the appointment, explore options such as electronic consults or other telehealth modalities to limit exposure of the resident to other healthcare settings. Some offices may have a physician, nurse practitioner, or physician assistant who is willing to come see residents at your building. We also recommend suspending all non-emergent dental visits either in or out of the facility.

For residents that must go to a medical appointment, we recommend that they wear a facemask as much as possible through the encounter. Consider sending them with a spare mask or two if supplies permit.

Several of our residents get hemodialysis. What should we do for them?
The CDC has interim guidance for hemodialysis facilities. The guidance is focused on infection prevention and control measures for the care of patients with a respiratory illness or with known or suspected COVID-19, including recommendations for cohorting.

We recommend that residents leaving your building for hemodialysis should wear a face mask to reduce the risk of acquiring COVID-19 from someone else at the building, This should help protect the resident from exposure both the healthcare personnel at the dialysis center as well as from other people from the community who are receiving dialysis.

ENVIRONMENTAL CLEANING

How do we clean the resident's room with possible COVID-19?
Daily cleaning: We recommend that to minimize the exposure and optimize use of PPE, only essential clinical staff enter the rooms of residents with suspected or confirmed COVID-19. CDC recommends that nursing staff taking care of residents perform the daily cleaning of frequently touched surfaces inside the resident's room (such as door handles, bedrails, tabletops, light switches, elevator buttons [inside and out], computers, remotes, phones etc.) with an EPA-registered, hospital-grade disinfectant that has an emerging viral pathogens claim for use against SARS-CoV-2. Staff assignment should account for extra services that the staff is providing to allow effective care of the residents.
List N: Disinfectants for Use Against SARS-CoV-2
CDC Infection Prevention and Control FAQ for COVID-19

Ensure that dedicated equipment is available and remains in the resident's room and that alcohol hand rub is available and a process is in place to refill empty dispensers and restock PPE.

All non-dedicated, non-disposable medical equipment used for patient care should be cleaned according to facility policies.

Environmental service staff should continue to clean the other resident rooms as their routine practice and should ensure that an adequate supply of alcohol-based hand sanitizers is in the dispensers. They should clean the frequently touched surfaces like handrails, doorknobs and door handles, and surfaces at the nurses' stations at least twice daily and more frequently as needed.

For terminal cleaning, environmental service staff should observe contact and droplet precautions (based on above recommendations) when cleaning residents' rooms. Educate staff on proper use of PPE and appropriate choice of disinfectant. A facemask and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated. Standard practices using an EPA-registered, hospital-grade disinfectant with an emerging viral pathogens claim are recommended for use against SARS-CoV-2.

Do we need any special precautions for laundry?
There are no special recommendations for management of laundry, food service utensils, and medical waste. Follow routine procedures.

Several of our family members do laundry for our residents. Should we stop that?
Family members should be allowed to do laundry for their loved ones. This is one of the ways they can continue to be involved in the care of their family member. Facility should handle laundry pick up and drop off similar to the procedures for deliveries. The handling of laundry should be done observing standard, contact and droplet precautions. This should be done away from patient care areas and ideally without direct contact with clinical staff.

What are the other precautions that facilities can take?
CMS, in its guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes, recommends the following measures:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019.
- Increase the availability and accessibility of alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc. Ensure ABHS is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect, and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurses' stations, phones, internal radios, etc.).