# Virginia Department of Health COVID-19 Webinar 11/9/2022: CDC and CMS COVID-19 Infection Prevention Updates Questions and Answers

**For the signage for visitors who have had close contact with someone positive for COVID-19, what exactly should we be telling them? Would "if you have had close contact with someone positive for COVID-19, please do not visit unless you have tested negative" be sufficient? Or are they not supposed to visit during the entire incubation period?**

- For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet any of the criteria described in Section 2 of CDC guidance (e.g., cannot wear source control).

**Where did it specifically say screening is no longer required? Was that an interpretation of the guidance or on a call with CMS/CDC because there is nothing spelled out in the guidance that states no screening?**

- The CDC/CMS guidance no longer mentions **active** screening. Instead, it outlines what should be in place to ensure everyone entering the facility is aware of recommended actions to prevent transmission to others if they have a positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection. This can be accomplished by **passive** strategies such as signage.

**If the community level is anything but high, does that mean a facility can go maskless? I have a cousin working at a hospital in Texas and they only have to mask when going into rooms.**

- When SARS-CoV-2 Community Transmission levels are not high, healthcare facilities could choose not to require universal source control. However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who:
    - Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
    - Had close contact (patients and visitors) or a higher-risk exposure (healthcare personnel) with someone with SARS-CoV-2 infection, for 10 days after their exposure; or
    - Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or
    - Have otherwise had source control recommended by public health authorities
- Individuals might also choose to continue using source control based on personal preference, informed by their perceived level of risk for infection

**If a resident tested positive on day 32 and is asymptomatic, is it reinfection, new case or continuation? Should the resident be isolated for COVID then?**

- The decision regarding if it is reinfection or continuation of an existing one can be made by consulting the treating physician. Immunocompromised patients might shed the SARS-CoV-2 virus for a long time but that doesn't mean they are infectious.
    - Additional testing might be needed and could include genomic sequencing or viral culture, in consultation with an infectious disease specialist.
- Testing should be considered for asymptomatic patients/residents with close contact with someone with SARS-CoV-2 infection and have recovered in the prior 31-90 days. However, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended; this is because some people may remain NAAT positive but not be infectious during this period. If they test positive by antigen test, they need to be placed on transmission-based precautions.

**Where can we find the new CMS updates for the Infection Control Preventionist?**

- CMS published a revised State Operations Manual Appendix PP - Guidance to Surveyors for Long-Term Care Facilities on 10/26/2022. Numerous sections related to infection prevention and control were updated including F880 (Requirements for the facility's infection prevention and control program) and F882 (Designating a qualified individual who is responsible for the infection prevention and control program; education requirements for this individual)

**Is there a requirement mandating that facilities inform family/visitors if they have an outbreak?**

- Clear communication to patients/residents and visitors is always prudent with any outbreak occurring in a healthcare facility. The only explicit reference to this in the CDC recommendations or CMS guidance is in the CMS visitation memo (9/23/2022) which states that visitors "should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention."

**In my facility we have three separate units. If we have a positive staff or resident who tests positive in that unit we would be in outbreak status. Will the entire facility need to be in outbreak status or just the unit that is affected? Is outbreak status for 10 or 14 days?**

- This depends on the circumstances around the individual who is positive. If it's a nurse who only cares for residents on Unit A, then only Unit A would be affected and in outbreak status. If it's a resident who lives on Unit A but has routine social contact with residents on Unit B, then Unit A and B may potentially be affected, and both would be in outbreak status. The duration of the outbreak will depend on whether additional cases are identified through testing. If this situation arises, work with your local health department to determine the populations at risk and discuss how long outbreak interventions need to remain in place. Per public health surveillance definitions, outbreaks remain open until at least 28 days with no new confirmed or probable cases identified.

**Can you clarify if a new employee is coming on board with no vaccines should they wait until the primary series vaccines are on board?**

- The Virginia Department of Health does not have a specific recommendation on this situation. It would be a facility decision taking into account factors including but not limited to the employee's role, facility staffing needs, and facility policies and procedures.
- Additional information on this situation is provided in Attachment A of the CMS QSO-23-02-ALL memo released on October 26, 2022:
    - §483.80(i)(3)(i): Requires the facility to have a process for ensuring all staff (as defined above) have received at least a single-dose, or the first dose of a multi-dose COVID-19 vaccine series, or have a pending, or have been granted a qualifying exemption, or identified as having a delay as recommended by the CDC, prior to providing any care, treatment, or other services for the facility and/or its residents.
    - §483.80(i)(3)(iii): Requires facilities to ensure those staff who are not yet fully vaccinated, or who have a pending or been granted an exemption, or who have a temporary delay as recommended by the CDC, adhere to additional precautions that are intended to mitigate the spread of COVID-19. Facilities have discretion to choose which additional precautions to implement that align with the intent of the regulation which is intended to "mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated." Facilities may also consult with their local health departments to identify other actions that can potentially reduce the risk of COVID-19 transmission from unvaccinated staff.

**With all these new changes loosening restrictions, will there be changes in requirements to declaring an outbreak or ending an outbreak at nursing homes/LTC facilities?**

- In nursing homes, an outbreak investigation should be initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed, per the CDC recommendations and CMS guidance. Facilities should continue to work with the local health department to determine when an outbreak is over; this is generally considered to be when there are no new cases for 28 days.

**[With new guidance] new admissions are not required to [quarantine] for 10 days (only mask and test 3 times). If a new admission tested positive on day 5th of the admission, could [they] be considered exposed at the facility (if they are in outbreak) as they will have lunch with other residents (without mask while eating)?**

- In this scenario, the new admission (Resident A) who tests positive on day 5 of the admission will have potentially exposed any residents who had close contact with Resident A starting the two days prior to symptom onset (or date of positive test, if Resident A is asymptomatic). Any residents with close contact or healthcare personnel with high-risk exposure to Resident A should be managed as outlined in the CDC recommendations (Section 2: Recommended IPC practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection and Section 3: Setting-specific considerations → Nursing Homes → Responding to a newly identified

SARS-CoV-2-infected HCP or resident). In addition, the facility will need to notify and work with your local health department to evaluate exposures and to investigate if there are any epidemiological links.

**If an employee is positive for SARS-CoV-2 and asymptomatic, when can they work again?**

- For conventional staffing strategies, healthcare personnel who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met:
    - At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test on day 5-7).
        - *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.
    - Source: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)