VDH COVID-19 Guidance for Nursing Homes

On May 8, 2023:

- CDC updated Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. These updates include:
  - Admission testing in nursing homes is at the discretion of the facility, as it already is for other healthcare settings.
  - Facilities are encouraged to look beyond SARS-CoV-2 and make broader masking decisions based on facility-level and patient-level characteristics and local metrics that could reflect increasing respiratory virus transmission in the community.
  - CMS related documents:
- CMS guidance changes:
  - New: CMS Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE)
  - Updated: CMS QSO-20-39-NH Nursing Home Visitation Guidance (5/8/2023)

VDH has revised IPC recommendations for nursing homes to reflect the latest CDC and CMS guidance documents. Updated VDH recommendations are in the following table:

Topic	Summary of Recommendations	Recommending Agency* and Resource Links
General Prevention Measures	● Goals: Early detection of possible infection, swift isolation of ill individuals, and interruption of potential exposure pathways. ○ Assign an individual with training in infection prevention and control to provide onsite management of all COVID-19 prevention and response activities. ○ Because of the end of the federal COVID-19 public health emergency (PHE) on May 11, 2023, CDC will no longer receive data needed to publish COVID-19 Transmission levels. So, facilities should consider performing a risk assessment to determine their IPC recommendations ▪ Incorporate identification of early risk recognition, people/areas with highest exposure risk, and other respiratory viruses ▪ Communicate and coordinate • External: With connected facilities	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

	• Internal: Update policies and procedures, inform and train staff, and audit and monitor implementation and compliance processes ● Facilities should establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: ○ Positive viral test for SARS-CoV-2 ○ COVID-19 symptoms, or ○ Close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP) ● The mechanism, frequency and the type of monitoring of asymptomatic individuals (HCP, residents) is at the discretion of the facility. ● Ensure everyone (HCPs, residents, visitors) is aware of recommended IPC practices in the facility. ○ Post visual alerts like signs & poster at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). ○ These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). ○ Dating these alerts can help ensure people know that they reflect current recommendations. ● Vaccination status is no longer used to inform screening testing, or post-exposure recommendations ● Even as nursing homes resume normal practices, nursing homes must sustain core infection prevention and control (IPC) practices (including HH, PPE, environmental cleaning and disinfection) and remain vigilant for SARS-CoV-2 infection among residents and HCP	

	to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.	
Hand Hygiene	Use alcohol-based hand rub (ABHR) with at least 60% ethanol or 70% isopropanol as the primary method for hand hygiene in most clinical situations. Perform hand hygiene at appropriate times before and after touching a resident, between residents, and frequently during care.	CDC: Clean Hands Count Campaign - https://www.cdc.gov/handhygiene/campaign/index.html Hand Hygiene in Healthcare Settings - https://www.cdc.gov/handhygiene/index.html
Source Control	● Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances: ○ By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or ○ Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission ○ Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high) ● When source control is not universally required, it remains recommended for individuals in healthcare settings who:	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html VDH: Healthcare Setting Guidance – Local Metrics to Determine Broader Use of Source Control: https://www.vdh.virginia.gov/coronavirus/get-the-latest-guidance/health-professionals/#Guidance%20and%20Resources

	○ 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 (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure ● Individuals might also choose to continue using source control based on personal preference, informed by their perceived level of risk for infection based on their recent activities, even if it is not required by their healthcare facility. ● Source control options for HCP include: ○ A NIOSH-approved particulate respirator with N95 filters or higher ○ A respirator approved under standards used in other countries that are like NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) ○ A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks ○ A well-fitting facemask	
Personal Protective Equipment (PPE)	Standard Precautions should be followed for the care of all residents at all times. This involves the practice of hand hygiene and respiratory etiquette, safe injection practices, and the use of PPE when contact with blood, body fluids, wounds, etc. is possible. ● When a staff member needs to enter a resident's room or care area, gloves should be added to Standard Precautions.	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

	• A gown and eye protection should be added when performing an aerosol-generating procedure; during care activities where splashes and sprays are anticipated; or during high-contact resident care activities, such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, or wound care. Proper donning (putting on) and doffing (taking off) procedures must be followed.	Optimizing Personal Protective Equipment (PPE) Supplies - https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
PPE for COVID-19	• If SARS-CoV-2 infection is not suspected in a resident presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions. • If SARS-CoV-2 infection is suspected, HCP should follow Transmission-Based Precautions. The resident must be isolated in their room with the door closed (if safe to do so), and HCP should wear all recommended PPE during the care of that resident. This includes a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) • NIOSH-approved respirators with N95 filters or higher and eye protection should be used for all aerosol-generating procedures • During a COVID-19 outbreak in a nursing home, wider use of N95 respirators might be considered at the discretion of the facility • As SARS-CoV-2 transmission in the community increases, the potential for encountering asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection also likely increases. In these circumstances, facilities should consider implementing broader use of respirators and eye protection by HCP during resident care encounters including:	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html VDH: Considerations for Personal Protective Equipment (PPE) During COVID-19 Response in Long-Term Care Facilities: https://www.vdh.virginia.gov/content/uploads/sites/174/2023/06/PPE-in-LTCF_Revised-1.pdf Healthcare Setting Guidance – Local Metrics to Determine Broader Use of Source Control: https://www.vdh.virginia.gov/coronavirus/get-the-

	○ Use of N95s for all aerosol-generating procedures or when additional risk factors for transmission identified (e.g., resident unable to use source control and area is poorly ventilated) ■ Universal use of N95s might be considered for all resident care encounters or areas of the facility at higher risk for SARS-CoV-2 transmission ○ Eye protection worn during all resident care encounters	latest-guidance/health-professionals/#Guidance%20and%20Resources
Empiric Transmission-Based Precautions	● In general, **asymptomatic** individuals (patients/residents or healthcare personnel) do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. ○ These individuals should still wear source control for 10 days post exposure ○ They should be tested (series of 3 tests) except those who have recovered from SARS-CoV-2 infection in the prior 30 days ○ Monitoring of symptoms ■ Prompt isolation or exclusion from work if symptoms develop or test positive for SARS-CoV-2 ● Empiric Transmission-Based Precautions (or exclusion from work, for HCP) following close contact may be considered in these scenarios: ○ Individual is unable to be tested or wear source control as recommended for the 10 days following their exposure ○ Individual is moderately to severely immunocompromised	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html VDH: Considerations for Personal Protective Equipment (PPE) During COVID-19 Response in Long-Term Care Facilities: https://www.vdh.virginia.gov/content/uploads/sites/174/2023/06/PPE-in-LTCF_Revised-1.pdf

	○ Individual is residing (or cares for patients/residents) on a unit with others who are moderately to severely immunocompromised ○ Individual is residing (or cares for patients/residents) on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions	
Resident Placement	● Place residents with suspected or confirmed SARS-CoV-2 infection in single-person rooms (preferred), ideally with a dedicated bathroom ○ If rooms are shared, only residents with the **same** respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable diseases should also be taken into consideration during the cohorting process. ● Keep door closed (if safe to do so) ● If limited single rooms available, or numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or COVID-19 symptoms, residents should remain in their current location. ● Facility could consider designating an area (e.g., a wing, ward, floor or end of a hallway) to care for residents with COVID-19 ○ A physically separated area with clear signage ○ COVID-19 positive and negative residents should not share common areas or bathrooms ■ Limit transport and movement of the patient outside of the room to medically essential purposes	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html VDH: Considerations for Personal Protective Equipment (PPE) During COVID-19 Response in Long-Term Care Facilities: https://www.vdh.virginia.gov/content/uploads/sites/174/2023/06/PPE-in-LTCF_Revised-1.pdf

	○ Dedicate equipment and staff to each cohort (i.e., all COVID-19 positive or all COVID-19 negative) to the extent possible. If equipment must be shared, clean and disinfect before and after each use. ○ Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift). ○ If possible, HCP working on the COVID-19 care unit should have access to a restroom, break room, and work area that are separate from HCP working in other areas of the facility.	
Environmental Cleaning and Disinfection	● Ensure appropriate environmental cleaning and disinfection of all areas according to a set schedule and as needed whenever environmental contamination may have occurred. ● Use disinfectants approved by EPA for use against the virus that causes COVID-19. Refer to List N on the EPA website, and follow EPA's 6 Steps for Safe and Effective Disinfectant Use. ● High-touch surfaces should be cleaned and then disinfected on each shift. High-touch surfaces include, but are not limited to: bed rails, bed frames, bedside tables, call bells, remote controls, room chairs, and light switches. ● Shared equipment should be cleaned and disinfected before and after each use. ● Cleaning on COVID-19 units may need to be delegated to clinical staff to reduce the number of staff interacting with COVID-19 positive residents. All staff in a unit need to have a clear understanding of who is responsible for cleaning what items and surfaces and the proper methods of doing so to ensure there are no accidental gaps in cleaning services.	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html EPA: 6 Steps for Safe and Effective Disinfectant Use - www.epa.gov/sites/production/files/2020-04/documents/disinfectants-onepager.pdf

	● For all cleaning and disinfection products, ensure HCP are appropriately trained on their use and follow the manufacturer's instructions (e.g., concentration, application method, and contact time). ● Once the resident has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.	
Linens and Laundry	Manage laundry, food service utensils, and medical waste in accordance with routine procedures. Wash hands after handling dirty items.	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html Cleaning and Disinfecting Your Facility - https://www.cdc.gov/hygiene/cleaning/facility.html
New Admissions / Readmissions	● Facilities should create a plan for managing new admissions and readmissions. ○ Performance of admission testing is at the discretion of the facility ● Residents with confirmed SARS-CoV-2 infection who have not met criteria to discontinue Transmission-Based Precautions should be placed appropriately (see *Resident Placement* section above).	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html VDH:

	• Residents who leave the facility for 24 hours or longer should generally be managed as a new admission. • Empiric use of Transmission-Based Precautions is generally NOT necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings). Empiric Transmission-Based Precautions may be considered if the resident had close contact with someone with SARS-CoV-2 infection and meets any of the following criteria: ○ Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure ○ Resident is moderately to severely immunocompromised ○ Resident is residing on a unit with others who are moderately to severely immunocompromised ○ Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions • VDH recommendations for discharging hospitalized patients with a COVID-19 diagnosis to long-term care (LTC) are presented as a flow diagram. Discharge decisions are based on clinical status and the ability of the accepting facility to meet care needs and adhere to infection prevention and control practices. • Meeting the criteria for discontinuation of transmission-based precautions is not a prerequisite for discharge from the hospital.	Recommendations for Hospitalized Patients Being Discharged to a Long-Term Care Facility During the COVID-19 Pandemic – https://www.vdh.virginia.gov/content/uploads/sites/174/2023/06/VDH-hosp-to-LTCF-transfer-guidance_updated-2.pdf

Visitation	• The facility's policies regarding face coverings and masks should be based on risk assessment, recommendations from the CDC, and state and local health departments.
	• Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19.
	  ○ Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation.
	  ○ For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
	  ■ Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
	• During peak times of visitation and large gatherings (e.g., parties, events) facilities should encourage physical distancing.
	• If indoor visitation is occurring in areas of the facility experiencing transmission, it should ideally occur in the resident's room. The resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit.
	• More information about visitation is available in the CMS guidance.
		CMS:
		
		Visitation Guidance for Nursing Homes - https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

Testing	• Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible • Asymptomatic residents with close contact with someone with SARS-CoV-2 infection should have a series of **three** viral tests for SARS-CoV-2 infection. ○ Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. • Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days • Testing should be considered for those who 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.	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html CMS: LTC Facility Testing Requirements - https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf

Routine Screening Testing in Nursing Homes	• Routine testing of asymptomatic staff is no longer recommended but may be performed at the discretion of the facility.
	• However, facilities should instruct their staff, regardless of their vaccination status, to report any of the following criteria to occupational health or another point of contact designated by the facility so they can be properly managed:
	  ○ A positive viral test for SARS-CoV-2, or
	  ○ Symptoms of COVID-19, or
		CDC:
		Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
		CMS:

	○ A higher-risk exposure to someone with SARS-CoV-2 infection ● Screening testing for new admissions to nursing homes is at the discretion of the facility. ● Generally, screening testing performed in areas with lower levels of SARS-CoV-2 community transmission will likely have lower yield. ○ Results may continue to be useful in certain situations to inform the type of infection control precautions used. Examples: ■ When performing higher-risk procedures to determine what PPE to use ■ For healthcare personnel caring for patients who are moderately to severely immunocompromised to help determine room assignments/cohorting	Long-Term Care Facility Testing Requirement-Revised: https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf
Outbreak Investigations in Nursing Homes	● An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. ● An outbreak investigation would NOT be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP is discontinued. ● Outbreak response should be coordinated with the local health department. ● Facilities have the option to perform outbreak testing through two approaches: contact tracing or broad-based (e.g. facility-wide, unit or floor) testing. More info is available in the CDC guidance.	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html CMS: Long-Term Care Facility Testing Requirement-Revised: https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf

	• Upon identification of a single new case of COVID-19 infection in any staff or residents:
	  ○ Testing should be conducted for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
	  ○ Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
	  ○ Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Antigen tests recommended if recovered from SARS-CoV-2 infection in the prior 31-90 days.
	• Testing might be conducted for multiple pathogens during outbreaks of respiratory illness, especially during influenza season.
	• If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility.
	• As part of the broad-based approach, testing should continue affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
		VDH:
		COVID-19 Outbreak Response Method in LTCFs - https://www.vdh.virginia.gov/content/uploads/sites/174/2023/06/COVID-19-Outbreak-Response-Method-in-LTCFs_Revised-2.pdf

Vaccination Planning	• Facilities should encourage their staff and residents to get vaccinated against SARS-CoV-2. • Weekly vaccination numbers of nursing home residents and HCP should be reported into the CDC National Healthcare Safety	CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic -

	Network (NHSN) LTCF Weekly HCP & Resident COVID-19 Vaccination module. ● Provide influenza vaccination for all residents and staff for the current influenza season. Consider tracking and monitoring weekly influenza vaccination data for residents and staff through NHSN.	https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html Weekly COVID-19 Vaccination Data Reporting (NHSN) - https://www.cdc.gov/nhsn/ltc/weekly-covid-vac/index.html Weekly Influenza Vaccination Data Reporting (NHSN) - www.cdc.gov/nhsn/ltc/vaccination/index.html VDH: Influenza Information for Healthcare Professionals and Facilities - https://www.vdh.virginia.gov/epidemiology/influenza-flu-in-virginia/influenza-information-for-healthcare-professionals-and-facilities/
Communication	● Routinely update residents and families about the status of COVID-19 and pandemic response activities in the facility. ● Discuss concerns about disease, infection prevention, laboratory testing, etc. with the local health department.	VDH local health department contact information - https://www.vdh.virginia.gov/local-health-districts/
Reporting	● Facilities are required to report suspected or confirmed outbreaks ○ Outbreak reporting portal ● Physicians and directors of medical care facilities (i.e., hospitals, nursing homes): report when a person who is infected with or who is suspected of having COVID-19 is treated or examined, and if the person is hospitalized or admitted to an ICU ○ Submit data electronically within 3 days (online confidential morbidity report portal or electronic case reporting)	CDC: NHSN LTC Module - www.cdc.gov/nhsn/ltc/covid19/index.html LTC Module Enrollment - www.cdc.gov/nhsn/ltc/covid19/enroll.html

	• Negative and inconclusive SARS-CoV-2 test results, for both PCR and antigen test results, and all antibody testing results are no longer required to be reported. • For CMS-certified LTCFs, COVID-19 reporting to NHSN continues after the COVID-19 public health emergency ends.	CMS: Requirements for Reporting SARS-CoV-2 Test Results - www.cms.gov/files/document/qso-20-37-clianh.pdf VDH: Virginia *Regulations for Disease Reporting and Control* (12 VAC 5-90-80) Outbreak Reporting Portal - https://redcap.vdh.virginia.gov/redcap/surveys/?s=M3YRJPNRHP Point of Care (POC) Reporting Portal - apps.vdh.virginia.gov/POCreporting
Training	Before providing care to a person with COVID-19, HCP must: 1) Receive comprehensive training on when and what PPE is necessary, where PPE is located, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE. 2) Get fit-tested for N95 respirator use if providing direct care to residents with suspected or confirmed SARS-CoV-2. 3) Demonstrate competency in performing appropriate infection prevention and control practices and procedures.	CDC: LTC mini webinars: • Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig • Clean Hands - https://youtu.be/xmYMUly7qiE • Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA • Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw CMS:

		CMS/CDC Fundamentals of COVID-19 Prevention Training - qioprogram.org/cms-cdc-fundamentals-covid-19-prevention-nursing-home-management

*CDC and CMS are continually updating guidance; recommendations may change accordingly. Additional tools and resources may be found on the HAI Infection Prevention Information and Resources for LTC website: https://www.vdh.virginia.gov/haiar/ip/infection-prevention-resources-by-setting/long-term-care-settings/

Revision History:

On September 23, 2022:

- CDC made the following changes to guidance documents for COVID-19 infection prevention and control (IPC) recommendations in healthcare settings including nursing homes:
  - Updated
    - COVID-19 IPC Recommendations for Healthcare Personnel
    - Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
    - Strategies for Mitigating Healthcare Personnel Staffing Shortages
  - Archived
    - Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes
- CMS updated the following documents:
  - Nursing Home Visitation - COVID-19 (REVISED) (QSO-20-39-NH REVISED)
  - Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements (QSO-20-38-NH REVISED)

Agency Acronyms:

CDC – Centers for Disease Control and Prevention
CMS – Centers for Medicare and Medicaid Services
EPA – Environmental Protection Agency
VDH – Virginia Department of Health