VDH VIRGINIA DEPARTMENT OF HEALTH

VDH COVID-19 Interim Guidance for Long-Term Care Facilities

Updated June 19, 2020

Table of Contents:

Changes Made Since Last Version:

- Added section on hand hygiene
- Added information to further clarify recommendations related to cohorting, PPE use (especially related to gowns), and cleaning and disinfection
- Revised language to reflect the lifting of restrictions during phased reopening in accordance with the Forward Virginia and the VDH Nursing Home Guidance for Phased Reopening
- Differentiated nursing home recommendations from those for other LTCFs where applicable

Long-term Care Facility Guidance for COVID-19 – KEY POINTS

Educate

- Train staff
  - Sick leave policies – stay home when sick
  - Expectations for health monitoring and illness reporting
  - Personal protective equipment (PPE) – gloves, gowns, goggles/face shields, masks
    - How to don and doff PPE properly
    - Fit-testing for respirators (e.g., N95) as necessary for role
- Explain facility plan for health monitoring, illness reporting, and expected response to illness to residents and their families.

Surveill

- Screen all employees upon arrival at the facility on every shift for symptoms of COVID-19
- Check on each resident for signs of illness every shift, during waking hours
- Report illness to designated person
- Follow VDH recommendations for laboratory testing

Isolate

- Send ill staff home
- Place ill residents in private room with door shut or in COVID-19 unit in nursing home
- Separate people – restrict meals and activities, limit visitation and non-essential services, maintain social distance, depending on reopening phase that is in effect

Protect

- Cloth face coverings on all residents and facemasks on all staff all the time they are in the facility
- Hand hygiene – alcohol-based hand rub; soap and water if visibly soiled. Gloves if enter resident room or care area
- Add gown and eye protection if high contact, splashes or sprays possible, aerosol-generating
- Fit-tested respirator if aerosol-generating procedure and wearer has been fit-tested
- All the above PPE (respirator if available) when caring for possible COVID-19 patient
- All the above PPE (respirator if available) for all resident care during an outbreak
- Environmental cleaning and disinfection of all high touch surfaces on every shift
- Dedicate space and staff to care for residents with COVID-19 in nursing homes

Collaborate

- Call local health department if concerned about level of illness or a case of COVID-19 is confirmed or suspected
  - Review infection control practices and outbreak prevention and management
  - Plan for public health laboratory testing
  - Develop plan for communicating with families and the public

INTRODUCTION:

Governor Northam and the Virginia Department of Health (VDH) have released Nursing Home Guidance for Phased Reopening (6/19/2020). This document has been updated to reflect those expectations for nursing homes. Because the pandemic has an impact on all of Virginia's long-term care facilities (LTCFs), directors of other LTCFs that are not nursing homes are encouraged to assess their ability to implement these best practices and follow as many recommendations included in this guidance as possible as well as any reopening plans issued by their licensing agency. Expectations for nursing homes have been distinguished from best practices for others throughout this guidance document.

LTCFs include but are not limited to:

- Nursing homes/skilled nursing facilities,
- Residential rehabilitation facilities,
- Assisted living facilities (ALFs) and memory care units,
- Residential behavioral health facilities, and
- Facilities providing hospice services.

By this point in the pandemic, directors of these facilities are familiar with the disease and have implemented measures to prevent its entry into the facility and/or control its spread and protect staff and residents if the disease is identified. This document will highlight some measures that should already be in place and additional steps that should be taken during this time when a state of emergency is in effect for Virginia. The guidance is based on recommendations of the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS), and summarizes COVID-19 best practices known to date. Individual facilities may need to tailor guidance to meet their specific needs. Additional resources are listed throughout the document, with some of utmost importance provided as a resource list at the end of the document.

COVID-19 has been shown to be particularly severe in persons aged 65 years or older and those with underlying medical conditions, such as chronic heart and lung disorders or conditions that weaken the immune system and to spread easily among persons in close quarters, putting LTCFs at higher risk of severe disease and rapid spread. To date, there is no vaccine and no specific antiviral medicine to prevent or treat COVID-19. Thus, it is vital for LTCFs to implement and strictly adhere to all recommended measures to prevent and control this disease.

TRAINING:

- Audiences: staff, residents, families
- Topics:
    - Symptoms of COVID-19
        - Note: the primary symptoms of COVID-19 have been reported to be fever (temperature $\geq$ 100°F), a new or changed cough, and shortness of breath. However, as more information has come out about the disease, additional symptoms have been noted, including chills, muscle pain, new loss of taste or smell, vomiting or diarrhea, and sore throat. Furthermore, residents of LTCFs with COVID-19 may show atypical symptoms, such as new or worsening malaise (tiredness or discomfort), new dizziness or increased falls, or mental status change such as confusion.
        - Any change in a resident's behavior that could indicate a new infection should prompt isolation and further evaluation for COVID-19.
    - How to monitor and report related illness
    - Importance of social distancing
    - Hand hygiene, respiratory hygiene/cough etiquette
    - Proper use of masks and other forms of personal protective equipment (PPE)
    - Facility's anticipated response to COVID-19-like illness during the pandemic

- Additional Topics for Staff:
    - Sick leave policies for staff
    - Plan for regular temperature checks and symptom screening upon arrival on each shift
    - Expected actions if symptoms are identified upon screening or develop while the staff person is at work
    - Extensive training on PPE use for any staff person who might provide care for patients with confirmed or suspected COVID-19.
        - Before providing care to a person with COVID-19, healthcare personnel (HCP) must: 1) Receive comprehensive training on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE. 2) Get fit testing for respirator use if providing direct care for COVID-19 positive residents. 3) Demonstrate competency in performing appropriate infection control practices and procedures.
        - See links to CDC training webinars on next page
    - Cleaning and disinfection methods, timing, and responsibility

- Resources to Assist with Training:
    - Symptoms of Coronavirus - CDC poster – https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf
    - Employee Screening Form - VDH - (See Attachment 1)
    - Hand hygiene - VDH fact sheet - http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/HandHygieneFactSheet.pdf
    - Cover Your Cough - VDH poster – https://www.vdh.virginia.gov/content/uploads/sites/3/2016/01/CoverYourCoughSign.pdf
    - CDC poster - PPE for COVID-19 - https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
    - **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
        - PPE Lessons - https://youtu.be/YYTATw9yav4

Symptoms of COVID-19

- Fever (temperature $\geq$ 100°F),
- Cough (new or different),
- Shortness of breath,
- Chills,
- Muscle pain,
- New loss of taste or smell,
- Vomiting or diarrhea
- Sore throat

ATYPICAL SYMPTOMS IN OLDER PERSONS:

- New/worse tiredness or discomfort
- New dizziness, increased falls
- Confusion

WATCH FOR ANY CHANGE THAT MIGHT INDICATE A NEW INFECTION

SUPPLY INVENTORY, ESTIMATION OF ANTICIPATED USE, ASSURANCE OF SUPPLY CHAIN, AND PLANS FOR SHORTAGES OR HEAVY CASE LOADS:

- Plan for surge capacity to ensure adequate staffing in case shortages occur

- Inventory supplies needed and identify locations for storage and distribution:
  - Hand and respiratory hygiene
    - Supplies and locations of alcohol-based hand rub (with 60% ethanol or 70% isopropanol), soap, paper towels, tissues, trash cans
  - Personal protective equipment (PPE)
    - Facemasks and respirators, gowns, gloves, and eye protection
  - Environmental cleaning and disinfection
    - Use products approved by EPA for use against the virus that causes COVID-19
    - Refer to List N on the EPA website

- Estimate expected usage of the above supplies, based on:
  - Facility recommendations for use of face coverings, facemasks, and fit-tested respirators
  - Number of COVID-19 cases in the facility
  - PPE Burn Rate – Calculate using the CDC tool at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html
  - Scheduled mass testing (baseline, serial, Point Prevalence Survey (PPS)) events
  - Environmental cleaning and disinfection expectations based on facility's schedule and assignments of responsibility

- Discuss supply availability with supply chain vendors
  - If necessary, identify alternate sources for necessary supplies
  - Plan for extended use or reuse of items, according to CDC and VDH recommendations – (See Attachment 2)
  - If unavailable, contact your Regional Healthcare Coalition for advice https://vhass.org/regional-info/

- Nursing homes must plan to designate a portion of the facility (e.g., a wing or end of a hallway) to care for residents confirmed to have COVID-19. When cohorting residents, and if facility space allows, it is recommended to cohort known COVID-19 positive residents, cohort new admissions with an unknown status, and cohort current, healthy asymptomatic residents, separately from each other with designated staffing for each group. The cohorting areas should be physically separated from the rest of the care areas in the facility with clear signage. An additional observational unit/care area would consist of private rooms for housing residents with unknown COVID-19 status, symptomatic residents who tested negative for COVID-19, and roommates of COVID-19 positive residents or others considered exposed.
  - Ensure adequate staffing and supplies for each designated area. Staff and supplies, including equipment, would be dedicated to that area and not used in other parts of the facility.
  - If equipment must be shared, a plan must be in place for cleaning and disinfecting it.

- Determine what type of care can be provided at the facility, how it will be provided and by whom, and what measures will be taken if a resident's need for care exceeds facility capacity.

- Nursing homes must assign at least one individual with training in Infection Prevention and Control to provide on-site management of COVID-19 prevention and response activities. This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services.

RESTRICTED ACCESS AND SOCIAL DISTANCING:

- Restrict access to the premises by visitors, volunteers, and non-essential HCP, depending on the reopening phase in effect at the time. This part of the nursing home reopening guidance is recommended for all LTCFs.
    - Alternate means of communication with family members should be planned, such as by phone or electronic conferencing technology.
    - Use signage to explain restricted access to the facility and communicate directly with families of residents.
    - Permitting visitation for compassionate care in end-of-life situations may be considered on a case-by-case basis during reopening phases when visitation is not allowed. Limited visitation is at the discretion of each facility based on their temporary visitation policy and capacity for implementation. If allowed, the visitor must be screened for fever and symptoms prior to the visit and excluded if illness is identified. The visitor must wear a mask and perform hand hygiene upon arrival and visit only the resident's room.
    - Facility directors should determine which services are essential and which can be deferred. A rule of thumb would be to restrict any person who provides a service that is not medically necessary. Some persons who provide services to residents of a LTCF work at a number of different facilities and thus may pose a risk of introducing the virus into the facility.
        - For example, a facility director may determine that the services of barbers, musicians, pet therapists, clergy, volunteers, and others who usually enter the facility routinely are not medically necessary and restrict them from entering the facility during the pandemic.
        - The services of other providers, such as podiatrists and wound care specialists, may be deemed essential and those providers allowed entry when their services are medically necessary.
        - Anyone permitted to enter the facility must be screened for temperature and symptoms upon arrival and their movement within the facility and interactions with residents kept to a minimum.
        - Lifting of these restrictions can occur in accordance with the nursing home reopening guidance and the Forward Virginia phase in effect at the time. Examples of ways to relax restrictions for visitors include having visitation only at set hours, for a limited number of visitors, at scheduled times, and in a designated location.
- Provide for meal service, group activities, and field trips in accordance with the nursing home reopening guidance and the Forward Virginia phase in effect at the time. Examples of ways to relax restrictions for dining and group activities include having a limited number of residents participate, rotate schedules to give everyone an opportunity, allow dining and group activities with social

distancing, using face covers to the extent possible. This could be established for persons who do not have COVID-19, including those who have recovered from the disease.

- Maintain social distancing
    - Social distancing means keeping six feet between staff members, between staff and residents, and between residents
    - Staff should be reminded that this pertains to staff interactions in break rooms, hallways, and common areas

STAFF SCREENING AND ASSIGNMENTS:

- Ill HCP, other staff, or vendors are potential sources of introduction of COVID-19 to the facility. That is why symptom screening for anyone who enters a LTCF is important, to identify symptoms of fever or any symptoms compatible with COVID-19 as early as possible and prevent the virus that causes COVID-19 from entering the facility. In addition, everyone entering the facility should wear a facemask/cloth mask which provides a universal source control and serves as a physical barrier to prevent respiratory pathogens including SARS-CoV-2 from being introduced, persons being exposed, or the environment being contaminated in a facility.
    - EMS providers entering in response to an emergency are exempt from this screening requirement but they have to be wearing a facemask. “They do not have to be screened, as they are typically screened separately.” (CMS, 4/2/2020)
- Staff should be aware of and follow facility sick leave policies that encourage them to stay home when they are ill. They should be aware of the signs and symptoms of COVID-19 (especially fever, cough, shortness of breath, and sore throat), monitor themselves for the development of these symptoms, and know the procedures for reporting illness to a facility designee.
- Upon arrival at the facility, each HCP should be asked about symptoms and have his or her temperature taken. Use of non-touch, non-oral options for temperature checks is recommended, such as a temporal thermometer that uses an infrared scanner to measure the temperature of the temporal artery in the forehead. Devices need cleaning and disinfection between each use.
- Temperature and absence of symptoms should be documented. The form provided as Attachment 1 can be used to collect this information.
    - If staff are ill, they should not be allowed in and should be sent home.
- If symptoms develop while at work, the ill staff member should keep a facemask on, report the illness to the supervisor or other facility designee, and go home.
- Staff should maintain social distancing with each other (including in break rooms and common areas) and with residents.
- Assign staff to care for certain residents and maintain those staffing assignments throughout the pandemic to the extent possible. This will ensure the staff are most familiar with the residents under their care and increase the chances that they will be able to detect a change in the residents’ health status. It also minimizes the number of staff interacting with a given set of residents. The number of face-to-face encounters with the residents should be minimized, too, and limited to those necessary to assure the care and well-being of the residents.

HAND HYGIENE

- Hand hygiene is an important practice to prevent the spread of COVID-19.
- CDC continues to recommend the use of alcohol-based hand rub (ABHR) with 60% ethanol or 70% isopropanol as the primary method for hand hygiene in most clinical situations. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare personnel after brief interactions with patients or the care environment. In addition, frequent use of ABHS formulated with emollients is less damaging to the skin than frequent hand washing. This factor, along with ease of use and greater access, leads to greater overall compliance with use of ABHR than hand washing with soap and water. (www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html)
- Hands should be washed for at least 20 seconds with soap and water when visibly soiled, before eating, and after using the restroom. (FAQ on Hand Hygiene). If ABHR is not available, soap and water is an acceptable alternative.
- It is important to make sure that hand hygiene is performed at the appropriate times before and after touching a resident, between residents and frequently during care. Resources to improve hand hygiene are located on the Clean Hands Count website.

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE), General Considerations:

- At this time of Public Health Emergency and widespread community transmission, it is recommended that **all HCP in every LTCF wear a facemask while in the facility**.
    - This serves a dual purpose of preventing entry of the virus into the facility and protecting staff from splashes and sprays of infectious material.
        - This is an example of what CDC refers to as “source control”, which is a physical measure taken to prevent respiratory pathogens including SARS-CoV-2 from being introduced, persons being exposed, or the environment being contaminated in a facility. An example of source control includes recommending cloth face covering for visitors and masking for HCP.
    - HCPs should wear a cloth face covering when outside the facility, change into a facemask when they enter the facility, wear facemasks while on duty, and change into a cloth face covering when they exit the facility.
        - Cloth face coverings are not PPE. They help prevent entry of the virus into the facility but do not offer the HCP a higher level of protection from exposures while at work.
    - A facemask can be a surgical mask, which has been approved by the FDA, or a procedure mask, which is not regulated by FDA. A surgical mask should be worn if splashes or sprays are anticipated and supplies are adequate. The most important thing is for staff to wear a facemask at all times when they are in the facility.
    - This recommendation for use of facemasks by HCPs applies as long as supplies are available. Other means of covering the nose and mouth might need to be taken during times of shortage, especially by residents or non-clinical staff members. More information on PPE use in times of shortage is provided in a section of this document below and in Attachment 2.
        - If facemasks are in short supply, they should be prioritized for direct care personnel.

    - N95 respirators, to the extent they are available, should be prioritized first for staff performing an aerosol-generating procedure (e.g., nebulizer therapy), followed by those caring for residents with COVID-19. They should be used only by staff who have been fit-tested and trained in their use. OSHA has waived the requirement for the annual fit-test, but an initial fit-test with the same respirator is still required (https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit). Other NIOSH-approved respirators may also be used.
- Description of other forms of PPE:
    - Gloves should always be changed between residents and hand hygiene performed by those providing care to the resident. No extended use options are offered for gloves.
    - Eye protection means goggles or a face shield. They come in disposable and reusable forms. If reusing, careful steps need to be followed for cleaning and disinfecting.
    - Gowns can be disposable isolation gowns or washable cloth gowns. Surgical gowns should be reserved for surgeries and sterile procedures. A lab coat is not a substitute for a gown. A person wearing a lab coat should wear a gown on top of it and change the gown as recommended.
    - Recommended use of these items is described in the next section.

USE OF PPE, Specific Situations:

- 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.
- The addition of items of PPE beyond Standard Precautions is referred to as Transmission-based Precautions because they protect the staff member and resident based on ways the virus is transmitted (spread). That is, use of gowns and gloves can protect against the virus spreading through touching the ill person or contaminated items; the use of facemasks can protect against the virus spreading through droplets that are released when an infected person coughs or sneezes; the use of a fit-tested respirator (such as an N95) can protect against the virus spreading if it is released into and spread through the air, such as in aerosol-generating activities.
- A facemask should be worn by all staff while in the facility. Additional PPE should be worn in the situations described below. In situations in which PPE is recommended, staff should not substitute a cloth face covering in place of the recommended respiratory protection.
    - When a staff member needs to enter a resident's room or care area, gloves should be added to Standard Precautions.
    - A gown and eye protection should be added when performing an aerosol-generating procedure; during care activities where splashes and sprays are anticipated; and 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.
    - **If caring for a resident with symptoms of COVID-19**, the resident must be isolated to his or her room with the door closed, and HCP should wear all recommended PPE during the care of

that resident. This includes fit-tested respirator or facemask (if fit-tested respirator is not available or fit-testing has not been conducted for a staff member), eye protection (i.e., face shield that covers the front and sides of the face or goggles), gloves, and a gown.

- If COVID-19 is identified in the facility or sustained transmission is occurring in the community, restrict all residents to their rooms (to the extent possible) except for medically necessary purposes. HCP should wear all recommended PPE for care of all residents in the affected unit or facility-wide depending on the availability of PPE and the prevalence of COVID-19 in the facility specifically and in the local community in general**.** Staff must don gloves, fit-tested respirator or facemask, eye protection, and gown for care of all residents on the affected unit (or facility-wide depending on the situation). Source: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
- When leaving the room in any of these scenarios, in a time of PPE supply availability, gloves, facemask, gown, and goggles/face shield should be removed according to prescribed doffing procedures. Disposable items should be put in a trash can provided near the exit of the room, and washable items placed in a plastic bag and taken to the area designated for such laundry. The staff member should perform hand hygiene.
- Gowns and gloves should not be worn in common areas. Staff should doff and discard them and perform hand hygiene before entering common areas.
- The facility should appoint trained staff members to continually observe PPE use and correct behaviors on all shifts to ensure proper use and safety.

Use of PPE, Summary Table:

What to Perform/Wear in Different Situations in Long-Term Care

When	Hand Hygiene	Facemask	Gloves	Gown	Eye Protection	Fit-tested Respirator
All residents, all the time	X	X				
Within resident room or care area	X	X	X			
High contact activity	X	X	X	X	X	
Splash/spray possible	X	X	X	X	X	
Aerosol-generating procedure[1]	X	X	X	X	X	X
Caring for a COVID-19 patient	X	X	X	X	X	X[2]
All residents if outbreak*	X	X	X	X	X	X[2]

[1] Such as suction, ventilation, CPR, nebulizer treatments, etc.

[2] If available, otherwise wear facemask

*If the outbreak is limited to one wing/floor, and the PPE supply is limited, only HCPs providing resident care in that area need to wear all recommended PPE

EXTENDED USE OF PPE:

- In a time of shortage of PPE supplies, the facility may need to change disposal recommendations to extend the use of items in short supply.
    - No extended use or reuse option is available for gloves. Staff providing care to residents need to change gloves and perform hand hygiene between residents.
    - Facemasks, eye protection, and gowns have extended use options.
        - Extended use means keeping them on between residents or reusing items each time a person provides care for the same resident.
        - Any item of PPE should be removed and discarded if it becomes soiled, damaged, contaminated with blood or body secretions, or used in an aerosol-generating procedure.
        - It is important for staff to not touch the item of PPE while wearing it and to not touch their face. If the item or face is touched, hand hygiene needs to be practiced immediately.
    - Recommendations for extended use of gowns are as follows:
        - Allow reuse of gowns across more than one resident if they have the same diagnosis (e.g., in a COVID-designated unit), but NOT if a resident has another diagnosis, such as a multi-drug resistant organism (MDRO) or *Clostridium difficile* infection.
        - HCPs should not reuse gowns across residents who do not have the same diagnosis (e.g., in a mixed unit)
        - If gowns are in limited supply and residents have unknown COVID-19 status, limiting use of gowns to high-touch activities (e.g., bathing) and not across residents may be considered
        - Other practices such as a gown per resident's room are not encouraged due to the high risk of self-contamination (less risky is the practice of a gown per staff member per resident but there still exists a risk of self-contamination)
- More severe measures may be considered if PPE supplies reach a crisis point.
    - Examples include limiting use of items to situations where splashes are anticipated or close contact will be prolonged or substituting other products, such as safety glasses, lab coats or patient gowns, or cloth masks.
    - At these times, staffing changes may also be considered to protect the workforce, such as excluding HCP who are at high risk for severe illness with COVID-19 (over age 65 years, have underlying medical conditions that increase their risk; https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html) from caring for residents with COVID-19 and having HCP who have recovered from the disease provide care to residents with COVID-19. All disease control recommendations (e.g., screening, use of PPE) would remain in effect for everyone providing care to residents, even those who have recovered from the disease.
    - If such critical shortages occur, consult with an infection preventionist or local health department for the best ways to protect staff and residents.
- More detail on optimizing the supply of PPE is available in Attachment 2 and on CDC's website (Strategies to Optimize the Supply of PPE and other Equipment).

Extended Use of PPE in Times of Supply Shortages

- Not possible for gloves – always change gloves between residents when providing care
- Facemasks, eye protection – can keep them on between residents or reuse when caring for the same resident
- Gowns – limit use to high-touch activities, reuse for residents with same diagnosis only
- Remove and discard items that become soiled, damaged, contaminated with blood or body secretions, or used in an aerosol-generating procedure
- Don't touch item of PPE or face while wearing

RESIDENT SCREENING, MOVEMENT, AND MASKING:

- Actively screen all residents on each shift (during waking hours) for symptoms compatible with COVID-19. Take their temperature at least once per day. Immediately isolate anyone who is symptomatic.
- Watch for any change in the resident that might indicate a new infection. Symptoms may include:
    - Fever (temperature $\geq$ 100°F),
    - Cough (new or different),
    - Shortness of breath,
    - Chills,
    - Muscle pain,
    - New loss of taste or smell,
    - Vomiting or diarrhea
    - Sore throat
    - In addition, atypical symptoms may occur in older persons:
        - New/worse tiredness or discomfort
        - New dizziness, increased falls
        - Confusion
- Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- Check on residents with symptoms more frequently to allow for the early detection of any decline in health status and need for a higher level of care.
- Report any new or worsening illness to facility nursing or other staff according to facility protocol.
- Resident movement, activities, and meal service should be provided in accordance with the nursing home reopening guidance and Forward Virginia phase in effect at the time.
    - They should be allowed to leave the facility for medically necessary purposes.
    - If a resident leaves the room, he or she should cover the nose and mouth if possible (facemask preferred as long as supplies permit, otherwise use a cloth covering). This applies if a resident needs to leave the facility to visit other medical facilities, such as transport to a hemodialysis facility.
    - If residents are outside their rooms, staff should ensure they remain 6 feet apart, have their nose and mouth covered (facemask preferred as long as supplies permit, otherwise use a cloth covering), return to their rooms as soon as possible, and wash their hands upon return.
    - Residents should cover their nose and mouth when a staff member is present in their room. This can be done with tissues or a cloth mask.
        - A resident needs to wear a facemask while in their own room only if COVID-19 is suspected or confirmed.
- If COVID-19 occurs in a resident of the facility, family members should be notified. The attached sample letters from the Virginia Health Care Association and LeadingAge Virginia may be used as a template (See Attachment 3).

IF ONE CASE OF COVID-19 OCCURS WITHIN THE FACILITY:

- Any staff member who identifies any symptoms of COVID-19 in a resident needs to report it to nursing, the supervisor, or other person designated to receive these illness reports in the facility.
- Any ill staff member who develops these symptoms should report it to the supervisor or other designee, be sent home with a facemask on, and self-isolate at home.
    - They should be tested as soon as possible and residents they cared for while symptomatic or during the 48 hours before symptom onset restricted to their rooms and cared for by staff wearing full COVID-19 PPE.
    - If they test positive, the residents they cared for should be cared for by staff wearing full COVID-19 PPE for 14 days and tested if symptoms develop.
    - Other HCP who may have been exposed should be assessed for risk and for the need for exclusion.
    - Testing of exposed residents or HCP or steps to take if more are found to be positive should be discussed with the local health department.
    - Source: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html
- Ill resident:
    - Maintain any ill resident in a private room with the door closed. Arrange for laboratory testing to be done as soon as possible. Nursing home residents who test positive should be moved to the COVID-19 care unit.
    - A resident with suspected or confirmed COVID-19 needs to wear a facemask while anyone else is in their room.
    - Staff entering the room should strictly adhere to PPE recommendations.
        - This includes fit-tested respirator or facemask (if fit-tested respirator is not available or staff member has not been fit-tested), eye protection (i.e., face shield that covers the front and sides of the face or goggles), gloves, and a gown.
    - Monitor residents with symptoms for any new or worsening symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam at least 3 times daily.
- Other residents:
    - 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. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html)
    - Restrict all residents in the affected unit to their rooms (to the extent possible) except for medically necessary purposes.
    - Monitor all residents diligently for any indication of new illness and alert nursing, the supervisor, or other person designated to receive these illness reports in the facility if any are detected.

- Facility management, in consultation with the local health department, may institute additional policies, including halting admissions, increasing monitoring of ill residents, and having HCP wear all

recommended PPE for care of all residents (regardless of symptoms) in the affected unit (or facility-wide depending on the situation).
    - This includes using fit-tested respirator or facemask (if fit-tested respirator is not available or staff member has not been fit-tested), eye protection (i.e., face shield that covers the front and sides of the face or goggles), gloves, and a gown when caring for all residents on the affected unit (or facility-wide depending on the situation).
- Notify family members.
    - The attached sample letters from the Virginia Health Care Association and LeadingAge Virginia may be used as a template (See Attachment 3).
- Any ill staff person or resident may be tested by the state public health laboratory (DCLS).
    - Specimens should be collected, labeled, packaged, and shipped in accordance with DCLS guidelines (https://dgs.virginia.gov/division-of-consolidated-laboratory-services/updates/hot-topics/) and local health department advice.
- Additional testing will occur for nursing home residents and staff in accordance with the nursing home reopening guidance, including baseline and weekly testing, and may be considered for other LTCFs.
- Nursing homes/skilled nursing facilities must enroll in CDC's National Healthcare Safety Network (NHSN) and enter data on the impact of infections on residents and staff, PPE supplies, and ventilator capacity and supplies to help identify problems and track progress. Other LTCFs are encouraged to do this, too. More details, including instructions on how to enroll in and use the system, are available at https://www.cdc.gov/nhsn/ltc/covid19/index.html.
- Consult with the local health department for further advice.

Reporting Positive COVID-19 Cases

All LTCFs: Notify your Local Department of Health – this is required by state regulation for nursing homes. Outbreak reporting is required for all LTCFs and important for discussing outbreak management and control

Enroll in and report weekly to CDC's National Healthcare Safety Network (NHSN). Required for nursing homes; recommended for other LTCFs

In Addition:
Nursing Homes: The VDH Office of Licensure and Certification requests a Facility Reported Incident (FRI) form

Assisted Living Facilities or Others Licensed by the Department of Social Services:
DSS requests that you notify your DSS inspector

Also consider:

Engaging Your Regional Healthcare Coalition

IF MULTIPLE CASES OF COVID-19 OCCUR WITHIN THE FACILITY:

A COVID-19 outbreak in a LTCF is defined as suspected if one confirmed COVID-19 case and additional related cases with signs or symptoms are identified and as confirmed if two lab-confirmed cases are identified. Outbreaks must be reported to the local health department serving the city or county in which the facility is located as well as to the licensing agency for the facility.

- Coordinate with the local health department for outbreak management and testing to confirm the cause of the outbreak as recommended.
    - Testing of symptomatic residents and staff with direct contact to a confirmed case will be prioritized by public health.
    - Specimens must be collected, labeled, packaged, and shipped according to DCLS guidelines (https://dgs.virginia.gov/division-of-consolidated-laboratory-services/updates/hot-topics/)

In addition to continuing with steps taken prior to an outbreak, take the following actions:

Facility-Wide:

- Ensure appropriate environmental cleaning and disinfection of all areas according to a set schedule Fand as needed whenever environmental contamination may have occurred. Refer to CDC's environmental cleaning and disinfection guidance for healthcare facilities.
    - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified for use against SARS-CoV-2, the coronavirus that causes COVID-19, and follow EPA's 6 Steps for Safe and Effective Disinfectant Use (www.epa.gov/sites/production/files/2020-04/documents/disinfectants-onepager.pdf).
    - 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.
    - Equipment should be cleaned and disinfected after each use.
    - See Attachment 4 for VDH tips on cleaning and disinfection in long-term care. Allow disinfecting agents to have adequate contact time on the surface being disinfected.
    - Cleaning on COVID-19 units may need to be delegated to clinical staff to reduce the number of staff interacting with 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 inadvertent gaps in cleaning services.
- Maintain a line list to organize information about affected residents and staff (See Attachment 5).
- Ensure residents with suspected or confirmed COVID-19 are kept separate from other residents.
    - At a minimum, each should be isolated in his or her room with the door kept closed. Nursing homes will maintain separate units for providing care as noted in the nursing home reopening guidance.
    - If the number of confirmed positive residents increases, any LTCF is encouraged to discuss with your local health department the risks and benefits of using the pre-designated location within the facility where they could be cohorted together with dedicated staff to care for them and dedicated supplies and equipment that stay in that area.
- Wherever care is provided, strictly enforce infection control practices, including use of PPE.
- In an extreme situation in which the number of cases grows to the point where residents ill with COVID-19 symptoms cannot be maintained in an area of a facility, multiple facilities can collaborate to care for ill persons in one or more facility.

  - This would require extensive transfer of residents between facilities and a great deal of discussion with the health department and the facilities involved in advance of implementation.
  - Such moves can be traumatic for residents and staff and potentially be associated with disease transmission so need to be conducted only after careful planning and communication.
  - Terminal cleaning of rooms is needed after a positive resident was removed from the room.
  - CMS has provided guidance that pertains to these scenarios:
    - https://www.cms.gov/files/document/qso-20-25-nh.pdf
- Ensure adequate resources are available, including staff and supplies.
- Monitor ill residents (including documentation of temperature and oxygen saturation via pulse oximetry) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.
- During an outbreak of COVID-19, closure of facilities (e.g., LTCFs and other healthcare settings) to new admissions may be recommended as a standard part of VDH disease control measures. The decision to close a facility to new admissions should be made in consultation with the LHD and shall continue for at least 7 days. The following criteria should be met when making a decision on accepting new admissions or readmissions:
  - The number of COVID-19 cases identified in the facility (staff and residents) is decreasing.
  - No evidence of widespread transmission of COVID-19 in the facility.
  - Facility is compliant with Infection Prevention and Control best practices.
  - For nursing homes - Enough space for cohorting positive versus negative residents and an observational unit for new admissions is available.
  - Adequate staffing, PPE, and other supplies are assured.
  - The facility has a plan to manage new admissions and readmissions.
- Additional testing will be conducted in nursing homes in accordance with the nursing home reopening guidance and may be considered for other LTCFs.
  - Facility-wide laboratory testing to identify residents and staff who test positive for the virus that causes COVID-19 at a given point in time (point prevalence surveys) might be considered, and would need to be discussed with the local health department. (https://www.vdh.virginia.gov/content/uploads/sites/182/2020/04/PPS-Guidance-for-LTCF_Congregated-Settings-FINAL-4-28-2020.pdf).
- Identify and update key messages regarding the status of the outbreak in the facility and coordinate communication among facility and health department spokespersons to ensure current and consistent information sharing.

Staff:

- Strictly enforce universal use of facemasks for HCP while in the facility.
  - Implement pre-established protocols for having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator or facemasks) for the care of all residents, regardless of presence of symptoms.
  - Implement protocols for extended use of eye protection and facemasks, as necessary.
  - Follow all previously described infection control practices.
- Do not allow staff to work across units or floors. Apply this rule to non-clinical staff, including environmental services staff, as well as staff who normally provide services in multiple areas, such as therapists and hospice workers.

  - Depending on the extent of spread, other LTCFs should consider cohorting staff to care for either ill or non-ill residents as is done in nursing homes.
- During an outbreak, it is best to restrict staff from working in more than one facility.
- Ensure consistent monitoring of staff health status, documenting temperature and absence of symptoms upon arrival to the facility. Monitoring must be done for each shift at each entrance to the facility. The form provided as Attachment 1 can be used to collect this information.
- CDC has established criteria for when a HCP with suspected or confirmed COVID-19 can return to work, based on whether or not they had symptoms. The return to work criteria are summarized below and available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html.

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19

Symptomatic HCP with suspected or confirmed COVID-19:

- *Symptom-based strategy*. Exclude 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 **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 10 days have passed *since symptoms first appeared*

- *Test-based strategy.* Exclude from work until:
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)[1].

HCP with laboratory-confirmed COVID-19 who have not had any symptoms:

- *Time-based strategy.* Exclude from work until:
  - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

- *Test-based strategy*. Exclude from work until:
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).

Residents:

- Restrict residents to their rooms except for medically necessary purposes.

  - If they leave their room, residents should wear a facemask, perform hand hygiene, and limit their movement in the facility.
  - Social distancing should be maintained at all times.
- As stated above, ill residents must be confined to their rooms with the door closed. Nursing home care will be provided in special care units depending on symptom status and laboratory test result, as defined in the nursing home reopening guidance. If numbers of confirmed positive residents increases, residents of other LTCFs who are confirmed to have COVID-19 might also need to be cohorted in a specified area within the facility or even a dedicated separate facility for ill persons with dedicated HCP assigned to care for them (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html). These situations should be discussed with the local health department.
- Roommates who have been exposed to a resident with COVID-19 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. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html)
- Admission/Readmission:
  - Virginia has released Guidance on Hospital Transfer and Admission of Patients to Long Term Care Facilities (LTCFs) During COVID-19 Emergency and the Hospital to Long Term Care Facility (LTCF) Transfer – COVID-19 Assessment to aid in decision-making and documentation of transfers between hospitals and LTCFs.
  - That guidance includes a protocol for patients positive for COVID-19 testing (Category 4), which states:
    - An LTCF can accept a new admission and readmission with a diagnosis of COVID-19 and who is still requiring transmission-based precautions for COVID-19 as long as the facility can follow CDC infection prevention and control recommendations for the care of COVID-19 patients, including having adequate staffing levels and adequate supplies of PPE.
    - If transmission-based precautions have been discontinued AND patient's symptoms have resolved, a patient can be discharged back to the facility they came from. Hospital discharge planners should provide advanced notice to the LTCF for any transfer of a patient with COVID-19.
    - CDC's guidance for discontinuing transmission-based precautions is the same as the return to work criteria noted above for staff with COVID-19 and can be found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
    - COVID-19 testing may be conducted based on hospital or health system protocols, but is not required prior to transfer of a resident from an acute care facility to a nursing home (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html)
  - A resident admitted or readmitted to the facility during the pandemic should be placed in a single person room or a separate observation area if their COVID-19 status is unknown. They

may be transferred out of that area in 14 days if no symptoms compatible with COVID-19 develop. All recommended PPE should be worn while caring for residents under observation. Source: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#interim-guidance

- Discontinuation of transmission-based precautions:
  - The criteria for discontinuing transmission-based precautions are the same as those for a HCP returning to work. See text box above for the criteria or refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
  - VDH testing guidance: Clinicians can submit specimens to DCLS to inform the discontinuation of transmission-based precautions using the test-based strategy on healthcare workers, first responders, or persons returning to a congregate setting. Source: https://www.vdh.virginia.gov/coronavirus/health-professionals/vdh-updated-guidance-on-testing-for-covid-19/
- Update communications with family members to keep them informed of the status of the situation in the facility.

Local Health Department:

- The local health department is available to receive case and outbreak reports from the facility and provide the following services in response:
  - Advice regarding disease control measures to institute
  - Assessment of infection prevention practices in place and recommendations for improvement
  - Assistance with data collection and evaluation
  - Information regarding laboratory testing
    - Clinicians can pursue private laboratory testing on any patient for whom such testing is clinically indicated
    - Public health laboratory testing would be offered 1) if a staff member or resident of a long-term care facility develops symptoms compatible with COVID-19, 2) to confirm an outbreak in a long-term care facility, and 3) to conduct a point prevalence survey /baseline testing approved by the health department (https://www.vdh.virginia.gov/content/uploads/sites/182/2020/04/PPS-Guidance-for-LTCF_Congregated-Settings-FINAL-4-28-2020.pdf).
  - Coordination on public messaging
  - Identification of community resources potentially available to meet identified needs (supplies or services)
  - Approval and coordination of point prevalence surveys and advice on steps to take based on the results

Public Health Laboratory Testing

- LTCF resident with symptoms compatible with COVID-19
- LTCF staff with symptoms compatible with COVID-19
- Confirm an outbreak
- Point Prevalence Survey

Consult with your local health department

Attachments:

1. VDH Daily Screening of Healthcare Personnel (HCP) Form
2. VDH Optimization Strategies for Personal Protective Equipment (PPE) in Long-Term Care Facilities
3. VHCA and Leading Age Template Letters for Family Members for Facilities Impacted by COVID-19
    a. VHCAVCAL Template Letter for Family Members if COVID-19 is Diagnosed
    b. LeadingAge – Positive Diagnosis – Letter to Residents and Families
    c. LeadingAge – Positive Diagnosis in Staff – Letter to Residents and Families
    d. LeadingAge – COVID-19 Death – Letter to Residents and Families
4. VDH Guidelines for cleaning and disinfection for SARS-CoV-2
5. VDH Line List for COVID-19 Outbreaks

Key Resources for Additional Information:

Centers for Disease Control and Prevention (CDC):

Preparing for COVID-19: Long-term Care Facilities, Nursing Homes
www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Strategies to Optimize the Supply of PPE and Other Equipment
www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Responding to COVID-19 in Nursing Homes
www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities
www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html

Centers for Medicare and Medicaid Services (CMS):

CMS COVID-19 Long-Term Care Facility Guidance, April 2, 2020
www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf

CMS 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios, April 13, 2020
www.cms.gov/files/document/qso-20-25-nh.pdf

CMS Upcoming Requirements for Notification of Confirmed COVID-19 Among Residents and Staff in Nursing Homes, April 19, 2020
www.cms.gov/files/document/qso-20-26-nh.pdf

CMS Nursing Home Reopening Guidance for State and Local Officials (May 18, 2020)
www.cms.gov/files/document/nursing-home-reopening-recommendations-state-and-local-officials.pdf

Environmental Protection Agency (EPA):

EPA list of disinfectants for use against SARS-CoV-2
www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2