Maricopa County Department of Public Health

COVID-19 Guidance for Long-Term Care Facilities (Updated 5/15/20)

A new respiratory disease – coronavirus disease 2019 (COVID-19) – is widespread in the United States, including in Arizona. **All long-term care facilities (LTCF), including long-term acute care hospitals, skilled nursing facilities, assisted living facilities, rehabilitation facilities, hospice, and group homes,** should assume COVID-19 is in their community, restrict all non-essential visitors to their facilities, and follow the guidance outlined below.

***Symptoms consistent with COVID-19 include:** fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, body/muscle aches, sore throat, headache, and new loss of taste or smell.

Prevent the introduction of respiratory germs INTO your facility:

Ill visitors and healthcare personnel (HCP) are the most likely sources of introduction of COVID-19 into a facility. MCDPH and CDC recommend aggressive visitor restrictions and enforcing sick leave policies for ill staff, even before COVID-19 is identified in a community or facility.

- **Restrict all visitation** except for certain compassionate care situations, such as end of life situations.
    - Decisions about visitation during an end of life situation should be made on a case by case basis, which should include careful screening of the visitor for fever and symptoms consistent with COVID-19*. Those with symptoms should **not** be permitted to enter the facility.
- **Actively screen everyone (including residents, HCP, and visitors) for fever and symptoms** of COVID-19* before they enter the healthcare facility. (This does not include first responders responding to an emergency or call, as they are being screened by their workplace.)
    - **Fever** is either measured as ≥100.4^{o}F or subjective.
- HCP who work in multiple locations may pose a higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.
- **To protect others in case of asymptomatic or pre-symptomatic transmission,** everyone entering the facility (e.g., healthcare personnel, patients, visitors) should wear a mask or cloth face covering.
    - This action is recommended to help prevent transmission from infected individuals who may or may not have symptoms of COVID-19*.
    - Cloth face coverings are not considered PPE because their capability to protect healthcare personnel is unknown. Surgical facemasks, if available, should be reserved for HCP.
    - For visitors and patients, a cloth face covering may be appropriate. If a visitor or patient arrives to the healthcare facility without a cloth face covering, a surgical facemask may be used for source control if supplies are available.
- **Restrict all volunteers and non-essential HCP from entering the facility,** including non-essential healthcare personnel (e.g., barbers, consultants).
- **Cancel** all group activities and communal dining.
- Ensure sick leave policies are non-punitive and **allow employees to stay home if they have symptoms** consistent with COVID-19*.

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Prevent the spread of respiratory germs WITHIN your facility:

Employee-specific guidance

- **Develop a system** to regularly monitor all employees for fever and symptoms consistent with COVID-19*. (For example, employees could be expected to monitor their temperature and any symptoms twice a day or before working a shift.)
- Reinforce that **employees should not report to work when ill.**
- **Reinforce adherence** to standard infection prevention and control measures including hand hygiene and selection and use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing resident care activities.
- **All HCP should wear a surgical facemask at all times while they are in the facility.** Cloth face coverings are not sufficient for HCP as they do not protect the wearer against exposure to splashes and sprays of infectious material from others.
- All HCP should be reminded to **maintain at least 6 feet apart** when in break rooms or common areas, to the extent possible.
- Per CMS Guidance released on April 2, "**When possible,** all long-term care facility residents, whether they have COVID-19 symptoms or not, should cover their noses and mouths when staff are in their room. Residents can use tissues for this. They could also use cloth, non-medical masks when those are available. Residents should not use surgical facemasks unless they are COVID-19-positive or are assumed to be COVID-19-positive."
- Identify dedicated employees to care for COVID-19 patients and provide infection control training.
    - Guidance on implementing recommended infection prevention practices is available in CDC's free online course — The Nursing Home Infection Preventionist Training — which includes resources and checklists for facilities and employees to use.

Resident-specific guidance

- **Monitor** residents for fever or symptoms consistent with COVID-19*.
- **Restrict** residents with fever or symptoms consistent with COVID-19* to their room. If they must leave the room for medically necessary procedures or appointments, have them wear a surgical facemask (if tolerated).
- **Implement** the correct precautions for residents with respiratory infection.
    - For care of residents with an undiagnosed respiratory infection use **Standard, Contact, and Droplet Precautions with eye protection** unless a suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
- Encourage good hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees.
    - Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).
    - Put alcohol-based hand rub in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
    - Make sure tissues and trash cans are available in common areas and resident rooms, and any sink is well-stocked with soap and paper towels for hand washing.

PPE-specific guidance

- Make sure you have a system to track your PPE supply.
    - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.
- Implement strategies to optimize current PPE supply before shortages occur.
    - Bundle resident care and treatment activities to minimize entries into residents' rooms (e.g., having clinical staff clean and disinfect high-touch surfaces when in the room).
    - Extend use of respirators, surgical facemasks, and eye protection, which refers to the practice of wearing the same respirator or surgical facemask and eye protection for the care of more than one resident (e.g., for an entire shift). If this must occur, HCP should perform hand hygiene immediately before and after contact to prevent contaminating themselves or others. Hand hygiene should also occur each time the surgical facemask or face shield is touched as the items become contaminated. **This does not apply to gloves and gowns.**
    - Develop a process for decontamination and reuse of PPE such as face shields and goggles.
- Make necessary PPE available in areas where resident care is provided.
    - Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.
    - Make PPE, including **surgical facemasks, eye protection, gowns, and gloves,** available immediately outside of the resident room.
    - Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.
- Encourage staff to review appropriate donning and doffing of PPE outlined in the CDC video and signage.

Disinfection and cleaning-specific guidance

- Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas.
- Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
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    - Refer to the EPA list for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.

Facility-specific guidance

- Dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with **laboratory-confirmed COVID-19.**
    - Assign dedicated HCP to work only in this area of the facility.
    - To the extent possible, restrict access of ancillary personnel to the unit.
    - To the extent possible, assign environmental services staff to work only on the unit.

- Have a plan for how residents in the facility who develop COVID-19 will be managed (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive).
    - Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them.

Prevent the spread of respiratory germs BETWEEN facilities:

- **Notify facilities prior to transferring** a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- **Report** any possible COVID-19 illness in residents and employees to the local health department.
- **HCP who work in multiple locations may pose higher risk** and should be asked about exposure to facilities with recognized COVID-19 cases.
    - Consider encouraging staff to work at only one facility.
- When transmission in the community is identified, nursing homes and assisted living facilities may face staffing shortages. Facilities should develop (or review existing) plans to mitigate staffing shortages.

Evaluate and Manage Residents with Symptoms Consistent with COVID-19*

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19*.
- Actively monitor all residents upon admission and at least daily for fever and symptoms consistent with COVID-19*.
    - If a resident has fever or symptoms consistent with COIVD-19*, **implement transmission-based precautions, including Standard, Contact, and Droplet precautions with eye protection** unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis). This includes restricting residents with respiratory infection to their rooms. If they leave the room, residents should wear a surgical facemask.
- Residents with fever or symptoms consistent with COVID-19* should:
    - Be prioritized for COVID-19 testing;
    - Be placed in a private room with their own bathroom, if possible;
    - Be monitored more frequently (at least 3 times daily), including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious illness.
- Residents with symptoms consistent with COVID-19* can be tested at the **state public health laboratory or through a commercial laboratory.**
    - To obtain testing through the state public health laboratory, you must contact MCDPH to facilitate testing.
    - You do **NOT** need to call MCDPH to order a commercial COVID-19 test.
- The health department should be notified about residents with severe respiratory infection, or a cluster (e.g., ≥3 residents or healthcare personnel with new-onset respiratory symptoms over 72 hours) of people with respiratory infections.

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When to Report to MCDPH

LTCFs should notify MCDPH about any of the following:

- Resident or HCP with suspected or confirmed COVID-19
- Resident with severe respiratory infection resulting in hospitalization or death, and
- ≥3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

If/When a Resident is Diagnosed with COVID-19 in My Facility

- **Facilities should notify the health department immediately** and follow CDC recommendations for PPE, including use of Standard, Contact, and Droplet precautions with eye protection (i.e., surgical facemask, gown, gloves, and eye protection) for the resident with COVID-19.
- **If the resident may have been exposed in the facility** (i.e., was in the facility at any point during the 14 days before they became symptomatic/were tested), **HCP should wear all recommended PPE (gown, gloves, eye protection, surgical facemask) for the care of all residents, regardless of presence of symptoms.** Implement protocols for extended use of eye protection and surgical facemasks.
- Encourage residents to remain in their room and restrict movement except for medically necessary purposes. If residents leave their room, residents should wear a surgical facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others).
- **Room sharing or placing residents in a dedicated area of the facility ("cohorting")** should be considered if there are multiple residents with known or suspected COVID-19 in the facility.
    - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
    - **Residents who are symptomatic and being tested for COVID-19 should not be roomed** with those who are confirmed to have COVID-19 unless they are already a roommate of a COVID-19 positive resident.
- If possible, **designate a ward or section of the facility for COVID-19 patients with dedicated staff.**
- **Implement protocols for having dedicated healthcare personnel** caring for cohorted residents with COVID-19.
- Isolation of **residents without respiratory symptoms or laboratory-confirmed COVID-19 can be lifted after 28 days** (2 maximum COVID-19 incubation periods) have passed **with no new cases identified in the facility who might have been exposed in the facility** (i.e., resident was in the facility at any point during the 14 days before they became symptomatic/were tested)**. This does not include those who were known to be positive upon admission**.
    - The decision to lift these isolation precautions should be made in partnership with Public Health.

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Accepting Patients/Residents from Higher Acuity Facilities

When accepting/discharging patients/residents from higher acuity facilities, per the Governor's Executive Order 2020-22, the following apply:

- Patients/Residents should be discharged from higher acuity care **based on their clinical needs,** not based on the isolation period for COVID-19 or additional testing.
- Patients/Residents who have **tested COVID-19 positive AND require ongoing isolation** should be isolated for **14 days** after initial admission or readmission to a long-term care facility with COVID-19 isolation precautions.
    - **A patient/resident with symptomatic COVID-19 requires ongoing isolation if they have not completed** the following isolation duration while in a higher acuity facility:
        - At least **10 days** have passed since symptoms first appeared; **-AND-**
        - At least **3 days (72 hours)** have passed since resolution of fever (including fever, chills, rigors, and body/muscle aches) without the use of fever-reducing medications AND improvement in respiratory symptoms (including cough, shortness of breath/difficulty breathing, sore throat, and loss of taste or smell).
    - **A patient/resident without symptoms who tested positive for COVID-19 requires ongoing isolation if they have not completed** the following isolation duration while in a higher acuity facility:
        - At least **10 days** have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not developed symptoms since that test.
    - **However, if there is active transmission of COVID-19 in a receiving long-term care facility,** the discharged patient/resident **should be placed in isolation** in accordance with the long-term care facility guidelines stating **all patients/residents should be in isolation.**
- Patients/Residents with **unknown COVID-19 testing** should be quarantined in their rooms using COVID-19 isolation precautions for **14 days** after admission or readmission to a long-term care facility from an acute care facility.
    - **However, if there is active transmission of COVID-19 in a receiving long-term care facility,** the discharged patient **should be placed in isolation** in accordance with the long-term care facility guidelines stating **all patients/residents should be in isolation.**

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If employees develop any symptoms consistent with COVID-19* they must:

- **Cease contact** with residents.
- **Put on a surgical facemask** immediately (if not already wearing).
- **Notify** their supervisor or occupational health services prior to leaving work.
- **HCP with suspected COVID-19 should be prioritized for testing**

What to do if employees have had a known exposure to COVID-19:

- Allow **asymptomatic** employees to continue to work after consultation with their occupational health program. Use your monitoring system to **ensure exposed employees are monitored daily** for the 14 days after the last exposure.
- All HCP should be wearing a surgical facemask at all times while in the facility, regardless of their exposure history.

***Symptoms consistent with COVID-19 include:** fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, body/muscle aches, sore throat, headache, and new loss of taste or smell.

Communicating with Residents and Families:

- Send letters or emails (example template) to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations.
- Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.
- Educate residents and families including information about COVID-19; actions the facility is taking to protect them and/or their loved ones, including visitor restrictions; and actions they can take to protect themselves in the facility, emphasizing the importance of social distancing, hand hygiene, respiratory hygiene and cough etiquette, and wearing a cloth face covering.
- Have a plan and mechanism to regularly communicate with residents, family members and HCP, including if cases of COVID-10 are identified among residents or HCP.

Additional Resources:

- CDC LTCF Recommendations
- CDC Key Strategies to Prepare for COVID-19 in LTCFs
- CDC Responding to COVID-19 in Nursing Homes
- Testing for COVID-19 in Nursing Homes
- CDC Interim Infection Prevention and Control Recommendations
- CDC COVID-19 Preparedness Checklist
- CDC guidance to assist facilities with mitigating staffing shortages
- CMS COVID-19 Focused Survey for Nursing Homes in the CMS Memo from May 6th
- MCDPH COVID-19 Release from Isolation Guidance

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CMS Requirements*

1) Per CMS memos on April 19th and May 6th, CMS will require Medicare and Medicaid-participating nursing homes to report the following to CDC through the National Healthcare Safety Network (NHSN). Electronic reporting must include, but is not limited to:
   - Confirmed and suspected COVID-19 infections (in both residents and staff), including residents previously treated for COVID-19;
   - Total deaths and COVID-19 deaths (both residents and staff);
   - PPE and hand hygiene supplies in the facility;
   - Resident beds and census;
   - Access to COVID-19 testing while the resident is in the facility;
   - Staffing shortages;
   - Other information as specified by the Secretary;

   Reporting frequency will be specified by the Secretary, but will be **no less than weekly (and on the same day).**

2) CMS also requires Medicare and Medicaid-participating nursing homes to inform its residents and their representatives by **5pm the next calendar day** following the occurrence of:
   - A single confirmed case of COVID-19; -OR-
   - 3 or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other.
     - MCDPH has a templated letter you can download and edit to meet your facility's needs.
     - CDC also has a template you can use to communicate with residents and families.

   Information must:

   - **Not include personally identifiable information**;
   - Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
   - Include any cumulative updates for residents, their representatives, and families **at least weekly or by 5pm next calendar day** following:
     - Each time a confirmed infection of COVID-19 is identified; -OR-
     - Whenever 3 or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

   Facilities should submit their first set of data by 11:59 p.m. Sunday, May 17, 2020 through NHSN.

3) Additional information, including how to access NHSN and the CMS COVID-19 Focused Survey for Nursing homes is available in the CMS Memo from May 6th.

* Maricopa County Department of Public Health is not a regulatory agency and does not report to CMS. This information here is for guidance only. Detailed requirements can be found at www.cms.gov.