

Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

Coronavirus-(COVID-19)

The Centers for Disease Control has published interim guidance entitled, “Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings” Updated [April 13, 2020](#), stating, “This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), gloves, and gowns..”¹ This information has been utilized, to develop the following policy and procedure.

Policy

It is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Federal and State/Local recommendations (to include, for example: Admissions, Visitation, Precautions: Standard, Contact, Droplet and/or Airborne Precautions, including the use of eye protection).

Note: *All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements. Check the following link regularly for [critical updates](#), such as updates to guidance for using and optimizing [PPE](#), [infection control guidance for LTC Facilities](#) and [CMS admission process guidelines](#). Nursing Homes should immediately ensure that they are complying with all [CMS and CDC guidance](#) related to infection control.*

- *In particular, facilities should focus on adherence to appropriate [hand hygiene](#) as set forth by CDC.*
- *CMS has recently issued extensive [infection control guidance](#), including a [self-assessment checklist](#) that long-term care facilities can use to determine their compliance with these crucial infection control actions.*
- *Facilities should refer to CDC’s guidance to long-term care facilities on COVID-19 and also use guidance on [conservation of personal protective equipment \(PPE\)](#) when unable to follow the long-term care facility guidance.*

Procedure

Signs and Symptoms of COVID-19

- People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness.
- Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms or combinations of symptoms may have COVID-19:
 - Cough
 - Shortness of breath or difficulty breathing
 - *Or at least two of these symptoms:*
 - Fever
 - Chills
 - Repeated shaking with chills
 - Muscle pain
 - Headache

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- Sore throat
 - New loss of taste or smell
- This list is not all inclusive. Please consult your medical provider for any other symptoms that are severe or concerning to you

Resident Care

▪ Admission Guidance

- The facility will design a plan related to physical plant and resident placement to residents who have COVID-19 from patients and residents who do not or have an unknown status.
- The facility will work with State and local community leaders to identify and designate units or a specific facility dedicated to patients and residents with known COVID-19-positive and those with suspected COVID-19, ensuring they are separate from patients and residents who are COVID-19-negative
- The facility will coordinate with state agencies including health departments, hospitals, and nursing home associations for coordination among entities/facilities to determine if the designated unit/facility will meet designation criteria as well as the other needs outlined in the [CMS guidance](#) and (i.e. staffing, supplies and PPE)
 - COVID-19 Positive Designated Units/Facilities
 - Will be capable of maintaining strict infection control practices and testing protocols, as required by regulation
 - Will actively provide education for staff designated to the unit/facility
 - Shall exercise consistent assignment or have separate staffing teams for COVID-19-positive and COVID-19-negative patients when feasible based upon surge capacity and needs in the community.
- Prior to admission, identify on the preadmission screen if resident is exhibiting symptoms of any respiratory infection (i.e. cough, fever, shortness of breath, etc.) to determine appropriate placement within the facility.
- It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room.
- Isolate all admitted residents (including readmissions) in their room in the COVID-19-positive designated location for 14 days if their COVID-19 status is unknown
- Patients and residents who enter facilities should be screened for COVID-19 through testing, if available.
- Limit transport and movement of the resident outside of the room to medically essential purposes (i.e. diagnostics).
- Residents being admitted or readmitted should be screened upon entering the facility and apply a cloth face covering for source control
- When resident comes into the facility, they should be instructed that if they touch or adjust their cloth face covering, they should perform hand hygiene.
- For new residents (or residents with recent travel) obtain a detailed travel history, contact with anyone with lab confirmed COVID-19 and identify if resident exhibits fever and signs and/or symptoms of acute respiratory illness.
- 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.
 - [Per CMS](#), residents can use tissues for this. They could also use cloth, non-medical masks when those are available. Residents should not use medical facemasks unless they are COVID-19-positive or assumed to be COVID-19-positive.
- No group activities (internal and external) or communal dining will occur in the facility at this time

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- Residents will be reminded to practice social distancing and perform frequent hand hygiene
- **Screening**
 - Prompt detection, triage, and isolation of potentially infected residents:
 - Ongoing, frequent, active screening of every resident for fever and respiratory symptoms (i.e. should be assessed for symptoms and have their temperature taken)
 - In accordance with previous CMS guidance, every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked.
 - An exception to this is Emergency Medical Service (EMS) workers responding to an urgent medical need. They do not have to be screened, as they are typically screened separately.
 - Actively screen all residents daily for fever and symptoms of COVID-19; if symptomatic, immediately isolate and implement [appropriate Transmission-Based Precautions](#).
 - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
 - Notify your state or local health department immediately (<24 hours) if these occur:
 - Severe respiratory infection causing hospitalization or sudden death
 - Clusters (≥3 residents and/or HCP) of respiratory infection
 - Individuals with suspected or confirmed COVID-19
 - [CDC - Key Strategies to Prepare for COVID-19 in Long-term Care Facilities \(LTCFs\)](#)
 - Contact physician and public health authorities for COVID-19 testing consistent with current CDC and State Public Health recommendations
 - Work with state and local health departments to determine and address COVID-19 tests, requirements, prioritization and specimen collection.
 - For suspected cases of COVID-19, contact the State or local health department for directions and testing. <https://www.cms.gov/files/document/qso-20-14-nhpdf.pdf>
 - Notifications and communication:
 1. Contact and inform resident's physician
 2. Contact and inform resident representative
 3. Contact and inform the facility Medical Director
 - For identified increase in the number of respiratory illnesses regardless of suspected etiology for residents and/or employees, immediately contact the local or State health department for further guidance.
- **Suspected or Known COVID-19**
 - A resident with known or suspected COVID-19, immediate infection prevention and control measures will be put into place. Symptoms may vary in severity. If symptoms are mild and do not require transfer to the hospital:
 - Place resident in an AIIR if available. If no AIIR, place on both contact and droplet precautions.
 - Contact State/Local Public Health immediately for direction, for example:
 - “Facilities without an airborne infection isolation room (AIIR) are not required to transfer the patient assuming: 1) the patient does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19”.
<https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- Residents that develop more severe symptoms that require transfer to the hospital for a higher level of care
 - Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis and precautions to be taken including placing a facemask on the resident during transfer.
 - Pending transfer or discharge, place a facemask on the patient and isolate him/her in a room with the door closed.
<https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>
- Acute Change of Condition
 - Immediate isolation in private room (or cohort residents with same symptoms/COVID-19 confirmation) with door closed.
 - Implement transmission-based precautions (COVID-19)
 - Complete clinical assessment of resident
 - Monitor ill residents (including documentation of temperature and oxygen saturation) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.
 - [CDC - Key Strategies to Prepare for COVID-19 in Long-term Care Facilities \(LTCFs\)](#)
 - Call EMS (notify of COVID-19 status - be alerted to the resident's diagnosis and precautions to be taken)
 - Call receiving hospital (notify of COVID-19 status - be alerted to the resident's diagnosis and precautions to be taken)
 - Notify Medical Director
 - Complete notifications per policy
 - Complete Discharge Process per facility policy
 - Immediately notify Public Health department of discharge to acute care (COVID-19)
 - Limit only essential personnel to enter the room with appropriate PPE and respiratory protection. Implement consistent assignment as indicated in the facility plan.
 - Log - keep a log of all persons who enter the room, including visitors and those who care for the resident
 - Add to Line List
- Resident Remains in the Facility
 - Implement transmission-based precautions (COVID-19)
 - Implement isolation to designated room/unit per plan
 - Closely monitor resident for change of condition
 - Complete notifications per policy
 - notify Public Health department of suspected/known COVID-19
 - Notify Medical Director
 - Completed notification per policy
 - Implement consistent assignment of staff for resident(s)
 - Only essential staff are to enter room/unit with appropriate PPE and respiratory protection
 - Log - keep a log of all persons who enter the room, including visitors and those who care for the resident
 - Add to Line List
- Residents suspected or confirmed with COVID-19 that remain in facility upon advice of local/State public health agency, will be assessed and evaluated for a minimum of 14 days for potential change in condition or additional signs and symptoms.
- The facility can make a determination to readmit residents diagnosed with COVID-19 from the hospital based upon the below criterion (<https://www.cms.gov/files/document/qso-20-14-nhpdf.pdf>):
 - The facility is able to follow CDC guidance for Transmission-based Precautions for COVID-19.

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- If the facility is unable to follow CDC guidance for Transmission-based Precautions for COVID-19, it must wait until these precautions are discontinued at the hospital
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html#clinical-management-treatment%3C>
- Consultation with State/local Health Department
- If possible, the facility will dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab unit or returning to long-stay original room).
- For suspected or confirmed COVID-19, the facility will keep a log of all persons who enter the room, including visitors and those who care for the resident.
 - Employees who have unprotected exposure to a resident with COVID-19 should report to the Infection Preventionist or designee for further direction as indicated by State/Local Health Departments
- Resident Transport: Prior to resident transport, both the emergency medical services and the receiving facility will receive alerted information regarding:
 - Resident diagnosis or suspected diagnosis
 - Precautions necessary
 - A facemask will be placed on the resident prior to transport
- Dedicated or disposable patient-care equipment should be used. If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations using EPA-registered disinfectants against COVID-19:
<https://www.epa.gov/newsreleases/epa-releases-list-disinfectants-use-against-covid-19>
- Discontinuation of Isolation Precautions will be determined on a case-by-case basis in conjunction with the State and/or Local Health Department
- Cleaning and disinfecting room and equipment will be performed using products that have EPA-approving emerging viral pathogens: <https://www.epa.gov/newsreleases/epa-releases-list-disinfectants-use-against-covid-19>
- Outbreak
 - In the event of a facility outbreak, institute outbreak management protocols:
 - Define authority (Infection Preventionist, DON, Administrator, Medical Director, etc.)
 - **Immediate** reporting/notification and consultation with the Local/State Public Health Department for specific directions to include, for example:
 - Place residents in private rooms on standard, contact, droplet (airborne if available) precautions.
 - Cohort residents identified with same symptoms/COVID-19 confirmation
 - Implement consistent assignment of employees
 - Only essential staff to enter rooms/wings
 - Decisions on admissions will be based upon consultation with facility leadership, infection preventionist, Medical Director, acute care partner and Public Health Department
 - Limit only essential personnel to enter the room with appropriate PPE and respiratory protection.

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

Personal Protective Equipment and Supplies

- State and local health departments should work together with long-term care facilities in their communities to determine and help address long-term care facility needs for PPE and/or COVID-19 tests. Refer to [CMS Guidance](#)
- Staff will use appropriate PPE when they are interacting with residents, to the extent PPE is available and per CDC guidance on conservation of PPE.
 - For the duration of the state of emergency in their State, all facility personnel should wear a facemask while they are in the facility. *Follow specific state guidance
 - It is recommended that an N95 or surgical mask is to be used – if no surgical mask or N95 is available a cloth face covering can be used but is not considered a PPE. **See policies and procedures for PPE's (face mask, face shield, gowns)
 - Per [CDC](#), Ensure all staff wear a facemask or cloth face covering for source control while in the facility.
 - Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.
 - Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE.
 - If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 diagnosis or symptoms on the affected unit (or facility-wide depending on the situation)
- The facility will monitor necessary supplies and equipment (PPE, ABHR, thermometers, pulse oximeters, soap, towels, etc.)
 - If facility is unable to obtain needed supplies and equipment from vendor, contact the local and state public health agency
- Personal Protective Equipment (PPE) includes:
 - Gloves
 - Isolation Gowns
 - In the event of supply capacity concerns, see CDC "[Strategies for Optimizing the Supply of Isolation Gowns](#)"
 - Facemasks:
 - In the event of supply capacity concerns, see CDC "[Strategies for Optimizing the Supply of Facemasks](#)"
 - Respiratory Protection if facility has a respiratory protection program (Fit-tested NIOSH-certified disposable N95 filtering facepiece respirator prior to entry and removal after exiting-). If disposable respirator is used, it should be removed and discarded after exiting the resident room and closing the door. Perform hand hygiene after discarding. If reusable respirator is used, clean and disinfect according to the manufacturer's recommendations. If facility is using Fit-tested NIOSH-certified disposable N95 filtering respirators, staff must be medically cleared and fit-tested and trainer prior to use.
 - In the event of supply capacity concerns for respiratory protection, the CDC has outlined measures in the "Strategies for Optimizing the Supply of N95 Respirators" at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html> and "Guidance for use of Certain Industrial Respirators by Health Care Personnel" at: <https://www.cms.gov/files/document/gso-20-17-all.pdf>
 - The facility will document efforts to obtain necessary PPEs and supplies needed. The facility will take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap

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Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility will contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents.

- <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html> and “Guidance for use of Certain Industrial Respirators by Health Care Personnel” at: <https://www.cms.gov/files/document/qso-20-17-all.pdf>
- If no Fit-Tested NIOSH-Certified N95 respirators available or used in facility, the Infection Preventionist will identify appropriate mask that will be donned when entering and after exiting resident room:
 - Examples include:
 - https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html
 - <https://www.cms.gov/files/document/qso-20-17-all.pdf>
- Eye Protection that covers both the front and sides of the face. Remove before leaving resident room. Reusable eye protection will be cleaned and disinfected according to manufacturer’s recommendation. Disposable eye protection will be discarded after use
- Hand Hygiene using Alcohol Based Hand Sanitizer before and after all patient contact, contact with infectious material and before and after removal of PPE, including gloves
 - If hands are soiled, washing hands with soap and water is required for at least 20 seconds.
- Ensure ABHS is accessible in all resident-care areas including inside and outside resident rooms.

Employees

*Also applies to other health care workers such as Hospice workers, EMS personnel or dialysis technicians, which provide care to the residents

- The facility will review facility sick leave plan for facility employees, align with current CDC and State/Local health department requirements
- Screening Employees:
 - Facility will actively verify absence of fever and respiratory symptoms when employees report to work-beginning of their shift. Document temperature, absence of shortness of breath, new or change in cough and sore throat and other criteria as identified by State guidance
 - If employee is ill, employee will put on a facemask, immediately leave the facility and self-isolate at home
 - Employees who develop symptoms to COVID-19 (fever, cough, shortness of breath or sore throat and other criteria as identified by State guidance) will be instructed to not report to work and referred to public health authorities for testing, medical evaluation recommendations and return to work instructions.
 - Employees who develop symptoms on the job will be:
 - Instructed to immediately stop work, provide with a facemask and immediately leave the facility
 - Instructed on self-isolation at home
 - The Infection Preventionist will work with the employee to identify individuals, equipment and locations the employee came in contact with
 - The Infection Preventionist will contact the local health department for recommendations on next steps.
 - The facility will identify employees that work at multiple facilities and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- Follow state and local public health department guidance as it relates to staff working between multiple locations.
- The Infection Preventionist will identify exposures that may warrant restricting asymptomatic employees from working based upon CDC guidance for exposures.
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
- The facility will re-educate employees and reinforce:
 - Strong hand-hygiene practices
 - Cough etiquette
 - Respiratory hygiene
 - Transmission Based Precautions
 - [Appropriate utilization of PPE's as indicated](#)
 - PPE Sequencing
 - [PPE Decontamination](#) and Reuse of Filtering Facepiece Respirators
 - [Cleaning and disinfection](#)
- Facility will provide adequate work supplies to avoid sharing and disinfect workplace areas frequently

Employee Return to Work Criteria

Return to Work Criteria for Employees with Confirmed or Suspected COVID-19. Per CDC guidelines, use one of the below strategies to determine when an employee may return to work in healthcare settings (<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>)

Symptomatic HCP with suspected or confirmed COVID-19 (Either strategy is acceptable depending on local circumstances):

- *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 respiratory specimens collected ≥24 hours apart (total of two negative specimens)[1]. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

- *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

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

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 respiratory specimens collected ≥ 24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Return to Work Practices and Work Restrictions

After returning to work, an employee should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
 - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
 - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in [CDC's interim infection control guidance](#) (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Crisis Strategies to Mitigate Staffing Shortages

Healthcare systems, healthcare facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that the recommended approaches cannot be followed due to the need to mitigate healthcare staffing shortages. In such scenarios:

- Employees should be evaluated, as guided by the State and Local health department, to determine appropriateness of earlier return to work than recommended above
- If an employee returns to work **earlier than recommended above**, they should still adhere to the Return to Work Practices and Work Restrictions recommendations above. For more information, see:
 - [CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19](#)
 - [CDC's Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)

Visitor Restrictions

- The facility will **restrict** visitation of **all** visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only.

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- For individuals that enter in compassionate situations (e.g., end-of-life care), the facility will require visitors to perform hand hygiene and use Personal Protective Equipment (PPE), such as facemasks.
 - Decisions about visitation during an end of life situation will be made on a case by case basis, which includes careful screening of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) will **not be permitted** to enter the facility at any time (even in end-of-life situations).
 - Those visitors that are permitted, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility (such as a dedicated area by an entrance of the building, if possible for the visit to occur)
 - The visitation room will be disinfected after each visit
 - Visitors will be reminded to frequently perform hand hygiene.
 - Prior to entry to the facility, visitor will be instructed on:
 - Hand Hygiene
 - Limiting surfaces touched
 - Use of PPE
 - Refrain from physical contact with residents and others in the facility, (practice social distancing by remaining 6 feet apart from others and not handshaking, hugging, etc.)
- Visitors that enter in compassionate situations (e.g., end-of-life) and any individuals who entered the facility will be advised (e.g., hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility.
 - If symptoms occur, they will be advised to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited.
 - The facility will immediately screen the individuals of reported contact, and take all necessary actions based on findings.
- The facility will notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.). Communication will be provided through multiple means of the visitation restriction such as signage, letters, emails, phone calls and recorded messages for receiving calls).
 - Note: If a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor's executive order, a facility would not be out of compliance with CMS' requirements. In this case, surveyors would still enter the facility, but not cite for noncompliance with visitation requirements.
- Exceptions to restrictions:
 - Health care workers: The facility will follow CDC guidelines for restricting access to health care workers found at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
 - This also applies to other health care workers, such as hospice workers, EMS personnel, or dialysis technicians, which provide care to residents.
 - They should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers.
 - The facility will contact their local health department for questions, and will review the CDC website dedicated to COVID-19 for health care professionals <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>
 - Surveyors: CMS and state survey agencies are constantly evaluating surveyors to ensure they don't pose a transmission risk when entering a facility as outlined in <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> . However, there are circumstances under which surveyors should still not enter, such as if they have a fever.
 - Ombudsman – residents still have the right to the Ombudsman program. Their access should be restricted per the guidance for visitors (except in compassionate care situations) however, the

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

facility will review this on a case by case basis and will identify alternate means of communication and access in coordination with the Ombudsman.

- The facility will increase visible signage at entrances/exits, offer temperature checks, increase availability to hand sanitizer, offer PPE for individuals entering the facility for end of life visits (if supply allows).
- Volunteers will not be permitted in the facility.
- Vendors will not be permitted in the facility.
 - Vendors will be instructed to drop off supplies at a dedicated location (loading dock)
- EMS personnel (e.g., when taking residents to offsite appointments, etc.) will take necessary actions to prevent any potential transmission.
- In lieu of visits (either through limiting or discouraging), The facility will consider:
 - Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
 - Creating/increasing listserv communication to update families, such as advising to not visit.
 - Assigning staff as primary contact to families for inbound calls and conduct regular outbound calls to keep families up to date.
 - Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.
 - Residents still have the right to access the Ombudsman program.
 - In-person access is restricted at this time except for compassionate care situation
 - This will be reviewed on a case by case basis
 - Facility will facilitate resident communication (by phone or another format) with the Ombudsman program

Communication

- The facility will review facility communication procedures for COVID-19 (initial, ongoing and upon suspected or confirmed outbreak) through multiple means (i.e. signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls) to inform individuals and non-essential health care personnel of the visitation restrictions, as outlined in <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>
- Reporting and Communication
 - In addition to requiring reporting to CDC per public health requirements, facilities must notify:
 - Residents and their representatives to keep them informed of the conditions inside the facility.
 - Facilities must inform residents and their representatives within 12 hours of the occurrence of a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours.
 - Also, updates to residents and their representatives must be provided weekly, or each subsequent time a confirmed infection of COVID-19 is identified and/or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours.
 - Facilities will include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered.
 - This information must be reported in accordance with existing privacy regulations and statute.
- The facility will, to their fullest extent possible, inform residents and their families of limitations of their access to and ability to leave and re-enter the facility, as well as any requirements and procedures for placement in alternative facilities for COVID-19-positive or unknown status.
 - Develop and implement key talking points

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- Preparation strategies for COVID-19
- Visitor restriction protocols
- Suspected or confirmed cases
- Facility process if an outbreak occurs
- Determine communication (written, verbal, electronic) for:
 - Residents
 - Resident Representatives
 - Employees
 - Vendors
 - Visitors
 - Media
 - State/local health departments
 - Local hospitals, EMS providers and provider community
 - Other Key Stakeholders
- Determine and implement a communication lead
- Develop key facts and talking points for media (preparation and response)
- Facility Signage
 - Signs will be posted at the entrances, elevators and breakrooms to provide residents, staff and visitors on instructions on hand hygiene, PPE, respiratory hygiene and cough etiquette. Facemasks, Alcohol-based hand rub (ABHR), tissues and a waste receptacle will be available at the facility entrances.

References and Resources

NOTE: The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

¹Centers for Disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Evaluating and Reporting Persons Under Investigation (PUI). : <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Information for Healthcare Providers. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html>

Centers for Disease Control and Prevention. "Healthcare Personnel Preparedness Checklist for 2019-nCoV that can be downloaded and completed by the Infection Preventionist at: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp-preparedness-checklist.pdf>

Centers for Medicare & Medicaid Services. Upcoming requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes <https://www.cms.gov/files/document/qso-20-26-nh.pdf>

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Infection Prevention and Control Manual

Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>

Centers for Medicare & Medicaid Services. QSO-20-14-NH. Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes: <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>

Centers for Medicare and Medicaid Services QSO-20-20-ALL <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0>

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Strategies for Optimizing the Supply of N95 Respirators. February 29, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

Centers for Medicare & Medicaid Services. QSO-20-17-ALL. Guidance for the use of Certain Industrial Respirators by Health Care Personnel. <https://www.cms.gov/files/document/qso-20-17-all.pdf>

Local Health Department Listing and Contacts. <https://www.naccho.org/membership/lhd-directory>

Information on affected US locations: <https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html>

FDA Resources:

Emergency Use Authorizations: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

CMS Additional Resources

Long term care facility – Infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf

Infection control toolkit for bedside licensed nurses and nurse aides (“Head to Toe Infection Prevention (H2T) Toolkit”): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment>

Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>

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