GENERATIONS	**Policy: Coronavirus Prevention, Response and Reporting** **Infection Prevention Surveillance**

Purpose: Prevention of the spread of COVID-19.

Policy: The facility will ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections. COVID-19 information will be reported through the proper channels as per federal, state and/or local health authority guidance.

Procedure:

1. The Infection Preventionist will assess facility risk associated with COVID-19 through surveillance activities of COVID-19 infection in the community and illnesses present in the facility.
    a. No current risk noted, the facility will implement interventions for prevention and prepare for a potential outbreak.
    b. Risk detected, the facility will respond promptly and implement emergency and/or outbreak procedures.
2. Staff will be alert to signs of COVID-19 and notify the resident's physician/practitioner if evident:
    a. Fever or chills
    b. Cough
    c. Shortness of breath or difficulty in breathing
    d. Fatigue
    e. Muscle or body aches
    f. Headache
    g. New loss of taste or smell
    h. Sore throat
    i. Congestion or runny nose
    j. Nausea or vomiting
    k. Diarrhea
3. The facility will offer resources and counseling to healthcare personnel, residents and visitors on the importance of receiving the COVID-19 vaccine and staying up to date with all recommended COVID-19 vaccine doses.
4. The facility will establish a process to identify and manage individuals with suspected or confirmed SARS-COV-2 infections to include:
    a. Ensuring that everyone is aware of the recommended Infection Prevention Control (IPC) practices in the facility by posting visual alerts (e.g., signs, posters) at the entrance and in strategic places to include instructions about current IPC recommendations.

b. Establishing a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
    i. A positive viral test for SARS-CoV-2
    ii. Symptoms of COVID-19, or
    iii. Close contact with someone with SARS-CoV-2 infection for residents and visitors or a higher-risk exposure for healthcare personnel (HCP)

5. The facility will instruct HCP to report any of the above three criteria to the Infection Preventionist (IPN) or designee for proper management.
6. The facility will provide guidance about recommended actions for residents, visitors and vendors who have any of the above three criteria.
7. Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation (which is longer than what is recommended in the community). For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet any of the criteria as per CDC guidance.

8. The facility will allow individuals to use a mask or respirator (even when the facility does not require masking for source control) based on personal preference, informed by their perceived level of risk for infection based on their recent activities and their potential for developing severe disease if they are exposed.
9. Source control measures:
    a. Source control options for HCP:
        i. A NIOSH-approved particulate respirator with N95 filters or higher;
        ii. A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators;
        iii. A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks;
        iv. A well-fitting face mask.
    b. Source control (as noted above) can be used for an entire shift unless they become soiled, damaged, or hard to breathe through.
    c. If source control is used during the care of a resident for which a NIOSH-approved particulate respirator or facemask is indicated for PPE, they should be removed and discarded after the resident care encounter and a new one donned.
    d. Source control is recommended for individuals in healthcare settings who:
        i. Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
        ii. Had a close contact (residents and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure

e. Source control is recommended more broadly in the following circumstances:
    i. By residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over. (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
    ii. Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas or resident populations during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission;
    iii. Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high).

10. Broader use of masking should be determined by the facility as to how and when to implement. Several factors to consider include:
    a. The types of residents cared for in the facility;
    b. Input from stakeholders;
    c. What data is available to make decisions.
11. Personal Protective Equipment Considerations:
    a. HCP should follow standard precautions if SARS-CoV-2 infection is not suspected in a resident presenting for care or transmission-based precautions if required based on suspected diagnosis.
    b. The facility may consider implementing broader use of respirators and eye protection by HCP during resident care encounters if SARS-CoV-2 transmission in the community increases, as follows:
        i. NIOSH-approved particulate respirators with N95 filters or higher used for:
            1) All aerosol-generating procedures;
            2) In other situations, where additional risk factors for transmission are present, such as the resident is unable to use source control and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas in not already in place
            3) Resident care encounters or in specific units or areas of the facility at higher-risk for SARS-CoV-2 transmission.
        ii. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all resident care encounters.
12. Engineering Controls and Indoor Air Quality:
    a. The facility will optimize the use of engineering controls to reduce or eliminate exposure by shielding HCP and other residents from infected individuals.
    b. The facility will explore options to improve ventilation delivery and indoor air quality in resident rooms and all shared spaces.
    c. The facility will take measures to limit crowding in communal spaces.

13. The facility will perform viral testing for SARS-CoV-2 as per national standards such as CDC recommendations.
14. IPC practices when caring for residents with suspected or confirmed SARS-CoV-2 infection:
    a. These following recommendations (e.g., resident placement, recommended PPE) also apply to residents with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic residents who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection. These residents however, should not be cohorted with residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.
    b. The facility will decide to discontinue empiric transmission-based precautions for symptomatic resident being evaluated for SARS-CoV-2 infection based upon having negative results from at least one viral test.
        i. If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exist, consider maintaining transmission-based precautions and confirming with a second negative NAAT.
        ii. If using an antigen test a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.
        iii. If the suspected resident is never tested, the decision to discontinue transmission-based precautions can be made based on time from symptom onset.
    c. Duration of empiric Transmission -Based Precautions for asymptomatic residents following close contact with someone with SARS-CoV-2 infection is as follows:
        i. Asymptomatic residents do not require empiric use of transmission-based precautions while being evaluated for SARS-CoV-2 infection following close contact with someone with SARS-CoV-2 infection. The resident should still wear source control and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as per national standards such as the CDC recommendations.
        ii. Empiric transmission-based precautions following close contact to be considered may include:
            1) Resident is unable to be tested or wear source control as recommended for 10 days following their exposure.
            2) Resident is moderately to severely immunocompromised.
            3) Resident is resident on a unit with others who are moderately to severely immunocompromised.
            4) Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

iii. Residents placed in empiric transmission-based precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in transmission-based precautions for the following time periods:
    1) Residents can be removed from transmission-based precautions after day 7 following the exposure if they do not develop symptoms and all viral testing as per CDC guidance is negative.
    2) If viral testing is not performed, residents can be removed from transmission-based precautions after day 10 following exposure if they do not develop symptoms.

15. Resident placement considerations:
    a. Residents with suspected or confirmed SARS-CoV-2 infection should be placed in a single-person room with the door kept closed, if safe to do so, and a dedicated bathroom if possible.
        i. If cohorting, only residents with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable diseases should also be taken into consideration during the cohorting process.
        ii. If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.
    b. The facility may consider designating entire units within the facility, with dedicated HCP to care for residents with SARS-CoV-2 infection when the number of residents with SARS-CoV-2 infection is high.
    c. Limit transport and movement of the resident outside the room to medically essential purposes.
    d. Communicate information about residents with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility or to other healthcare facilities.
16. HCP who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves and eye protection.
17. Respirators should be used in the context of a comprehensive respiratory protection program in accordance with OSHA Respiratory Protection Standard.
18. Aerosol-generating procedures should be performed cautiously and avoided if appropriate alternatives exist. They should be performed in the resident room with only the HCP necessary to perform the procedure present. Visitors should not be present during the procedure.
19. Visitation will be carried out as per facility policy. (See COVID-19 Visitation Policy)
20. Environmental infection control:
    a. Dedicated medical equipment should be used when caring for a resident with suspected or confirmed SARS-CoV-2 infection. All non-dedicated, Rnon-disposable medical equipment used for that resident should be

cleaned and disinfected according to manufacturer's instructions and facility policy before use on another resident.

b. Routine cleaning and disinfection procedures using EPA-registered products to disinfect frequently touched surfaces or objects should be performed as per manufacturer's instructions for use including appropriate contact times.
c. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
d. Once the resident has been discharged or transferred, HCP, including environmental service personnel, should refrain from entering the vacated room without all recommended PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

21. Duration of Transmission-Based Precautions for Residents with SARS-CoV-2 Infection
    a. The criteria to determine when discontinuing Transmission-Based Precautions is influenced by the severity of symptoms and presence of immunocompromising conditions.
    b. If symptoms recur (e.g., rebound), these residents should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.
    c. Discontinuation of transmission-based precautions on SARS-CoV-2 is as follows:
        i. Symptom Based Strategy
            A. Residents with <u>mild to moderate illness</u> who are **not** moderately to severely immunocompromised:
                a) At least 10 days have passed since symptoms first appeared **and**
                b) At least 24 hours have passed since last fever without the use of fever-reducing medications **and**
                c) Symptoms (e.g., cough, shortness of breath) have improved.
            B. Residents who were **asymptomatic** through out their infection and are **not** moderately to severely immunocompromised:
                a) At least 10 days have passed since date of their first positive viral test.
            C. Residents with <u>severe to critical illness</u> who are **not** moderately to severely immunocompromised:
                a) At least 10 and up to 20 days have passed since symptoms first appeared **and**
                b) At least 24 hours have passed since last fever without the use of fever-reducing medications **and**

c) Symptoms (e.g., cough, shortness of breath)have improved
d) The test-based strategy as described for moderately to severely immunocompromised residents can be used to inform the duration of isolation.

D. Residents who are **moderately to severely immunocompromised** may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.
a) Use of a test-based strategy and (if available) consultation with infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these residents.

ii. Test-Based Strategy
A. Residents who are **symptomatic**:
a) Resolution of fever without the use of fever-reducing medications **and**
b) Symptoms (e.g., cough, shortness of breath) have improved, **and**
c) Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

B. Residents who are **not symptomatic:**
a) Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

C. Note: Consider other conditions that would require specific precautions (e.g., c. difficile, TB) when determining the duration of transmission-based precautions.

d. Indicate COVID-19 history on the resident's plan of care and monitor for recurrent symptoms.

22. Managing admissions and residents who leave the facility:
a. Admission testing is at the discretion of the facility
b. Residents who leave the facility for 24 hours or longer should generally be managed as an admission.

23. Empiric use of transmission-based precautions is generally not necessary for admission or for residents who leave the facility for less than 24 hours and do not meet criteria as noted in #14.

24. Residents who leave the facility should be reminded to follow all recommended IPC practices and to encourage those around them to do the same. Individuals accompanying the resident should be educated as well and assist the resident with adherence as indicated.

25. For residents going to medical appointments, regular communication between the medical facility and the facility (both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions are implemented.
26. Responding to a newly identified SARS-CoV-2 infected HCP or resident:
    a. The facility should defer to the recommendations of the jurisdiction's public health authority when performing an outbreak response to a known case.
    b. A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.
    c. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach (e.g., unit, floor, or specific area(s) of the facility) is preferred if all potential contact cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
    d. Perform testing for all resident and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
    e. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP are not generally necessary unless residents meet the criteria as noted in #14 or HCP meet criteria as noted in the Return to Work Criteria for Healthcare Personnel with COVID-19 Infection or Exposure to COVID-19 policy.
27. The Infection Preventionist, or designee, will monitor and track COVID-19 related information to include, but not limited to:
    a. The number of residents and staff who exhibit signs and symptoms of COVID-19.
    b. The number of residents and staff who have suspected or confirmed COVID-19 and the date of confirmation.
    c. Staff and resident vaccination status.
    d. Employee compliance with hand hygiene.
    e. Employee compliance with standard and transmission-based precautions.
    f. Employee compliance with cleaning and disinfection policies and procedures.
    g. Supply of personal protective equipment, cleaning/disinfection supplies, alcohol-based hand rub, and other relevant supplies.
    h. Other information as per federal, state and/or local guidance.

28. COVID-19 Reporting and Vaccine Reporting:

    a. The CDC is notified of reportable information through the National Healthcare Safety Network (NHSN) no less than weekly. The following information will continue to be reported until December 31, 2024 as per CMS guidance:
        i. Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19
        ii. Total deaths and COVID-19 deaths among residents and staff.

iii. Personal protective equipment and hand hygiene supplies in the facility
iv. Ventilator capacity and supplies available in the facility.
v. Resident beds and census.
vi. Access to COVID-19 testing while the resident is in the facility.
vii. Staff shortages
viii. Therapeutics administered to residents for treatment of COVID-19
ix. Any other information specified by the Health and Human Services (HHS) Secretary.

b. The facility will continue to report weekly the COVID-19 vaccination status of residents and staff, total numbers of residents and staff vaccinated, each dose of vaccine received, COVID-19 vaccination adverse events. (NOTE: This will continue indefinitely unless additional regulatory action is taken.)
c. All COVID-19 data must be submitted to NHSN weekly, but not later than Sunday at 11:59 pm each week. Data must be submitted at least every seven days but submissions may be done multiple times a week if the facility chooses.

References:

Center for Disease Control and Prevention. *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic*. Located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. Accessed May 8, 2023.

Centers for Medicare & Medicaid Services. *Appendix PP: Guidance to Surveyors for LTC Facilities, State Operations Manual*: (February 2023), 42 C.F.R. 483.80, F884

Centers for Medicare & Medicaid Services. *QSO-20-29-NH: Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes* (May 6, 2020).

Centers for Medicare & Medicaid Services. *QSO-23-13-ALL: Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE)* (May 1, 2023)