ARIZONA DEPARTMENT OF HEALTH SERVICES

Long-term Care Facility COVID-19 Guidance

Coronavirus disease 2019 (COVID-19) is the clinical disease caused by infection with SARS-CoV-2. This document serves as guidance to long-term care facilities (LTCF) such as skilled nursing and residential healthcare facilities to implement best practices for the prevention, detection and infection control necessary to contain the spread of COVID-19 within a facility. Some of the recommendations are more specific for skilled nursing facilities; residential facilities can utilize these recommendations as applicable.

SIGNS AND SYMPTOMS
It takes 2–14 days after exposure for symptoms of COVID-19 to develop (median is ~4 days). Symptoms may include:
- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms.

RISK FACTORS
Based on what we know now, those at increased risk for severe illness from COVID-19 are:
- Older adults.
- People of all ages with underlying medical conditions.
- Pregnant and recently pregnant people.

COVID-19 spreads easily in the LTCF population and outcomes can be severe. Rates of pneumonia and death are increased in this population as compared to the general population. COVID-19-infected staff and visitors are the most likely sources of introduction into a facility. There is increasing evidence that COVID-19 can be spread by asymptomatic individuals and by presymptomatic individuals up to 48 hours prior to symptom onset.

<u>Prepare for COVID-19: Prevent the introduction of COVID-19 into your facility.</u>

IDENTIFY PLANS AND RESOURCES
- Review and update your pandemic influenza preparedness plans. The same planning applies to COVID-19.
    - If you do not have a plan, a template can be found here: https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf
- Identify one or more individuals with training in infection control to provide on-site management of the infection prevention and control program.
    - CDC has created an online training course that can orient individuals to this role in long-term care facilities.
- Identify public health and professional resources.
    - Local Health Departments
    - ADHS COVID-19 Website
    - CDC Healthcare Workers: Information on COVID-19
    - CDC Long-term Care Facility Guidance
    - Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
    - CDC Post Vaccine Considerations for Residents
- Identify contacts for local, regional or state emergency preparedness groups.
    - Local Health Departments: azhealth.gov/localhealth
- Identify contacts at local hospitals in preparation for potential need to hospitalize residents or to receive patients discharged from the hospital.
    - If a resident is referred to a hospital, coordinate transport with the hospital and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the facility.
    - Opening bed capacity in hospitals is vitally important as the outbreak spreads. LTCFs can help by efficiently working to transfer residents to and from healthcare facilities.
    - Receiving and planning for COVID-19 positive patients discharged from the hospital is critical. Facilities should be prepared from an infection control perspective to safely receive and care for these patients.
- Ensure facility transfer protocols are in place for residents with an acute respiratory illness.
- Ensure plans are in place to track and clear staff to return to work after illness.
- Ensure plans are in place to address insufficient staffing.
    - Develop (or review existing) strategies to mitigate staffing shortages from illness or absenteeism.
    - Ensure you have a process to rapidly on-board new staff.
    - Update staffing ratios based on current resident census and needs.
    - As a contingency, work with your local health department for the Arizona Emergency System for Advance Registration of Volunteer Health Professionals (AZ-ESAR-VHP).
- Establish contingency plans for resident discharge or transfer in the event the facility has insufficient staffing to safely meet patient care needs. This may include outreach to families/guardians outlining potential options for discharge home and home care, depending on level of patient acuity.

CREATE A TESTING PLAN AND IDENTIFY TESTING RESOURCES.
- Establish a plan that outlines who is responsible for performing specimen collection from staff and residents, a process for specimen collection and transport (if needed), and who is responsible for conducting POC testing.
  - Consider what facility staff can collect specimens on themselves/from other staff or whether additional support is needed for specimen collection (i.e., specimen collection contractor). The facility's staff may need to be trained to collect specimens correctly. Training should include infection prevention and control requirements.
- Determine whether staff can be tested at the facility or if they will be tested off-site.
  - Develop an informed consent process to ensure the facility can receive results.
  - Although CMS requires routine staff testing, facility policies and procedures should be referenced for staff refusing to be tested.
- Identify testing resources
  - If your facility is concerned about a potential or imminent shortage of testing kits, notify your local health department of the shortage, including your current supply of the item and projected shortage date.
  - CDC's Operation Expanded Testing (OpET) hubs can provide sample collection supplies, shipping materials, laboratory testing and results reporting at no direct cost to recipients. This resource can support vulnerable populations in congregate settings.
    - Arizona hub information: https://letsendthistogether.com/
- For recommendations on testing methods, procedures, results interpretation for LTCFs, refer to
  - Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing.
  - SARS-CoV-2 Antigen Testing in Long Term Care Facilities
  - Interim Guidance for Antigen Testing for SARS-CoV-2
  - Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings
  - Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating
- Determine how results will be shared with the facility, the Arizona Department of Health Services (ADHS), and the local health department.
- Determine a process that captures which staff were tested or were unable to be tested.

CREATE A PLAN FOR MANAGING COVID-19 IN YOUR FACILITY
- Identify space in the facility that could be dedicated 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 COVID-19.
- Identify staff who will be assigned to work only on the COVID-19 care unit when it is in use.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to a single room, implement use of transmission-based precautions, prioritize for testing, transfer to COVID-19 unit if positive).
- Residents in the facility who develop symptoms consistent with COVID-19 should be moved to a single room with a private bathroom pending results of SARS-CoV-2 testing.

- They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing.
- While awaiting results of testing, staff should wear a N95 or higher-level respirator, eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.
- Have a plan for how close contacts who may have been exposed to an individual with COVID-19 will be handled.
  - Residents who are not up-to-date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative.
    - Staff caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).
    - Residents can be removed from transmission-based precautions after day 10 following the exposure (day 0) if they do not develop symptoms.
    - Residents can be removed from transmission-based precautions after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of transmission-based precautions.
  - Residents who are up-to-date with all recommended COVID-19 vaccine doses and residents who have recovered from SARS-CoV-2 infection in the prior 90 days who have had close contact with someone with SARS-CoV-2 infection should wear source control.
    - In general, these residents do not need to be quarantined, restricted to their room, or cared for by staff using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.
  - Asymptomatic residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure.
    - In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- 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 pending return of test results.
- Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection.
- Create a plan for managing new admissions and readmissions.

- ○ Residents with confirmed SARS-CoV-2 infection who have not met [criteria to discontinue transmission-based precautions](#) should be placed in the designated COVID-19 care unit, regardless of vaccination status.
- ○ Residents who are up-to-date with all recommended COVID-19 vaccine doses and residents who recovered from SARS-CoV-2 infection in the prior 90 days do not need to be placed in [quarantine](#).
    - Quarantine might be considered if the resident is moderately to severely immunocompromised.
- ○ In general, all residents who are not up-to-date with all recommended COVID-19 vaccine doses and are new admissions and readmissions (left the facility for ≥24 hours) should be placed in a 10-day quarantine, even if they have a negative test upon admission; COVID-19 vaccine should also be offered. They can discontinue quarantine after 7 days if they are asymptomatic and test negative on a PCR/antigen test within 48 hours before discontinuing quarantine.
    - Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which residents who are not up-to-date with COVID-19 vaccine doses require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to infection prevention and control (IPC) practices in healthcare settings, during transportation, or in the community prior to admission.
    - Staff should wear a N95 or higher level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.
    - Testing at the end of this period can be considered to increase certainty that the resident is not infected.
- ○ Newly-admitted and readmitted residents (left the facility for ≥24 hours), regardless of vaccination status, should have a series of two viral tests for SARS-COV-2 infection; immediately and, if negative, again 5–7 days after their admission.
    - In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- ● Create a plan for residents who leave the facility.
    - ○ Residents who leave the facility should be reminded to follow recommended IPC practices (e.g., source control, physical distancing, and hand hygiene) and to encourage those around them to do the same.
        - Individuals accompanying residents (e.g., transport personnel, family members) should also be educated about these IPC practices and should assist the resident with adherence.
    - ○ For residents going to medical appointments, regular communication between the medical facility and the nursing home (in 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 can be implemented.

- ○ In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with SARS-CoV-2 infection.
- ○ Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.
- ○ Residents who leave the facility for 24 hours or longer should generally be managed as new admissions and readmissions.

ASSESS CLEANING AND ACCESS TO HAND HYGIENE

- ● Ensure access to alcohol-based hand sanitizer, with 60–95% alcohol, in every resident room (inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, therapy gym).
  - ○ Unless hands are visibly soiled, performing hand hygiene using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands.
- ● Make sure that sinks are well stocked with soap and paper towels for handwashing.
- ● Make tissues and facemasks available to residents and staff.
- ● Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
- ● Ensure proper cleaning of environmental surfaces.
  - ○ Develop a schedule for regular cleaning and disinfection of shared equipment and frequently touched surfaces in resident rooms and common areas.
  - ○ Appropriate disinfectants include:
    - ■ Bleach-and-water solution (0.1% solution; 1:50 dilution).
    - ■ List N: Disinfectants for Coronavirus (COVID-19).

MAINTAIN INVENTORY OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

- ● Select appropriate PPE and provide it to staff in accordance with Occupational Safety and Health Administration PPE standards (OSHA).
- ● Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
- ● Routinely perform and maintain an inventory of PPE in the facility.
- ● Contact your local health department to obtain assistance during PPE shortages.
- ● Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.

IMPLEMENT VISITOR RESTRICTIONS

- Allow visitation in accordance with [CMS Nursing Home Visitation guidance](#)..
- Communicate visitation policies and rules to residents and families.
- Facilitate remote communication between residents and visitors (e.g., video call applications on cell phones or tablets; be sure to disinfect high-touch surfaces between uses).
- Post instructional signage throughout the facility and educate visitors on facility practices.
- Ensure visitors and residents wear masks and physically distance during visits when the county has substantial or high community transmission.
- Screen visitors (i.e., individuals that are not facility staff) and restrict anyone with:
  - A positive viral test for SARS-CoV-2 and who has not [met resident criteria for discontinuation of isolation precautions](#).
  - Fever or symptoms consistent with COVID-19 (e.g., cough, sore throat, or shortness of breath), regardless of vaccination status.
  - Close contact with an individual with COVID-19 during their infectious period:
    - Individual who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period,
    - Individual providing care in a household without using recommended infection control precautions,
    - Individual who has had direct physical contact (hugging or kissing),
    - Individual who has shared eating and/or drinking utensils, or
    - Individual who has been sneezed on, coughed on, or got respiratory droplets on them.
  - Close contact restrictions do not apply to individuals who are up-to-date with all recommended COVID-19 vaccine doses or who recovered from SARS-CoV-2 infection in the prior 90 days, or to healthcare providers or EMS providers using appropriate PPE and implementing appropriate infection control practices.
- Have visitors sign visitor logs, in case contact tracing becomes necessary.
- Provide instructions, before visitors enter, on hand hygiene, limiting surfaces touched, use of PPE according to current facility policy, and limit their movement and interactions with others in the facility (e.g., designated visiting areas).
- Clean and/or disinfect frequently touched surfaces in the facility often and in designated visitation areas after each visit.
- Advise exposed visitors (e.g., contact with a COVID-19 positive resident unidentified at time of visit) to report any signs and symptoms of acute illness to their healthcare provider for a period of at least -10 days after the last known exposure to a resident with COVID-19.
- Maintain contact information for residents' family or next of kin and continue open communication.

SCREEN STAFF
- Implement universal use of a well-fitting respirator or facemask for source control by all staff when they enter the facility.
- Establish a process to identify staff, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for

SARS-CoV-2, 2) [symptoms of COVID-19](#), or 3) who meets criteria for [quarantine](#) or [exclusion from work](#).
   - ○ Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.
- Instruct staff that if they become ill while working, they should immediately stop working, keep their respirator or facemask on, notify their facility supervisor, and go home.
   - ○ Implement a tracking system for clearing staff to return to work after illness.
- Encourage staff to inform their facility supervisor if they have had close contact (not using appropriate PPE and implementing appropriate infection control practices) with an individual with COVID-19 during their infectious period.

SCREEN RESIDENTS
- Actively screen all residents, at least daily, and at time of admission, for fever (≥100.0℉) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry.
   - ○ Perform a temperature check, using a non-touch thermometer, if available.
   - ○ Ask residents to report and assess for symptoms of COVID-19.
- Older adults may not show typical symptoms such as fever or respiratory symptoms.
   - ○ Less common symptoms include: new or worsening malaise, headache, new dizziness, diarrhea, vomiting, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
   - ○ Because some of the [symptoms are similar](#), it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections, based on symptoms alone. [Consider testing for pathogens](#) other than SARS-CoV-2 and initiating appropriate infection prevention precautions for symptomatic older adults.
- Implement a tracking system for ill residents. CDC has [resources](#) that can assist with tracking infections.
- Immediately isolate residents symptomatic with respiratory illness.
   - ○ Use standard, contact, and droplet precautions with eye protection when caring for residents with undiagnosed respiratory infection, unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis).
- Residents should wear a well-fitting facemask or cloth face covering (if tolerated) or use tissues to cover their mouth and nose when staff/visitors are in their room and when leaving the room, including for procedures done outside of the facility.
- Coordinate offsite medical appointments with the offsite medical facility to avoid potential spread of COVID-19.
- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.

EDUCATE STAFF

- Educate all staff (including consultants, ombudsmen, and volunteers as applicable) on the prevention of respiratory diseases, including COVID-19.
    - Ensure education includes basic hand washing, respiratory hygiene, and implementation of standard, contact, and droplet precautions with eye protection.
    - Review CDC's [Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic](#) regularly for current information and ensure staff and residents are updated when this guidance changes.
    - CDC has created [training resources](#) for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
- Ensure [training](#) and adherence to proper donning and doffing of personal protective equipment (PPE).
- Consider a dedicated donning/doffing observer to monitor, protect, and guide health care providers through the protocols of donning and doffing PPE.
- Instruct staff to practice physical distancing (maintain a distance of at least 6 feet from others) when in break rooms or common areas.
- Ensure staff wear eye protection during all resident care activities (including residents not in isolation or quarantine and regardless of resident vaccination status) if the facility is in an area with substantial to high community transmission.
- Ensure staff wear well-fitting respirators or facemasks for source control at all times, while they are in the healthcare facility, including in break rooms or other spaces where they might encounter co-workers.
    - To reduce the number of times staff must touch their face and potential risk for self-contamination, staff should consider continuing to wear the same respirator or well-fitting facemask throughout their entire work shift unless they become soiled, damaged, or hard to breathe through when the respirator or facemask is used for source control.
    - Staff who are up-to-date on all recommended COVID-19 vaccine doses could choose not to wear source control or physically distance when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen).
        - They should wear source control when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors).
- Ensure staff remove their respirator or facemask, perform hand hygiene, and put on their community source control (i.e., mask), when leaving the facility at the end of their shift.
- Encourage staff to be up-to-date on all vaccinations, including their COVID-19 and seasonal influenza vaccination. [More information and additional COVID-19 vaccine resources](#) are provided by the Health Services Advisory Group.
- Remind staff not to report to work when ill.
- Exclude staff from work if they have symptoms consistent with COVID-19 until meeting [return to work criteria](#).
- Ensure staff monitor all residents for signs and symptoms consistent with COVID-19.

EDUCATE RESIDENTS
- Educate all residents and families on the prevention of respiratory diseases, including COVID-19.
  - Ensure education includes basic hand washing and respiratory hygiene.
  - Enforce physical distancing (at least 6 feet) between residents.
  - Ensure residents are up-to-date on vaccinations, including their COVID-19, seasonal influenza, and pneumococcal vaccinations.
- Ask residents to report and assess for symptoms consistent with COVID-19 and if they have close contact with a person with SARS-CoV-2 infection while outside the facility.
- Explain actions the facility is taking to protect them and their loved ones from COVID-19.
- Residents should wear a well-fitting facemask or cloth face covering (if tolerated) or use tissues to cover their mouth and nose when leaving the room for medically necessary purposes and when staff are in their room.
  - Source control should not be placed on anyone who cannot wear a mask safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask or who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
  - Residents who are up-to-date on vaccination in areas of low to moderate transmission could choose not to use source control when in communal areas of the facility; however, residents at increased risk for severe disease should still consider continuing to practice physical distancing and use of source control.

VACCINATIONS

Vaccinate residents and staff against SARS-CoV-2.
- Remaining up-to-date with all recommended COVID-19 vaccine doses is an important step to protect both staff and residents against SARS-COV-2 infection.
  - Current COVID-19 vaccine recommendations are available in the Interim Clinical Considerations for Use of COVID-19 Vaccines.
- The CDC COVID-19 Vaccines for Long-term Care Facility Residents provides resources including information about COVID-19 vaccines for residents and family members.
- Maintain a record of the vaccination status of residents and staff.

Manage COVID-19: Prevent the spread of COVID-19 within your facility.

USE OF TESTING TO INFORM THE RESPONSE
- Testing should be implemented **in addition** to recommended infection prevention and control measures. Facilities should develop a plan for testing residents and staff.
- Follow CMS guidance on facility testing requirements for residents and staff in CMS certified facilities.

REPORT POSITIVE TEST RESULTS
- Report positive results of on-site COVID-19 testing (e.g., antigen testing) directly to ADHS pursuant to A.A.C. R9-6-204 and to fulfill Coronavirus Aid, Relief, and Economic Security (CARES) Act reporting requirements. There are two main methods for reporting these results to ADHS:

- The easiest method to implement is to register your facility with this [form](#). Once registered, you will receive another link to enter reports into a separate form. A guidance document on this process is available on the [Lab Resources webpage](#).
- The second option is to follow the flat file reporting requirements outlined on the [Lab Resources webpage](#). If files are not submitted in the proper format, you will be required to resubmit the file in the appropriate format.
- If your facility is reporting in the NHSN COVID-19 test module, ADHS needs to conduct data validation to make sure the reports coming from NHSN are meeting the Arizona reporting requirements for your facility.
  - Please make sure your facility is reporting all positive test results to both reporting methods (POC web entry and NHSN) paying special attention to the collection & result dates.
  - To meet the state requirements, reports from tests performed at your facility still need to be submitted through the POC web entry until you receive communication from ADHS indicating you passed the validation.
- Ensure COVID-19 positive results and suspected outbreaks are reported to the [local health department](#) pursuant to Arizona Administrative Code [R9-6-202](#).
  - Submit a report within 24 hours after a case or suspect case is diagnosed, treated, or detected or an occurrence is detected.
  - Submit a report within 24 hours after detecting an outbreak of Respiratory Disease in a Health Care Institution or Correctional Facility.
- Your staff, residents, and residents' families/guardians should also be notified.
  - [Template Letter for Staff](#)
  - [Template Letter for Residents, Families/Guardians, and Visitors](#)

RESPONSE TO NEWLY IDENTIFIED CASES

Due to the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any staff or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak. An outbreak can be investigated by two approaches: 1) Contact tracing approach 2) Broad-based approach.

- The approach to an outbreak investigation should take the following into consideration:
  - facility's experience and resources to perform individual contact tracing,
  - the vaccination acceptance rates of staff and residents,
  - whether the index case is a resident or staff,
  - whether there are other individuals with suspected or confirmed SARS-CoV-2 infection identified at the same time as the index case, and
  - the extent of potential exposures identified during the evaluation of the index resident.
- Consider increasing monitoring of all residents from daily to every shift to more rapidly detect those with new symptoms.

CONTACT TRACING APPROACH

- Perform contact tracing to identify any staff who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-CoV-2 infection.
  - Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.

- Guidance for staff with higher-risk exposures, including exposures in the community is available in the [CDC's Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#).
- Asymptomatic residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure.
  - Testing is not necessary for people who recovered from SARS-CoV-2 infection in the prior 90 days if they remain asymptomatic, including if they have had close contact or a higher-risk exposure; however, if testing is performed on these people, an antigen test instead of a NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Residents who are not up-to-date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. Staff caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).
  - Residents can be removed from transmission-based precautions after day 10 following the exposure (day 0) if they do not develop symptoms.
  - Residents can be removed from transmission-based precautions after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of transmission-based precautions.
- Residents who are up-to-date with all recommended COVID-19 vaccine doses and residents who recovered from SARS-CoV-2 infection in the prior 90 days do **not** need to be quarantined, restricted to their room, or cared for by staff using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.
  - Residents who are up-to-date with all recommended COVID-19 vaccine doses and residents who have recovered from SARS-CoV-2 infection in the prior 90 days who have had close contact with someone with SARS-CoV-2 infection should wear source control.
- If testing of close contacts reveals additional staff or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or staff with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection.
  - A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.

BROAD-BASED APPROACH

If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility).

- Perform testing for all residents and staff on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5–7 days later.
  - In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Residents who are not up-to-date with all recommended COVID-19 vaccine doses should generally be restricted to their rooms, even if testing is negative, and cared for by staff using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.
- Residents who are up-to-date with all recommended COVID-19 vaccine doses and residents who recovered from SARS-CoV-2 infection in the prior 90 days do not need to be restricted to their rooms or cared for by staff using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.
  - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for residents and work restriction of staff with higher-risk exposures, even if they are up-to-date with all recommended COVID-19 vaccine doses.
- If no additional cases are identified during the broad-based testing, room restriction and full PPE use by staff caring for residents who are not up-to-date with all recommended COVID-19 vaccine doses can be discontinued after 14 days and no further testing is indicated.
- If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3–7 days in addition to room restriction and full PPE use for care of residents who are not up-to-date with all recommended COVID-19 vaccine doses, until there are no new cases for 14 days.
  - If antigen testing is used, more frequent testing (every 3 days), should be considered.

MANAGE RESIDENTS WITH SUSPECTED OR CONFIRMED SARS-COV-2 INFECTION
- Ensure the resident with new-onset suspected or confirmed COVID-19 is isolated and cared for using all recommended COVID-19 PPE.
- Place the resident in a single room with a private bathroom pending results of SARS-CoV-2 testing if possible.
  - In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. However, in some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need

to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.
- 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 at their current location pending return of test results.
- Designate a COVID-19 care unit for positive residents.
  - Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection.
  - Identify dedicated staff to care for COVID-19 positive residents and provide infection control training.
  - Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.
  - Place signage at the entrance to the COVID-19 care unit that instructs staff they must wear all recommended COVID-19 personal protective equipment (PPE) at all times while on the unit. Transfer confirmed COVID-19 resident to the designated COVID-19 care unit, regardless of symptoms.
- Residents who have tested COVID-19 positive and who have met criteria for discontinuation of isolation precautions can go to a regular unit.
- Perform appropriate monitoring of ill residents (including documentation of oxygen saturation via pulse oximetry) at least 3 times daily to quickly identify residents who require a higher level of care.
- Notify the receiving facility, EMS and transport service personnel prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.

OPTIMIZE PPE AND ASSESS SUPPLY
- Consider designating staff to steward PPE supplies and encourage appropriate use.
- Make PPE accessible outside of the resident room and in resident care areas.
- Implement PPE preserving strategies when PPE supplies are stressed, running low, or absent.
  - Continue to assess PPE supply and current situation to determine when a return to conventional standard practices can be considered.
- In areas of substantial to high transmission in which staff are using eye protection for all patient encounters, extended use of eye protection may be considered as a conventional capacity strategy.
- Beyond anticipated shortages, increased feasibility and practicality may also be considered in decisions to implement extended use of N95 respirators for staff who are sequentially caring for a large volume of patients with suspected or confirmed SARS-CoV-2, including those cohorted in a SARS-CoV-2 unit, those placed in quarantine, and residents on units impacted during a SARS-CoV-2 outbreak.
- If your facility is concerned about a potential or imminent shortage of PPE, notify your local health department of the shortage, including your current supply of the PPE item and projected shortage date.

RELEASE FROM ISOLATION AND QUARANTINE GUIDANCE
COVID-19 positive residents or staff are considered infectious 48 hours prior to symptom onset (date of first positive test if asymptomatic) until meeting release from isolation criteria.

Isolation and quarantine recommendations for residents, including those who were previously infected and/or those who are up-to-date with recommended COVID-19 vaccine doses can be found in the ADHS 'Release from Isolation and Quarantine' guidance. Work restrictions for staff can be found in the CDC's Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.

ADMISSION CRITERIA
LTCFs must develop policies and procedures to facilitate the admission and readmission of residents who are ready for safe discharge from an acute care hospital without the requirement of a negative SARS-CoV-2 test result and should adhere to the following ADHS Admission Criteria:
- Patients' clinical needs are appropriate to the post-acute clinical care facility.
- Facility has appropriate PPE and staff to maintain transmission-based precautions as needed for the patient.
- If a facility does not have appropriate PPE or the isolation capability to maintain transmission-based precautions as needed for the patient, then the patient will be appropriately admitted once they meet criteria for release from isolation or quarantine as determined by the Arizona Department of Health Services.
- The facility shall follow the ADHS 'Release from Isolation and Quarantine' guidance.

CONTACT YOUR LOCAL HEALTH DEPARTMENT ABOUT STAFFING CONCERNS
- If staffing needs are not being met due to an outbreak in the facility, notify your local health department of your scheduled staffing, current variance, and minimum number of staff by category needed to meet resident care needs. If staffing is insufficient to run the facility safely, reach out to families/guardians outlining potential options for discharge home and home care, depending on level of patient acuity.