RECOMMENDATIONS TO PREVENT AND RESPOND TO COVID-19 IN LONG TERM CARE, BASIC CARE, & ASSISTED LIVING FACILITIES

Daily Prevention Measures

Core Prevention:

- Post visual alerts (e.g., signs, posters) in strategic places (e.g., waiting areas, elevators, cafeterias) to provide instructions about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include wearing a KN95 or facemask (for visitors) for source control, and how and when to perform hand hygiene.
- Prepare your facility for a wing or section of rooms away from other residents to be used for new admits and residents that are suspect or confirmed COVID-19 cases.
  - Have a plan in place to provide dedicated staff for these areas.
- All staff should wear face masks. Face masks are preferred over cloth face coverings for all staff because they offer both source control and protection for the wearer against exposure to splashes and sprays of infectious materials from others. Cloth face coverings are not personal protective equipment (PPE).
  - Healthcare personnel (HCP) should remove their respirator or facemask and put on their community source control mask when leaving the facility at the end of their shift (cloth face coverings are recommended for all people when outside the home).
  - If HCP must touch or adjust their facemask or cloth face covering, hand hygiene should be performed immediately before and after touching.
- In general, source control is recommended for EVERYONE in a healthcare setting.
- There are a few exceptions in counties with low to moderate community transmission where individuals who are up to date on all recommended COVID-19 vaccines, including booster dose(s) when eligible, and do not have other indications for source control (e.g., close contact with someone with SARS-CoV-2 infection or symptomatic) could choose not to wear source control:
  - Up to date HCP when they are in well-defined areas that are restricted from resident access (e.g., staff meeting rooms, kitchen)
  - Up to date resident and their up-to-date visitors in single-person rooms; in multi-person rooms where roommates are not present; in designated visitation areas when others are not present.
  - Up to date residents in nursing homes.
- Even in the exempted situations, source control remains recommended for individuals who have:
  - Are not up to date on all COVID-19 vaccines; or
- Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (patient and visitors) or a higher risk exposure (HCP) with someone with SARS-CoV-2 infection for 14 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission (i.e., outbreak); or
- Otherwise had source control and physical distancing recommendations by public health authorities.

- Up to date HCP might also choose to continue using source control if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is not up to date.
- Review training with staff for isolation protocols, donning and doffing of PPE, hand hygiene, and cough etiquette.
  - Ongoing auditing should be in place for PPE use and hand hygiene with immediate feedback and retraining as needed.
  - Make hand sanitizer and necessary PPE available in areas where resident care is provided. Put 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 to another resident in the same room.

- Screen HCP at start of their shift for fever, any symptoms and COVID-19 risk.
  - Document symptoms and ask that HCP also regularly monitor themselves for fever and other symptoms.
  - Establish a process, 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.
  - Healthcare personnel (HCP), even if up to date, should report any of the 3 above criteria to occupational health or another point of contact designated by the facility. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
  - If HCP develop symptoms while at work, they should immediately put on a face mask (if not wearing one under universal masking), inform their supervisor, and leave the workplace.
  - HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.

- All healthcare workers must be permitted to come into the facility as long as they are not subject to a work exclusion or showing signs or symptoms of COVID-19. In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance.
  - All staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.
- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill HCP to stay home. Remind HCP not to report to work when ill.
• Mask donning and doffing training should be provided. Mask use with hand hygiene should be monitored.
  o In general, up to date HCP should continue to wear a well fitted face mask while at work. However, up to date HCP could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If not up to date HCP are present, everyone should wear source control and not up to date HCP should physically distance from others.
    ▪ Masks should not be hung from the ear, pushed up on forehead, worn under the chin or nose, or hung from a lanyard/neck strap.
  o The supply and availability of facemasks have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices.
  o Facemasks are recommended for source control while HCP are in the healthcare facility, to cover one’s mouth and nose to prevent spread of respiratory secretions when talking, sneezing, or coughing. When used for this purpose, facemasks may be used until they become soiled, damaged, or hard to breathe through. They should be immediately discarded after removal, e.g., lunch breaks.
  o HCP should remove and discard their respirator or facemask, perform hand hygiene, and put on their community source control mask when leaving the facility at the end of their shift.
  o If gloves and/or gowns are used with each resident encounter, ensure they are being discarded between residents and hand hygiene is performed after gloves are discarded.
  o Eye protection should be worn during not up to date resident care encounters to ensure the eyes are also protected from exposure to respiratory secretions.
• Educate staff, including up to date HCP, that outside of work should continue to:
  o Take precautions in public like wearing a well-fitted mask and physical distancing as recommended by the Centers for Disease Control and Prevention (CDC).
  o Wear masks, practice physical distancing, and adhere to other prevention measures when visiting with not up to date people who are at increased risk for severe COVID-19 disease or who have an not up to date household member who is at increased risk for severe COVID-19 disease.
  o Wear masks, maintain physical distance, and practice other prevention measures when visiting with not up to date people from multiple households.
  o Take precautions while attending gatherings or avoid crowded poorly ventilated spaces when precautions cannot be adhered to.
• Continue to educate not up to date staff about the important role COVID-19 vaccines, including booster dose(s), have in preventing resident illness, hospitalization, and death.
• Up to date HCP may be exempt from routine testing. However, all HCP, regardless of vaccination status, should have a viral test if the HCP is symptomatic, has a higher-risk exposure or is working in a facility experiencing an outbreak.
• Asymptomatic HCP with a higher-risk exposure AND residents with close contact, 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 no sooner than 1 days, and if negative 5–7 days after
exposure, best practice recommends that HCP should continue to wear an N95 mask in all areas for 14 days after exposure.

- In nursing homes, not up to date HCP should continue expanded testing.
- **Testing is performed according to community transmission levels, not test positivity.**
  - In nursing homes located in counties with **substantial to high community transmission**, not up to date HCP should have a **viral test twice a week**.
    - If not up to date HCP work infrequently at these facilities, they should ideally be tested within 3 days before their shift and the day of their shift.
  - In nursing homes located in counties with **moderate community transmission**, not up to date HCP should have a viral test **once a week**.
  - In nursing homes located in counties with **low community transmission**, expanded screening testing for asymptomatic HCP, regardless of vaccination, is **not recommended**.
  - While not required, facilities in counties with substantial or high levels of community transmission are encouraged to offer testing to visitors, if feasible. If facilities do not offer testing, they should encourage visitors to be tested on their own before coming to the facility (e.g., within 2–3 days).

**CDC’s COVID-19 Data Tracker should be used to determine SARS-CoV-2 community transmission for the county where the facility is located.**

**Visitor Practices:**

- **Visitation is now allowed for all residents at all times.**
- Limit and monitor entry points to the facility.
- Visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or currently meet the criteria for quarantine, should not enter the facility. Facilities should screen all who enter for these visitation exclusions.
  - 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.
- Even if the visitor has met **community criteria** to discontinue isolation or quarantine, visitors **should not visit** if they have any of the following listed below, and have not met the same criteria used to discontinue isolation and quarantine for patients (typically until **10 days** after last exposure or onset of symptoms has passed):
  1) a positive viral test for SARS-CoV-2,
  2) **symptoms of COVID-19**, or
  3) close contact with someone with SARS-CoV-2 infection
  - **If visitation cannot be postponed (such as for end-of-life visits) the visitor may be subject to additional precautions.**
- Post signs at the entrances to the facility advising that no visitors may enter the facility without entry screening for fever, symptoms, and COVID-19 exposure.
- Visitors should wear a clean well fitted cloth mask or face mask for source control.
Before allowing indoor visitation, the risks associated with visitation should be explained to residents and their visitors so they can make an informed decision about participation.

If the nursing home’s county COVID-19 community level of transmission is substantial to high, all residents and visitors, regardless of vaccination status, should wear face coverings or masks and physically distance, at all times.

In areas of low to moderate transmission, the safest practice is for residents and visitors to wear face coverings or masks and physically distance, particularly if either of them is at increased risk for severe disease or are not up to date.

- Up to date residents can choose to have close contact with their visitor while wearing a well-fitting face mask and performing HH before and after.
- If the resident and all their visitor(s) are up to date and the resident is not moderately or severely immunocompromised, they may choose not to wear face coverings or masks and to have physical contact.
- Visitors should wear face coverings or masks when around other residents or healthcare personnel, regardless of vaccination status.

The safest approach, particularly if either party is not up to date, is for residents and their visitors to maintain physical distancing (maintaining at least 6 feet between people). Visitors should physically distance from other residents and HCP in the facility.

Not up to date residents may also choose to have physical touch based on their preferences and needs, such as with support persons for individuals with disabilities and visitors participating in certain religious practices, including in end-of-life situations. In these situations, not up to date residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit.

Residents on transmission-based precautions (TBP) or quarantine, while not recommended, can still receive visitors in the resident’s room. The resident should wear a well-fitting facemask (if tolerated). Visitors should be made aware of the risks of visitation, core principles of infection prevention. A facility is not required but may offer masks and other PPE as appropriate.

If visitors are for a confirmed COVID-19 or presumptive cases, HCP needs to assist them with donning and doffing full COVID-19 PPE. Do NOT give N95 mask as they are not fit tested.

- Educate not to touch eyes, adjust mask, etc. with gloved hands.
- Visits should be conducted using social distancing, however if during a compassionate care visit, personal contact can be allowed while adhering to infection control guidelines.
  - Have hand sanitizer available so HCP can perform HH when assisted doffing is completed. Have visitor complete hand hygiene and don clean mask before exiting the facility.

Compassionate care visits are allowed at all times.

Hand hygiene should be performed by the resident and the visitors before and after contact.

- Visitors should be instructed that if they touch or adjust their face covering, they should perform hand hygiene immediately.

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.
• Facilities should have a plan to manage visitation and visitor flow. Although there is no limit on visit length, frequency, or the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. Facilities should ensure that physical distancing can still be maintained during peak times of visitation (e.g., lunch time, after business hours, etc.). Also, facilities should avoid large gatherings (e.g., parties, events) where large numbers of visitors are in the same space at the same time and physical distancing cannot be maintained.
• If a resident’s roommate is not up to date or immunocompromised (regardless of vaccination status), visits should not be conducted in the resident’s room, if possible.
• For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of infection prevention including source control and physical distancing.

Resident Practices:
• When tolerated, cloth face coverings or a face mask should be used for source control when a resident leaves their room.
• Cloth face coverings should not be placed on anyone who has trouble breathing or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
  o A face shield may be considered if facemasks are not tolerated by the resident, however face shields are not considered adequate respiratory protection for source control.
• Residents may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room.
• Implement a laundering process for the residents’ cloth masks.
• Residents with close contact to a COVID-19 positive individual, 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 no sooner than 1 day, and if negative 5–7 days after exposure and wear a mask for 14 days after exposure when around others.
• 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.
• 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 who have had close contact with someone with SARS-CoV-2 infection should wear source control and be tested as described above.
• Residents who are up to date and residents who have had SARS-CoV-2 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP 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 NDDoH.
• Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices including wearing a face covering or mask, physical distancing, and hand hygiene and to encourage those around them to do the same.
• Screen residents upon return for signs or symptoms of COVID-19.
• If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, test the resident for COVID-19, regardless of vaccination status. Place the resident on quarantine if the resident is not up to date on all COVID-19 vaccines.
• If the resident develops signs or symptoms of COVID-19 after the outing, test the resident for COVID-19 and place the resident on Transmission-Based Precautions, regardless of vaccination status. If the resident tests negative, they can be removed from transmission-based precautions.
• Residents going to the Emergency Room (ER) or Clinic:
  o Residents should wear a mask if tolerated.
  o Assess resident twice a day for 14 days for fever and new onset of symptoms.
  o Consider placing not up to date residents on transmission-based precautions if they were in ER or comparable setting for more than 24 hours.
• Not up to date residents leaving the facility for family outings/events should be closely monitored for 14 days. If they do not reside in a private room, the curtain should always be pulled between residents during the 14 days and roommate should be assessed for signs and symptoms as well.
  o Educate resident and family on the importance of source control, physical distancing, and hand hygiene.
  o Consider testing 5-7 days after outing.
  o A nursing home may also opt to test not up to date residents without signs or symptoms if they leave the nursing home frequently or for a prolonged length of time, such as over 24 hours.
  o Facilities might consider quarantining not up to date residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention measures.
• Group activities/communal dining:
  o While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. The safest approach is for everyone, regardless of vaccination status, to wear a face covering or mask while in communal areas of the facility.
  o For more information, see the Implement Source Control section of the CDC guidance “Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.”
  o Up to date residents in Nursing Homes in Areas of Low to Moderate Transmission: Nursing homes are healthcare settings, but they also serve as a home for long-stay residents and quality of life should be balanced with risks for transmission. In light of this, consideration could be given to allowing up to date residents to not 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.
In situations when residents are not up to date with all recommended COVID-19 vaccine dose(s) and could be in the same space (e.g., communal dining, activities, beauty/barber shop) arrange seating so that residents can sit at least 6 feet apart, especially in counties with substantial or high transmission.

- Screen residents for symptoms and fever, on admission and at least daily.
  - Residents with a temp ≥100.0°F (people 70 or immunocompromised may have fever at 99.6°F) or repeated low-grade temps (>99°F) or symptoms should be placed in a single room, if possible, and placed in isolation precautions using personal protective equipment (PPE) including gown, gloves, and N95 or higher respirator (facemask if respirator is not available) with face shield or goggles for eye protection pending further evaluation. These residents should be tested for COVID-19 if clinically indicated.
    - Ideally, include an assessment of oxygen saturation via pulse oximetry.
    - Dedicate equipment to these residents and disinfect between use.
    - Resident should remain in the single room and HCP should wear the PPE listed above while awaiting COVID-19 test results.
  - Residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
    - Document daily screening results.

- Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas and make sure sinks are well-stocked with soap and paper towels for handwashing.
- Make tissues and face masks available for coughing people. Consider designating staff to steward those supplies and encourage appropriate use by residents and staff.
- Ensure all residents are up to date for routine immunizations, including influenza and pneumococcal vaccines.
- Notify the NDDoH at 1-888-391-3430 about any residents with severe respiratory infection or if the facility identifies ≥3 cases of respiratory illness among residents and/or HCP within 72 hours of each other.
  - These situations should prompt further investigation in addition to testing for COVID-19.
- When a resident or HCP with suspected or confirmed COVID-19 is identified, facilities should be instructed to notify the NDDoH immediately at 1-888-391-3430.

**New Admission and Readmission Recommendations**

**COVID-19 Quarantine Recommendations:**
• 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** do not need to be placed in quarantine but should be tested immediately (but no sooner than 24 hours) and, if negative, again in 5–7 days. Quarantine might be considered if the resident is moderately to severely immunocompromised.

• A new admission that is **not up to date** and **not** confirmed or suspected of having COVID-19 should be placed in a private room, with droplet precautions including an N95 mask. If possible, the resident should continue to wear a mask or cloth face covering for source control for a total of 14 days. If the individual remains asymptomatic, then he/she can be moved to another room with a roommate after 10 days or 7 days with a negative viral test.
  
  o Assess the resident twice a day for symptoms and fever for 14 days.
  
  o Keep the door to the resident room closed.
  
  o Attempts should be made to have these residents cohorted with dedicated staff.
  
  o If a resident becomes symptomatic, then he/she should be tested for COVID-19.
  
  o Increase monitoring of residents for worsening of symptoms.
  
  o If transfer to an acute hospital is needed due to worsening condition, without testing or before test results are known, call ahead to make arrangements and notify the facility and transfer crew that the resident may have COVID-19.
  
  o Newly admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection: immediately (but no sooner than 24 hours) and, if negative, again 5–7 days after their admission.
  
  o Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which not up to date residents 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 IPC practices in healthcare settings, during transportation, or in the community prior to admission.

• If the admit is a close contact to a COVID-19 positive person, testing is recommended immediately but no sooner than 1 day, and, if negative, 5–7 days after exposure. Up to date residents who are close contacts do not need to quarantine. Not up to date close contacts should be placed in a 10 day quarantine.
  
  o Following close contact, potentially exposed residents should continue to wear source control.

**Suspect, or Confirmed COVID-19 Case:**

• If a new admit is a confirmed or suspect case, prior to admission, they should have been in isolation until at least 10 days have passed since symptom onset and it has been 24 hours since last fever without the use of fever-reducing medications and improvement in symptoms OR 10 days have passed since the date of their first positive COVID-19 test (if asymptomatic).
  
  o For positive COVID-19 cases with severe or critical illness or severely immunocompromised, duration of isolation for at least 10 days and up to 20 days after symptom onset or after first positive COVID-19 test for severely immunocompromised patients who are asymptomatic, a test-based strategy and (if available) consultation with an infectious disease specialist or other expert is recommended to determine when these patients can be released from isolation.
If a new admit is suspected of having COVID-19 prior to admission, the individual should be tested. If negative, follow guidance above for new admissions.

Facility has a COVID-19 Case in a Resident or Staff

Mitigation and Prevention Recommendations:
- Because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak.
  - Healthcare facilities should continue to follow infection prevention and control recommendations for not up to date individuals (e.g., use of Transmission-Based Precautions for those that have had close contact to someone with SARS-CoV-2 infection) when caring for up to date individuals with moderate to severe immunocompromise due to a medical condition or receipt of immunosuppressive medications or treatments.
  - Consider having pregnant or immunocompromised staff assigned to other areas in the facility.
  - If the resident is having mild symptoms, you can keep them in your facility as long as their clinical care needs can be met.
  - Place resident in a private room or cohort COVID-19 positive residents together (COVID Unit), ideally placed 6 feet apart. Space should be dedicated to care for residents with COVID-19 such as a floor, unit, or wing in the facility or a group of rooms at the end of the unit.
    - Consider multi-drug resistant organism (MDRO) infection/colonization status when making resident placement decisions. Staff must change their gown after working with residents infected or colonized with a MDRO.
  - 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 shelter-in-place at 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.
  - Roommates of residents with SARS-CoV-2 infection should be considered exposed and potentially infected. Not up to date residents, if at all possible, should not share rooms with other residents while they are in quarantine (i.e., for the 14 days following the date their roommate was moved to the COVID-19 care unit).
  - Place COVID-19 positive resident(s) in droplet precautions, with the addition of an N95 mask for PPE.
    - Best practice recommends staff should be fit tested for use of N95 masks in healthcare settings and perform self-seal checks each time a mask is donned.
    - The same mask and eye protection can be used for multiple residents that are cohorted, but gown and gloves should be changed between residents and hand hygiene performed. Mask should be discarded at the end of each shift or before if visibly soiled, damaged, or difficult to breathe through.
- Same gown may be considered if there is supply shortage, but resident MDRO history needs to be identified and staff trained on individual gown use for those residents.
- Eye protection should be disinfected, adhering to contact time, when visibly soiled and at end of shift. Eye protection should be stored between shifts, labeled with HCP name, and dedicated to a single person for use.
- Cloth face coverings should NOT be worn in place of face masks or N95 respirators.
- If N95 masks are not available or HCP are not fit tested, a surgical mask and face shield or goggles can be worn.
- Additional PPE may be ordered at hanassets.nd.gov.

- Keep the door to the resident room closed.
  - 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.

- Dedicate equipment to these residents and disinfect between use.
- A log should be kept of all staff going in and out of room. Include family if compassionate care visits were to occur.
- Increase monitoring for worsening of symptoms.
- Monitor staff for proper use of PPE and hand hygiene.
- Have dedicated staff care for the resident(s).
- See CDC’s Strategy to Mitigate Healthcare Personnel Staffing Shortages.
- Positive COVID-19 residents and staff should remain in isolation until at least 10 days have passed since symptom onset and it has been 24 hours since last fever without the use of fever-reducing medications and improvement in symptoms OR 10 days have passed since the date of their first positive COVID-19 test (if asymptomatic).
  - For positive COVID-19 cases with severe or critical illness or severely immunocompromised^, duration of isolation for at least 10 days and up to 20 days after symptom onset or after first positive COVID-19 test for severely immunocompromised patients who are asymptomatic, may be warranted. Consider consultation with infection control experts.
  - The test-based strategy is not recommended to determine when to discontinue isolation, except in rare circumstances.
- If resident worsens, arrange for transport and admission to acute care, calling ahead to make arrangements and notify both services of COVID-19 diagnosis.
- Nursing staff should organize their work and take on the duties of environmental cleaning to decrease number of staff entering room.
  - Environmental staff are usually not fit tested for N95 masks.
- If nursing staff from the unit are working with residents other than COVID-19 confirmed or suspected residents, separate PPE, including masks should be used for working with residents who are not suspect or COVID-19 positive.
• N95 masks used with COVID-19 confirmed or suspected residents should be discarded after each treatment if receiving a nebulizer or other aerosolized therapy.
• Disinfect eye protection after each treatment adhering to contact time if resident is receiving nebulizer or other aerosolized therapy.
• Provide notification to resident’s families/guardians when there is a case of COVID-19 identified in your facility.
• Once residents have recovered from COVID-19 they may return to their rooms, facility activities and communal dining.
• Continue to monitor daily once they have returned to their baseline.

Conduct testing of residents and staff according to QSO-20-38-NH REVISED (cms.gov)

CMS Testing Summary Table

<table>
<thead>
<tr>
<th>Testing Trigger</th>
<th>Staff</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic individual identified</td>
<td>Vaccinated and not up to date staff with signs or symptoms must be tested.</td>
<td>Vaccinated and not up to date residents with signs or symptoms must be tested.</td>
</tr>
<tr>
<td>Newly identified COVID-19 positive staff or resident – facility can identify close contacts*</td>
<td>Vaccinated and not up to date staff that had a higher-risk exposure with a COVID-19 positive individual should be tested.</td>
<td>Vaccinated and not up to date residents that had close contact with a COVID-19 positive individual should be tested.</td>
</tr>
<tr>
<td>Newly identified COVID-19 positive staff or resident – facility unable to identify close contacts*</td>
<td>Vaccinated and not up to date staff, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor) should be tested.</td>
<td>Vaccinated and not up to date residents, facility-wide or at a group level (e.g., unit, floor) should be tested.</td>
</tr>
<tr>
<td>Routine Testing</td>
<td>According to SARS-CoV-2 county level community transmission -see table below.</td>
<td>Not generally recommended.</td>
</tr>
</tbody>
</table>

*The approach to an outbreak investigation should take into consideration whether the facility has the experience and resources to perform individual contact tracing, the vaccination acceptance rates of staff and residents, whether the index case is a healthcare worker or resident, whether there are other individuals with suspected or confirmed SARS-CoV-2 infection identified at the same time as the index resident, and the extent of potential exposures identified during the evaluation of the index resident.

CMS Routine Testing Table

<table>
<thead>
<tr>
<th>Level of Community Transmission</th>
<th>Minimum Testing Frequency of Not up to date Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (blue)</td>
<td>Not recommended</td>
</tr>
<tr>
<td>Moderate (yellow)</td>
<td>Once a week</td>
</tr>
</tbody>
</table>
Substantial (orange) | Twice a week
---|---
High (red) | Twice a week

Additional Facility Outbreak Mitigation Actions:
- Consider increasing monitoring of all residents from daily to every shift, to more rapidly detect those with new symptoms.
- Consider temporarily halting admissions to the facility/unit, at least until the extent of transmission can be determined and interventions implemented. Avoid internal transfers to the affected area/unit.
- While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility.
  - Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident’s room.
  - Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.
- Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-CoV-2 infection:
  - If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to 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.
- If the outbreak investigation is broadened to either facility wide or unit-based approach, follow recommendations below for alternative approaches to individual contact tracing.
  - Alternative, broad-based approach:
    - If the 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).
      - Broader approaches might also be required if the facility is directed to do so by the jurisdiction’s public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.
      - 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 not up to date residents, until there are no new cases for 14 days.
      - If antigen testing (Binax) is used, more frequent testing (every 3 days), should be considered.
• Not up to date residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.

• Up to date residents should be tested as described above; they do not need to be restricted to their rooms or cared for by HCP using the full PPE recommended 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.

  o All HCP who has had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested immediately but not before 1 days and if negative, tested 5-7 days after exposure.

  o In general, asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days do not require work restriction following a higher-risk exposure.

  o **CDC’s mitigation strategies offer a continuum of options for addressing staffing shortages.** Contingency, followed by crisis capacity, strategies augment conventional strategies and are meant to be considered and implemented sequentially (i.e., implementing contingency strategies before crisis strategies).

  o HCP with SARS-CoV-2 infection and exposures should be restricted from work under the following circumstances. Refer to CDC’s updated recommendations below.

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**Work Restrictions for HCP with SARS-CoV-2 Infection and Exposure**

“Up to Date” with all recommended COVID-19 vaccine doses is defined in Stay Up to Date with Your Vaccines.

**Work Restrictions for HCP with SARS-CoV-2 Infection**

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Conventional</th>
<th>Contingency</th>
<th>Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to Date and Not Up to Date</td>
<td>10 days OR 7 days with negative test¹, if asymptomatic or mild to moderate illness (with improving symptoms)</td>
<td>5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)</td>
<td>No work restrictions, with prioritization considerations (e.g., types of patients they care for)</td>
</tr>
</tbody>
</table>

**Work Restrictions for Asymptomatic HCP with Exposures**

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Conventional</th>
<th>Contingency</th>
<th>Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to Date</td>
<td>No work restrictions, with negative test on days 1± and 5-7</td>
<td>No work restrictions</td>
<td>No work restrictions</td>
</tr>
</tbody>
</table>

| Not Up to Date | 10 days OR 7 days with negative test | No work restrictions with negative test on days 1², 2, 3, & 5-7 (if shortage of tests) | No work restrictions (test if possible) |
prioritize Day 1 to 2 and 5-7)

¹ Negative test within 48 hours before returning to work

² For calculating date of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0.

- For more details, including recommendations for HCP who are immunocompromised, refer to Healthcare Personnel with SARS-CoV-2 Infection or Exposures to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).

- Contingency and Crisis standards should only be considered after all alternative routes to obtain additional staff have been explored (e.g., Department Operations Center 701-328-0707, travel agencies, reassigning duties, reviewing your emergency staffing plan, etc.) and discussed with the NDDoH HAI/COVID 19 team.

- Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and for safe patient care.

- Maximizing interventions to protect HCP, patients, and visitors are critical at all times, including when considering strategies to address staffing shortages.
  - Consider cohorting quarantined not up to date close contacts together.
  - HCP and residents with symptoms of COVID-19:
    - Symptomatic HCP, regardless of vaccination status, should be restricted from work pending evaluation for SARS-CoV-2 infection.
    - Symptomatic residents, regardless of vaccination status, should be restricted to their rooms and cared for by HCP using an 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.
  - Separate PPE needs to be used when moving between residents on precautions for new admissions, hospital returns, close contact quarantine and COVID negative/status unknown residents in addition to the COVID-19 Unit.
  - Restrict healthcare personnel movement from affected areas of the facility to non-affected areas.
  - Consideration should be given to halting social activities and communal dining; if these activities must continue for uninfected residents, they should be conducted using source control and physical distancing for all participants.
  - Guidance about visitation during facility outbreaks is available from CMS.
  - Whether not up to date residents are known to be close contacts or are identified as a part of a broad-based outbreak response but not known to be close contacts, indoor visitation should ideally occur only in the resident’s room, the resident (if tolerated) and their visitors should wear well-fitting source control and physically distance.
    - Source control and physical distancing recommendations should also be followed for vaccinated residents (if possible).
  - Adhere to CDC recommendations for Testing and Management for Nursing Home Residents with Acute Respiratory Illness when COVID-19 and Influenza Viruses are circulating.
o Recovered residents are not tested for 90 days unless they develop new onset of symptoms, however source control needs to remain in place due to risk of reinfection. Natural immunity time frame is uncertain and is not to be perceived as 90 days due to testing recommendations.

For additional information, please review guidance from the Centers for Disease Control and Prevention for preventing the spread in long-term care facilities.

Guidance is subject to change based on state and facility PPE supply and capacity. See CDC’s PPE Optimization Strategies for healthcare settings.

See North Dakota’s Long-Term Care Guidance for recommendation about testing, service, and visitation guidance.

Definitions:

- **Healthcare Personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).
- **Source Control:** Use of a cloth face covering or facemask to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Up to date** means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.
- **Not up to date** means a person has NOT received all recommended COVID-19 vaccines, including any booster dose(s) when eligible (5 months after final dose of mRNA series or 2 months after Jansen vaccine).
- **Healthcare Settings:** refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.
- **Severe Illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- **Critical Illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
- **Who Is Moderately or Severely Immunocompromised?**
People are considered to be moderately or severely immunocompromised if they have:
- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

• **Nursing Home-onset SARS-CoV-2 Infections:** Refers to infections that originated in the nursing home. It does not refer to the following:
  - Residents who were known to have SARS-CoV-2 infection on admission to the facility and were placed into appropriate transmission-based precautions to prevent transmission to others in the facility.
  - Residents who were placed into transmission-based precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.

• **Close Contact:** Refers to someone who had been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period.

• **Higher-risk Exposure:** Refers to exposure of an individual’s eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff do not wear adequate PPE.

• **Level of Community Transmission:** Refers to a facility’s county level of COVID-19 transmission. This metric uses two indicators for categorization, which can be found on the [CDC COVID-19 Data Tracker](https://www.cdc.gov/coronavirus/2019-ncov/cases-in-the-us.html).
  - Total number of new cases per 100,000 persons within the last 7 days.
  - Percentage of positive diagnostic and screening nucleic acid amplification (NAAT) during the last 7 days.

^ Residents with **severe to critical illness** or who are **severely immunocompromised**:
- At least 10 days and up to 20 days have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved.

Residents who are **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.

- Use of a test-based strategy and consultation with an infectious disease specialist, local, or state health department is recommended to determine when these HCP may return to work.