

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

Daily prevention measures:

Recommendations to prevent COVID-19 in skilled nursing facilities, basic care, and assisted living facilities include:

- 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 cloth face covering or facemask 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.
 - HCP should remove their respirator or facemask and put on a cloth face covering 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.
- Review training with staff for isolation protocols, donning and doffing of personal protective equipment (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 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](#) healthcare personnel (HCP) at beginning of their shift for fever, symptoms and risk of COVID-19.
 - Actively take their temperature and document symptoms and ask that HCP also regularly monitor themselves for fever and other symptoms.
 - 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.
- 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.
 - If mask shortage, HCP can be given 5 masks to use on a daily rotation basis, storing masks in individual paper bags with names on them. Please see [NDDoH reuse guidance](#).

- 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.
- Follow visitor allowance and service guidance according to the [re-opening phase](#) of your facility.
 - If visitors do come in, screen visitors for fever and other symptoms before they enter the facility. If fever or COVID-19 symptoms are present, the visitor should not be allowed entry into the facility.
 - Visitation for compassionate care reasons, such as end-of-life situations, can be permitted in all phases.
 - If visitors are for confirmed COVID-19 or presumptive cases, HCP needs to assist them with donning and doffing full COVID PPE. Do NOT give N95 mask as they are not fit tested.
 - Educate not to touch eyes, adjust mask, etc. with gloved hands.
 - Have hand sanitizer available so can perform HH when assisted doffing is completed.
 - Post signs at the entrances to the facility advising that no visitors may enter the facility without entry screening for fever and symptoms, and visitors should wear a cloth face covering while in the facility. Visitors using their [own face coverings](#) should be assessed. Assess for cleanliness and that it is free of rips or tears. Facilities may choose to issue cloth face coverings for all visitors.
- To address asymptomatic and presymptomatic transmission and to help prevent transmission from infected individuals who may or may not have symptoms of COVID-19, cloth face coverings should be considered (if tolerated) and worn for all patients and visitors during duration of time in the facility, regardless of symptoms.
 - Cloth face coverings are not considered PPE because their capability to protect healthcare personnel (HCP) is unknown. **HCP should wear facemasks rather than cloth face coverings.**
 - Visitors
 - Essential visitors could wear their own cloth face covering (see comments above regarding personal face coverings). If not, they should be offered a cloth face covering or facemask (as supplies allow).
 - They should be instructed that if they touch or adjust their cloth face covering, they should perform hand hygiene immediately.
 - Cloth face coverings should not be placed on young children under age 2 or anyone who has trouble breathing.
 - Residents
 - 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.
 - A faceshield may be considered if facemasks are not tolerated by the resident.
 - Patients 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.
- Limit residents from leaving the facility for non-medical reasons when a facility is in re-opening phase 1.
 - Residents going to the Emergency Room or Clinic:
 - Residents should wear a mask if tolerated.
 - Assess resident twice a day for 7 days for fever and new onset of symptoms.
- Limit and monitor entry points to the facility.
- Allow group activities, communal dining, and outside trips in accordance with the re-opening phase of the facility with appropriate phase-level source control practices.
- Screen residents for symptoms and fever, at least daily (twice daily if in re-opening phase 1).

- Residents with a temp ≥ 100.4 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 droplet precautions using personal protective equipment (PPE) including gown, gloves, and facemask with face shield or goggles for eye protection pending further evaluation. These residents should be tested for COVID-19 if clinically indicated.
 - Dedicate equipment to these residents and disinfect between use.
- 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.
- 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 and 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. Notification should occur regardless of re-opening phase status.
- If a resident needs to leave the facility for routine medical care, advise them to wear a clean, cloth face covering or face mask (if cloth face covering is unavailable).
- Ensure all residents are up-to-date for routine immunizations, including influenza and pneumococcal vaccines.

Admission Recommendations:

Not a Contact to or a Case of COVID-19:

- A new admission that is **not** suspected of having COVID-19 or a confirmed case should be placed in a private room and put in [enhanced precautions](#), including resident wearing a mask or cloth face covering. If the individual remains asymptomatic, then he/she can be moved to another room with a roommate.
 - Assess the resident twice a day for respiratory symptoms and fever.
 - If a resident becomes symptomatic, then he/she should be put in droplet precautions and tested for COVID-19.
 - Increase monitoring of residents for worsening of symptoms.
 - If transfer to an acute hospital needs to be made 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.
 - Keep the door to the resident room closed.
 - Attempts should be made to have these residents cohorted with dedicated staff.

Contact to a Case of COVID-19:

- A close contact to a case of COVID-19 should be placed in a private room and put in enhanced precautions +mask for 14 days, including resident wearing a mask or cloth face covering. This includes contacts to cases in another healthcare setting (hospital, clinic, etc.) or in the community.
 - If the resident has not already been tested for COVID-19 due to being a close contact, consider testing the resident for COVID-19, ideally 7-10 days from a known exposure to a confirmed case and again on day 14.
 - Assess the resident twice a day for respiratory symptoms and fever.
 - If a resident becomes symptomatic, then he/she should be put in droplet precautions and tested for COVID-19.
 - Increase monitoring of residents for worsening of symptoms.
 - If transfer to an acute hospital needs to be made 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.
 - Keep the door to the resident room closed.
 - Attempts should be made to have these residents cohorted with dedicated staff.
 - Close contacts may be removed from quarantine after 14 days from last contact with a case.

Suspect, Probable or Confirmed COVID-19 case:

- If a new admit is a confirmed or probable 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).
 - 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 no longer recommended to determine when to discontinue isolation, except in rare circumstances.
- 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. Residents who are an admit from a hospital should have one negative test prior to admission.

Our facility has identified a confirmed COVID-19 case in a resident or staff:

Mitigation and Prevention Recommendations

- 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 in private room or cohort COVID-19 positive residents together, ideally placed 6 feet apart.
- Place resident(s) in droplet precautions, with the addition of an **N95** mask for PPE.
 - Staff should have been fit tested for use of N95 masks and perform self-seal checks **each** time 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 soiled/contaminated.
- Please do not discard N95 masks. There are several processes available to decontaminate the masks and a number of hospitals have this capability. The CDC recommends that users store used N95 masks in a breathable container, that is well marked (to prevent accidental use), and according to the manufacturer's recommendations for temperature and moisture.
- 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 can be worn.
- Additional PPE may be ordered at hanassets.nd.gov.
- Keep the door to the resident room closed.
- 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 end of life 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).
 - The test-based strategy is no longer 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 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 masks should be used for working with residents who are not suspect or COVID-19 positive.
- Masks used with these residents should be discarded if resident is receiving nebulizer or other aerosolized therapy, after each treatment.
- Disinfect face shields after each use adhering to contact time.
- Provide notification to resident's families/guardians when there is a case of COVID-19 identified in your facility.
- Conduct facility-wide testing of all residents and staff according to NDDoH [Congregate Setting Testing Strategy](#).

Additional Facility Mitigation Actions

- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be determined and interventions implemented. Avoid internal transfers to the affected area/unit.

- Restrict healthcare personnel movement from areas of the facility affected to non-affected areas.
- Restrict all residents to their room to the extent possible. Once the scope of transmission can be determined, these precautions can be prioritized to affected areas/units.
- Restrict visitation to affected areas/units, except for compassionate care situations.
- Restrict communal dining, group activities, non-essential trips outside of the building to affected areas/units.
- Post signs at facility entrances notifying visitors of the restrictions and include where the restrictions are implemented. If restrictions are isolated to affected areas/units, post clear signage indicating the restricted access at each entry point.
- Consider implementing restrictions facility-wide until the scope of transmission can be determined.

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

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.
- **Enhanced Barrier Precautions:** expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:
 - Dressing
 - Bathing/showering
 - Transferring
 - Providing hygiene
 - Changing linens
 - Changing briefs or assisting with toileting
 - Device care or use of a device: central line, urinary catheter, feeding tube, tracheostomy
 - Wound care: any skin opening requiring a dressing

Gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities.

- **Contact isolation precautions:** used for infections, diseases, or germs that are spread by touching the patient or items in the room (examples: MRSA, VRE, diarrheal illnesses, open wounds, RSV). Healthcare workers should: Wear a gown and gloves while in the patient's room.
- **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.
- **Severely Immunocompromised:** Some conditions, such as being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions. 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.

^ Patients 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

For **severely immunocompromised** patients who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.