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 cloth face covering (for visitors) 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. Cloth face coverings are not personal protective equipment (PPE).
  - 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.
- 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 healthcare personnel (HCP) at start of their shift for fever, any symptoms and COVID-19 risk.
  - 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.
  o HCP should wear a well-fitting facemask for source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.
    ▪ 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.
    ▪ Remove mask during eating and drinking, placing in a breathable container or on a clean paper towel away from food. Practice social distancing and hand hygiene when doffing and redonning mask. Disinfect surface area after break.
  o To reduce the number of times HCP must touch their face which is a potential risk for self-contamination, when used for source control, HCP should consider continuing to wear the same respirator or well-fitting facemask (extended use) throughout their entire work shift.
  o HCP should remove 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 mask shortage, HCP can be given 5 face masks to use on a daily rotation basis, storing masks in individual paper bags with names on them. Please see NDDoH reuse guidance.
  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.
    Eye protection should be worn during unvaccinated resident care encounters to ensure the eyes are also protected from exposure to respiratory secretions.
• Educate staff, including fully vaccinated HCP, that outside of work should continue to:
  o Take precautions in public like wearing a well-fitted mask and physical distancing.
  o Wear masks, practice physical distancing, and adhere to other prevention measures when visiting with unvaccinated people who are at increased risk for severe COVID-19 disease or who have an unvaccinated 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 unvaccinated people from multiple households.
  o Avoid medium- and large-sized in-person gatherings.
  o Get tested if experiencing COVID-19 symptoms.
• Continue to educate unvaccinated staff about the important role COVID-19 vaccine has in preventing resident illness and death.

Visitor Practices:
• Limit and monitor entry points to the facility.
• Screen all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and deny entry for those with signs or symptoms, those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor’s vaccination status), or have had a diagnosis of COVID-19 in the prior 10 days.
• 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.

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• Visitors should wear a clean well fitted cloth mask or face mask for source control.
• Ideally, unvaccinated residents who wish to be vaccinated should not start indoor visitation until they have been fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine).
• 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.
  o Fully vaccinated residents can choose to have close contact with their visitor while wearing a well-fitting face mask and performing HH before and after.
• Indoor visitation for unvaccinated residents should be limited solely to compassionate care situations if the COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated.
• Indoor visitation should be limited solely to compassionate care situations, for:
  o Vaccinated and unvaccinated residents with SARS-CoV-2 infection until they have met criteria to discontinue Transmission-Based Precautions.
  o Vaccinated and unvaccinated residents in quarantine until they have met criteria for release from quarantine.
• Facilities in outbreak status should follow guidance from state and local health authorities and CMS on when visitation should be paused.
  o Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility if they are permitted to visit.
• If visitors are for confirmed COVID-19 or presumptive cases (compassionate care visits), HCP needs to assist them with donning and doffing full COVID-19 PPE. Do NOT give N95 mask as they are not fit tested.
  o Educate not to touch eyes, adjust mask, etc. with gloved hands.
  o 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.
• Restric visitation to affected areas/units, except for compassionate care situations.
• The safest approach, particularly if either party has not been fully vaccinated, 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.
• Hand hygiene should be performed by the resident and the visitors before and after contact.
  o 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. Visitors should physically distance from other residents and HCP in the facility. Facilities may need to limit the number of visitors per resident at one time as well as the total number of visitors in the facility at one time in order to maintain infection control precautions.
• Visits for residents who share a room should ideally not be conducted in the resident’s room. If in-room visitation must occur (e.g., resident is unable to leave the room), an unvaccinated roommate should not be present during the visit. If neither resident is able to leave the room, facilities should attempt to enable in-room visitation while maintaining recommended infection prevention and control practices, including physical distancing and source control.

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.
• Consider limiting unvaccinated residents from leaving the facility for non-medical reasons.
  o Residents going to the Emergency Room (ER) or Clinic:
    • Residents should wear a mask if tolerated.
    • Assess resident twice a day for 14 days for fever and new onset of symptoms.
    • Consider placing unvaccinated residents on transmission-based precautions if they were in ER or comparable setting for more than 24 hours.
  o Unvaccinated 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 be pulled between residents at all times during the 14 days and roommate should be assessed for signs and symptoms as well.
    • Educate resident and family on the importance of source control.
    • See Holiday Recommendations for Resident Outings
    • Consider testing 5-7 days after outing.
    • If the outing is greater than 24 hours, the resident should be evaluated for the need to be placed in a private room upon return and quarantined for 14 days, based on vaccination status, source control measures in place during outing, risk of exposure or if identified as a close contact to a positive case.
• Allow group activities, communal dining, and outside trips with appropriate source control practices according to county positivity rate guidance and based on status of Covid 19 infections in the facility.
• Screen residents for symptoms and fever, on admission and at least daily.
  o 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.
  o 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.
  o 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.
  o 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:
• Quarantine is not recommended for residents who are being admitted to a post-acute care facility if they are within 3 months of SARS-CoV-2 infection OR if fully vaccinated, asymptomatic, and have not had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days.
• Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which 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.
• A new admission that is not fully vaccinated 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 wear a mask or cloth face covering for source control for 14 days. If the individual remains asymptomatic, then he/she can be moved to another room with a roommate.
  o Assess the resident twice a day for symptoms and fever for 14 days.
  o Keep the door to the resident room closed.
    • 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.
    • Increase monitoring of residents for worsening of symptoms.
• 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.

• 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.
  o Close contacts may be removed from quarantine after 14 days from last contact with a COVID-19 case.
  o Fully vaccinated residents should continue to quarantine following prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with SARS-CoV-2 infection; HCP should use transmission based precautions plus an N95 mask. This is due to limited information about vaccine effectiveness in this population, the higher risk of severe disease and death, and challenges with physical distancing in healthcare settings.

• Although not preferred, healthcare facilities could consider waiving quarantine for fully vaccinated patients and residents following prolonged close contact with someone with SARS-CoV-2 infection as a strategy to address critical issues (e.g., lack of space, staff, or PPE to safely care for exposed patients or residents) when other options are unsuccessful or unavailable. These decisions could be made in consultation with public health officials and infection control experts.

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, may be warranted. Consider consultation with infection control experts.
  o 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. Consider testing residents who are an admit from a hospital at the end of their 14-day quarantine period to increase certainty that the resident is not infected.

Facility has a 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 (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.
  o 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 and, 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 resident(s) in droplet precautions, with the addition of an N95 mask for PPE.
  o Staff should have been fit tested for use of N95 masks and perform self-seal checks each time a mask is donned.
  o 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.
  o 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.
  o 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.
  o Cloth face coverings should NOT be worn in place of face masks or N95 respirators.
  o If N95 masks are not available or HCP are not fit tested, a surgical mask and face shield or goggles can be worn.
  o Additional PPE may be ordered at hanassets.nd.gov.
• Keep the door to the resident room closed.
  o 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.

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• Have dedicated staff care for the resident(s).
• See [CDC’s Strategy to Mitigate Healthcare Personnel Staffing Shortages](www.health.nd.gov/diseases-conditions/coronavirus).
• 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).
  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, may be warranted. Consider consultation with infection control experts.
  o 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 Covid-19 diagnosis.
• Nursing staff should organize their work and take on the duties of environmental cleaning to decrease number of staff entering room.
  o 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 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.
• Conduct facility-wide testing of all residents and staff according to NDDoH [Congregate Setting Testing Strategy](www.health.nd.gov/diseases-conditions/coronavirus) and CMS-QSO-20-38-NH.
• 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.

**Additional Facility Outbreak Mitigation Actions:**
• 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.
• Consider cohorting quarantined close contacts together.
• HCP should care for residents 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.
- Residents should generally be restricted to their rooms and serial SARS-CoV-2 testing performed.
- 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.
- 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. Residents could leave their rooms to permit visitation; visitors should be informed about the outbreak in order to make informed decisions about visitation.
  - If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.
    - For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.
  - If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.
- Adhere to CDC recommendations for Testing and Management for Nursing Home Residents with Acute Respiratory Illness when COVID-19 and Influenza Viruses are circulating.
- 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.

- **Fully Vaccinated**: refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose 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.

- **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.

^ 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

For severely immunocompromised residents 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.