**Coronavirus (COVID-19)**

**Date Initiated: 6/3/22 (from multiple policies since 3/20)**

**Date Revised:**  6/10/22, 10/14/22, 4/14/23, 5/4/23, 7/31/23

**POLICY:**

It shall be the policy to utilize accepted infection control methods to prevent and control the spread of a respiratory illness caused by *novel Coronavirus (COVID-19)*.

**PURPOSE:**

The primary goals of *COVID-19* prevention and control in long-term care facilities are:

1. Preventing the transmission of *COVID-19* to residents, staff, and visitors while preserving the quality of life for residents with *COVID-19*.
2. Screening all hospital patients for *COVID-19*, prior to admission or re-admission to our facilities.

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**POLICY DEFINITIONS**:

**Healthcare Personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, 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).

**Healthcare settings**: refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others.

**Source control**: Use of respirators, well-fitting facemasks, or well-fitting cloth masks to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing one safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control. At a minimum, source control devices should be changed if they become visibly soiled, damaged, or hard to breathe through. Further information about source control options is available at: Masks and Respirators (cdc.gov)

**Cloth mask**: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. Guidance on design, use, and maintenance of cloth masks is available.

**Facemask**: OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as ‘medical procedure masks’.” Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are approved by CDC/NIOSH, including those intended for use in healthcare.

**Immunocompromised**: Moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the Interim Clinical Considerations for Use of COVID-19 Vaccines

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* Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise. However, people in this category should still consider continuing to use of source control while in a healthcare facility.
* Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

**Close contact**: Being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

**SARS-CoV-2 Illness Severity Criteria**: (adapted from the NIH COVID-19 Treatment Guidelines)

The studies used to inform this guidance did not clearly define “severe” or “critical” illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the [National Institutes of Health (NIH) COVID-19 Treatment Guidelines](https://www.covid19treatmentguidelines.nih.gov/overview/clinical-spectrum/) are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions. Clinical judgment regarding the contribution of SARS-CoV-2 to clinical severity might also be necessary when applying these criteria to inform infection control decisions.

**Mild Illness**: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

**Moderate Illness**: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

**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.

**PROCEDURE:**

**SECTION 1:** **Recommended Routine Infection Prevention and Control (IPC) Practices for COVID-19**

1. **Encourage everyone to** [**remain up to date**](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html) **with all recommended COVID-19 vaccine doses.**

* HCP, patients, and visitors should be [offered resources and counseled](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html) about the importance of receiving the COVID-19 vaccine.

**NOTE: Refer to the “COVID-19 Vaccination Programs Policy” for details regarding the SARSCoV-2 (COVID-19) Vaccine.**

1. **Establishing a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection**

* Ensure everyone is aware of recommended IPC practices in the facility.
* Post [visual alerts](https://www.cdc.gov/flu/pdf/protect/cdc_cough.pdf) (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations.
* Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
  + a positive viral test for SARS-CoV-2
  + [symptoms of COVID-](https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html)19, or
  + close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a [higher-risk exposure (for healthcare personnel (HCP).](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)
    - For example:
      * Instruct HCP to report any of the 3 above criteria to their supervisor or another point of contact designated by the facility so these HCP can be properly managed.
        + The definition of higher-risk exposure and recommendations for evaluation and work restriction of these HCP are in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV2 Infection or Exposure to SARS-CoV-2.](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)
      * Provide guidance (e.g., posted signs at entrances, instructions when scheduling appointments) about recommended actions for patients and visitors who have any of the above three criteria.
        + Patients should be managed as described in Section 2.
        + Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation (see Section 2); this time period is longer than what is recommended in the community. For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at [higher risk for transmission](https://www.cdc.gov/coronavirus/2019-ncov/your-health/risks-exposure.html), it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet any of the criteria described in Section 2 (e.g., cannot wear source control).

Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available [at Policy & Memos to States and Regions | CMS.](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions)

**3. Implement Source Control Measures**

[Source control](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#sourcecontrol) refers to use of respirators or well-fitting facemasks to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Masks and respirators also offer varying levels of protection to the wearer. Further information about types of masks and respirators, including those that meet standards and the degree of protection offered to the wearer, is available at: [Masks and Respirators](https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html). People, particularly those at high risk for severe illness, should wear the most protective mask or respirator they can that fits well and that they will wear consistently.

Even when a facility does not require masking for source control, it should allow individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

Source control options for HCP include:

* A NIOSH Approved® particulate respirator with N95® filters or higher;
* A respirator approved under standards used in other countries that are similar to NIOSH Approved N95 filtering face piece respirators (Note: These should not be used instead of a NIOSH Approved respirator when respiratory protection is indicated);
* A [barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks](https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html); OR
* A well-fitting facemask.
* When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned. Additional information is available in the FAQ: [Can employees choose to wear respirators when not required by their employer](https://search.cdc.gov/search/index.html?query=approved%20face%20masks&siteLimit=coronavirus%2F2019-nCoV&dpage=1)?

**4. Source control is recommended for individuals in healthcare settings who**:

* Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
* Had [close contact](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#closecontact) (patients and visitors) or a [higher-risk exposure](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure

5. Source control is recommended more broadly as described in [CDC’s Core IPC Practices](https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html) in the following circumstances:

* By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or

other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or

* Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission.
* Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when [COVID-19 hospital admission levels](https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html) are high)

**6. Implement Universal Use of Personal Protective Equipment for HCP**

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow [Standard Precautions (and Transmission-Based Precautions](https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html) if required based on the suspected diagnosis).

As [SARS-CoV-2 transmission in the community](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#SARS-CoV-2-metrics) increases, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during patient care encounters as described below.

NIOSH Approved particulate respirators with N95 filters or higher used for:

* All aerosol-generating procedures (refer to [Which procedures are considered aerosol generating procedures in healthcare settings](https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html)?).
* All surgical procedures that might pose higher risk for transmission if the patient has SARS-CoV-2 infection (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract).
* NIOSH Approved particulate respirators with N95 filters or higher can also be used by HCP working in other situations where additional risk factors for transmission are present, such as when the patient is unable to use source control and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place.
* To simplify implementation, facilities may consider implementing universal use of NIOSH Approved particulate respirators with N95 filters or higher for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.

Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.

**7. Optimize the Use of Engineering Controls and Indoor Air Quality**

* Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception / triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas).
* Take measures to limit crowding in communal spaces, such as scheduling appointments to limit the number of patients in waiting rooms or treatment areas.

8. Perform SARS-CoV-2 Viral Testing

* COVID-19 antigen tests may now include serial (repeat) testing on both symptomatic and
* asymptomatic individuals.
* Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.
* Symptomatic individuals should have COVID-19 antigen testing at least twice over three days with at least 48 hours in between tests.
* Asymptomatic individuals with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
* Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
* Guidance for work restrictions, including recommended testing for HCP with higher-risk exposures, are in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
* Guidance for use of empiric Transmission-Based Precautions for patients with close contact with someone with SARS-CoV-2 infection are described in Section 2.
* Testing considerations for healthcare facilities with an outbreak of SARS-CoV-2 are described in this policy.
* The yield of screening testing for identifying asymptomatic infection is likely lower when performed on those in areas with lower levels of SARS-CoV-2. However, these results might continue to be useful in some situations (e.g., when performing higher-risk procedures or for HCP caring for patients who are moderately to severely immunocompromised) to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used) and prevent unprotected exposures. If implementing a screening testing program, testing decisions should not be based on the vaccination status of the individual being screened. To provide the greatest assurance that someone does not have SARS-CoV-2 infection, if using an antigen test instead of a NAAT, facilities should use 3 tests, spaced 48 hours apart, in line with [FDA recommendations](https://www.fda.gov/medical-devices/safety-communications/home-covid-19-antigen-tests-take-steps-reduce-your-risk-false-negative-results-fda-safety).
  + In general, performance of pre-procedure or pre-admission testing is at the discretion of the facility.
  + Performance of expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility.

**9. Process to Respond to SARS-CoV-2 Exposures Among HCP and Others**

Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed.

If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. For example, in an outpatient dialysis facility with an open treatment area, testing should ideally include all patients and HCP. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCP and patients on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.

Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities.

**SECTION 2: Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection**

The IPC recommendations described below (e.g., patient placement, recommended PPE) also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions based on [close contact](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#closecontact) with someone with SARS-CoV-2 infection. However, these patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

1. **Duration of Empiric Transmission-Based Precautions for Symptomatic Patients being Evaluated for SARS-CoV-2 infection**

The decision to discontinue empiric [Transmission-Based Precautions](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test.

* If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
* If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgment and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric [Transmission-Based Precautions](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

**2. Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection**

In general, asymptomatic patients do not require empiric use of [Transmission-Based](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) Precautions while being evaluated for SARS-CoV-2 following [close contact](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#closecontact) with someone with SARS-CoV-2 infection. These patients should still wear source control and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.

Examples of when empiric Transmission-Based Precautions following close contact may be considered include:

* Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
* Patient is moderately to severely immunocompromised
* Patient is residing on a unit with others who are moderately to severely immunocompromised
* Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

* Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
* If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

**3. Patient Placement**

* Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom or commode.
  + If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
* Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.
* Limit transport and movement of the patient outside of the room to medically essential purposes.
* Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

**4. Personal Protective Equipment**

* HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to [Standard Precautions](https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html) and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
* Respirators should be used in the context of a comprehensive respiratory protection program,
* which includes medical evaluations, fit testing and training in accordance with the
* Occupational Safety and Health Administration’s (OSHA) Respiratory Protection standard ([29](https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134)

[CFR 1910.134](https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134))

* Additional information about using PPE is available in [Protecting Healthcare Personnel | HAI |CDC](https://www.cdc.gov/infectioncontrol/oai-hcp.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhai%2Fprevent%2Fppe.html)

**5. Aerosol-Generating Procedures (AGPs)**

* Procedures that could [generate infectious aerosols](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-after-vaccination.html&cm_ven=ExactTarget&cm_cat=Member+Email+5.8.23&cm_pla=Marks+Memos+2023+Marketing+List&cm_ite=Interim+Infection+Prevention+and+Control+recommendations+for+Healthcare+Personnel+During+the+Coronavirus+Disease+2019+(COVID-19)+Pandemic&cm_lm=1275142994&cm_ainfo=&&&&&#aerosol) should be performed cautiously and avoided if appropriate alternatives exist.
* The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.

6. Visitation

* For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at [Policy & Memos to States and Regions | CMS](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions).
  + Counsel patients and their visitor(s) about the risks of an in-person visit.
  + Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
* Facilities should provide instruction, before visitors enter the patient’s room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
* Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.

**7. Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection**

The following are criteria to determine when Transmission-Based Precautions could be discontinued for patients with SARS-CoV-2 infection and are influenced by severity of symptoms and presence of immunocompromising conditions. Patients should self-monitor and seek re-evaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these patients should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.

In general, patients who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for patients with severe to critical illness.

In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for patients.

**Patients with** [**mild to moderate illness**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#illnessseverity) **who are not** [**moderately to severely immunocompromised**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#immunocompromised)**:**

* At least 10 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

Patients who were asymptomatic throughout their infection and are not [moderately to severely immunocompromised:](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#immunocompromised)

* At least 10 days have passed since the date of their first positive viral test.

**Patients with severe to critical illness and who are not** [**moderately to severely immunocompromised:**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#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
* The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific patients. For a summary of the literature, refer to [Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)

**Patients who are** [**moderately to severely immunocompromised**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#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 (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.

**The criteria for the test-based strategy are:**

**Patients who are symptomatic**:

* Resolution of fever without the use of fever-reducing medications **and**
* Symptoms (e.g., cough, shortness of breath) have improved, **and**
* Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

**Patients who are not symptomatic:**

* Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

**8. Environmental Infection Control**

* Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
  + All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer’s instructions and facility policies before use on another patient.
* Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product’s label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which AGPs are performed.
  + Refer to [List](https://www.epa.gov/coronavirus/about-list-n-disinfectants-coronavirus-covid-19-0) on the EPA website for EPA-registered disinfectants that kill SARS-CoV2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a difficile sporicidal agent is recommended to disinfect the rooms of patients with C. difficile infection).
* Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
* Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE. The room window should be opened, door closed and no entry should occur for a minimum of 1 hour to allow for enough air changes to remove potentially infectious particles. After this time has elapsed, the room should undergo appropriate terminal cleaning and surface disinfection before it is returned to routine use.

**9. Notice to Funeral Director**

If, at the time of death, a resident was diagnosed as having a specific communicable disease or an infectious disease, a written report of such disease shall accompany the body when it is released to the funeral director or his or her agent, except that no HIV-related information shall be disclosed to the funeral director unless the funeral director has access in the ordinary course of business to HIV-related information on the death certificate of the deceased individual.

**SECTION 3: Nursing Homes**

* Assign one or more individuals with training in IPC to provide on-site management of the IPC program
* Stay connected with the local NYS epidemiologist as well as completing the HERDS reporting by 1pm daily. Report SARS-CoV-2 infection data to National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module. See Centers for Medicare & Medicaid Services (CMS) COVID-19 [reporting requirements](https://www.cms.gov/files/document/qso-20-29-nh.pdf).
* Managing admissions and residents who leave the facility:
  + Admission testing is at the discretion of the facility. Pros and cons of screening testing are described in [Section 1](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#admission_testing).
  + Residents who leave the facility for 24 hours or longer should generally be managed as an admission.
* Empiric use of Transmission-Based Precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings) and do not meet criteria described in Section 2.
* Placement of residents with suspected or confirmed SARS-CoV-2 infection
  + Ideally, residents should be placed in a single-person room as described in Section 2.
* If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.
* Responding to a newly identified SARS-CoV-2-infected HCP or resident
* When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction’s public health authority.
* A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.
* The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
* Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
  + - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
    - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
* Empiric use of Transmission-Based Precautions for residents and work restriction for HCP are not generally necessary unless residents meet the criteria described in Section 2 or HCP meet criteria in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html), respectively. However, source control should be worn by all individuals being tested.
  + In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction’s public authority recommends these and additional precautions.
  + If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV2](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html), respectively.
* If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
  + If antigen testing is used, more frequent testing (every 3 days), should be considered.
  + **Indoor visitation during an outbreak response:**
    - Facilities should follow guidance from CMS about visitation.
    - Visitors should be counseled about their potential to be exposed to SARS-CoV2 in the facility.
  + If indoor visitation is occurring in areas of the facility experiencing transmission, it should ideally occur in the resident’s room. The resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit.

**SECTION 4: Considerations for Implementing Broader Use of Masking**

Use of well-fitting masks in healthcare settings are an important strategy to prevent the spread of respiratory viruses. Well-fitting masks can help block virus particles from reaching the nose and mouth of the wearer (wearer protection) and, if someone is ill, help block virus particles coming out of their nose and mouth from reaching others (source control). Masking by healthcare personnel as part of [Standard and Transmission-Based Precautions](https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html) and by ill individuals as part of [respiratory hygiene and cough etiquette](https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html) (i.e., for people with symptoms) are already well-described. This section describes considerations for implementing broader use of masking in healthcare settings. However, even when masking is not required by the facility, individuals should continue using a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

**1. When to Implement Broader Use of Masking**

The overall benefit of broader masking is likely to be the greatest for patients [at higher risk for severe outcomes](https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html) from respiratory virus infection and during periods of high respiratory virus transmission in the community.

Facilities should consider several factors when determining how and when to implement broader mask use:

* The types of patients cared for in their facility.
* Facilities might tier their interventions based on the population they serve. For example, facilities might consider a lower threshold for action in areas of the facility primarily caring for patients at highest risk for severe outcomes. Except when experiencing an outbreak within the facility, facilities with residents or patients that generally do not leave the facility might consider implementing masking only for staff and visitors
* Input from stakeholders.
* Reviewing plans with stakeholders including patient and family groups and healthcare personnel can help a facility determine practices that will be more broadly supported.
* Plans from other facilities in the jurisdiction with whom the facility shares patients.
* Some jurisdictions might consider a coordinated approach for all facilities in the jurisdiction.
* What data are available to make decisions.
* Facilities and jurisdictions might have access to more granular data for their jurisdiction to help guide efforts locally
* **SARS-CoV-2 Specific Metrics**

During the COVID-19 pandemic one of the strongest indicators of increasing cases in nursing homes was increasing community incidence. If a jurisdiction still has access to SARS-CoV-2- community incidence, using these data to guide local recommendations at the levels previously described (community incidence > or = to 100/100,000) could be considered.

CDC will also continue to collect and report SARS-CoV-2 hospital admissions data on the [CDC COVID Data Tracker](https://covid.cdc.gov/covid-data-tracker/#datatracker-home). These data continue to be available at the county level and are used by CDC to help the public decide when masking in the community should be considered. Based on CDC analyses from data from late 2022 and early 2023, these levels might be less useful to inform masking recommendations in healthcare facilities.

CDC continues to recommend that healthcare facilities institute facility-wide masking when masks are recommended in the community.

**Section 5: COVID-19 Treatment**

**Treatment for COVID-19 Positive Residents with Mild to Moderate Symptoms**

1. Two oral antivirals have received Emergency Use Authorization from the US FDA: **Paxlovid (nirmatrelvir with ritonavir) and Legevrio (molnupiravir).** These antivirals are authorized for the treatment of mild-to-moderate COVID-19 with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. According to the CDC, NIH COVID-19 guidelines and NYS DOH, the two antivirals are expected to be active against newer subvariants.
2. There are no EUA monoclonal antibody treatments currently available to treat COVID-19 in the nursing facility.
3. **Paxlovid (nirmatrelvir with ritonavir) is the preferred treatment in the nursing facility**. Lagevrio is only for residents who are not candidates for Paxlovid or other COVID-19 treatment options (such as outpatient remdesivir where it is available in infusion centers.)

**Important:**

1. Paxlovid is contraindicated in residents with GFR less than 30 ml/min.
2. Paxlovid is not recommended for residents with severe liver impairment.
3. Residents with GFR 30 to 60 ml/min should receive the renal dose Paxlovid.
4. Potentially significant drug interactions with Paxlovid must be cleared before starting Paxlovid. Review carefully the resident's drug regimen profile. Consult with the Pharmacist. Refer to the EUA for the drug interaction list.
5. Monitor for signs of bacterial superimposed infection. Treat with empiric antibiotic as necessary if bacterial infection is suspected.
6. Pulse oxymetry every 4 hours. If pulse ox is less than 94% on room air (defined as hypoxemia) or for residents with chronic hyoxemia, a decrease from baseline of greater than 3%, review again goals of care with the resident or activated Health Care Proxy, and review MOLST. Consider transfer to the hospital for IV remdesivir.

**Steroids:**

1. If the resident has a do not transfer to hospital order, or the resident and HCP prefer in-facility care first for severe COVID-19, then can start oral dexamethasone. Document discussion of risks/benefits.
2. Do not use dexamethasone and other systemic corticosteroids to treat patients with mild to moderate COVID-19 who do not require hospitalization or supplemental oxygen (or increase of oxygen from baseline); these drugs have no proven benefit in these patients and can cause harm.

**Section 6: Facility Reporting**

**NHSN (National Healthcare Safety Network) Reporting - Data entered into NHSN pushes to ECLRS or data can be entered directly into ECLRS per below.**

1. The information will be used to monitor trends in infection rates and inform public health policies. Information reported will be shared with CMS and will be retained and publicly reported to support protecting the health and safety of residents, personnel, and the general public. Reporting is required on a weekly basis.

2. Requirements for Reporting related to COVID-19 - CMS published an IFC (CMS-5531-IFC) requiring all LTC facilities report COVID-19 information using the Center for Disease Control (CDC) National Healthcare Safety Network (NHSN) (42 CFR 483(g)). This reqirement to report information was extended through a final rule (CMS-1747-F) and is set to terminate on December 31, 2024, with the exception of the requirements at § 483.80(g)(1)(viii), which will continue to be in effect as a requirement to support national efforts to control the spread of COVID-19.

**ECLRS (Electronic Clinical Laboratory Reporting System) Reporting**

1. Providers are required to report SARS-CoV-2 diagnostic or serology testing results, including those using SARS-CoV-2 point-of-care tests, to the Commissioner of Health through the Electronic Clinical Laboratory Reporting System (ECLRS) within 24 hours. Required reporting includes all positive test results.

**HERDS (Health Emergency Response Data System) Reporting**

1. Any positive test result must be reported to the Department by 1:00pm of the day following receipt of such test results, in accordance with existing reporting protocols and mechanisms.

**Section 7: Passive Staff Screening and Reporting**

Signage should be posted to staff regarding the 3 scenarios below which should be reported to their supervisor, infection preventionist/designee.

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 (for patients and visitors) or a higherrisk exposure (for healthcare personnel (HCP)).

**Testing of Staff and Residents During an Outbreak Investigation**

1. An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP are discontinued. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission.

**Refusal of Testing**

1. **Staff Refusal** - Staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member, who is not up-to-date, and refuses testing, the staff member will be restricted from the building until the procedures for outbreak testing have been completed. The facility will follow occupational health and local jurisdiction policies with respect to any asymptomatic staff.

2. **Resident Refusal** - Residents (or resident representatives) may exercise their right to decline COVID-19 testing in accordance with the requirements under 42 CFR § 483.10(c)(6). In discussing testing with residents, staff will use person-centered approaches when explaining the importance of testing for COVID-19. Ensure that residents who have signs or symptoms of COVID-19 and refuse testing are placed on TBP until the criteria for discontinuing TBP have been met. If outbreak testing has been triggered and an asymptomatic resident refuses testing, the facility will thoroughly monitor to ensure the resident maintains appropriate distance from other residents, wears a face mask, and practices effective hand hygiene until the procedures for outbreak testinghave been completed.

**Section 8: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2**

1. **Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 Infection** HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays.

When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.

* + If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.
  + If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses.

**2. Return to Work Criteria for HCP with SARS-CoV-2 Infection**

The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek reevaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

**HCP** [**with mild to moderate illness**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#MildIllness) **who are not** [**moderately to severely immunocompromised**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#Immunocompromised) **could return to work after the following criteria have been met:**

* At least 7 days have passed since symptoms first appeared if a negative viral test\* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **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.

\*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

**HCP who were asymptomatic throughout their infection and are not** [**moderately to severely immunocompromised**](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#Immunocompromised) **could return to work after the following criteria have been met:**

* At least 7 days have passed since the date of their first positive viral test if a negative viral test\* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

\*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

HCP with [severe to critical illness](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#MildIllness) who are not [moderately to severely immunocompromised](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#Immunocompromised) could return to work after the following criteria have been met:

* 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.
* The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction. The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to  [Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)

HCP who are [moderately to severely immunocompromised](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#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 (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

**Test-based strategy**

**HCP who are symptomatic could return to work after the following criteria are met:**

* Resolution of fever without the use of fever-reducing medications, **and**
* Improvement in symptoms (e.g., cough, shortness of breath), **and**
* Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

HCP who are not symptomatic could return to work after the following criteria are met:

* Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

**3. Return to Work Criteria for HCP Who Were Exposed to Individuals with Confirmed SARS-CoV-2 Infection**

Exposures that might require testing and/or restriction from work can occur both while at work and in the community. Higher-risk exposures generally involve exposure of HCP’s eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure.

Other exposures not classified as higher-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth. When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission.

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged[[1]](#endnote-1) close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and:

* HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
* HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
* HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure Following a higher-risk exposure, HCP should:
  + Have a series of three viral tests for SARS-CoV-2 infection.
  + Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
  + Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
* Follow all [recommended infection prevention and control practices](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html), including wearing well fitting source control, monitoring themselves for fever or [symptoms consistent with COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html), and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
* Any HCP who develop fever or [symptoms consistent with COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include:
  + HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure;
  + HCP is moderately to severely immunocompromised;
  + HCP cares for or works on a unit with patients who are moderately to severely immunocompromised;
  + HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions;

If work restriction is recommended, HCP could return to work after either of the following time periods:

* HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following a higher-risk exposure is negative.
* If viral testing is not performed, HCP can return to work after day 10 following the exposure
* (day 0) if they do not develop symptoms.

In addition to above:

* HCP should follow all [recommended infection prevention and control practices](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html), including wearing well-fitting source control, monitoring themselves for fever or [symptoms consistent with COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html), and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
* Any HCP who develop fever or [symptoms consistent with COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

Footnotes:

1. For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.
2. For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARS-CoV2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.
3. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious:
   1. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.
   2. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.
   3. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with SARS-CoV-2 infection, facemasks still confer some level of protection to HCP, which was factored into this risk assessment if the patient was also wearing a cloth mask or facemask

**SECTION 9: Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC**

This guidance is for facilities that are expecting or experiencing staffing shortages due to COVID19. Conventional strategies for return to the workplace for HCP with SARS-CoV-2 infection or higher-risk exposures are described in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC

1. Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. If community transmission levels rise, staffing shortages could occur due to HCP illness or the need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these shortages. These plans and processes include communicating with HCP about actions the facility is taking to address shortages, maintaining patient and HCP safety, and providing resources to assist HCP with anxiety and stress.
2. 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). For example, if, despite efforts to mitigate, HCP staffing shortages occur, healthcare systems, facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that, in order to ensure the availability of healthcare, certain HCP with suspected or confirmed SARS-CoV-2 infection should return to work before the full conventional Return to Work Criteria have been met under the criteria set forth below.
3. Allowing HCP with SARS-CoV-2 infection to return to work before meeting the conventional criteria could result in healthcare-associated SARS-CoV-2 transmission. Healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is utilizing these strategies, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill staffing needs.

**As part of conventional strategies, it is recommended that healthcare facilities:**

1. Ensure any COVID-19 vaccine requirements for HCP are followed, and where none are applicable, encourage HCP to remain up to date with all recommended COVID-19 vaccine doses.
2. Understand their normal staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care under normal circumstances.
3. Understand the local epidemiology of COVID-19-related indicators (e.g., community transmission levels).
4. Communicate with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed.

**Contingency Capacity Strategies to Mitigate Staffing Shortages**

1. When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. These include: Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities.
2. Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation and training to work in these areas that are new to them.
3. Attempt to address social factors that might prevent HCP from reporting to work, such as need for transportation or housing that allows for physical distancing, particularly if HCP live with individuals with underlying medical conditions or older adults.
4. Consider that these social factors disproportionately affect persons from some racial and ethnic groups, who are also disproportionally affected by COVID-19 (e.g., African Americans, Hispanics and Latinos, and American Indians and Alaska Natives).
5. Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
6. As appropriate, request that HCP postpone elective time off from work. However, there should be consideration for the mental health benefits of time off and that care-taking responsibilities may differ substantially among staff.
7. Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection.
8. Allowing HCP with SARS-CoV-2 infection who are well enough and willing to work to return to work as follows:

**HCP with mild to moderate illness who are not moderately to severely immunocompromised:**

1. At least 5 days have passed since symptoms first appeared (day 0), and
2. At least 24 hours have passed since last fever without the use of fever-reducing medications, and
3. Symptoms (e.g., cough, shortness of breath) have improved.

Healthcare facilities may choose to confirm resolution of infection with a negative nucleic acid amplification test (NAAT) or a series of 2 negative antigen tests taken 48 hours apart\*.

**HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised:**

1. At least 5 days have passed since the date of their first positive viral test (day 0).

Healthcare facilities may choose to confirm resolution of infection with a negative NAAT (molecular) or a series of 2 negative antigen tests taken 48 hours apart\*.

\* Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred if testing asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

**Considerations for determining which HCP should be prioritized for this option include:**

1. The type of HCP shortages that need to be addressed.
2. The types of symptoms they are experiencing (e.g., persistent fever, cough).
3. Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
4. The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than patients who are immunocompromised).

**If HCP are requested to return to work before meeting all conventional Return to Work Criteria, they should still adhere to the recommendations described below.**

1. They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
2. Until they meet the conventional return to work criteria:

* They should wear a respirator or well-fitting facemask at all times, even when they are in nonpatient care areas such as breakrooms.
* If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
* To the extent possible, they should practice physical distancing from others.
* Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.

**Crisis Capacity Strategies to Mitigate Staffing Shortages**

1. When staffing shortages occur, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care:

* Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing.
* If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, if they are well enough and willing to work, even if they have not met all the contingency return to work criteria described above.

**Considerations for determining which HCP should be prioritized for this option include**:

1. The type of HCP shortages that need to be addressed.
2. Where individual HCP are in the course of their illness (e.g., viral shedding is likely to be higher earlier in the course of illness).
3. The types of symptoms they are experiencing (e.g., persistent fever, cough).
4. Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
5. The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than patients who are immunocompromised).
6. If HCP are requested to work before meeting all criteria, they should be restricted from contact with patients who are moderately to severely immunocompromised (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:

* If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
* Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.
* Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with suspected SARS-CoV-2 infection.
* As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients without suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies that do not involve care of uninfected patients by potentially infectious HCP. Strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential.

**If HCP are requested to return to work before meeting all Return to Work Criteria, they should still adhere to recommendations described below.**

1. They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
2. Until they meet the conventional return to work criteria:

* They should wear a respirator or well-fitting facemask at all times, even when they are in nonpatient care areas such as breakrooms.
* If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
* To the extent possible, they should practice physical distancing from others.
* Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.

**Emergency Medication Pass**

1. At the discretion of the Medical Director and Director of Nursing, when staffing is considered critical non-essential medications and treatments can be held per policy. Every effort will be made to avoid omitted and delayed doses of critical medicines.

**Section 10: Source Control (PPE)**

1. The facility must possess and maintain at least a 60-day supply of all necessary items of PPE sufficient to protect facility staff, consistent with DOH/CDC guidance. The PPE can be stored at the facility or in a separate storage unit that is within New York State. The facility (or its corporate network) has the right to access as needed and the facility has at least a 10-day supply of all required PPE on site, as determined by the calculations set forth below, to cover resident needs until such time that the off-site PPE can be accessed.
2. PPE stored in offsite central supply can be accessed by the facility within at least 24 hours and is available 24 hours a day/7 days a week. Corporate Security Associates will be contacted in the event PPE is needed at a facility. An Associate will make delivery arrangements with the corporate van/designated service.
3. The facility Administrator/designee will compare existing inventories of PPE (face shields, gowns, gloves, masks, N95 respirators) against the required inventories to determine the quantities needed to be on hand. Optimize and conserve PPE where appropriate as supply chain interruptions have been noted due to the high demand.
4. 60-day stockpile of PPE is based on the following requirements:

* Single gloves – fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 550;
* Gowns – fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 41;
* Surgical masks –fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 21; and
* N95 respirator masks –fifteen percent, multiplied by the number of the facility’s staffed beds as determined by the Department, multiplied by 9.6.

1. The Department will determine the facility’s average census annually, by January 1st of each year, and will communicate such determination to each facility.
2. The Commissioner has the discretion to increase the stockpile requirements from 60 days to 90 days where there is a State or local public health emergency declared.
3. In order to maximize shelf life of the stockpiled inventory, facilities will follow the appropriate storage conditions outlined by manufactures and are encouraged to rotate inventory through regular usage and replace what has been used in order to ensure a consistent readiness and level and reduce waste. Expired products will be disposed of when their expiration date has passed.
4. Applicable positivity rate - defined as the greater of the following positivity rates:

* The facility’s average COVID-19 positivity rate, based on reports made to the Department, during the period of April 26, 2020 through May 20, 2020; or
* The facility’s average COVID-19 positivity rate, based on reports made to the Department, during the period of January 3, 2021 through January 31, 2021; or
* 20.15%, representing the highest Regional Economic Development Council average COVID-19 positivity rate, as reported to the Department, during the periods April 26, 2020 through May 20, 2020 and January 3, 2021 through January 31, 2020.

1. Facilities that identify a shortage of PPE, should use existing plans and vendor agreements to procure additional assets, by taking the following steps:

* Use existing vendor agreements and procurement plans to place orders for quantities needed by type and size of PPE.
* Activate existing Mutual Aid Agreements to obtain available support from those partners.
* Notify County Office of Emergency Management (OEM) when all existing agreements are exhausted and supply needs exceed those available from these sources.
* Coordinate with County OEM to identify and utilize other existing county resources.
* Notify the respective Department’s Regional Office of ongoing need.
* If all local resources have been exhausted, submit a request, via your County OEM, to the state OEM. The request should include as much detail as available, but include at a minimum the following elements:
  + Type and Quantity of PPE by size
  + Point of Contact at the requesting facility or system
  + Delivery location
  + Date request is needed to be filled by
  + Record of pending orders

**Websites for OEM and county offices**:

<https://data.ny.gov/widgets/jwkb-x5v6?mobile_redirect=true>

<https://data.ny.gov/Public-Safety/County-Emergency-Management-Offices/jwkb-x5v6>

**Section 11: Policy References**

1. Centers for Disease Control and Prevention (CDC)
2. World Health Organization (WHO)
3. NY State Department of Health (NYSDOH)
4. Centers for Medicare and Medicaid Services (CMS)
5. The Society for Post-Acute and Long Term Care
6. NY State Health Facilities Association (NYSHFA)
7. Greater NY Health Care Facilities Association (GNYHCFA)
8. American Health Care Association (AHCA)
9. AMDA - The Society for Post-Acute and Long-Term Care Medicine
10. US Food and Drug Administration (FDA)

1. [↑](#endnote-ref-1)