

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

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COVID-19 Infection Control and Testing Guidance for Nursing Homes [Updated Guidance – June 5, 2020]

Infection prevention and control (IPC) measures taken by Connecticut Nursing Homes (NHs) have contributed to reductions in COVID-19 cases. As we further contain COVID-19, testing and continued IPC vigilance will be mainstay strategies to prevent further outbreaks.

The Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) have updated guidance about tiered reopening of NHs and the role of testing.^{1, 2} This guidance from the Connecticut Department of Public Health (DPH) supplements and updates prior DPH guidance and addresses common questions regarding resident quarantine/isolation, cohorting, and testing.

Immediate steps NHs should take include:¹

- Strengthen the facility's IPC Program and provide additional support to the Infection Preventionist as needed. At least one person with IPC training should be dedicated to on-site management of the IPC Program, which includes staff/resident/visitor education, staff and resident testing, cohorting, and more.
- Create a plan for testing residents and healthcare personnel for SARS-CoV-2.
- NH leadership should become familiar with the latest CDC and CMS guidance for NHs (See References).

Additional Cohorting Guidance

DPH recommends cohorting residents into 3 separate units/areas, each with its unique PPE use strategy, as outlined in interim guidance from May 11.³

Cohort descriptions have been clarified since prior interim guidance:

- **"Positive"**: residents confirmed to have COVID-19 due to a positive PCR test, within their infectious period.⁴
- **"Negative/unexposed"**: asymptomatic residents with no known exposures to COVID-19 during the 14 days prior to their negative test for COVID-19.
 - o These residents are COVID-naïve and need to be physically separated from those potentially infectious.
 - o Recovered residents who meet criteria for lifting of transmission-based precautions⁴ can also be placed in this cohort.
- **"Negative/Exposed"**: residents under a 14-day quarantine due to exposure or potential exposure to COVID-19.
 - o This cohort includes roommates of COVID-positive residents who tested negative, and new admissions or readmissions, even with negative test results.
 - o Persons Under Investigation (PUIs) may be moved into this cohort while awaiting test results, or they may stay in place.



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New Admissions and Readmissions

New admissions and readmissions **with confirmed COVID-19** should be cohorted based on CDC criteria for discontinuation of Transmission-Based Precautions.⁴

- New admissions and readmissions with **confirmed COVID-19 who have NOT met criteria for discontinuation of Transmission-Based Precautions⁴** should be placed in the COVID-positive cohort.
- New admissions and readmissions with **confirmed COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions⁴** can be placed in the “negative/unexposed” cohort because we can assume that they are no longer infectious.

CDC recommends that for new admissions and readmissions **with an unknown COVID-19 status**, depending on community prevalence of COVID-19, consider placing the resident in observation for 14 days.^{1,5} For individuals who did not have a previous diagnosis of COVID-19 arriving with one or more negative COVID-19 test results, *the negative result simply indicates that the resident is not positive upon admission; it does not guarantee that they will not start shedding the virus in a few hours to a few days.*

- **DPH recommends placing new admissions with unknown COVID-19 status in the “observation/exposed” cohort for 14 days upon admission**, due to continued elevated prevalence of COVID-19 in CT at this time.
 - o Single rooms and transmission-based precautions are recommended for this cohort, which can include residents who are asymptomatic and potentially contagious AND residents who do not have COVID-19.
 - o Testing at the end of the 14-day quarantine can increase certainty that the resident did not acquire COVID-19 before moving into the “negative/unexposed” cohort, however this is not a requirement.
- **Readmission of residents with unknown COVID-19 status after a non-COVID hospitalization can be placed into either “negative” cohort. A risk assessment to inform the placement decision should be conducted and documented.** Considerations for this risk assessment should include (but not be restricted to) evaluation of:
 - o Extent of COVID-19 activity and infection control measures in the hospital. In general, hospitalizations should be considered low-risk for COVID-19 exposure.
 - o Transportation mode and potential for unprotected (others unmasked) exposures during transportation.
 - o Extent of exposure from potentially higher-risk procedures including IV infusion and dialysis.
 - o Level of potential exposure from other procedures performed.
 - o Level of physical distancing and source control of others who interacted with the resident.
 - o Degree to which the resident can maintain physical distancing.
 - o Degree to which the immune system of the resident might be compromised.
 - o Risks and benefits of making a room change.

Residents Leaving for Medical Appointments and Other Visits

Previously, DPH had recommended that any resident leaving a NH for any reason should be placed in observation/quarantine for 14 days. With adequate IPC measures, medical appointments are in fact a low-risk activity. Thus, “negative/unexposed” residents who leave a NH for a medical visit do not necessarily need to move to the “observation/exposed” cohort upon return. **A risk assessment to inform the placement decision should be conducted and documented.** See considerations for risk assessment above.

Testing of Staff and Residents

CDC recommends repeat testing of all previously negative staff and residents until no new cases of COVID-19 are identified for 14 days.⁶ CMS similarly recommends weekly testing of all staff and testing of all residents until all residents test negative.² **Consistent with CDC and CMS, DPH also recommends weekly retesting of previously-negative residents and staff until no new cases are identified for 14 days.** NHs should document their testing plans, as well as dates and testing results.

Specimens from mass testing (PPS or mass staff testing) should not be submitted to the CT State Public Health Laboratory (SPHL), as rapid turn-around-times for a high volume of specimens cannot be guaranteed.

Staff testing

Executive Order No. 7UU from the Office of the Governor mandates weekly testing of all NH staff, to begin no later than the week starting June 14. Many NHs have already begun staff testing. To conform with CMS guidance, NHs that do not have a plan in place should immediately begin to develop a strategy to implement regular testing of staff. DPH is available to assist NHs in formulating their plans.

Staff who refuse testing are not necessarily at greater risk to the NH than staff who test negative and have an unknown COVID status the next day. Thus, DPH is not recommending that testing is a requirement of employment. NHs may decide that staff who refuse testing do not care for the “negative/unexposed” cohort.

Staff who test positive for COVID-19 and are asymptomatic should be excluded from work until 10 days have passed since the date of specimen collection, assuming they do not become symptomatic. Staff who develop COVID-19 disease should follow CDC’s return-to-work guidelines.⁷

Repeat Testing of Residents

DPH recommends weekly testing of previously negative residents until no new cases are identified for 14 days (staff and residents). For repeat testing of residents, the State of Connecticut is available to assist facilities in implementation of their plans if needed.

Contact Tracing Within the Nursing Home

For residents and staff member who test positive for COVID-19, contact tracing should be conducted to identify staff and residents who might have had a significant unprotected exposure. Please refer to CDC guidance for risk assessment and work restrictions for healthcare personnel with potential exposure to COVID-19.⁸ The community-related exposure guidance can be used to inform risk assessment for patients and visitors exposed in the NH.⁹

Use of Air Conditioning (AC) and Fans

Ensuring comfortable ambient temperatures is important for prevention of heat stroke and dehydration. While there is no official CDC guidance about fans and heating, ventilation, and air conditioning (HVAC) use, there are several considerations that NHs should consider:

- In COVID-positive and COVID-negative/exposed rooms, fans can potentially spread infectious droplets beyond a normal range. HVAC and window AC units have air return vents to reduce the air pressure gradient and are thus a lower risk.
- Air should flow from clean to dirty areas. Exhaust from AC units should be kept away from areas where people may pass by this unfiltered air.
- AC units should have dampers open to maximize outdoor air being brought in, and vents pointed away from individuals who may be infected.
- Window fans should be pointed to exhaust air out the window rather than bring it in, because the large volume of air brought in by fans can push air from the room into common areas
- Free standing fans not in a window should not be used because they are just blowing air around the room and not providing any dilution benefit.
- NHs should develop a policy or process whereby the Infection Control Practitioner oversees risk assessment, cleaning and maintenance, and safe placement of AC units and fans.

Resident Room Doors: On May 29, DPH blast-faxed guidance about resident room doors.¹⁰ Doors are only required to be closed for aerosol-generating procedures conducted in the COVID-positive and “negative/exposed” cohorts.

Recreation and Visitation

NH administrators should review CMS' Nursing Home Reopening Recommendations for State and Local Officials, which includes recreation and visitation guidance.²

Recreation and Outdoor Time for by Cohort

Recreation and time outdoors are important for the well-being of NH residents. There are safe ways for NH residents to enjoy these activities. Effective cohorting ensures these activities remain safe. Recreation and outdoor time should occur at least once per week, be with others from the same cohort, and involve physical distancing (> 6 feet) and face coverings as tolerated.

- "Negative/unexposed" residents should be allowed to have group activities, including outdoor time, with physical distancing, face coverings, and handwashing as appropriate.
- "Negative/exposed" residents are under quarantine and thus should be kept to their rooms as much as possible. This cohort should not have any communal activities; residents in this cohort should not interact with each other whether within the facility or outside. This group should be provided recreational services inside their room and be allowed outside their room on an individual basis with staff accompanying them in full transmission-based precautions to ensure these potentially contagious residents do not expose others.
- "Positive" residents can similarly have group activities and outdoor time with appropriate control measures, in addition to staff with full transmission-based precautions.

Outdoor Visitation for Residents in the "Negative/Unexposed" Cohort

When NHs have effectively cohorted residents, the "negative/unexposed" cohort can have outdoor visits given:

- Visitors are screened per facility policies for facility entrance
- All visitors and residents wear cloth face coverings or procedure masks
- Physical distancing (at least 6 feet apart) is adhered to
- Visitor limits are instituted to minimize the number of people to which a resident is exposed
- Visitations should be scheduled such that the total number of visitors present does not exceed maximum established visitor limits. The visitor limits should be determined by the facility based on availability of outdoor space and the ability to monitor for infection control measures.
- Ensure the availability of hand sanitizer and extra facemasks

References: Note that COVID-19 websites are updated regularly.

1. CDC. Preparing for COVID-19 in Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
2. CMS. Nursing Home Reopening Recommendations for State and Local Officials: <https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>
3. CT DPH. Blast Fax 2020-55: COVID-19 Point Prevalence Survey Testing and Cohorting in Nursing Homes [Interim Guidance – May 11, 2020]: <https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/Facility-Licensing--Investigations/Blast-Faxes/2020-55-and-up/Blast-Fax-202055-Interim-Guidance-and-COVID19-Cleaning-Protocol.pdf>
4. CDC. Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>
5. CDC. Responding to Coronavirus (COVID-19) in Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html>
6. CDC. Testing Guidance for Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>
7. CDC. Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>
8. CDC. Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
9. CDC. Public Health Guidance for Community-Related Exposure: <https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html>
10. CT DPH. Blast Fax 2020-61: Resident Room Doors: <https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/Facility-Licensing--Investigations/Blast-Faxes/2020-55-and-up/Blast-Fax-202061-Resident-Room-Doors.pdf>