



Preparing for and Responding to COVID-19 in Long-term Care and Assisted Living Facilities

Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by coronavirus disease 2019 (COVID-19). If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness. The following recommendations from Maryland Department of Health (MDH) supplement CDC's general [infection prevention and control recommendations for COVID-19](#) and CDC's [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#). The following recommendations should continue until otherwise determined by public health.

COVID-19 Description

Typical COVID-19 symptoms include fever, cough, and shortness of breath. Additional symptoms might include sore throat, fatigue/malaise, loss of sensation of smell and/or taste, diarrhea, or dizziness. Additionally, recent experience with outbreaks in nursing homes has reinforced that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms.

Case Definitions

Suspect COVID-19 case: Clinical illness as described above in an individual AND:

- Has known contact with a COVID-19 case OR resides or works at a facility with confirmed cases within the past 14 days; OR
- Does not have known contact with a COVID-19 case and does not reside or work at a facility with confirmed cases within the past 14 days AND no alternative diagnosis.

Confirmed COVID-19 case: an individual with a positive SARS-CoV-2 PCR test regardless of signs and symptoms

Testing/Laboratory Diagnosis:

COVID-19 testing:

- Facilities should evaluate their capacity to safely collect specimens for COVID-19 testing.
- Facilities are encouraged to have a low threshold to test symptomatic residents and staff for COVID-19, preferably at the MDH Laboratory unless testing at a private lab can provide results within 24 hours.
- Facilities should assess supplies of testing kits and the potential for acquiring additional specimen collection kits from private laboratories. They should also consult with their local health department (LHD) to ask about the availability of COVID test kits.

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- Facilities should develop a protocol for specimen collection in collaboration with public health.
- Consider rapid flu and influenza PCR and respiratory panel if the COVID PCR test is negative

Pneumonia cases:

In addition to testing for COVID-19, run the following tests simultaneously:

- Rapid flu and influenza PCR and respiratory panel if the COVID PCR test is negative
- Sputum culture, including for Legionella
- Legionella and Streptococcus pneumoniae urinary antigen tests

Testing for staff:

- Facilities should make arrangements/encourage symptomatic staff to be evaluated and have testing as above for residents.
- Facilities should encourage ill staff to seek medical advice from their own healthcare providers or from occupational health.

Outbreak definitions:

COVID-19 outbreak: One or more confirmed cases of COVID-19 in a resident or staff member.

Other respiratory outbreaks (see [respiratory illness guidelines](#) for managing these outbreaks):

- Influenza-like illness (ILI) outbreak: 3 or more ILI cases in 7 days
- Influenza outbreak: 2 residents and/or staff with ILI or pneumonia within 7 days and at least one has a positive influenza test
- Pneumonia outbreak: 2 or more cases of pneumonia in a unit within 7 days
- A combination of ILI, influenza, and pneumonia cases

What to report - the following scenarios must be reported to LHD:

- Immediate reporting
 - One or more confirmed COVID-19 cases among residents and/or staff
 - Two or more cases of suspect COVID-19 cases within 14 days
- Within one day
 - Respiratory outbreaks as defined in the respiratory outbreak guidelines

Preventive Measures Against COVID-19

Share the [latest general information about COVID-19](#) with staff, residents, and families

Personal protective equipment (PPE):

- As part of source control efforts, healthcare personnel (HCP) and essential visitors should wear a facemask or cloth face covering at all times while they are in the facility.
- When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of

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COVID-19 (as supply allows). [Guidance on extended use and reuse of facemasks](#) is available.

- If PPE supply allows, consider having HCP wear all recommended PPE (gown, gloves, eye protection, facemask) for the care of all residents, regardless of presence of symptoms.
- Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment (PPE).
- Have HCP demonstrate competency with putting on and removing PPE.
- Implement or continue program for observing and monitoring adherence to hand hygiene and PPE, all days and shifts

Ensure adequate supplies for infection prevention and control practices:

- Assess supply of PPE and initiate measures to optimize current supply.
- Alcohol-based hand sanitizer should be available inside and outside of every resident room and other resident care and common areas.
- Sinks should be kept well stocked with soap and paper towels for handwashing.
- PPE should be readily available and kept well stocked in areas where resident care is provided.
- If a facility anticipates shortages of PPE supplies, they should notify their local health department.

Reinforce sick leave policies:

- Staff should not report to work ill. Signs and symptoms of COVID-19 can be very mild, so even mild signs of illness should result in HCP exclusion.
- Staff should be actively monitored for signs and symptoms of illness. At the start of each shift, HCP should be required to check their temperature and report whether they are experiencing any signs or symptoms of illness.
- Active monitoring should be repeated every 8 hours and as needed.
- Any staff that develop signs and symptoms consistent with COVID-19, including temperature $\geq 100.0^{\circ}\text{F}$, while working should keep their facemask on, inform their supervisor, and leave the workplace.
- Current [CDC guidance](#) communicates a preference for a test-based method to determine when HCP can return to work after infection. However, MDH recognizes that that is not always possible; therefore, staff may return to work after at least 7 days since symptoms first appeared AND at least 3 days (72 hours) since recovery, defined as resolution of fever without the use of fever-reducing meds AND improvement in COVID-19 symptoms. If HCP had a positive COVID-19 test but were never symptomatic, they can return to work 10 days after their first positive test, assuming they have not developed symptoms since their positive test.
- If staff shortages are experienced by a facility, they should consult their local health department to determine whether any staff may return to work earlier than recommended to address the need for staffing.

Identify infections early:

- Actively screen all residents every shift for fever and symptoms of COVID-19; immediately isolate anyone who is symptomatic. Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Additional symptoms may include new or worsening malaise, new dizziness, loss of sensation of taste

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and/or smell, diarrhea, or sore throat. Identification of these symptoms should result in prompt isolation and further evaluation for COVID-19.

- All residents with suspect COVID-19 should be cared for using standard, contact, and droplet precautions with eye protection (i.e. gown, gloves, facemask, and face shield or goggles), at least until diagnosis is clarified.

Admissions and readmissions:

- Create a dedicated observation area (this could be a separate unit/wing if possible or dedicated rooms in one area) to house non-COVID-19-positive residents being admitted or re-admitted from an outside facility. Ideally, this area would have private rooms with private bathrooms.
- Patients being admitted to this area do not need to be tested for COVID-19 prior to admission. They should be screened for COVID-19 symptoms prior to admission using the following methods:
 - Verbal report received from the transferring facility
 - Temperature taken (cutoff for fever is $>100.0^{\circ}\text{F}$)
 - Questions asked about symptoms, e.g. cough, shortness of breath, sore throat, fatigue/malaise, loss of sensation of taste and/or smell, diarrhea, dizziness
- If a new resident screens negative, they should be admitted to this observation unit/area for 14 days.
- Residents in the observation unit should be placed on strict isolation using contact and droplet precautions with eye protection, to the extent possible considering PPE supplies.
- They should also be screened daily with temperature and symptom checks, and if they screen positive, moved to an area dedicated to the care of suspect COVID-19 patients and promptly tested for COVID-19.
- After 14 days on the observation unit, if the resident does not ever screen positive, they can be relocated outside of the observation unit.
- All residents in nursing homes should be restricted to their rooms as much as possible, except for medically necessary purposes. It is particularly important that residents in the observation area not mix with residents from other parts of the facility.
- Patients who have been hospitalized for suspect or confirmed COVID-19 can be discharged from the hospital whenever it is clinically indicated. They do NOT require re-testing to be discharged.
- A nursing home can accept a resident diagnosed with COVID-19 and who is still on Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions.
- The placement of newly admitted residents who have been previously diagnosed with suspect or confirmed COVID-19 should be based on whether they still require the use of Transmission-Based Precautions:
 - Patients who meet criteria for discontinuation of Transmission-Based Precautions for COVID-19 can be admitted to the general population using Standard Precautions.
 - Patients who do not yet meet criteria for discontinuation of Transmission-Based Precautions for COVID-19 should be admitted to a private room with a private bathroom on Standard, Contact, and Droplet Precautions (including eye protection). Like other residents, these patients should be restricted to their rooms except for necessary medical procedures.

Discontinuation of Transmission-Based Precautions:

- Current [CDC guidance](#) expresses a preference for a test-based strategy for the removal of Transmission-Based Precautions.
- In situations where the use of a test-based strategy is not possible, guidance for discontinuation of in-home isolation precautions is the same as that to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 and is as follows:
 - At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in COVID-19 symptoms (e.g., cough, shortness of breath); AND
 - At least 7 days have passed since symptoms first appeared.
- Facilities can also consider extending the period of isolation beyond the non-test-based-strategy duration, on a case by case basis in consultation with local and state public health authorities.
- If the patient was never tested for COVID-19 but was suspected to have the illness, the criteria for discontinuation of Transmission-Based Precautions should still be followed.

Visitor and movement restrictions:

- All visitors should be restricted from entering the facility except for in extenuating circumstances (e.g. a resident is at the end of life).
- Visitors to the facility should be instructed to report the onset of fever or any COVID-19 symptoms to the facility in the 14 days after visitation.
- Potential visitors must be screened prior to entry for fever and COVID-19 symptoms. Those with symptoms are not permitted to enter the facility.
- Visitors that are permitted inside must wear a facemask or cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.
- Cancel communal dining and all group activities in the facility.
- Residents should remain in their room to the extent possible, except for medically necessary purposes.
- Have any residents who leave their rooms, including those who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis) wear a facemask or cloth face covering outside of their room, including for procedures outside of the facility.
- When possible, cohort residents and staff by unit.

Communication:

- Educate both facility-based and consultant personnel (e.g. wound care, podiatry, barber) and volunteers who provide care or services in the facility about COVID-19. Inclusion of consultants is important, since they commonly provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.
- Prepare facility internal and external communications in the event of a COVID-19 case being identified in your facility.
- Brief leadership team on priority activities in the event of a suspected or confirmed case (e.g. ensuring vigilant infection control).

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- Have an updated phone tree with public health communicable disease contacts and leadership contacts readily accessible.
- Ensure frequent and ongoing communication with all staff.

When You Have Suspected COVID19 Case(s)

Please note: Activities implemented before a suspected/confirmed case still apply

Admissions and transfers:

- Facilities should remain open to new admissions unless specifically instructed otherwise by public health officials. However, incoming residents (and family if designated decision-maker for resident) should be notified of the outbreak.
- Transport personnel and any facility receiving residents with suspect COVID-19 must be verbally notified about the suspected diagnosis prior to transfer.
- While awaiting transfer, symptomatic residents should wear a facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE should be used by HCP when coming in contact with the resident.

Environmental cleaning:

- Frequently touched surfaces should be disinfected three times per day and as needed (e.g. tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones) with an [EPA-registered disinfectant on List N](#) with an emerging pathogens or human coronavirus claim or a 1:10 bleach solution.
- Environmental services staff should wear appropriate PPE (i.e. gown, gloves, and face mask with eye protection) when cleaning the room of any resident for daily and terminal cleaning.
- To the extent possible, dedicate medical equipment to residents with fever or signs or symptoms of COVID-19.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.

Care of residents:

- Use Standard, Contact and Droplet precautions with eye protection (i.e. gown, gloves, face mask, and face shield or goggles) for residents with signs or symptoms consistent with COVID-19.
- Your local health department can assist with resident placement decisions.
- Create a plan, in collaboration with public health, for cohorting residents with symptoms of COVID-19, including dedicating HCP to work only with ill or well residents and/or dedicating a wing or space for suspect or confirmed COVID-19 residents.
- Aerosol-generating procedures should be avoided. If unavoidable, they should ideally be performed in an airborne infection isolation room (AIIR) or if not possible, in a private, closed room with a closed door while wearing appropriate PPE (i.e. gown, gloves, N95 or higher-level respirator, and eye protection).

When You Have Confirmed COVID-19 Case(s)

Please note: Activities implemented before confirming a COVID-19 case still apply

Response priorities:

When a COVID-19 case is confirmed, ensure:

- Quick identification and isolation of residents and exclusion of HCP with signs or symptoms of COVID-19.
- Ongoing strict active monitoring of all residents and facility staff members
- Ongoing compliance with strict visitor restrictions
- Correct donning and doffing of PPE
- Reinforcement of hand hygiene practices and respiratory etiquette for staff and residents
- Enhanced environmental cleaning of frequently touched surfaces three times per day
- Frequent, transparent communication with public health

Communication:

- Inform residents (and family member or other persons who serve as designated decision-makers for any residents) and staff of confirmed case(s) with prepared communication materials.
- Discuss response to confirmed case(s) with public health authorities.
- Complete staff/leadership rounds at the facility on every shift to ensure staff have an opportunity to discuss concerns with leadership.
- Coordinate public communications with state and local authorities.

Personal protective equipment (PPE):

- As part of source control efforts, HCP and other essential visitors must wear a facemask or cloth face covering at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of COVID-19 (as supply allows). [Guidance on extended use and reuse of facemasks](#) is available.
- If PPE supply allows, consider having HCP wear all recommended PPE (gown, gloves, eye protection, facemask) for the care of all residents, regardless of presence of symptoms.