COVID-19 INFECTION PREVENTION AND CONTROL			C-IC-28
Dept: ALL	New ☐ Revised ☒	**Last Date Revised:**	8/15/23
Manual: Clinical Manual		**Prev. Date Revised:**	3/14/20;3/19/20;;4/6/20 4/22/20;5/11/20;5/14/22; 7/16/20;7/20/20;8/6/20; 8/11/20;9/21/20;11/3/20; 12/2/20;12/24/20;1/25/21; 2/25/21;3/2/21;5/4/21; 7/5/21;9/24/21;12/10/21; 2/18/22; 10/6/22; 4/13/23; 5/12/23; 5/19/23;6/8/23
		Creation Date:	3/11/20
	Reviewed ☒	**Review Date**	10/2022; 2/2023; 5/2023, 5/2024, 5/2025, 9/2026
RELATED FORMS:	PA HAN references 624, 626, 627, 663, 694 701, CMS QSO-20-38-NH (9/23/22), CMSQSO-23-13-ALL;		

Infection

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Appendix

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Background Information

COVID 19 Information

Corona Viruses are a large family of viruses, some causing illness in people and others circulating among Animals including camels, cats, and bats and at times evolves and infects people before spreading through human to human contact.

The 2019 novel corona virus (COVID -19) is a new virus that causes respiratory illness in people and can rapidly spread from person to person. The virus was first identified during an investigation in Wuhan, China. A PHE was ordered and continued until May 11, 2023.

Risk:

Risk of infection with COVID -19 is higher for people who are close contacts of someone known to have COVID -19, for example healthcare workers or household members. People infected are capable of exposing others to COVID-19 even if their symptoms are mild, such as a cough, or even if they are asymptomatic. Additionally, exposure is possible by touching a surface or object that has the virus on it and then touching one's mouth, nose, or eyes. Others at higher risk for infection are those who live in or

have recently been in an area with ongoing spread of COVID-19. Older adults and people who have serious chronic medical conditions are at a higher risk for serious illness

Symptoms:

Per CDC, prompt detection, triage, and isolation of potential infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel (HCP) and visitors at the facility.

Symptoms may appear in as few as 2 days or as long as 14 days after exposure. Reported illnesses have ranged from people with little to no symptoms to being severely ill and dying.

Common signs and symptoms

- Fever
- cough
- Shortness of breath

Less common signs and symptoms

- Confusion or change in mental status. If noted, check pulse oximetry for O2 Sats
- Muscle aches, headache
- Sore throat, runny nose
- Chest pain
- Diarrhea, nausea and vomiting
- Myalgia
- chills; chills with shaking
- Sudden onset of loss of taste/smell

Human corona virus spreads just like the flu or cold:

- Through the air by cough/sneezing
- close personal contact such as touching or shaking hands
- touching an object or surface with the virus on it
- Occasional fecal contamination
- Possible spread thru just speaking, (still not proven fact)

Healthcare personnel (HCP) are on the front lines of caring for residents/patients with confirmed or possible Infection with undiagnosed respiratory illness and coronavirus disease 2019 (COVID-19) and therefore have an increased risk of exposure to this virus. HCPs can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control Guidelines, including use of recommended personal protective equipment (PPE) and receiving

appropriate vaccinations.

The facility, consistent with CDC/CMS/DOH implements standard infection control practices. This may include information pertaining to:

- Standard Precautions
- Transmission Based Precautions
- Hand hygiene
- Respiratory hygiene
- Vaccinations
- Signs and symptoms of common communicable diseases

Defining Community Transmission of SARS-CoV-2

Select IPC measures (e.g., use of source control, screening testing of long-term care facility admissions) are influenced by levels of SARS-CoV-2 transmission in the community. Community Transmission is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention before there is strain on the healthcare system and to better protect the individuals seeking care in these settings. The Community Transmission metric is different from the COVID-19 Community Level metric used for non-healthcare settings. Community Transmission refers to measures of the presence and spread of SARS-CoV-2. COVID-19 Community Levels place an emphasis on measures of the impact of COVID-19 in terms of hospitalizations and healthcare system strain, while accounting for transmission in the community.

Implications for Community Transmission Metric with the End of the Public Health Emergency (PHE)

With the end of the PHE on May 11, 2023, CDC will no longer receive data needed to publish

Community Transmission levels for SARS-CoV-2. This metric informed CDC's recommendations for broader use of source control in healthcare facilities to allow for earlier intervention, to avoid strain on the healthcare system, and to better protect individuals seeking care in these settings.

As described in CDC's Core IPC Practices, source control remains an important intervention during periods of higher respiratory virus transmission. Without the Community Transmission metric,

healthcare facilities should identify local metrics that could reflect increasing community viral activity to determine when broader use of source control in the facility might be warranted (See Appendix within this policy).

1. RECOMMENDED ROUTINE INFECTION PREVENTION AND CONTROL (IPC) PRACTICES DURING THE COVID-19 PANDEMIC

DOH recommends using the following additional infection prevention and control practices related to COVID-19, along with standard practices recommended as a part of routine healthcare delivery to all residents/patients. These practices are intended to apply to all residents/patients, not just those with suspected or confirmed SARS-CoV-2 infection (See Section 2 for additional practices that should be used when caring for residents/patients with suspected or confirmed SARS-CoV-2 infection).

A. The Facility will encourage everyone to remain up to date with all recommended COVID-19

vaccine doses. HCP, residents/patients, and visitors should be offered resources and be counseled about the importance of receiving the COVID-19 vaccine. Educating residents and staff on COVID-19 vaccine and/or boosters and offering assistance to get them vaccinated remains in effect until 5/21/24 unless additional regulatory action is taken.

If a facility is in Philadelphia County in Pennsylvania, the COVID-19 vaccine mandate remains in effect.

B. Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection

- Provide awareness to everyone of recommended IPC practices in the facility:

B. Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2

Infection - Continued

- o Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting Areas, elevators, cafeterias) with 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.

- Facility will continue to conduct HCP and visitor screening to make everyone entering the facility, regardless of their vaccination status, aware of recommended actions to prevent transmission to others if they have any of the following three criteria. Options for screening on

arrival to facility could include implementing an electronic monitoring system or a face to face individual screening.

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 residents/patients and visitors) or a higher-risk exposure (for health care personnel (HCP)).
4) For example:
    a. Instruct HCP to report any of the 3 above criteria to Director of Nursing/Infection Preventionist or another point of contact designated by the facility so these HCP can be properly managed.
    i. The definition of higher-risk exposure and recommendations for evaluation and work restriction of these HCP are in Policy C-IC-28aa.
    b. Provide guidance (e.g., posted signs at entrances, instructions when scheduling appointments) about recommended actions for residents/patients and visitors who have any of the above three criteria.
    i. Residents/Patients should be managed as described in Section 2.
    ii. Visitors:

1. 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.
2. 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, should 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).
3. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at Policy & Memos to States and Regions.

C. Implement Source Control Measures

Source control refers to use of respirators or well-fitting facemasks or cloth masks 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

C. Implement Source Control Measures – Continued

Standards and the degree of protection offered to the wearer, is available at CDC's Types of Masks and Respirators. People, particularly those at high risk for severe illness, should wear the most protective form of source control they can that fits well and that they will wear consistently.

Masking is no longer mandated by the facility for HCP, residents and or visitors, but guidance for masking within this policy is in accordance with CDC recommendations. 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.

For example, if an individual or someone in their household is at increased risk for severe disease, they should consider wearing masks or respirators that provide more protection because of better filtration and fit to reduce exposure and infection risk, even if source control is not otherwise required by the facility. HCP and healthcare facilities might also consider using or recommending source control when caring for patients who are moderately to severely immunocompromised.

The Facility may choose to offer well-fitting facemasks as a source control option for visitors but should allow the use of a mask or respirator with higher-level protection that is not visibly soiled by people who chose that option based on their individual preference. Additional information is available in the FAQ: What should visitors use for source control (masks or respirators) when visiting healthcare facilities?

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; OR
- A well-fitting facemask.

When used solely for source control, any of the options listed above could be used by HCP for an entire shift unless they become soiled, damaged or hard to breathe through. If they are used during the care of a resident/patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved N95 or equivalent or higher-level respirator during the care of a resident/patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a resident/patient on Droplet Precautions), they will be removed using proper doffing technique and discarded after the resident/patient care encounter and a new one should be donned.

- **Source control is recommended in healthcare settings for individuals who:**
  - Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or

C. Implement Source Control Measures – Continued

  - Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure.
- **Source control is recommended more broadly as described in CDC's Core IPC Practices 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 (See Appendix) o

Have Otherwise had source control recommended by public health authorities (e.g., in Guidance for the community when COVID-19 hospital admission levels are high).

Individuals might also choose to continue using source control 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. For example, if an individual or someone in their household is at increased risk for severe disease, They should consider wearing masks or respirators that provide more protection because of better Filtration and fit to reduce exposure and infection risk, even if source control is not otherwise Required by the facility. The facility/HCP might also consider using or recommending source control When caring for residents/patients who are moderately to severely immunocompromised.

D. Implement Universal Use of Personal Protective Equipment for HCP

If SARS-CoV-2 infection is not suspected in a resident/patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

Make PPE, including facemasks, N95 masks, eye protection, gowns, and gloves, readily available outside of the resident's room when it's determined PPE is needed. Position a trash can near the exit in the resident's room to make it easy for HCP to discard PPE. Perform hand hygiene upon exiting resident/patient rooms.

SARS-CoV-2 transmission in the community 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 should be used for:
    - All aerosol- As generating procedures (refer to the Infection Control FAQ: Which procedures are considered aerosol generating procedures in healthcare settings?).
    - All surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic

D. Implement Universal Use of Personal Protective Equipment for HCP - Continued

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 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 in counties with higher levels of SARS-CoV-2 Transmission 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.
- **E. Optimize the Use of Engineering Controls and Indoor Air Quality**

- The facility will optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other residents/patients from infected individuals (e.g., physical barriers at reception/triage locations and dedicated pathways to guide symptomatic residents/patients through waiting rooms and triage areas).
- Take measures to limit crowding in communal spaces, such as dining rooms, activity rooms, and/or waiting rooms/lobby to limit the number of residents/patients in those areas.
- Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in all shared spaces.
    - Guidance on ensuring that ventilation systems are operating properly is available in the following resources:
        - Guidelines for Environmental Infection Control in Health-Care Facilities
        - American Society of Heating, Refrigerating and Air-Conditioning Engineers; (ASHRAE) resources for healthcare facilities, which also provides COVID-19 technical resources for healthcare facilities; and
        - Ventilation in Buildings, which includes options for non-clinical spaces in healthcare facilities.

F. Perform SARS-CoV-2 Viral Testing

- CMS expectation is for facility to conduct COVID-19 testing in accordance with accepted national Standards, such as CDC recommendations. Non-compliance with this expectation will be cited as A deficiency at F880 for failure to implement an effective Infection Prevention Control Program In accordance with accepted national standards.
- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.
- 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.
- Residents (or resident representatives) may exercise their right to decline COVID-19 testing. In discussing testing with residents, staff should use person-centered approaches when explaining the importance of testing for COVID-19. Residents who have signs or symptoms of COVID-19

and refuse testing are placed on Quarantine precautions until the criteria for discontinuing precautions have been met.

F. Perform SARS-CoV-2 Viral Testing – Continued

Asymptomatic residents/patients with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, will have a series of three viral tests for SARS-CoV-2 infection.

- If the date of a discrete exposure is known, 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.
- If the date of a discrete exposure is NOT known (for example, a household exposure with an undefined start date), testing is recommended immediately and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

- In general, testing is not necessary 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 Policy C-IC-28aa.
  - Guidance for use of empiric Transmission-Based Precautions (quarantine) for patients With close contact with someone with SARS-CoV-2 infection are described in Section 2.

- Testing considerations for facilities with an outbreak of SARS-CoV-2 are described below (Section 1.G).
- The yield of screening testing for identifying asymptomatic infection is likely lower when Performed on those in counties with lower levels of SARS-CoV-2 community transmission. However, these results might continue to be useful in some situations (e.g., when performing Higher-risk procedures or for HCP caring for residents/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 NAAT, facilities should use 3 tests, Spaced 48 hours apart, in line with FDA recommendations.
  - In general, performance of pre-procedure or pre-admission testing is at the discretion of the facility. However, for residents/patients admitted to long-term care facilities admission testing is recommended and described in Section 3.
  - Performance of expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility.

G. Create a Process to Respond to SARS-CoV-2 Exposures among HCP and Others

The facility will investigate SARS-CoV-2 exposures within the facility and manage how contact tracing will be performed.

When an HCP is identified as infected with COVID-19, anyone who had prolonged close contact will be considered potentially exposed. The use of a facemask or source control and adherence to other recommended IPC measures by the HCP help to reduce, but not eliminate, the risk of transmission.

G. Create a Process to Respond to SARS-CoV-2 Exposures among HCP and Others – Continued

The following will be considered when determining which residents/patients are at higher risk for transmission and might be prioritized for notification, evaluation, and testing:

- Facemask use by the resident/patient – Mirroring the risk assessment guidance for healthcare personnel, residents/patients not wearing a facemask would likely be at higher risk for infection compared to those that were wearing a facemask.
- Type of interaction that occurred between the resident/patient and infected provider – An interaction involving manipulation or prolonged close contact with the resident/patient's eyes, nose, or mouth (e.g., intubation, dental cleaning, suctioning) likely poses higher risk of
- Transmission to the resident/patient compared to other interactions (e.g., blood pressure check).
- PPE used by infected HCP – HCP wearing a facemask (or respirator) and face shield that extends down below the chin might have had better source control than wearing only a facemask.

- Current status of resident/patient – Is the resident/patient currently admitted to a hospital or long-term care facility? These individuals, if infected, can be at higher risk for severe illness and have the potential to expose large numbers of individuals at risk for severe disease.

If healthcare-associated transmission is suspected or identified, the facility will consider expanded testing of HCP and residents/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, the facility may elect to initially expand testing only to HCP and residents/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.

Guidance for outbreak response in long-term care facilities is described in setting-specific

considerations below.

The facility responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities. The facility will continue to follow notification and reporting requirements (Refer to policy C-IC-28c).

2. RECOMMENDED INFECTION PREVENTION AND CONTROL (IPC) PRACTICES WHEN CARING FOR A RESIDENT/PATIENT EXPOSED TO COVID-19 OR WITH SARS-CoV-2 INFECTION

Hand and respiratory hygiene as well as cough etiquette (i.e. coughing into elbow versus hands) by Residents, visitors, and employees is imperative. Everyone is encouraged to wash their hands using Soap and water or hand sanitizer frequently. Hand sanitizer dispensers should be located throughout The nursing units for ease in staff usage. Staff may also be provided individual small containers to

Carry on their person for use. Training for staff should be completed on use and proper technique for Use when placing in a uniform pocket and removing for use.

Employees are educated and reminded to clean their hands according to CDC guidelines, including Before and after any contact with residents, after contact with contaminated surfaces or equipment,

2. RECOMMENDED INFECTION PREVENTION AND CONTROL (IPC) PRACTICES WHEN CARING FOR A

RESIDENT/PATIENT EXPOSED TO COVID-19 OR WITH SARS-CoV-2 INFECTION - Continued

And after removing personal protective equipment (PPE).

Put alcohol-based hand rub in common areas, including hallways. Encourage staff, residents and Visitors to perform hand hygiene, washing hands with soap and water or to use the hand sanitizer Frequently.

The IPC recommendations described below apply to:

- Residents/Patients with symptoms of COVID-19 (even before results of diagnostic testing);
- Asymptomatic residents/patients who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection; and

- Residents/Patients with SARS-CoV-2 infection.

However, quarantined residents/patients and those with suspected infection should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

A. Duration of Empiric Transmission-Based Precautions (Quarantine) for Symptomatic Patients being evaluated for SARS-CoV-2 infection

The decision to discontinue empiric Transmission-Based Precautions (Quarantine) by excluding the Diagnosis of current SARS-CoV-2 infection for a resident/patient with symptoms of COVID-19 can be Made based upon having negative results from a 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 a second negative antigen test taken 48 hours after the first negative test.

If a resident/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 judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

B. Duration of Empiric Transmission-Based Precautions (Quarantine) for Asymptomatic

Residents/Patients following Close Contact with Someone with SARS-CoV-2 Infection

In general, asymptomatic residents/patients do not require empiric use of Transmission-Based Precautions (quarantine) while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These residents/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 (Quarantine) following close contact may be considered include:

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

B. Duration of Empiric Transmission-Based Precautions (Quarantine) for Asymptomatic Residents/Patients following Close Contact with Someone with SARS-CoV-2 Infection

Residents/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.

- Residents/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.

C. Resident/Patient Placement

- Place a resident/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). The resident/patient should have a dedicated bathroom.
    - If cohorting, only residents/ patients with the same respiratory pathogen should be Housed in the same room. Multidrug-resistant organism (MDRO) colonization status And/or presence of other communicable disease should also be taken into Consideration during the cohorting process.
- The facility could consider designating entire units within the facility, with dedicated HCP, to care for residents/patients with SARS-CoV-2 infection when the number of residents/patients with SARS-CoV2 infection is high. Dedicated means that HCP are assigned to care only for these residents/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 resident/patient outside of the room to medically essential purposes.
- Communicate information about residents/patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility and to other healthcare facilities.
- Post signs on the door or wall outside of the resident room/wing/unit that clearly describe the type of precautions needed and required PPE within or in immediate area of type of Precaution signage. If the entire unit is a designated COVID care unit, several signs posted throughout the unit would suffice vs signs on each door.

D. Personal Protective Equipment

- HCP who enter the room of a resident/patient with suspected or confirmed SARS-CoV-2 infection will adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that
- Covers the front and sides of the face). This is also known as Transmission-based Precautions for COVID-19.
- 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 CFR 1910.134). (Refer to Policies C=RP- 4 through 10 related to fit testing, medical evaluations and training)
- Additional information about using PPE is available from CDC in Protecting Healthcare Personnel.

E. Aerosol Generating Procedures (AGPs)

- Procedures that could generate infectious aerosols should be performed cautiously and avoided if appropriate alternatives exist.

- AGPs should take place in an airborne infection isolation room (AIIR), if possible.
- The number of HCP present during the procedure should be limited to only those essential for resident/patient care and procedure support. Visitors should not be present for the procedure.

F. Visitation

- The facility will not restrict visitation without a reasonable clinical or safety cause. The Facility will not limit the frequency and length of visits for residents, the number of visitors, Or require advance scheduling of visits.
- For the safety of the visitor, in general, residents/patients should be encouraged to limit in-person visitation while they are infectious. However, the facility will adhere to local, state, and federal regulations related to visitation and act in accordance with their written policy. Visitation guidance for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from CMS.
    - Counsel residents/patients and their visitor(s) about the risks of an in-person visit.
    - Encourage use of alternative mechanisms for resident/patient and visitor interactions Such as video-call applications on cell phones or tablets, when appropriate.
- There are still risks associated with COVID-19 and visitation, but the risks are reduced by Adhering to the core principles of COVID-19 infection.
- Post signs at entrance reminding visitors of the:
    - Importance of remaining up to date with all recommended COVID-19 vaccine doses;
    - Recommendations for source control and physical distancing; and
    - Any other facility instructions related to visitation.

Indoor Visitation during an Outbreak Investigation

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. To swiftly detect cases, the facility will adhere to CDC/CMS regulations.

Indoor Visitation during an Outbreak Investigation- Continued

If residents or their representatives would like to have a visit during an

Outbreak investigation, the visit should be 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.

- The facility will provide instruction, before visitors enter the resident/patient's room, on Hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Visitors will be instructed to only visit the resident/patient's room. They should minimize Their time spent in other locations in the facility.
- Visitors are expected to adhere to instructions from the Administrator, DON and/or Charge Nurse on duty regarding facility infection control practices and visitation Restrictions. Visitors who do not follow or are unable to follow said directions may be Asked to leave the facility.

G. Duration of Transmission-Based Precautions for Residents/Patients with SARS-CoV-2 Infection

The following are criteria to determine when Transmission-Based Precautions could be discontinued For residents/patients with SARS-CoV-2 infection and are influenced by severity of symptoms and Presence of immunocompromising conditions. Residents/Patients should self-monitor and seek Reevaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these

Residents/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, residents/patients who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for residents/patients with severe to Critical illness.

In general, residents/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 residents/patients.

Residents/Patients with mild to moderate illness who are not moderately to severely 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:

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

Residents/Patients with severe to critical illness and who are not moderately to severely immunocompromised:

- At least 10 days and up to 20 days have passed since symptoms first appeared; and
- At least 24 hours have passed since last fever without the use of fever-reducing medications; and

G. Duration of Transmission-Based Precautions for Residents/Patients with SARS-CoV-2 Infection- Continued:

- Symptoms (e.g., cough, shortness of breath) have improved.
- The test-based strategy for moderately to severely immunocompromised residents/patients below can be used to inform the duration of isolation.

Residents/Patients with severe to critical illness and who are not moderately to severely immunocompromised: Continued

The exact criteria that determine which residents/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

residents/patients. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID19: Interim Guidance.

Residents/Patients who are moderately to severely immunocompromised:

These residents/patients 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:
    - Residents/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.
    - Residents/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.

H. Discharge of Patients with COVID-19 from a Healthcare Facility

Residents/Patients should be discharged from the healthcare facility whenever clinically indicated.

- If discharged to home; Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions. Information on ending home isolation will be provided to the resident/resident representative prior to discharge. Information on ending home isolation can be found here.
- If discharged to another skilled nursing facility or other long-term care facility (e.g., personal care home, assisted living facility); the receiving facility will be made aware of the COVID diagnosis and information provided on the status of isolation (i.e., completed on day x).

I. Environmental Infection Control

Dedicated medical equipment should be used when caring for a resident/patient with suspected or confirmed SARS-CoV-2 infection.

- All non-dedicated, non-disposable medical equipment used for that resident/ patient will be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another resident/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 resident/patient-care areas in which aerosol generating procedures are performed.
    - Refer to List N on the EPA website for EPA-registered disinfectants that kill SARSCoV-2; 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 resident/patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles [more information (to include important footnotes on its application) on clearance rates under differing ventilation Conditions is available]. After this time has elapsed, the room will be terminally cleaned and surface disinfection before it is returned to routine use.

3. SETTING-SPECIFIC CONSIDERATIONS

In addition to the recommendations described in the guidance above, here are additional considerations for the settings listed below.

A. Dialysis Facilities Considerations for Resident/Patient Placement – If Applicable to Facility

- Residents/Patients on dialysis with suspected or confirmed SARS-CoV-2 infection or who have reported close contact should be dialyzed in a separate room with the door closed.
    - Hepatitis B isolation rooms can be used if: 1) the resident/patient is hepatitis B Surface antigen positive or 2) the facility has no residents/patients on the census with Hepatitis B infection who would require treatment in the isolation room.
- If a separate room is not available, residents/patients with confirmed SARS-CoV-2 infection should be cohorted to a specific well-ventilated unit or shift (e.g., consider the last shift of the day). Only residents/patients with confirmed SARS-CoV-2 infection should be cohorted together:
    - In the context of an outbreak or an increase in the number of confirmed SARS-CoV-2 Infections at the facility, if a separate shift or unit is not initially available, efforts Should be made to create specific shifts or units for residents/patients with confirmed

SARS- CoV-2 infection to separate them from residents/patients without SARS-CoV-2.

Additional Guidance for Use of Isolation Gowns

- When caring for residents/patients with suspected or confirmed SARS-CoV-2 infection, gowns Should be worn over or instead of the cover gown (e.g., laboratory coat, gown, or apron with Incorporate sleeves) that is normally worn by hemodialysis personnel.

Cleaning and Disinfecting Dialysis Stations

- Current procedures for routine cleaning and disinfection of dialysis stations are appropriate for residents/patients with SARS-CoV-2 infection.
- Internal disinfection of dialysis machines is not required immediately after use unless otherwise indicated (e.g., post-blood leak). It should be done according to the dialysis machine manufacturer's instructions (e.g., at the end of the day).

B. Long-term Care Facilities

- Infection Preventionist: assign one or more individuals with training in IPC to provide on-site management of the IPC program:

- This should be a full-time role for at least one person in facilities that have more than 100 Residents or that provide on-site ventilator or hemodialysis services. Smaller facilities Should consider staffing the IPC program based on the resident population and facility Service needs identified in the IPC risk assessment.

- Notification/reporting: Stay connected with the healthcare-associated infection program in your state health department, as well as your local health department, and their notification requirements. When applicable, 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 (Refer to policy C-IC-28c, notification and reporting.
- **Managing admissions and residents who leave the facility:**
    - Admission testing is at the discretion of the facility. Additional information on screening Testing is described in Section 1.
    - Residents who leave the facility for 24 hours or longer should generally be managed as a New admission.
- Empiric use of Transmission-Based Precautions (quarantine) 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: Outbreak Identification:**
    - Surveillance includes the identification and tracking of:
- Exposures to COVID-19 among residents/patients and staff
- Symptom presentation among resident/patients and staff
- Confirmed and probable cases of COVID-19 among residents/patients and staff
- Outbreak definitions and thresholds will expedite investigation of cases and

Appropriate reporting to agencies

- An outbreak is considered closed when 14 days have passed with no new confirmed or Probable cases in the facility. new cases identified following a 14-day period with no New cases will be evaluated according to the outbreak definition for a new outbreak.

Long Term Care Facilities-Continued

- 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 (see Figure 1) could involve either contact Tracing (see Figure 2) or a broad- based approach (see Figure 3); 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 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-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.
- **Outbreak Reporting:**

- Report COVID-19 outbreaks in the facility according to Local, State and Federal Requirements
- Facilities are not required to report every new case once an outbreak is identified
- Refer to Table prior to “Definitions” in this policy for defining COVID-19 outbreaks In healthcare settings.
    - Empiric use of Transmission-Based Precautions for residents (quarantine) and work Restriction for HCP are not generally necessary unless residents meet the criteria Described in Section 2 or HCP meet criteria identified in policy C-IC-28aa. 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 Empiric use of Transmission-Based Precautions (quarantine) 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 (quarantine) for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and policy C-IC-28aa respectively.
    - If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and

Long Term Care Facilities-Continued

- 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 should be considered.
- **Indoor Visitation during an outbreak response:**

- The facility will follow guidance from CMS about visitation.
- Visitors will be counseled about their potential to be exposed to SARS-CoV-2 in the Facility.
- If indoor visitation is occurring in areas of the facility experiencing an Outbreak, 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.

o Facility should follow CMS requirements that recommend physical distancing during peak times of visitation and large gatherings. Crowding should be limited in communal spaces.

- **Continued Surveillance**

o On May 11, 2021, CMS issued guidance requiring all LTC facilities to educate Residents and staff on the COVID-19 vaccine (Including any additional doses) And offer to help them get vaccinated. Pursuant to section 1871 (a) (3) of the Act, Medicare interim final rules expire 3 years after issuance unless the Secretary determines an earlier end date. Therefore, this requirement will Remain in effect until May 21, 2024 unless additional regulatory action is Taken.

▪ In an earlier CMS bulletin (QSO-20-31-All) DOH Offices in all States are

Required to conduct Focused Infection Control (FIC) surveys in 20% of their Nursing homes in fiscal year 2023. They are not required to conduct

Additional surveys in 2024. CMS will continue to make the FIC surveys Available for States to use at their discretion (e.g., to conduct complaint Surveys when concerns related to COVID-19 infection control arise).

TABLE: Definition of an COVID-19 outbreak within healthcare settings

Facility Type	**COVID-19 Case**	
	Patients or Residents	**Healthcare Personnel**
Hospital	≥2 cases of probable* or confirmed COVID-19 in a patient 4 or more days after admission for a non- COVID condition, with epi-linkage	≥3 cases of probable* or confirmed COVID-19 in HCP with epi-linkage§ AND no other more likely sources of exposure for at least 2 of the cases
Long-term Care Facilities	≥1 facility-acquired¶¶ probable* or confirmed COVID-19 case in a resident	≥1 probable* or confirmed COVID19 case in HCP who was working in the facility while infectious
Outpatient Healthcare Settings	≥3 cases of probable* or confirmed COVID-19 cases in patients with epi-linkage AND no other more likely sources of exposure for at least 2 of the cases	≥3 cases of probable* or confirmed case in HCP with epi-linkage§, AND no other more likely sources of exposure for at least 2 of the cases

*Probable case is defined as a person meeting presumptive laboratory evidence. Presumptive laboratory evidence includes the detection of SARS-CoV-2 specific antigen in a clinical or post-mortem specimen using a diagnostic test performed by a CLIA-certified provider.

Epi-linkage among patients is defined as overlap on the same unit or ward, or other patient care location (e.g., radiology suite), or having the potential to have been cared for by common HCP within a 7-day time period of each other.

Determining epi-linkages requires judgment and may include weighing evidence whether patients had a common source of exposure.

§Epi-linkage among HCP is defined as having the potential to have been within 6 ft. for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility. Determining epi-linkages requires judgment and may include weighing evidence whether or not transmission took place in the facility, accounting for likely sources of exposure outside the facility

¶¶Facility-acquired COVID-19 infection in a long-term care resident refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:

- Residents who were known to have SARS-CoV-2 infection on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
- Residents who were placed into Transmission-Based Precautions (quarantine) on admission and developed SARS-CoV-2 infection while in quarantine.

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, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management,

administrative, billing, and volunteer personnel).

Healthcare settings: refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, inpatient rehabilitation facilities, nursing homes, 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 as the degree to which cloth masks protect the wearer might vary.

Guidance on design, use, and maintenance of cloth masks is available.

Definitions Continued:

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 certified by the CDC/NIOSH, including those intended for use in healthcare.

Definitions - Continued

Airborne Infection Isolation Rooms (AIIRs):

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 12 air changes per hour (6 air changes per hour are allowed for AIIRs last renovated or constructed prior to 1997).
- Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

Immunocompromised: For the purposes of this guidance, moderate to severely

immunocompromising conditions include, but might not be limited to, those defined in the CDC Interim Clinical Considerations for Use of COVID-19 Vaccines.

- 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.

Up-to Date means individuals have received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.

Definitions – Continued

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 Institute of Health (NIH) COVID-19 Treatment Guideline 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 judgement 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.

APPENDIX: CONSIDERATIONS FOR IMPLEMENTING BROADER USE OF MASKING IN HEALTHCARE SETTING

Introduction:

Use of well-fitting masks in healthcare settings is 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 and by ill individuals as part of respiratory hygiene and cough etiquette (i.e., for people with symptoms) are already well-described. This appendix 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.

When to implement broader use of masking

The overall benefit of broader masking is likely to be the greatest for resident/patients at higher risk for severe outcomes 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 residents/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 residents/ patients at highest risk for severe outcomes (e.g., cancer clinics, transplant units) or in areas more likely to provide care for residents/patients with a respiratory infection (e.g., urgent care, emergency department). 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 the stakeholders.
    - Reviewing plans with stakeholders including resident/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 residents/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.

Appendix- Continued

Metrics for community respiratory virus transmission

CDC is in the early stages of developing metrics that could be used to guide when to implement select infection prevention and control practices for multiple respiratory viruses. However, at this time there are some general metrics that could be used to help facilities make decisions about community respiratory virus incidence. Data on the exact metric thresholds that correspond with a higher risk for transmission are lacking. In addition, data from these systems are generally not available for all jurisdictions.

Some facilities might consider recommending masking during the typical respiratory virus season (approximately October-April).

Facilities could also follow national data on trends of several respiratory viruses.

- **SARS-CoV-2 specific metrics**

During the COVID-19 pandemic one of the strongest indicators of increasing cases in skilled nursing facilities 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. These data continue to be available at the county level and are provided by CDC to help the public decide when masking in the community should be considered. Based on CDC analyses of data from late 2022 and early 2023, these levels might be less useful to inform masking recommendations in healthcare facilities. Using the current cutoff for masking in the community (>20 new COVID-19 admissions per 100,000 population over the last 7 days), the ability of these levels to indicate ongoing SARS-CoV2 transmission at nursing homes (at 1 new infection per 100 resident-weeks, or higher) was low (sensitivity < 20%), although the specificity was high. Using a lower cutoff of 10 new COVID-19

admissions per 100,000 population (7-day total) increased sensitivity to about 40% but reduces specificity. CDC continues to recommend that healthcare facilities institute

facility-wide masking when masks are recommended in the community.

- **Metrics encompassing other respiratory viruses**

The RESP-NET interactive dashboard or data from the National Emergency Department Visits for COVID-19, Influenza, and Respiratory Syncytial Virus can be used to inform when respiratory virus season is beginning or ending. The National Respiratory and Enteric Virus Surveillance Systems (NREVSS) also provides additional information on the circulation of several respiratory viral pathogens. Lastly, outpatient respiratory illness visits determined by data reported to ILINet, are aggregated to provide state level estimates of influenza-like illness. Weekly statewide activity levels are provided which can serve as a guide when determining whether respiratory virus activity is increasing/decreasing. Additional

information on influenza in Pennsylvania is also posted weekly when activity is determined to be above background levels.

FIGURE 1: CHOOSING AN OUTBREAK RESPONSE METHOD FOR LONG-TERM CARE FACILITIES

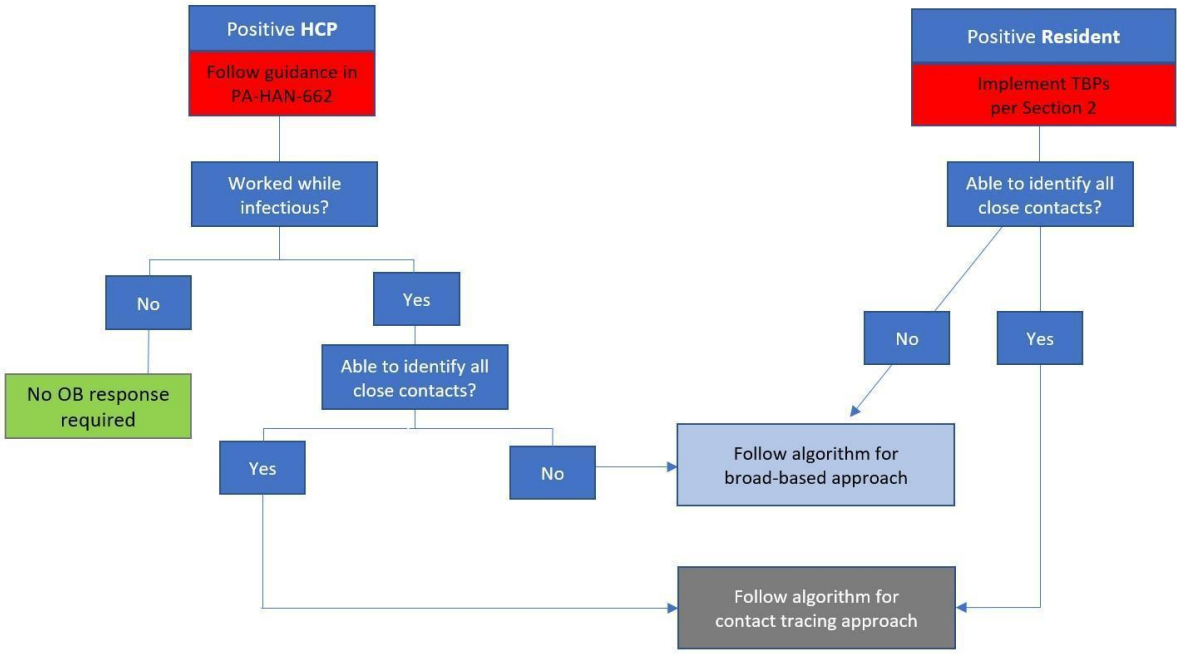


FIGURE 2: IMPLEMENTING A CONTACT-TRACING BASED APPROACH TO OUTBREAK RESPONSE FOR LONG-TERM CARE FACILITIES

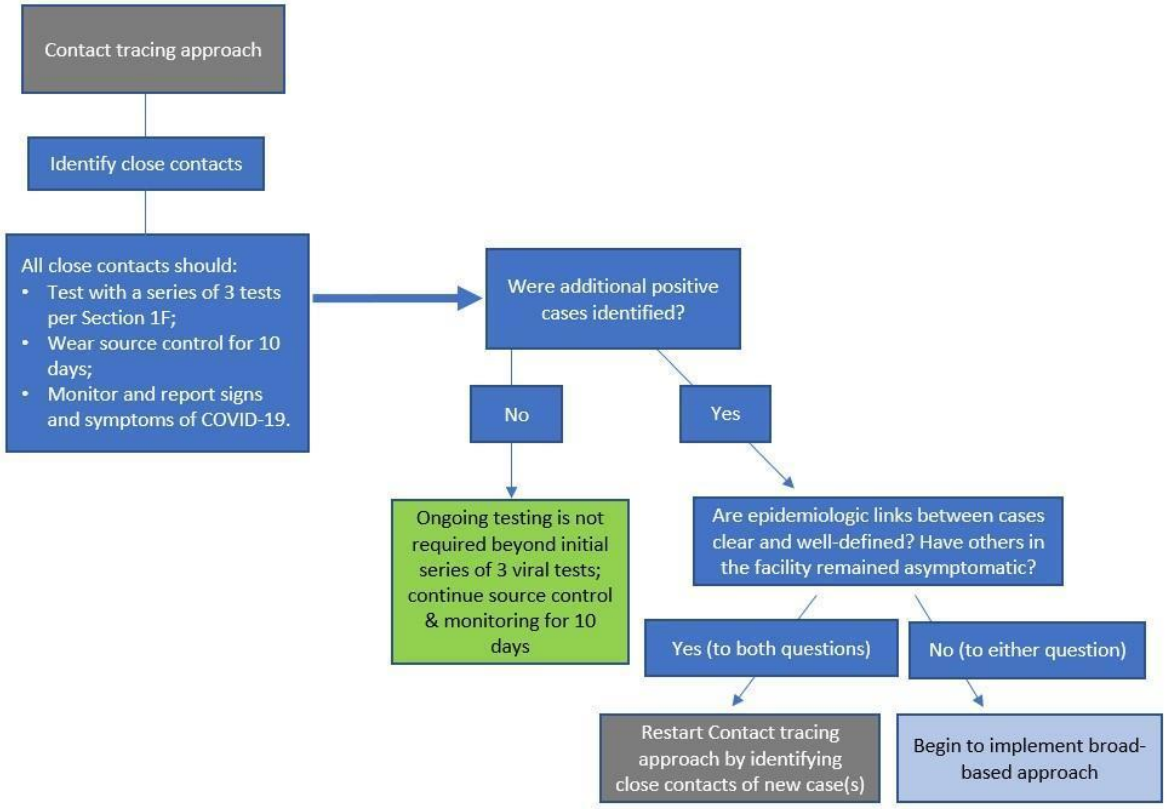
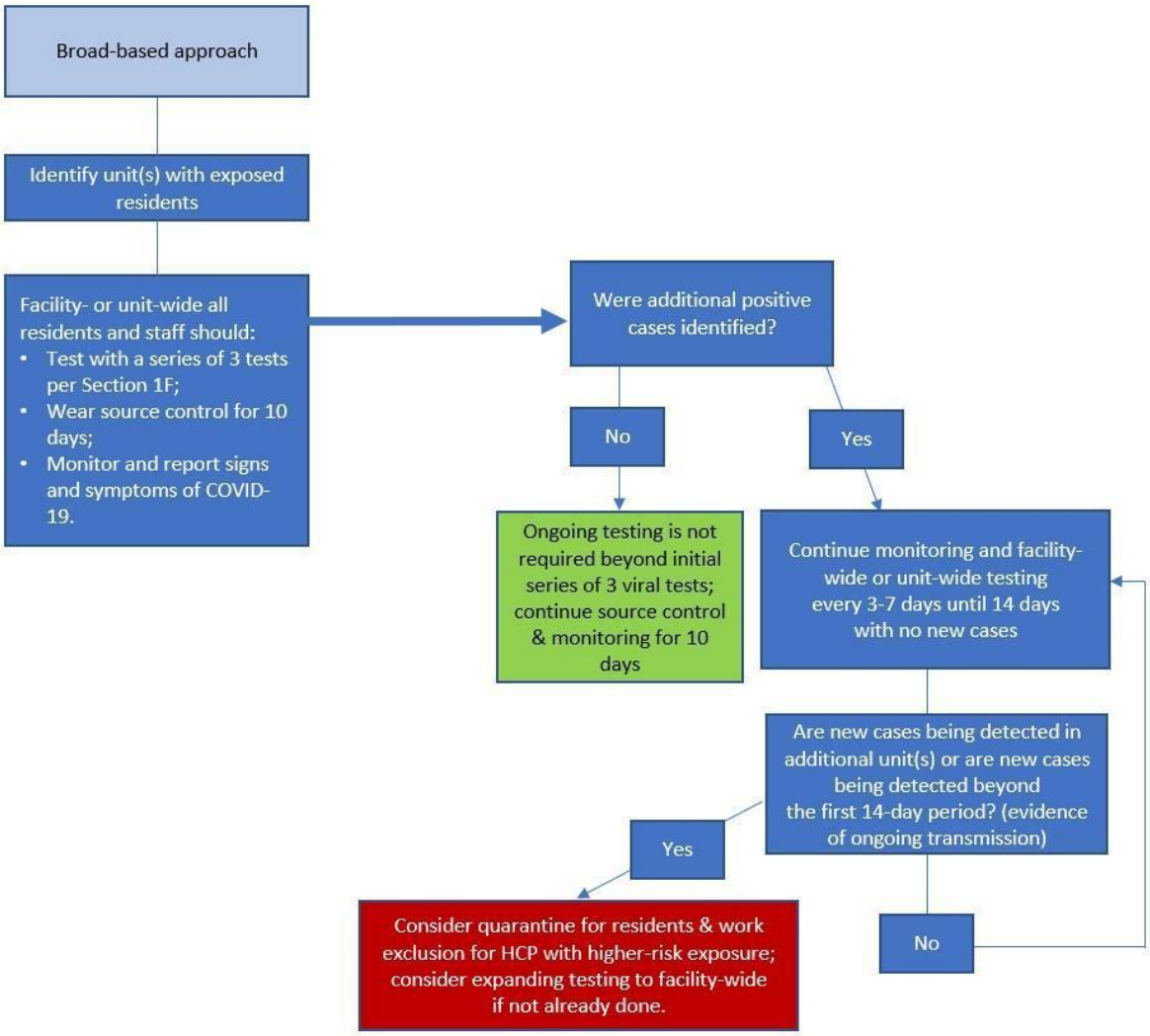


FIGURE 3: IMPLEMENTING A UNIT-BASED OR FACILITY-WIDE APPROACH TO OUTBREAK RESPONSE FOR LONG-TERM CARE FACILITIES


Broad-based approach
Identify unit(s) with exposed residents
Facility- or unit-wide all residents and staff should:
• Test with a series of 3 tests per Section 1F;
• Wear source control for 10 days;
• Monitor and report signs and symptoms of COVID-19.
Were additional positive cases identified?
No
Yes
Ongoing testing is not required beyond initial series of 3 viral tests; continue source control & monitoring for 10 days
Continue monitoring and facility-wide or unit-wide testing every 3-7 days until 14 days with no new cases
Are new cases being detected in additional unit(s) or are new cases being detected beyond the first 14-day period? (evidence of ongoing transmission)
Yes
No
Consider quarantine for residents & work exclusion for HCP with higher-risk exposure; consider expanding testing to facility-wide if not already done.