

# Infection Prevention and Control Manual

## Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

### Coronavirus-(COVID-19)

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#### Policy

It is the policy of this facility to minimize exposures to respiratory pathogens, promptly identify residents or healthcare personnel with signs or symptoms of COVID-19, manage residents confirmed with COVID-19 and implement interventions based upon Federal and State/Local recommendations (to include Admissions, Visitation, Standard and Transmission-based Precautions, hand hygiene, universal source control, PPE use, resident placement and more) to prevent and/or mitigate the spread of COVID-19.

**Note:** All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements. Check the following link regularly for [critical updates](#), such as updates to guidance for using and optimizing [PPE](#), [Preparing for COVID-19 in Nursing Homes](#) and [CMS admission process guidelines](#). Nursing Homes should immediately ensure that they are complying with all [CMS and CDC guidance](#) as well as State-specific requirements related to infection control. Facilities should also work close with their local health department for ongoing support.

- In particular, facilities should focus on adherence to appropriate [hand hygiene](#) as set forth by CDC.
- CMS has issued extensive guidance: <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> and <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>
- CDC has prepared an “Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19”: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf>.
- Facilities should refer to CDC’s guidance to long-term care facilities on COVID-19 and also use guidance on [optimizing personal protective equipment \(PPE\)](#) when unable to follow the long-term care facility guidance.

#### Procedure

##### Signs and Symptoms of COVID-19

- “People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness.
- Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms or combinations of symptoms may have COVID-19:
  - Fever or chills
  - Cough
  - Shortness of breath or difficulty breathing
  - Fatigue
  - Muscle or body aches
  - Headache
  - New loss of taste or smell
  - Sore throat
  - Congestion or runny nose

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- Nausea or vomiting
- Diarrhea<sup>1</sup>
- This does not include all possible symptoms. Please continue to monitor the CDC website for updates for COVID-19.

### Resident Care

#### ▪ Admission Guidance

- The facility will design a plan related to physical plant and resident placement to residents who have confirmed COVID-19, residents quarantined and for residents who are COVID-19 negative.
- Prior to admission, identify on the preadmission screen if resident is exhibiting symptoms of COVID-19 and results of COVID-19 testing to determine appropriate placement within the facility.
- Isolate all admitted residents (including readmissions) in a private room with own bathroom, in the quarantine designated location for 14 days.
  - Residents being admitted or readmitted should be screened upon entering the facility and apply a cloth face covering for source control.
- Residents who enter facilities should be screened for COVID-19 through testing, if available.
- Limit transport and movement of the resident outside of the room to medically essential purposes.
- When resident comes into the facility, they should be instructed that if they touch or adjust their cloth face covering, they should perform hand hygiene.
- For new residents obtain a travel history if possible, contact with anyone with lab confirmed COVID-19 and identify if resident exhibits signs or symptoms of COVID-19.
- When possible, all long-term care facility residents, whether they have COVID-19 symptoms or not, should cover their noses and mouths when staff are in their room.
  - Per CMS, residents can use tissues for this. They could also use cloth, non-medical masks when those are available.
  - “Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance”<sup>2</sup>. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
- No group activities (internal and external) or communal dining will occur in the facility at this time.
- Residents will be reminded to practice social distancing and perform frequent hand hygiene.
  - For residents with dementia or memory care units, structured activities at staggered time during the day with social distancing will be care planned and implemented on an individualized basis. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html>

#### ▪ Screening

- Prompt detection, triage, and isolation of potentially infected residents:
  - Ongoing, frequent, active screening for COVID-19 signs and symptoms (i.e. should be assessed for symptoms and actively have their temperature taken each shift)
    - In accordance with previous CMS guidance, every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked.
      - An exception to this is Emergency Medical Service (EMS) workers responding to an urgent medical need. They do not have to be screened, as they are typically screened separately.
- Actively screen all residents daily for fever (T $\geq$ 100.0°F) and symptoms of COVID-19. Include an assessment of oxygen saturation using a pulse oximetry. Two or more temperatures greater than 99.0°F may also be a sign of fever in the elderly. If symptomatic, immediately isolate and implement [appropriate Transmission-Based Precautions](#).

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- Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
  - Notify your state or local health department immediately (<24 hours), or per State guidance, if these occur:
    - Severe respiratory infection causing hospitalization or sudden death
    - Clusters ( $\geq 3$  residents and/or HCP) of respiratory infection or new onset respiratory symptoms within 72 hours of each other.
    - Individuals with suspected or confirmed COVID-19
    - [CDC – Preparing for COVID-19 in Nursing Homes](#)
  - Contact physician and public health authorities for COVID-19 testing consistent with current CDC and State Public Health recommendations
    - Work with state and local health departments to determine and address COVID-19 tests, requirements, prioritization, and specimen collection.
  - For suspected cases of COVID-19, contact the State or local health department for directions and testing.
  - Notifications and communication:
    1. Contact and inform resident's physician
    2. Contact and inform resident representative
      - a. <https://www.cms.gov/files/document/qso-20-29-nh.pdf>
    3. Contact and inform the facility Medical Director
  - For identified increase in the number of respiratory illnesses regardless of suspected etiology for residents and/or employees, immediately contact the local or State health department for further guidance.
- **Suspected or Known COVID-19**
    - “Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
      - Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use”<sup>2</sup>
    - Identify a space in the facility that can be dedicated to care for new admissions or suspected COVID-19 for quarantine (i.e. residents that develop COVID-19 symptoms consistent with COVID-19)
      - These residents should not be placed in a room with new admissions or other residents with COVID-19 signs or symptoms. While awaiting results, employees should wear full PPE when caring for these residents
    - Roommates or other residents and employees exposed to a resident with confirmed COVID-19 will be closely monitored for 14 days. Do not place unexposed residents in a shared space with these residents.
- **Acute Change of Condition**
    - Immediate isolation in private room (or cohort residents only with COVID-19 confirmation) with door closed.
      - Implement Transmission-based Precautions (COVID-19)
    - Complete clinical assessment of resident
    - Monitor ill residents (including documentation of temperature and oxygen saturation) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.
      - [CDC - Preparing for COVID-19 in Nursing Homes](#)

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- Call EMS (notify of COVID-19 status - be alerted to the resident's diagnosis and precautions to be taken) if indicated
- Call receiving hospital (notify of COVID-19 status - be alerted to the resident's diagnosis and precautions to be taken)
- Notify Medical Director
- Complete notifications per policy
- Complete Discharge Process per facility policy
- Immediately notify Public Health department of discharge to acute care (COVID-19)
- Limit only essential personnel to enter the room with appropriate PPE and respiratory protection. Implement consistent assignment as indicated in the facility plan.
- Log - keep a log of all persons who enter the room, including visitors and those who care for the resident
- Add to Line List
  
- **Resident Remains in the Facility (Non-acute)**
  - Implement Transmission-based Precautions (COVID-19)
  - Implement isolation to designated room/unit per plan
  - Closely monitor resident for change of condition (including documentation of temperature and oxygen saturation) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.
    - [CDC -Preparing for COVID-19 in Nursing Homes](#)
  - Complete notifications per policy
  - Notify Public Health department of suspected/known COVID-19
  - Notify Medical Director
  - Completed notification per policy
    - <https://www.cms.gov/files/document/qso-20-29-nh.pdf>
  - Implement consistent assignment of staff for resident(s)
  - Only essential staff are to enter room/unit with appropriate PPE and respiratory protection
  - Log - keep a log of all persons who enter the room, including visitors and those who care for the resident
  - Add to Line List
  - Residents suspected or confirmed with COVID-19 that remain in facility upon advice of primary care physician, will be assessed and evaluated for a minimum of 14 days for potential change in condition or additional signs and symptoms.
  
- **Readmission**
  - The facility can make a determination to readmit residents diagnosed with COVID-19 from the hospital based upon the below criterion
    - The facility is able to follow CDC guidance for Transmission-based Precautions for COVID-19.
    - If the facility is unable to follow CDC guidance for Transmission-based Precautions for COVID-19, it must wait until these precautions are discontinued at the hospital
      - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html#clinical-management-treatment%3C>
    - Consultation with State/local Health Department
    - CMS guidance: <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>
    - If possible, the facility will dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a quarantine unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab unit or returning to long-stay original room).
  - For suspected or confirmed COVID-19, the facility will keep a log of all persons who enter the room, including visitors and those who care for the resident.

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- Employees who have unprotected exposure to a resident with COVID-19 should report to the Infection Preventionist or designee for further direction as indicated by State/Local Health Departments
- Resident Transport: Prior to resident transport, both the emergency medical services and the receiving facility will receive alerted information regarding:
  - Resident diagnosis or suspected diagnosis
  - Precautions necessary
  - A facemask will be placed on the resident prior to transport
- Dedicated or disposable patient-care equipment should be used. If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations using EPA-registered disinfectants against COVID-19: <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19>
- Discontinuation of Isolation Precautions will be determined on a case-by-case basis in conjunction with the State and/or Local Health Department and Federal Guidance
  - CDC Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance). July 17, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>
- Upon discontinuation of isolation precautions: Cleaning and disinfecting room and equipment will be performed using products that have EPA-approving emerging viral pathogens: <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19>
- **Outbreak**
  - In the event of a facility outbreak (CDC defines as a single new case of SARS-CoV-2 in any healthcare worker or resident<sup>3</sup>) institute outbreak management protocols:
    - Define authority (Infection Preventionist, DON, Administrator, Medical Director, etc.)
      - **Immediate** reporting/notification and consultation with the Local/State Public Health Department
      - Place resident(s) with confirmed COVID-19 in private rooms on transmission-based precautions on designated COVID-19 unit
      - Cohort residents identified with same COVID-19 confirmation if indicated
      - Implement consistent assignment of employees
      - Only essential staff to enter rooms/wings
      - Decisions on admissions will be based upon consultation with facility leadership, infection preventionist, Medical Director, acute care partner and Public Health Department
    - Consult with Public Health on testing expansion consistent with CDC Testing Guidelines for Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

### **Personal Protective Equipment and Supplies**

- State and local health departments should work together with long-term care facilities in their communities to determine and help address long-term care facility needs for PPE and/or COVID-19 tests. Refer to [CMS Guidance](#)
- Staff will use appropriate PPE when they are interacting with residents, to the extent PPE is available and per CDC guidance on conservation of PPE.
  - For the duration of the state of emergency in their State, all facility personnel should wear a facemask while they are in the facility. \*Follow specific state guidance

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- It is recommended that an N95 or surgical mask is to be used – if no surgical mask or N95 is available a cloth face covering can be used but is not considered a PPE. \*\*See policies and procedures for PPE's (face mask, face shield, gowns)
  - Per [CDC](#), Ensure all staff wear a facemask while in the facility.
    - Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.
- Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE.
- If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 diagnosis or symptoms on the affected unit (or facility-wide depending on the situation)
- **“HCP working in facilities located in areas with moderate to substantial community transmission** are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow [Standard Precautions](#) (and [Transmission-Based Precautions](#) if required based on the suspected diagnosis).  
They should also:
  - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters.”<sup>3</sup>
  - All residents should wear a cloth face covering for source control when they leave their room or leave the facility for essential medical appointments. When healthcare workers enter the resident room, resident should cover their mouth and nose with a cloth facemask or tissue.
- The facility will monitor necessary supplies and equipment (PPE, ABHR, thermometers, pulse oximeters, soap, towels, etc.) <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>
  - If facility is unable to obtain needed supplies and equipment from vendor, contact the local and state public health agency
- Personal Protective Equipment (PPE) includes:
  - Gloves
  - Isolation Gowns
    - In the event of supply capacity concerns, see CDC [“Strategies for Optimizing the Supply of Isolation Gowns”](#)
  - Facemasks:
    - In the event of supply capacity concerns, see CDC [“Strategies for Optimizing the Supply of Facemasks”](#)
  - Respiratory Protection if facility has a respiratory protection program (Fit-tested NIOSH-certified disposable N95 filtering facepiece respirator prior to entry and removal after exiting-). If disposable respirator is used, it should be removed and discarded after exiting the resident room and closing the door. Perform hand hygiene after discarding. If reusable respirator is used, clean and disinfect according the manufacturer’s recommendations. If facility is using Fit-tested NIOSH-certified disposable N95 filtering respirators, staff must be medically cleared and fit-tested and trainer prior to use.
    - In the event of supply capacity concerns for respiratory protection, the CDC has outlined measures in the “Strategies for Optimizing the Supply of N95 Respirators” at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html> and “Guidance for use of Certain Industrial Respirators by Health Care Personnel” at: <https://www.cms.gov/files/document/qso-20-17-all.pdf>

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- The facility will document efforts to obtain necessary PPEs and supplies needed. The facility will take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility will contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents.
  - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html> and
  - “Guidance for use of Certain Industrial Respirators by Health Care Personnel” at: <https://www.cms.gov/files/document/qso-20-17-all.pdf>
- If no Fit-Tested NIOSH-Certified N95 respirators available or used in facility, the Infection Preventionist will identify appropriate mask that will be donned when entering and after exiting resident room:
  - Examples include:  
[https://www.cdc.gov/niosh/nptl/topics/respirators/disp\\_part/default.html](https://www.cdc.gov/niosh/nptl/topics/respirators/disp_part/default.html)  
<https://www.cms.gov/files/document/qso-20-17-all.pdf>
- Eye Protection that covers both the front and sides of the face. Remove before leaving resident room. Reusable eye protection will be cleaned and disinfected according to manufacturer’s recommendation. Disposable eye protection will be discarded after use
- If facilities need to optimize eye protection supplies:
  - CDC “Strategies for Optimizing the Supply of Eye Protection”:  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html>
- Hand Hygiene using Alcohol Based Hand Sanitizer before and after all patient contact, contact with infectious material and before and after removal of PPE, including gloves
  - If hands are soiled, washing hands with soap and water is required for at least 20 seconds.
- Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.

### Employees

This “applies to other health care workers such as Hospice workers, EMS personnel or dialysis technicians, which provide care to the residents”<sup>4</sup>

- The facility will review facility sick leave plan for facility employees, align with current CDC and State/Local health department requirements
- Screening Employees:
  - Facility will actively screen employees for signs and symptoms of COVID-19 when employees report to work-beginning of their shift. Document temperature, absence of symptoms of COVID-19 <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>
    - If employee is ill, employee will be provided with a clean facemask and will immediately leave the facility and self-isolate at home and follow directions for testing in collaboration with Public Health
  - Employees who develop symptoms to COVID-19 will be instructed to not report to work and referred to public health authorities for testing, medical evaluation recommendations and return to work instructions.
  - Employees who develop symptoms on the job will be:
    - Instructed to immediately stop work, provide with a new facemask, and immediately leave the facility
    - Instructed on self-isolation at home
    - Follow directions for testing in collaboration with Public Health

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- The Infection Preventionist will work with the employee to identify individuals, equipment, and locations the employee came in contact with
- The Infection Preventionist will contact the local health department for recommendations on next steps for active monitoring.
- The facility will identify employees that work at multiple facilities and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19
  - Follow state and local public health department guidance as it relates to staff working between multiple locations.
- The Infection Preventionist will identify exposures that may warrant restricting asymptomatic employees from working based upon CDC guidance for exposures.  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>
- The Infection Preventionist will add employee on the line list.
- The facility will re-educate employees and reinforce:
  - Strong hand-hygiene practices
  - Cough etiquette
  - Respiratory hygiene
  - Transmission Based Precautions
  - [Appropriate utilization of PPE's as indicated](#)
  - PPE Sequencing
  - PPE Optimization based upon CDC guidance: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html> and facility policy/procedures and [PPE Decontamination](#) and Reuse of Filtering Facepiece Respirators
  - [Cleaning and disinfection](#)
    - EPA List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19)  
<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19>
- Facility will provide adequate work supplies to avoid sharing and disinfect workplace areas frequently

### **Employee Return to Work Criteria**

Return to Work Criteria for Employees with Confirmed or Suspected COVID-19. Per CDC guidelines, use one of the below strategies to determine when an employee may return to work in healthcare settings (<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>)

Unless it is a rare circumstance, a test-based strategy is no longer recommended by CDC for employee to return to work.

#### **“Symptom-based strategy for determining when HCP can return to work.**

*HCP with [mild to moderate illness](#) who are not 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

**Note:** HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

*HCP with [severe to critical illness](#) or who are severely immunocompromised<sup>1</sup>:*

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- At least 10 days and up to 20 days have passed *since symptoms first appeared*
- 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
- Consider consultation with infection control experts

**Note:** HCP who are **severely immunocompromised** but who were **asymptomatic** throughout their infection may return to work when at least 1-0 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

As described in the [Decision Memo](#), an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered in determining the appropriate duration for specific HCP. For example, HCP with characteristics of severe illness may be most appropriately managed with at least 15 days before return to work.

### Test-Based Strategy for Determining when HCP Can Return to Work.

In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the [Decision Memo](#), many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised<sup>1</sup>) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

The criteria for the test-based strategy are:

*HCP who are symptomatic:*

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

*HCP who are not symptomatic:*

- Results are negative from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).<sup>5</sup>

### Return to Work Practices and Work Restrictions

After returning to work, an employee should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by

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these healthcare workers for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.

- A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection
- Self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen.”<sup>5</sup>
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in [CDC's interim infection control guidance](#) (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

### Crisis Strategies to Mitigate Staffing Shortages

“Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home.”<sup>5</sup>

The following includes the plan and processes in place to mitigate staffing shortages for safety and quality of care provided to the residents of the facility.

- The leadership team will identify staffing needs and identify the minimum number of staff necessary to provide a safe work environment and quality of resident care
- Leadership will be in communication with local healthcare coalitions and public health partners to identify staffing resources if indicated.
- Schedules may be adjusted to meet the needs of the residents
- Agency employees will receive adequate orientation, training, and verification of competency
- Employees will be requested to postpone elective time off if able.
- Return to work after confirmed COVID-19
  - Employees should be evaluated, as guided by the State and Local health department, to determine appropriateness of earlier return to work than recommended
  - If an employee returns to work **earlier than recommended**, they should still adhere to the Return to Work Practices and Work Restrictions recommendations above. For more information, see:
    - [CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#)
    - [CDC's Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)

### Visitor Restrictions

- The facility will **restrict** visitation of **all** visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation until visitation is permitted under the State and Federal guidance for reopening: <https://www.cms.gov/files/document/qso-20-30-nh.pdf>
- For visitor restrictions, visitors will be limited to a specific room only.

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# Infection Prevention and Control Manual

## Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- For individuals that enter in compassionate situations (e.g., end-of-life care), the facility will require visitors to perform hand hygiene and use Personal Protective Equipment (PPE), such as facemasks.
  - Decisions about visitation during an end of life situation will be made on a case by case basis, which includes careful screening of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms. Those with symptoms of COVID-19 will **not be permitted** to enter the facility at any time (even in end-of-life situations).
  - Those visitors that are permitted, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility (such as a dedicated area by an entrance of the building, if possible for the visit to occur)
    - The visitation room will be disinfected after each visit
  - Visitors will be reminded to frequently perform hand hygiene.
  - Prior to entry to the facility, visitor will be instructed on:
    - Hand Hygiene
    - Limiting surfaces touched
    - Use of PPE
    - Refrain from physical contact with residents and others in the facility, (practice social distancing by remaining 6 feet apart from others and not handshaking, hugging, etc.)
- Visitors that enter in compassionate situations (e.g., end-of-life) and any individuals who entered the facility will be advised (e.g., hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility.
  - If COVID-19 symptoms occur, they will be advised to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited.
  - The facility will immediately screen the individuals of reported contact, and take all necessary actions based on findings.
- The facility will notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.). Communication will be provided through multiple means of the visitation restriction such as signage, letters, emails, phone calls and recorded messages for receiving calls).
  - Note: If a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor's executive order, a facility would not be out of compliance with CMS' requirements. In this case, surveyors would still enter the facility, but not cite for noncompliance with visitation requirements.
- Exceptions to restrictions:
  - Health care workers: The facility will follow CDC guidelines Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 found at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
  - This also applies to other health care workers, such as hospice workers, EMS personnel, or dialysis technicians, which provide care to residents.
    - They should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers.
    - The facility will contact their local health department for questions, and will review the CDC website dedicated to COVID-19 for health care professionals <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>
    - Surveyors: CMS and state survey agencies are constantly evaluating surveyors to ensure they don't pose a transmission risk when entering a facility as outlined in <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> and <https://www.cms.gov/files/document/qso-20-31-all.pdf>. However, there are circumstances under which surveyors should still not enter, such as if they have a fever.
  - Ombudsman – residents still have the right to the Ombudsman program. Their access should be restricted per the guidance for visitors (except in compassionate care situations) however, the

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# Infection Prevention and Control Manual

## Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

facility will review this on a case by case basis and will identify alternate means of communication and access in coordination with the Ombudsman.

- The facility will increase visible signage at entrances/exits, perform temperature checks and COVID-19 symptom evaluation, increase availability to hand sanitizer, offer PPE for individuals entering the facility for end of life visits (if supply allows).
- Volunteers will not be permitted in the facility.
- Vendors will not be permitted in the facility unless extraordinary circumstances would warrant.
  - Vendors will be instructed to drop off supplies at a dedicated location (loading dock)
- EMS personnel (e.g., when taking residents to offsite appointments, etc.) will take necessary actions to prevent any potential transmission.
- In lieu of visits (either through limiting or discouraging), The facility will consider:
  - Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
  - Creating/increasing listserv communication to update families, such as advising to not visit.
  - Assigning staff as primary contact to families for inbound calls and conduct regular outbound calls to keep families up to date.
  - Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.
  - Residents still have the right to access the Ombudsman program.
    - In-person access is restricted at this time except for compassionate care situation
      - This will be reviewed on a case by case basis
    - Facility will facilitate resident communication (by phone or another format) with the Ombudsman program

### Communication

- **Reporting and Communication to Residents, their Representatives and Families:**
  - The facility will “inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—
    - (i) Not include personally identifiable information.
    - (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
    - (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.”<sup>6</sup>
  - The facility will review facility communication procedures for COVID-19 (initial, ongoing and upon suspected or confirmed outbreak) through multiple means (i.e. signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls) to inform individuals and non-essential health care personnel of the visitation restrictions, as outlined in <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> and <https://www.cms.gov/files/document/qso-20-26-nh.pdf>
  - The facility will, to their fullest extent possible, inform residents and their families of limitations of their access to and ability to leave and re-enter the facility, as well as any requirements and procedures for placement in alternative facilities for COVID-19-positive or unknown status.
    - Develop and implement key talking points

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# Infection Prevention and Control Manual

## Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

- Preparation strategies for COVID-19
- Visitor restriction protocols
- Suspected or confirmed cases
- Facility process if an outbreak occurs
- Determine communication (written, verbal, electronic) for:
  - Residents
  - Resident Representatives
  - Employees
  - Vendors
  - Visitors
  - Media
  - State/local health departments
  - Local hospitals, EMS providers and provider community
  - Other Key Stakeholders
- Determine and implement a communication lead
- Develop key facts and talking points for media (preparation and response)
- Facility Signage
  - Signs will be posted at the entrances, elevators, and breakrooms to provide residents, staff, and visitors on instructions on hand hygiene, PPE, respiratory hygiene, and cough etiquette. Facemasks, Alcohol-based hand rub (ABHR), tissues and a waste receptacle will be available at the facility entrances.

### Reporting COVID-19 Information to CDC's NHSN

- Facility will to NHSN COVID-19 Module <https://www.cdc.gov/nhsn/pdfs/covid19/lcf/cms-covid19-reg-508.pdf> and <https://www.cdc.gov/nhsn/lcf/covid19/index.html> :
  - Resident Impact & Facility Capacity
  - Staff & Personnel Impact
  - Supplies & Personal Protective Equipment
  - Ventilator Capacity & Supplies

### References and Resources

*NOTE: The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.*

<sup>1</sup>Centers for Disease Control and Prevention: Coronavirus Disease 2019 (COVID-19) Symptoms of Coronavirus. Updated May 13, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

<sup>2</sup>Centers for Disease Control and Prevention: Preparing for COVID-19 in Nursing Homes. June 25, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html>

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# Infection Prevention and Control Manual

## Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

<sup>3</sup>Centers for disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. July 15, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

<sup>5</sup>Centers for Disease Control and Prevention. Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance). August 10, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

Centers for Disease Control and Prevention. Strategies to Mitigate Healthcare Personnel Staffing Shortages. April 30, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

Centers for Disease Control and Prevention: Testing Guidelines for Nursing Homes. June 13, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

Centers for Medicare & Medicaid Services. Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes. May 6, 2020: <https://www.cms.gov/files/document/qso-20-29-nh.pdf>

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Overview of Testing for SARS-CoV-2: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. June 18, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Information for Healthcare Providers about Coronavirus (COVID-19). <https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html>

Centers for Disease Control and Prevention. "Healthcare Personnel Preparedness Checklist for 2019-nCoV that can be downloaded and completed by the Infection Preventionist at: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp-preparedness-checklist.pdf>

Centers for Medicare & Medicaid Services. Upcoming requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes <https://www.cms.gov/files/document/qso-20-26-nh.pdf>

Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>

<sup>4</sup>Centers for Medicare & Medicaid Services. QSO-20-14-NH. Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes: <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>

Centers for Medicare and Medicaid Services QSO-20-20-ALL <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0>

Centers for Medicare & Medicaid Services QSO-20-29-NH: <https://www.cms.gov/files/document/qso-20-29-nh.pdf>

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Centers for Medicare & Medicaid Services QSO-20-30-NH: <https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>

Centers for Medicare & Medicaid Services. QSO-20-17-ALL. Guidance for the use of Certain Industrial Respirators by Health Care Personnel. <https://www.cms.gov/files/document/qso-20-17-all.pdf>

Local Health Department Listing and Contacts. <https://www.naccho.org/membership/lhd-directory>

Information on affected US locations: <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

### FDA Resources

Emergency Use Authorizations: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations-medical-devices>

### CMS Additional Resources

Long term care facility – Infection control self-assessment worksheet: [https://qsep.cms.gov/data/252/A\\_NursingHome\\_InfectionControl\\_Worksheet11-8-19508.pdf](https://qsep.cms.gov/data/252/A_NursingHome_InfectionControl_Worksheet11-8-19508.pdf)

Infection control toolkit for bedside licensed nurses and nurse aides (“Head to Toe Infection Prevention (H2T) Toolkit”): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment>

Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>

CMS COVID-19 Focused Survey for Nursing Homes: <https://www.cms.gov/files/document/qso-20-29-nh.pdf>

### CDC Additional Resources

CDC Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and Other Long-Term Care Settings: [https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist\\_3\\_13.pdf](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf)

CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf>

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