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COVID-19 Information for Nursing Homes

The purpose of this document is to serve as **COVID-19 guidance for Rhode Island Nursing Homes**. It incorporates the Rhode Island Department of Health's (RIDOH) recommendations based on May 8, 2023, guidance from the Centers for Disease Control and Prevention (CDC) and Centers for Medicare & Medicaid Services (CMS).

This document includes guidance for Nursing Homes on the following topics:

Summary of Recent Changes – June 15, 2023

- Updated recommendations for universal source control and admissions testing and visitation.
- Updated guidance to align with data changes:
  - Replaced COVID-19 community transmission metric with local-level metrics which include COVID-19 wastewater surveillance and percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis.
  - Replaced COVID-19 community levels with COVID-19 hospital admission levels.

Nursing homes should consider COVID-19, and other respiratory virus transmission, in the community, as well as recommendations by public health authorities, to guide decisions about extra precautions related to infection prevention and control practices.

In Rhode Island, local-level metrics such as percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis and COVID-19 wastewater surveillance

provide earlier signals of increasing COVID-19 in the community.

Extra precautions, such as broad use of source control and personal protective equipment (PPE), are recommended during periods of higher levels of COVID-19, and other respiratory virus transmission, in the community.

Facilities should also consider their own facility-specific risk factors and may implement broad use of source control and PPE at lower levels of COVID-19 community incidence.

Find weekly updates on COVID-19 on the Rhode Island Department of Health's COVID-19 Data Response Portal.

Isolation
Isolation starts on the first day of symptoms (day 0) or on the day of a positive test if there are no symptoms (asymptomatic) (day 0).

• **Residents who are asymptomatic** isolate at least 10 full days since the date of their first positive test.
• **Residents with mild to moderate illness** isolate
  ○ At least 10 full days since symptoms first appeared/date of the first positive test* **AND**
  ○ Fever-free for 24 hours without fever-reducing medications **AND**
  ○ Symptoms have improved.
• **Residents with severe to critical illness** isolate
  ○ At least 10 full days and up to 20 days since symptoms first appeared **AND**
  ○ Fever-free for 24 hours without fever-reducing medications **AND**
  ○ Symptoms have improved.
  ○ The test-based strategy can be used to inform the duration of isolation for residents who have severe to critical illness.

• **People who have moderately to severely compromised immune systems** may be contagious for more than 20 days after symptom onset/the date of the first positive test.   ○ Nursing Homes should determine when to end isolation and other precautions through use of the test-based strategy and (if available) consultation with an infection control team and/or healthcare provider.
Test-Based Strategy **(Used to determine the end of isolation for residents with severe to critical illness or who have moderately to severely compromised immune systems)**
• Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration of isolation for residents. • Residents with **symptoms** isolate until

- Fever-free without the use of fever-reducing medications **AND**
- Symptoms have improved **AND**
- Negative test results from at least 2 consecutive tests 48 hours apart (antigen test or PCR).

- Residents who are **asymptomatic**
  - Isolate until negative test results from at least 2 consecutive tests 48 hours apart (antigen test or PCR).

Empiric Transmission-Based Precautions

(Used in addition to Standard Precautions while awaiting a clear diagnosis)

In addition to standard precautions for infection prevention and control, the CDC recommends that nursing homes use empiric transmission-based precautions to rule out COVID-19 infection for symptomatic residents, close contact exposures, and admissions. Facilities should use clinical judgment about using empiric transmission-based precautions if residents remain symptomatic in consultation with primary care providers.

CDC provides detailed information about empiric transmission-based precautions.

Symptomatic Residents

- Quarantine and use of source control (e.g., masking or respirators as defined by the CDC) around others until COVID-19 is ruled out through diagnostic testing.
  - Empiric transmission-based precautions, including source control, may be discontinued when residents test negative for COVID-19: If using antigen tests, residents should have at least 2 negative results from consecutive antigen tests taken 48 hours apart or at least 1 PCR test.
- If a symptomatic resident is never tested, the decision to discontinue empiric transmission-based precautions, including source control, can be made based on symptom onset and isolation recommendations.

Close Contact Exposure Regardless of Vaccination Status

- Asymptomatic residents usually do not require use of empiric transmission-based precautions after close contact with someone with COVID-19. However, they should
  - Wear source control for 10 days; **AND**
  - Test negative on 3 antigen tests taken 48 hours apart (the first test taken no sooner than 24 hours after exposure).
    - Residents who tested positive for COVID-19 within the past 30 days should not get tested.
- Empiric transmission-based precautions and quarantine may be considered after close contact when a resident
  - Is unable to be tested or wear source control for 10 full days following exposure;
  - Has a moderately to severely compromised immune system;

- Resides on a unit with others who have moderately to severely compromised immune systems; **OR**
- Resides on a unit experiencing ongoing COVID-19 transmission that has not been controlled with initial interventions.

- Empiric transmission-based precautions and quarantine for residents may be discontinued after
  - 10 full days if they don't develop symptoms

    OR
  - 7 full days following exposure if they test negative on 3 consecutive tests:
    - Antigen or PCR tests should be taken 48 hours apart following exposure – typically on days 1, 3, and 5 (the first test should be at least 24 hours after exposure).

Admissions/Residents Returning to the Facility After More than 24 Hours

- Residents arriving at the facility as admissions (new admissions to the facility and those returning after leaving for more than 24 hours will be referred to as "admissions" in this guidance) should wear source control for 10 full days.
- Testing admissions is at the discretion of the facility.
- RIDOH strongly encourages nursing homes to consider testing for all new admissions/residents returning to the facility after more than 24 hours due to the vulnerability of populations served by most nursing homes in Rhode Island. Data show that **age remains the strongest risk factor for severe COVID-19 outcomes**.
  - Residents should test negative on 3 consecutive antigen tests taken 48 hours apart.
- Empiric transmission-based precautions and quarantine are not required for residents who leave the facility for less than 24 hours (e.g., for medical appointments or community outings).

Testing

- Nursing Homes should base decisions about testing on revised CDC guidance for symptomatic, post-exposure, and outbreak testing. Find a summary in the **Testing Summary Table:**

When to Test Someone for COVID-19	
Testing Trigger	**Staff and Residents**
When a symptomatic individual is identified:	Test all staff and residents with signs or symptoms of COVID-19, regardless of vaccination status.
When a COVID-19-positive staff or resident is newly identified in a facility that can identify close contacts:	Test all staff and residents who had a close contact or higher-risk exposure with a COVID-19-positive individual, regardless of vaccination status.
When a COVID-19-positive staff or resident is newly identified in a facility that is unable to identify close contacts:	Focused testing for staff and residents, regardless of vaccination status.
Routine Testing:	Not required. May be recommended during periods of high COVID-19 transmission. If implementing a screening testing program, it should not be based on vaccination status of the individuals being screened.

- For outbreaks, Nursing Homes should follow current guidance for reporting cases and clusters in the Long-Term Care Portal [portal.ri.gov/reportcovidresult].

On-Site Testing

- Nursing Homes should consider using antigen tests. Antigen tests deliver accurate and rapid results.
  - In addition to Clinical Laboratory Improvement Amendments (CLIA)-certified antigen point-of-care testing at the facility, staff may use antigen self-tests at home.
- To provide the greatest assurance that someone doesn't have COVID-19, if using an antigen test instead of a PCR, facilities should follow US Food and Drug Administration (FDA) guidelines:
  - Asymptomatic individuals with close contact exposure or admissions/residents returning to the facility after more than 24 hours should take 3 consecutive antigen tests 48 hours apart.
  - Symptomatic individuals should take 2 consecutive antigen tests 48 hours apart.

Source Control and Universal Use of Personal Protective Equipment (PPE)

Source Control

- Nursing Homes should use source control for everyone in areas of patient care when COVID-19, or other respiratory virus transmission, is increasing in the community: such as when COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings.
  - Facilities may offer well-fitting facemasks as a source control option for visitors but should allow the use of a mask or respirator that is not visibly soiled.
  - Source control options for healthcare personnel include
    - National Institute for Occupational Safety & Health (NIOSH)-approved particulate respirator with N95 filters or higher;
    - Respirator approved under standards used in other countries that are like NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of NIOSH-approved respirator when respiratory protection is indicated);
    - Barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; or
    - Well-fitting facemask, such as a surgical or procedural mask.

Universal Use of PPE by Healthcare Personnel (HCP)

- Facilities should implement broad use* of respirators and eye protection by HCP during patient care encounters when COVID-19, or other respiratory virus transmission, is increasing in the community: such as when COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings.
  - NIOSH-approved particulate respirators with N95 filters or higher should be used for
    - All aerosol-generating procedures;
    - All surgical procedures that might pose higher risk for transmission if the resident has COVID-19;
    - Areas where residents are unable to use source control and the area is poorly ventilated, healthcare-associated transmission is identified, or universal respirator use by HCP working in affected areas is not already in place; and
  - Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.

*Facilities may implement **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 COVID-19 transmission when COVID-19, or other respiratory virus transmission, is increasing in the community: such as when COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater

surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings.

Visitation

- Per 42 CFR § 483.10(f)(4), a resident has the right to receive visitors of their choosing at the time of their choosing, and in a manner that does not impose on the rights of another resident, such as a clinical or safety restriction. Find detailed information about visitation in the CMS QSO-20-39 NH – Revised 05.08.2023.
- Facilities should post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) that include instructions about current IPC recommendations (i.e., when to use source control).
- Visitors with COVID-19 or symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation, this time period is longer than what is recommended in the community.
- Visitors who have had close contact with someone with COVID-19 or were in another situation that put them at higher risk for transmission, it's safest to defer non-urgent in-person visitation until 10 days after their close contact if they can't wear source control).

COVID-19 Vaccination

- Vaccination remains one of the best strategies to prevent severe COVID-19 infection.
- Long-term care facility residents who are not up to date with their COVID-19 vaccines when they arrive at a long-term care facility should follow CDC information for COVID-19 vaccines for long-term care residents.
- CDC and the CDC's National Healthcare Safety Network (NHSN) have additional reporting requirements for long-term care facilities.
- Per Rhode Island Regulation 216-RICR-20-15-7 for Immunization, Testing, and Health Screening for Healthcare Workers**, **healthcare workers are required**
    - **To be up to date** with all CDC-recommended doses of FDA-approved or authorized COVID-19 vaccine

      OR
    - Wear an N95 mask at each healthcare facility when Community Transmission level statewide is greater than or equal to 50 cases per 100,000 people per week, as reported by RIDOH.

** Rhode Island Regulation 216-RICR-20-15-7 is currently being revised.

Therapeutics (Treatments/Medications)

• As a RIDOH standard of care, Nursing Homes should
  ○ Offer therapeutics to every resident who has recently been diagnosed with COVID-19
  OR
  ○ Record why therapeutics were not indicated or appropriate.
• Find detailed information about therapeutics for COVID-19 in the National Institutes of Health's COVID-19 Treatment Guidelines.
• Supply of preventative and treatments therapeutics can be found via the COVID-19 Therapeutics Locator.

Healthcare Personnel (HCP) at Nursing Homes

Definition of healthcare personnel: www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

(Note: Nursing Home staff should follow recommendations for the General Public when they're NOT involved in resident care)

All HCP should wear source control (i.e., masks) if returning to work before the duration of their full isolation (i.e., 10 full days for HCP with asymptomatic or mild to moderate illness).

Strategies for mitigating staff shortages: www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html.

Facilities may implement more restrictive mitigation policies.

Work Restrictions for HCP with COVID-19 Infection by Staffing Capacity Levels
See full guidance here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Severity of Symptoms	Conventional	Contingency[i]	Crisis[ii]
Mild to moderate	Isolate for 10 full days **OR** Isolate for at least 7 full days with a negative test within 48 hours before returning to work (day 5 or later) **AND** • Fever-free for 24 hours without the use of fever-reducing medications; and • Symptoms have improved.	Isolate for at least 5 full days **AND** • Fever-free for 24 hours without the use of fever-reducing medications; and • Symptoms have improved. **Note:** Healthcare facilities may choose to have HCP test negative before returning to work.	Notify RIDOH Center for Health Facilities Regulation **AND** Review updated CDC recommendations for prioritization of personnel, services performed, patients served, and source control for HCP and patient.
Asymptomatic *throughout the infection*	Isolate for 10 full days **OR** Isolate for at least 7 full days with a negative test within 48 hours before returning to work (day 5 or later)	Isolate for at least 5 full days since the date of their first test. **Note:** Healthcare facilities may choose to have HCP test negative before returning to work.	
Severe to critical	Isolate for at least 10 full days and up to 20 days since symptoms first appeared		

	AND • Fever-free for 24 hours without the use of fever-reducing medications Symptoms have improved. ***Note:*** *The test-based strategy for returning to work can be used to inform the duration of work restriction.*
Work Restrictions for HCPs who Have Moderately to Severely Compromised Immune Systems (Immunocompromised) See full guidance here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html	
• People who have moderately to severely compromised immune systems may remain contagious longer than 20 days after symptom onset or the date of their first positive test (for those who were asymptomatic throughout their infection). • They should use the test-based strategy for returning to work and consult with an infectious disease specialist or other expert. An occupational health specialist is recommended to determine when the HCP may return to work.	
Test-based strategy to return to work after severe to critical illness or those who have moderately to severely compromised immune systems	
If **symptomatic**, HCP may return to work if • Fever-free for 24 hours without the use of fever-reducing medications; **AND** • Symptoms have improved; **AND** • After testing negative on at least 2 consecutive tests taken 48 hours apart using antigen or PCR tests.	
If **asymptomatic**, HCP may return to work after • Testing negative on at least 2 consecutive tests taken 48 hours apart using antigen tests or PCRs.	
Work Restrictions for Asymptomatic HCP with COVID-19 Exposure See full guidance at: www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html	
Exposures that might require testing and/or restriction from work can occur both while at work and in the community. In general, HCP who have had prolonged close contact with someone with COVID-19 in the community (e.g., household contacts) should be managed the same way as HCP who have higher-risk occupational exposures. Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing COVID-19, particularly if these HCP were present in the room for an aerosol-generating procedure. For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 infection and any of the following are true: • HCP was not wearing a respirator	

<table>
<tr><td colspan="4">

- HCP was wearing a facemask, but the person with COVID-19 infection was not wearing a cloth mask or facemask
- HCP was not wearing eye protection, but the person with COVID-19 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure.

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<tr><th>All Exposures</th><th>Higher-Risk Exposure</th><th>Higher-Risk Exposure with Work Restrictions</th><th>If Fever or COVID-19 Symptoms Develop</th></tr>
<tr>
<td>HCP should follow all recommended infection prevention and control practices for 10 days:
Wear well-fitting source control
Monitor for fever or COVID-19 symptoms
Do not report to work when sick</td>
<td>HCP should have a series of 3 consecutive tests 48 hours apart following exposure – typically days 1, 3, and 5.
(First test should be after 24 hours after exposure.)
AND
For 10 days, follow all recommended infection prevention and control practices:
Wear well-fitting source control
Monitor for fever or COVID-19 symptoms
Do not report to work when sick.</td>
<td>HCP can return to work after 10 full days
OR
After 7 full days with negative results on 3 consecutive tests as described for asymptomatic HCP following a higher-risk exposure.</td>
<td>Immediately self-isolate and contact their occupational health program to arrange for medical evaluation and testing.</td>
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<tr><th colspan="4">Work Restrictions for Asymptomatic HCP With Recent Travel</th></tr>
<tr><td colspan="4">HCP with travel or community exposures should consult their occupational health program for guidance about work restrictions.</td></tr>
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Note: Upon changing staffing category (e.g., from “contingency” to “crisis”), nursing homes must notify RIDOH by reporting to the Center for Health Facilities Regulation (CHFR). Additionally, nursing homes that shift from contingency to crisis staffing should post their staffing status and an explanation on their websites or other public-facing areas.

[i] Contingency staffing means staffing shortages are anticipated at healthcare facilities. Such facilities, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem.

[ii] Crisis staffing means there are no longer enough staff to provide safe patient/resident care.