COLORADO
Department of Public Health & Environment

COVID-19 GUIDANCE

Residential Care Facility (RCF) Mitigation Guidance

Issued: 1/10/2021

Scope: The purpose of this document is to provide guidance to residential care facilities (RCF) when a resident or staff member is suspected or confirmed to have COVID-19 and to provide recommendations to prevent transmission within the facility. These recommendations are specific for RCFs. Guidance provided in this document is based on currently available information at the time it was drafted and is subject to change.

Background: Since early 2019, a new respiratory disease, coronavirus-19 (COVID-19) has been spreading globally and within the United States. This disease is caused by the virus SARS-CoV-2. The Colorado Department of Public Health and Environment (CDPHE) continues to monitor the situation closely. Updated case counts are available on the CDPHE website: Coronavirus Disease 2019 (COVID-19) in Colorado.

Residents of RCFs, which are often older people and/or those with underlying health conditions, are at especially high risk for developing serious illness associated with COVID-19. Healthcare personnel and close contacts of people with COVID-19 are also at elevated risk for exposure. Respiratory illnesses have the potential to spread easily in these settings due to the communal nature of the environment. Rapid response is key to limiting transmission in the facility. Ensure infection control measures remain in place consistently, taking immediate action if even a single case (staff or resident) is suspected.

Definitions: For the purpose of this document, definitions are as follows:

Outbreak definitions have been standardized across outbreak settings. An outbreak in a residential setting is defined as two or more confirmed cases of COVID-19 among residents and/or staff in a facility with onset in a 14 day period OR one confirmed case and two or more probable cases of COVID-19 among residents and/or staff in a facility with onset in a 14 day period. Of note: Colorado COVID-19 Case and Outbreak Definitions for residential settings was updated on 12/7/2020 to include staff.

Healthcare Personnel (HCP) refers to all persons, paid and unpaid, working in healthcare settings engaged in resident care activities, including: resident assessment for triage, entering examination rooms or resident rooms to provide care or clean and disinfect the

environment, obtaining clinical specimens, handling soiled medical supplies or equipment, and coming in contact with potentially contaminated environmental surfaces.

POD refers to a hall, wing, unit, neighborhood, etc., that is a group assignment in which the same staff and residents are assigned consistently and across multiple shifts in order to limit the number of individuals interacting. It is best practice to enforce POD designation for care activities, communal dining, and group activities, consistently and according to the social distancing calculator, however, not to exceed 10 residents per POD. The smaller the POD size, the easier it will be to prevent transmission.

Quarantine refers to someone who was possibly exposed to COVID-19 and needs to stay away from others for a certain period of time to determine whether they develop infection. This is to limit transmission in the event the exposed individual develops COVID-19. Because the incubation period for COVID-19 is 2-14 days, individuals should remain on quarantine until 14 days has passed since their last possible exposure. Testing during this time will not rule out incubating disease and therefore cannot be used to shorten the incubation period.

- Of note: The options to shorten quarantine that CDC recently published do not apply to high-risk settings such as residential care facilities. The quarantine period for residential settings will remain 14-days post exposure.
- New guidance for residential care facilities regarding vaccinations and quarantine is not out yet from CDPHE or federal agencies. Continue on with current recommendations for quarantine (full 14 days regardless of vaccination status).

Isolation refers to someone who has developed illness (i.e., COVID-19 like symptoms) or who has tested positive for COVID-19. Individuals with COVID-19 are infectious and can transmit COVID-19 to others. Individuals who have illness and/or who test positive for COVID-19 should remain in isolation until at least 10 days has passed since their illness began or from the date of test if asymptomatic. For more information go to CDC: COVID-19: Quarantine vs. Isolation.

Preparation

Steps that facilities can take to prepare for COVID-19:

1. Review the facility emergency plan.
2. Establish relationships with key healthcare and public health partners.
3. Communicate about COVID-19 with your residents and resident families, including actions taken to protect the residents from COVID-19.
4. Communicate about COVID-19 with your staff, including changes to policies and procedures.
5. Reinforce sick leave policies and restrict ill HCP from work and those reporting a high risk exposure (e.g., household contact with COVID-19 or caring for a COVID-19 positive resident without proper use of a mask and/or eye protection).
6. Screen residents and HCP for symptoms and signs of infection at least daily, and more frequently if illness is suspected. (See Surveillance and Monitoring, below).

7. Designate residents and staff to a POD to limit movement in the facility and the number of persons interacting with residents and each other.
8. Conduct an inventory of available PPE and ensure adequate supply.
9. Ensure proper use of recommended personal protective equipment (PPE).
10. Ensure proper hand hygiene and respiratory etiquette, making sure that supplies are available in residential care areas, throughout the facility, and at entrances.
11. Ensure adequate supplies and procedures for environmental cleaning and disinfection.
12. Facilities should assign at least one individual (full-time) with training in IPC to provide on-site management of their COVID-19 prevention and response activities.
13. Remain vigilant for COVID-19 among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death. Consider CDC's training modules for front-line staff.
14. Monitor the two-week average test positivity rate ("Colorado Covid Dial") to determine the frequency for surveillance testing and the level of communal dining and group activities allowed within their facility.
15. Create a plan for testing residents and healthcare personnel for COVID-19 in accordance with the Fifth Amended Public Health Order.

Key Information about COVID-19

- **Agent:** SARS-CoV-2
- **Incubation Period:** Range 2 to 14 days
- **Transmission/Communicability:** The virus is thought to spread mainly from person-to-person.
    - Between people who are in close contact with one another (within about 6 feet),
    - Through respiratory droplets produced when an infected person talks, coughs, or sneezes.
    - These droplets can land in the eyes, mouths, or noses of people who are nearby or possibly be inhaled into the lungs.
    - It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- **Symptoms:** Symptoms associated with COVID-19 include: Fever (measured at >100.0˚F or subjective), chills, cough, shortness or breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose. Consider also rhinorrhea, diarrhea, nausea or vomiting.

Reporting

- COVID-19 is a reportable condition in Colorado requiring labs to report negative and positive results. Whoever performs the test is obligated to report the results to public health.
    - Polymerase chain reaction (PCR) tests are currently the most effective test available for detecting COVID-19 infection and why The Fifth Amended PHO requires all residential care facilities utilize PCR testing for surveillance and outbreak testing. CDPHE has contracted with Curative in order to provide PCR testing services for all residential care facilities. However, facilities may choose to procure their own resources for PCR testing. All PCR results (negative and positive) will be reported to CDPHE directly by the performing laboratory on behalf of the facility.
    - POC antigen tests can be performed by the facility in addition to the required PCR testing (as outlined above) but not as a replacement. The facility assumes reporting responsibilities for all POC testing results (negative and positive) as they are the acting laboratory. Facilities performing POC testing must report results to CDPHE directly. **For additional reporting questions, email the team in PHIRR cdphe_covidreporting@state.co.us.**
    - Of note: Reporting of COVID-19 results to CDPHE (as outlined above) does not fulfill NHSN reporting requirements or outbreak reporting requirements.
- Any suspected or confirmed case **or** outbreak (e.g., one or more cases) of COVID-19 among residents or staff shall immediately be reported to the local or state public health agency using the COVID-19 Outbreak report form. Facilities can send this form to their local public health agency OR to CDPHE by securely emailing the completed form to cdphe_covid_outbreak@state.co.us. Facilities may also contact CDPHE at 303-692-2700 (8:30 - 5:00, Monday - Friday) or 303-370-9395 (after-hours, holidays and weekends).
    - Additionally, facilities should promptly notify public health for any of the following: Suspected or confirmed case of influenza in a resident or HCP (may indicate co-circulation); a resident with severe respiratory infection resulting in hospitalization or death; or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
- ALL residential care facilities should report COVID-19 information daily, using the CDPHE EMResource.
- CMS nursing homes must report COVID-19 cases, facility staffing, supply information and both positive and negative COVID-19 point of care antigen test results to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module at least weekly (test results as completed).
    - CDC's NHSN provides long-term care facilities with a customized system to track infections and prevention process measures in a systematic way. Nursing homes can report into the four pathways of the LTCF COVID-19 Module including:
        - Resident impact and facility capacity
        - Staff and personnel impact

        - Supplies and personal protective equipment
        - Ventilator capacity and supplies
    - Weekly data submission to NHSN will meet the CMS COVID-19 reporting requirements.

Surveillance and Monitoring

- **Surveillance for Respiratory Illness in Residents during COVID-19**
    - Routinely monitor residents for symptoms and actively take their temperature and other vital signs, including pulse oximetry daily. **Increase monitoring of all residents to two times daily (at a minimum) if there is an outbreak of COVID-19 in the facility (suspected or confirmed).**
    - Ensure residents have been educated on the signs and symptoms of COVID-19 and how to report if they develop illness.
    - Residents with the following symptoms should be considered for potential COVID-19:
        - Cough
        - Shortness of breath, difficulty breathing, or signs of new hypoxemia
        - Fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)
        - Other symptoms in the setting of a suspected or confirmed COVID-19 outbreak (e.g., rhinorrhea, diarrhea, nausea or vomiting)
        - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include changes in cognition, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0˚F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
    - Residents should ***also*** be assessed for other etiologies (e.g. influenza, RSV, etc.) according to clinical suspicion and considering local circulation of respiratory viruses.
- **Surveillance for Respiratory Illness in Staff during COVID-19**
    - Facilities should have a process in place to ensure all staff (including consultant and ancillary personnel) are screened at the beginning of their shift for fever or respiratory symptoms. A sample form can be found here.
        - Screening should ask about close contact with a person infected with COVID-19 and any ill household member.
    - Discourage staff from working in multiple facilities as this can increase the risk of transmission and an outbreak amongst multiple facilities. If such limitations cannot be maintained, keep a record of other healthcare facilities where your staff are working and ask about exposure to facilities with recognized COVID-19 cases.

    - As part of routine practice, ask staff to regularly monitor themselves for fever and symptoms of respiratory infection and how to report illness promptly.
- **When SARS-CoV-2 and Influenza Viruses are Co-circulating**
    - When SARS-CoV-2 and Influenza viruses are found to be co-circulating based upon local public health surveillance data and/or testing at local healthcare facilities, facilities should implement the following:
        - Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for COVID-19 and test for both viruses (COVID-19 and influenza).
        - Because some of the symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two infections based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in current room, pending results of viral testing. **They should not be placed in a room with new roommates nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by SARS-CoV-2 (PCR) testing.**
        - Facilities should promptly notify the health department for consultation and further investigation if co-circulating is suspected.
        - Additional CDC guidance for influenza can be found here. The CDPHE guidelines for influenza outbreaks in long-term care facilities can be found here.
- CDPHE provides a basic tracking tool: Line List Template to Monitor Residents and Staff. Collection of additional variables may be recommended in the setting of a suspected or confirmed COVID-19 outbreak.

Infection Prevention

- Infection prevention and control recommendations have been consolidated into the following checklist: COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities. Consistent application of prevention and response measures help reduce the risk of transmission and severe disease from COVID-19. The more infection control measures we can maintain, the more effective we will be at preventing transmission.
    - **Prevention measures**, which should already be implemented to protect residents from possible COVID-19 infection, and
    - **Rapid response measures** that should be implemented immediately when even a single case of respiratory illness is identified in a resident or during suspected or confirmed outbreaks of COVID-19.

    - Do not wait for illness to occur before implementing prevention measures as these are intended to prevent infection from occurring and/or spreading in the facility. A delay in implementation could result in increased spread of infection.
- Provide written infection prevention policies and procedures that are available, current, and based on evidence-based guidelines (e.g. CDC, CMS, or CDPHE).
- Require training before individuals are allowed to perform their duties and at least annually as a refresher or sooner if there are recognized lapses in adherence.
- Ensure that a process is in place to monitor staff adherence to recommended infection prevention practices, including at minimum:
    - Hand hygiene (HH) observations.
    - PPE use, to include proper glove use
    - Shared medical equipment cleaning and disinfection
    - Isolation precautions and cohorting
    - Environmental decontamination, to include isolation rooms.
    - Surveillance
- Provide feedback on performance and adherence to individuals and maintain documentation of these efforts.
- Visit CDC's website for infection control guidance (Infection Control (CDC)) and Strategies to Prevent Spread of COVID-19 in LTCFs: Healthcare Facilities (CDC).
- CMS has additional guidance:
    - Guidance for Infection Control and Prevention of Coronavirus Disease 2019(COVID-19) in nursing homes (CMS)
    - Nursing home guidance (CMS)
    - 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios.

Infection Prevention and Control Post COVID-19 Vaccination

- COVID-19 vaccines will be an important tool to help slow/stop the pandemic but it is going to take time. Even after vaccination, everyone should continue to follow all the current guidance to protect themselves and others from COVID-19. All of CDC's and CDPHE's guidance should be followed until the guidance is updated. Including:
    a. Proper mask use (covering both the nose and the mouth)
    b. Social distancing of at least 6 feet
    c. Current isolation and quarantine guidance
    d. Surveillance and testing requirements
    e. Proper hand hygiene
- Because there is a lack of information on transmission reduction following vaccination and the duration of protection, vaccinated HCP should continue to follow all current infection prevention and control recommendations to protect themselves and others from SARS-CoV-2 infection
- Guidance for Managing Healthcare Personnel (CDP) Post COVID-19 Vaccination can be found here.

- Additional guidance for COVID-19 vaccination, infection control and testing in residential care facilities can be found here.

Strategies to Optimize the Supply of PPE

- CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent.
- When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to HCP before they carry out patient care activities. **As PPE availability returns to normal, health care facilities should promptly resume standard practices.**
- For PPE resource requests, facilities should notify their local public health agency or refer to Concept of Operations (CONOPS) for Coronavirus Disease (COVID-19) Personal Protection Equipment Shortage (CDPHE).
- CDPHE FAQ for Personal Protective Equipment can be found here.

Universal Source Control

- CDC recommends everyone entering the facility wear a mask at all times while in the building, regardless of symptoms. The mask must cover both the nose and mouth to be effective.
    - Respirators with exhalation valves protect the wearer from COVID-19, but may not prevent the virus from spreading to others (that is, they may not be effective for source control) as the exhalation valve allows unfiltered air from the wearer to escape. If only a respirator with an exhalation valve is available and source control is needed, cover the exhalation valve with a surgical mask, procedure mask, or a cloth face covering that does not interfere with the respirator fit.
    - It is important to remember that masks do not negate the need for social distancing. Maintaining social distances and ensuring proper mask use (covering both the nose and the mouth) support and increase successful source control.
- **All staff** that comes into close proximity with residents (including contractors and ancillary staff) should wear a medical facemask (not a cloth mask) at all times that covers both their nose and mouth while they are in the facility.
    - Surgical masks and respirators are recommended for staff as they offer both source control and protection for the wearer against exposure to splashes and sprays. Cloth face coverings are not personal protective equipment (PPE) and should NOT be worn by staff if more than source control is required.
    - Ensure staff are wearing a mask upon arrival to the facility. This can be a cloth mask but must be changed to a surgical mask or respirator after the screening process is complete and before proceeding into the facility.
    - Some staff that do not come in contact with residents or other staff (e.g., clerical personnel) might wear a cloth face covering for source control while in the facility.

- **All residents** should wear a cloth face covering or facemask (if tolerated) when they leave their room or when others (e.g., staff, visitors, etc.) enter their room.
    - Residents leaving the facility should wear a cloth face covering or facemask while out of the facility and until they return to the facility (if tolerated). Ensure residents are educated on how to safely remove their masks (should they need to do so) while out of the facility. .
- **All visitors** entering the facility should, ideally, be wearing their own cloth face covering or facemask upon arrival and wear it at all times while in the facility.

Respiratory Illness Identified

- What to do when a resident with respiratory illness is identified:
    - Do not wait for confirmation of a diagnosis to implement infection control precautions.
    - Place a facemask over the resident's nose and mouth (if tolerated) until the resident can be properly isolated. In times of PPE shortages, consider the use of tissues, a cloth face covering, or other barriers to cover the resident's mouth and nose. Ensure that residents have access to a trash receptacle to dispose of used tissues and a method for hand hygiene.
    - Residents with symptoms should be immediately isolated (preferably in a private room) and tested for COVID-19. **Note that prompt response and COVID-19 testing is necessary to limit transmission and should not wait for results of other virus testing.**
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        - If roommates are being moved, ensure they are moved to a private room and quarantined for 14 days with the use of transmission-based precautions in the event exposure has occurred and they may have incubating infection. Moving the roommate to a private room promptly can prevent exposure and limit ongoing transmission.
        - If roommates cannot be moved, ensure at least 6 feet separation between residents and utilize curtains or other physical dividers for separation, ensuring the roommate is quarantined for 14 days from their last exposure with the use of transmission-based precautions.
        - It is important to note that when roommates are not separated, potential exposure risks remain until the resident with COVID-19 meets the discontinuation of isolation criteria, extending the quarantine period for the non-COVID roommate. The quarantine period should begin again after the last potential exposure to COVID-19.
        - New guidance for residential care facilities regarding vaccinations and quarantine is not out yet from CDPHE or federal agencies. Continue on with current recommendations for quarantine (full 14 days regardless of vaccination status).

    - Avoid transferring residents with symptoms of respiratory illness to unaffected units or other facilities unless medically necessary. If such a transfer must occur, place the resident in a private room with the door closed.
    - Per CDC guidance, residents with known or suspected COVID-19 in the residential care setting do not need to be placed into an airborne infection isolation room (AIIR) (Preparing for COVID-19: Long-term Care Facilities, Nursing Homes (CDC)).
    - Only essential personnel should enter the room. Implement staffing policies to minimize the number of staff who enter the room. Consider having designated staff care for ill residents and/or bundle care activities to limit the number of interactions.
    - If symptomatic residents need to leave their room (e.g., for medical care), the resident should wear a facemask, cloth face covering, or use tissues as source control when they are outside of their room or affected unit. Prioritize medical facemasks for staff.
- What to do when staff with symptoms is identified:
    - Remind staff to stay home when they are ill or when high risk exposures to COVID-19 have occurred (e.g., household contact tests positive or providing care to a COVID-positive resident without proper PPE).
    - Staff should avoid working when quarantined for an exposure to COVID-19.
    - If staff develop a fever or symptoms of respiratory infection while at work, they should immediately inform their supervisor and leave the workplace. It is assumed that staff are already wearing a facemask given the universal masking requirements. Ensure staff keep their mask on until they have left the building and are isolated.
    - Staff with symptoms should be isolated at home and tested for COVID-19 through their usual healthcare provider, alternate testing site, at the workplace (preferably outside the facility), or as part of a public health response.
    - Facilities should ensure that staff who have signs or symptoms of COVID-19 are prohibited from entering the building until the return to work criteria are met.
    - Consult occupational health/infection prevention or other appropriate administrative personnel on decisions about further evaluation and return to work. See also the section “Return of HCP to Work after Confirmed or Suspected COVID-19,” below. Consult public health as necessary.

Case Management

- **Management in facility:** Residents with milder illness may be treated in the facility if felt to be medically appropriate by their healthcare provider. For more information about clinical management and treatment, see: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) (CDC).
- **Acute care management:** Transfer of residents to an acute care facility could be considered in the following circumstances:

    - If a resident requires a higher level of care due to medical necessity.
    - If the facility is not able to implement or maintain recommended precautions to appropriately care for and protect other residents, transfer to another facility should be considered in consultation with public health and the accepting facility.
- **Transport:** When transporting residents who require hospitalization, residents should wear a facemask over their nose and mouth to contain secretions. **Ensure transport personnel and the receiving hospital are informed of COVID-19 suspicion or diagnosis before arrival. This will allow the transport service and healthcare facility the opportunity to properly prepare.**

Testing Requirements

- Effective November 20, 2020, the Fifth Amended Public Health Order requires all Facilities to implement COVID-19 surveillance testing, and outbreak testing as needed, for all staff and residents utilizing polymerase chain reaction (PCR) tests.
    - **Surveillance Testing Requirements:** All facilities must implement surveillance testing for all staff, using the Colorado COVID-19 dashboard to determine the frequency.
        - At a minimum, facilities will be testing all staff weekly.
            - Frequency will increase to twice a week if the county positivity rate reaches 10% or greater. Testing at this increased frequency will continue until the two-week positivity rate returns to a rate of less than 10% for two consecutive weeks. Facilities should check the two-week positivity rate each Friday.
        - Facilities shall also implement weekly surveillance testing for all residents who have left the Facility premises in the last 14 days.
        - Facilities may choose to expand surveillance testing for residents, testing all residents on a weekly basis.
    - **Outbreak Testing Requirements:** Upon notification of a single positive COVID-19 (staff or resident), the facility must implement facility-wide testing of all staff and residents to identify additional asymptomatic, pre-symptomatic, or symptomatic infections. See reporting requirements above.
        - The purpose of expanded testing is to facilitate rapid infection prevention interventions, including isolation and cohorting of infected residents, use of appropriate personal protective equipment, and removal of infected staff from the workplace. When one case is detected, there are often others in the facility that can lead to ongoing transmission of COVID-19.
        - Facility leadership should expect to identify multiple asymptomatic and pre-symptomatic residents and HCP with COVID-19 and be prepared to respond rapidly and mitigate potential staffing shortages.

        - Facility leadership should ensure continued testing of all previously negative residents and staff as outlined in the CDPHE testing guidance until no new positives are identified.
            - **For an outbreak in a residential healthcare setting to resolve, weekly testing must continue until no new cases of COVID-19 infection are identified for a period of at least 14 days since the most recent positive result. Given the new testing requirements, CDPHE is no longer using 28 days for outbreak resolution.**
- Immediately perform viral PCR testing of any resident or staff member who subsequently develops signs or symptoms consistent with COVID-19.
    - POC testing can be used (in addition to the required PCR testing but not as a replacement) to assist with prompt identification of COVID-19 if a resident develops symptoms.
- Facilities should work with public health to coordinate initial expanded testing and repeat testing in response to an outbreak and if viral testing capacity is limited.
- Postmortem testing for COVID-19 should be completed following undiagnosed deaths suspected to be due to COVID-19 (e.g., during an outbreak of COVID-19).
- See the following guidance for expanded testing:
    - INTERIM Expanded Testing & Cohorting Public Health Strategy to Prevent SARS-CoV-2 Transmission in Nursing Homes, Skilled-Nursing Facilities, and Assisted Living Residences (CDPHE)
    - Testing Guidance for Nursing Homes (CDC)
    - Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes (CDC)

Testing Previous Positives

- CDPHE does not recommend repeat testing of persons who previously tested positive for COVID-19 within 90 days.
- Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset at levels where infectiousness is unlikely.
- To date, reinfection appears to be uncommon during the initial 90 days after symptom onset of the preceding infection (Annex: Quarantine of Persons Recovered from Laboratory-diagnosed SARS-CoV-2 Infection with Subsequent Re-Exposure). Thus, for persons recovered from SARS-CoV-2 infection, a positive PCR without new symptoms during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.
- If such a person remains *asymptomatic* during this 90-day period, then any re-testing is unlikely to yield useful information, even if the person had close contact with an infected person.
- If such a person becomes symptomatic during this 90-day period and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the

person may warrant evaluation for SARS-CoV-2 reinfection in consultation with an infectious disease or infection control expert.
    - Quarantine may be warranted during this evaluation, particularly if symptoms developed after close contact with an infected person.
    - Serologic testing should not be used to establish the presence or absence of SARS-CoV-2 infection or reinfection. See Duration of Isolation and Precautions for Adults with COVID-19.

Refusal to Test

- Facilities must have written infection control policies and procedures in place to address staff and residents who refuse COVID-19 testing.
    - Staff and residents (or resident representatives) may exercise their right to decline COVID-19 testing, however, they must be offered testing. Facilities cannot decline on behalf of the resident.
    - Procedures should ensure that 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.
    - If outbreak testing has been triggered (identification of a positive resident or staff member) and an asymptomatic staff member refuses testing, the staff member should be restricted from the facility building for 14-days following each round of refused testing or until the procedures for outbreak testing have been completed (e.g., outbreak resolved).
    - Symptomatic residents that refuse testing should be placed on transmission based precautions in a private room until symptom based criteria for the discontinuation of isolation precautions have been met.
    - Asymptomatic residents that refuse testing should be quarantined and staff shall use PPE effective against COVID-19 until the outbreak resolves (e.g., no cases are identified and 14-days has passed since the last positive case).

Point of Care (POC) Antigen Testing

Antigen tests are available as point-of-care (POC) diagnostics for SARS-CoV-2, offering a rapid turnaround time. Although specificity for SARS-CoV-2 is similar to RT-PCR, it has a lower sensitivity. Considerations for use are outlined below:

- POC tests can be used in addition to the required PCR testing (outlined above) but not as a replacement. POC testing **DOES NOT** meet the testing requirements.
- In order for a facility to conduct POC testing, the facility must have a CLIA Certificate of Waiver. Information on obtaining a CLIA Certificate of Waiver can be found here.
- Facilities should be aware of the FDA EUA for antigen tests and potential implication for the Clinical laboratory improvement Amendments (CLIA) certificate of waiver when used in asymptomatic individuals and persons >5 days from symptoms. More information can be found here.

- Considerations for interpreting antigen test results in nursing homes can be found here.
- Facilities that choose to use POC testing need to report results (negative and positive) to CDPHE as the performing laboratory (as outlined above in Reporting).

Specimen Collection

- Follow guidance from CDC and CDPHE regarding which specimens to obtain for COVID-19 testing (e.g., nasopharyngeal or anterior nares specimens). There are multiple acceptable upper respiratory specimens.
- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 resident, CDC recommends:
    - Specimen collection should be performed in a private area, such as an examination or a private room with the door closed.
    - HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection (e.g., goggles or face shield), gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors and roommates should not be present for specimen collection.
- In the RCF setting, consider the following options for appropriate specimen collection activities:
    - Collect the specimen outdoors (if weather allows and is feasible given resident status).
    - Collect the specimen in the resident's room with the door closed.
        - If the resident has roommates, move the roommate to another location while the specimen is being collected, if possible.
        - If roommates cannot be moved, ensure at least 6 feet separation between residents, and use curtains or other physical dividers for seperation.
    - Consider self-collection of anterior nares specimens for residents who are able to do so. Staff should still wear appropriate PPE, maintain social distances, and guide the resident on proper collection.
- Clean and disinfect procedure room surfaces promptly in accordance with CDC guidance additional guidance for infection prevention during sample collection can be found here.

Discontinuation of Isolation for Residents

- Residents 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: For residents who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.
- Residents with severe to critical illness or who are severely immunocompromised1:
    - At least 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
    - Symptoms (e.g., cough, shortness of breath) have improved.
    - Note: For severely immunocompromised residents who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.
- If transmission-based precautions were started based on assessment observations (empirically) for a symptomatic resident and there is no suspected or confirmed COVID-19 outbreak in the facility, the decision to discontinue empiric precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 patient can be made based upon having negative results from at least one PCR.
    - **If a higher level of clinical suspicion for COVID-19 exists, maintain transmission-based precautions and perform a second PCR test**≥24 hours apart**.**
    - **If a patient suspected of having COVID-19 is never tested, the decision to discontinue transmission-based precautions can be made based upon using the symptom-based strategy described above.**
- In some instances, a test-based strategy could be considered for discontinuing isolation 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.
    - *Test-based criteria for residents 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 ≥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).
    - *Test-based criteria for patients who are not symptomatic:*
        - Results are negative from at least two consecutive respiratory specimens collected ≥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).
- Additionally, all residents should remain in their rooms as much as possible, making sure residents remain safe and considering resident well-being and mental health.

- For more information, see Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

Return to work criteria for HCP after Confirmed or Suspected COVID-19

- Staff 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: Staff 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.
- Staff with severe to critical illness or who are severely immunocompromised:
    - At least 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
    - Note: Staff who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.
- In some instances, a test-based strategy could be considered for discontinuing isolation 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.
    - *Test-based criteria for HCP 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 ≥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).
    - *Test-based criteria for HCP who are not symptomatic:*
        - Results are negative from at least two consecutive respiratory specimens collected ≥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).

Staff with Potential Exposure to COVID-19

- CDC has guidance to assist with assessment of risk and application of work restrictions for asymptomatic staff with potential exposure to residents, visitors, or other staff with confirmed COVID-19: Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 (CDC).

- The feasibility and utility of performing contact tracing of exposed staff and application of work restrictions depends upon the degree of community transmission of SARS-CoV-2 and the resources available for contact tracing.
- CDCs updated guidance has been simplified to focus on exposures that are believed to result in higher risk for HCP (e.g., prolonged exposure to patients with COVID-19 when HCP's eyes, nose, or mouth are not covered). Other exposures not included as higher risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touches their eyes, nose, or mouth. The specific factors associated with these exposures should be evaluated on a case by case basis; interventions, including restriction from work, can be applied if the risk for transmission is deemed substantial.
    - Prolonged" refers to a cumulative time period of 15 or more minutes during a 24-hour period, which aligns with the time period used in the guidance for community exposures and contact tracing. Although this definition can be used to guide decisions about work restriction, appropriate follow-up, and contact tracing, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For the purposes of this guidance, any duration should be considered prolonged if the exposure occurs during performance of an aerosol generating procedure.
- Guidance for Managing Healthcare Personnel (CDP) Post COVID-19 Vaccination can be found here.

Staff with alternate diagnosis

- If staff have COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. However, if concurrent COVID-19 infection is suspected based on association with a suspected or confirmed outbreak, return to work criteria should follow the strategies above.
- After returning to work, staff should follow return to work practices and work restrictions as outlined by CDC.

Return to Work After Travel

- With ongoing transmission of COVID-19 within the United States and in destinations throughout the world, staff may have been exposed during their travels (domestic and/or international) and may pose a risk to other staff and residents. Facilities are encouraged to have processes in place that assess staff risk and their return to work status after travel. CDC travel recommendations can be found here.

Communal Dining/Group Activities

- Facilities should use the Colorado COVID-19 Dial to determine the level of communal dining and group activities allowed within their facility. A table which assists facilities in determining their current level (e.g., red, yellow, green) can also be found in the COVID-19 LTCF Checklist.

- Residents should be restricted from participating in communal dining and group activities if:
    - Resident has symptoms of an illness, including signs and symptoms of COVID-19
    - Newly admitted residents and those returning from an overnight stay outside the facility who require a 14 day observation period to assess for COVID-19 symptoms
    - Any resident requiring transmission-based isolation precautions for any condition (e.g. flu, C. diff etc.)
    - Any facility experiencing an outbreak amongst the residents should stop all communal dining and group activities until cleared by public health to resume such activities.
        - Of note: An outbreak amongst staff only may not impact communal dining and group activities if infection control measures are maintained, outbreak testing requirements have been implemented and positive staff have been excluded from the facility.
- When communal dining and group activities resume, facilities should designate **PODs**, that is a group assignment in which the same staff and residents are assigned consistently and across multiple shifts in order to limit the number of individuals interacting. It is best practice to enforce POD designation for care activities, communal dining, and group activities, consistently and according to the social distancing calculator, however, not to exceed 8 residents per POD. The smaller the POD size, the easier it will be to prevent transmission.
- Residents should wear face coverings and maintain social distances while moving throughout the facility. HCP should ensure (and assist) residents with hand hygiene prior to participating in group activities, prior to eating, and when returning to their room (at a minimum).

Indoor/Outdoor Visitation

- Residential care facilities may allow for **outdoor visitation** in accordance with CDPHEs Outdoor Visitation Guidance, ensuring written policies and implementation plans include the minimum requirements.
    - Outdoor visitation may not be offered on the premises if:
        - The resident participating in the visit has symptoms of COVID-19 or an active infection.
        - The resident participating in the visit is on transmission-based precautions for any reason (isolation, observation, quarantine).
        - The facility has an active outbreak of COVID-19 amongst residents.
        - Statewide restrictions are implemented due to increased cases of COVID-19,
- Residential care facilities should refer to the PHO and the CDPHE published indoor visitation guidance before initiating **indoor visitation** and continuously re-evaluate their visitation plans as updated guidance, facility resources and community spread

will change. Facilities must be in compliance with all public health orders and have met the following six criteria before implementing indoor visitation:
    - Degree of community spread is less than 10% average using the COVID-19 Dial
    - Surveillance and outbreak testing requirements outlined in PHO are maintained
    - Facility remains outbreak free
    - Personal protective equipment (PPE) supply maintained
    - Adequate staffing without the need for contingency arrangements
    - Staff are trained and updated on most current infection control policies
- Facilities should notify their local public health agency before beginning indoor visitation and adhere to any additional guidance they provide. This is not an approval process but a courtesy.
- When indoor visitation resumes, notify families and educate them on the visitation plan and what to expect, including at a minimum:
    - Precautions taken to keep them and their family members safe.
    - Screening processes
    - Universal masking requirements
    - All other terms and conditions as outlined in the visitation guidelines

COVID-Recovered Admissions:

- Hospitalized residents with a history of COVID-19 can be admitted to the facility if transmission-based precautions have been discontinued in the hospital based on the above test-based or non-test-based strategies.
    - If the resident's symptoms are resolved, and they are within 90 days of their infection, no further restrictions (e.g., isolation or quarantine) are necessary and the resident can be admitted into the general population, unless resident activities are restricted due to an ongoing potential or confirmed outbreak in the facility.
    - If the resident has recovered, is within 90 days of their positive test, and met the above test-based or non-test-based strategies but has persistent symptoms from COVID-19 (e.g., persistent cough or above baseline), they can still be admitted to the facility and with the general population but they should be placed in a single room and restricted to their room to the extent possible until all symptoms are completely resolved or at baseline. Ensure the residents remain safe and consider resident well-being and mental health.
        - Ensure the resident wears a cloth face covering or facemask (if tolerated) that covers both the nose and mouth if leaving their room and during care activities until all symptoms are completely resolved or at baseline.

COVID-Positive Admissions:

- Residents with COVID-19 that have **not** met criteria for discontinuation of transmission-based precautions should go to a facility with adequate personal

protective equipment supplies and an ability to adhere to infection prevention and control recommendations for the care of COVID-19-positive patients.

- Preferably, the patient would be placed at a facility that has already cared for COVID-19 cases, in a specific area designated to care for COVID-19 residents.
- It is recommended that facilities develop and maintain a COVID-19-positive area for rapid movement of residents who develop COVID-19 and/or for the admissions of residents with COVID-19. These areas should be designed to separate residents with COVID-19 from residents without COVID-19 and include physical separation, separate resident populations, separate staff, separate equipment, and adequate PPE.
- Consultation with public health is advised during the creation of a COVID-19-positive area. Guidance for preparing a COVID-19-positive area can be found here.

Admission of Residents Without COVID-19 or With Unknown COVID-19 Status

- During a suspected or confirmed COVID-19 outbreak, the facility should halt new admissions until the outbreak has been resolved. It may be possible to admit residents to the facility if an unaffected area can clearly be established; however, consultation with public health is recommended.
- When an outbreak is not occurring, facilities should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.
    - For admission of residents who are not suspected or confirmed to have COVID-19, but whose COVID-19 status is unknown, admit to a private room and consider admission to a separate wing/unit or floor (observation area) in order to observe for 14 days.
    - All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Follow strategies to optimize the supply of PPE when supplies are limited. Of note: facilities cannot implement extended use of gowns for these observation units.
    - Testing at the end of this period could be considered to increase certainty that the resident is not infected.
    - If the newly admitted resident develops respiratory illness or develops symptoms compatible with COVID19, follow the infection prevention recommendations for isolation and transmission-based precautions (Standard, Contact, and Droplet Precautions, including eye protection).
- Observation is not necessary following medical appointments as these are assumed to have occurred in a controlled environment in which proper infection control measures were maintained; however, these residents will need to participate in surveillance testing as outlined in the PHO.
- Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. In addition, residents with a negative test prior to admission should be managed the same as residents with unknown COVID-19 status, including transmission-based precautions during an observation period. The rationale is that a negative test does not rule out incubating disease that might develop during the observation period.

Communication

- Communicate with staff, residents, and families about the suspected or confirmed COVID-19 outbreak, and steps the facility is taking in response to the outbreak.
- Confirmed outbreaks will be publicly reported by facility name on the CDPHE website: https://covid19.colorado.gov/outbreak-data.