GEORGIA DEPARTMENT OF PUBLIC HEALTH

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Interim Guidance for Long-Term Care (LTC) Facilities Admitting Residents from a Hospital, November 24, 2021

LTC facilities should admit/readmit hospitalized residents who are no longer acutely ill to their long-term care residence, regardless of COVID-19 status. The decision to admit to a LTC facility should be based on clinical care needs, not on COVID-19 status. LTC facilities should not require hospitals to perform COVID-19 testing as a condition for LTC admission.

This guidance provides information on implementing and discontinuing appropriate transmission-based precautions for persons admitted to LTC facilities and refers to CDC Guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html unless otherwise stated.

LTC Facilities should be prepared to accept hospitalized residents

For resident placement upon facility admission, refer to Section 2.1.g of the current Georgia DPH Long-Term Care Administrative Order at https://dph.georgia.gov/administrative-orders.

Long-term care facilities should designate a COVID-19 unit or cluster of rooms with dedicated staff for cohorting and managing care for residents who test positive for COVID-19 and for admitting residents with COVID-19 who have not met criteria for discontinuation of transmission based precautions.

The Observation Unit, such as a floor, a unit, a wing, or a group of rooms at the end of the unit, is for newly admitted unvaccinated residents with unknown COVID-19 status to monitor them for COVID-19 symptoms for 14 days. The Observation Area should be separate from the COVID-19 unit and needs to be located outside of any traffic patterns for non-quarantined residents. If designation of an observation area is not feasible, LTC facilities should plan to place residents meeting criteria for observation admitted from the hospital in single rooms.

Manage new resident admission and re-admission placement.

- Residents with confirmed COVID-19 who have not met criteria for discontinuation of transmission-based precautions should be placed in the designated COVID-19 care unit.
- New admissions and readmissions whose COVID-19 status is unknown or are not vaccinated should be placed in the observation unit.
- With the exception of compassionate care visits, residents in quarantine should not have visitors until they have met criteria for discontinuation of transmission-based precautions.

A resident may be placed in the general population (and not in the observation unit) if the following criteria are met:

1. Resident has fully recovered from COVID-19 and completed transmission-based precautions.

AND

2. Is within 3 months of COVID-19 onset (either first positive test or symptom onset, whichever occurred first)

AND

3. Is asymptomatic or has improvement in symptoms and is afebrile for 24 hours.

OR

1. Is fully vaccinated (i.e., ≥ 2 weeks following receipt of second dose in a 2-dose series or ≥ 2 weeks following receipt of one dose of a single-dose vaccine;
    a. Note: vaccinated residents that have had prolonged close contact (within 6 feet for a cumulative total of >15 minutes over a 24-hour period) with someone with SARS-CoV 2 infection in the past 14 days should wear source control and be tested no sooner than 2 days post exposure, and if negative, test again between days 5 and 7.
    b. Note: we do not recommend quarantine for the purpose of addressing residents undergoing hemodialysis at outpatient clinics or for resident day outpatient visits. For residents returning from outpatient visits, DPH recommends increased sign and symptom monitoring.

LTC facilities ideally would not admit new residents when they have a confirmed outbreak. However, the ability of facilities to admit must be evaluated with some flexibility during periods when hospital capacity is limited to assess the feasibility of admitting new residents while also maintaining safety standards. The following factors should be considered:

- availability of leadership and patient care staff to direct and implement proper infection prevention practices
- sufficient PPE to properly provide quarantine and transmission-based precautions
- an established Observation Unit with sufficient capacity for new residents
- an established COVID-19 Unit with the ability to provide designated staff
- no evidence of ongoing transmission of COVID-19 among residents

Examples of situations where admissions may be feasible include facilities where two staff persons have tested positive, but subsequent testing of residents yielded no cases. In contrast, a facility which is undergoing outbreak testing that identifies additional resident cases, particularly when they are dispersed throughout the facility, would likely not be a candidate for new admissions. Because there are many possible scenarios, DPH Infection Preventionists are available for consultation. Requests should be sent to HAI@dph.ga.gov.

If a facility has existing COVID-19 cases at its facility and determines using the above criteria that it can safely admit a new resident, it should disclose the presence and disposition of COVID-19 cases to the resident, the resident's family/representative, and the transferring facility during the pre-admission assessment before resident placement.

Recommendations for residents admitted to LTC facilities, according to COVID-19 status

Admitted unvaccinated residents who are neither known to have COVID-19, nor suspected to have it, should be placed on transmission-based precautions in an observation areas or single

room for 14 days. They should be monitored for COVID-19 signs and symptoms at least 3 times per day. LTC residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise (general feeling of discomfort, illness, or uneasiness), new dizziness, diarrhea, sore throat, or new loss of smell or taste. Identification of these symptoms should prompt further evaluation for COVID-19.

Admitted residents who have confirmed or suspected COVID-19 should be placed on transmission-based precautions in a COVID-19 care unit or single room until they meet the criteria for discontinuation of these precautions, as described below.

Admitted residents who are vaccinated should be placed in a regular room, be required to wear a mask when with other residents/staff for 14 days and be tested no sooner than day two, and if negative, again on day 5-7.

Recommendations for Transmission-Based Precautions

Residents should be placed in an (non-airborne) isolation room with door closed, if possible.

- Airborne isolation is only necessary for aerosol producing procedures, NOT for routine care.
- Symptomatic residents should wear a facemask (if tolerated) and be separated from others (e.g., kept in their single occupancy room with the door closed, if possible).
- They should only leave the room when absolutely necessary, perform hand hygiene/be assisted with performing hand hygiene prior to leaving their room, and wear a facemask (if tolerated) or use tissues to cover their mouth and nose when they do.
- If a separate isolation room is not available, the patient can be cohorted with other residents with confirmed COVID-19, and dedicated staff should be provided if possible. Are these for all positive residents or just symptomatic?

Precautions to be taken include standard, contact, and droplet precautions. Staff PPE include gown, gloves, respirator, and eye protection (i.e., goggles or face shield). N95 respirators should be worn for all direct care activities with confirmed and suspected COVID-19 residents. N95 respirators should be fit-checked to assess for air leaks each time they are donned. Follow CDC guidelines for conventional, contingency, and crisis PPE strategies: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/.

Discontinuation of Transmission-Based Precautions for patients with confirmed or suspected COVID-19 admitted to a LTC facility:

The decision to discontinue Transmission-Based Precautions should be made using a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or time-based strategy as described below. As noted above, meeting criteria for discontinuation of Transmission-Based Precautions is required for release from isolation but is NOT a prerequisite for discharge from the hospital.

If the resident has met criteria for discontinuation of transmission-based precautions before admission to the nursing home and has no improvement in symptoms, no further restrictions need to be applied to the resident.

1. **Residents with symptomatic COVID-19 infection:**

Residents with COVID-19 with mild to moderate illness who are not severely immunocompromised[1] should remain in transmission-based precautions until:

- 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

Residents with COVID-19 with severe to critical illness or who are severely immune-compromised[1] should remain in transmission-based precautions until:

- 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

Residents diagnosed with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions but have persistent symptoms from COVID-19 (e.g., persistent cough), should be placed in a single room, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until further clinical evaluation, including considering the test-based strategy, has been conducted.

A test-based strategy could be considered for some patients, such as those who are severely immunocompromised, in consultation with infection control or infectious disease experts if concerns exist for the patient being infectious for more than 20 days. The criteria for the test-based strategy are resolution of fever without the use of fever-reducing medications, improvement of 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-CoV2 RNA.

2. **Residents with asymptomatic COVID-19 infection**

- For residents who were asymptomatic throughout their infection are not severely immunocompromised, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.
- For residents who were asymptomatic throughout their infection and are severely immunocompromised[1], Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.

3. **Residents suspected of having COVID-19:**

The decision to discontinue empiric Transmission-Based 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 FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA.

- If a higher level of clinical suspicion for COVID-19 exists, facilities should consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.
- If a resident 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.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Recommendations for Long-Term Care Staff

- All staff in LTC facilities should be masked. N95 respirators are recommended for providing care to suspect and confirmed COVID-19 patients (https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/).
- Healthcare personnel (HCP) that are ill should stay home and notify their supervisor, especially if symptoms are consistent with COVID-19. If symptoms develop at work, HCP should immediately go home to isolate.
- Facilities should implement sick leave policies that are non-punitive, flexible, and consistent with the goal of allowing ill HCP to stay home.
- Facilities should ensure that staff affirm absence of COVID-19 symptoms (sore throat, cough, fever) upon arrival for each shift.

Recommendations for Visitors

- For specifics on visitation, including compassionate care visitation, see current Long-Term Care Administrative Order at https://dph.georgia.gov/administrative-orders.
- All essential people entering the facility must be actively assessed for COVID-19 symptoms and no persons with any symptoms should be allowed to enter the facility.
- Any visitors should be masked, (cloth masks are acceptable if surgical masks are not available), only visit the area necessary, and perform hand hygiene frequently.

[1.] Definitions for severity of illness and for being moderately to severely immunocompromised Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g.,

cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

- Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
- Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Moderate to Severe immunocompromised:

Due to a medical condition or receipt of immunosuppressive medications or treatments. These conditions and treatments include but are not limited to:

- Active treatment for solid tumor and hematologic malignancies
- Receipt of solid-organ transplant and taking immunosuppressive therapy
- Receipt of CAR-T-cell therapy or HCT (within 2 years of transplantation or taking immunosuppression therapy)
- Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection (people with HIV and CD4 cell counts <200/mm^3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV)
- Active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.

Factors to consider in assessing the general level of immune competence in a patient include disease severity, duration, clinical stability, complications, comorbidities, and any potentially immune-suppressing treatment. Age or place of residence alone (e.g., residence in a long term care facility) independent of a patient's medical condition, should not be used to determine the level of immune competence. Consultation with an individual's treating physician is recommended.