GEORGIA DEPARTMENT OF PUBLIC HEALTH

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Interim Guidance for Long-Term Care (LTC) Facilities Admitting Residents from a Hospital, December 24, 2020

LTC facilities should admit hospitalized residents who are no longer acutely ill back 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. Given ongoing community transmission throughout Georgia, all residents admitted to LTC facilities should be considered exposed to COVID-19. Most residents will therefore require transmission-based precautions after admission.

LTC Facilities should be prepared to accept hospitalized residents

Long-term care facilities should designate an Observation Unit, such as a floor, a unit, a wing, or a group of rooms at the end of the unit, for newly admitted residents with unknown COVID-19 status to monitor them for COVID-19 symptoms. If designation of an observation area is not feasible, LTC facilities should plan to place residents admitted from the hospital in single rooms. Because of the risks associated with introduction of COVID-19 into LTC facilities, admitted residents who are not known to have COVID-19 should be considered exposed, and should be quarantined for 14 days. The Observation Area should be separate from the COVID-19 unit, which is a unit or cluster of rooms for cohorting and managing residents who test positive for COVID-19 and have not met criteria for discontinuing transmission-based precautions.

LTC facilities ideally would not admit residents when they have diagnosed any cases among staff or residents and are conducting follow up weekly testing. 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 a staff person has 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 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.

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.

Precautions to be taken include standard, contact, and droplet precautions. Staff PPE include gown, gloves, respirator or facemask, and eye protection (i.e., goggles or face shield). Facilities should contact the health department for assistance in submitting a PPE request if PPE is limited. If the facility has sufficient supply of N95 respirators, the 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. If N95s are not available, a

surgical mask may be worn except for when an aerosol generating procedure is being performed or splashes or sprays are anticipated. 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. **The test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious**. 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 persistent 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 all symptoms are completely resolved or at baseline.

   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-educing medications, improvement of symptoms (e.g. cough, shortness of breath), and results are negative from at least two consecutive respiratory specimens collected ≥ 24 hors apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV2 RNA.

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.

LTC facilities should consider consulting with infection control or infectious disease experts when making decisions about discontinuing Transmission-Based Precautions for patients who might remain infectious longer than 20 days (e.g., severely immunocompromised).

2. 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. If the facility does not have sufficient N95s surgical masks can be used unless an aerosol-generating procedure is being performed or exposure to splashes or sprays are anticipated. Cloth masks have not been approved for use as Personal Protective Equipment. See the following for PPE optimization strategies: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

- 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 the Long Term Care Administrative Order (updated 10/8/2020) at https://dph.georgia.gov/administrative-orders.
- Indoor visitation is prohibited when community transmission levels are high. Outdoor visits are only for non-symptomatic and non-COVID positive residents.
- All essential people entering the facility must be actively assessed for fever and respiratory symptoms and no persons with any symptoms should be allowed to enter the facility.
- All 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 degree of illness and for being severely immunocompromised (source: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html)

- Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
- Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
- Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Severely immunocompromised:

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.

- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.