NORTH Dakota | Health & Human Services
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RECOMMENDATIONS TO PREVENT AND RESPOND TO COVID-19 IN LONG TERM CARE, BASIC CARE, BASIC CARE MEMORY CARE IN ASSISTED LIVING & OTHER CONGREGATE LIVING SETTINGS

Section 1. Recommended Routine Infection Prevention and Control (IPC) Practices During the COVID-19 Pandemic

In general, long-term care settings (excluding nursing homes) whose staff provide non-skilled personal care similar to that provided by family members in the home (e.g., many assisted livings, group homes), should follow community prevention strategies based on COVID-19 Community Levels, similar to independent living, retirement communities or other non-healthcare congregate settings. See *Section 3* for more information specific to Assisted Living, Group Homes, and Other Residential Care Settings (excluding nursing homes) and what qualifies as non-skilled personal care.

Basic Care facilities are considered a setting where healthcare is delivered per NDHHS Division of Health Facilities and therefore will need to follow Infection Prevention and Control Recommendations for Healthcare as described below.

Encourage Everyone to Remain Up to Date with All Recommended COVID-19 Vaccine Doses

HCWs, residents, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.

Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection

- Ensure everyone is aware of recommended IPC practices in the facility.
- Post visual alerts (e.g., signs, posters) in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can let help ensure people know that they reflect current recommendations.
- Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
    1) A positive viral test for SARS-CoV-2
    2) Symptoms of COVID-19, or
    3) Close contact with someone with SARS-CoV-2 infection (for residents and visitors) or a higher Exposure (for healthcare workers (HCW).

For example:

- Instruct HCW to report any of the three above criteria to occupational health or another point of contact designated by the facility so these HCW can be properly managed.
- The definition of higher-risk exposure and recommendations for evaluation and work restriction of these HCWs are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
- Provide guidance (e.g., posted signs at entrances, instructions when scheduling appointments) about recommended actions for residents and visitors who have any of the above three criteria.
- Residents should be managed as described in *Section 2*.
- Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation (see *Section 2*); this time period is longer than what is recommended in the community. For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet any of the criteria described in *Section 2* (e.g., cannot wear source control).
- Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at Policy & Memos to States and Regions | CMS.

All healthcare workers must be permitted to come into the facility if they are not subject to a work exclusion or showing signs or symptoms of COVID-19. In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance.

- All staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.
- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill HCW to stay home. Remind HCW not to report to work when ill.

Implement Source Control Measures

Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Source control is recommended for individuals in healthcare settings who:

- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (residents and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure.

Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances:

- By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
- Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or resident populations (e.g., when caring for residents with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission.
- Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high).

Individuals might also choose to continue using source control based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease. For example, if an individual or someone in their household is at increased risk for severe disease, they should consider wearing masks or respirators that provide more protection because of better filtration and fit to reduce exposure and infection risk, even if source control is not otherwise required by the facility. HCW and healthcare facilities might also consider using or recommending source control when caring for residents who are moderately to severely immunocompromised.

When to Implement Broader Use of Masking

The overall benefit of broader masking is likely to be the greatest for residents at higher risk for severe outcomes from respiratory virus infection and during periods of high respiratory virus transmission in the community. Facilities should consider several factors when determining how and when to implement broader mask use:

- The types of residents cared for in their facility.
    - Facilities might tier their interventions based on the population they serve. For example, facilities might consider a lower threshold for action in areas of the facility primarily caring for residents at highest risk for severe outcomes or in areas more likely to provide care for

residents with a respiratory infection. Except when experiencing an outbreak within the facility, facilities with residents that generally do not leave the facility might consider implementing masking only for staff and visitors.

- Input from stakeholders.
    - Reviewing plans with stakeholders including resident and family groups and healthcare personnel can help a facility determine practices that will be more broadly supported.
- Plans from other facilities in the jurisdiction with whom the facility shares residents.
    - Some jurisdictions might consider a coordinated approach for all facilities in the jurisdiction.
- What data are available to make decisions.
    - Facilities and jurisdictions might have access to more granular data for their jurisdiction to help guide efforts locally. See *Section 4*. for Metrics for Community Respiratory Virus Transmission.

Implement Universal Use of Personal Protective Equipment for HCW

If SARS-CoV-2 infection is not suspected in a resident presenting for care (based on symptom and exposure history), HCW should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

As SARS-CoV-2 transmission in the community increases, the potential for encountering asymptomatic or presymptomatic residents with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during resident care encounters as described below.

NIOSH-approved particulate respirators with N95 filters or higher used for:

- All aerosol-generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings?).
- HCW working in other situations where additional risk factors for transmission are present, such as the resident is unable to use source control and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCW working in affected areas is not already in place.
- To simplify implementation, facilities in counties with high transmission may consider implementing universal use of NIOSH-approved particulate respirators with N95 filters or higher for HCW during all resident care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.

- Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all resident care encounters.

Optimize the Use of Engineering Controls and Indoor Air Quality

- Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCWs, residents, and others from infected individuals (e.g., physical barriers and dedicated pathways to guide symptomatic individuals that need to move through the facility).
- Take measures to limit crowding in communal spaces, such as dining rooms, activities, or other areas.
- Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in resident rooms and all shared spaces.
    - Guidance on ensuring that ventilation systems are operating properly, and other options for improving indoor air quality, are available in the following resources:
        - Guidelines for Environmental Infection Control in Health-Care Facilities
        - American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities, which also provides COVID-19 technical resources for healthcare facilities
        - Ventilation in Buildings, which includes options for non-clinical spaces in healthcare facilities

Perform SARS-CoV-2 Viral Testing

- Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test for SARS-CoV-2 as soon as possible.
- Asymptomatic residents with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. ***This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.***
    - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
    - Guidance for work restrictions, including recommended testing for HCWs with higher-risk exposures, are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
    - Guidance for use of empiric Transmission-Based Precautions for residents with close contact with someone with SARS-CoV-2 infection are described in *Section 2*.
- Testing considerations for healthcare facilities with an outbreak of SARS-CoV-2 are described below.
- The yield of screening testing for identifying asymptomatic infection is likely lower when performed on those in counties with lower levels of SARS-CoV-2 community transmission. However, these results might continue to be useful in some situations (e.g., when performing higher-risk procedures or for HCWs caring for residents who are moderately to severely immunocompromised) to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used) and prevent

unprotected exposures. If implementing a screening testing program, testing decisions should not be based on the vaccination status of the individual being screened. To provide the greatest assurance that someone does not have SARS-CoV-2 infection, if using an antigen test instead of a NAAT, facilities should use 3 tests, spaced 48 hours apart, in line with FDA recommendations.

- In general, performance of pre-procedure or pre-admission testing is at the discretion of the facility. For more information on testing upon admission see *Section 3*.
- Performance of expanded screening testing of asymptomatic HCWs without known exposures is at the discretion of the facility.

Create a Process to Respond to SARS-CoV-2 Exposures Among HCWs and Others

- Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed.
- If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCPs and residents as determined by the distribution and number of cases throughout the facility and ability to identify close contacts.
    - For example, in a locked memory care unit where residents wander and exposures are unknown, testing should ideally include all residents and HCWs. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCPs and residents on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.
- Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities.

Return to Work for Healthcare Workers

https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html

Section 2. Recommended Infection Prevention and Control (IPC) Practices When Caring for a Resident with Suspected or Confirmed SARS-CoV-2 Infection

The IPC recommendations described below (e.g., resident placement, recommended PPE) also apply to residents with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic residents who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection. However, these residents should NOT be cohorted with residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

Duration of Empiric Transmission-Based Precautions for Symptomatic Residents being Evaluated for SARS-CoV-2 Infection

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a resident with symptoms of COVID-19 can be made based upon having negative results from at least one viral test.

- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

If a resident suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Duration of Empiric Transmission-Based Precautions for Asymptomatic Residents Following Close Contact with Someone With SARS-CoV-2 Infection

In general, asymptomatic residents do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These residents should still wear source control (if tolerated) and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.

Examples of when empiric Transmission-Based Precautions following close contact may be considered include:

- Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Resident is moderately to severely immunocompromised
- Resident is residing on a unit with others who are moderately to severely immunocompromised
- Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Residents placed in empiric Transmission-Based Precautions based on close contact with someone with SARSCoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

- Residents can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
- If viral testing is not performed, residents can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

Resident Placement

- Place a resident with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the resident should have a dedicated bathroom.
    - If cohorting, only residents with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
    - If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.
- Facilities could consider designating entire units within the facility, with dedicated HCWs, to care for residents with SARS-CoV-2 infection when the number of residents with SARS-CoV-2 infection is high. Dedicated means that HCWs are assigned to care only for these residents during their shifts. Dedicated units and/or HCWs might not be feasible due to staffing crises or a small number of residents with SARS-CoV-2 infection.
- Limit transport and movement of the resident outside of the room to medically essential purposes.
- Communicate information about residents with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other areas in the facility and to other healthcare facilities.

Personal Protective Equipment

- HCWs who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
- Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134).
- Mask donning and doffing training should be provided. Mask use with hand hygiene should be monitored.
- Review training with staff for isolation protocols, donning and doffing of PPE, hand hygiene, and cough etiquette.
- Additional information about using PPE is available in Protecting Healthcare Personnel | HAI | CDC.

Aerosol-Generating Procedures (AGPs)

- Procedures that could generate infectious aerosols should be performed cautiously and avoided if appropriate alternatives exist.
- The number of HCPs present during the procedure should be limited to only those essential for resident care and procedure support. Visitors should not be present for the procedure.

Environmental Infection Control

- Dedicated medical equipment should be used when caring for a resident with suspected or confirmed SARS-CoV-2 infection.
    - All non-dedicated, non-disposable medical equipment used for that resident should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another resident.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those resident-care areas in which AGPs are performed.
    - Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a *difficile* sporicidal agent is recommended to disinfect the rooms of residents with *C. difficile* infection).
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Once the resident has been discharged or transferred, HCWs, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles [more information (to include important footnotes on its application) on clearance rates under differing ventilation conditions is available]. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

Visitation

- For the safety of the visitor, in general, residents should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at QSO-20-39.
    - Counsel residents and their visitor(s) about the risks of an in-person visit.
    - Encourage use of alternative mechanisms for resident and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
- Facilities should provide instruction, before visitors enter the resident's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Visitors should be instructed to only visit the resident's room. They should minimize their time spent in other locations in the facility.

Indoor visitation during an outbreak response:

- Facilities should follow guidance from CMS about visitation.
- Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility. If indoor

visitation is occurring in areas of the facility experiencing transmission, it should ideally occur in the resident's room. The resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit.

- Visitation must be allowed for all residents at all times.
- Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in person visitation until they have met the healthcare criteria to end isolation (typically until **10 days** after last exposure or onset of symptoms has passed).
- For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet any of the criteria described in *Section 2* (e.g., cannot wear source control).
    - Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available on QSO-20-39-NH.
- For the safety of the visitor, in general, residents should be encouraged to limit in-person visitation while they are infectious.
    - Counsel residents and their visitor(s) about the risks of an in-person visit.
    - Encourage use of alternative mechanisms for resident and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
- Facilities should provide instruction, before visitors enter the resident's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Visitors should be instructed to only visit the resident room. They should minimize their time spent in other locations in the facility.
- If visitors are for a confirmed COVID-19 or presumptive cases, HCWs needs to assist them with donning and doffing full PPE.
    - Educate not to touch eyes, adjust mask, etc. with gloved hands.
    - Visits should be conducted using social distancing, however if during a compassionate care visit, personal contact can be allowed while adhering to infection control guidelines.
        - Have hand sanitizer available so HCW can perform hand hygiene when assisted doffing is completed. Have visitor complete hand hygiene and don clean mask before exiting the facility.
- Compassionate care visits are allowed at all times.
- Hand hygiene should be performed by the resident and the visitors before and after contact. ○ Visitors should be instructed that if they touch or adjust their face covering, they should perform hand hygiene immediately.

Additional Resident Practices

- When tolerated, cloth face coverings or a face mask should be used for source control when a resident leaves their room during an outbreak or after being identified as a close contact.
- Cloth face coverings should not be placed on anyone who has trouble breathing or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

- A face shield may be considered if facemasks are not tolerated by the resident, **however face shields are not considered adequate respiratory protection for source control.**

- Implement a laundering process for the residents' cloth masks.
- Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices according to community level, that may include wearing a face covering or mask, physical distancing, and hand hygiene.
- If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, test the resident for COVID-19, regardless of vaccination status as described above in Duration of Empiric Transmission-Based Precautions for Asymptomatic Residents following Close Contact with Someone with SARS-CoV-2 Infection.
- If the resident develops signs or symptoms of COVID-19 after the outing, test the resident for COVID19 and place the resident on Transmission-Based Precautions, regardless of vaccination status as described above in Duration of Empiric Transmission-Based Precautions for Symptomatic Residents being Evaluated for SARS-CoV-2 infection.
  Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas and make sure sinks are well-stocked with soap and paper towels for handwashing.
- Make tissues and face masks available for coughing people. Consider designating staff to steward those supplies and encourage appropriate use by residents and staff.
- Ensure all residents are up to date for routine immunizations, including influenza and pneumococcal vaccines.
- Notify the NDHHS at dohcovidhai@nd.gov about any residents with severe respiratory infection or if the facility identifies ≥3 cases of respiratory illness among residents and/or HCW within 72 hours of each other.
  - These situations should prompt further investigation in addition to testing for COVID-19.
- When a resident or HCW with confirmed COVID-19 is identified, facilities should be instructed to notify the NDHHS within 1 business day at dohcovidhai@nd.gov .

Duration of Transmission-Based Precautions for Residents with SARS-CoV-2 Infection

The following are criteria to determine when Transmission-Based Precautions could be discontinued for residents with SARS-CoV-2 infection and are influenced by severity of symptoms and presence of immunocompromising conditions. Residents should be monitored and seek re-evaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these residents should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.

In general, residents should continue to wear source control (if tolerated) until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to

usual facility source control policies for residents.

Residents with mild to moderate illness who are *not* moderately to 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

Residents who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 10 days have passed since the date of their first positive viral test.

Residents with severe to critical illness and who are *not* moderately to severely immunocompromised:

- At least 10 days and up to 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
  The test-based strategy as described for moderately to severely immunocompromised residents below can be used to inform the duration of isolation.

The exact criteria that determine which residents will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific residents. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov).

Residents who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these residents.

Criteria for Test-based Strategy

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 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Residents who are not symptomatic

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Section 3. Setting Specific Guidance: Nursing Homes

Assign one or more individuals with training in IPC to provide on-site management of the IPC program

- This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the IPC risk assessment.

Stay connected with the NDHHS HAI program. Report SARS-CoV-2 infection data to National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module. See Centers for Medicare & Medicaid Services (CMS) COVID-19 reporting requirements.

Managing Admissions and Residents Who Leave the Facility

- **In general, admissions testing is at the discretion of the facility.**
    - Residents who leave the facility for 24 hours or longer should generally be managed as an admission.
- Empiric use of Transmission-Based Precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings) and do not meet criteria described in *Section 2*.

Responding to a Newly Identified SARS-CoV-2 HCW or Resident

- When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.
- A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.
- Lookback for exposures has been updated utilizing The Council for Outbreak Response: Healthcare Associated Infections and Antimicrobial-Resistant Pathogens (CORHA) definition for Epi-Linkage among residents and HCP.
    - **Epi-linkage among residents** is defined as overlap on the same unit or ward, or other resident care location (e.g., dining room, activity room), or having the potential to have been cared for by common HCW within a 7-day time period of each other.
    - **Epi-linkage among HCW** is defined as having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility.
        - Determining epi-linkages requires judgment and may include weighing evidence

whether or not transmission took place in the facility, accounting for likely sources of exposure outside the facility. For more information regarding Investigating/Reporting Thresholds and Outbreak Definition for COVID-19 in Healthcare Settings, click here.

- The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
- Perform testing for all residents and HCWs identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
    - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
    - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Empiric use of Transmission-Based Precautions for residents and work restriction for HCWs are not generally necessary unless residents meet the criteria described in *Section 2* or HCW meet criteria in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. However, source control should be worn by all individuals being tested.
    - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCWs with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
    - If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCWs who met criteria can be discontinued as described in *Section 2* and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively.
    - If additional cases are identified, strong consideration should be given to shifting to the broad based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
        - If antigen testing is used, more frequent testing (every 3 days), should be considered.

Assisted Living, Group Homes, and Other Residential Care Settings (excluding nursing homes)

Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses.

Staff, residents, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.

Residents should be counseled about strategies to protect themselves and others, including recommendations for source control if they are immunocompromised or at high risk for severe disease. CDC has information and resources for older adults and for people with disabilities.

Visiting or shared healthcare personnel who enter the setting to provide healthcare to one or more residents (e.g., physical therapy, wound care, intravenous injections, or catheter care provided by home health agency nurses) should follow the healthcare IPC recommendations in this guidance. In addition, if staff in a residential care setting are providing in-person services for a resident with SARS-CoV-2 infection, they should be familiar with recommended IPC practices to protect themselves and others from potential exposures including the hand hygiene, personal protective equipment and cleaning and disinfection practices outlined in this guidance.

Non-skilled personal care consists of any non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing; it may also include the kind of health-related care that most people do themselves, like taking oral medications. In some cases where care is received at home or a residential setting, care can also include help with household duties such as cooking and laundry.

Section 4. Metrics for Community Respiratory Virus Transmission

Facilities should be aware of community trends for respiratory illnesses and follow state and national data on trends of several respiratory viruses.

NEW RESPIRATORY INFECTION ACTIVITY METRIC

- Starting October 4, 2024, a new acute respiratory illness metric has replaced the influenza-like illness (ILI) metric on the Centers for Disease Control and Prevention (CDC)'s Respiratory Illness Data Channel. This new metric offers a more comprehensive measurement of both the “big three" respiratory viruses (COVID-19, flu, RSV) and other respiratory infections.

- **Long term care facilities are encouraged to use this metric** to guide Infection Prevention and Control (IPC) measures. For example, a facility might task its Infection Control Preventionist with checking this metric on a regular basis to determine if action is necessary. When levels of respiratory virus activity in the community are higher or trending upward, facilities should consider implementing additional prevention measures such as:

- Requiring visitors and health care personnel (HCP) to always wear masks while in the facility, regardless of symptoms.
- Asking residents to wear masks when outside of their rooms.

- Respiratory viruses, including influenza and COVID-19, may be most contagious just before symptoms appear. Therefore, the level of respiratory virus activity in your community is a strong indicator of potential spread within your facility.

SARS-CoV-2 Specific Metrics

- During the COVID-19 pandemic one of the strongest indicators of increasing cases in nursing homes was increasing community incidence. Be aware of what is happening in your community and if COVID-19 is active in your community be proactive in your preventive measures in your facility.
- CDC will continue to collect and report SARS-CoV-2 hospital admissions data on the CDC COVID Data Tracker. These data continue to be available at the county level and are used by CDC to help the public decide when masking in the community should be considered. Based on CDC analyses from data from late 2022 and early 2023, these levels might be less useful to inform masking recommendations in healthcare facilities. Using the current cutoff for masking in the community (>20 new COVID-19 admissions per 100,000 population over the last 7 days), the ability of these levels to indicate ongoing SARS-CoV-2 transmission at nursing homes (at 1 new infection per 100 resident-weeks, or higher) was low (sensitivity < 20%), although the specificity was high. Using a lower cutoff of 10 new COVID-19 admissions per 100,000 population (7-day total) increased sensitivity to about 40% but reduces specificity.

Metrics Encompassing Other Respiratory Viruses

- The RESP-NET interactive dashboard or data from the National Emergency Department Visits for COVID-19, Influenza, and Respiratory Syncytial Virus can be used to inform when respiratory virus season is beginning or ending, as described above. For more granular information, outpatient respiratory illness visits determined by data reported to ILINet, are aggregated to provide state level estimates. Cutoffs for action are not well-defined and data are reported as 13 activity levels which correspond to the number of standard deviations below, at, or above the mean for the current week compared with the mean during non-influenza weeks. Choosing a lower level will likely increase sensitivity for true increases in ILI.

North Dakota Department of Health and Human Services Respiratory Virus Tracking

- Respiratory Illnesses and Prevention | Health and Human Services North Dakota

Definitions:

- **Healthcare Worker (HCW):** HCW include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and

trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in resident care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

- **Source Control:** Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Healthcare Settings:** refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, in resident rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.
- **Cloth mask:** Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal protective equipment (PPE) appropriate for use by healthcare personnel.** Guidance on design, use, and maintenance of cloth masks is available.
- **Facemask:** OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as 'medical procedure masks'." Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.
- **Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.
- **SARS-CoV-2 Illness Severity Criteria** (adapted from the NIH COVID-19 Treatment Guidelines)
- The studies used to inform this guidance did not clearly define "severe" or "critical" illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the National Institutes of Health (NIH) COVID-19 Treatment Guidelines are one option for defining severity of illness categories. The highest level of illness severity experienced by the resident at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions. Clinical judgement regarding the contribution of SARS-CoV-2 to clinical severity might also be necessary when applying these criteria to inform infection control decisions.
- **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 residents 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.
- **Who Is Moderately or Severely Immunocompromised?**

People are considered to be moderately or severely immunocompromised if they have:

  - Been receiving active cancer treatment for tumors or cancers of the blood
  - Received an organ transplant and are taking medicine to suppress the immune system
  - Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
  - Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
  - Advanced or untreated HIV infection
  - Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response
  - 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 resident is determined by the treating provider, and preventive actions are tailored to each individual and situation.
- **Nursing Home-onset SARS-CoV-2 Infections:** Refers to infections that originated in the nursing home. It does not refer to the following:
  - Residents who were known to have SARS-CoV-2 infection on admission to the facility and were placed into appropriate transmission-based precautions to prevent transmission to others in the facility.
  - Residents who were placed into transmission-based precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.
- **Close Contact:** Refers to someone who had been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period.
- **Higher-risk Exposure:** Refers to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff do not wear adequate PPE.

Updated October 2024