Missouri Interim Guidance for Long Term Care Facilities with Confirmed COVID-19

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As COVID-19 continues to spread across the country, more long term care communities may have COVID-19 enter the facility. These guidelines describe implementation steps to help limit the spread of infection when a staff member or resident develops COVID-19 in your facility.

Administrative Actions

- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
- Quarantine: If an resident who has no symptoms consistent with COVID-19 or who has tested negative for COVID-19 is required to enter the facility ensure the resident is assigned to a single room and restricted from communal activities with the rest of the resident population for 14 days. A negative test prior to admission does not alter the need for 14 day quarantine. Continuously monitor for the development of symptoms. See section for Resident Management.
    - If the resident remains asymptomatic and testing is available, consider COVID-19 testing for the resident at the end of the quarantine period before returning them to the general population.
    - If the resident develops any symptoms arrange for COVID-19 testing as soon as possible.
- Facilities may also consider readmitting residents with a recent COVID-19 diagnosis based on their ability to care for such patients and with proper infection prevention control in place. Readmission to long term care for eligible patients from hospitals will help ensure availability of hospital beds for COVID-19 patients with acute care needs. A key component in determining care for these residents is based on the need for Transmission-Based Precautions to continue. If Transmission-Based Precautions are still required, the facility must have the ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents. CDC's infection prevention and control recommendations can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html and https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html.
    - Discontinuation of Transmission-Based Precautions
        - In general, a test-based strategy is no longer recommended to determine when to discontinue Transmission-Based Precautions. According to the CDC guidance on Discontinuation of Transmission-Based Precautions of Patients with COVID-19 in Healthcare Settings Transmission-Based Precautions may be discontinued based on the resident's symptoms. However, some may choose to use a more conservative approach based on their populations, and may still use testing if it is clinically advised.

- Residents can generally be removed from Transmission-Based Precautions when:
    - 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 medication **AND**
    - Symptoms (e.g., cough, shortness of breath) have improved
- A limited number of persons with severe illness may have infectious virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset. Residents with severe or critical illness, or who are severely immunocompromised (For definitions please see [Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)](#)) may be removed from Transmission-Based Precautions when:
    - All the same above are met but at least **20 days** have passed since symptom onset, or, for asymptomatic severely immunocompromised patients, 20 days after their initial positive SARS-CoV-2 diagnostic test.
    - A test-based strategy could be considered in consultation with infectious diseases experts.
- Residents who were asymptomatic may be removed from Transmission-Based Precautions when:
    - At least **10 days** have passed since the date of their first viral diagnostic test.
- If Transmission-Based Precautions have been discontinued and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.
- Review potential discharges with family or receiving facilities that residents are transferred to or must visit for care. State and/or Federal discharge notification requirements must be followed if the resident is being discharged from the facility.
- Ensure advance notification of appropriate health care entities, such as hospitals, medical transport, etc. of suspected or confirmed COVID-19 diagnoses within the facility.

Reporting and Notification Requirements

- Congregate Living Facilities are required to notify the Department of Health and Senior Services **within 24 hours** of the positive staff/resident.
    - Use the online portal to report all positive cases at https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/. Use the "Electronic COVID-19 Case Reporting" button.
    - After submission to the online portal, DHSS Section for Long Term Care Regulation (DHSS-SLCR) will contact the facility to provide assistance and coordination of Facility Wide testing. For questions, regional contacts at the can be found here: https://health.mo.gov/seniors/nursinghomes/pdf/LongTermCareRegions.pdf.

- o Facility-wide testing spreadsheets can be uploaded at: https://health.mo.gov/safety/longtermcare.php.
- Notify the Local Public Health entity to coordinate patient and contact investigations.
- Notify the Department of Health and Senior Services of positive case(s) and deaths utilizing the https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/. Use the "Electronic COVID-19 Case Reporting" button.
- Orders requiring reporting can be found here:
  - o Health Update, April 6, 2020: Update: Reporting COVID-19 Cases https://health.mo.gov/emergencies/ert/alertsadvisories/pdf/update4620.pdf
  - o Congregate Facility Reporting Order May 18, 2020: https://ltc.health.mo.gov/wp-content/uploads/sites/18/2020/05/Congregate-Living-COVID-19-Reporting-Order-Final-5-18-20.pdf

Personal Protective Equipment (PPE)

- Assess the amount of PPE available and necessary for staff use. Use the CDC PPE burn rate calculator to anticipate PPE needs.
- Visit the MO DHSS COVID-19 site for information on PPE.
  - o To attempt to obtain necessary PPE from vendors, including partial shipments, visit the Missouri PPE Marketplace under the heading "Expanding Access to PPE"
- Ensure staff using N95 respirators are medically cleared and fit tested to confirm the N95 fits properly and the staff is able to safely wear it.
- Utilize strategies to manage PPE use and ensure adequate supplies
  - o Consider using the Battelle CCDS Critical Care Decontamination System to extend the use of N95 respirators. Information on sign-up and logistics is under the heading "Optimization of PPE"
  - o When necessary, utilize CDC's guidance for Optimizing the Supply of PPE and Equipment

Testing

Under no circumstances does testing supersede infection control strategies.

- Viral tests are recommended to diagnose infection. Authorized assays for viral testing include those that detect COVID-19 nucleic acid or antigen. Viral (nucleic acid or antigen) tests check samples from the respiratory system (such as nasal or oral swabs) or saliva to determine whether COVID-19 is present (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html).
- Utilize viral tests, such as reverse transcription polymerase chain reaction (RT-PCR) or Antigen Point-of-Care testing, where available, as described below. When screening asymptomatic individuals, facilities should consider using a highly sensitive test, especially if rapid turnaround times are available. If highly sensitive tests are not feasible, or if turnaround times are prolonged, facilities may consider use of less sensitive point-of-care tests, even if they are not specifically authorized for this indication (commonly referred to as "off-label"). For congregate care settings, like nursing homes or similar settings, repeated use of rapid point-of-care testing may be superior for overall infection control compared to less frequent, highly sensitive tests

with prolonged turnaround times. https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2.

- Serological (antibody) tests are not considered confirmatory and should not be used for diagnostic purposes.
- Testing should be used to lead to specific infection prevention activities such as decisions for resident cohorting, identifying asymptomatic COVID-19 positive staff for work exclusion, etc.

Testing When a COVID-19 Case is Detected

- Facility-wide testing for all residents and staff (point prevalence study). Testing utilizing RT-PCR, Antigen Point-of-Care testing or a combination of both as described below is recommended as soon as possible once a COVID-19 positive resident or staff is confirmed. Initial facility-wide testing can help identify positive but asymptomatic or pre-symptomatic staff and residents.
- Repeat testing for all residents and staff who previously tested negative. Frequency should be shortly (e.g., 3 days) after the initial facility-wide testing, and then weekly to detect those with newly developed infections.
- Continued weekly retesting of all residents and staff who previously tested negative until at least two rounds of testing result in all negative results AND at least 14 days have passed since the last identified positive. (Residents and staff who have previously tested positive generally do not need to be tested again.)
- When outbreak has been resolved and there are no cases of infection among residents and staff, consider routine testing of staff at some frequency based on community prevalence of infections (e.g., once a week). For Medicare and/or Medicaid certified facilities, follow CMS Guidance at https://www.cms.gov/files/document/qso-20-38-nh.pdf.
- Symptomatic residents who decline testing should be placed on Transmission-Based precautions and remain so until they meet the symptom based criteria for discontinuation. Or (if asymptomatic) they may be quarantined until a 14 day incubation period has passed. Quarantine separates and restricts the movements of people who have been exposed to see if they become sick. Only residents who have a confirmed positive viral test should be move to isolation in COVID-19 designated areas.
- Staff who decline testing should be presumed to have COVID-19 and be excluded from work. Return to work decisions should be based on Return to Work guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html) at the discretion of the facility's occupational health program.

- Additional Guidance for facilities utilizing Antigen Point-of-Care testing. Facilities should follow CDC Guidance - Considerations for Use of SARS-CoV2 Testing in Nursing Homes for interpreting Antigen Point-of-Care testing results:
    - Testing of **symptomatic** residents or staff
        - If an antigen test is positive, no confirmatory test is necessary.
            - Residents should be placed in Transmission-Based Precautions or staff should be excluded from work.
        - If an antigen test is presumptive negative, perform RT-PCR immediately (e.g., within 48 hours).

- Symptomatic residents and staff should be kept in transmission-based precautions or excluded from work until RT-PCR results return.
- Some antigen platforms have higher sensitivity when testing individuals within 5 days of symptom onset. Clinical discretion should be utilized to determine if individuals who test negative on such platforms should be retested with RT-PCR.
  - Testing of **asymptomatic** residents or staff
    - If an antigen test is positive, no confirmatory test is necessary.
      - Residents should be placed in transmission-based precautions, and staff should be excluded from work.
      - If an antigen test is presumptive negative, residents should be placed in appropriate precautions for facilities with an outbreak. Staff should be allowed to continue to work with continued symptom monitoring. The facility should continue serial viral testing (antigen or RT-PCR) every 3-7 days until no new cases are identified for a 14-day period.
  - An algorithm for interpreting antigen test results can be found here: [Considerations for Interpreting Antigen Test Results in Nursing Homes.](#) Consider consultation with local and State public health agencies regarding all decisions on widespread testing and retesting in the facility.

Residents or staff who have previously tested positive may warrant retesting if they develop new symptoms consistent with COVID-19 and it has been longer than 3 months after the date of initial symptom onset AND if an alternative etiology cannot be identified by a provider. Consultation with infectious disease or infection control experts is recommended. Quarantine may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.

For data collection, DHSS asks facilities to complete and send at the end of the day of testing and retesting, a staff and resident testing worksheet. This worksheet will be provided by SLCR. Testing spreadsheets can be uploaded at: https://health.mo.gov/safety/longtermcare.php Please submit information in an Excel format. Collection and analysis of these data are a crucial part of making important public health decisions at the local, state, and national levels.

Physical Environment

- Cohort patients based on symptoms and/or test results (symptomatic residents away from asymptomatic residents, COVID-19 positive residents away from negative residents, etc.)
  - Ensure at least 6 feet of space between beds
  - Provide physical barrier between beds (such as a privacy curtain) and ensure resident privacy during care.
- Dedicate a physically separate COVID-19 positive area within the facility when possible:
  - Separate wing within the building with fire doors or other structure barrier to create a natural physical barrier,
  - Work with DHSS-SLCR to identify other building locations that can be used (independent living, cottages, unoccupied floors or wings, closed facilities, etc.) and obtain approval for housing residents.

- When at or over capacity, identify spaces not normally used for resident bedrooms that could be used for cohorting, such as a therapy gym or enclosed dining room. Work with DHSS-SLCR on approval for use while cohorting.
- Provide sufficient designated space for clean and dirty storage on the COVID unit.
- Ensure that air exchange is sufficient in rooms, and take necessary steps to increase air flow as needed.

Visitor Management

- Suspend visitor access to the facility except for end of life or other compassionate care circumstances. Ensure proper infection control procedures are followed in these limited visiting situations.
    - provide instruction on hand hygiene
    - limit surfaces touched
    - Visitors must wear a cloth face covering or facemask for the duration of the visit; provide PPE according to current facility policy while in the resident's room
    - Individuals with fevers, other symptoms of COVID-19, or unable to demonstrate proper use of infection control techniques should be restricted from entry.
- Post "No visitors" signs on the doors, and consider limiting access through only one access point, ensuring that emergency egress can still be accomplished.
- Ensure notification letters are distributed to family of residents so they are aware of restrictions at the facility. If possible, consider ensuring availability of electronic communication between residents and families.
- Review and revise how interactions with vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery, etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility. Have them dropped off at a dedicated location (e.g., loading dock). Allow entry of these visitors if needed, as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions.
- Limited outdoor and window visitation may be allowed. See the [Department's guidance](#) for these visits.

Resident Management

- Suspend group dining and activities. Residents should stay in their rooms as much as possible. If a resident must leave their room for medically necessary reasons, they must wear a facemask and perform hand hygiene and social distancing measures, staying at least 6 feet from others.
- Assess vital signs and check for symptoms at least daily, including temperature, cough or shortness of breath for all residents. *Any other symptoms outside of the residents' normal baseline should be reason for further evaluation including but may not be limited to:*
    - unexplained/increased fatigue/malaise
    - lethargy
    - chest pain
    - sore throat
    - diarrhea
    - delirium (acutely altered mental status and inattention)

- o falls
- o acute functional decline
- o exacerbation of chronic conditions
- o chills
- o headaches
- o croup
- o unexplained tachycardia
- o decrease in blood pressure
- o unexplained hypoxia (even if mild i.e. O_2 sat <90%)

- Execute a cohort plan to ensure that ill residents are separated from those that are not ill.
  - o When possible, care should be provided in a single-person room with the door closed.
  - o Residents should have dedicated bathrooms, as applicable, and should be restricted to their room to the extent possible.
  - o If a resident must leave their room for medically necessary reasons, they must wear a facemask and perform hand hygiene and social distancing measures, staying at least 6 feet from others.
- Where possible, assign dedicated staff to care for ill residents only while cohort procedure is in place.
- Continually reevaluate physical location of cohorting areas to maximize staffing in those areas.
- Initiate droplet precautions and standard precautions for all residents. Recent evidence suggests that transmission prior to symptom onset is possible, so each resident in a facility with a confirmed COVID-19 case should be under the same precautions in order to reduce spread of the disease within the facility.
- Staff entering the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important, such as performance of aerosol generating procedures. Prioritize full recommended PPE for confirmed COVID-19 residents, especially those still under Transmission-Based Precautions, and symptomatic residents, whether there is a confirmed COVID-19 test or not.
- Ensure isolation carts and isolation supplies with isolation signs are outside resident rooms. Include signs to instruct staff on donning and doffing PPE.
- Prior to entering and exiting the unit and resident room, staff must perform hand hygiene by washing hands with soap and water or applying alcohol-based hand sanitizer.
- Minimize visits into rooms by bundling patient care activities.
- Assess the use and necessity of aerosolizing procedures (nebulizer treatments, suction, etc.). In consultation with the residents' health care providers, minimize aerosol generating procedures to only those that are essential.
- When performing aerosolizing procedures, or if a resident's cough is heavy or productive:
  - o Staff should utilize full PPE including an N95 respirator
  - o The number of staff should be minimized

Considerations for Special Populations

- Assist residents with frequent hand hygiene, social distancing, and use cloth face coverings.
- Dedicate personnel to work only on memory care units when possible and try to keep staffing consistent. Limit personnel on the unit to only those essential for care.

- Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time.
- Resources for Memory Care units: https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html
- Resources for Behavioral Health Units: https://www.thenationalcouncil.org/covid-19-guidance-for-behavioral-health-residential-facilities/

Staff Management

- Implement universal facemask use by staff at all times
- Ensure access to supplies for hand hygiene in resident rooms, as well as easy availability for staff and encourage frequent use.
- Assess training needs of staff (hand hygiene, donning and doffing of PPE, infection control measures, etc.) and provide as needed. Include audits and spot checks for hand hygiene. See CDC references and videos and DHSS references and videos on PPE training and guidance.
- Trash disposal bins should be positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room.
- Actively monitor and record signs and symptoms of fever or respiratory illness of all staff at the beginning of each shift.
    - Log temperature and any symptoms.
    - Provide clear instructions, including posting them in writing, for ill staff regarding when to stay home and how to seek health care and/or COVID-19 testing.
        - Staff without close contact to confirmed case should be excluded with fever (measured or reported subjective fever), cough, or shortness of breath

        - Staff with close contact to confirmed case should be excluded when any new symptoms that could be consistent with COVID-19 are reported, including:
            - Measured or reported subjective fever
            - Cough
            - Shortness of breath
            - Sore throat
            - Loss of taste/smell
            - Diarrhea
            - Nausea
            - Vomiting
            - Headache
            - Myalgia
            - Fatigue
            - Malaise

    - Ensure they know to contact the healthcare facility ahead of arrival and identify themselves as a possible COVID-19 contact.
    - If possible, check in daily with ill staff members that are at home.

- Ensure staff are educated to notify other facilities they are work with that they are working at a facility with COVID-19 case(s).
- Ensure contingencies are in place for high staff absenteeism. Options to consider:
    - Enter into a contract with a staffing agency to provide additional staffing support.
    - Explore corporate assistance with staffing and possibilities of designating COVID facilities.
    - Initiate additional recruitment strategies such as tapping into local job recruitment efforts and consider offering additional incentives for working with positive residents.
    - Determine how waivers of state and federal regulations will assist in increasing the staffing pool, for example, the ability to hire nurse aides without the requirement to complete CNA training program within four months.
    - Utilize the Disaster Medical Assistance Team (DMAT). This is a resource of last resort after all other options are exhausted and a critical need still exists. Requests to DMAT must be coordinated Shelly Williamson at shelly.williamson@health.mo.gov
- Consult the CDC guidance on staff who may have been exposed to a COVID-19 positive case.
    - In general, staff who have been exposed to a COVID-19 positive case and fall within the medium or high risk categories should exclude themselves for work while monitoring for symptoms.
    - During times of high staff absenteeism, exposed but *asymptomatic* staff *may* work with the following in place for 14 days after the last exposure:
        - Staff must remain asymptomatic while performing resident care
        - Staff must wear facemasks during their entire shift.
        - Monitoring must continue for fever and respiratory symptoms through the facility employee health program before each shift
- If staff develop *even mild symptoms consistent with COVID-19, they must cease patient care activities* and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.
- Staff who test positive for COVID-19, should be excluded from work for the appropriate amount of time based on the Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance).
    - During *crisis* staffing shortages such that patient care may become severely compromised, contact the DHSS-SLCR for assistance in developing alternative staffing strategies. See CDC Strategies to Mitigate Healthcare Staffing Shortages.
- Consider providing childcare services for staff.

Environmental Management

- Ensure training and access to appropriate supplies and PPE for environmental staff.
- Ensure that appropriate EPA disinfectants are being used according to instructions for dilution and contact times.
- Implement at least daily cleaning and disinfection of resident rooms.
- Implement cleaning and disinfection several times a day for high touch surfaces in the facility, such as doorknobs and countertops.

- Consider dedicated environmental services staff for specific zones in the facility, at a minimum assigning according to cohort (well, ill) status.
- Use dedicated medical equipment where possible for each resident and sanitize rental and shared equipment prior to use.
- Ensure personnel providing laundry services are using appropriate PPE and performing hand hygiene after gathering clothing and linens.