

Long Term Care Guidance for Operations During COVID-19 Health Emergency

Revised Date:
10/26/2022

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Introduction

Vermont guidance to skilled nursing facilities and other long term care facilities incorporates the newest information from CMS and CDC, including CMS revised memos (**most recently revised on 9/23/22**) to nursing homes ([QSO-20-38-NH](#)) and ([QSO-20-39-NH](#)). Please refer to www.cdc.gov and [Policy & Memos to States and Regions | CMS](#) for details not found in this document.

The Vermont Department of Health (VDH) continues to assist long term care facilities (LTCFs) in their response to COVID19 exposures. In the event of a positive COVID19 test result, please refer to [The Long-Term Care Facility Checklist](#) for initial and ongoing steps, and also information for the necessary notification of VDH and DAHL.

In general, the *requirements* that are still in place for long term care facilities are put forth by CMS, and are largely limited to licensed skilled nursing facilities, while CDC and VDH make *recommendations* for infection prevention and control for long term care facilities overall.

Even as staff and resident vaccination and booster rates increase, COVID19 cases drop, and restrictions loosen up, LTCFs must remain vigilant to protect residents. No vaccine is 100% effective and the following core principles and best practices can reduce the risk of COVID-19 transmission, and should be maintained at all times.

Core Principles of COVID-19 Infection Prevention for staff, residents, and visitors

- Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for residents in long term care settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
- Hand hygiene.
- Face covering or mask (covering mouth and nose) in accordance with [CDC guidance](#); ***note important changes to CDC guidance for HCP regarding source control below.**
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, and infection control precautions.

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- Appropriate staff use of [Personal Protective Equipment \(PPE\)](#), including for up-to-date staff;
- Cleaning and disinfecting frequently touched surfaces in the facility often, and designated visitation areas after each visit.
- Effective cohorting of residents to the extent possible when facility structure and staffing can accommodate, while also maintaining resident rights (e.g. separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required by [CMS](#) or as recommended by the [State of Vermont](#).

Source Control/Facemasks

Universal HCP use of facemasks is not required in CDC recommendations for counties without high transmission. However, to provide protection for those who may be at higher risk, consider your population (both staff and residents) when setting your facility policy around universal use of facemasks during patient care interactions. Consider talking with your residents and staff during this transition to discuss expectations and needs, such as continuing universal source control during times of substantial to high transmission. It is VDH's stance that it is best practice to continue utilizing universal source control during times of substantial transmission or higher, based on the needs of your residents. **It is important to regularly (at least once weekly) monitor your county's transmission rate via the [Community Transmission map](#).**

High Transmission Rates: When SARS-CoV-2 Community Transmission rates are **high**, source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients.

- HCP could choose not to wear source control when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms) if they do not otherwise meet the criteria described below and Community Transmission rates are not also high. When Community Transmission rates are high, source control is recommended for everyone.

Other Transmission Rates: When SARS-CoV-2 Community Transmission rates are **not** high, healthcare facilities could choose not to require universal source control. However, even if source control is not universally required, it remains 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) [symptomatic staff should not report to work]; **or**

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- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure; or
- Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; **or**
- Have otherwise had source control recommended by public health authorities

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. HCP and healthcare facilities might also consider using or recommending source control when caring for patients who are moderately to severely immunocompromised.

COVID19 Testing

Routine Surveillance Testing

Routine surveillance testing of staff who are not up to date on their COVID-19 vaccinations based on level of community transmission is **no longer required** for skilled nursing facilities. However, due to increased risk of transmission to the staff and patients when county transmission is elevated and the potential increased risk for severe disease among some patient populations, routine surveillance testing is **recommended** by VDH for all long term care facilities if your community is experiencing substantial to high transmission.

You can find your county's community transmission **rate** [here](#). This is not to be confused with CDC's COVID-19 community levels which do not apply to healthcare workers or CMS facilities with respect to infection prevention and control guidance.

With rapidly changing guidance from CMS and CDC, **VDH guidance may change**. Please refer to [this site](#) for updated HANs which may supersede this information.

Instruct facility staff, regardless of their vaccination status, to report any of the following criteria to occupational health or another point of contact designated by your facility so they can be properly managed: a positive viral test for SARS-CoV-2, symptoms of COVID-19, or a higher-risk exposure to someone with SARS-CoV-2 infection.

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Testing of Staff and Residents with COVID-19 Symptoms or Signs

Staff with symptoms or signs of COVID-19, *regardless of vaccination status*, are required to be tested *immediately* and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidelines “[Criteria for Return to Work for Healthcare Personnel with SARS-CoV2 Infection](#).” Staff who do not test positive for COVID-19 but have symptoms should follow facility policies to determine when they can return to work. Staff who work infrequently at the facility should ideally be tested within the three days prior to their shift (including the day of the shift).

Residents who have signs or symptoms of COVID-19, *regardless of vaccination status*, are required to be tested *immediately*. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with [CDC guidance](#). Once test results are obtained, the facility must take the appropriate actions based on the results.

Outbreak/Response Testing

In Skilled Nursing Facilities, following the identification of a positive staff or resident, revised CMS guidance now allows for a more targeted approach instead of broad, facility wide testing, when appropriate to the circumstances. **Please note that the local public health authority (VDH) maintains the right to call for a broader approach than what CMS indicates.**

When there is a newly identified COVID-19 positive staff or resident in a facility that can identify close contacts:

1. The facility is to test all **staff**, regardless of vaccination status, that had a **higher-risk exposure** with a COVID-19 positive individual (see definitions section for definition of “higher-risk exposure”);
2. The facility is to test all **residents**, regardless of vaccination status, that had **close contact** with a COVID-19 positive individual (see definitions section for definition of “close contact”).

When there is a newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts:

1. The facility is to test all **staff**, regardless of vaccination status, facility-wide **or** at a group level if staff are assigned to a specific location where the new case occurred (e.g. unit, floor, or other specific area(s) of the facility);
2. The facility is to test all **residents**, regardless of vaccination status, facility-wide **or** at a group level (e.g. unit, floor, or other specific area(s) of the facility).

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*Staff and residents that test negative should be retested according to CDC recommendations. The testing plan for staff and residents will be established by VDH during the outbreak investigation.

Testing of Staff with a Higher-Risk Exposure and Residents who had a Close Contact

For information on testing staff with a higher-risk exposure to COVID-19 and residents who had close contact with a COVID-19 positive individual, when the facility is not in an outbreak status, see the CDC's "[Interim Infection Prevention and Control Recommendations to Prevent SARSCoV-2 Spread in Nursing Homes](#)" and "[Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.](#)" Examples may include exposures from a visitor, while on a leave of absence, or during care of a resident on the COVID-19 unit.

Documentation and Reporting of COVID-19 Test Results

Any positive COVID-19 test results for staff and residents need to be reported to the Vermont Department of Health immediately.

Any facilities using Point of Care testing devices through a CLIA certificate of waiver are required by federal CLIA regulations to **report all results** to the Vermont Department of Health, **using the instructions on [the lab results reporting page](#)**. All COVID-19 results (positive, negative, etc.) are required to be reported to the Vermont Department of Health within 24 hours of test report completion. You may find more information on [how to report point of care results here](#). Electronic reporting to the Department of Health is preferred.

Refusal of Testing

Facilities must have procedures in place to address staff who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the [return to work criteria](#) are met. If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed.

Facilities must also have procedures in place to address residents who refuse testing. In discussing testing with residents, staff should use person-centered approaches when explaining the importance of testing for COVID-19. Procedures should ensure that residents who have signs or symptoms of COVID-19 and refuse testing are placed on transmission-based precautions (TBP) until the [criteria for discontinuing TBP](#) have been met. If outbreak testing has been triggered and an asymptomatic resident refuses testing, then the facility should be vigilant with the core principles listed above, regarding this resident.

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Other Testing Considerations

In general, testing is not necessary for asymptomatic people who have recovered from SARS CoV-2 infection in the prior 30 days. Testing should be considered for asymptomatic individuals who have recovered in the prior 31-90 days using an antigen test instead of a nucleic acid amplification test (NAAT). This is because some people may remain NAAT positive but not be infectious during this period.

Symptomatic individuals, regardless of vaccination status, should be tested, even if they have been positive within the last 30 days. Antigen tests instead of NAATs are recommended for these individuals.

Facilities should continue to monitor CMS and CDC guidance and FAQs for the latest information.

New Admissions

- It is not required to be vaccinated for COVID-19 prior to admission to a long-term care facility.
- It is not required to have a negative COVID-19 test to be admitted to a long-term care facility.
- In general, admissions in counties where Community Transmission rates are **high** should be tested upon admission; admission testing at lower levels of Community Transmission is at the discretion of the facility.
 - Testing is recommended at admission, and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. In other words, on days 1, 3, and 5.
 - This pertains to individuals who are readmitted to the facility and those who leave the facility for 24 hours or longer.

Quarantine

Quarantine is, in general, no longer recommended for residents who have had an exposure to a known case of COVID-19, participated in a high-risk activity such as a large gathering, or who is being newly admitted or readmitted, regardless of vaccination status. There are certain instances where quarantine may still be considered, such as:

- The exposed resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
- The exposed resident is moderately to severely immunocompromised

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- The exposed resident is residing on a unit with others who are moderately to severely immunocompromised
- The exposed resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Additionally, residents who have had a known exposure are recommended to follow modified precautions. VDH is available to work with you to create a plan.

- Exposed residents should be monitored closely every shift for symptoms and should be placed on quarantine if they develop symptoms.
- Exposed residents should wear source control (surgical mask or cloth face covering) when they are in communal spaces or interacting with other residents or staff.
- Social distancing should be encouraged, maintaining 6-foot space when possible.
- Facility should consider ways to reduce risk during higher-risk activities such as dining. Examples include cohorting and environmental spacing.
- Exposed residents should be included in all viral response testing. If the facility is utilizing PCR tests for response testing, point of care tests may also be used on these residents (as supplies allow and as tolerated) to reduce the number of potential exposure days to the facility with a same-day result.

Entry of Health Care Workers and Other Providers of Services

Health care workers who are not employees of the facility but provide direct care to the facility's residents, must be permitted to come into the facility provided they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened. In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance.

Visitation

Please refer to [this CMS document](#) regarding visitation. It is important that each facility develop visitation policies that consider both the impact of resident isolation and the importance of the core principles of COVID19 infection prevention. Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.

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- Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. **During peak times of visitation and large gatherings (e.g., parties, events), facilities should encourage physical distancing.**
- If the nursing home's county COVID-19 community level of transmission is substantial to high, all residents and visitors, regardless of vaccination status, should wear face coverings or masks and physically distance, at all times during visits.
- While not recommended, residents who are on transmission-based precautions (TBP) or quarantine can still receive visitors if they so choose. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated). Before visiting residents who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident.

Face Coverings and Masks During Visits

If the nursing home's county COVID-19 community transmission is **high**, everyone in a healthcare setting should wear face coverings or masks. If the nursing home's county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility could choose not to require visitors wear face coverings or masks while in the facility, except during an outbreak. Consider speaking with your residents to assess needs and comfort levels regarding communal areas.

The facility's policies regarding face coverings and masks should be based on recommendations from the CDC, state and local health departments, and individual facility circumstances. Regardless of the community transmission level, residents and their visitors when alone in the resident's room or in a designated visitation area, may choose not to wear face coverings or masks and may choose to have close contact (including touch). Residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit. If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.

Indoor Visitation during an Outbreak Investigation

An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff **to determine if others have been exposed**. While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits and visits should ideally occur in the resident's room. **While an outbreak**

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investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. **Also, visitors should physically distance themselves from other residents and staff, when possible.**

Visitor Testing and Vaccination

We encourage visitors to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, **visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation.**

Communal Activities, Dining and Resident Outings

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. The safest approach is for everyone, **particularly those at high risk for severe illness**, to wear a face covering or mask while in communal areas of the facility. For more information, see the Implement Source Control subsection of [Section 1](#) of the CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic." 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 **such as** wearing a face covering or mask, **especially for those at high risk for severe illness and when community transmission is high, performing** hand hygiene, and encouraging those around them to do the same.

- Upon the resident's return, nursing homes should screen residents upon return for signs or symptoms of COVID-19:
 - If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, **see the CDC's [guidance for residents who have had close contact for next steps regarding testing and quarantine.](#)**
 - If the resident develops signs or symptoms of COVID-19 after the outing, see the CDC's guidance for residents with symptoms of COVID-19.
- **In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) except in certain situations, described in the [CDC's empiric transmission-based precautions guidance.](#)** Residents who leave the facility for 24 hours or longer should generally be managed as a new admission, as recommended by the CDC in the "Managing admissions and residents who leave the facility" section.

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Resources

Accessing PCR Tests

The State of Vermont no longer holds a contract to assist with PCR testing. Facilities who are interested in PCR testing need to make their own arrangements.

Accessing Antigen Tests

Facilities are encouraged to begin to immediately source their own antigen test kits through the private market. If your facility faces specific challenges requiring more time to transition, you can request professional antigen test kits by emailing AHS.COVIDTesting@vermont.gov while supplies last. As of this publication, the State has a large quantity of Binax Professional Kits that will expire in the coming months.

Personal Protective Equipment

*Hyperlinks updated.

Proper [use of PPE](#), as determined or recommended by CDC and CMS guidelines, must be maintained throughout all Phases.

PPE Resources:

- [Infection Control Guidance](#)
- [Use of PPE for COVID-19](#)
- [PPE Optimization](#)

Access to the Long-Term Care Ombudsman and/or Disability Rights Vermont

In-person access to residents may not be limited. Representatives of the Office of the Ombudsman and Protection and Advocacy Programs should adhere to the core principles of COVID-19 infection prevention. If an ombudsman or advocate is planning to visit a resident who is in TBP or quarantine, or an unvaccinated resident in a nursing home in a county where the level of community transmission is substantial or high in the past 7 days, the resident and ombudsman/advocate should be made aware of the potential risk of visiting, and the visit should take place in the resident's room. If the resident or the Ombudsman/advocate program requests alternative communication in lieu of an in person visit, facilities must, at a minimum, facilitate alternative resident communication with the ombudsman and/or advocate, such as by phone or through use of other technology.

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Definitions

“**Close contact**” refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period.

Facility staff - includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility’s nurse aide training programs or from affiliated academic institutions. For the purpose of testing “individuals providing services under arrangement and volunteers,” facilities should prioritize those individuals who are regularly in the facility (e.g., weekly) and have contact with residents or staff. We note that the facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source (e.g., their employer or on their own).

“**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 personal protective equipment during care or interaction with an individual. For more information, see CDC’s ["Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARSCoV-2."](#)

“**Level of community transmission**” refers to facility’s county level of COVID-19 transmission. This metric uses two indicators for categorization (1. Total number of new cases per 100,000 persons within the last 7 days and 2. Percentage of positive diagnostic and screening nucleic acid amplification tests (NAAT) during the last 7 days), which can be found on the Centers for Disease Control and Prevention (CDC) COVID-19 Integrated County View site at https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=Vermont&data-type=Risk

“**Up-to-Date**” means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html?s_cid=11747:cdc%20up%20to%20date%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY22