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

Effective Date: 03/19/2021

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Color coding information: Red text is new text from this March 2021 update, purple text is the new text from the February 2021 update, and black text is original language still applicable.

Background

The information contained in this guidance supersedes and replaces previously issued guidance and recommendations in the October 12, 2020 and February 26, 2021 Restart Guidance.

Key updates in this revised document include acknowledgement of Vermont's successful vaccination program for Long Term Care Facilities (LTCF), minor changes to the Phase charts, criteria for when a facility can limit indoor visitation, guidance for indoor visitation during an outbreak, guidance for allowing physical touch, and allowable quarantine modifications.

On March 13, 2020, Governor Scott issued an Executive Order prohibiting most visitation at nursing homes and other residential care facilities in Vermont, recognizing the particularly vulnerable, congregate populations at such facilities. On August 26, 2020, CMS issued a memo to nursing homes (QSO-20-38-NH) setting new requirements around resident/staff testing and providing guidance, which remain in effect. On September 16, 2020, CMS issued a memo to nursing homes regarding visitation and allowable activities, which was just revised on March 10, 2021, superseding and replacing former CMS guidance regarding visitation (QSO-20-39-NH). CMS requirements around frequency of staff surveillance testing in CMS certified skilled nursing

facilities have not changed. Also please note that the VT Department of Health may have different recommendations for frequency of staff surveillance testing, communicated via Health Alert Notifications.

The guidance below was developed using CMS's most recent guidance, and should be used by licensed long term care facilities to guide operations and easing of restrictions, based on county positivity rates; essentially re-starting modified visitation, group dining and activities unless a facility is in an active outbreak situation. We have added information to be taken into consideration acknowledging vaccination status as a factor to be considered in decision-making at your facility. Each facility is unique in its layout, geography, resident population, and needs. Recognizing the toll that separation has taken on residents and families and the equally important need to maintain safety in facilities, the phases outlined below include recommendations designed to provide for the safety of residents, staff, and visitors alike, while allowing facilities the flexibility to determine the best implementation strategy for their specific operations. Skilled Nursing Facilities should consider this guidance in addition to CMS issued requirements.

Additionally, many aspects of COVID-19, its properties and the vaccine remain unknown. This framework is based on current knowledge and may be revisited from time to time as knowledge of the virus changes.

Easing of restrictions can be conducted through different means based on a facility's structure, staffing, supplies, and residents' needs and abilities. As licensed long-term care facilities ease restrictions and continue to operate during this public health emergency, the following core principles and best practices, which reduce the risk of COVID-19 transmission, should be maintained at all times, throughout each phase.

Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g.,temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)

- Hand hygiene;

- Face covering or mask (covering mouth and nose) – for all staff, all visitors (outdoor or indoor), and as tolerated by residents during visits or congregate meals/activities;

- Physical distancing of at least six feet between persons, unless using "safe" physical touch practices described below when a fully vaccinated resident makes that choice, or the benefit of physical touch for specific residents unable to communicate choice has

been assessed to outweigh the risk in consultation with the resident's legally responsible party;

• Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene);

• Cleaning and disinfecting frequently touched surfaces in the facility often, and designated visitation areas after each visit;

• Appropriate staff use of Personal Protective Equipment (PPE);

• Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care); and cohorting and assigning of staff as feasible

• Resident and staff testing conducted as required by CMS or as recommended by the state of Vermont

Phases of Operation

The Phases and their accompanying screening requirements, visitation guidance, congregate activity limits and testing requirements are applied to ALL long-term care residential facilities, which include nursing homes (also known as Skilled Nursing Facilities), residential care homes, assisted living residences, therapeutic community residences, the home for the terminally ill and the intermediate care facility for individuals with intellectual disabilities.

The Phases for the purposes of staff surveillance testing still correspond to county positivity rates. Facilities should monitor their county positivity rate at least every other week. Use this link to obtain county positivity rates. The Division of Licensing and Protection will also continue to send out a list of county positivity rates via email.

County positivity rates are now less of a factor when it comes to allowable activities and visitation, as those should be allowed/occurring unless the criteria for restricting visitation stated below are met. Each facility should have policies and procedures guiding their practices. Facilities can monitor other factors to understand the level of COVID-19 risk, such as the percent of emergent care visits for COVID-19-like illness and influenza-like illness in Vermont, as well as at the national and regional level, taking into consideration, if they are near a state border, the rates of surrounding counties in other states.

Impact of Vaccines on Phases of Operation

Since November 2020, when the spread and incidence of COVID-19 increased significantly in Vermont, many LTCF's have been in a very restrictive state to protect residents. Vermont's vaccination efforts of LTCF staff and residents are complete in most facilities at this time, which allows for facilities to implement this revised guidance. Regardless of vaccination status, all

infection control precautions listed in this document need to be followed, until there are revised recommendations from CDC that apply to long term care settings.

Phase Zero: Facilities with new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident	
Screening	Screen 100% of all persons entering the facility Screen 100% of residents at least daily Increase monitoring of all ill residents to at least three times daily
Visitation	Compassionate Care only at first, then refer to "Indoor Visitation During an Outbreak"
Non-essential personnel	Personnel providing direct care to residents must be permitted entry (unless excluded due to exposure or symptom screening) per the below guidance. Consult with VDH and DAIL to discuss additional situations/details.
Trips outside the facility	Only medically necessary trips outside the facility at first, and consult with VDH regarding specific situations for non-necessary trips.
Communal Dining	Consult with VDH and DAIL to review appropriate infection prevention and control measures tailored to your situation.
Group activities	Consult with VDH and DAIL to review appropriate infection prevention and control measures tailored to your situation.
Testing*	Any symptomatic residents or staff SNF: Facility-wide testing of all staff and residents with repeat testing of all negatives every 3 – 7 days until no new positives identified for a period of 14 days* Non-SNF: As recommended by VDH

Phase One: Facilities in a county with >10% positivity rate	
Screening	Screen 100% of all persons entering the facility Screen 100% of residents at least daily
Visitation	- Only compassionate care visits allowed indoors for unvaccinated residents, if less than 70% of residents in the facility are fully vaccinated - All other visits allowed, including outdoor visits for unvaccinated residents
Non-essential personnel	Non-essential healthcare and contractors allowed. Services should be coordinated among residents to reduce repeated visits.
Trips outside the facility	Non-medically necessary trips permitted, based on risk of activity
Communal Dining	Communal dining permitted with physical distancing, cohorting encouraged
Group activities	Group activities permitted with physical distancing, cohorting encouraged
Required Testing	Any symptomatic residents or staff, and outbreak response testing
Staff Testing*	Twice per week, ongoing (optional for non-SNF)
Facility-Wide Testing	Following detected positive COVID-19 case in a resident or staff as recommended by VDH; please consult directly with the VDH team

Phase Two: Facilities in a county with 5%-10% positivity rate	
Screening	Screen 100% of all persons entering the facility Screen 100% of residents at least daily
Visitation	Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)
Non-essential personnel	Non-essential healthcare and contractors allowed. Services should be coordinated among residents to reduce repeated visits.
Trips outside the facility	Non-medically necessary trips permitted, based on risk of activity
Communal Dining	Communal dining permitted with physical distancing, cohorting encouraged
Group activities	Group activities permitted with physical distancing, cohorting encouraged
Required Testing	Any symptomatic residents or staff, and outbreak response testing
Staff Testing*	Weekly, ongoing (optional for non-SNF)
Facility-Wide Testing	Following detected positive COVID-19 case in a resident or staff as recommended by VDH; please consult directly with the VDH team

Phase Three: Facilities in counties with <5% positivity rate	
Screening	Screen 100% of all persons entering the facility Screen 100% of residents at least daily
Visitation	Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)
Non-essential personnel	Non-essential healthcare and contractors allowed. Services should be coordinated among residents to reduce repeated visits.
Trips outside the facility	Non-medically necessary trips permitted, based on risk of activity
Communal Dining	Communal dining permitted with physical distancing, cohorting encouraged
Group activities	Group activities permitted with physical distancing, cohorting encouraged
Required Testing	Any symptomatic residents or staff, and outbreak response testing
Staff Testing*	Monthly, ongoing (optional for non-SNF)
Facility-Wide Testing	Following detected positive COVID-19 case in a resident or staff as recommended by VDH; please consult directly with the VDH team

*SNFs (CMS-Certified Skilled Nursing Facilities) need to follow CMS requirements for resident and staff testing, as required by *QSO-20-38-NH*

Screening

Active screening involves three components: physical screening, risk assessment, and information.

1. **Physical Screening**: Recommendations for screening and triage of those entering a healthcare facility, in part, include:
   - Screen everyone entering the healthcare facility for symptoms [cdc.gov] consistent with COVID- 19.
   - Actively take their temperature and document absence of symptoms consistent with COVID-19.
   - Fever is either measured temperature ≥100.0°F or subjective fever.
   - Ask them if they have been advised to self-quarantine because of exposure to someone with COVID-19.

   According to the CDC, COVID-19 symptoms [cdc.gov] may include, but are not limited to the following:

   - Fever or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Fatigue
   - Muscle or body aches
   - Headache
   - New loss of taste or smell
   - Sore throat
   - Congestion or runny nose
   - Nausea or vomiting
   - Diarrhea

2. **Risk Assessment: The general areas that could be addressed/considered during screening as risk factors include:**
   - Vaccination Status (not required for visitation)
   - Latest COVID test (not required for visitation)
   - History of contact with exposed individuals
   - Travel to or from out of state – refer to ACCD travel guidance (not applicable to end of life visits)

3. **Information: The information to communicate to visitors should include the following:**
   - PPE wear and use;
   - Hand hygiene expectations;
   - Where to go and where is off limits in the facility, and how those are marked; What to do at the conclusion of the visit and how to exit the building.

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, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as 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. Note that EMS personnel do not need to be screened so they can attend to an emergency without delay. We remind facilities that 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 (testing required in SNF-only).

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

In-person access to residents may not be limited without reasonable cause. Representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention. If in-person access is not advisable, such as the Ombudsman or Advocate having signs or symptoms of COVID-19 or the facility being in an active outbreak situation, 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.

Outdoor Visitation

Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable even when the resident and visitor are fully vaccinated* against COVID-19. Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots. When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend reasonable limits on the number of individuals visiting with any one resident at the same time.

"Window visits" may occur, following the below outdoor visitation guidance, as long as the facility is able to accommodate this type of visit while ensuring core principles are followed.

- Visits must be arranged in advance and scheduled with the facility;
- Visitors are screened for symptoms of COVID-19 immediately prior to any visitation with staff or residents of a facility. Those with symptoms must be excluded from visitation;

• All visitations must be documented and tracked, including maintaining a log of times and dates of all visitors, and their contact information;

• Visitors must have completed quarantine following high risk travel according to ACCD guidance prior to any visits;

• Visitors must be able to adhere to the core principles (including face coverings/masks) and staff should provide monitoring for those who may have difficulty adhering to core principles;

• Residents will also be encouraged to wear facemasks or cloth face coverings during visits if they can tolerate them;

• Facilities shall provide visitors with an alcohol-based hand rub/hand sanitizer prior to interaction with any staff members or residents;

• Facilities shall provide staff supervision as needed to ensure social distancing of at least six feet between people, and that other infection prevention measures are maintained at all times during the visit;

• Facilities should develop and provide advance notice about facility-specific policies and procedures for safe visitation to scheduled visitors;

• Any gifts or items to be delivered to the resident shall be handled per the facility policy for receiving and sanitizing items;

• Facilities may limit times, dates, and lengths of stays by visitors based on available resources to ensure the proper care and safety of staff and patients;

• Homes may place physical barriers or visual reminders/signage to ensure proper distancing during visits.

Indoor Visitation

When outdoor visits are not feasible due to weather conditions, facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times). These scenarios include limiting indoor visitation for:

• Unvaccinated residents, if the facility's COVID-19 county positivity rate is greater than 10% and less than 70% of the residents in the facility are fully vaccinated;

• Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; or

• Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

Facilities should accommodate and support indoor visitation for all residents, based on the following guidelines:

a) The facility is not currently conducting outbreak testing (compassionate care & end of life visits should still be allowed during this time). See below section regarding indoor visitation during an outbreak;

b) Visitors must be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;

c) Facilities should consider limiting the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and

d) Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the designated visitation area or resident room; and

Visitation should be person-centered; consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglas dividers, curtains). Also, facilities should enable visits to be conducted with an adequate degree of privacy when possible or requested. Visits for residents who share a room should not be conducted in the resident's room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave.

Indoor Visitation Recommendations

Since indoor visitation poses increased risk to residents, outdoor visitation remains the preferred method for enabling contact between residents and visitors when that is possible in the warmer months. The recommendations below are designed to create the safest possible environment to mitigate the enhanced risk posed by indoor visits.
Each facility must have a policy for indoor visitation that incorporates the following:

• A demonstrated mechanism to assess that all visitors can and do comply with core principles throughout the entire visit;

• All visitors must be screened for symptoms of COVID-19 prior to entering the facility. Visitors must have completed quarantine following high risk travel, or when traveling from out of state according to ACCD guidance prior to any visits (not applicable to end of life visits). Also, see ACCD FAQ "Do I need to quarantine if I make a short trip (day trip)?" for border areas as it applies to allowing visitors in your facility if you are located near a state border;

• Hand sanitizer must be made available for immediate use prior to the visit; upon entry to the facility and in the visitation area;

• Face coverings or masks must be worn at all times;

• Use of signage and clear visual reminders of all core principles, best practices and infection prevention and control procedures, which are easily seen and understood by visitors;

• Names and contact information of all visitors must be documented for each visit, to enable any necessary contact tracing. Duration of visits must also be recorded;

• Visits should be scheduled in advance and limited to 2 visitors per visit when possible;

• Visits can be of limited duration to decrease risk; compassionate care situations may call for a more flexible approach;

• Physical distancing should be maintained at all times, and whenever possible, barriers should be used to increase safety, unless using "safe" physical touch practices described below when a fully vaccinated resident makes that choice, or the benefit of physical touch for specific residents unable to communicate choice has been assessed to outweigh the risk in consultation with the resident's legally responsible party;

• Visits should be conducted in a designated area (if possible), as separate from patient care areas as possible (dependent on the physical layout of the facility). Preferably, using entrances and exits that do not require visitors to travel through patient care areas. Compassionate care situations may call for a more flexible approach;

• The designated visitor area must be cleaned and disinfected between each visit;

• The designated area should not have its HVAC system, if one is in place, disabled. Effort should be taken to increase area ventilation to the outdoors and air filtration, as feasible in the space;

• Visitors should be directed to a designated visitor bathroom whenever possible within the facility or encouraged not to use the bathrooms in the facility. If a resident/staff bathroom must be used, ensure it is cleaned and disinfected between use;

• Staff should be prepared to end visits if visitors demonstrate an unwillingness or inability to comply with the core principles.

Indoor Visitation during an Outbreak

An outbreak exists when a new facility onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except compassionate care and end-of-life visits), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

•If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

•If the first round of outbreak testing **reveals one or more additional COVID-19 cases in other areas/units of the facility** (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak, but does not change any expectations for testing and adherence to infection prevention and control practices.

NOTE: In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

Compassionate Care Visits

While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care" does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:

- A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations would be consistent with the intent of, "compassionate care." Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident's needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. Compassionate care visits, and visits required under federal disability rights law, should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak.

Visitor Testing and Vaccination

While not required, facilities may encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days). Similarly, 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.** This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below.

Physical Touch

Note: CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, **if the resident is fully vaccinated**, they can choose to have close contact (including touch) with their

visitor **while wearing a well-fitting face mask and performing hand-hygiene before and after**. Regardless, visitors should physically distance from other residents and staff in the facility.

Using a person/resident-centered approach, facilities can decide when physical touch is allowable during visits, on a case by case basis, when the resident is not able to communicate their choice, in consultation with the resident's legally responsible party. When weighing risk versus benefit of adding physical touch for residents unable to communicate choice, please consider the following:

- Vaccination status of the resident (should be fully vaccinated);
- Vaccination status of the visitor;
- COVID-19 status of the visitor (if recently tested);
- Risk factors of the visitor (travel from high-risk location, any recent exposure to positive individuals, ability to follow hand hygiene practices, etc.);
- COVID-19 activity in the community (or community the visitor resides in) or COVID-19 variants that may lessen the effectiveness of vaccines.

Ways to make physical touch as safe as possible (after considering risk factors above):

- Ensure visitors perform hand hygiene upon entrance to the facility, prior to interacting with the resident;
- Ensure visitors still wear a mask at all times during their visit, as well as residents;
- Ensure that at the conclusion of the visit, the resident is assisted with or cued to perform hand hygiene;
- Risk of physical touch increases when the duration of the physical touch increases, so consider brief physical touch, like a hug at the beginning and/or end of the visit, or briefly holding hands; versus something like prolonged snuggling or any kissing, where there is a higher chance of bodily fluids being exchanged.

Communal Activities and Dining

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining should occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Facilities should consider additional limitations based on status of COVID-19 infections in the facility.

Additionally, group activities should also be facilitated (for residents who have fully recovered from COVID-19, and for those not in quarantine for observation, or in isolation with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering when tolerated. Facilities may be able to offer a variety of activities while also taking necessary precautions.

Documentation and Reporting of COVID-19 Test Results

Any positive COVID-19 test results 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. The Department of Health's secure fax number is: 802-951-4061. Additional guidance addressing result reporting is available here.

For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results.

Upon identification of a new COVID-19 case in the facility (i.e., outbreak), document the date the case was identified, the date that all other residents and staff are tested, and the dates and results of subsequent re-testing per VDH guidance.

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.

Residents (or resident representatives) may exercise their right to decline COVID-19 testing in accordance with the requirements around resident rights to refuse treatment. In discussing testing with residents, staff should use person-centered approaches when explaining the importance of testing for COVID-19. Facilities must have procedures in place to address residents who refuse testing. 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, that resident should be placed on TBP.

Document the facility's procedures for addressing residents and staff that refuse testing or are unable to be tested, and document any staff or residents who refused or were unable to be tested and how the facility addressed those cases.

New Admissions

It is not required to have a negative COVID-19 test to be admitted to a long-term care facility. Some people who are fully recovered from COVID-19 may test positive for several weeks after the initial positive test. It is also not required to be vaccinated for COVID-19 prior to admission to a nursing home.

Allowable Quarantine flexibilities:

- If a new admission has been confirmed COVID-19 positive by PCR test in the past 90 days, the resident is not subject to quarantine requirements if they are past their infectious period (see link to CDC information regarding infectious periods).
- Quarantine is no longer recommended for residents who are being admitted to a long term care facility if they are fully vaccinated and have not had prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with SARS-CoV-2 infection in the prior 14 days. CDC source

New facility admissions that have not been COVID-19 positive or fully vaccinated in the past 90 days should still quarantine upon admission for a period of 14 days. Also, residents who are not new admissions should continue to quarantine following prolonged close contact with someone with a confirmed COVID-19 infection. During quarantine, those residents should not participate in communal dining, group activities, or non-medically essential services like salon services for at least 14 days. New admissions may be able to safely participate in visitation, if visitation can be accommodated while maintaining quarantine (e.g. without coming in close contact with other residents/staff, outdoor visits via an entrance directly to the quarantine area, window visits, or a designated indoor visitation space within the quarantine area).

Other Testing Considerations

In keeping with current CDC recommendations, staff and residents who have recovered from COVID-19 (previously tested positive) and are asymptomatic do not need to be retested for COVID-19 within 90 days after symptom onset or date of specimen collection for persons remaining asymptomatic.

Collecting and handling specimens correctly and safely is imperative to ensure the accuracy of test results and prevent any unnecessary exposures. The specimen should be collected and, if necessary, stored in accordance with the manufacturer's instructions for use for the test and CDC guidelines.

During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens.

Accessing PCR Tests

The Vermont Agency of Human Services has established a contract with CIC Health to assist long-term care facilities in accessing reliable PCR testing through the Broad Institute. Facilities can contact surveyandcertification@vermont.gov to arrange for testing under the State's agreement.

Accessing Antigen Tests

Some long-term care facilities have received antigen testing equipment and/or supplies directly from the federal government. These supplies may be used. Facilities that have not received a federal allocation, or that need additional antigen testing capacity, will receive Abbott BinaxNOW™ COVID-19 antigen tests from the Health Department. Questions may be sent to ahs.binaxnowtesting@vermont.gov.

Personal Protective Equipment

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

PPE Resources:

- Department of Health PPE Guidance
- Infection Control Guidance
- Use of PPE for COVID-19
- PPE Optimization

Definitions:

"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).

"Fully vaccinated": greater than or equal to 2 weeks following receipt of the second dose in a 2-dose series, **or** greater than or equal to 2 weeks following receipt of one dose of a single-dose vaccine.