COVID-19 PROTOCOL PHASE III

ADMISSION OF CONFIRMED/SUSPECTED CASES

Policy and Procedure

Title: Admission of Known or Suspected COVID-19

Policy

To ensure compliance with CDC guidelines while minimizing the chance for exposure.

Procedure

Guidelines for admitting patients with known or suspected COVID-19:
PPE should be setup out and in place before patient arrival, upon arrival, throughout the duration of the patient's visit, and until the patient's room is cleaned and disinfected. It is particularly important to protect individuals at increased risk for adverse outcomes from COVID-19 (e.g. older individuals with comorbid conditions), including HCP who are in a recognized risk category.

Before Arrival

- Speak to discharging HCP about symptoms of a respiratory infection (e.g., cough, sore throat, fever1) on the day of admission.
- When scheduling appointments for patients requesting evaluation for a respiratory infection, use nurse-directed screening procedures to determine if an appointment is necessary or if the patient can be managed from home.
    - Instruct patient to wear a facemask upon entry and throughout their stay, if a facemask cannot be tolerated while in room, use a tissue to contain respiratory secretions.
- If a patient is arriving via transport by EMS personnel should contact the receiving healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.

Upon Arrival and During the Visit

- Limit points of entry to the facility.
- Take steps to ensure all persons with symptoms of COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and screening procedures throughout the duration of their stay.
    - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, dining room) to provide patients and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
    - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances and nurses station.
    - Consider establishing stations outside patient care areas to screen patients before they enter.

- Ensure rapid safe screening and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough).
    - Prioritize screening patients with respiratory symptoms.
    - Screening personnel should have a supply of facemasks and tissues for patients with symptoms of respiratory infection. These should be provided to patients with symptoms of respiratory infection upon admission. Source control (putting a facemask over the mouth and nose of a symptomatic patient) can help to prevent transmission to others.
    - Ensure that, at the time of admission, all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of COVID-19 or contact with possible COVID-19 patients.
    - Isolate the patient in their room with the door closed. Ensure the patient does not roam patient care areas.
- Incorporate questions about new onset of respiratory symptoms into daily assessments of all admitted patients. Monitor for and evaluate all new fevers and respiratory illnesses among patients. Place any patient with unexplained fever or respiratory symptoms on appropriate Transmission-Based Precautions and evaluate.

Suspected or Confirmed Case:

- Place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.
    - Airborne Infection Isolation Rooms should be reserved for patients who will be undergoing aerosol-generating procedures (See Infection Control Manual)
- As a measure to limit HCP exposure and conserve PPE, facilities should consider designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients. Dedicated means that HCP are assigned to care only for these patients during their shift.
    - Determine how staffing needs will be met as the number of patients with known or suspected COVID-19 increases and HCP become ill and are excluded from work.
    - It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should not be housed in the same room as a patient with an undiagnosed respiratory infection.
    - During times of limited access to respirators or facemasks, facilities could consider having HCP remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use). Risk of transmission from eye protection and facemasks during extended use is expected to be very low.
        - HCP must take care not to touch their eye protection and respirator or facemask.
        - Eye protection and the respirator or facemask should be removed, and hand hygiene performed if they become damaged or soiled and when leaving the unit.
    - HCP should strictly follow basic infection control practices between patients (e.g., hand hygiene, cleaning and disinfecting shared equipment).

- Limit transport and movement of the patient outside of the room to medically essential purposes.
- Patients must wear a facemask to contain secretions during transport. If patients cannot tolerate a facemask or one is not available, they should use tissues to cover their mouth and nose.
- Personnel entering the room should use PPE as described above.
- Whenever possible, perform procedures/tests in the patient's room.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. (3 hour minimum)
    - After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use
    - Environmental Service staff will be required to wear full PPE to clean and disinfect
    - Any resident's personal belongings must be placed in plastic bags and tied prior to cleaning

Reporting within and between Healthcare Facilities and Public Health Authorities:

- The Administrator or Director of Nursing will ensure HCP and frontline staff are informed and educated about known or suspected COVID-19 patients and facility plan for response
- The Administrator or Director of Nursing will communicate with public health officials regarding known and suspected COVID-19 patients.
- The Administrator, or designee, will inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other.
- The Administrator, or designee, will provide cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Attachments: COVID-19 Screening
Accepting Hospital Admissions

COVID-19 Screening

Resident: _____ Date: _____

Signs and Symptoms:

If no vitals taken in last 8 hours, take new vitals and enter as new

Most Recent Temperature

Temp:_____

Route: _____

Date: _____ ☐New

Most Recent O2 Sats

O2 Sat: _____

Method: _____

Date: _____ ☐New

Most Recent Blood Pressure

BP: _____

Position: _____

Date: _____ ☐New

Most Recent Pulse

Pulse:_____

Type: _____

Date: _____ ☐New

Most Recent Respiration

Resp: _____

Date: _____ ☐New

Does the patient/resident have new onset of a runny nose? ☐Yes ☐No

Does the patient/resident have new onset of a sore throat? ☐Yes ☐No ☐Unable to Determine

Does the patient/resident have new onset of nasal congestion? ☐Yes ☐No ☐Unable to Determine

Does the patient/resident have new onset of chest congestion? ☐Yes ☐No

Does the patient/resident have new onset of a cough? ☐Yes ☐No

Does the patient/resident have new onset or increase of shortness of breath? ☐Yes ☐No

Does the patient/resident have new onset of tachycardia? (more than 100 bpm) ☐Yes ☐No

Does the patient/resident have a fever (100.4* or greater)? ☐Yes ☐No

Does the patient/resident have new onset or worsening confusion? ☐Yes ☐No

Are there any other new symptoms present? ☐Yes ☐No

Other new symptoms: _____

Action:

If you answered 'Yes' to any of the questions above you **must** complete the SBAR and notify the physician and nursing leadership as these are indicators of COVID-19.

Nursing Note:

_____

_____

_____

Accepting Hospital Admissions
When There Are **No** COVID-19 Cases Present in the Facility

The following are potential steps that can be taken to reduce the spread of COVID-19 in your facility.

	Patient is tested COVID-19 (-) Or no history of COVID-19	**Patient COVID Status unknown (asymptomatic)[1]**	**Patient tested (+) in hospital or suspected with COVID**	**Patient had a positive test for COVID-19 and has recovered (ideally, has 1 negative COVID-19 test)**
COVID-19 cases <u>not</u> in the surrounding hospital catchment area	Admit patient and: ✓ Monitor for fever & respiratory symptoms at least once daily	Admit patient and: ✓ Monitor for fever & respiratory symptoms at least once daily.	Do not admit patient.	Admit patient, and: ✓ Monitor for fever & respiratory symptoms at least once per shift ✓ Limit contact with other residents until new information from CDC becomes available. ✓ Put in single room (if possible) ✓ If COVID-19 test is not available at discharge, Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible

[1]For hospital discharges with symptoms of fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 (-) they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 (+). Additionally, patients with fever and respiratory symptoms should have a negative flu test.

NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies.

	Patient is tested COVID-19 (-) Or no history of COVID-19	Patient COVID Status unknown (asymptomatic)[1]	Patient tests (+) in hospital or suspected with COVID	Patient had a positive test for COVID-19 and has recovered (ideally, has 1 negative COVID-19 test)
COVID-19 cases present in the surrounding community of hospital catchment area	Admit patient and: ✓ Monitor for fever & respiratory symptoms once per shift	Admit patient and: ✓ Monitor for fever & respiratory symptoms once per shift ✓ Put in single room or cohort with other recent admissions	Do not admit patient.	Admit patient, and: Monitor for fever & respiratory symptoms at least once per shift ✓ Limit contact with other residents until new information from CDC becomes available. ✓ Put in single room (if possible) ✓ If COVID-19 test is not available at discharge, Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible

[1]For hospital discharges with symptoms of fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 (-) they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 (+). Additionally, patients with fever and respiratory symptoms should have a negative flu test.

NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies.

	Patient is tested COVID-19 (-) Or no history of COVID-19	Patient COVID Status unknown (asymptomatic)[1]	Patient tests (+) in hospital or suspected with COVID	Patient had a positive test for COVID-19 and has recovered (ideally, has 1 negative COVID-19 test)
COVID-19 cases wide-spread in the surrounding community and hospitals are at or past capacity	Admit patient and: ✓ Monitor for fever & respiratory symptoms once per shift ✓ Limit contact with other residents until new information from CDC becomes available. ✓ Put in a single room (if possible)	Admit patient and: ✓ Monitor for fever & respiratory symptoms once per shift ✓ Put in single room or cohort with other recent admissions ✓ Limit contact with other residents until new information from CDC becomes available. ✓ If COVID-19 test is not available at discharge, Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible	Do not admit patient.	Admit patient, and: ✓ Monitor for fever & respiratory symptoms at least once per shift ✓ Limit contact with other residents until new information from CDC becomes available. ✓ Put in single room (if possible) ✓ If COVID-19 test is not available at discharge, Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible

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NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies.

Accepting Hospital Admissions
When there are COVID-19 Cases Present in the Facility

The following are potential steps that can be taken to reduce the spread of COVID-19 in your facility.

	Patient is tested COVID-19 (-) Or no history of COVID-19	Patient COVID Status unknown (asymptomatic)[1]	Patient tests positive for COVID-19 in hospital or suspected with COVID-19	Patient had a positive test for COVID-19 and has recovered (ideally, has 1 negative COVID-19 test)
COVID-19 cases present in the surrounding community of hospital catchment area	Do not admit patient.	Do not admit patient.	Admit patient, and if possible: ✓ Cohort in rooms (and wings if possible) with other COVID-19 (+) residents or those suspected with COVID-19. If not, then: ✓ Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible. If not possible then: ✓ Put in single room. ✓ Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. ✓ Limit contact with other residents until new information from CDC becomes available.	Admit patient, and: ✓ Monitor for fever & respiratory symptoms at least once per shift ✓ Limit contact with other residents until new information from CDC becomes available. ✓ Put in single room (if possible) ✓ If COVID-19 test is not available at discharge, Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible

[1]For hospital discharges with symptoms of fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 (-) they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 (+). Additionally, patients with fever and respiratory symptoms should have a negative flu test.

NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies

	Patient is tested COVID-19 (-) Or no history of COVID-19	Patient COVID Status unknown (asymptomatic)[1]	Patient tests positive for COVID-19 in hospital or suspected with COVID-19	Patient had a positive test for COVID-19 and has recovered (ideally, has 1 negative COVID-19 test)
COVID-19 cases wide-spread in the surrounding community and hospitals are at or past capacity	Do not admit unless: ✓ COVID-19 test is available at discharge, and a separate wing/unit or floor was created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible	Do not admit unless: ✓ COVID-19 test is available at discharge, and a separate wing/unit or floor was created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible	Admit patient, and if possible: ✓ Cohort in rooms (and wings if possible) with other COVID-19 (+) residents or those suspected with COVID-19. If not, then: ✓ Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible. If not possible then: ✓ Put in single room. ✓ Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. ✓ Limit contact with other residents until new information from CDC becomes available.	Admit patient, and if possible: ✓ Cohort in rooms (and wings if possible) with other COVID-19 (+) residents or those suspected with COVID-19. If not, then: ✓ Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible. If not possible then: ✓ Put in single room. ✓ Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. ✓ Limit contact with other residents until new information from CDC becomes available.

[1]For hospital discharges with symptoms of fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 (-) they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 (+). Additionally, patients with fever and respiratory symptoms should have a negative flu test.

NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies.

AHCA/NCAL Guidance: Accepting Admissions from Hospitals During COVID-19 Pandemic

REVISED March 30, 2020

Purpose

The purpose of this document is to provide guidance to long term care facilities (SNFs and ALs) to determine when making decisions about accepting hospital discharges to LTC facilities. The decision-making and guidance are revised from March 20. The revisions are based on new evidence from CDC but may change as new data becomes available, the prevalence of COVID-19 varies in communities, hospital surge increases, or state officials issue additional orders. It is likely state public health officials may issue state or regional specific guidance that supersedes this guidance.

COVID-19 Epidemiology

The COVID-19 virus disproportionality impacts the elderly, with mortality increasing in every 10-year cohort to approximately 30% for those over the age of 80 and with chronic disease. It also appears to spread easily between people, particularly since younger people often have mild symptoms and can be infectious to others without symptoms. In addition, the incubation period is 2-14 days, which raises concerns that individuals admitted from the hospital maybe infected but asymptomatic as they are in their incubation period.

CDC data published in its Morbidity and Mortality Weekly Report (MMWR) on March 27, 2020, found that 57% of elderly patients without symptoms tested positive for COVID-19, who later went on to develop symptoms seven days later. When they tested positive, they shed virus at levels that likely made them infectious to others**.** Based on this data, **unless a person is tested for COVID-19 and negative before admitting them to your building, you should assume the person has COVID-19 regardless of their having or not having symptoms**.

Hospital Discharges to a LTC Facility

During the COVID-19 pandemic, the elderly will still have other medical problems that require hospitalization and post-acute care (e.g., strokes, CHF exacerbations, surgeries, etc.). The volume of some traditional post-acute admission has decreased as hospitals discontinuing most elective surgeries and elective admissions. However, hospitals expect to see a surge in admissions nationally related to COVID-19 as already seen in some U.S. cities. Hospitals will need more post-acute care beds to help with this surge. CMS has also waived the 3-day stay requirement for all discharges, regardless of COVID-19 status, to allow hospitals to more easily create new beds for the surge in COVID-19 admissions.

As such, LTC facilities will face the challenge as to which hospital discharges they can accept. The decision-making process will vary depending on the ability of the LTC facility to manage residents who are COVID-19 positive or suspected to have COVID-19.

We strongly urge LTC facilities to begin now creating separate wings, units or floors by moving current residents to handle admissions from the hospital and keep current resident separate, if possible. LTC facilities should also develop plans for consolidating residents between facilities to create "new" facilities to accept hospital discharges who may be COVID positive or negative or harboring the virus because testing is not available.

Transfers from LTC Facilities to the Hospital

A person with a positive test for COVID-19 or with fever or respiratory symptoms does not necessarily need to be hospitalized. They should be put in contact precautions and follow CDC guidance for COVID-19 positive or presumptive cases in long term care. If a resident requires IV fluids, oxygen and other treatments due to their respiratory symptoms, Medicare will allow you to switch the person over to Medicare Part A without a 3-day SNF stay.

Discussion with families and residents should occur about the risks of hospitalization with COVID-19 during this pandemic period. **We urge members to update residents advanced directives accordingly after having these discussions**.

Recommended Guidance for Admissions to LTC Facilities from the Hospital

The table below provides guidance on what to do with admission referrals whose COVID-19 status is positive, negative, or unknown. Patients should be tested for COVID before hospital discharge; if not tested, they should be assumed to be COVID positive based on CDC data showing the high proportion of COVID positive elderly who are asymptomatic. Accepting residents from the hospital is also contingent on the LTC facility having adequate staffing levels and PPE to manage COVID positive residents. If not possible, the LTC facility should stop accepting all admissions until the facility has staffing levels and PPE to manage residents, which may not be at typical levels, prior to this pandemic.

Accepting Hospital Admissions

Revised as of March 30, 2020

The following are potential steps that can be taken to reduce the spread of COVID-19 in your facility

	Patient is tested & COVID-19 negative1	Patient COVID Status unknown (asymptomatic)2	Patient tests positive for COVID-19 in hospital or with COVID symptoms
No COVID-19 threat (Usual circumstance)	Not Applicable: At this time, assume COVID is in your area.	Not Applicable: At this time, assume COVID is in your area.	Not Applicable: At this time, assume COVID is in your area.
COVID-19 cases present not in the surrounding hospital catchment area	Not Applicable: At this time, assume COVID is in your area.	Not Applicable: At this time, assume COVID is in your area.	Not Applicable: At this time, assume COVID is in your area.

1This includes patients hospitalized with COVID who have recovered and now test negative on at least one most recent test at discharge.
2For hospital discharges with respiratory symptoms or fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 negative they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 positive. Additionally, patients with fever and respiratory symptoms should have a negative flu test.
NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies

	Patient is tested & COVID-19 negative1	Patient COVID Status unknown (asymptomatic)2	Patient tests positive for COVID-19 in hospital or with COVID symptoms
When Cases are Present in the Surrounding Area/Community of Your Hospital Catchment Area	**Admit patient and:** ✓ Monitor for fever & respiratory symptoms once per shift ✓ Limit contact with other residents as much as possible. ✓ Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room. **If Possible:** ✓ Cohort in rooms (and wings if possible) with similar residents (e.g. if COVID positive cohort with other COVID-19 positive residents or if unknown, cohort with other recent admissions from the hospital with similar status).	**Do Not Admit unless:** ✓ A separate wing/unit or floor has been created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible. **Then:** ✓ Monitor for fever & respiratory symptoms once per shift ✓ Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. ✓ Limit contact with other residents as much as possible. ✓ Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room. **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**	**Do Not Admit unless:** ✓ A separate wing/unit or floor has been created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible. **Then:** ✓ Monitor for fever & respiratory symptoms once per shift ✓ Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. ✓ Limit contact with other residents as much as possible. ✓ Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room. **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**

1This includes patients hospitalized with COVID who have recovered and now test negative on at least one most recent test at discharge.
2For hospital discharges with respiratory symptoms or fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 negative they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 positive. Additionally, patients with fever and respiratory symptoms should have a negative flu test.

NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies

***No admissions/transfers from a positive facility are permitted as long as the accepting facility is negative**

****1 negative test is required for an admission from the hospital. 2 negative tests are required if the admission was previously positive and recovered from COVID**

*****COVID test must be conducted and negative results received no more than 48 hours prior to admission. A copy of the lab results must also be obtained.**

	Patient is tested & COVID-19 negative1	Patient COVID Status unknown (asymptomatic)2	Patient tests positive for COVID-19 in hospital or with COVID symptoms
When Cases are Wide-Spread in the Surrounding Area/Community & Hospitals are at or Past Capacity	**Admit patient and:** ✓ Monitor for fever & respiratory symptoms once per shift ✓ Limit contact with other residents as much as possible. ✓ Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room. **If Possible:** ✓ Cohort in rooms (and wings if possible) with similar residents (e.g. if COVID positive cohort with other COVID-19 positive residents or if unknown, cohort with other recent admissions from the hospital with similar status).	**Admit only if :** ✓ A separate wing/unit or floor has been created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible. **If not possible then:** ✓ Put in single room. **Or** ✓ Cohort in rooms (and wings if possible) with similar residents (e.g. if COVID positive cohort with other COVID-19 positive residents or if unknown, cohort with other recent admissions from the hospital with similar status). **Then:** ✓ Monitor for fever & respiratory symptoms once per shift ✓ Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. ✓ Limit contact with other residents as much as possible. ✓ Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**	**Admit only if :** ✓ A separate wing/unit or floor has been created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible. **If not possible then:** ✓ Put in single room. **Or** ✓ Cohort in rooms (and wings if possible) with similar residents (e.g. if COVID positive cohort with other COVID-19 positive residents or if unknown, cohort with other recent admissions from the hospital with similar status). **Then:** ✓ Monitor for fever & respiratory symptoms once per shift ✓ Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. ✓ Limit contact with other residents as much as possible. ✓ Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**

1This includes patients hospitalized with COVID who have recovered and now test negative on at least one most recent test at discharge.
2For hospital discharges with respiratory symptoms or fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 negative they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 positive. Additionally, patients with fever and respiratory symptoms should have a negative flu test.

NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies

***No admissions/transfers from a positive facility are permitted as long as the accepting facility is negative**
****1 negative test is required for an admission from the hospital. 2 negative test are required if the admission was previously positive and recovered from COVID**
*****COVID test must be conducted and negative results received no more than 48 hours prior to admission. A copy of the lab results must also be obtained.**

Guidance on Hospital Transfer and Admission of Patients to Long Term Care Facilities (LTCFs) During COVID-19 Emergency
April 22, 2020

Because COVID-19 disproportionately affects the elderly, LTCFs (nursing homes and assisted living facilities) are taking all necessary precautions to prevent the exposure of COVID-19 to their residents. At the same time, ensuring that acute care hospitals can discharge patients safely and timely to LTCFs is a critical component to maintaining available inpatient bed capacity to treat COVID-19 patients throughout Virginia. This guidance has been developed to protect the health and safety of LTCF residents while assuring patients can be transferred to these facilities when it is safe to do so.

Hospitalized patients must be assessed for respiratory illnesses and COVID-19 prior to transfer to a LTCF. Patients with progressing respiratory infections will not be discharged from the hospital until stable and ready. All patient transfers will be coordinated with the receiving LTCF in accordance with this protocol and in compliance with federal and state law. Accepting patients from the hospital is also contingent on the LTCF having adequate staffing levels and personal protective equipment (PPE) to meet the individual's care needs.

Protocol to Discharge from Hospital to LTCF for New Admissions and Readmissions

Category 1: Patients with no clinical concern for COVID-19:

- Acceptable for transfer to the LTCF following standard procedures. Hospitals are NOT required to perform COVID-19 testing on patients solely for discharge considerations unless new respiratory infection symptoms develop.

Category 2: Patients investigated for possible COVID-19, but negative testing:

- If patient has negative testing and meets usual clinical criteria for discharge, then he/she is acceptable for transfer to LTCF. Hospitals should communicate results and any indication for continued transmissions-based precautions upon transfer.

Category 3: Patients under investigation for COVID-19, but test results pending:

- These patients will NOT be transferred to an LTCF until tests results are completed and provided to the facility.

Category 4: Patients positive for COVID-19 testing:

- An LTCF can accept a new admission and readmission with a diagnosis of COVID-19 and who is still requiring transmission-based precautions for COVID-19 as long as the facility can follow CDC infection prevention and control recommendations for the care of COVID-19 patients, including having adequate staffing levels and adequate supplies of PPE.
- If transmission-based precautions have been discontinued* AND patient's symptoms have resolved, a patient can be discharged back to the facility they came from. Hospital discharge planners should provide advanced notice to the LTCF for any transfer of a patient with COVID-19.

Hospitals and LTCFs will work cooperatively to implement these protocols and facilitate discharges and are encouraged to proactively develop transfer and admission plans within their communities in anticipation of the need to identify alternative facilities for appropriate transfer.

*Transmission-based precaution for COVID-19 should be used for at least 7 days from symptoms onset AND 3 days of recovery, defined as being afebrile without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath). Lingering cough after 72 hours would not be an indication for continuation of transmission-based precautions. Consideration should be given to extending transmission-based precautions for individuals with immunocompromising conditions.

Admission Guidance

Negative Facility

Admission's COIVD-19 Status		Transferring From: Hospital or Community	Transferring From: LTC Facility
	Category 1 Patients with no clinical concern for COVID-19	**Yes** **Requirement(for an added layer of protection):** 1. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.	**Yes** **Requirement:** 1. Discharging LTC facility **must** have a negative COVID status 2. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission (for an added layer of protection) **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.
	Category 2 Patients investigated for possible COVID-19, but negative testing	**Yes** **Requirement:** 1. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.	**Yes** **Requirement:** 1. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission 2. Discharging LTC facility **must** have a negative COVID status. **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.
	Category 3 Patients under investigation for COVID-19, but test results pending	**No**	**No**
	Category 4 Patients positive for COVID-19 testing	**No** This includes residents who are deemed recovered by CDC guidelines (2 negative tests)	**No** This includes residents who are deemed recovered by CDC guidelines (2 negative tests)

Positive / Recovered Facility

Admission's COIVD-19 Status		Transferring From: Hospital or Community	Transferring From: LTC Facility
	Category 1 Patients with no clinical concern for COVID-19	**Yes** **Requirement:** 1. Proper disclosure 2. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission 3. Copy of lab result **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.	**Yes** **Requirement:** 1. Proper disclosure 2. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission 3. Copy of lab result **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.
	Category 2 Patients investigated for possible COVID-19, but negative testing	**Yes** **Requirement:** 1. Proper disclosure 2. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission 3. Copy of lab result **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.	**Yes** **Requirement:** 1. Proper disclosure 2. One negative nasopharyngeal gold standard* COVID test. Resident must have been swabbed **and** results received within 48 hours prior to admission 3. Copy of lab result **Upon admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.
	Category 3 Patients under investigation for COVID-19, but test results pending	**No**	**No**

Positive / Recovered Facility Continued

Admission's COIVD-19 Status		Transferring From: Hospital or Community	Transferring From: LTC Facility
	Category 4 Patients positive for COVID-19 testing	**Yes** **Requirement:** 1. A separate wing/unit or floor has been created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible 2. Copy of lab results 3. Cohort with positive or recovering residents **Upon admission:** 1. Monitor for fever & respiratory symptoms once per shift 2. Limit contact with other residents as much as possible. 3. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room 4. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**	**Yes** **Requirement:** 1. A separate wing/unit or floor has been created to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible 2. Copy of lab results 3. Cohort with positive or recovering residents **Upon admission:** 1. Monitor for fever & respiratory symptoms once per shift 2. Limit contact with other residents as much as possible. 3. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room 4. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**
	Category 4 Patients recovered from COVID-19	**Yes** **Requirement:** 1. Two negative nasopharyngeal gold standard* COVID tests collected ≥24 hours apart. Resident must have been swabbed **and** results received within 48 hours prior to admission 2. Copy of lab results **Upon Admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**	**Yes** **Requirement:** 1. Two negative nasopharyngeal gold standard* COVID tests collected ≥24 hours apart. Resident must have been swabbed **and** results received within 48 hours prior to admission 2. Copy of lab results **Upon Admission:** 1. Place on OBS Unit for 15 days **and** a. Monitor for fever & respiratory symptoms once per shift b. Limit contact with other residents as much as possible. c. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room d. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies. **FACILITY MUST HAVE ADEQUATE STAFFING LEVELS AND PPE TO MANAGE COVID POSITIVE RESIDENTS**

Admission Guidance for ALFs

- Do not accept any admissions with respiratory symptoms
- Move new admissions into a private room/ private bath (if possible)
- Post the Isolation Tracking Calendar on the outside of the door
  - Circle date of admission
  - Count 15 days (from the date of admission-including date of admission) and circle the date.
  - Mark each day off as time progresses
- Have resident wear a mask for full 15 days
- Monitor for signs and symptoms of COVID-19 daily
  - Should be tracked on Resident Symptom and Vital Log (Phase II) and kept in the facilities COVID-19 binder.
- Resident may be released from wearing masks and moved to their permanent room (if applicable) after 15 days

Please Note: All Direct Care Staff should be wearing masks throughout their shift

COVID-19 Planning/Checklist

Containment/Observation Area

The facility will designate a section of rooms that will be able to have a temporary barrier installed (plastic vs identified line) for housing residents with suspected or confirmed cases of COVID-19.

Preparation and Set up

- ☐ Identify and implement a designated containment / observation area
  - Identify how many open rooms you have in your facility.
  - Arrange to have a couple of your open rooms in this designated area so symptomatic residents can be promptly moved to the designated area.
    - Preferably at the end of a unit near an exit door (3-5 rooms) – will increase as needed for symptomatic
- ☐ Obtain supplies equipment to be utilized in this area only
  - Laptop
  - Lift
  - Vital machine
  - Communication devices (walkie/radio/cell phone)
  - Crash cart/equipment/bags
  - Oxygen concentrators (one per room)
  - Blood borne pathogens spill kit
  - Adequate amount of red bags for waste
  - PPE
  - Personal hygiene items for each resident
  - Stocked linen cart
  - Nourishment carts (snacks in disposable containers- ice cream, pudding, sandwiches, crackers etc.)
    - May need small refrigerator.
  - Ice cart
  - Styrofoam cups
  - Cleaning supplies
  - Activity cart (puzzles, books, games etc.)

Staffing

- ☐ This area will be staffed by one (set) person(s)
  - Review staffing needs – night shift – need additional nurse or aide for that area?
- ☐ Bundle cares and tasks to limit staff exposure and minimize PPE usage
  - PPE to be used is gown, gloves, mask and eye protection

Daily Operations

MAXIMIZE WHAT IS GOING IN AND MINIMIZE WHAT IS COMING OUT"

- ☐ Employees working the unit should wear masks and gowns for the duration of their shift.
  - N95 masks may be washed and reused
  - Mask are to be stored in a paper bag when not in use
- ☐ If access to the unit is deemed necessary, the individual must wear all required PPE
- ☐ Utilize the lock box in each resident room for meds to decrease exposure to med cart (Excluding narcotics. They will need to be placed in the room under double lock)
- ☐ MARs should be printed and placed on a clipboard inside the room
- ☐ Small cart may be used for resident charts
- ☐ Laptop is not to be taken into individual resident rooms
- ☐ Vital sign machine **MUST BE CLEANED AFTER EVERY USE**
- ☐ If possible, delay therapy orders until the observation period passes. (contact physician to obtain a hold order)
- ☐ Hospice services will be suspended during the observation period

- Meals will be served on disposables
- Ice can be delivered in bags to the unit
- All resident laundry/linen must be red bagged before being transported to the laundry room
- Housekeeping may enter once a day for cleaning/disinfecting. Staff working the unit are responsible for tidying resident rooms
- Tablets are to be utilized for telemedicine, intake screenings from other departments, and for residents to communicate with their families.

Suspected Resident (symptomatic) or COVID-19 Positive Resident

- Contact your local public health department when:
  - A resident has a severe respiratory infection
  - Positive COVID-19 test
  - Cluster of new onset respiratory symptoms
- Notify Regional team and CCO
  - CCO/Designee will notify vendors to get increased PPE and other needed supplies
- The Administrator, or designee, will inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence
  - The Administrator, or designee, will provide cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following each time a confirmed COVID-19 infection is identified
- Move resident into a room in the containment area
- Ensure signage is posted on outside of door (type of precautions and Donning/Doffing PPE)
- Ensure PPE station is ready – refer to AHCA and CDC PPE Guidance on use of masks, gowns, and eye protection to conserve supplies
  - Utilize daily logs to identify how much PPE is being used
- Begin tracking the staff going in and out of room (use Staff Tracking log)
- Monitor vital signs and assessment twice daily – specifically heart rate, pulse ox, temp and lung sounds for residents on affected units (to be determined by IP Nurse and Nurse Leadership—contact RCD with questions)
- If resident must leave room, ensure there is a mask on them prior to leaving their room
- Have resident cover mouth with barrier while team members are in the room providing cares
- Resident has diagnosis of COVID – ONLY in case of emergency call 911 and notify EMS that this is a COIVD-19 Positive resident (breathing or circulatory issues) –Not every transport service will be equipped to manage – Health department will help set that up.

PPE

- Begin active monitoring to determine utilization rate of used PPE to help guide your needs
  - Utilize daily logs to identify how much PPE is being used
- Contact your local public health department when reviewing management of PPE

Staff Education

- Reeducate all staff to precautions and plan moving forward with special emphasis on the staff that will be working with these residents
  - PPE
  - Hand Hygiene
  - Cleaning needs
  - Documentation
  - Isolation precautions
- Education provided to nursing team by environmental services supervisor/designee to ensure proper cleaning techniques are being followed

COVID Positive Employee

- Contact Public Health and follow their guidance
- Contact Regional Team and HR
- Initiate UDA's to be completed twice a day on residents exposed to employee
- All team members that had contact with identified team member should initiate self-monitoring twice daily including temperature

Policy and Procedure

Title: Resident Isolation on Observation Units

Policy

To ensure compliance with CDC guidelines when admitting or readmitting residents to the facility after a hospital visit. Residents coming or returning from the hospital must be treated as if they are infected. Each admission / readmission from the hospital must be isolated on the Observation unit for 15 days.

Procedure

1. Resident is admitted and assigned a room on the Observation unit
    A. To avoid bed lock, a roommate may be assigned for the first 4 days following admission.
    B. After the 4 day window has passed, a new admission / readmission from the hospital must be placed in a separate room on the Observation unit.
2. Charge nurse or Unit Manager will post the Isolation Tracking Calendar on the outside of the door
    A. Date of admission is circled
    B. Count 5 days and draw a 'x' to symbolize the end of the 4 day window for a roommate
    C. Count 15 days (from the date of admission-including date of admission) and circle the date.
    D. Mark each day off as time progresses
3. Resident may be moved from the unit after 15 days with no symptoms

Attachments: Isolation Tracking Calendar

Isolation Tracking Calendar

Bed: _____

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Bed: _____

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Employee Return to Work Criteria

Definitions

Mild Illness: Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Immunocompromised: degree of immunocompromise for HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Criteria

Decisions about return to work for HCP with SARS-CoV-2 infection should be made in the context of local circumstances. In general, a symptom-based strategy should be used as described below. The time period used depends on the HCP's severity of illness and if they are severely immunocompromised.

Symptom-based strategy for determining when HCP can return to work.

HCP with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved

Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

HCP with severe to critical illness or who are severely immunocompromised:

- At least 20 days have passed since symptoms first appeared
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved

Note: HCP who are severely immunocompromised1 but who were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.

As described in the Decision Memo, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, the more conservative period of 20 days was applied in this guidance**. However, because the majority of severely or critically ill patients no longer appear to be infectious 10 to 15 days after onset of symptoms, facilities operating under critical staffing shortages might choose to allow HCP to return to work after 10 to 15 days, instead of 20 days.**

Test-Based Strategy for Determining when HCP Can Return to Work.

In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised1) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

HCP who are symptomatic:

- Resolution of fever without the use of fever-reducing medications and
- Improvement in symptoms (e.g., cough, shortness of breath), and
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

HCP who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
- A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen

Symptomatic Employee Return to Work Checklist

Employee: _____ Today's Date: _____

Timeline:

Date symptoms began: _____ Last day of work: _____

Date of positive test result: _____ Return date: _____

Symptoms included:

☐Fever or chills ☐Muscle or body aches ☐Congestion
☐Cough ☐Headache ☐Runny nose
☐SOB /difficulty breathing ☐Loss of taste or smell ☐Nausea or vomiting
☐Fatigue ☐Sore throat ☐Diarrhea

Severity of illness:

☐Mild: Various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

☐Moderate: Evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level

☐Severe: respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

☐Critical: Respiratory failure, septic shock, and/or multiple organ dysfunction.

Check the box for the strategy used when evaluating readiness to return to work:

☐**Symptom-based strategy for HCPs with mild to moderate illness who are not severely immunocompromised are to be excluded from work until:**

At least 1 day (24 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); **and**,

Date of respiratory symptom improvement: _____

Date of last fever: _____

At least 10 days have passed since symptoms first appeared

Date symptoms appeared: _____

☐**Symptom-based strategy for HCP with severe to critical illness or who are severely immunocompromised are to be excluded from work until:**

At least 1 day (24 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); **and**,

Date of respiratory symptom improvement: _____

Date of last fever: _____

At least 20 days have passed since symptoms first appeared

Date symptoms appeared: _____

☐ **Test-based strategy. Exclude from work until:**

Resolution of fever without the use of fever-reducing medications **and**

Date of last fever: _____

Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**

Date of respiratory symptom improvement: _____

Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens)

Date of 1st negative test result: _____
Date of 2nd negative test result: _____

Explanation for using Test-based strategy: _____

_____

Employee: _____ **Date:** _____

Administrator: _____ **Date:** _____

Asymptomatic Employee Return to Work Checklist

Employee: _____ Today's Date: _____

Timeline:

Last day of work: _____ Return date: _____

Check the box for the strategy used when evaluating readiness to return to work:

☐ **Time-based strategy for HCPs who are not severely immunocompromised and were asymptomatic throughout their infection must be excluded from work until:**

10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

Date of positive test result: _____

If symptoms developed use the 'Symptomatic Employee Return to Work Checklist'

☐ **Time-based strategy for HCPs who are severely immunocompromised but who were asymptomatic throughout their infection must be excluded from work until:**

20 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

Date of positive test result: _____

If symptoms developed use the 'Symptomatic Employee Return to Work Checklist'

☐ **Test-based strategy. Exclude from work until:**

Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens).

Date of 1st negative test result: _____

Date of 2nd negative test result: _____

Explanation for using Test-based strategy: _____

_____

☐ Due to facility staffing shortages, this employee is permitted to continue working under the CDC's 'Mitigating Staffing Shortages' guidance. The employee will be practicing all recommended precautions while in the facility.

Employee: _____ **Date:** _____

Administrator: _____ **Date:** _____

COVID-19 Checklist for Visitors & Staff

On March 13, 2020, CMS and CDC updated guidance on restricting all SNF visitors and non-essential healthcare personnel, except for certain compassionate care situations. ALL individuals (staff, other health care workers, family, visitors, government officials, etc.) entering the building must follow the below steps and answer the outlined questions:

Essential Visitor

1. Has this individual washed their hands or used alcohol-based hand rub (ABHR) on entry? ☐Yes ☐No
2. Take the individuals temperature. Is it higher than 99.5?
   ☐Yes ☐No
   Ask if they have any of the following respiratory symptoms?
   ☐Sore throat
   ☐Cough
   ☐New shortness of breath
   If YES to any, restrict them from entering the building.
   If NO to all, proceed to question #3 for HCPs and question #4 for all others.
3. **Health Care Providers (HCP) (e.g., health care workers such as hospice, EMS, dialysis technicians that provide care to residents)**
   Ask if they have worked in facilities or locations with recognized COVID-19 cases?
   ☐Yes ☐No

   If **YES**, ask if they worked w/a person(s) with confirmed COVID-19?
   ☐Yes ☐No

   If **YES**, require them to wear PPE including mask, gloves, gown before any contact with residents & proceed to step 4.
   If **NO**, proceed to step 4.
4. Have visitor complete the attestation log
5. Provide the visitor with an education packet and proper PPE
6. Allow entry and remind the individual to:
   A. Wash their hands or use ABHR throughout their time in the building.
   B. Not shake hands with, touch or hug individuals during their visit.
   C. Wear a facemask while in the building and restrict their visit to the resident's room

Staff Member

1. Has this individual washed their hands or used alcohol-based hand rub (ABHR) on entry? ☐Yes ☐No
2. Have a nurse asses for the following symptoms
   ☐Fever (higher then 99.5)
   ☐Sore throat
   ☐Cough
   ☐New shortness of breath
   If YES to any, restrict them from entering the building.
   If NO proceed to step 3
3. Have they worked in facilities or locations with recognized COVID-19 cases?
   ☐Yes ☐No

   If **YES**, ask if they worked with a person(s) with confirmed COVID-19?
   ☐Yes ☐No

   If **YES**, require them to wear PPE including mask, gloves, gown before any contact with residents & proceed to step 4.
   If **NO**, proceed to step 4.
4. Complete Staff Attestation Log (assessing nurse must sign online provided)
5. Provide PPE
6. Allow entry and remind the individual to:
   A. Wash their hands or use ABHR throughout their shift
   B. Practice social distancing
   C. Wear a facemask at all times and to store it in a paper bag while eating
   D. Notify leadership if they begin to feel ill during their shift

Therapy on the Observation Unit

1. One therapy staff member will be assigned to the observation unit. This will limit available therapy to one discipline.
2. The assigned therapy staff member will be oriented to the protocols of the observation unit for compliance.
3. Tablet being used by therapy will remain on the unit.
4. Tablet will be kept in a zip lock bag which will allow for wiping.
5. Tablet will be secured on the observation unit in the narcotic storage area. The nurse will unlock and lock the tablet up for therapist.
6. Assigned therapist will enter and exit the unit using the designated observation door.
7. Once therapist exits the observation unit, therapist will not return to the facility until the next day.
8. On those rare occasions where the supervising therapist must go to the observation unit (ex. evaluations), the supervising therapist will end his/her day on the observation unit and exit for the day by the designated door.

Daily Symptom Attestation Form COVID-19

Dear Visitor:

Please help us to protect your loved ones and others by completing this form regarding symptoms of COVID-19 and travel history immediately upon entry to the facility.

- If you have any of the symptoms on this form, we cannot allow your entry until your symptoms have resolved.
- If you have recently traveled to a Centers for Disease Prevention and Control (CDC) Level 3 Affected Country/Area or if you have had **prolonged contact** to an exposed person we cannot allow your entry at this time.

*****FORM IS TO BE COMPLETED IN ITS ENTIRETY*****

Visitor Attestation		Recent Exposure		Symptom Review					Education
Date/Time	Name	Recent travel outside of the USA (Y/N)	Exposed to a person diagnosed with or symptoms of COVID-19 (Y/N)	Fever greater than 99.5 (List Temp)	Sneezing (Y/N)	Cough (Y/N)	Sore Throat (Y/N)	Shortness of Breath (Y/N)	Pre/Post Visit Education (Y/N)

****https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html**

Daily Symptom Attestation Form COVID-19

Dear Staff:

Please help us to protect our residents and others by completing this form regarding symptoms of COVID-19 and travel history immediately upon entry to the facility.

- If you have any of the symptoms on this form, we cannot allow your entry until your symptoms have resolved.
- If you have recently traveled to a Centers for Disease Prevention and Control (CDC) Level 3 Affected Country/Area or if you have had **prolonged contact** to an exposed person we cannot allow your entry at this time.

Staff Attestation		**Recent Exposure**		**Symptom Review**				
Date/Time	Name	Recent travel to CDC designated Level 3 Affected Countries/ Areas** (Y/N)	Exposed to a person diagnosed with or symptoms of COVID-19 (Y/N)	Fever greater than 99.5 (List Temp)	Sneezing (Y/N)	Cough (Y/N)	Sore Throat (Y/N)	Shortness of Breath (Y/N)

Assessing Nurse's Signature: _____

**https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

Duty Transfer Acknowledgement

In the absence of the Medical Director_____

(Name of Medical Director)

His/her duties will be assumed by _____

(Assuming Physician)

Administrator: _____ Date: _____

Medical Director: _____ Date: _____

Assuming Physician: _____ Date: _____

Contingency Acknowledgement

In the event the acuity or needs of a resident cannot be met the facility will proceed with the following:

A. Transfer to another facility (list 3 closest facilities)

1) Name: _____

   Address: _____

   _____

   Phone #: _____

2) Name: _____

   Address: _____

   _____

   Phone #: _____

3) Name: _____

   Address: _____

   _____

   Phone #: _____

B. Transfer to another hospital (list 3 closest hospitals)

1) Name: _____

   Address: _____

   _____

   Phone #: _____

2) Name: _____

Address: _____

_____

Phone #: _____

3) Name: _____

Address: _____

_____

Phone #: _____

C. Alternatives for additional staffing:

1) Contact sister facility for PRN staff (see attached Trio facility listing)

2) Temporary employment for licensed clinical positions

3) Utilize staffing agencies (list 3 agencies)

   i. Name: _____

      Phone #: _____

   ii. Name: _____

      Phone #: _____

   iii. Name: _____

      Phone #: _____

Administrator: _____ Date: _____

Medical Director: _____ Date: _____

Trio Facility Listing

Alleghany Health and Rehab
1725 Main Street
Clifton Forge, VA 24422
phone 540-862-5791

Bayside of Poquoson Health and Rehab
1 Vantage Drive
Poquoson, VA 23662
phone 757-868-9960

Elizabeth Adam Crump Health and Rehab
3600 Mountain Road
Glen Allen, VA 23060
phone 804-672-8725

Elizabeth House Assisted Living
3590 Mountain Road
Glen Allen, VA 23060
phone 804-672-7580

Fredericksburg Health and Rehab
3900 Plank Road
Fredericksburg, VA 22407
phone 540 786 8351

Fredericksburg Assisted Living
3902 Plank Road
Fredericksburg, VA 22407
phone 540-786-5589

Galax Health and Rehab
836 Glendale Road
Galax, VA 24333
phone 276-236-9991

Martinsville Health and Rehab
1607 Spruce Street Ext
Martinsville, VA 24112
phone 276-632-7146

Portsmouth Health and Rehab
900 London Blvd
Portsmouth, VA 23704
phone 757-393-6864

Rose Hill Health and Rehab
110 Chalmers Court
Berryville, VA 22611
phone 540 955 9995

Shenandoah Valley Health and Rehab
3737 Catalpa Avenue
Buena Vista, VA 24416
phone 540-261-7444

Beavercreek Health and Rehab
3854 Park Overlook Drive
Beavercreek, OH 45431
937-429-9655

Bellbrook Health and Rehab
1957 N. Lakeman Drive
Bellbrook, OH 45305
937-848-7800

Centerville Health and Rehab
7300 McEwen Road
Dayton, OH 45459
937-433-3441

Centerville Place Assisted Living
7300 McEwen Road
Dayton, OH 45459
937-433-3441

Centerville Senior Independent Living
7300 McEwen Road
Dayton, OH 45459
937-433-3441

Englewood Health and Rehab
425 Lauricella Court
Englewood, OH 45322
937-836-5143

Jamestown Place Health and Rehab
4960 US Route 35 East
Jamestown, OH 45335
937-675-3311

Portsmouth Health and Rehab
727 Eighth Street
Portsmouth, OH 45662
740-354-8150

Xenia Health and Rehab
126 Wilson Drive
Xenia, OH 45385
937-376-2121

Edgeworth Park at New Town
5501 Discovery Park Blvd
Williamsburg, VA 23188
757-345-500