	POLICY AND GUIDELINES FOR IMPLEMENTATION
COVID-19 Exposure & Outbreak Policy – Florida	**June 1, 2022** **Revised July 26, 2022** **Revised September 26, 2022** **Revised October 4, 2022** **Revised May 15, 2023** **Revised August 1, 2023**

POLICY

Outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled.

The facility will sustain core infection prevention and control (IPC) practices and remain vigilant for SARS-CoV-2 infection among residents and healthcare personnel (HCP) in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.

The facility will follow Centers for Medicare and Medicaid Services (CMS) core principles of COVID-19 infection prevention.

Core prevention measures for COVID-19 include:

1. Infection prevention and control program
2. Vaccinate residents and HCP against SARS-CoV-2
3. Implement universal source control, physical distancing, and eye protection
4. Have a plan for visitation
5. Evaluate and manage HCP
6. Identify a COVID Care Unit dedicated to monitor and care for residents with confirmed SARS-
1. CoV-2 infection when appropriate
7. Evaluate residents for signs and symptoms of SARS-CoV-2
8. Create a plan for testing residents and HCP for SARS-CoV-2 9. Create a staffing plan

DEFINITIONS

Close contact: Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period, during their infectious period. The infectious period begins from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to specimen collection date of the positive test).

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body

substances (e.g. blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g. clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the CDC Interim Clinical Considerations for Use of COVID-19 Vaccines.

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise and not clearly affect decisions about need for or duration of Transmission-Based Precautions if the individual had close contact with someone with SARS-CoV-2 infection. However, people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility, even if they are up to date with all recommended COVID-19 vaccine doses.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Isolation for residents: The term isolation refers to the implementation of measures for a resident with COVID-19 infection during their infectious period, to prevent transmission to other residents, HCP, or visitors.

Nursing home-onset COVID-19: SARS-CoV-2 infection that originated in the nursing home. It does not refer to the following:

- Residents who were known to have COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
- Residents who were placed into empiric Transmission-Based Precautions (quarantine) on admission and developed SARS-CoV-2 infection while in quarantine.
- Residents with a known exposure to COVID-19 from a visitor or during an outing who later developed COVID-19 but who were under empiric Transmission-Based Precautions (quarantine) for their entire infectious period.

Outbreak: The occurrence of one or more cases of COVID-19 in a LTCF that meet the following criteria:

- New nursing home-onset of COVID-19 in a resident; or
- New onset of COVID-19 in an HCP who was working in the facility while infectious (during the 2 days prior to symptom onset or positive test if asymptomatic).

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

Source control: Use of well-fitting cloth masks, well-fitting facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing a cloth mask, facemask, or respirator safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their cloth mask, facemask, or respirator without assistance. Face shields alone are not recommended for source control.

Testing or test: This term refers to authorized nucleic acid or antigen detection assays that have received an FDA Emergency Use Authorization for SARS-CoV-2.

Transmission-based precautions for COVID-19: HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.

Up to date: In general, being up to date on COVID-19 vaccination includes receiving all vaccines according to the recommendations provided by CDC. This includes a primary series of vaccine, booster doses, and any recommended third doses for immunocompromised people. For specifics, refer to CDC guidance.

SIGNS AND SYMPTOMS

RESIDENTS OR HCP WITH SIGNS AND SYMPTOMS OF COVID-19

Residents:

- COVID-19 symptoms can include:
  - Fatigue
  - Muscle or body aches
  - Headache
  - Sore throat
  - Loss of taste and/or smell, or
  - New dizziness
  - Nausea
  - Vomiting, or diarrhea.
- Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection.
- Because some of the symptoms are similar, it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections, based on symptoms alone. Consider testing for pathogens other than SARS-CoV-2 and initiating appropriate infection prevention precautions for symptomatic older adults.
- Resident should be placed in a single room when available. The door should be kept closed (if safe to do so).
  - The resident should have a dedicated bathroom

- If limited single rooms available, or if numerous residents are simultaneously identified to have know SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location
    - If cohorting, only residents with the same respiratory pathogen should be housed in the same room. Multidrug-resistant organism (MDRO) colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
    - The facility will respect the rights of residents who refuse to move and want to remain in their "bedroom" during outbreak. The resident will be educated on the risks, which will be documented in the resident's electronic medical record.
- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of residents with SARS-CoV-2 infection is high and the physical plant allows.
    - Dedicated means that HCP are assigned to care only for these residents during their shifts.
    - Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of residents with SARS-CoV-2 infection.
- Limit transport and movement of the resident outside of the room to medically essential purposes.
- Communicate information about residents with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

Duration of Empiric Transmission-Based Precautions for Symptomatic Residents being evaluated for SARS-CoV-2 infection

- The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a resident with symptoms of COVID-19 can be made based upon having negative results from a viral test:
    - If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
    - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or a second negative antigen test taken 48 hours after the first negative test.
- If a resident suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset
    - Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Healthcare Personnel (HCP):

- Refer to return to work policy

IDENTIFICATION OF EXPOSURE TO RESIDENTS

For residents in the facility, use the definition of a close contact as defined above to identify exposures related to any of the following situations:

- By visitors outside or inside the facility; or
- At outside medical facilities or clinics; or

- During a social outing outside the facility that is either not hosted by the facility or involves only a small group of residents and staff.

Refer to guidance on response to a positive case in the facility that meets the definition of an outbreak. Following identification that a close contact has occurred, manage resident(s) as outlined below.

MANAGING RESIDENTS WITH EXPOSURE

If a resident is exposed the facility should:

- Monitor for symptoms
- Series of 3 tests as per frequency
  - If the date of a discrete exposure is known:
    - testing is recommended immediately (but not earlier than 24 hours after the exposure) and,
    - if negative, again 48 hours after the first negative test and, if negative,
    - again 48 hours after the second negative test
    - This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
  - If the date of a discrete exposure is NOT known (for example, a household exposure with an undefined start date),
    - testing is recommended immediately and, if negative,
    - again 48 hours after the first negative test and, if negative,
    - again 48 hours after the second negative test
- Wear source control for 10 days

If resident develops symptoms or tests positive resident will be promptly placed on transmission-based precautions.

Residents who are exposed do not have to be quarantined unless:

- Resident is unable to be tested or wear source control
- Resident is moderately to severely immunocompromised
- Resident is residing on a unit with others who are moderately to severely compromised
- Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions
- Resident becomes symptomatic
- Resident tests positive

Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection

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

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

TESTING FOR SARS-COV-2

Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.

Asymptomatic patients with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of three viral tests for SARS-CoV-2 infection.

- If the date of a discrete exposure is known, testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
- If the date of a discrete exposure is NOT known (for example, a household exposure with an undefined start date), testing is recommended immediately and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

In general, testing is not necessary for asymptomatic people who have recovered from SARSCoV-2 infection in the prior 30 days; testing should be considered for those who have recovered in the prior 31-90 days however, if testing is performed on these people, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended.

COVID-19 Refusal for Testing

Residents (or resident representatives) may exercise their right to decline COVID-19 testing. In discussing testing with residents, the facility staff will use person-centered approaches when explaining the importance of testing for COVID-19. The facility will ensure that residents who refuse testing are managed in accordance with the CDC guidance for use of TBP.

- At any time, the resident may rescind their decision not to be tested.

MANAGING RESIDENTS WITH SARS-CoV-2 Infection

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

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

In general, residents who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for residents with severe to critical illness. In general, residents should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for residents.

Recovery

Patients with mild to moderate illness who are not moderately to severely immunocompromised:

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

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

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

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

- At least 10 days and up to 20 days have passed since symptoms first appeared; and
- At least 24 hours have passed since last fever without the use of fever-reducing medications; and
- Symptoms (e.g., cough, shortness of breath) have improved.
- The test-based strategy for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific patients.

Patients who are moderately to severely immunocompromised:

These patients may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.
- The criteria for the test-based strategy are:
- Patients who are symptomatic:
    - Resolution of fever without the use of fever-reducing medications; and
    - Symptoms (e.g., cough, shortness of breath) have improved; and
    - Results are negative from at least two consecutive respiratory specimens collected ≥ 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.
- Patients who are not symptomatic:
    - Results are negative from at least two consecutive respiratory specimens collected ≥ 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

RESPONSE TO AN OUTBREAK OF COVID-19

Definition of an outbreak: A single new case of SARS-CoV-2 infection in any resident or HCP should be evaluated as a potential outbreak. An outbreak is defined as the occurrence of one or more cases of COVID-19 in a LTCF that meet the following criteria:

- New nursing home-onset of COVID-19 in a resident
    - An outbreak is not triggered when a resident with known COVID-19 is admitted directly into TBP
    - Residents know to have close contact with someone with COVID019 is admitted directly into TBP and develops COVID-19 before TBPO are discontinued.
- New onset of COVID-19 in an HCP who was working in the facility while infectious (during the 2 days prior to symptom onset or positive test, if asymptomatic).

Identification of a single new case 14 days after the last known case would meet the criteria for a new outbreak and prompt the need for an outbreak response.

Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing.

If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.

For further information on contact tracing and broad-based testing, including frequency of repeat testing, see CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic"

The approach to an outbreak investigation (see Figure 1) could involve either contact tracing (see Figure 2) or a broad-based approach (see Figure 3); however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.

Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.

- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
- Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period

In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to Empiric use of Transmission-Based Precautions (quarantine) for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.

If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated.

If additional cases are identified, consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.

- If antigen testing is used, more frequent testing should be considered

OTHER RESPONSE MEASURES TO CONSIDER

1. Consult with Medical Director and applicable consultants
2. Consult with Home Office
3. Hold ad hoc Infection Prevention Committee throughout to discuss items specific to outbreak.
4. Contact any local (community) or state agency as appropriate to determine if any actions need to be taken.
5. Consult with committee regarding visitor and/ or employee screening.
6. Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control
    - Hand Hygiene Supplies:
        - Utilize FDA-approved alcohol-based hand sanitizer with 60-95% alcohol.
        - Unless hands are visibly soiled, performing hand hygiene using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are an effective method of cleaning hands.
        - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
    - Personal Protective Equipment (PPE):
        - The facility will select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration (OSHA) PPE standards (29 CFR 1910 Subpart I).
        - Follow, Department mandates regarding PPE that may apply.
        - The facility will have supplies of facemasks, N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles).
        - Follow the respiratory protection program that is compliant with the OSHA respiratory protection standard (29 CFR 1910.134)
        - The program should include medical evaluations, training, and fit testing.
    - Perform and maintain an inventory of PPE in the facility.
        - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools, such as the PPE Preservation Planning Toolkit.
        - During PPE shortages, refer to the Department's website to submit a resource request.
        - Use the Supplies and PPE pathway in the National Healthcare Safety Network (NHSN) LTCF COVID-19 Module to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of CDC PPE optimization strategies). Even if you submit a request to the Department, NHSN data assist with nationwide tracking.
    - Make necessary PPE available in areas where resident care is provided.

        - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback, promoting appropriate use by staff.
    - Follow CDC PPE optimization strategies, which offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted.
    - Environmental Cleaning and Disinfection:
        - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas.
        - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
        - Use an EPA-registered disinfectant
        - Ensure HCP are appropriately trained on its use and follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).
7. Discuss communal programming including but not limited to dinning and activities.
8. Prioritize critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations in reference to exposure and PPE utilization.
    - Showers
    - Restorative
    - Weights
        - If the interdisciplinary team determines that the resident's weight is critical to their plan of care, the weight will be obtained following appropriate infection control techniques. The weight will be documented in the electronic medical record.
        - Infection control techniques include properly cleaning / sanitizing scale and/ or hoyer lift between residents as per CDC guidelines.
        - Residents that were not weighed following review, will have no weight recorded and classified as "safety precaution" / "unable to weigh" with a corresponding progress note.
        - Residents not weighed will continue to be monitored by the dietitian and interdisciplinary team for any change in intake, visual appearance, and medical status.
        - These identified residents will be care planned, if appropriate, for risk for malnutrition.
        - Weights unable to be obtained in the 30-day window, will be re-assessed upon the conclusion of outbreak.
9. Maintain a line listing of identified cases on the appropriate report / surveillance tracking following Federal and Local guidelines/ requirements
10. Update Facility Assessment as needed

COMMUNICATION

The facility will put a plan in place for effective and clear communication with staff, residents, their families or guardians about any infectious disease outbreaks.

The facility has policies and procedures for virtual communication (e.g. phone, video-communication, Facetime, window visits etc.) with residents, families, and resident representatives, in the event of visitation restrictions due to an outbreak of infectious disease or in the event of an emergency.

STAFF

Staff who test positive for COVID-19 infection shall be excluded from working in the facility in accordance with CDC Guidelines. Staff who refuse to participate in COVID-19 testing, or refuse to authorize release of their testing results to the facility shall be excluded from working in the facility until such time as such staff undergoes testing and the results of such testing are disclosed to the facility.

Any individual Staff member who is excluded from work because they tested positive for COVID-19 may return to work in accordance with CDC/DOH recommendations as to timeframes and requirements.

If an employee works at multiple healthcare facilities the staff member only must undergo prevalence testing at one of the locations. If this testing is performed at their alternate employer, the facility will obtain proof of test. The facility will utilize the *Authorization to Release Health Information* to increase the ease of obtaining such results.

REPORTING

The facility will comply with the federal and state requirements of reporting including but not limited to the National Healthcare Safety Network.

Facial Coverings Opt-Out Requirements

Residents

The facility will follow the Florida Patient Bill of Rights and Responsibilities section 381.026 when residents want to request to opt-out of facial covering recommendations.

Visitors

Provisions for opting out of wearing a facial covering

- The facility will explore if alternative methods of infection control or infectious disease prevention are available.

Staff

There are requirements for an employee to be able to opt out of facial covering requirements unless an employee is:

- Conducting sterile procedures
- Working in a sterile area

- Working with a resident whose treating health care practitioner has diagnoses the resident with or confirmed a condition affecting the immune system in a manner which is known to increase risk of transmission of an infection from employees without signs or symptoms of infection to a resident and whose treating practitioner has determined that the use of facial coverings is necessary for the resident's safety.
- With a resident on droplet or airborne isolation or
- Engaging in non-clinal potentially hazardous activities that require facial coverings to prevent physical injury or harm in accordance with industry standards.