



Guidance to Protect Residents of Long-Term Care Facilities (Upon Readmission or Current Stay)

Michigan.gov/Coronavirus

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For purposes of this document, a long-term care facility means any residential setting that cares for aged population. This includes, but not limited to, Skilled Nursing Facility, Assisted Living Facility, Adult Foster Care, Independent Living Facility, Home for the Aged, Community-Based Residential Facility, or Residential Care Apartment Complex.

The decision to discharge a patient from the hospital is made based on the clinical condition of the patient. Residents without COVID-19 who required hospitalization can and should be discharged back to the facility of residence once they are clinically stable. If a COVID-19 test was not warranted based on U.S. Centers for Disease Control and Prevention (CDC) or Michigan Department of Health and Human Services (MDHHS) criteria (see below), then a patient does not need to be tested prior to discharge back to a facility. **Continued hospitalization until a resident can be tested is counter to MDHHS testing criteria and will overwhelm the healthcare system and should be avoided.**

COVID-19 Testing Strategy

Following the March 24, 2020 MDHHS Emergency Order Pursuant to MCL 333.2253, MDHHS updated the evaluation criteria for prioritization of collection and testing of specimens for COVID-19. In an effort to conserve limited COVID-19 testing supplies and capacity, MDHHS prioritized testing eligibility for Priority Groups One, Two, and Three in the [U.S. Public Health Services \(PHS\) Guidance](#).

Priority Group One ensures optimal care options for all hospitalized patients, lessen the risk of healthcare-associated infections, and maintain the integrity of the U.S. healthcare system. This includes hospitalized patients and healthcare facility workers *with symptoms*

Priority Group Two ensures those at highest risk of complication of infection are rapidly identified and appropriately triaged. This includes:

- Residents in long-term care facilities *with symptoms*
- Residents over age 65 years *with symptoms*
- Residents with underlying conditions *with symptoms*
- First responders *with symptoms*

Priority Group Three ensures testing for critical infrastructure workers *with symptoms*.

For those who do qualify for testing, Medicare is now covering COVID-19 testing when furnished to eligible beneficiaries by certified laboratories. These laboratories [may also choose](#) to enter facilities to conduct COVID-19 testing.

Best Practices for Long-Term Care Facilities (Based on CMS Guidance)

Certified Nursing homes must comply with CMS and CDC guidance related to infection control

- Facilities must adhere to appropriate hand hygiene as set forth by [CDC](#).
- CMS has issued extensive [infection control guidance](#), including a self-assessment checklist that can be used to determine compliance with crucial infection control actions.
- Facilities should refer to CDC's [guidance](#) on COVID-19 and [guidance](#) on conservation of personal protective equipment (PPE).

Long-term care facilities should immediately implement symptom screening for all

- In accordance with [previous CMS guidance](#), every individual regardless of reason entering a facility (including residents, staff, visitors, outside healthcare personnel (HCP), vendors, etc.) should be asked about COVID-19 symptoms and have their temperature checked.
 - An exception to this is Emergency Medical Service (EMS) workers responding to an urgent medical need, as they are typically screened prior to each shift.
- Facilities should limit access points and ensure all accessible entrances have a screening station.
- In accordance with [previous CDC guidance](#), every resident should be assessed for symptoms and have their temperature checked every day.

Identify infections early:

- Screen residents daily for fever and respiratory symptoms; immediately isolate if symptomatic.
- Residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt immediate isolation and further evaluation for COVID-19.
- Notify the local health department immediately (<24 hours) for: severe respiratory infection causing hospitalization or sudden death (within 2 hours), clusters (≥ 3 residents and/or HCP) of respiratory infection, or individuals with known or suspected COVID-19 are identified.

Long-term care facilities should exercise as best as possible consistent assignment

- Consistent assignment (meaning the assignment of staff to certain residents) for all residents regardless of symptoms or COVID-19 status.
- This practice can enhance staff's familiarity with their assigned residents, helping them detect emerging condition changes that unfamiliar staff may not notice.
- The goal is to decrease the number of different staff interacting with each resident as well as the number of times those staff interact with the resident.
 - Also, staff as much as possible should not work across units or floors.
 - Facilities should redeploy existing training related to consistent assignment, and ensure staff are familiar with the signs and symptoms of COVID-19.

Contingency Planning for COVID-19 in a Facility

If a healthcare worker worked while symptomatic with symptoms consistent with COVID-19:

- Prioritize the symptomatic healthcare worker for COVID-19 testing.

- Residents that were cared for by the healthcare worker while they were symptomatic should be:
 - Restricted to their room,
 - Monitored for fever and respiratory symptoms at least daily,
 - Required to wear face masks if leaving their room, and
 - Cared for using recommended PPE (Please see Table 1, below) until results of the healthcare worker's testing are known.
- If COVID-19 is diagnosed in the healthcare worker, residents should be cared for using recommended PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.

If a resident is found to have COVID-19:

- Ensure the resident is isolated and cared for using recommended PPE (Please see Table 1, below). Place resident in a single room if possible. The facility should conduct surveillance to actively identify other symptomatic residents and HCP as well as increase assessment of residents from daily to every shift.
 - Facility should review new admissions based on their current situation and interventions being implemented.
- Facility should counsel residents on the affected unit (or in the facility if cases widespread) and restrict residents to their room.
- HCP should use recommended PPE [from Table 1] for the care of residents in affected areas (or facility); this includes both symptomatic and asymptomatic residents. Facility should also:
 - Reinforce basic infection control practices (i.e., hand hygiene, PPE use, social distancing, environmental cleaning)
 - Provide educational sessions or handouts for HCP and residents/families
 - Maintain ongoing, frequent communication with residents, families and HCP with updates on the situation and facility actions
 - Monitor hand hygiene and PPE use in affected areas
 - Increased vitals/assessments of residents infected with COVID-19 to detect clinically deteriorating residents more rapidly (e.g., every shift). Include assessment of pulse oximetry as part of vital signs, if not already being done.
 - Educate HCP in the facility about the potential for rapid clinical deterioration in residents with COVID-19
 - Consider increasing from daily to every shift surveillance for new symptomatic residents among residents not known to be infected with COVID-19
- COVID-19 residents could share rooms with other similarly infected residents. These residents could be cohorted together in a designated location with dedicated HCP providing care.
 - Roommates of residents infected with COVID-19 should be considered potentially infected and not share rooms with other residents unless they remain asymptomatic for 14 days after their last exposure.
- Maintain interventions while assessing for new clinical cases (symptomatic residents):
 - Ideally maintain precautions for residents on the unit until no additional clinical cases for 14 days or until cases subside

- Residents infected with COVID-19 could be accepted back into the facility if the facility can care for the resident using recommended interventions, have adequate PPE, and single rooms or they can room share with another resident infected with COVID-19.
- Removing residents infected with COVID-19 from Transmission-Based Precautions should follow current [CDC recommendations](#).
- Facility should keep in mind that the incubation period can be up to 14 days and the identification of new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions to control transmission

Facilities should separate residents infected with COVID-19 or symptomatic from residents who do not have or show symptoms.

- COVID-19-positive units and facilities must be capable of maintaining strict infection control practices.
 - Facility should exercise consistent assignment or have separate staffing teams for COVID-19-positive and COVID-19-negative residents.
 - For facilities with ventilator capabilities and residents with COVID-19, there may be a need for the facility to have the capacity, staffing, and infrastructure to manage higher intensity residents, including ventilator management.
- Facilities should inform residents and their families of [limitations of their access](#) to and ability to leave and re-enter the facility, as well as any requirements and procedures for placement in alternative units or facilities for COVID-19-positive or unknown status.

The MDHHS is actively working with other state agencies, local health departments, hospitals, and various provider associations to ensure coordination during this emergency.

Personal Protective Equipment (PPE) Recommended Utilization

At note about N95 respirators:

N95 respirator masks are only indicated for use when there is a risk of airborne transmission. In the care of residents with COVID-19 or suspected COVID-19 when there is a shortage of N95 respirators, these respirators should be reserved for use during aerosol-generating procedures (Please see Table 2, below). Additionally, N95 respirators should only be used in a setting where the facility has a respiratory protection program with trained, medically cleared, and fit-tested healthcare workers.

Optimization of PPE:

The CDC provides [strategies](#) that can be utilized by HCP to optimize use of PPE during periods of known shortages. These strategies should only be used when there is limited supply that has exceeded the ability to provide conventional standards.

Table 1. PPE Considerations by Facility Type

Facility type	N95 Respirator	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
Skilled Nursing Facility							
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)		X		X	X		X
Daily resident care (Standard Precautions)		X		X ^a	X ^a		X ^b
Upon entering the facility		X	X				
Assisted Living Facility							
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)		X		X	X		X
Daily resident care (Standard Precautions)		X		X ^a	X ^a		X ^b
Upon entering the facility			X				
Adult Foster Care							
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)		X		X	X		X
Daily resident care (Standard Precautions)		X		X ^a	X ^a		X ^b
Upon entering the facility			X				
Independent Living Facility							
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)		X		X	X		X
Daily resident care (Standard Precautions)		X		X ^a	X ^a		X ^b
Upon entering the facility			X				
Home for the Aged							
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)		X		X	X		X
Daily resident care (Standard Precautions)		X		X ^a	X ^a		X ^b
Upon entering the facility			X				
Notes:							
^a During care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions							
^b During care activities where contact with blood, body fluids, or other potentially infectious materials may occur							

Table 2. PPE Considerations by Care Provided

Care Type	N95 Respirator	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
Wound care		X ^a		X ^a	X ^a	X	X
Tracheostomy care		X ^a		X ^a	X ^a		X
Feeding tube care (e.g., PEG, NG)		X ^a		X ^a	X ^a		X
Peripheral IV care		X ^a		X ^a	X ^a		X
Central venous catheter care (e.g., PICC, Dialysis port)		X ^a		X ^a	X ^a	X	X
Urinary catheter care		X ^a		X ^a	X ^a		X
Colostomy care		X ^a		X ^a	X ^a		X
Aerosol-generating procedure, may include but not limited to: Bronchoscopy Cardiopulmonary resuscitation Endotracheal intubation and extubation Manual ventilation Non-invasive ventilation (e.g., BiPAP, CPAP) Open suctioning of airways Sputum induction	X			X ^a	X ^a		X
High-flow O2 delivery	X ^c						
Nebulizer administration	X ^{c,d}	X ^{c,d}					

Notes:

^a During care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions

^b During care activities where contact with blood, body fluids, or other potentially infectious materials may occur

^c Based on limited available data, it is uncertain whether aerosols generated from these procedures may be infectious

^d Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected residents.

Nebulizers and COVID-19

No studies have been performed on the specific transmission risk for nebulizers during the treatment of patients with confirmed COVID-19. One study has demonstrated aerosol stability of SARS-CoV-2, but whether this is applicable to clinical situations outside of laboratory conditions is unknown (van Doremalen et al. N Engl J Med 2020 March DOI:10.1056/NEJMc2004973). The available data suggest that while the risk of viral transmission from nebulizers is lower than with procedures such as intubation or bronchoscopy, transmission remains a possibility. MDHHS recommends the following to minimize risk to health care providers:

- If patient can tolerate, switch to metered-dose inhalers with a dedicated spacer.
- HCP should wear a facemask (as well as eye protection, gloves and a gown) during the procedure if an N95 or higher-level respirator is unavailable.
- Close resident room door when providing nebulizer treatment.
- Upon set-up of nebulizer, have HCP maintain a safe distance (6 feet or greater), possibly outside the door.
- Residents do not need to be transferred to a higher level of care solely for the purpose of providing nebulizer treatment.

References:

1. [CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#)
2. Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J (2012) Aerosol Generating Procedures and Risk of Transmission of Acute Respiratory Infections to Healthcare Workers: A Systematic Review. PLoS ONE 7(4); <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338532/#!po=72>.
3. van Doremalen et al. "Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1." N Engl J Med 2020 March DOI:10.1056/NEJMc2004973; www.nejm.org/doi/full/10.1056/NEJMc2004973.
4. <https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf>