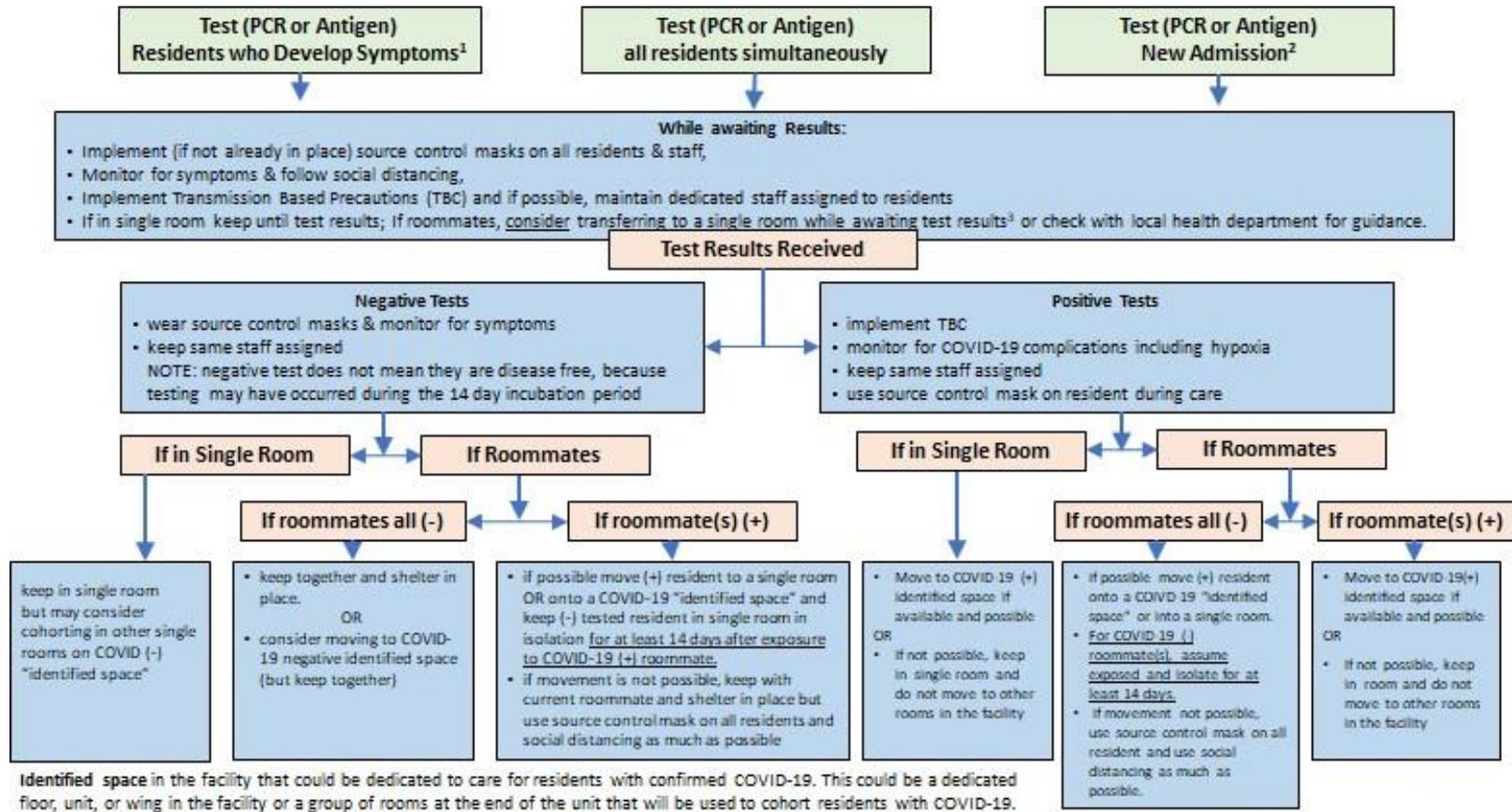


AHCA/NCAL Algorithm for Testing and Cohorting Nursing Home Residents



¹Testing based on symptoms per CDC include fever, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, vomiting or diarrhea, body aches, difficulty breathing, headache, congestion, runny nose, nausea, and/or sore throat. As of May 13, 2020 [Testing Guidance for Nursing Homes](#).

²Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. [Responding to Coronavirus in Nursing Homes](#)

³CDC guidance: "Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should **not** be placed in a room with a new admission **nor** should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.

CDC has recommendations for when nursing homes should test all residents and healthcare personnel in nursing homes. As of May 19, 2020, [Performing Facility-wide COVID-19 Testing in Nursing Homes](#).

Sections from CDC website are cut and pasted below about cohorting

Preparing for COVID-19 in Nursing Homes¹

Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19.

- Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
 - Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive).
 - Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. **Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated.**
- Have a [plan](#) for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them).
- Additional information about cohorting residents and establishing a designated COVID-19 care unit is available in the [Considerations for the Public Health Response to COVID-19 in Nursing Homes](#)

Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown.

- Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the

¹ [Preparing for COVID-19 in Nursing Homes](#); last reviewed by CDC on June 25, 2020.

end of this period can be considered to increase certainty that the resident is not infected.

Evaluate and Manage Residents with Symptoms of COVID-19.

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever ($T \geq 100.0^{\circ}\text{F}$) and [symptoms consistent with COVID-19](#). Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below.
 - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures $>99.0^{\circ}\text{F}$ might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
 - Contact information for the healthcare-associated infections program in each state health department is available here: <https://www.cdc.gov/hai/state-based/index.html>
 - Refer to CDC [resources](#) for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of patients with COVID-19 is described in the [Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\)](#). CDC has also developed guidance on [Evaluating and Reporting Persons Under Investigation \(PUI\)](#).
- **If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#). This guidance should be implemented immediately once COVID-19 is suspected**
 - Residents with suspected COVID-19 should be prioritized for testing.
 - Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
 - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
 - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with

- another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
- Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. **Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.**
 - Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
 - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms.
 - If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. **Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.**
 - While awaiting transfer, residents should be separated from others (e.g., in a private room with the door closed) and should wear a cloth face covering or facemask (if tolerated) when others are in the room and during transport.
 - [All recommended PPE](#) should be used by healthcare personnel when coming in contact with the resident.
 - Because of the higher risk of unrecognized infection among residents, universal use of [all recommended PPE](#) for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is newly identified in the facility; this could also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.
 - For decisions on removing residents who have had COVID-19 from Transmission-Based Precautions refer to the [Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19](#)

CDC Resident Cohorting (for Nursing Homes)²

Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19

- Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit.

² [Responding to Coronavirus in Nursing Homes](#); Updated April 30, 2020

- Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected).
- Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19.
 - Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms³.
- Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
 - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
 - Assign environmental services [EVS] staff to work only on the unit.
 - If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to [mitigate staffing shortages](#), restrict their access to the unit. Also, assign HCP dedicated to the COVID-19 care unit (e.g., NAs) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from [List of agents effective against COVID-19](#) into the room and wipe down high touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.
 - Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
 - Ensure HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).
- Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- Ensure that HCP have been trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE).
- If PPE shortages exist, implement [strategies to optimize PPE supply](#) on the unit, such as:
 - Bundle care activities to minimize the number of HCP entries into a room.

³AHCA Note: If it is not physically separated the risk for spread will be greater, thus a facility may not provide a dedicated unit if the physical plant does not allow for the intended use of such a unit. See subsequent CDC guidance above on “identified space” which could include a cluster of rooms.

- Consider extended use of respirators (or facemasks if respirators are not available), eye protection, and gowns. Limited reuse of PPE may also be considered.
- [Consider prioritizing gown use](#) for high-contact resident care activities and activities where splash or spray exposures are anticipated.
- Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.

Considerations for new admissions or readmissions to the facility

- Newly admitted and readmitted residents with confirmed COVID-19 who have not met [criteria for discontinuation of Transmission-Based Precautions](#) should go to the designated COVID-19 care unit.
- Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit.
 - If Transmission-Based Precautions have been discontinued, but the resident with COVID-19 remains symptomatic (i.e., persistent symptoms or chronic symptoms above baseline), they can be housed on a regular unit but should remain in a private room until symptoms resolve or return to baseline. These individuals should remain in their rooms to the extent possible during this time period. If they must leave their rooms, facilities should reinforce adherence to universal source control policies and social distancing [e.g., perform frequent hand hygiene, have the resident wear a cloth face covering or facemask (if tolerated) and remain at least 6 feet away from others when outside of their room].
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown⁴. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
 - All [recommended COVID-19 PPE](#) should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.
 - Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all

⁴ AHCA Note: admissions with unknown status should be admitted to a single room and tested as soon as possible. While testing is pending, assume they person may have COVID-19. If the test results are negative, you should still keep the person in isolation for 14 days as the negative test may be due to the person being infected during the 2 to 14-day incubation period people experience with this virus. CDC recommends creating if possible a “holding” space or unit for new admissions to be held for 14 days.

recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home.⁵

- New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty.

Response to Newly Identified SARS-CoV-2-infected HCP or Residents

HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset

- Prioritize these HCP for SARS-CoV-2 testing. Exclude HCP with COVID-19 from work until they have met all [return to work criteria](#).
- Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.
 - Residents who were cared for by these HCP should be restricted to their room and be cared for using [all recommended COVID-19 PPE](#) until results of HCP COVID-19 testing are known. If the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
 - Exposed HCP should be [assessed for risk and need for work exclusion](#).
- If testing is available, asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for testing (see information on testing below). If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above.

Resident with new-onset suspected or confirmed COVID-19

- Ensure the resident is isolated and cared for using [all recommended COVID-19 PPE](#). Place the resident in a single room if possible. Alternatively, if an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room on that unit pending results of SARS-CoV-2 testing.⁶
 - **Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected**

⁵ While testing is not required prior to transfer from a hospital, a facility needs to be able to provide care for residents with suspected COVID-19 including adequate PPE, testing and staff; otherwise the facility may consider not admitting patients whose COVID-19 status is unknown or testing them as soon as possible after admission (which they remain in 14 day isolation).

⁶ AHCA notes that this is an “alternate” approach and dependent on having a separate unit created. Also, moving residents with tests pending can result in exposing residents who have symptoms but are not related to COVID-19 and discouraged with more recent guidance released by CDC which is specified above. Before moving symptomatic residents with pending tests results should be done in consultation with the local or state Department of Public Health. Also, see CDC guidance on moving residents on dementia unit (see below) about the risk of moving residents’ with dementia.

- residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).**
- If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.
 - If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.⁷
 - **Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).**
 - **Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.**
 - Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
 - Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections.
 - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
 - Counsel all residents to restrict themselves to their room to the extent possible.
 - HCP should use [all recommended COVID-19 PPE](#) for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.
 - If HCP PPE supply is limited, implement [strategies to optimize PPE supply](#), which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated. Point prevalence surveys (PPS) could be utilized to prioritize PPE supplies (see section on use of PPS).
 - Notify HCP, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning).
 - [Promptly \(by 5pm next calendar day\) notify residents, their representatives and families about identification of COVID-19 in the facility pdf](#)
 - Provide educational sessions or handouts for HCP, residents, and 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
 - Maintain all interventions while assessing for new clinical cases (symptomatic residents):

⁷ AHCA Notes: this is dependent on the ability of facility to create a COVID-19 dedicated unit or “identified space” and space on the unit. Also, if the facility wide COVID-19 is occurring some local or state Departments of Public Health may recommend sheltering in place. If moving the resident may increase the risk of spread or care for the resident, we recommend checking with the local or state public health department for guidance on sheltering in place.

- Maintain [Transmission-Based Precautions](#) for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.
- If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing
- **The incubation period for COVID-19 can be up to 14 days and the identification of a new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.**

Use of Testing to Inform the Response to COVID-19 in Nursing Homes

Considerations for use of COVID testing to inform cohort decisions

- If testing supplies or capacity are limited, testing of [symptomatic HCP and symptomatic](#) residents should be prioritized.
 - If unit-wide or facility-wide testing is not available in response to newly identified SARS-CoV-2 infected residents or HCP, **moving any residents other than those confirmed to have COVID-19 should be done with caution given the risk of asymptomatic infection**; in those situations, all recommended COVID-19 PPE should be used during care of all residents on the affected unit or facility.
- If testing capacity allows, use of point prevalence surveys (PPSs) following identification of newly identified SARS-CoV-2 infected residents or HCP could be particularly important. PPSs can help identify asymptomatic or pre-symptomatic residents with COVID-19 to guide movement into COVID-19 designated spaces.

For additional information on testing in response to COVID-19 in nursing homes please refer to [Considerations for Use of Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes](#).

When residents on a memory care unit are suspected or confirmed to have COVID-19⁸

As it may be challenging to restrict residents to their rooms, [implement universal use of eye protection and N95 or other respirators \(or facemasks if respirators are not available\)](#) for all personnel when on the unit to address potential for encountering a wandering resident who might have COVID-19.

- Consider potential risks and benefits of moving residents out of the memory care unit to a [designated COVID-19 care unit](#).
 - Moving residents with confirmed COVID-19 to a designated COVID-19 care unit can help to decrease the exposure risk of residents and HCP; **however,**

⁸ CDC, [Considerations for Memory Care Units in Long-Term Care Facilities](#); last updated May 12, 2020

- **Moving residents with cognitive impairment to new locations within the facility may cause disorientation, anger, and agitation as well as increase risks for other safety concerns such as falls or wandering.**
- Additionally, at the time a resident with COVID-19 or asymptomatic SARS-CoV-2 infection has been identified, other residents and personnel on the unit may have already been exposed or infected, and [additional testing may be needed](#).
- Facilities may determine that it is safer to maintain care of residents with COVID-19 on the memory unit with dedicated personnel.
- If residents with COVID-19 will be moved from the memory care unit
 - Provide information about the move to residents and be prepared to repeat that information as appropriate.
 - Prepare personnel on the receiving unit about the habits and schedule of the person with dementia and try to duplicate it as much as possible.
 - Move familiar objects into the space before introducing the new space to the resident. Familiar objects such as favorite decorations or pictures can help make the person feel more comfortable; this applies to their new surroundings as well if residents are moved to new spaces.