Policy for Emergent

Infectious Diseases

(COVID-19) **(Outbreak Plan)**

PURPOSE

To provide guidance to long term care providers on how to prepare for new or newly evolved Infectious diseases whose incidence in humans has increased or threatens to increase in the near future and that has the potential to pose a significant public health threat and danger of infection to the residents, families and staff of the skilled nursing center.

ASSUMPTIONS

This document contains general policy elements that are customizable depending on the specific care center demographics, location, and current disease threats. It is not comprehensive and does not constitute medical or legal advice.

Every disease is different. The local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing center response related to a specific disease threat.

This document contains recommendations that may not be applicable to all types of long- term care facilities. Modifications should be made based upon the regulatory requirements and the structure and staffing for the specific care setting.

GOAL

To protect our residents, families, and staff from harm resulting from exposure to an emergent infectious disease while they are in our care center.

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1. General Preparedness for Emergent Infectious Diseases (EID)

a. The care center's emergency operation program will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza. This plan will:
   i. build on the workplace practices described in the infection prevention and control policies
   ii. include administrative controls (screening, isolation, visitor policies and employee absentee plans
   iii. address environmental controls (isolation rooms, plastic barriers sanitation stations, and special areas for contaminated wastes)
   iv. Address human resource issues such as employee leave
   v. Be compatible with the care center's business continuity plan

b. Clinical leadership will be vigilant and stay informed about EIDs around the world. They will keep administrative leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.

c. As part of the emergency operations plan, the care center will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, foot and head coverings, surgical masks, assorted sizes of disposable N95 respirators, and gloves. The amount that is stockpiled will minimally be enough for several days of center-wide care but will be determined based on storage space and costs.

d. The care center will develop plans with their vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including an EID outbreak.

e. The care center will regularly train employees and practice the EID response plan through drills and exercises as part of the center's emergency preparedness training

2. Local Threat

a. Once notified by the public health authorities at either the federal, state and/or local level that the EID is likely to or already has spread to the care center's community, the care center will activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or the local public health authorities.

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b. The care center’s Infection Preventionist (IP) will research the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies.

c. Working with advice from the care center’s medical director or clinical consultant, Facility laboratory safety officer, human resource director, local and state public health authorities, and others as appropriate, the IP will review and revise internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.

d. Staff will be educated on the exposure risks, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand washing.

e. If EID is spreading through an airborne route, then the care center will activate its respiratory protection plan to ensure that employees who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.

f. Provide residents and families with education about the disease and the care center’s response strategy at a level appropriate to their interests and need for information.

g. Brief contractors and other relevant stakeholders on the care center's policies and procedures related to minimizing exposure risks to residents.

h. Post signs regarding hand sanitation and respiratory etiquette and/or other

prevention strategies relevant to the route of infection at the entry of the care center along will the instruction that anyone who sick must not enter the building.

i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the care center, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work. All administrative staff, including Director of Nursing, Administrator, the Infection Control Preventionist, Caregiver, Contractors,

Consultants, Volunteers, and visitors shall complete screening questionnaire and complete temperature checks prior to entrance of the facility.

j. Self-screening – Staff will be educated on the care center's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
   i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health.
   ii. Precautionary removal of employees who report an actual or suspected exposure to the EID.
   iii. Self-screening for symptoms prior to reporting to work.
   iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.

k. Self-isolation - in the event there are confirmed cases of the EID in the local community, the care center may consider closing the care center to new admissions, and limiting visitors based on the advice of local, state and federal public health authorities.

l. Environmental cleaning - the care center will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.

m. Engineering controls – The care center will utilize appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

n. When reporting please refer to: **(Exposure Reporting and Investigating Policy)**
   ExposureReportingInvestigating.pdf

3. Suspected case in the care center

a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation room and notify local public health authorities.

b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible.

c. If the suspected infectious person requires care while awaiting transfer, follow care center policies for isolation procedures, including all recommended PPE for staff at risk of exposure.

d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional “just in time” training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.

e. If feasible, ask the isolated person to wear a facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless it advised otherwise by public health authorities.

f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.

g. Implement the isolation protocol in the care center (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the care center’s infection prevention and control plan. Please refer to: (**Isolation Categories of Transmission Based Precautions Policy**)

IsolCategoriesTransBasedPrec.pdf and/or recommended by local, state, or federal public health authorities.

h. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC. Please refer to**: (Quarantine Policy)** Quarantine.pdf

4. Employer Considerations

a. Management will consider its requirements under OSHA, (Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the

residents and other employees shall be of paramount concern. Management shall take into account:

i. The degree of frailty of the residents in the care center.
ii. The likelihood of the infectious disease being transmitted to the residents and employees.
iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces)
iv. The precautions which can be taken to prevent the spread of the infectious disease and other relevant factors

b. Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.

c. Apply whatever action is taken uniformly to all staff in like circumstances.

d. Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.

e. Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.

f. Generally, accepted scientific procedures, whenever available, will be used to determine the level of risk posed by an employee.

g. Permit employees to use sick leave, vacation time, and FMLA where appropriate while they are out of work.

h. Permit employees to return to work when cleared by a licensed physician, however, additional precautions may be taken to protect the residents.

i. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline.

j. Please refer to notification for families in staff**: (Corona Virus Letter to Families) (Employee Information FAQ COVID-19)**

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5. Definitions

Emerging Infectious disease -- Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:

i. New infections resulting from changes or evolution of existing organisms.
ii. Known infections spreading to new geographic areas or populations.
iii. Previously unrecognized infections appearing in areas undergoing ecologic transformation.
iv. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

Pandemic -- A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

Isolation – Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease. Quarantine – Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

Cohorting – The practice of grouping patients who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other patients.

When cohorting residents the facility Shall identify a minimum of three cohort groups:

1. Individuals who are showing symptoms of COVID-19 or who have tested positive for COVID-19.
2. Individuals who have been exposed to someone who has tested positive for COVID-19 or has shown symptoms of COVID-19 (i.e.,

individuals who are not themselves symptomatic, but may potentially be incubating the virus); and

3. Individuals who are not ill and has not been exposed.
4. Facility shall assign dedicated staff to each cohort and allow for necessary space to do so at the onset of an outbreak.

6. Test Based Prevention Strategy (PPS) Point Prevalence Survey

Testing of Residents

1. If testing capacity allows, **facility-wide PPS of all residents** should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience from nursing homes with COVID-19 cases suggests that when residents with COVID-19 are identified, there are often asymptomatic residents with SARS-CoV-2 present as well.
2. PPS of all residents in the facility can identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility. If undertaking facility-wide PPS, facility leadership should be prepared for the potential to identify multiple asymptomatic residents with SARS-CoV-2 infection and make plans to cohort them.
3. If testing capacity is not sufficient for facility-wide PPS, performing PPS on **units with symptomatic residents** should be prioritized.

When testing capacity is available and facility spacing permits, patients/residents should be organized into the following **cohorts**:

a) Cohort 1 – COVID-19 Positive:

This cohort consists of both symptomatic and asymptomatic patients/residents who test positive for COVID-19, including any new or re-admissions. If feasible, care for COVID-19 positive patients/residents on a separate closed unit. Patients/residents who test positive for COVID-19 are known to shed virus, regardless of symptoms; therefore, all positive patients/residents would be placed in this positive cohort. This Cohort will be isolated for 10 days. Individuals who have cleared Transmission Based Precautions and it has been <3months after the date of symptoms onset or positive viral test (for asymptomatic) of prior infection can go to cohort 3.

b) Cohort 2 – COVID-19 Negative, Exposed:

This cohort consists of symptomatic and asymptomatic patients/residents who test negative for COVID-19 with an identified exposure to someone who was positive. **All symptomatic COVID-19 negative patients/residents should be considered exposed but should also be evaluated for other causes of their symptoms.** To the best of their ability, separate symptomatic and asymptomatic patients/residents, ideally having one group housed in private rooms. Even though symptomatic COVID-19 negative patients/ residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Asymptomatic patients/residents should be closely monitored for symptom development.

c) Cohort 3 – COVID-19 Negative, Not Exposed:

This cohort consists of patients/residents who test **negative for COVID-19 with no COVID-19 like symptoms and are thought to have no known exposures**. The index of suspicion for an exposure should be low, as COVID-19 has been seen to rapidly spread throughout the post-acute care setting. In situations of widespread COVID-19, all negative persons in a facility would be considered exposed. **Cohort 3 should only be created when the facility is relatively certain that patients/residents have been properly isolated from all COVID-19 positive and incubating patients/residents and staff.** Facilities may not be able to create this cohort.

d) Cohort 4 – New or Re-admissions:

This cohort consists of all persons from the community or other healthcare facilities whose COVID-19 status is unknown. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be compatible with COVID-19. **Testing at the end of this period could be considered to increase certainty that the person is not infected.**

- **If there are multiple cases on the wing/unit and when movement would otherwise introduce COVID- 19 to another occupied wing/unit, do not relocate them. Limit the movement of all patients/residents and staff in general.**

4. **Refusal of testing**- If a resident /patient refuses to undergo testing, then the LTC shall treat the individual as a Person Under Investigation, make a notion in the resident's chart, notify any authorized family members or legal representatives of this decision, and continue to check temperature on the resident at least twice per day. Onset of temperature or other symptoms consistent with COVID-19 require immediate cohorting in accordance with the plan. At any time, the resident may rescind their decision not to be tested.

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If testing capacity is not sufficient for unit-wide PPS, testing should be prioritized for **symptomatic residents and other high-risk residents**, such as those who are admitted from a hospital or other facility, roommates of symptomatic residents, or those who leave the facility regularly for dialysis or other services.

5. **Staff Refusal -**Please Note**: Work exclusion will be effective immediately** of staff who test positive for COVID-19 infection, **refuse to participate in COVID-19 testing**, or **refuse to authorize release of their testing results to the CTDOH via the LTC Facility,** until such time as such staff undergoes testing and the results of such testing are disclosed to the LTC.

Testing of nursing home HCP

1. If testing capacity allows, PPS of **all HCP** should be considered in Complete Care facilities with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well.
2. Baseline testing shall be completed by or before May 26,2020.
3. Testing will be completed in a cyclic approach separating staff into 3 populations and initiate testing and findings.
4. Testing Consent will be obtained from each employee.
5. Retesting of individuals who test negative at baseline withing 3-7 days after baseline testing: and
6. Further retesting in accordance with the CDC guidance, amended and supplemented. CDC recommends **HCP with COVID-19 be excluded from work** .
7. If a staff member test positive for COVID-19 (Symptomatic or Asymptomatic), Complete Care facilities may permit them to return to work subject to the CDC/CTDOH as follows:
8. All staff will complete Bi- weekly testing as long as Cali scores are >10.
9. Any staff member who missed weekly testing due to LOA, must be tested prior to returning to work.
10. Staff who tested positive will be excluded from work for 10days.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

1. ***Time-based strategy***. Exclude from work until:

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  - 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. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

2. ***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). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

- Complete Care facilities should continue to **assess the risk of exposed healthcare personnel to COVID-19** using the CTDOH Healthcare Personnel (HCP) Exposure to COVID-19 Case Risk Algorithm, which would include a 10-day furlough from work, while actively monitoring for symptoms.

- In facilities where staff attendance is strained by excessive callouts and furloughs, Complete Care facilities **may consider allowing asymptomatic HCP who have had a HIGH or MEDIUM risk exposure to a COVID-19 patient to continue to work provided the following**:
  1. HCP should **report temperature and absence of symptoms each day** prior to starting work (at least every 12 hours while at work) for the 10-day period after their exposure.
     - If HCP develop even **mild** symptoms consistent with COVID-19, they must **cease patient care activities**, **don a facemask (if not already wearing)** and **notify their supervisor or occupational health services** prior to leaving work.
  2. **HCP wears a facemask while at work for the same 10-day period.**
- **Asymptomatic HCP who tested positive for COVID-19** should continue home isolation for 10 days after their first positive COVID-19 test AND have had no subsequent symptoms. Out of an abundance of caution they should follow masking guidance below.
- **Symptomatic HCP who has tested positive for COVID-19** may return to work 10 days after symptoms first developed AND 24 hours (1 day) after fever has resolved without the use of fever-reducing medications with a significant improvement in symptoms (whichever period is longer). HCP who has tested positive for COVID-19 shall be:

1. Masked at work until symptoms have completely resolved or until 14 days after illness onset/positive test (whichever is longer).
2. Restricted from caring for severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset/positive test (whichever is longer).
3. Work exclusion will be implemented effective immediately of staff who test positive for COVID-19 infection, refuse to participate in COVID-19 testing, or refuse to authorize release of their testing results to the LTC, until such time as such staff undergoes testing and the results of such testing are disclosed to the LTC.

7. Contingency Staffing Capacity Strategies

Complete Care facilities will review and adjust staff schedules, hire additional HCP, and rotate HCP to positions that support patient care activities within Complete Care facilities. Additional guidance includes but is not limited to:

1. Cancel all non-essential procedures and visits.
2. Shift HCP who work in other areas to support patient care activities in the facility.
3. Complete Care facilities will need to ensure these HCP have received appropriate cross- training to work in these areas that are new to them.
4. Initiate Staff Communication meetings to attempt to address social factors in **(Staff Meetings/ Individual Meetings)** that might prevent HCP from reporting to work such as transportation or housing if HCP with vulnerable individuals.
5. Identify additional HCP to work in the facility via Agency Assistance.
6. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP assistance.
7. Request that HCP postpone elective time off from work where applicable.

8. Outdoor Facility Visitation

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As of June 21, 2020, by direction of the CT Department of Health, facilities may allow in-person visitation in a designated outdoor visitation space provided that the following safety, care and infection prevention and control measures are in place:

1. Starting on the effective date appointments may be scheduled.
2. A resident who is suspected (PUI) or confirmed to be infected with COVID-19 or quarantined for an exposure to a COVID-19 case CANNOT be visited except for an end-of-life situation. A resident who has been diagnosed with COVID-19 may be visited only after they have met the criteria for discontinuation of isolation as defined in guidance from CTDOH and CDC.
3. The facility is to honor the RESIDENT'S RIGHT to have and choose visitors and to MAKE PREFERENCES. The facility should CONSULT EVERY RESIDENT to determine who the resident would wish to visit in person. These consultations also serve as a personalized communication (document this in their record) with the resident to explain how visitation will work and what the resident can expect.
4. Clear communication of the visitation policy should be provided to residents, resident's visitors, staff, and others, as needed in writing, or via the methods the facility uses to convey information or policy changes. Consider providing these in various languages as determined by your resident and staff population.
5. A designated area for visitors to be screened that accommodates for social distancing and infection control standards will be provided and visitors will be directed to that area and provided guidelines upon check in. Signage will be provided to assist residents and family with social distance spacing. Visitors will not be allowed past the reception desk and will not be allowed to use facility rest rooms at this time. Visitors should receive information on the guidelines for proper hand hygiene when they register.
6. Special accommodations will be offered (if needed) to meet the mobility and other needs of visitors along with designating seating. Residents will be assisted with transportation and the use of any adaptive equipment needed for the visit.
7. Before the resident can be transported to the designated area, the visitors (no more than 2 per visit) will be screened for any infectious communicable diseases, including COVID-19 symptoms. Any visitors with suspected symptoms of infection or subjective/objective fever equal to or greater than 100.4 or with chills, cough, shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea, vomiting, or diarrhea will not be permitted to visit with a resident.
8. Transport of a resident to and from the designated area for visitation will remain safe and orderly. The resident will not be transported through any space designated as COVID-19 care space or space where residents suspected or confirmed to be infected with COVID-19 are present. Transport is to be done while keeping 6 feet distance between other residents and staff.
9. Staff member familiar with the resident and the protocol must always remain with the resident during the visit.
10. Each resident is limited to no more than two (2) visitors at a time. A visitor must always remain at least 6 feet from the resident and attending staff member(s) during the visit. Visitors should be encouraged to wait in their vehicle prior to visitation time. If using public transportation for

the visit, they should wait in an outdoor space that ensures at least six feet of social distancing space.

11. Staff are to wear surgical masks. Residents and visitors must wear a face covering or mask for the duration of the visit. Visits are scheduled in advance and dependent on permissible weather conditions, availability of outdoor space, and sufficient staffing at the facility to meet resident care needs, as well as the health and well-being of the resident. Facilities reserve the right to limit the length of any visit, the hours of the day and the number of times during a day or week a resident may be visited to be able to accommodate all requests.
12. Food is not permitted during the visits. Visitors may bring items to the resident, but items must be left at the reception area or other designated location. Visitors may bring their own water which cannot be shared with the resident. The facility will provide appropriate hydration for the resident during the visit.
13. At the conclusion of the visit the resident is to be transported back to their rooms by a facility staff member.
14. Staff member familiar with the resident and the protocol must always remain with the resident during the visit.
15. staffing at the facility to meet resident care needs, as well as the health and well-being of the resident. Facilities reserve the right to limit the length of any visit, the hours of the day and the number of times during a day or week a resident may be visited to be able to accommodate all requests.
16. The facility must receive informed consent for the visitor and resident in writing that they are aware of the possible dangers of exposure of COVID-19 for both the resident and the visitor and they are to follow the rules set by the facility in regard to the outdoor visitation. A signed statement from each visit and resident (or by their designee if they are unable to sign) with a copy given to the visitor and resident so they are aware of their risk of exposure to COVID-19 and they will strictly comply with the facility policies set forth for the outdoor visit. The visitor(s) also agree to notify the facility if they test positive for COVID-19 or exhibit symptoms of COVID-19 within fourteen (14) days of the visit.

Through this uncharted territory Complete Care has gain insight in serval areas. No nation, state, hospital system, LTC organization or single individual can foresee the challenges associated with a pandemic however, we can learn valuable information along the way from our response to, and experience with COVID-19. The lessons drawn from the Corona Virus remain a focus within the facility as follows:

1. Following the guidance of the healthcare experts such as the CDC, HHS, CTDOH and Local DOH.
2. Constant review and revision of Infection Control policies and procedures.
3. Continued education in Infection Control policies and procedures.
4. Importance of the Screening Process.
5. Importance of Testing and Continued Testing.
6. Continued Notification of Residents, Families and Staff on COVID-19 updates.
7. Hypervigilance of and oversight of the environment to search anything reminiscent of activity or threat of the spread of COVID-19.

10.Communication Strategy

Complete Care Utilizes the following alternatives to in-person visits:

Virtual Communication Coordinators provide alternative means of communication for all residents are available such as virtual communications (phone calls, video-communication, Facetime, Zoom Google Docs etc.).

Established email listserv communications to update families are currently utilized.

Information Officers serve as primary contact to families for inbound calls, and conducting regular outbound calls to keep families up to date and offers phone line with a voice recording (ROBO CALLS) updated at set times (e.g., daily) with the facility's general operating status. Complete Care updates the websites weekly : Updating the facility's website to share the status of the facility, and include information that helps families know what's happening in the loved one's environment, such as food menus and activities that residents can do while still practicing social distancing.

Complete care also through the Information Officer updates resident's, representatives, and families of residents by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

All staff testing must continue weekly until directed by DOH to do otherwise.
Staff who tested positive for COVID-19 three or more months ago **must** now be tested bi-weekly.

Residents who previously tested positive within three months **do not have to be tested unless they develop symptoms or have been exposed to a COVID-19 positive individual.**

Resources:

https://www.cdc.gov/ https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html