



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

Michigan.gov/Coronavirus

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

Updated August 6, 2020

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 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 High Priority in the [U.S. Public Health Services \(PHS\) Guidance](#).

High Priority:

- Hospitalized patients with symptoms.
- Any health care worker, first responder, or congregate care facility worker with symptoms.
- Residents in any congregate care facility, including prisons and shelters, with symptoms.

Priority:

- Persons with symptoms of potential COVID-19 infection, including:
 - Shortness of breath.
 - Muscle pain.
 - New loss of taste or smell.
 - Vomiting or diarrhea.
 - Sore throat.
- Asymptomatic patients in preparation for surgical procedures, as deemed necessary by the treating clinician.

- Asymptomatic people with known exposure to a person with COVID-19 or exposure to a person with COVID-19 symptoms.
- Asymptomatic people living or working in a congregate care facility or other high-risk setting (such as nursing home, jail, prison, homeless shelter, assisted living facility, etc.) that:
 - Had a confirmed case among residents or workers.
 - Is located in a region of medium risk or higher, or
 - Is receiving patients from an area of medium risk or higher.
- Asymptomatic people who work in a profession that puts them at high risk of exposure, including:
 - Repeated close contact of prolonged duration with the public.
 - Working in a high-risk profession where clusters of infections have been identified (such as migrant workers, food processing facilities, etc.).
 - Working in-person during a period of strict social distancing or, in areas with some sectors re-opening, having worked in-person during the period of strict social distancing.
- Persons identified by clinicians or public health officials who can be tested for public health monitoring research purposes.
- People without symptoms who live in communities where there has been inequitable access to testing and a need to increase the rate of people tested per day – such as areas with higher proportion of racial/ethnic minorities, rural communities.

Permissible:

- Persons without symptoms who are prioritized by local health departments or clinicians, for any reason.
- Asymptomatic people living or working in a congregate care facility or other high-risk setting (such as a nursing home, jail, prison, homeless shelter, assisted living facility) in any region.
- Asymptomatic people leaving their home for work.

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. Additionally, under [Medicaid Policy 20-17](#) all medically necessary diagnostic testing for the COVID-19 virus is a covered benefit for Medicaid.

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 symptoms of COVID-19 including:
 - Fever or chills
 - Cough
 - Shortness of breath or difficulty breathing
 - Fatigue
 - Muscle or body aches
 - Headache
 - New loss of taste or smell
 - Sore throat
 - Congestion or runny nose
 - Nausea or vomiting
 - Diarrhea
- Immediately isolate if symptomatic
- 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.
- If testing is available, asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for 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.
 - Weekly testing of residents and staff would be required until no additional cases are detected among residents or staff for at least 14 days since the most recent positive case.

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 on COVID-19 unit if available. If the long term care facility does not have a dedicated unit, it must attempt to transfer the resident to a regional hub, alternate care facility with capacity to care for the resident, or an available swing bed at a hospital. 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 isolated 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.
 - 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.

If you're unable to safely care for you residents using the above procedures, you may contact an MDHHS Designated Regional Hub to discuss the ability to transfer residents to the nearest regional hub.

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:

In the care of residents with COVID-19 or suspected COVID-19 when there is a shortage of N95 respirators (or equivalent or higher-level respirator), these respirators should be reserved for use during aerosol-generating procedures (Please see Table 2, below). Additionally, N95 respirators (or equivalent or higher-level respirator) should only be used in a setting where the facility has a respiratory protection program with trained, medically cleared, and fit-tested healthcare workers. When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with suspected or confirmed SARS-CoV-2 infection. Those that do not currently have a respiratory protection program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program.

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

Skilled Nursing Facility	N95 Respirator (or equivalent or higher-level respirator)	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)	Y	Y ^b	N	Y	Y	N	Y
Daily resident care (Standard Precautions)	Y	Y ^b	N	Y ^{c,d}	Y ^c	N	Y
Upon entering the facility	N	Y	Y	N	N	N	N

Assisted Living Facility	N95 Respirator (or equivalent or higher-level respirator)	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)	Y	Y ^b	N	Y	Y	N	Y
Daily resident care (Standard Precautions)	Y	Y ^b	N	Y ^{c,d}	Y ^c	N	Y ^e
Upon entering the facility	N	Y	Y	N	N	N	N

Notes:

^a Other respirators may include other disposable filtering facepiece respirators, powered air purifying respirators (PAPRs), or elastomeric respirators

^b If a respirator is not available

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

^d In facilities located in areas with moderate to substantial community transmission

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

Adult Foster Care	N95 Respirator (or equivalent or higher-level respirator)	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)	Y	Y ^b	N	Y	Y	N	Y
Daily resident care (Standard Precautions)	Y	Y ^b	N	Y ^{c,d}	Y ^c	N	Y ^e
Upon entering the facility	N	Y	Y	N	N	N	N

Independent Living Facility	N95 Respirator (or equivalent or higher-level respirator)	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)	Y	Y ^b	N	Y	Y	N	Y
Daily resident care (Standard Precautions)	Y	Y ^b	N	Y ^{c,d}	Y ^c	N	Y ^e
Upon entering the facility	N	Y	Y	N	N	N	N

Notes:

^a Other respirators may include other disposable filtering facepiece respirators, powered air purifying respirators (PAPRs), or elastomeric respirators

^b If a respirator is not available

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

^d In facilities located in areas with moderate to substantial community transmission

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

Home for the Aged	N95 Respirator (or equivalent or higher-level respirator)	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
COVID-19 Transmission-based precautions (Standard, Droplet, Contact)	Y	Y ^b	N	Y	Y	N	Y
Daily resident care (Standard Precautions)	Y	Y ^b	N	Y ^{c,d}	Y ^c	N	Y ^e
Upon entering the facility	N	Y	Y	N	N	N	N

Notes:

^a Other respirators may include other disposable filtering facepiece respirators, powered air purifying respirators (PAPRs), or elastomeric respirators

^b If a respirator is not available

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

^d In facilities located in areas with moderate to substantial community transmission

^e 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 (or equivalent or higher-level respirator) ^a	Surgical Mask	Cloth Face Covering	Eye Protection (Goggles or Face Shield)	Isolation Gown	Sterile Gloves	Gloves
Wound care	Y ^a	Y ^b	N	Y ^{c,d}	Y ^c	Y	Y
Tracheostomy care	Y ^a	Y ^b	N	Y ^{c,d}	Y ^c	N	Y
Feeding tube care (e.g., PEG, NG)	Y ^a	Y ^b	N	Y ^{c,d}	Y ^c	N	Y
Peripheral IV care	Y ^a	Y ^b	N	Y ^{c,d}	Y ^c	N	Y
Central venous catheter care (e.g., PICC, Dialysis port)	Y ^a	Y ^b	N	Y ^{c,d}	Y ^c	Y	Y
Urinary catheter care	Y ^a	Y ^b	N	Y ^{c,d}	Y ^c	N	Y
Colostomy care	Y ^a	Y ^b	N	Y ^{c,d}	Y ^c	N	Y
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	Y ^a	N	N	Y ^c	Y ^c	N	Y
High-flow O2 delivery	Y ^{a,e}	Y ^{b,e}	N	Y ^c	N	N	N
Nebulizer administration	Y ^{a,e,f}	Y ^{b,e,f}	N	Y ^c	Y ^c	N	Y

Notes:

^a Other respirators may include other disposable filtering facepiece respirators, powered air purifying respirators (PAPRs), or elastomeric respirators

^b If a respirator is not available

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

^d In facilities located in areas with moderate to substantial community transmission

^e Based on limited available data; it is possible that aerosols generated from these procedures may be infectious

^f 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. Several studies have demonstrated aerosol stability of SARS-CoV-2, but whether this is applicable to clinical situations outside of laboratory conditions is unknown. 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 equivalent 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>
5. Edelson et al. "Interim Guidance for Basic and Advanced Life Support in Adults, Children and Neonates With Suspected or Confirmed COVID-19." American Heart Association Circulation. 9 Apr 2020. <https://www.ahajournals.org/doi/pdf/10.1161/CIRCULATIONAHA.120.047463>
6. Harding et al. "Aerosol-generating procedures and infective risk to healthcare workers: SARS-CoV-2 – the limits of the evidence." J Hosp Infect. 2020 Jun 1:S0195-6701(20)30277-2. doi: 10.1016/j.jhin.2020.05.037. Epub ahead of print. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7263217/>