Preventing and Managing COVID-19 Outbreaks in Assisted Living Facilities and Skilled Nursing Facilities

Division of Public Health
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A. Outbreak Prevention in Assisted Living Facilities (ALF) and Skilled Nursing Facilities (SNF)

We advise reviewing this checklist even before your facility has an outbreak to plan for each management step and address potential issues in advance where possible. While this guide was developed for long-term care facilities (LTCFs) as part of the COVID-19 pandemic, many of the infection prevention principles in this guide remain applicable for other types of outbreaks. These COVID-19-specific recommendations should be considered until CDC indicates they are no longer needed or changes the guidance for health care settings.

Key factors to consider at all times that may prevent outbreaks include:

- **Educate and reinforce that all sick staff should stay home in accordance with facility employee health policies.** Health care personnel (HCP) should stay home when sick, including if they only have mild symptoms that would not normally cause them to miss work. “Presenteeism” is a risk for exposure and disease transmission.

- **All staff should wear procedure/surgical masks when in the building.** Eye protection is also recommended during resident care encounters in geographic areas with moderate to substantial community transmission. Cloth face coverings are not considered PPE and should not be used by HCP. Residents should wear a cloth face covering or facemask whenever they leave their room, including for procedures outside the facility, as well as when staff enter their rooms for resident care.

- **Assess all staff at the beginning of each shift for all symptoms consistent with COVID-19 and remind them to stay home if they are sick.** Monitoring and screening should be documented and those with symptoms should immediately be excluded from work and tested. In addition to screening, routine testing can also identify positive HCP. Fully vaccinated HCP may be exempt from expanded screening testing.

- **Actively monitor all residents upon admission and at least daily for all symptoms consistent with COVID-19.** Ideally, include an assessment of oxygen saturation via pulse oximetry. Monitoring and screening should be documented and those with symptoms should immediately be placed in transmission-based precautions and tested.

- **Protect residents through source control measures and hand hygiene practices.**
  - Source control and physical distancing (when physical distancing is feasible and will not interfere with the provision of care) are recommended for everyone in a health care setting. This is particularly important for
individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission. Extended use of facemasks can be considered to minimize the number of times staff touch their faces and risk self-contamination while wearing source control.

- Post signs at the entrance and in strategic places throughout the building with instructions on wearing a cloth face covering or facemask, and how and when to perform hand hygiene.
- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand sanitizer (ABHS) with 60-95% alcohol, tissues, and no-touch receptacles for disposal, in facility entrances and common areas.
- Residents should wear a mask when receiving care. Some resident populations (e.g., memory care) may be more challenging to maintain this. Residents should also wear a mask in common areas.
- Encourage frequent hand hygiene among all staff and residents.

**Evaluate environmental disinfecting products and procedures.**

- Frequently clean and disinfect all high-touch surfaces in common areas and resident rooms. Train all staff who perform any type of cleaning and disinfecting on the right techniques based on the products they will use. Non-housekeeping staff may be involved in cleaning and disinfecting as care is bundled and more frequent high-touch surface cleaning is needed.
- All disinfection products used in the facility should be listed on EPA’s List N to ensure their efficacy against SARS-CoV-2. Facilities may need to purchase new products due to supply shortages. Ensure all products used for disinfection are included on List N.
- Products should be used according to instructions on their label, including maintaining the required contact time. Contact time is the length of time the product must remain wet on the surface to disinfect. Some products may have an extended contact time (e.g., 10 minutes), which may be more challenging to properly use. It may be helpful in those circumstances to identify an alternative product with a short contact time if available. It may be helpful to maintain a list of all products used, along with their indications and wet times.
- All shared equipment should be cleaned and disinfected after each use according to the manufacturer’s instructions.

**Fit test staff who will have a need to wear N95s in preparation for suspected and confirmed COVID-19 cases.**

- Fit testing should be done for the specific brand of N95s in-house before use to check for an appropriate fit for each staff member so that the respirator can offer full protection. One important aspect to fit testing is the medical evaluation to determine if there are conditions that make wearing a respirator unsafe for individual staff, such as asthma. This step should not be skipped.
There may be shortages in fit testing supplies at this time, but you can explore local resources for qualified fit testers, including emergency management, your local health department, fire departments, manufacturers that use respirators, and hospitals. DHS also offers free fit testing kits on the [DHS Stockpile](https://dhs.stockpile.wi.gov) web page. Please indicate in your email to [dhsstockpile@dhs.wisconsin.gov](mailto:dhsstockpile@dhs.wisconsin.gov) that you are requesting a fit testing kit. Supplies are limited.

- DHS and the Wisconsin State Laboratory of Hygiene’s Occupational Health Division [WisCon team](https://wiscon.wisc.edu) also collaborated to offer a [pre-fit testing checklist](https://wiscon.wisc.edu) and [online tutorials](https://wiscon.wisc.edu) that walk through each aspect of building an OSHA-compliant Respiratory Protection Program with respirator fit testing to promote staff and resident safety. The WisCon team’s occupational safety and health consultants also offer individual consultation to facilities upon request.

✅ **Assess emergency plans for potential staffing shortages.**

- Facilities should anticipate staffing shortages when there is significant community transmission and have plans and processes in place to [mitigate staff shortages](https://wisconsin.gov). Staff who test positive for COVID-19 need to be restricted from work per [CDC infection prevention and control guidance](https://www.cdc.gov/coro.../).  

- Facilities should assess staffing needs and the minimum number of staff necessary to provide a safe work environment and resident care. Facilities should develop a contingency plan that will ensure minimum staffing is maintained and that resident needs are met. Consider contracting with staffing agencies, local hospitals, and clinics. Facilities can also cross-train staff so that they are able to work in multiple roles, adjust staff schedules, and address barriers and social factors that might prevent well staff from working (e.g., transportation). The [Wisconsin Emergency Assistance Volunteer Registry (WEAVR)](https://weavr.wisc.gov) program, an online registration system for Wisconsin health professional volunteers willing to serve in an emergency, may be another option. Additional details to prepare for staffing shortages and resource options are available on the DHS web pages ([SNF](https://dhs.stockpile.wi.gov), [ALF](https://dhs.stockpile.wi.gov)).

### B. Outbreak Identification and Management

Outbreak identification and management focuses on mitigation principles including isolation of suspected cases, contact tracing, quarantine of those exposed, and testing to rapidly identify additional cases, particularly those that may be asymptomatic. Infection prevention core elements, such as appropriate use of PPE, environmental cleaning and disinfection, staff and resident cohorting, and continued symptom monitoring are also instrumental in limiting spread and containing an outbreak.

**How is a suspected COVID-19 respiratory disease outbreak defined in a long-term care facility?**
According to DHS guidance, an outbreak of COVID-19 is defined as one or more confirmed case of COVID-19 among residents OR one or more confirmed case among staff who worked during their infectious period within a long-term care facility. The infectious period look-back for staff working in the facility is two days prior to onset of symptoms or, if asymptomatic, two days prior to collection of a positive test. Those positive cases may be the result of residents/staff developing symptoms that lead to testing, staff tested through routine testing, staff testing in the community, or residents/staff tested as part of ongoing outbreak testing. Residents who are known to have COVID-19 on admission and were placed into the appropriate transmission-based precautions to prevent transmission to others in the facility do not initiate an outbreak. Also, residents who were placed into transmission-based precautions on admission and developed SARS-CoV-2 infection within 14 days after admission do not count as nursing home-onset and do not initiate an outbreak.

What should happen when a resident or staff member develops symptoms compatible with COVID-19?

- Regardless of vaccination status, residents who develop COVID-19 symptoms should be tested and preemptively quarantined in their room while awaiting results. These residents should not be moved to a COVID unit or a new admission/readmission quarantine unit until and unless they test positive for COVID-19 (including a confirmatory test if applicable), or they could be unnecessarily exposed.
- Regardless of vaccination status, staff who develop symptoms should be tested and preemptively excluded from work while awaiting results. Point-of-care antigen tests can be used to test symptomatic residents and staff for faster results. Interpretation of those results and the need for confirmatory testing is covered in the next section.
- Facilities should also remain vigilant for other communicable disease outbreaks, including, but not limited to:
  - Suspected non-COVID-19 respiratory disease outbreaks, defined as having three or more residents and/or staff from the same unit with illness onset within 72 hours of each other who have pneumonia, acute respiratory infections, or laboratory-confirmed viral or bacterial infections, including influenza.
  - Suspected acute gastroenteritis (AGE) outbreaks, defined as when three or more residents and/or staff experience AGE symptoms (e.g., vomiting, diarrhea) within a 72-hour period and have a geographic commonality (e.g., same wing, unit, floor).

Does a positive result from all types of COVID-19 tests immediately trigger an outbreak?
In alignment with the CDC antigen testing algorithm and DHS HAN 17:
• If the positive result is from a PCR test, proceed with the management steps below.
• If the positive result is from an antigen test and the individual was symptomatic, proceed with the management steps below.
• If the positive result is from an antigen test, and the individual was asymptomatic, collect another test (preferably a PCR) within 48 hours to confirm the result. Isolate the resident or exclude the staff member from work until the confirmatory test results are known.
  o If the second test is positive, proceed with the management steps below.
  o If the second test is negative, the first antigen test is considered a false positive and the isolation/exclusion for this individual can be ended. This situation would not trigger or extend an outbreak. If this situation occurs during an existing outbreak, outbreak testing would continue as previously indicated. Resident close contacts who are not vaccinated would continue to quarantine for the 14 days, and staff would return to work per a risk assessment or guidance provided in HAN 22 for early return to work in staffing shortage situations.

Conducting additional confirmatory testing beyond what is advised in the CDC antigen testing guidance and HAN 17 is not recommended and may lead to conflicting and confusing results.

What steps do I need to take when a case of COVID-19 is suspected or confirmed in a staff person, resident, or individual who provides services at my facility?

1. Immediately isolate individuals with suspected or confirmed COVID-19 and quarantine residents and staff who were possibly exposed.
   • Both symptomatic and asymptomatic staff with confirmed COVID-19 should be excluded from work until they have met the CDC return to work criteria. Most often this will be:
     o At least 10 days since the onset of symptoms, or since receipt of a positive test result for individuals who remain asymptomatic, AND
     o At least 24 hours since resolution of fever without the use of fever-reducing medication, AND
     o Symptoms have improved.
   • Staff with close contact exposure to someone with COVID-19 should be excluded from work whenever possible. Fully vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure. Testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure.
   • In times of crisis-level staffing shortages, facilities may need to consider making exceptions to this policy to maintain the safety of residents. A risk assessment
should be done and all other staffing mitigation strategies explored before pursuing this. If a decision is made to have these asymptomatic, exposed staff work before the end of their quarantine period, facilities should follow the guidance in HAN 22.

- Use CDC’s guidance for workplace, travel, and community exposures to determine possible contacts. Workplace exposures are determined based on the type of PPE worn, procedures conducted, whether the resident wore a cloth face covering or facemask, and length of time individuals were in contact. Community exposures include being within six feet of an individual with COVID-19 for 15 minutes or more within a 24-hour period.
- **Per CDC**, if a household member of a staff person is diagnosed with COVID-19, that staff person should be quarantined and excluded from work.
- If staff work at more than one facility, all of their workplaces should be notified in the event the staff person is diagnosed or exposed to COVID-19 to determine whether an outbreak investigation is warranted.
- Residents who test positive for COVID-19 should be isolated from other residents and either placed in a COVID unit or in a single room with physical distancing from other resident rooms (e.g., barriers, end of a hallway). Clearly mark any isolation rooms with signage and PPE requirements.
- Residents with pending test results should be placed in a single room and kept on transmission-based precautions until the diagnosis is confirmed. Residents with pending tests should not be placed on a COVID-19 unit until there is a positive result, including a positive confirmatory result for antigen tests that require one. Placing residents on a COVID-19 unit prior to confirmation of positive status could potentially expose them to COVID-19.

2. **Contact your local health department** (LHD) when a case of COVID-19 is suspected or confirmed in anyone who works, resides, or provides services in your facility. Indicate whether the positive result was from an antigen or PCR test. Your LHD may be able to assist you with next steps regarding quarantining staff and residents with possible exposures, continuing symptom monitoring of all staff and residents, performing outbreak testing, and other recommendations. The LHD will report the outbreak into WEDSS for DHS awareness.

3. **Notify resident families of positive cases and restrict non-essential visitors to the affected unit per your facility policy or requirements.** Note that compassionate care visits and visits required under federal disability rights law should be allowed at all times for any resident.
   - **SNFs:** CMS provides requirements for outdoor and indoor visitation with a preference toward outdoor visitation when possible.
   - **ALFs:** Follow current DHS visitation guidance, which includes similar accommodations for visitation. DHS offers safer visitation guidance for facilities to assist with interpretation of this guidance. These visits incorporate visitor
education and infection prevention recommendations and should be in alignment with the latest CDC guidance.

- Any units that are currently conducting outbreak testing or have identified new resident cases or positive staff who worked during their infectious period within the past 14 days should review visitation options based on guidance. Any residents in quarantine or transmission-based precautions should not receive in-person visitors and should instead have virtual visitation options facilitated.

4. **Order COVID-19 testing supplies for outbreak testing.**
   - DHS prioritizes testing supplies for facilities experiencing outbreaks. Once you have confirmed with your LHD that your facility is experiencing an outbreak, you can order molecular testing supplies (i.e., PCR) through the DHS website. When completing the testing supply request form, indicate this is part of outbreak testing. Supplies will be made available to test residents and staff on a weekly basis for the duration of the outbreak.
   - All SNFs and ALFs should plan to test all residents and staff, regardless of vaccination status, to establish the extent of the outbreak. Outbreak testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure. If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered. It may take several days to receive supplies, so order them as soon as possible.

5. **Implement outbreak testing procedures for residents and staff.**
   - **Skilled Nursing Facilities:** Per CMS testing requirements, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure. If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.
     - Note: The frequency of routine unvaccinated staff testing should continue based on the community transmission level.
     - For facility outbreaks all residents and staff should follow outbreak testing guidance. If it is too difficult to maintain two different testing frequencies (for example, twice a week for unvaccinated staff and once per week for residents and vaccinated staff), the facility should implement twice per week outbreak testing to simultaneously meet both the requirement for routine staff testing and outbreak testing for residents and vaccinated staff.
   - **Assisted Living Facilities:** Per the DHS ALF testing framework, outbreak testing will be supported by the State. An initial round of testing should be completed
for all residents and staff to establish the scope of the asymptomatic positive population in the facility.

6. **Provide appropriate PPE for staff.**
   - Care for COVID-19 positive residents with standard and transmission-based precautions, including:
     - Fit-tested N95 (equivalent or higher-level respirator)
     - Eye protection (i.e., goggles or a face shield that covers the front and sides of the face)
     - Gloves
     - Gown
   - Facilities should ensure adherence to appropriate infection prevention and control (IPC) measures in outbreak settings, including use of transmission-based precautions for the care of all exposed unvaccinated residents (even those who have negative tests) on affected units (or facility-wide, if cases are widespread).
   - Ensure staff know the proper donning and doffing procedures for the type of PPE currently in stock and needed for their job duties.
   - Operate within conventional PPE capacity whenever possible. Assess PPE use with the CDC burn rate calculator and use CDC optimization strategies as needed even before shortages occur, trying to stay in the conventional PPE use category as long and as often as possible. Extended use of PPE is only one part of the optimization strategies; also consider bundling resident care activities to preserve PPE supplies.

   - Notify, and maintain communication with, your LHD and your county emergency manager if you are having PPE supply shortages. They may be able to assist with supply procurement.

7. **Monitor PPE, disinfectants, and other supplies daily during the outbreak response.**
   While facilities should always be proactively managing PPE and disinfection supplies, utilization will likely be higher during an outbreak response.

8. **When possible, cohort staff working with COVID-19 positive residents and on units where the index case was identified.**
   Avoid having staff care for COVID-19 positive residents on one shift and then negative residents on the next day. It is best to have staff dedicated to caring for negative or positive residents. Similarly, any staff who worked on the unit where the index case was identified should not work in other units, which could expose additional units. New staff
should not work on the affected unit unless resident care will suffer without the addition of float staff. Grouping residents and staff into dedicated units (e.g., COVID-19 positive, quarantine) are also ways to optimize PPE through extended use in alignment with CDC contingency and crisis capacity strategies.

9. Work through the facility’s emergency plans to address any staffing shortages.
Facilities should put their emergency staffing plans into action as necessary to maintain resident and staff safety and explore the CDC staffing shortage mitigation strategies. If all staffing alternatives in the plan are exhausted, the facility may explore returning asymptomatic quarantined staff to work as noted in HAN 22. As a last resort, facilities (SNF, ALF) can evaluate their ability to meet the conditions for bringing asymptomatic positive COVID-19 staff back to work early to care for residents on a COVID-19 unit. This includes only allowing these staff to work on a COVID wing, having sufficient PPE and separate physical spaces like restrooms and break rooms to prevent transmission, enforcing facemask use by these staff at all times, and monitoring symptoms to isolate staff who develop symptoms immediately.

10. Continue to screen all staff and residents through symptom monitoring.
Immediately test any resident or staff who develops symptoms. Symptomatic individual antigen testing does not need a follow up test for confirmation. Notify the LHD of additional positives. Re-evaluate additional contacts and the need to quarantine other residents or staff, going back up to step 1.

C. Frequently Asked Questions (FAQs)
Additional FAQs are available on the DHS website.

How long will my facility remain in outbreak status?
Outbreak investigations are officially considered closed by a LHD when two incubation periods (i.e., 28 days for COVID-19) have passed since the last possible exposure to a COVID-19 case in the facility without any new cases. SNFs will be listed on the DHS website as having an open investigation until the outbreak is considered closed in WEDSS.

Can we admit new residents during an outbreak?
CDC’s LTC-focused infection prevention guidance has a section covering new admissions and readmission considerations. DPH also offers additional guidance on admissions and readmissions during respiratory outbreaks in its “Prevention and Control of Acute Respiratory Illness Outbreaks in Long-Term Care Facilities” memo.

There are no specific restrictions on taking admissions from certain settings as long as the receiving facility is open to admissions and can accommodate the care needed. For example, COVID positive residents still on transmission-based precautions ideally should be admitted to a LTCF COVID unit. Those who have recovered and are no longer in transmission-based...
precautions can be admitted to a regular unit since they are in their 90-day post-infection period.

Asymptomatic, fully vaccinated residents and residents within 90 days of a SARS-CoV-2 infection being admitted or readmitted without known close contact exposures do not need to be put into a 14-day quarantine. Unvaccinated residents admitted or readmitted should be in a 14-day quarantine, even if they have a negative test upon admission.

Are visitors allowed in my facility during an outbreak?

- Skilled nursing facilities should follow guidance from CMS about visitation and assisted living facilities should reference the DHS safer visitation guidance.
- Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility.
- Whether unvaccinated residents are known to be close contacts or are identified as a part of a broad-based outbreak response but not known to be close contacts, indoor visitation should ideally occur only in the resident’s room, the resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible).
- Source control and physical distancing recommendations should also be followed for vaccinated residents.
- Outdoor visitation could be allowed, but residents should wear well-fitting source control (if tolerated), maintain physical distancing from others, and not linger in common spaces when moving from their rooms to the outdoors.

Are we in an outbreak if an asymptomatic staff member tests positive by an antigen test but negative on PCR?

If the positive result is from an antigen test, and the individual was asymptomatic, collect another test (preferably a PCR) within 48 hours to confirm the result. Isolate the resident or exclude the staff member from work until the confirmatory test results are known. If the second test is positive, proceed with outbreak management. If the second test is negative, the first antigen test is considered a false positive and the isolation/exclusion for this individual can be ended. This situation would not trigger a new outbreak.

Can we just have our asymptomatic positive staff work with our positive residents?

See the prevention section on page 2 and outbreak management step 7 above for strategies to have asymptomatic positive staff return to work. Mitigation strategies to address staffing shortages should be exhausted before planning to have asymptomatic positive staff return to work prior to meeting CDC return to work criteria. Facilities should refer to the DHS guidance by setting (SNF, ALF) for the process steps to allow asymptomatic staff to return to work on COVID-19 units.
D. Contacts for Questions Related to Your Outbreak

- Local health departments
- Regulatory questions (e.g., staffing crises, admissions, transfers, discharges): Reach out to your DQA BNHRC or BAL regional office
- Infection prevention-specific questions (e.g., PPE use; COVID-focused, educational, infection control assessments (ICARs); NHSN reporting): WIDHSHAIPreventionProgram@dhs.wisconsin.gov
- Testing supplies: WICOVIDTest@WI.gov
- Other DQA COVID-19 questions: DHSDQACOVID19@dhs.wisconsin.gov
- HAN message archives: https://www.dhs.wisconsin.gov/covid-19/han.htm