

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



**WISCONSIN DEPARTMENT**  
*of* **HEALTH SERVICES**

Division of Public Health  
P-02897 (01/2021)

## **Table of Contents**

<b>A. Outbreak Prevention in Assisted Living Facilities and Skilled Nursing Facilities ..</b>	<b>1</b>
<b>B. Outbreak Identification and Management.....</b>	<b>3</b>
<b>C. Frequently Asked Questions.....</b>	<b>8</b>
<b>D. Contacts for Questions Related to Your Outbreak .....</b>	<b>10</b>

## 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.

### 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 workers 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](#) due to the high levels of [community activity](#) across Wisconsin. Cloth face coverings are not considered PPE and should not be used by health care workers. 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.
- ✓ **Actively monitor 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 quarantined, excluded from work, and tested.
- ✓ **Actively monitor all residents upon admission and at least daily for [all symptoms consistent with COVID-19](#).** Monitoring and screening should be documented and those with symptoms should immediately be quarantined and tested.
- ✓ **Protect residents through [source control measures](#) and [hand hygiene](#) practices.**
  - Staff should wear a facemask at all times when in the building including in breakrooms or other spaces they may be in close contact with co-workers as a means of source control. [Extended use](#) of the facemask can be considered to minimize the number of times staff touch their faces and risk self-contamination.
  - 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 or when in common areas. Some resident populations (e.g., [memory care](#)) may be more challenging to maintain this.
  - 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 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 it can protect them as long as used correctly. 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 and the Wisconsin State Laboratory of Hygiene's Occupational Health Division [WisCon team](#) also collaborated to offer a [pre-fit testing checklist](#) and [online tutorials](#) 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](#). Staff who test positive for COVID-19 need to be restricted from work per DHS Return to Work Guidance ([SNF](#), [ALF](#)).
  - 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 \(WEAVR\)](#) program, an online registration system for Wisconsin health professional volunteers willing to serve in an emergency, may be another option.

## **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 residents and/or staff (who worked during their infectious period) within a long-term care facility who have a case of COVID-19. 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, or residents/staff tested as part of ongoing outbreak testing.

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

- 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 they test positive for COVID-19 (including a confirmatory test if applicable) or they could be unnecessarily exposed.
- Staff who develop symptoms should be tested and preemptively excluded 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 [suspected non-COVID-19 respiratory disease outbreaks](#), defined as having three or more residents/staff from the same unit with illness onsets within 72 hours of each other who have pneumonia, acute respiratory infections, or laboratory-confirmed viral or bacterial infections, including influenza.

## 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.
  - **If the second test is positive**, proceed with the management steps below.
  - **If the second test is negative**, the first 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 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:
  - At least 10 days since the onset of symptoms, or since receipt of a positive test result for individuals who remain asymptomatic, AND
  - At least 24 hours since resolution of fever without the use of fever-reducing medication, AND
  - Symptoms have improved.
- Staff who have been [close contact exposures](#) to someone with COVID-19 should be excluded from work whenever possible. 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, 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
- Staff are discouraged from working at more than one LTCF, due to the potential to expose multiple facilities. If staff do 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 standard, contact, and droplet 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 exposes them.

**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.**

- **SNFs:** [CMS](#) provides requirements for outdoor and indoor visitation with a preference toward outdoor visitation when possible. Facilities that identified new COVID-19 cases in the last 14 days or are in the process of conducting outbreak testing should not hold indoor visitation, but exceptions may be made for compassionate care situations. Indoor visitation options are also affected by the [county positivity rate](#) that determines routine staff testing frequency.
- **ALFs:** Follow [current DHS visitation guidance](#), which includes restricting all non-essential visitors in facilities experiencing outbreaks except for compassionate care situations. DHS offers [safer visitation guidance](#) for facilities with no known or suspected COVID-19 cases. 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 limit visitation to compassionate care reasons. Any residents in 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 within 3-5 days from the initial positive case notification to identify the extent of the outbreak. 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](#), test all staff and residents after identifying a positive case in the facility and continue to test all negative staff and residents every 3-7 days until at least 14 days pass since the last identified positive. **Note:** If your facility has a red county/"high" county positivity rate percentage per [CMS](#) and are required to conduct twice weekly routine staff testing, continue to test all staff twice a week and test all residents once per week.
- **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. The state will provide weekly testing supplies until at least 14 days pass since the last identified positive.

**6. Provide [appropriate PPE for staff.](#)**

- **Care for COVID-19 positive residents with standard and transmission-based precautions**, including:
  - Fit-tested N95 or higher-level respirator (or facemask if a respirator is not available or fit-tested)
  - Eye protection (i.e., goggles or a face shield that covers the front and sides of the face)
  - Gloves
  - Gown
- Due to the higher risk of unrecognized infection among residents, universal use of [all recommended PPE](#) for the care of all residents on the affected unit(s) is recommended by [CDC](#) when even a single case among residents or staff is newly identified in the facility. This could also be considered when there is sustained transmission in the community due to the risk of unknown asymptomatic positives from community exposure.
- Ensure staff know 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.

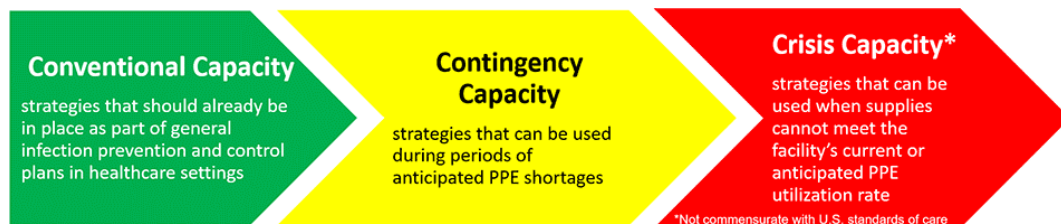
**7. Monitor PPE, disinfectants, and other supplies daily during the outbreak response.**

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 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 patient 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. 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, nor will PCR testing. 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

### **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.

There are criteria within the [DPH outbreaks memo](#) and companion considerations for admissions during outbreaks guidance that allow [ALFs](#) and [SNFs](#) to open to admissions before the two incubation periods have passed. [CMS](#) indicates that indoor visitation should be suspended until there is no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing (i.e., testing every 3-7 days until at least 14 days pass since identifying the last positive).

### **What if we keep finding staff cases and are not able to go 14 days without identifying a positive?**

Community-level activity will certainly affect the identification of LTCF staff positive cases and may lead to longer-term outbreaks. If a positive staff member only works on one unit, other units can qualify to open to admissions, creating a rotation of available units for admissions even as new staff positives are identified and thought to be connected to community, rather than facility, spread. Facilities should refer to the considerations for admissions during outbreaks guidance that allows [ALFs](#) and [SNFs](#) to determine if individual factors are present that could support earlier admissions during an outbreak.

### **Can we admit new residents during an outbreak?**

The [DPH outbreaks memo](#) allows facilities to open to admissions and pre-outbreak activity levels in units that did not identify any resident or staff cases during a round of facility-wide testing to establish the extent of the outbreak. Testing and contact tracing in combination are the only way to fully understand the extent of the outbreak and protect residents and other staff from further exposure.

For outbreaks that were triggered by staff in non-direct resident care roles, admissions may continue once contact tracing establishes that no direct patient contacts were identified. Outbreak-affected units can admit residents as soon as 14 days pass since the last positive was identified, unless as part of the outbreak response the LHD and facility agree that conditions in the jurisdiction or facility require a faster path to new admissions. DPH released one-page

checklists that walk through considerations facilities ([SNF](#), [ALF](#)) should have when deciding to admit new residents during an outbreak.

If the affected unit is the previously designated quarantine unit for new admissions or readmissions, facilities can designate another quarantine area in a non-affected unit or could initiate a room-based quarantine, rather than designating a whole unit. Facilities should cohort staff caring for those new quarantine rooms and try to have them in a physical space (e.g., at the end of the hallway) that would limit exposure to others on the unit. Resident readmissions can be made to the facility, but those residents should be placed in a 14-day quarantine. That can happen in a designated quarantine unit or in a single room.

The goal is to balance safety with access, so if there are difficulties discharging people to LTCFs in the local area due to outbreak admission restrictions, the LHD or Healthcare Emergency Readiness Coalition (HERC) Region Coordinators could help identify LTCFs better able to accept admissions early based on staffing and supply levels. This exception does not require all LTCFs in a region to be in outbreak status. There is no intention that residents will be placed in other regions of the state or other states, which would place a burden on the emotional well-being of residents and their families.

Facilities can consider newly admitting known COVID-19 positive residents to their COVID-19 units even when there is an established COVID-19 outbreak in the facility as long as the additional residents do not create a staffing or space burden on the facility that compromises resident care and outbreak response. This should be done in consultation with the LHD when possible. Facilities should use the [ALF](#) and [SNF](#) considerations checklists to guide their decision and notification processes.

### **Are visitors allowed in my facility during an outbreak?**

- **Skilled Nursing Facilities:** Per [CMS](#), facilities that identified new COVID-19 cases in the last 14 days or are in the process of conducting outbreak testing should not hold indoor visitation. Unaffected units could consider outdoor visitation as long as it aligns with CMS requirements.
- **Assisted Living Facilities:** Follow [current DHS visitation guidance](#), which includes restricting all non-essential visitors in facilities experiencing outbreaks except for compassionate care situations.
- 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 limit visitation. Any residents in transmission-based precautions should not receive in-person visitors and should instead have virtual visitation options facilitated.

### **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 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](mailto:WIDHSHAIPreventionProgram@dhs.wisconsin.gov)
- Testing supplies: [WICOVIDTest@WI.gov](mailto:WICOVIDTest@WI.gov)
- Other DQA COVID-19 questions: [DHSDQACOV19@dhs.wisconsin.gov](mailto:DHSDQACOV19@dhs.wisconsin.gov)
- HAN message archives: <https://www.dhs.wisconsin.gov/covid-19/han.htm>