Nursing Facility (NF) COVID-19 Frequently Asked Questions

Updated: October 27, 2021

On March 13, 2020, Governor Greg Abbott declared a state of disaster for all counties in Texas due to the COVID-19 pandemic and directed state agencies to restrict visitation at nursing facilities (NFs) to protect those most vulnerable to COVID-19. In addition, the Centers for Medicare and Medicaid Services (CMS) directed all NFs to restrict visitation and allow access only to staff or other individuals providing critical services.

The Texas Health and Human Services Commission (HHSC) is committed to sharing pertinent COVID-19 information with all NFs via a regularly updated Frequently Asked Questions (FAQs) document.

With each update, information in this FAQ document will be arranged by topic, and if guidance changes from previous FAQs, it will be noted in red font. Questions regarding these FAQs can be directed to Long-term Care Regulatory Policy and Rules at LTCRPolicy@hhs.texas.gov.

The frequently asked questions document now includes a table of contents to make it easier to use. Just click on a topic or question to automatically be redirected to a specific place on the page.

These frequently asked questions are published to offer providers resources to consult when they are making decisions. They are guidance, recommendations, and best practices that LTC Regulation has collected for the convenience of the providers, to assist in decision making related to the health and safety of residents during this unprecedented time.

As the information in this document is subject to change, please continue to check the CDC website and DSHS website for the latest updates and information regarding COVID-19.

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Reporting

I'm required to submit COVID-19 death report data to the National Healthcare Safety Network system. Do I still have to submit COVID-19 and non-COVID-19 death reporting data to HHSC?

Yes. NFs are required to submit death reports to HHSC within ten working days after the last day of the month via TULIP. NFs must report all deaths that occur within the facility and those that occur within 24 hours after transferring a resident to a hospital from the NF. NFs can be cited for failing to submit timely and accurate death report information to HHSC.

See PL 20-08, PL 20-37, THSC §260A.016, §554.606 and §554.1010 for details.

If a facility is having trouble registering or submitting data to the National Healthcare Safety Network (NHSN) system, will there be any extensions on the deadlines to submit our reports? We have heard that some facilities have been cited for failure to submit their data.

Questions about the reporting requirements should be directed to NH_COVID_Data@cms.hhs.gov**.**

Questions about the NHSN system and enrollment should be directed to NHSN@cdc.gov

In addition, the following information can assist providers with challenges they have with COVID-19 reporting to NHSN:

1. The first step is enrolling your facility in National Healthcare Safety Network (NHSN) https://www.cdc.gov/nhsn/ltc/covid19/enroll.html
    a. Here is slide set for enrolling in NHSN: https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/covid19-enroll-508.pdf
2. Next, review the COVID-19 module overview presentation: https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/ltcf-covid19-module-508.pdf
3. Utilize the NHSN forms to gather data to be entered into NHSN
    a. Resident Impact and Facility Capacity: https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/57.144-res-blank-p.pdf
    b. Staff and Personnel Impact: https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/57.145-staff-blank- p.pdf
    c. Supplies and Personal Protective Equipment: https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/57.146-supp-blank- p.pdf

d. Ventilator Capacity and Supplies: https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/57.147-vent-blank-p.pdf

For additional resources, visit the CDC NHSN LTCF COVID-19 website: https://www.cdc.gov/nhsn/ltc/covid19/index.html

What can we expect as a facility after we make a report of a staff or resident that has tested positive for COVID-19? What kind of public resource response can we anticipate? Will HHSC or DSHS or local health department come to the facility to assist?

The response will depend on the level of COVID-19 event a facility is experiencing or whether the facility requests assistance. The facility must report every confirmed case of COVID-19 to their local health department (LHD), or DSHS in jurisdictions where there is no LHD.

If you suspect your facility is experiencing an outbreak of COVID-19, immediately notify your local health department by phone. You can find contact information for your local/regional health department here: https://www.dshs.state.tx.us/rls/localservices/default.shtm?terms=local%20health%20entities Work with your local health department to complete the COVID-19 case report form if and when necessary.

HHSC will serve as the lead state agency in the state's response to an LTC COVID-19 event. HHSC actions may include:

- Development of testing recommendations, in consultation with DSHS
- Ensuring appropriate/assistance with resident movement
- Providing subject matter experts (SME): LTC, HAI, epidemiology
- Coordination of HHSC, DSHS, emergency management and local actions

In addition to the activities above, HHSC coordinates the formation of a Texas COVID-19 Assistance Team – LTC (TCAT-LTC). This team will include representatives from HHSC, DSHS, local health department (as applicable) and emergency management (as applicable.) This team will assist facilities with management of a COVID-19 event through provision of SMEs, resource request management, and support to facility actions through initial response activities. The TCAT-LTC will remain available for a maximum of 48 hours from activation. State and local entities will provide SMEs and continued assistance after TCAT- LTC deactivation.

See COVID-19 Response for Long-term Care Facilities for more information.

Do NFs need to report to HHSC when there is a case of COVID-19 in the facility?

Yes. NFs must report the first confirmed case of COVID-19 in staff or residents, as well as the first confirmed case of COVID-19 after a facility has been without new

cases for 14 days or more. to HHSC as a self-reported incident within 24 hours of the confirmed positive result.

The reports should include all information a facility would include in any self-reported incident. The 3613-A should also be completed and submitted within five days from the day a confirmed case is reported to CII. The provider investigation report can be submitted:

- via TULIP
- by email at ciiprovider@hhsc.state.tx.us
- by fax at 877-438-5827 See PL 20-37

Cohorting / Resident COVID-19 Status

Which residents are considered to have "unknown COVID-19 status"?

UPDATED 7/19/21: Unknown COVID-19 Status: the status of a resident, except as provided by the CDC for fully-vaccinated residents or residents who have recovered from COVID-19, who is a:

- New admission
- Readmission
- Resident who has spent one or more nights away from the facility
- Resident who has known exposure or close contact with a person who is COVID-19 positive
- Resident who is exhibiting symptoms of COVID-19 while awaiting test results

Which residents can be cohorted?

Nursing facility residents need to be cohorted with residents who have the same COVID-19 status. Facilities should be prepared to have three categories of residents for cohorting purposes:

- Residents without COVID-19 (confirmed negative, recovered, and meet all CDC criteria to discontinue transmission-based precautions, not showing symptoms)
- Residents with confirmed cases of COVID-19
- Residents with unknown COVID-19 status and possible cases of COVID-19 or awaiting test results

If a resident is in a quarantine period and then gets a new roommate, does the first resident's quarantine period start over when the new roommate is admitted?

No. Residents who are in the 14-day quarantine and monitoring period do not have to start the quarantine and monitoring time over if a roommate with unknown COVID-19 status is brought in at a later date, unless the roommate later tests positive for COVID-19. If either resident later tests positive, the 14- day quarantine and monitoring period starts again the day of the diagnosis.

While the CDC still endorses a 14-day quarantine period, it now offers two alternatives and guidance to reduce quarantine timeframes. Local public health authorities make the final decisions about how long quarantine should last, based on local conditions and needs, and providers must follow such decisions. However, in the absence of stricter local quarantine requirements, CDC's two alternatives are:

- Alternative #1 - Quarantine can end *after* day 10 without testing if the person has no symptoms as determined by daily monitoring.
- Alternative #2 - Quarantine can end *after* day 7 if the person tests negative and has no symptoms as determined by daily monitoring. The test must occur on day 5 or later. Quarantine cannot be discontinued earlier than after day 7.

CDC guidance includes the following information:

- Persons can discontinue quarantine at either alternative described above only if the following criteria are also met:
  - No COVID-19 symptoms were detected in the persons by daily symptom monitoring during the entirety of the quarantine, including up to the time at which quarantine is discontinued;
  - Daily symptom monitoring continues through day 14; and
  - Persons are counseled about the need to adhere strictly through day 14 to all mitigation strategies, such as wearing a mask, avoiding crowds, practicing physical distancing, and practicing hand and cough hygiene. Individuals should be advised that if any symptoms develop, they must immediately self-isolate and contact their health care provider to report this change in clinical status.
  - If a nursing facility chooses one of the shortened quarantine options and a resident develops symptoms at any time within 14 days after the quarantine begins, the facility must isolate the resident and report the change in clinical status to the resident's attending physician.
- Testing under alternative #2 above should be considered only if it will have no impact on community diagnostic testing. Testing of persons seeking evaluation for an actual infection must be prioritized.

Persons can continue to be quarantined for 14 days without testing, per existing recommendations. This option is maximally effective.

If a resident leaves the facility for a medically necessary appointment and returns the same day, is the resident considered to have unknown COVID-19 status, and do the resident need to be quarantined?

No. Residents who leave the facility for medically necessary appointments and return the same day are not considered to have unknown COVID-19 status. Rather, their COVID-19 status is the same as it was when the resident left the facility for their appointment, and they can return to their assigned room. These residents should wear face coverings, as tolerated, while out of the facility.

Can testing be used to verify COVID-19 status and decrease the number of days a resident is required to be quarantined and monitored?

All residents who have unknown COVID-19 status must be quarantined and monitored in accordance with CDC guidance.

While the CDC still endorses a 14-day quarantine period, it now offers two alternatives and guidance to reduce quarantine timeframes. Local public health authorities make the final decisions about how long quarantine should last, based on local conditions and needs, and providers must follow such decisions. However, in the absence of stricter local quarantine requirements, CDC's two alternatives are:

- Alternative #1 - Quarantine can end *after* day 10 without testing if the person has no symptoms as determined by daily monitoring.
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  - No COVID-19 symptoms were detected in the persons by daily symptom monitoring during the entirety of the quarantine, including up to the time at which quarantine is discontinued;
  - Daily symptom monitoring continues through day 14; and
  - Persons are counseled about the need to adhere strictly through day 14 to all mitigation strategies, such as wearing a mask, avoiding crowds, practicing physical distancing, and practicing hand and cough hygiene. Individuals should be advised that if any symptoms develop, they must immediately self-isolate and contact their health care provider to report this change in clinical status.
  - If a nursing facility chooses one of the shortened quarantine options and the resident develops symptoms at any time within 14 days after the quarantine begins, the facility must isolate the resident and report the change in clinical status to the resident's attending physician.
- Testing under alternative #2 above should be considered only if it will have no impact on community diagnostic testing. Testing of persons seeking evaluation for an actual infection must be prioritized.

Persons can continue to be quarantined for 14 days without testing, per existing recommendations. This option is maximally effective.

UPDATED 3/23/21: Quarantine and fully-vaccinated residents

The following recommendations are based on what is known about currently available COVID-19 vaccines. Please continue to check the CDC's Infection Control after Vaccination for the latest updates to these recommendations.

Fully-vaccinated refers to a person who is:

- At least two weeks following receipt of the second dose in a two-dose COVID-19 vaccine series, or at least two weeks following receipt of one dose of a single-dose COVID-19 vaccine.

Prolonged close contact refers to contact within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period.

For asymptomatic residents:

- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility, such as a nursing facility, if they are fully-vaccinated and have **not** had prolonged close contact with someone with a COVID-19 infection in the prior 14 days. This includes new admissions, readmissions, and a resident who was gone overnight – as long as the resident did not have prolonged close contact with someone with a COVID-19 infection.
- **UPDATED 10/27/2021**: Asymptomatic residents who have had prolonged close contact with someone with COVID-19 infection, regardless of vaccination status, should have a series of two viral tests for COVID-19 infection (immediately after exposure, but not earlier than 2 days after exposure AND 5-7 days after exposure) unless they have recovered from COVID-19 within the last 90 days. If they have recovered from COVID-19 in the last 90 days and remain asymptomatic, they do not need to be tested even if they had close contact.
- **UPDATED 10/27/2021**: Quarantine is no longer recommended for fully vaccinated residents following prolonged close contact with someone with a COVID-19 infection. Fully vaccinated, asymptomatic residents and asymptomatic residents who have recovered from COVID-19 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with COVID-19 infection, unless they develop symptoms of COVID-19, are diagnosed with COVID-19 infection, or the facility is directed to do so by the local public health authority.
    - There may be circumstances when quarantine for these residents might be recommended, e.g., when the resident is moderately to severely immunocompromised, if the initial diagnosis of COVID-19 infection might have been based on a false positive test result. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to quarantine for fully vaccinated residents on affected units and work restriction of fully vaccinated HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public health authority recommends these and additional precautions. See the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for more information.

Fully-vaccinated people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they

should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.

Unvaccinated residents who have had close contact with someone with COVID-19 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).

Although not preferred for healthcare settings, options for shortening quarantine are available.

Is there a statewide prohibition for new admissions if a facility has a positive case?

No. While local orders related to NF admissions might apply in parts of the state, there is not a statewide or federally mandated prohibition on new admissions for facilities that have COVID-19 cases. Facilities should continue to admit anyone they would normally admit but with all appropriate precautions.

If a resident is admitted from the hospital and is designated as having "unknown COVID-19 status," are they allowed to go to therapy?

Yes. The resident can go to therapy. The NF should have a plan to ensure the resident does not have contact with COVID-19 positive or COVID-19 negative residents; the resident should wear a facemask or face covering as tolerated, in accordance with CDC guidance, while out of the bedroom; and infection control measures should be followed to disinfect the therapy room and all equipment before and after each use.

Can newly admitted residents who are asymptomatic be tested for COVID-19 instead of having to be in quarantine for 14 days?

In general, unvaccinated new admissions, readmissions, and other residents with unknown COVID-19 status must remain in quarantine and be monitored for signs and symptoms of COVID-19 in accordance with CDC guidance.

While the CDC still endorses a 14-day quarantine period, it now offers two alternatives and guidance to reduce quarantine timeframes. Local public health authorities make the final decisions about how long quarantine should last, based on local conditions and needs, and providers should follow such decisions. However, in the absence of stricter local quarantine requirements, CDC's two alternatives are:

- Alternative #1 - Quarantine can end *after* day 10 without testing if the person has no symptoms as determined by daily monitoring.
- Alternative #2 - Quarantine can end *after* day 7 if the person tests negative and has no symptoms as determined by daily monitoring. The test must occur on day 5 or later. Quarantine cannot be discontinued earlier than after day 7.

CDC guidance includes the following information:

- Persons can discontinue quarantine at either alternative described above only if the following criteria are also met:
  - No COVID-19 symptoms were detected in the persons by daily symptom monitoring during the entirety of the quarantine, including up to the time at which quarantine is discontinued;
  - Daily symptom monitoring continues through day 14; and
  - Persons are counseled about the need to adhere strictly through day 14 to all mitigation strategies, such as wearing a mask, avoiding crowds, practicing physical distancing, and practicing hand and cough hygiene. Individuals should be advised that if any symptoms develop, they must immediately self-isolate and contact their health care provider to report this change in clinical status.
  - If a nursing facility chooses one of the shortened quarantine options and the resident develops symptoms at any time within 14 days after the quarantine begins, the facility must isolate the resident and report the change in clinical status to the resident's attending physician.
- Testing under alternative #2 above should be considered only if it will have no impact on community diagnostic testing. Testing of persons seeking evaluation for an actual infection must be prioritized.

Persons can continue to be quarantined for 14 days without testing, per existing recommendations. This option is maximally effective.

UPDATED 3/23/21: Quarantine and Fully-vaccinated Residents

The following recommendations are based on what is known about currently available COVID-19 vaccines. Please continue to check the CDC's Infection Control after Vaccination for the latest updates to these recommendations.

Fully-vaccinated refers to a person who is:

- At least two weeks following receipt of the second dose in a two-dose COVID-19 vaccine series, or at least two weeks following receipt of one dose of a single-dose COVID-19 vaccine.

Prolonged close contact refers to contact within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period.

For asymptomatic residents:

- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility, such as a nursing facility, if they are fully-vaccinated and have **not** had prolonged close contact with someone with a COVID-19 infection in the prior 14 days. This includes new admissions, readmissions, and a resident who was gone overnight – as long as the resident did not have prolonged close contact with someone with a COVID-19 infection.
- **UPDATED 10/27/2021**: Asymptomatic residents who have had prolonged close contact with someone with COVID-19 infection, regardless of vaccination status, should have a series of two viral tests for COVID-19 infection (immediately after exposure, but not earlier than 2 days after exposure, AND 5-

7 days after exposure), unless they have recovered from COVID-19 within the last 90 days. If they have recovered from COVID-19 in the last 90 days and remain asymptomatic, they do not need to be tested even if they had close contact.

- **UPDATED 10/27/2021**: Quarantine is no longer recommended for fully vaccinated residents following prolonged close contact with someone with a COVID-19 infection. Fully vaccinated, asymptomatic residents and asymptomatic residents who have recovered from COVID-19 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with COVID-19 infection, unless they develop symptoms of COVID-19, are diagnosed with COVID-19 infection, or the facility is directed to do so by the local public health authority.
    - There may be circumstances when quarantine for these residents might be recommended, e.g., resident is moderately to severely immunocompromised, if the initial diagnosis of COVID-19 infection might have been based on a false positive test result. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated residents on affected units and work restriction of fully vaccinated HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public health authority recommends these and additional precautions. See the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for more information.

Fully-vaccinated people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.

UPDATED 10/27/2021: Unvaccinated residents who have had close contact with someone with COVID-19 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).

Although not preferred for healthcare settings, options for shortening quarantine are available.

What are the risks of the two alternatives for a shortened quarantine?

Alternative #1 - Quarantine can end *after* day 10 without testing if the person has no symptoms as determined by daily monitoring.

Alternative #2 - Quarantine can end *after* day 7 if the person tests negative and has no symptoms as determined by daily monitoring. The test must occur on day 5 or later. Quarantine cannot be discontinued earlier than after day 7.

Both alternatives raise the risk of being less effective than the 14-day quarantine currently recommended. The specific risks are as follows, per the CDC:

- For alternative #1, the residual post-quarantine transmission risk is estimated to be about 1 percent, with an upper limit of about 10 percent.
- For alternative #2, the residual post-quarantine transmission risk is estimated to be about 5 percent, with an upper limit of about 12 percent.

For residents who are newly admitted or readmitted and are quarantined for 14 days, are they considered to be suspected of having COVID-19 and treated as positive, even if they have no signs or symptoms, and do staff have to wear an N95 mask?

A newly admitted or readmitted resident is not automatically considered suspected of having COVID-19 and treated as positive. Residents who are in 14-day quarantine because they are newly admitted or readmitted to the NF are considered to have "unknown" COVID-19 status. DSHS describes "unknown COVID-19 status" as people who have not yet been diagnosed with COVID-19 but might have been exposed, especially during times of localized or widespread COVID-19 transmission within the facility or community from where the resident is transferring and could therefore be within the incubation phase of the infection. Because there is the potential for COVID-19 infection, a NF should follow many of the same infection prevention and control protocols as caring for a resident who has signs and symptoms of infection. Staff providing care to residents with unknown COVID-19 status should wear all CDC recommended PPE, including N95s (or facemasks for droplet protection if N95s are not available), eye protection, gloves and gowns.

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Fully-vaccinated refers to a person who is:

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For asymptomatic residents:

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    - There may be circumstances when quarantine for these residents might be recommended, e.g., resident is moderately to severely immunocompromised, if the initial diagnosis of COVID-19 infection might have been based on a false positive test result. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated residents on affected units and work restriction of fully vaccinated HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public health authority recommends these and additional precautions. See the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for more information.

Fully-vaccinated people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.

UPDATED 10/27/2021: Unvaccinated residents who have had close contact with someone with COVID-19 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).

Although not preferred for healthcare settings, options for shortening quarantine are available.

If a resident receives dialysis or regular eye injections outside the facility, should they be quarantined for 14 days after each visit?

UDPATED 3/23/21: A resident who has frequent medical appointments outside of the facility, such as dialysis or regular eye injections, does not have to be in indefinite quarantine. A resident can go to their routine appointment, return the same day and be considered to have the same COVID-19 status as when they left earlier that day as long as they did not have prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with a COVID-19 infection. If they had a negative status when they left the facility, they do NOT need to be quarantined upon return. All infection control protocols should be followed, including:

- hand hygiene
- cough and sneeze etiquette
- wearing of a facemask or face covering, in accordance with CDC guidance
- physical distancing, in accordance with CDC guidance

Those with an unknown status who attend regular medical appointments should remain in quarantine for 14 days from the date of admission, readmission, return to the facility, or prolonged close contact, and then return to the negative or cold zone at the end of their quarantine period. Providers should not base the quarantine period on a rolling 14 days every time a resident leaves the facility for a medical appointment. Those with a positive status will return to isolation in the hot zone until they meet the criteria for the discontinuation of transmission based precautions, when they can then move to the negative or cold zone.

If a resident has recovered from COVID-19 and is still within 90 days of illness onset, is he or she required to quarantine upon return to the facility?

If a resident recently tested positive for COVID-19 and has met the criteria for the discontinuation of transmission-based precautions, the resident does not need to be quarantined upon readmission to the facility for the remainder of this 90-day period, as long as the resident remains asymptomatic.

HHSC and DSHS recommend that all residents who are positive for COVID-19 stay in isolation until they meet the criteria for the discontinuation of transmission-based precautions. These criteria indicate that at least 10 days must pass before an individual can stop self-isolation. Individuals with persistent symptoms, special health conditions, or immunocompromised status might need a longer isolation period than the 10-day minimum.

The CDC now indicates that people who have tested positive for COVID-19 and recovered by meeting the criteria for the discontinuation of transmission based precautions do not need to quarantine or get tested again for up to 90 days, *as long as they remain asymptomatic*. The resident can return to the non-quarantine

area of the facility (e.g., cold zone or COVID-19 negative cohort area) upon admission, readmission, or return to the facility.

The facility still needs to consider what additional precautions it needs to take for such residents, such as whether staff will wear full PPE when caring for individuals who have recently recovered from COVID-19. The facility also can quarantine these individuals out of an abundance of caution if it has reasonable health and safety concerns. Additionally, as the individual approaches 90 days since illness onset, the facility should also consider recent actions or interactions of the individual, such as participation in high-risk activities or contact with persons who are confirmed or suspected of having COVID-19. This will help the facility determine the need for quarantine, as the 90-day timeframe is not an absolute guarantee against transmission and long-term care residents are a high-risk population.

UPDATED 7/19/21: Additional considerations for those who are within the 90-day post recovery period: There may be scenarios where there is uncertainty about prior infection or immune response. Providers may consider testing for COVID-19 and quarantine following exposure that occurs less than 90 days after initial infection in the following situations:

- Residents with underlying immunocompromising conditions (e.g. organ transplantation, recipients of chemotherapy)
- Residents for whom there is concern that the initial diagnosis of COVID-19 may have been a false positive
- Residents for whom there is evidence that they were exposed to a novel variant of COVID-19

At this time, the CDC cannot say for certain that there is no chance of reinfection in the 90-day post recovery period. However, the CDC maintains that the risk of transmission in recovered persons is outweighed by the personal and societal benefits of avoiding unnecessary quarantine.

If a recovered individual experiences COVID-19 symptoms at any point during the 90-day post recovery period, he or she would need to be tested, quarantined, or isolated, depending on the test result, as well as evaluated by an attending physician to determine whether it is a case of reinfection with COVID-19 or another illness.

Please see the CDC's When to Quarantine and Reinfection for more information.

Additional information from the CDC's Discontinuation of Transmission Based Precautions:

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions.

Residents with *mild to moderate* illness who are not severely immunocompromised:

1. At least 10 days have passed *since symptoms first appeared;* **and**
2. At least 24 hours have passed *since last* fever without the use of fever-reducing medications; **and**
3. Symptoms (e.g., cough, shortness of breath) have improved

Note: For residents who are **not severely immunocompromised** and who were **asymptomatic** throughout their infection, Transmission-Based Precautions can be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Residents with *severe to critical illness* or who are severely immunocompromised:

1. At least 10 days and up to 20 days have passed *since symptoms first appeared;* **and**
2. At least 24 hours have passed *since last* fever without the use of fever-reducing medications; **and**
3. Symptoms (e.g., cough, shortness of breath) have improved
4. Consider consultation with infection control experts

Note: For **severely immunocompromised** residents who were **asymptomatic** throughout their infection, Transmission-Based Precautions can be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

It has taken my facility more than 14 days to receive test results. How do I treat that resident and those around them?

Because a resident with unknown COVID-19 status should have been in quarantine pending the result of the test and might have recovered, receiving a positive result 14 days after the test was taken decreases the utility of that result.

For a person whose test comes back positive: whether a staff member or resident, the facility must ensure that person has met the criteria to discontinue isolation. The CDC criteria to discontinue transmission-based precautions or return to work criteria can be symptom-based (i.e., 10 days since symptom onset AND at least 72 hours of no fever/improving symptoms) or test-based (i.e., at least two subsequent negative PCR tests). If the person was asymptomatic for the entire duration, they can use a time-based strategy (i.e., 10 days from the time of the positive test) to end their isolation period.

Any positive result reflects possible transmission within the facility and should prompt repeat testing at the facility. Facilities should work with their local health authorities to develop a plan for retesting.

Per CDC, the test-based strategy is no longer recommended in the majority of cases because it may result in prolonged isolation, as many individuals will continue to shed the virus, but are no longer infectious. A test-based strategy could be considered for some individuals (e.g., those who are severely immunocompromised) in consultation with a local infectious disease expert, if concerns exist for the individual being infectious for more than 20 days.

Can NF residents go outdoors on facility property (to the gazebo or within the fenced area of the property, for example) so long as there are 10 people or fewer?

UPDATED 10/27/2021: Quality of life should be balanced with risks of transmission when considering group activities. The facility should also consider the level of COVID-19 transmission in the community where they are located. To determine the level of COVID-19 transmission in the community where a healthcare facility is located, visit the CDC's COVID-19 Data Tracker. If the two indicators suggest different transmission levels, the higher transmission level is used.

Group activities may be considered for residents who do not have suspected or confirmed COVID-19, including those who have fully recovered and residents who have not had close contact with a person with COVID-19.

Source control and physical distancing are recommended for everyone in a healthcare setting. This is especially important for those who live in counties with substantial to high community transmission or who:

- have not been fully vaccinated;
- have suspected or confirmed COVID-19 infection or other respiratory infection;
- had close contact with someone with COVID-19 infection;
- are moderately to severely immunocompromised; or
- have otherwise had source control and physical distancing recommended by public health authorities

For nursing facilities in areas of low to moderate COVID-19 transmission, if all residents participating in the activity are fully vaccinated against COVID-19, then they may choose to have close contact and to not wear source control (face mask or face covering) during the activity. However, residents at increased risk for severe disease should still consider continuing to practice physical distancing and use source control.

If unvaccinated residents are present, then all participants in the group activity should wear source control and unvaccinated residents should physically distance at least 6 feet from others, per CMS and CDC.

For residents with COVID-19 positive status and residents with unknown COVID- 19 status, per CMS guidance, all group activities should be cancelled. Residents with a positive COVID-19 status require isolation until they meet the criteria to discontinue transmission-based precautions. Residents with an unknown COVID-19 status must quarantine per CDC guidance. Meals can be served in the dining room for residents who require assistance with feeding if physical distancing is practiced.

See the CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination, Infection Control for Nursing Facilities, NF Response Plan and QSO 20-39 for more information.

Can we have group games for residents if the residents are more than 6 feet apart in NFs?

UPDATED 10/27/2021: Quality of life should be balanced with risks of transmission when considering group activities. The facility should also consider the level of COVID-19 transmission in the community where they are located. To determine the level of COVID-19 transmission in the community where a healthcare facility is located, visit the CDC's COVID-19 Data Tracker. If the two indicators suggest different transmission levels, the higher transmission level is used.

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- had close contact with someone with COVID-19 infection; or
- are moderately to severely immunocompromised; or
- otherwise had source control and physical distancing recommended by public health authorities

For nursing facilities in areas of low to moderate COVID-19 transmission, if all residents participating in the activity are fully vaccinated against COVID-19, then they may choose to have close contact and to not wear source control (face mask or face covering) during the activity. However, residents at increased risk for severe disease should still consider continuing to practice physical distancing and use source control.

If unvaccinated residents are present, then all participants in the group activity should wear source control and unvaccinated residents should physically distance at least 6 feet from others, per CMS and CDC.

For residents with COVID-19 positive status and residents with unknown COVID- 19 status, per CMS guidance, all group activities should be cancelled. Residents with a positive COVID-19 status require isolation until they meet the criteria to discontinue transmission-based precautions. Residents with an unknown COVID-19 status must quarantine per CDC guidance. Meals can be served in the dining room for residents who require assistance with feeding if physical distancing is practiced.

See the CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination, Infection Control for Nursing Facilities, NF Response Plan and QSO 20-39 for more information.

Do NFs need to call ahead to the hospital if the facility is transferring a resident with respiratory symptoms?

Yes. NFs should work closely with local hospitals and health authorities to share all information needed to protect residents, health care workers, and hospital residents.

Should a NF readmit a resident who has been hospitalized when the resident is released from the hospital?

Yes. A NF should readmit a resident after hospitalization. If the resident was diagnosed with COVID-19, the individual should be admitted under transmission-based precautions for COVID-19. If a NF is unable to comply with the requirements for transmission-based precautions, readmission must wait until transmission-based precautions can be discontinued. CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory- confirmed COVID-19.

Note: Per CMS guidance, NFs should admit any individual they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, the NF should dedicate a unit/wing exclusively for any residents coming in or returning from the hospital. This can serve as a step-down unit where a resident should remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room).

Should NF residents be confined to their rooms?

If a resident is under transmission-based precautions, the individual should be confined to his or her room. CMS has also directed the following:

Implement active, daily screening of residents and staff for fever and respiratory symptoms. Remind residents to practice physical distancing and perform frequent hand hygiene.

See CMS QSO-20-14-NH and CMS SOM Appendix PP, F880.

If a resident has suspected or confirmed COVID-19, must the door to their room be kept shut?

UPDATED 7/19/21: In general, it is recommended that the door to a resident's room remain closed to reduce the transmission of COVID-19, per the CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. This is especially important for residents with suspected or confirmed COVID-19 infection being cared for outside of the COVID-19 care unit.

However, keeping doors closed is not required in rule and residents have the right to keep their door open. Furthermore, there may be specific circumstances, such as a resident on a memory care unit, where keeping the door closed may pose a safety risk to the resident. If doors must remain open, the CDC recommends that

the facility work with facility engineers to implement strategies to minimize airflow from the resident's room into the hallway.

If a resident is admitted from the hospital after recovering from COVID-19 per the CDC symptom-based recovery requirements, will the resident still be considered to be "unknown COVID-19 status"? Will that resident need to be placed into a 14-day quarantine?

In general, any newly admitted or readmitted resident must quarantine per CDC guidance. There are exceptions for asymptomatic residents who are fully vaccinated against COVID-19 and residents who have recovered from COVID-19 within the last 90 days. Under the emergency mitigation rule, "a person who is a new admission, readmission, or has spent one or more nights away from the facility…must be quarantined and monitored for fever and symptoms of COVID-19, per CDC Guidance." Current CDC guidance is for newly admitted unvaccinated residents and residents who have NOT recovered from COVID-19 in the last 90 days to quarantine.

The CDC now indicates that people who have tested positive for COVID-19 and recovered by meeting the criteria for the discontinuation of transmission based precautions do not need to quarantine or get tested again for up to 90 days, as long as they remain asymptomatic. The resident can return to the non-quarantine area of the facility (e.g., cold zone or COVID-19 negative cohort area) upon admission, readmission, or return to the facility.

HHSC and DSHS recommend that all residents who are positive for COVID-19 stay in isolation until they meet the criteria for the discontinuation of transmission-based precautions. These criteria indicate that at least 10 days must pass before an individual can stop self-isolation. Individuals with persistent symptoms, special health conditions, or immunocompromised status might need a longer isolation period than the 10-day minimum.

The facility still needs to consider what additional precautions it needs to take for such residents, such as whether staff will wear full PPE when caring for individuals who have recently recovered from COVID-19. The facility can quarantine these individuals out of an abundance of caution if it has reasonable health and safety concerns. Additionally, as the individual approaches 90 days since illness onset, the facility should also consider recent actions or interactions of the individual, such as participation in high-risk activities or contact with persons who are confirmed or suspected of having COVID-19. This will help the facility determine the need for quarantine, as the 90-day timeframe is not an absolute guarantee against transmission and long-term care residents are a high-risk population.

UPDATED 7/19/21: Additional considerations for those who are within the 90-day post recovery period: There may be scenarios where there is uncertainty about prior infection or immune response. Providers may consider testing for COVID-19 and quarantine following exposure that occurs less than 90 days after initial infection in the following situations:

- Residents with underlying immunocompromising conditions (e.g. organ transplantation, recipients of chemotherapy)
- Residents for whom there is concern that the initial diagnosis of COVID-19 may have been a false positive
- Residents for whom there is evidence that they were exposed to a novel variant of COVID-19

At this time, the CDC cannot say for certain that there is no chance of reinfection in the 90-day post recovery period. However, the CDC maintains that the risk of transmission in recovered persons is outweighed by the personal and societal benefits of avoiding unnecessary quarantine.

If a recovered individual experiences COVID-19 symptoms at any point during the 90-day post recovery period, he or she would need to be tested, quarantined, or isolated, depending on the test result, as well as evaluated by an attending physician to determine whether it is a case of reinfection with COVID-19 or another illness.

Please see the CDC's When to Quarantine and Reinfection for more information.

How often do residents need to be screened for signs and symptoms of COVID-19?

UPDATED 7/19/21: At least once a day, the facility must screen each resident for the following:

- fever, defined as a temperature of 100.4 degrees Fahrenheit and above;
- signs or symptoms of COVID-19, including 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, or diarrhea;
- any other signs and symptoms as outlined by CDC in Symptoms of Coronavirus at cdc.gov; and
- contact in the last 14 days with someone who has a confirmed diagnosis of COVID-19, is under investigation for COVID-19, or is ill with a respiratory illness.

Residents who are newly admitted or readmitted must also be screened for any positive COVID-19 test results from a test performed in the last 10 days.

Do fully-vaccinated residents still need to quarantine after exposure to COVID-19? Or on admission, readmission, return to a facility?

UPDATED 3/23/21: Quarantine and Fully-vaccinated Residents

The following recommendations are based on what is known about currently available COVID-19 vaccines. Please continue to check the CDC's Infection Control after Vaccination for the latest updates to these recommendations.

Fully-vaccinated refers to a person who is:

- At least two weeks following receipt of the second dose in a two-dose COVID-19 vaccine series, or at least two weeks following receipt of one dose of a single-dose COVID-19 vaccine.

Prolonged close contact refers to contact within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period.

For asymptomatic residents:

- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility, such as a nursing facility, if they are fully-vaccinated and have **not** had prolonged close contact with someone with a COVID-19 infection in the prior 14 days. This includes new admissions, readmissions, and a resident who was gone overnight – as long as the resident did not have prolonged close contact with someone with a COVID-19 infection.
- **UPDATED 10/27/2021**: Asymptomatic residents who have had prolonged close contact with someone with COVID-19 infection, regardless of vaccination status, should have a series of two viral tests for COVID-19 infection (immediately after exposure, but not earlier than 2 days after exposure, AND 5-7 days after exposure), unless they have recovered from COVID-19 within the last 90 days. If they have recovered from COVID-19 in the last 90 days and remain asymptomatic, they do not need to be tested even if they had close contact.
- **UPDATED 10/27/2021**: Quarantine is no longer recommended for fully vaccinated residents following prolonged close contact with someone with a COVID-19 infection. Fully vaccinated, asymptomatic residents and asymptomatic residents who have recovered from COVID-19 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with COVID-19 infection, unless they develop symptoms of COVID-19, are diagnosed with COVID-19 infection, or the facility is directed to do so by the local public health authority.
    - There may be circumstances when quarantine for these residents might be recommended, e.g., resident is moderately to severely immunocompromised, if the initial diagnosis of COVID-19 infection might have been based on a false positive test result. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated residents on affected units and work restriction of fully vaccinated HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public health authority recommends these and additional precautions. See the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for more information.

Fully-vaccinated people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.

UPDATED 10/27/2021: Unvaccinated residents who have had close contact with someone with COVID-19 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).

Although not preferred for healthcare settings, options for shortening quarantine are available.

How do we handle outbreak testing for residents?

UPDATED 10/27/2021: CMS updated QSO 20-38 on September 10, 2021. This document contains new information on testing. For outbreak testing, facilities now have the option to perform outbreak testing based on **contact tracing** or perform **broad-based testing**. Facilities must consider the extent of the outbreak, whether they can identify close contacts, and other factors. They should also continue to work with their local health department on the outbreak testing process.

For contact tracing:

If the facility can perform contact tracing, they need to test all close contacts of the individual with COVID-19. CDC defines close contact as someone who was within 6 feet of an infected person (laboratory-confirmed or a clinically compatible illness) for a cumulative total of 15 minutes or more over a 24-hour period (for example, *three individual 5-minute exposures for a total of 15 minutes).* The facility may also consider testing the entire affected unit. If additional cases are revealed, the facility needs to continue the contract tracing process.

For broad-based testing:

If the facility cannot do contact tracing, they can test at a group level (unit, floor, specific area) or facility wide. Facility-wide testing is no longer *required* for all residents and all staff in the case of an outbreak. However, facility-wide testing is still an option if the facility cannot perform contact tracing, if indicated by the local health department (LHD), if there are too numerous contacts to manage, or if contact tracing fails to stop transmission. This decision making should take into account guidance from the local health authority, the extent of outbreak, and whether new cases have been identified during the contact tracing and testing process.

Please see Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC and QSO 20-38 Revised for more detailed information.

Personal Protective Equipment (PPE)

What PPE should be used by staff caring for residents with unknown COVID- 19 status?

Staff caring for residents with unknown COVID-19 status should wear all CDC recommended PPE (N95s or equivalent respirator approved by FDA, eye protection (goggles or face shield), gloves and gowns – facemasks for droplet protection can be used if N95s or equivalent are not available).

Do fully-vaccinated staff still have to wear PPE?

UPDATED 3/23/21: Recommendations for the use of PPE by HCP remain unchanged. There are some exceptions for fully vaccinated staff in certain scenarios. Staff caring for residents with positive or unknown COVID-19 status should wear the following PPE during the provision of care:

- N95 or medical (surgical or procedural) facemask if a N95 respirator is not available
- eye protection- goggles or face shield
- gloves
- isolation gown

The minimum required PPE when caring for residents with a negative COVID-19 status in the cold zone is a medical (surgical or procedural) face mask.

UPDATED 7/19/21: While Executive Order (EO) GA 36 prohibits governmental entities, including HHSC, from mandating the use of masks, CMS requires any nursing facility (NF) that is Medicaid or Medicare certified to adhere to certain requirements. CMS requires all NFs to have an infection prevention and control program, which adheres to national standards. The national standard for COVID-19 infection prevention and control measures is the CDC. According to CMS requirements, everyone entering a nursing facility must still at least wear some form of source control while in the facility.

A nursing facility's infection prevention and control program may allow fully-vaccinated staff to dine and socialize together in break rooms and conduct in-person meetings without wearing a facemask or other PPE, and without physical distancing. If unvaccinated HCP are present, everyone should wear source control and unvaccinated HCP should physically distance from others.

Please continue to check the CDC's Infection Control after Vaccination for the latest updates to this information.

When is an N95 vs. a facemask vs. a face covering required?

UPDATED 7/19/21: Per the updated emergency mitigation rule, a nursing facility must develop and enforce written standards, policies, and procedures for the facility's infection prevention and control program which must include standard and transmission-based precautions to prevent the spread of COVID-19, including the appropriate use of PPE. All facemasks and N95 masks must be in good functional

condition, as described in the COVID-19 Response for Nursing Facilities at hhs.texas.gov, and worn appropriately, completely covering the nose and mouth.

While Executive Order (EO) GA 36 prohibits governmental entities, including HHSC, from mandating the use of masks, CMS requires any nursing facility (NF) that is Medicaid or Medicare certified to adhere to certain requirements. CMS requires visitation in a NF to adhere to CDC guidance. See QSO 20-39 for more information on the use of PPE during visitation.

Furthermore, NFs must have an infection control program that adheres to national standards, including the use of facemasks in accordance with CDC guidance. The national standard for COVID-19 infection prevention and control measures is the CDC.

UPDATED 10/27/2021: Per CMS and the CDC, in general, all staff should continue to wear source control while at work. Furthermore, CMS has directed all nursing facility staff to wear PPE. The minimum required PPE in a nursing facility is a facemask. When caring for residents with suspected or confirmed COVID-19, staff must wear a NIOSH approved N95 respirator.

In nursing facilities located in counties with low to moderate community transmission, fully vaccinated staff may choose not to wear source control or physically distance when they are in well-defined areas that are restricted from resident access (e.g., staff meeting rooms, kitchen). If unvaccinated staff members are present, everyone should wear source control and unvaccinated staff members should physically distance from others.

To determine the level of COVID-19 transmission in the community where a healthcare facility is located, visit the CDC's COVID-19 Data Tracker. If the two indicators suggest different transmission levels, the higher transmission level is used.

Per CMS and the CDC, all visitors should wear a facemask or face covering during:

- A personal visit if either the visitor or resident is not fully-vaccinated
- Walking to and from the private indoor or outdoor visitation area
- A personal visit not conducted in a private indoor or outdoor visitation area

Per the CDC, the safest practice is for residents and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or unvaccinated.

If both the visitor and resident are fully-vaccinated, both may remove their facemask or face covering during a visit in a private visitation area. Per CMS requirements, all visitors are still expected to wear a face mask in the NF, until they are in the private visitation area.

Please see the CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination and the alert published on May 21, 2021, New Guidance for Long-term Care Facilities, HCSSAs and In-patient Hospices on Masks for additional information.

Resources

Does the guidance provided by the Special Infection Control Assessment (SICA) team supersede the COVID-19 Response for Nursing Facilities?

No. Guidance by SICA teams does not supersede the COVID-19 Response for NFs. SICA guidance is an additional, consultative resource to assist providers with best practices. Questions regarding information provided by SICA teams can be sent to the Regional Director of your area.

Can facilities apply for money to buy communication devices to help residents stay connected with family and friends. How do I apply?

All nursing facilities are encouraged to apply for up to $3,000 per facility in federal Civil Money Penalty (CMP) funds. These funds are to be used for the purchase of communication devices to aid in connecting residents with their loved ones during the COVID-19 pandemic. Use awarded funds to buy items such as tablets, webcams, headphones, and certain accessories. Visit the CMP webpage and read the Special Application Period for Communicative Devices in Nursing Facilities section for complete details and an application.

How can I sign up for email alerts from Texas Health and Human Services?

Please visit the following link and select the topics you are interested in: https://service.govdelivery.com/accounts/TXHHSC/subscriber/network

Where can I get my COVID-19 Medicaid questions answered?

Managed Care Organizations can email MCO_COVID-19_Inquiries@hhsc.state.tx.us. All others can email Medicaid_COVID_Questions@hhsc.state.tx.us.

Where do NF providers go for COVID-19 information?

Reliable sources of information include:

- The Centers for Disease Control and Prevention
- The Centers for Medicare and Medicaid Services
- The Texas Department of State Health Services
- The Health and Human Services Commission
- CMS COVID-19 Long-Term Care Facility Guidance

UPDATED 3/23/21:

Additional Resources for Infection Prevention and Control (IPC)

- Project Firstline - CDC's national training collaborative for healthcare infection prevention and control. Project Firstline trainings are targeted towards healthcare workers in all healthcare settings, including nursing facilities.

- Infection Control Assessment Tool (ICAR) - This ICAR tool is used to systematically assess a nursing facility's IPC practices and guide quality improvement activities.
- IPC & Wellness Tool Kit video series and resources- Doctors without Borders/ Médecins Sans Frontières (MSF) has created a tool kit on IPC in nursing facilities, with special emphasis on training environmental services staff (EVS) in IPC.

Where can I get more information on how to get COVID-19 vaccines?

UPDATED 10/27/2021: The Centers for Disease Control and Prevention has recently updated resources for long-term care facilities on how to help residents and staff access COVID-19 vaccines:

- Vaccine Access in Long-term Care Settings
- Care Administrators and Managers: Options for Coordinating Access to COVID-19 Vaccines
- Jurisdictions Can Ensure COVID-19 Vaccine Access for Staff and Residents in Long-term Care Settings

HHSC also published the following alert on 9/14/2021:

Nursing, assisted living, and intermediate care facility staff and residents who want to receive the first, second or third dose of the COVID-19 vaccine may use the options below.

Contact the HHSC LTCR Regional Director in the region where the facility is located. Request a mobile vaccination clinic at your facility. The mobile vaccination clinic can administer first, second, or third doses of the COVID-19 vaccine to residents and staff. Facilities may need to make alternate arrangements for staff and residents to receive any more doses after the vaccination clinic.

Enroll as a DSHS COVID-19 Vaccine Provider. Once registration is complete, vaccine providers can request vaccines. Email COVID-19 Vaccination Enrollment or call the DSHS COVID-19 Vaccine Provider hotline at 877-835-7750 with questions. Read the DSHS Vaccine FAQs for more information.

Contact the pharmacy or vaccine supplier. Coordinate directly with your COVID-19 vaccine supplier to schedule vaccine administration for those who want the vaccine.

Use the following to locate vaccines:

- COVID-19 local health entities or DSHS region
- DSHS COVID-19 Vaccine Home page

What resources are available to help facilities with staffing shortages?

UPDATED 10/27/2021: HHSC published the following alert on 8/27/2021:

For Emergency Staffing Support:

The Office of the Governor directed DSHS to use staffing agencies to provide medical personnel from out-of-state to Texas health care facilities to assist in COVID-19 operations.

This support will be available to residential long-term care providers. Providers must demonstrate that they have exhausted all other options and have an urgent need for assistance before requesting emergency staffing support. The State is asking that jurisdictions and health care entities be judicious with requests for staffing, as the State will not be able to address all staffing needs, especially as the need for emergency staffing ramps up across the state.

LTC providers are always required to provide services to residents or clients before, during and after an emergency. The emergency plan must include:

- Planning for staff shortages
- A back-up plan to ensure operations and care of residents continues

For COVID-19 Vaccination, Testing Kits, PPE, Disinfection, and HAI/EPI Support:

Long-term care providers can request:

- COVID-19 mobile vaccine clinics for residents and staff
- BinaxNow testing kits. Read PL 2020-49 for details.
- PPE (providers should exhaust all other options before request)
- Facility cleaning and disinfection
- Healthcare-associated infection and epidemiological support

To Request Support:

To initiate a request for COVID-19 support described above, contact the HHSC LTCR Regional Director in the region where the facility is located.

HHSC LTCR staff are responsible for initiating a State of Texas Assistance Request on behalf of the long-term care provider.

HHSC LTCR staff may request supporting documentation to verify need.

Persons Allowed in Nursing Facilities

Should hospice workers be allowed to enter nursing facilities?

Yes. hospice workers are considered essential and can be allowed to enter NFs if they pass screening.

UPDATED 7/19/21: Hospice workers are included in facility staff testing requirements and need to provide proof of COVID-19 testing, based on the CMS testing requirements outlined in QSO 20-38-NH, if they are not already being tested at the facility where they are providing services.

From QSO 20-38-NH: facility staff includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. For the purpose of testing "individuals providing

services under arrangement and volunteers," facilities should prioritize those individuals who are regularly in the facility (e.g., weekly) and have contact with residents or staff. We note that the facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source (e.g., their employer or on their own). However, the facility is still required to obtain documentation that the required testing was completed during the timeframe that corresponds to the facility's testing frequency, as described in Table 2 below. The frequency of routine testing for COVID-19 is based on the county positivity rate and applies to all NF staff who have NOT been fully vaccinated.

UPDATED 10/27/2021: CMS updated QSO 20-38 on 9/10/2021. Revised COVID-19 routine staff testing is now based on the facility's county level of community transmission instead of the county positivity rate.

To determine the level of COVID-19 transmission in the community where a healthcare facility is located, visit the CDC's COVID-19 Data Tracker. If the two indicators suggest different transmission levels, the higher transmission level is used.

Routine Testing Intervals Vary by County COVID-19 Level of Community Transmission:

Level of COVID-19 Community Transmission	Minimum Testing Frequency of Unvaccinated Staff[+]
Low (blue)	Not recommended
Moderate (yellow)	Once a week*
Substantial (orange)	Twice a week*
High (red)	Twice a week*

[+]Vaccinated staff do not need to be routinely tested.

*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

When is visitation going to be allowed again?

UPDATED 7/19/21: HHSC updated the NF Expansion of Reopening Visitation Rule in June 2021. See PL 2021-20 for more information.

Are dentists considered essential visitors?

Yes. Dentists are considered essential. They can provide routine and emergency services within a facility as long as they enter with appropriate PPE and pass screening.

UPDATED 7/19/21: Dentists, and providers of care and services to residents on behalf of a facility are considered "facility staff" per CMS QSO 20-38. These individuals need to follow the routine staff testing requirements, based on the county positivity rate where the facility is located. Please see the table below.

From QSO 20-38-NH: facility staff includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. For the purpose of testing "individuals providing services under arrangement and volunteers," facilities should prioritize those individuals who are regularly in the facility (e.g., weekly) and have contact with residents or staff. We note that the facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source (e.g., their employer or on their own). However, the facility is still required to obtain documentation that the required testing was completed during the timeframe that corresponds to the facility's testing frequency, as described in Table 2 below.

UPDATED 10/27/2021: CMS updated QSO 20-38 on 9/10/2021. Revised COVID-19 routine staff testing is now based on the facility's county level of community transmission instead of the county positivity rate.

To determine the level of COVID-19 transmission in the community where a healthcare facility is located, visit the CDC's COVID-19 Data Tracker. If the two indicators suggest different transmission levels, the higher transmission level is used.

Routine Testing Intervals Vary by County COVID-19 Level of Community Transmission:

Level of COVID-19 Community Transmission	Minimum Testing Frequency of Unvaccinated Staff[+]
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High (red)	Twice a week*

[+]Vaccinated staff do not need to be routinely tested.

*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

Are private sitters considered providers of essential services if residents have dementia diagnosis and high risk for falls?

Providers will have to determine if they consider private sitters essential *Other Providers of Services* as described in QSO-20-39-NH. If so, these workers may be permitted to come into the facility as long as they are screened and meet the CDC guidelines for health care workers.

Do end-of-life circumstances apply to anyone receiving hospice services?

UPDATED 3/23/21: The updated NF Expansion of Reopening Visitation Emergency Rule has broadened the criteria for end-of-life visits. An end-of-life visit

is a personal visit between a visitor and a resident who is receiving hospice services; who is at or near the end of life, with or without receiving hospice services; or whose prognosis does not indicate recovery. An end-of-life visit is permitted in all facilities and for all residents at or near the end of life.

Is it okay for family members to do laundry for residents and leave it at the front door? If so, how do they get the laundry?

It is not recommended. NFs are required to have policies and procedures in place for staff to handle, store, process, and transport all linens and laundry in accordance with national standards to produce hygienically clean laundry and prevent the spread of infection to the extent possible. See guidance in CMS SOM Appendix PP, F880.

If there is a fire or an emergency medical situation, do emergency responders need to be screened before entering a NF?

The required screenings do *not* apply to emergency services personnel entering the facility in an emergency such as a fire or a resident requiring life- saving actions. See CDC guidance, CMS QSO-20-39-NH, CMS COVID-19 Long- Term Care Facility Guidance and CMS SOM Appendix PP, F880.

Are vendors that inspect, test, and maintain fire systems considered essential, and should they be granted entry into a NF?

Yes. These are considered essential services, and these vendors may be granted access to the facility if they are properly screened and follow all appropriate CDC guidelines for transmission-based precautions. See CMS QSO-20-39-NH, CMS COVID-19 Long-Term Care Facility Guidance and CDC guidance.

Are personal visitors or essential caregivers required to provide COVID-19 testing results or to be tested for COVID-19 before entering the facility?

UPDATED 3/23/21: No, a NF may not require a personal visitor or essential caregiver to provide documentation of a negative COVID-19 test as a condition of visitation, or in order to enter the facility. Previous versions of the emergency rule required initial testing of essential caregivers, as well as the NF provider to develop a testing strategy for essential caregivers. However, this is no longer required in the updated NF Expansion of Reopening Visitation Emergency Rule.

Can NF providers require visitors to provide proof of vaccination?

UPDATED 3/23/21: No, a NF may not require personal visitors or essential caregivers to provide documentation of their COVID-19 vaccination status as a condition of visitation, or to enter the facility.

UPDATED 7/19/21: While the NF may not require a personal visitor or essential caregiver to provide documentation of their COVID-19 vaccination status, a NF may ask about a visitor's or essential caregiver's vaccination status.

When screening staff or any other visitor, does it have to be done outside of the facility or can it be done inside at the front door or lobby area? What if temperatures taken outside are reading as higher than usual due to an excessively hot day?

Per the emergency mitigation rule and the expanded reopening visitation rule, anyone entering the facility must be screened for signs and symptoms for COVID-19 before entering the facility. In the event that an individual being screened suspects a higher temperature reading may be due to the temperature outside, the individual may request an additional temperature reading is taken after the individual rests for a few minutes in a shaded or cooler area outside of the facility.

Screenings can occur just inside the building, immediately upon entering. Screenings should not occur at an area inside the facility that would require an individual to walk through an area of the facility. If a building has a vestibule, foyer or other entryway that is separated from the rest of the building by a closed door, it is preferred that the person be screened inside the vestibule, foyer, or other entryway.

Staff Questions

If the lab results come back positive for a staff member, but more than 14 days have passed since the test was administered, does the staff member still have to self-quarantine?

A positive COVID-19 result, even if it comes late, reflects possible transmission of the virus within the facility and should prompt repeat testing at the facility.

In addition, the person who tested positive, whether it is a staff member or resident, will not require continued isolation if the person has met the criteria to discontinue isolation. The criteria to discontinue isolation can be symptom-based (i.e., 10 days since symptom onset AND at least 72 hours of no fever/improving symptoms) or test- based (i.e., at least two subsequent negative PCR tests). If the person was asymptomatic for the entire duration, they can use a time-based strategy (i.e., 10 days from the time of the positive test) to end their isolation period.

Per CDC, the test-based strategy is no longer recommended in the majority of cases because it may result in prolonged isolation, as many individuals will continue to shed the virus, but are no longer infectious.

When should staff use alcohol-based hand rub (ABHR) vs soap and water to sanitize hands?

UPDATED 7/19/21: CMS indicates a preference for ABHR in their core principles of COVID-19 infection prevention in QSO-20-39. The CDC also states that alcohol-based hand sanitizers are the preferred method for cleaning hands in most clinical settings. However, healthcare personnel should wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.

Ideally, the facility will have an adequate supply of ABHR dispensers AND soap and water at handwashing stations throughout the facility. This ensures that there are a couple options available to sanitize hands in all parts of the facility at all times.

See the CDC's Hand Hygiene in Healthcare Settings for more information and specific scenarios where ABHR or soap and water may be more appropriate.

When can a provider employee return to work after being diagnosed with COVID-19?

The CDC offers guidance to help providers make decisions about employees returning to work following confirmed or suspected COVID-19. The CDC notes that these decisions should be made in the context of local circumstances, and HHSC reminds providers that every employee, facility, and resident population requires individualized consideration.

According to the CDC, two options a provider can use to clear the employee to return to work are:

1. Symptom-based strategy - the employee can return to work when three conditions have been met:
Employee with mild to moderate illness who is not severely immunocompromised:

- **a.** at least 10 days have passed since symptoms first appeared **AND**
- **b.** at least 24 hours have passed since last fever without the use of fever-reducing medications **AND**
- **c.** cough and shortness of breath have improved

Note: an employee who was not severely immunocompromised and was asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

Employee with severe to critical illness or who are severely immunocompromised:

- **a.** at least 10 days and up to 20 days have passed since symptoms first appeared **AND**
- **b.** at least 24 hours have passed since last fever without the use of fever-reducing medications **AND**
- **c.** cough and shortness of breath have improved
- **d.** consider consultation with infection control experts

Note: an employee who is severely immunocompromised but who was asymptomatic throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

2. Test-based strategy – The employee can return when three conditions have been met:

- **a.** Fever-free without the use of fever-reducing medication **AND**
- **b.** Cough and shortness of breath have improved **AND**
- **c.** Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19

After the employee returns to work, both the provider and the employee must take all necessary measures to ensure the safety of everyone in the facility. The employee should wear a facemask at all times while in the health care facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. They should also be restricted from contact with severely immunocompromised residents until 14 days after illness onset, and they should adhere to all infection control procedures, including hand hygiene, respiratory hygiene, and cough etiquette.

Note: If the employee was diagnosed with a different illness (e.g., influenza) and was never tested for COVID-19, providers should base the employee's return to work on recovery criteria related to the specific diagnosis.

Resources

- Centers for Disease Control and Prevention (CDC) guidance on healthcare professionals returning to work
- CDC recommendations on infection control

Per CDC, the test-based strategy is no longer recommended in the majority of cases because it may result in prolonged isolation, as many individuals will continue to shed the virus, but are no longer infectious. A test-based strategy could be considered for some individuals (e.g., those who are severely immunocompromised) in consultation with a local infectious disease expert, if concerns exist for the individual being infectious for more than 20 days.

What is the best thing to do for facilities that have staff that go to multiple facilities?

Health care personnel (HCP) who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID- 19 cases. Facilities must screen all HCP at the beginning of their shift for fever and respiratory symptoms. Facilities must take HCPs temperature and document absence of shortness of breath, new or change in cough, and sore throat. If an HCP is ill, the HCP should follow CDC and CMS for the most recent guidance for staff with suspected or confirmed COVID-19. Facilities should also use the CDC's exposure risk assessment table for guidance on how to handle staff that have had different levels of exposure to COVID-19 cases.

Per the NF COVID-19 Response Emergency Rule updated in June 2021:

A nursing facility must develop and implement a policy regarding staff working with other long-term care (LTC) providers that limits the sharing of staff with other LTC providers and facilities, unless required in order to maintain adequate staffing at a facility.

Do you know if there is any consideration for pregnant employees?

UPDATED 7/19/21: The CDC is still investigating the impact of COVID-19 during pregnancy. Based on current evidence, pregnant women and recently pregnant women are at an increased risk for severe illness from COVID-19 compared to non-pregnant women, per CDC. Pregnant women should protect themselves from COVID-19 by:

- Avoiding people who are sick or who have been exposed to thevirus.
- Cleaning their hands often using soap and water or alcohol-based hand sanitizer.
- Cleaning and disinfecting frequently touched surfaces per CDC guidance. See the CDC's page regarding pregnancy for more information.

If a NF resident tests positive for COVID-19, how do we handle staff quarantine?

UPDATED 10/27/2021: Providers will have to determine which staff members had prolonged close contact (were within 6 feet for a cumulative total of 15 minutes over 24 hours) with the resident with COVID-19 infection, what kind of exposure (risk) the staff member had with a resident who tests positive, and whether the staff member is fully-vaccinated, or has recovered from COVID-19 in the last 90 days.

Higher risk exposures generally involve exposure of the staff member's eyes, nose, or mouth to material potentially containing COVID-19, particularly if the staff member was present in the room for an aerosol-generating procedure. Lower risk exposures may include having body contact with the resident without gown or gloves. The use of proper hand hygiene should also be assessed.

For unvaccinated HCP: Work restriction is recommended following a higher-risk exposure.

UPDATED 3/23/21: **Quarantine and Fully-vaccinated Healthcare Personnel (HCP)**

The following recommendations are based on what is known about currently available COVID-19 vaccines. Please continue to check the CDC's Infection Control after Vaccination for the latest updates to these recommendations.

Fully-vaccinated refers to a person who is:

- At least two weeks following receipt of the second dose in a two-dose COVID-19 vaccine series, or at least two weeks following receipt of one dose of a single-dose COVID-19 vaccine.

For asymptomatic HCP (fully vaccinated or recovered from COVID-19 in the last 90 days):

UPDATED 10/27/2021: Asymptomatic HCP who have had prolonged close contact with someone with COVID-19 infection, regardless of vaccination status, should have a series of two viral tests for COVID-19 infection (immediately after exposure, but not earlier than 2 days after exposure, AND 5-7 days after exposure), unless they have recovered from COVID-19 within the last 90 days. If they have recovered from COVID-19 in the last 90 days and remain asymptomatic, they do not need to be tested even if they had close contact.

Fully-vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure. Work restrictions for the following fully-vaccinated HCP populations with higher-risk exposures should still be considered for:

- HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact level of protection provided by the COVID-19 vaccine. However, data on which immunocompromising conditions might affect response to the COVID-19 vaccine and the magnitude of risk are not available.
- HCP who have traveled should continue to follow CDC travel recommendations and requirements, including restriction from work, when recommended for any traveler.

Fully-vaccinated people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.

Quarantine may be indicated by the jurisdiction's public health authority.

See the CDC's guidance on risk assessment, CDC definition of "close contact", and CMS COVID-19 Long-Term Care Facility Guidance for full details.

Additionally, nursing home-onset COVID-19 infections in residents will trigger the outbreak testing response CMS requirements as outlined in QSO 20-38.

While the CDC still endorses a 14-day quarantine period, it now offers two alternatives and guidance to reduce quarantine timeframes. Local public health authorities make the final decisions about how long quarantine should last, based on local conditions and needs, and providers must follow such decisions. However, in the absence of stricter local quarantine requirements, CDC's two alternatives are:

- Alternative #1 - Quarantine can end *after* day 10 without testing if the person has no symptoms as determined by daily monitoring.
- Alternative #2 - Quarantine can end *after* day 7 if the person tests negative

and has no symptoms as determined by daily monitoring. The test must occur on day 5 or later. Quarantine cannot be discontinued earlier than after day 7.

CDC guidance includes the following information:

- Persons can discontinue quarantine at either alternative described above only if the following criteria are also met:
  - No COVID-19 symptoms were detected in the persons by daily symptom monitoring during the entirety of the quarantine, including up to the time at which quarantine is discontinued;
  - Daily symptom monitoring continues through day 14; and
  - Persons are counseled about the need to adhere strictly through day 14 to all mitigation strategies, such as wearing a mask, avoiding crowds, practicing physical distancing, and practicing hand and cough hygiene. Individuals should be advised that if any symptoms develop, they must immediately self-isolate and contact their health care provider to report this change in clinical status.
  - If a nursing facility chooses one of the shortened quarantine options and the resident develops symptoms at any time within 14 days after the quarantine begins, the facility must isolate the resident and report the change in clinical status to the resident's attending physician.
- Testing under alternative #2 above should be considered only if it will have no impact on community diagnostic testing. Testing of persons seeking evaluation for an actual infection must be prioritized.
- Persons can continue to be quarantined for 14 days without testing, per existing recommendations. This option is maximally effective.

How do we handle outbreak testing for staff?

UPDATED 10/27/2021: CMS updated QSO 20-38 on September 10, 2021. This document contains new information on testing. For outbreak testing, facilities now have the option to perform outbreak testing based on **contact tracing** or perform **broad-based testing**. Facilities must consider the extent of the outbreak, whether they can identify close contacts, and other factors. They should also continue to work with their local health department on the outbreak testing process.

For contact tracing:

If the facility can perform contact tracing, they need to test all close contacts of the individual with COVID-19. CDC defines close contact as someone who was within 6 feet of an infected person (laboratory-confirmed or a clinically compatible illness) for a cumulative total of 15 minutes or more over a 24-hour period (for example, *three individual 5-minute exposures for a total of 15 minutes).* The facility may also consider testing the entire affected unit. If additional cases are revealed, the facility needs to continue the contract tracing process.

For broad-based testing:

If the facility cannot do contact tracing, they can test at a group level (unit, floor, specific area) or facility wide. Facility-wide testing is no longer *required* for all residents and all staff in the case of an outbreak. However, facility-wide testing is still an option if the facility cannot perform contact tracing, if indicated by the local health department (LHD), if there are too numerous contacts to manage, or if contact tracing fails to stop transmission. This decision making should take into account guidance from the local health authority, the extent of outbreak, and whether new cases have been identified during the contact tracing and testing process.

Please see Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC and QSO 20-38 Revised for more detailed information.

Do the alternatives for reduced quarantine apply to nursing facility staff?

UPDATED 1/27/21: The criteria for when an employee can return to work depends on whether the employee has symptoms of COVID-19 or has been diagnosed with COVID-19 and is in isolation, or whether the employee has been exposed to COVID-19 and requires quarantine.

Follow the CDC's Return to Work Criteria when an employee has confirmed or probable COVID-19 and requires isolation.

To determine whether an employee had potential exposure to someone with confirmed COVID-19 and must be excluded from work and quarantined, refer to the CDC's Potential Exposure at Work risk assessment tool. Exclusion from work and quarantine for 14 days is recommended for an employee who has had unprotected, prolonged close contact with a resident, visitor, or other staff member with confirmed COVID-19.

While the CDC has provided quarantine alternatives for the general public, the CDC, DSHS, and HHSC still recommend the 14-day quarantine period as the safest quarantine option with the least risk of viral transmission to others. Quarantine for 14 days is recommended for employees who have had a potential exposure to someone with confirmed COVID-19. However, facilities can choose to utilize a shorter quarantine period for employees, as long as the reduced quarantine alternative adheres to CDC guidance and is consistent with the local health authority's recommendations for quarantine duration.

The CDC's two alternatives are:

- Alternative #1 - Quarantine can end after day 10 without testing if the person has experienced *no symptoms* as determined by daily monitoring.
- Alternative #2 - Quarantine can end after day 7 if the person tests negative on a viral test (i.e., molecular or antigen test) and has experienced *no symptoms* as determined by daily monitoring. The test must occur on Day 5 or later. Quarantine cannot be discontinued earlier than after Day 7.

Both alternatives require that daily monitoring for fever and symptoms continue through day 14 after exposure.

Both alternatives raise the risk of being less effective than the 14-day quarantine as currently recommended. The specific risks are as follows:

- For Alternative #1, the residual post-quarantine transmission risk is estimated to be about 1 percent with an upper limit of about 10 percent.
- For Alternative #2, the residual post-quarantine transmission risk is estimated to be about 5 percent with an upper limit of about 12 percent.

The provider must determine what steps are necessary to protect the health and safety of the individual in quarantine, as well as the health and safety of other employees and residents. If an employee returns to work following a reduced quarantine period, facilities can require the employee to wear full PPE regardless of where the individual works in the facility or limit work activities. Facilities can utilize other precautions or restrictions to minimize the risk of viral transmission.

UPDATED 3/23/21: **Quarantine and Fully-vaccinated Healthcare Personnel (HCP)**

The following recommendations are based on what is known about currently available COVID-19 vaccines. Please continue to check the CDC's Infection Control after Vaccination for the latest updates to these recommendations.

Fully-vaccinated refers to a person who is:

- At least two weeks following receipt of the second dose in a two-dose COVID-19 vaccine series, or at least two weeks following receipt of one dose of a single-dose COVID-19 vaccine.

For asymptomatic HCP:

UPDATED 10/27/2021: Asymptomatic HCP who have had prolonged close contact with someone with COVID-19 infection, regardless of vaccination status, should have a series of two viral tests for COVID-19 infection (immediately after exposure, but not earlier than 2 days after exposure, AND 5-7 days after exposure), unless they have recovered from COVID-19 within the last 90 days. If they have recovered from COVID-19 in the last 90 days and remain asymptomatic, they do not need to be tested even if they had close contact.

Fully-vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure. Work restrictions for the following fully-vaccinated HCP populations with higher-risk exposures should still be considered for:

- HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact level of protection provided by the COVID-19 vaccine. However, data on which immunocompromising conditions might affect response to the COVID-19 vaccine and the magnitude of risk are not available.

- HCP who have traveled should continue to follow CDC travel recommendations and requirements, including restriction from work, when recommended for any traveler.

Fully-vaccinated people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.

When should we confirm an antigen test result?

In general, asymptomatic people who test antigen positive should have a confirmatory PCR test performed. Symptomatic people who test antigen negative should have a confirmatory PCR test performed.

Test sensitivity varies between antigen testing platforms. Facilities should be aware of which test is being used and its sensitivity for the resident population to be tested.

False positives have been identified, particularly when users do not follow the instructions for use of the antigen tests or perform testing in low-prevalence populations (e.g., screening asymptomatic HCP in non-outbreak settings).

Facilities should be aware of the FDA EUA for antigen tests and CMS's enforcement discretion regarding the Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver when using antigen tests in asymptomatic individuals.

Testing of **symptomatic** residents or HCP:

- If an antigen test is positive, no confirmatory test is necessary.
- If an antigen test is negative, perform confirmatory PCR test immediately (within 2 days).
    - Residents should be kept on Transmission-Based Precautions, and HCP should be excluded from work until the confirmatory PCR test results return.
    - If antigen and confirmatory tests are negative and the individual resides or works in an outbreak facility, the confirmatory negative test does not affect implementation of appropriate precautions for facilities with an outbreak. Additionally, both residents and HCP should be serially tested every 3-7 days until no new cases are identified for 14 days.
    - If antigen and confirmatory tests are negative and the person is a known close contact, residents should remain in quarantine for 14 days from exposure, and HCP should follow risk assessment guidance. Alternatives to the 14-day quarantine period are described in the Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing.

Testing of **asymptomatic** residents or HCP in the facility as part of an **outbreak response** or those who are known close contacts of persons with COVID-19:

- If an antigen test is positive, perform confirmatory PCR test.
    - Residents should be placed in transmission-based precautions in a single room or, if single rooms are not available, remain in their current room pending results of confirmatory testing. They should **not** be transferred to a COVID-19 unit or placed in another shared room with new roommates. HCP should be excluded from work.
    - If confirmatory PCR test is positive, the resident should transfer to the COVID-19 unit and isolate until he or she meets the criteria to discontinue transmission-based precautions. HCP should remain excluded from work until they meet return to work criteria.
- If an antigen test is presumptive negative OR if the antigen test is positive but the confirmatory PCR test (performed within 2 days) is negative:
    - In facilities experiencing an outbreak, residents should be placed on appropriate transmission-based precautions for facilities with an outbreak. HCP should be allowed to continue to work with continued symptom monitoring. The facility should continue serial viral testing (antigen or PCR) every 3-7 days until no new cases are identified for 14 days.
    - If a person is a known close contact of a person with confirmed COVID-19, residents should remain in quarantine for 14 days from exposure, and HCP should follow risk assessment guidance. Alternatives to the 14-day quarantine period are described in the Options to Reduce Quarantine for Contacts of Persons with COVID-19 Infection Using Symptom Monitoring and Diagnostic Testing.

Testing of **asymptomatic** HCP in a facility **without an outbreak**:

- If an antigen test is positive, perform confirmatory PCR test within 2 days of the antigen test. Asymptomatic HCP who are antigen test positive but in a facility without an outbreak should be excluded from work, but outbreak response, including facility-wide testing, can be delayed until confirmatory test results are completed.
    - If the confirmatory test is positive, then continue to exclude the HCP from work and initiate an outbreak response, including facility-wide testing of all residents and HCP.
    - If the confirmatory test is negative, the antigen test should be considered a false positive and the HCP should return to work.
- If an antigen test is negative, allow HCP to continue to work. The HCP should continue recommended infection prevention measures (e.g., universal masking), monitor for symptoms, and continue serial testing per an expanded screening testing strategy or CMS guidelines.

*Note: if a person has recovered from COVID-19 infection in the past 90 days and develops new symptoms suggestive of COVID-19, alternative diagnoses should be considered prior to retesting for COVID-19.

Please see the CDC's COVID-19 Antigen Testing in Nursing Homes for more information.

Do fully-vaccinated staff have to quarantine if exposed to COVID-19?

UPDATED 3/23/21: The following recommendations are based on what is known about currently available COVID-19 vaccines. Please continue to check the CDC's Infection Control after Vaccination for the latest updates to these recommendations.

Fully-vaccinated refers to a person who is:

- At least two weeks following receipt of the second dose in a two-dose COVID-19 vaccine series, or at least two weeks following receipt of one dose of a single-dose COVID-19 vaccine.

For asymptomatic HCP:

UPDATED 10/27/2021: Asymptomatic HCP who have had prolonged close contact with someone with COVID-19 infection, regardless of vaccination status, should have a series of two viral tests for COVID-19 infection (immediately after exposure, but not earlier than 2 days after exposure, AND 5-7 days after exposure), unless they have recovered from COVID-19 within the last 90 days. If they have recovered from COVID-19 in the last 90 days and remain asymptomatic, they do not need to be tested even if they had close contact.

Fully-vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure. Work restrictions for the following fully-vaccinated HCP populations with higher-risk exposures should still be considered for:

- HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact level of protection provided by the COVID-19 vaccine. However, data on which immunocompromising conditions might affect response to the COVID-19 vaccine and the magnitude of risk are not available.
- HCP who have traveled should continue to follow CDC travel recommendations and requirements, including restriction from work, when recommended for any traveler.

Fully-vaccinated people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.

Do fully-vaccinated staff still have to be routinely tested for COVID-19?

UPDATED 10/27/2021: Fully-vaccinated staff do not need to be routinely tested. CMS revised QSO 20-38 on September 10, 2021. Revised COVID-19 staff testing is now based on the facility's county level of community transmission instead of county test positivity rate. The frequency of testing has also been updated.

Routine Testing Intervals Vary by County COVID-19 Level of Community Transmission:

Level of COVID-19 Community Transmission	Minimum Testing Frequency of Unvaccinated Staff[+]
Low (blue)	Not recommended
Moderate (yellow)	Once a week*
Substantial (orange)	Twice a week*
High (red)	Twice a week*

[+]Vaccinated staff do not need to be routinely tested.

*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

Can nursing students enrolled in nursing school do their clinicals in our facilities?

Yes, nursing students may enter a facility to do their clinicals if the person passes the screening. Nursing students must adhere to all mitigation protocols, be screened upon entrance, and utilize proper PPE while in the facility. [Nursing students would also be considered facility staff for the purpose of CMS testing rules] Please note that Governor Abbott waived certain requirements for student nurses in response to COVID-19.