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Memorandum

TO: Long-Term Care Facilities
FROM: Elizabeth Daake Kelley, MBA, MPH,
Director, Bureau of Health Care Safety and Quality
SUBJECT: Update to Caring for Long-Term Care Residents during the COVID-19 Response, including Visitation Conditions, Communal Dining, and Congregate Activities
DATE: October 13, 2022

Updates Summary:
- Increased flexibility for screening at facility entrances to allow for posting signage as an option in lieu of active screening
- Adjusted outbreak testing frequency to align with CDC
- Removed quarantine and additional personal protective equipment requirements that were based on vaccination status

The Massachusetts Department of Public Health (DPH) recognizes that providing care for individuals seeking treatment for Coronavirus Disease 2019 (COVID-19) may prove to be especially challenging for health care practitioners and facilities, and we continue to appreciate the essential role you have in responding to this evolving situation. DPH is issuing this memorandum to long-term care facilities to update guidance on staff screening, quarantine and PPE use. This update replaces the June 10, 2022 version of "Caring for Long-Term Care Residents during the COVID-19 Response". DPH is issuing this updated guidance in alignment with the Centers for Medicare and Medicaid Services (CMS).

All rest homes and nursing homes must be prepared to care for COVID-19 positive residents. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms. Symptoms may be mild and not require admission to a hospital. All facilities are expected to follow the infection prevention and control practices recommended by DPH.

Screening of All Individuals

Long-term care facilities should screen all individuals entering the facility for symptoms but may utilize posted signage as a means to do so. Long term care facilities should have all individuals entering the facility, including healthcare personnel and visitors, self-assess for symptoms of COVID-19 (e.g.,

cough, shortness of breath, sore throat, runny nose, headache, myalgia, chills, fatigue, gastrointestinal symptoms, new onset loss of smell or taste and a fever). Self-screening should also include absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days. Long-term care facilities should post signage at facility entrance(s) explaining self-screening to visitors and staff. If an individual self-screens positively for symptoms or a diagnosis of SARS-CoV2 infection in the past 10 days, then they should not be allowed to enter the facility. Any healthcare personnel who had a diagnosis of SARS-CoV-2 infection in the prior 10 days must meet the return to work criteria outlined here: https://www.mass.gov/guidance/covid-19-isolation-and-quarantine-guidance-for-health-care-personnel

On unit(s) conducting outbreak testing, a long-term care facility should assess residents for symptoms of COVID-19 during each shift.

Use of Personal Protective Equipment (PPE)

Long-term care facilities should ensure all staff are using appropriate PPE when they are interacting with residents and in alignment with DPH and CDC guidance. All long-term care facility personnel should wear a facemask while they are in the facility, consistent with the DPH Comprehensive PPE Guidance.

Full PPE, including N95 respirator or alternative, eye protection, gloves, and gown, should be worn per DPH and CDC guidelines for the care of any resident with known or suspected COVID-19.

Separation of COVID-19 Positive Residents

Long-term care facilities should separate residents who are COVID-19 positive from residents who do not have COVID-19 or who have an unknown COVID-19 status. Whenever possible, residents with COVID-19 should be placed in a private room or in a room with another confirmed COVID-19 positive individual, with the door closed, unless the room is part of a physically separate, isolation unit in the facility or there is a serious safety concern. These residents should not share a bathroom with others who are not COVID-19 positive. Facilities could consider designating an entire unit within the facility, with dedicated staff, to care for residents with COVID-19 infection. Dedicated means staff are assigned to only care for these residents during their shifts. In some cases, it may be most appropriate to isolate positive residents in place. Residents with COVID-19 may be released from isolation after five days from symptom onset, if afebrile for at least 24 hours, any symptoms have improved and they have a negative viral test collected on day 5 or later or, if asymptomatic, after five days from specimen collection date of the positive COVID-19 test and have a negative viral test collected on day 5 or later. These residents must wear a mask around others through day 10.

Updated Admissions and Quarantine Policies

When a long-term care facility resident is transferred from a long-term care facility to a hospital for evaluation of any condition, including but not limited to, COVID-19 care, each long-term care facility must accept the resident's return to the facility when the resident no longer requires hospital level of care.

Long-term care facilities shall not condition admission or return to the facility on COVID-19 testing, COVID-19 test results or COVID-19 vaccination status. If a test is not performed before hospital discharge, the long-term care facility should test the resident upon admission, unless they are recovered in the last 30 days. Awaiting the test results should not delay an individual's discharge from the hospital to the long-term care facility. It is DPH's expectation that long-term care facilities will vaccinate any admitted resident who is not up to date with COVID-19 vaccine and consents to vaccination.

- Newly admitted or readmitted residents to a long-term care facility **do not need** to quarantine if they are asymptomatic.
    - Residents should receive a negative test on day 0 (i.e., upon admission), day 2, and day 5 or later and should wear a mask around others through day 10.

- Residents who are a close contact of a case of COVID-19 and are not recovered from COVID-19 in the last 30 days should be tested as soon as possible, but not sooner than 24 hours following exposure, on Day 3 and Day 5, and should wear a mask around others through day 10.

Testing *all* newly admitted residents for COVID-19 regardless of vaccination status is recommended unless the resident is recovered in the last 30 days. Long-term care facilities may use any FDA EUA-authorized rapid antigen test to perform admission testing.

Residents who leave the long-term care facility for less than 24 hours, e.g., dialysis treatment, medical appointments or offsite visits do not need to quarantine upon return regardless of vaccination status.

Please see Appendix C for a Detailed Isolation and Exposure Chart for Residents based upon recovered status.

Planned Resident Leave of Absences

Because there is increased risk of community transmission of COVID-19 within the Commonwealth of Massachusetts and due to concern for the health and safety of residents, the Department recommends that any resident, carefully consider any planned leaves of absence.

If, however, any resident wants to schedule a planned leave of absence from the facility, the facility clinical leadership should work with the resident and their loved ones to create a plan for a safer leave. This plan should include the following considerations and measures:

- Wearing face masks
- Practicing physical distancing and avoiding crowded environments whenever possible.
- Limiting interaction to the fewest number of people possible while the resident is on their planned leave
- Assessing the possible exposure risks while the resident is on their planned leave and instructions about how to mitigate them

Testing

In addition to the circumstance-specific testing requirements described above, long-term care facilities are required to perform surveillance testing of all staff in accordance with DPH Guidance: Updates to

Long-Term Care Surveillance Testing and outbreak testing of residents and staff as soon as possible. If the long-term care facility, identifies that the resident or staff member's first exposure occurred less than 24 hours ago, then they should wait to test until 24 hours after any exposure, if known.
As outlined in the checklist in Appendix B, once a new case is identified in a facility, following the requisite outbreak testing, long-term care facilities should test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case and then once per week until the facility goes 14 days without a new case unless a DPH epidemiologist directs otherwise. If no additional cases are identified in the first seven days of outbreak testing, it is not necessary to continue weekly testing until day 14. Residents and staff who are recovered from COVID-19 in the last 30 days can be excluded from this testing**.** In addition, facilities should immediately test any symptomatic resident or staff member. The facility may use any FDA EUA-approved rapid antigen test to perform testing described in this paragraph. Positive FDA EUA-approved rapid antigen test results no longer need to be confirmed with a molecular test.

Facilities must submit any positive test results to the Department of Public Health's Bureau of Infectious Diseases and Laboratory Sciences (BIDLS). Please contact ImmediateDiseaseReporting@mass.gov to share the primary contact details and the BIDLS team will follow up with you to set up reporting, if needed.

Long-Term Care Facility Outbreak Prevention and Management Checklist

The Department has developed an outbreak prevention and management checklist (see Appendix B) as a tool for long-term care facilities to use to mitigate the spread of COVID-19 and ensure the health and safety of long-term care residents and staff. All facilities should use this checklist as a reference tool while still referring to DPH guidance documents for the full recommendations and requirements for responding to COVID-19. If the Department determines that a facility is unable to implement or adhere to any of the components of the checklist, the Department may require the facility to engage external resources to assist with implementation and adherence

General Standards for In-Person Visitation

A long-term care facility must allow in-person visitation, which can occur in designated indoor or outdoor visitation space or the resident's room, with the following safety, care, and infection control measures and policies in place:

- Long-term care facilities should screen all individuals entering the facility for symptoms but may utilize posted signage as a means to do so. Facilities should encourage all individuals entering the facility to self-assess for symptoms of COVID-19 (e.g., cough, shortness of breath, or sore throat, myalgia, chills, or new onset loss of smell or taste and a fever). Self-screening should also include absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days. Long-term care facilities should post signage at facility entrance(s) explaining self-screening to visitors.
    - Any visitor who has a positive self-screen with symptoms of COVID-19 infection or a diagnosis of SARS-CoV2 infection in the prior 10 days (regardless of the visitor's vaccination status) will not be permitted to visit with a resident.
- Visitors, regardless of vaccination status, must wear masks and physically distance themselves from other residents and staff when in a communal area in the facility. While visitors should

wear masks when visiting residents in a private setting, such as a resident's room when the roommate isn't present, they may choose not to. Also, while not recommended, if a resident (or responsible party) is aware of the risks of close contact and/or not wearing a mask during a visit, and they choose to not wear a mask and choose to engage in close contact, the facility cannot deny the resident their right to choose, as long as the residents' choice does not put other residents at risk. Regardless, masks must be worn by visitors in a communal area.

- While not recommended, residents who are in isolation can still receive visitors. In these cases, visits should only occur in the resident's room and the resident must wear a well-fitting facemask (if tolerated). Before visiting residents who are in isolation, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention. It is strongly advised that visitors to COVID-19 positive residents should be up to date with COVID-19 vaccines and maintain physical distance. Facilities must offer and visitors must wear well-fitting facemasks and monitor visitor compliance with hand hygiene.

Any individual who enters the long-term care facility and develops signs and symptoms of COVID-19 such as fever, cough, shortness of breath, sore throat, myalgia, chills, or new onset loss of smell or taste or tests positive for SARS-CoV2 infection within two days after exiting the long-term care facility or designated outdoor space must immediately notify the long-term care facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Long-term care facilities should immediately screen the individuals who had contact with the visitor for the level of exposure and follow up with the facility's medical director or resident's care provider.

Visitor Testing and Vaccination

Facilities are encouraged to offer and perform rapid testing of visitors using any FDA EUA-approved rapid antigen test if feasible. However, a facility shall not condition a visit on testing.

Facilities must submit any positive test results, including visitors, to the Department of Public Health's Bureau of Infectious Diseases and Laboratory Sciences (BIDLS). Please contact ImmediateDiseaseReporting@mass.gov to share the primary contact details and the BIDLS team will follow up with you to set up reporting, if needed.

Facilities can also ask about vaccination status and strongly encourage visitors to become vaccinated when they have the opportunity. While visitor vaccination can help prevent the spread of COVID-19, a facility cannot require a visitor to be tested or vaccinated (or show proof of such) as a condition of visitation.

Indoor Visitation During Outbreak Investigation

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting when there have been cases in the last 14 days in the facility and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should

wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room.

While residents have the right to receive visitors at all times and make choices about aspects of their life in the facility that are significant to them, there may be times when the scope and severity of an outbreak warrants DPH to advise the facility pause visitation for a brief period of time. In accordance with CMS, DPH expects these situations to be extremely rare and only occur after the facility has worked with DPH to manage and prevent escalation of the outbreak. DPH, in accordance with CMS, also expects that if the outbreak is severe[1] enough to warrant pausing visitation, it would also warrant a pause on the facility accepting new admissions. For example, in a nursing home where, despite collaborating with DPH epidemiologists over several days, there continues to be uncontrolled transmission impacting a large number of residents (e.g., more than 30% of residents are suspected or confirmed to be infected with COVID-19), the facility may pause visitation and new admissions temporarily but for not more than 72 hours. In this situation, the nursing home would not be out of compliance with DPH and CMS requirements. A pause in visitation due to a severe outbreak would not apply to compassionate care visits.

Designated Indoor Visitation Space

In addition to the conditions described above, the long-term care facility should:

- Identify a designated space for visitation that is as close to the entrance as possible where visits can be socially distanced from other residents and minimize visitor impact in the facility.
- Ensure that ventilation systems operate properly, have been serviced in accordance with manufacturer recommendations and increase circulation of outdoor air as much as possible.

Resident Room Visitation Space

In addition to the conditions described above, the long-term care facility should allow residents to visit with loved ones in their rooms.

Outdoor Visitation Space

In addition to the in-person indoor visitation conditions described above, the long-term care facility should continue to offer outdoor visitation and adhere to the following:

- Ensure visits with a resident occur in a designated outdoor space; outdoor visits will be dependent on permissible weather conditions, availability of outdoor space, and the health and well-being of the resident.
- A long-term care facility staff member trained in such patient safety and infection control measures must remain immediately available to the resident at all times during the visit.
- Residents may visit with loved ones without maintaining social distancing or wearing masks.

Compassionate Care Visitation

[1] Neither DPH nor CMS have a specific threshold for what constitutes a severe outbreak, and this could vary based on facility size or structure. However, any visitation limits should be rare and applied when there are many cases in multiple areas of the facility.

Compassionate care visits are allowed at all times. Facilities must accommodate compassionate care visits for residents, regardless of vaccination and outbreak status.

For compassionate care situations long-term care facilities must limit visitors in the facility to a specific room: either the resident's room, or another location designated by the facility. Long-term care facilities must require visitors to perform hand hygiene and provide visitors a facemask. Decisions about visitation during a compassionate care situation should be made on a case-by-case basis.

Dining and Group Activities:

Long-term care facilities may provide outdoor entertainment and activities on the grounds of the facility if the facility meets the following conditions:

- All residents except for those residents in isolation, regardless of vaccination status, can participate in the outdoor group activities.

Long-term care facilities may provide communal dining and indoor group entertainment and activities in the facility if the facility meets the following conditions:

- All residents except for those residents in isolation, regardless of vaccination status, can participate in indoor group activities.

- Staff must wear appropriate PPE including a facemask.
- Staff should perform hand hygiene and observe or assist residents in performing hand hygiene before and after overseeing or engaging in any activity.
- The long-term care facility must implement a schedule for frequent cleaning and disinfection of the spaces used for indoor group activities, including cleaning high-touch surfaces using an appropriate EPA-registered disinfectant.
- Enhancements to ventilation, including open windows, HVAC filtration or use of HEPA filters should be encouraged in areas where groups congregate for activities or dining.

Ombudsman Program and Legal Representation:

Residents have the right to access the Ombudsman program and to consult with their legal counsel. When in-person access is not available, facilities must facilitate resident communication (by phone or another format).

Please note that reports of facilities found to not be adhering to this guidance will be referred to the DPH Complaint Intake Unit.

DPH continues to work with state, Federal, and local partners on the outbreak of novel Coronavirus 2019 (COVID-19), caused by the virus SARS-CoV-2, and we continue to appreciate the essential role you have in responding to this evolving situation.

DPH strongly encourages all nursing homes in Massachusetts to monitor the CMS website and CDC website for up-to-date information and resources:

- CMS website: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/facility-planning-operations.html

Additionally, please visit DPH's website that provides up-to-date information on COVID-19 in Massachusetts: https://www.mass.gov/2019coronavirus.

Appendix A

Personal Protective Equipment Used When Providing Care to Residents in Long Term Care

Resident Type	Recommended Staff PPE	Recommended Sign for Resident Room
COVID-19 Negative* Residents	Facemask	N/A
COVID-19-Positive Residents	Full PPE upon room entry to include fit-tested N95 respirator or alternative, Face Shield/Goggles, Gown and Gloves. Gown and gloves **must** be changed between residents.	**Isolation** Sign
COVID-19-Suspected Residents **(i.e., Symptomatic, with test results pending)**	Full PPE upon room entry to include fit-tested N95 respirator or alternative, Face Shield/Goggles, Gown and Gloves. Gown and gloves **must** be changed between residents.	**Isolation** Sign
COVID-19 negative* residents on units with uncontrolled transmission and at facility discretion	Facemask (or N95 respirator or alternative if ongoing transmission on unit), Face Shield/Goggles, Gown and Gloves. Gown and glove use can be prioritized for high-contact resident care activities[1]. Gown and gloves **must** be changed between residents.	**Enhanced PPE** Sign

*"Negative" refers to a resident who has not tested positive in the past 30 days.

**"Resident case" means a case that was potentially acquired in the facility

[1] https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

CDC provides these examples of high-contact resident care activities:

- Dressing
- Bathing/showering
- Transferring
- Providing hygiene

- Changing linens
- Changing briefs or assisting with toileting
- Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator
- Wound care: any skin opening requiring a dressing

https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html

Appendix B

Long-Term Care Facility Outbreak Prevention and Management Checklist

Purpose: DPH has developed this outbreak prevention and management checklist as a tool for long-term care facilities to use to prevent COVID-19 cases and, if any cases are confirmed, to mitigate the spread of COVID-19 within the facility and ensure the health and safety of long-term care residents and staff.

COVID-19 Prevention Checklist: Facilities that do not have a COVID-19 positive staff member or a resident with a potential facility-acquired COVID-19 infection are urged to maintain vigilance and to review and implement the checklist below:

Facility Assessment:

- ❑ Conduct an *Infection Prevention and Control Assessment* using the CDC tool at least quarterly. The tool may be found at the following link: https://www.cdc.gov/coronavirus/2019-ncov/hcp/assessment-tool-for-nursing-homes.html
    - Review findings with the facility's leadership team and make an actionable plan to address any improvement areas that includes a leader responsible for each area identified

Testing:

- ❑ Follow *DPH Surveillance Testing Guidance.*

- ❑ In addition to the surveillance testing outlined above, the facility should immediately test any symptomatic resident or staff member. The facility may use any FDA EUA-approved rapid antigen tests to perform such testing. *See DPH Testing Guidance.*

- ❑ **Following the identification of a new staff or resident case, see required outbreak testing outlined below**

Personal Protective Equipment (PPE) and Hand Hygiene:

- ❑ Perform routine PPE and hand hygiene audits using a tool, document the findings, review with the facility's leadership team, and provide feedback to frontline staff
    - Perform hand hygiene audits routinely on all units.
    - Perform PPE audits routinely on all units.

- ❑ Ensure that alcohol-based hand-rub (ABHR) stations with at least 60% alcohol are available throughout the facility
    - ABHR stations should be available outside of every resident room and accessible to staff unless otherwise contraindicated.

- ❑ All facility personnel are wearing a facemask while in the facility

COVID-19 Outbreak Checklist: If the facility identifies one new resident or staff case then the facility should take the following steps to mitigate any further transmission:

Facility Assessment:

- ❑ Conduct an Infection Prevention and Control Assessment using the CDC tool within 24 hours of a new case to identify potential vulnerabilities or deficiencies.
    - Review findings with the facility's leadership team and make an actionable plan to address any improvement areas that includes a leader responsible for each area identified.

Testing:

- ❑ Once a new case is identified, the facility should initiate outbreak testing. Outbreak testing should include:
    - Testing exposed staff and residents on the affected unit(s) must take place as soon as possible. If the long-term care facility, identifies that the resident or staff member's first exposure occurred less than 24 hours ago, then they should wait to test until, but not earlier than 24 hours after any exposure, if known. This testing can be performed with any FDA EUA authorized rapid antigen tests. Staff and residents who are recovered from COVID-19 in the last 30 days can be excluded from this testing.
    - Once the facility has completed the requisite initial outbreak testing described above, the facility should test staff and residents every 48 hours on the affected unit(s) until the facility goes seven days without a new case or a DPH epidemiologist directs otherwise. The facility may use any FDA EUA-authorized rapid antigen tests to perform this testing.

- ❑ In some situations, a contact tracing approach, rather than a unit-specific approach may be appropriate (i.e., staff member with exposure to only a limited number of residents, etc.).

- ❑ A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.

- ❑ Contact DPH Epidemiology at 617-983-6800 for any questions regarding outbreak response.

  Asymptomatic staff and residents who have recovered from COVID-19 in the last 30 days can be excluded from outbreak testing unless there is an identified exposure, and they become symptomatic.

- ❑ In addition to outbreak testing outlined above, the facility should immediately test any symptomatic resident or staff member or newly exposed resident or staff member. The facility may use the BinaxNOW tests or other FDA EUA-approved rapid antigen tests to perform such testing.

- ❑ *Continue to Follow DPH Surveillance Testing Guidance.*

Staffing:

- ❑ Limit direct care nursing staff to working on one unit for the duration of the outbreak, to the extent possible. If direct care staff need to be assigned to work on a different unit, then test the staff member using the BinaxNOW tests or other FDA EUA-approved rapid antigen tests prior to the beginning of the shift on the alternate unit.

- ❑ Environmental services, therapy and dietary staff should be limited to working on one unit to the extent possible.

Personal Protective Equipment (PPE) and Hand Hygiene:

- ❑ Ensure PPE and Hand Hygiene Compliance.

- ❑ Designate a PPE coach or coaches for each shift who are responsible for performing PPE and hand hygiene audits as well as performing just-in-time education to staff on PPE use.

- ❑ Perform PPE and hand hygiene audits using a tool, document the findings, share with facility's leadership team at least daily and provide feedback to frontline staff
    - o Perform hand hygiene audits during all shifts on all units.
    - o Perform PPE audits during all shifts on all units.
    - o Establish adherence goals for hand hygiene and PPE audits; if the facility's performance falls below the goal, then identify plan to address any causal factors for non-adherence.

- ❑ Ensure that alcohol-based hand-rub (ABHR) stations with at least 60% alcohol are available throughout the facility
    - o ABHR stations should be available outside of every resident room and accessible to staff unless otherwise contraindicated.

- ❑ Residents, as they are able to tolerate, should wear a facemask anytime a staff member enters their room during an outbreak on their unit and whenever they leave their room or are around others. This includes whenever they leave the facility for essential health care appointments.

- ❑ Post precaution signs immediately outside of resident rooms indicating appropriate infection control and prevention precautions. *See DPH Precautions Signs.*

Appendix C

Isolation and Exposure Chart for Residents

Resident Recovered Status	If resident identified as a close contact** of a case:	If resident tests positive for COVID-19:
Not recently recovered	No quarantine indicated. **Test** as soon as possible, but not sooner than 24 hours following exposure, on Day 3 and Day 5, or if symptoms develop.	**Isolate** for 10 days with release on day 11 or release after day 5 with a negative test on day 5 or later. If released before day 11, resident must be able to wear a mask when around others through day 10 and must have substantial improvement in symptoms (if any).
Recovered < 30 days (regardless of vaccination status)	No testing indicated unless symptoms develop and no alternate diagnosis.	If resident develops new symptoms and tests positive for COVID-19, then isolate for 10 days with release on day 11 or release after day 5 with a negative test on day 5 or later. If released before day 11, resident must be able to wear a mask when around others through day 10 and must have substantial improvement in symptoms (if any).

* Up to date means the resident has completed a COVID-19 vaccine primary series and received the most recent booster dose recommended for the individual by CDC.

**Close contact means being within 6 feet for 15 minutes or more (in a 24-hour period), of someone diagnosed with COVID-19, while that individual was potentially infectious.