

# Coronavirus Disease 2019 (COVID-19)

## Response and Containment Guide for Long-Term Care and Other Residential Facilities in Kansas

April 28, 2020, Updated October 29, 2020

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Long-term care facilities in Kansas cannot and *should not* turn away new residents or refuse to readmit previous residents for fear of COVID-19.

While it is understood there is significant resource and staffing burden for facilities taking care of patients with COVID-19, it must also be emphasized that it is an inappropriate use of hospital resources hospitals to house patients who are no longer meeting inpatient criteria. It is critical that all Kansas facilities participate in the care of patients with COVID-19, whether they are caring for current residents who are ill but stable enough to remain in the facility or are receiving patients with COVID-19 no longer requiring hospitalization. Please help us all do our part to ensure safe and effective care for our residents in Kansas. If your facility medical provider [suspects COVID-19](#), please **report it to the KDHE Epidemiology Hotline via fax 877-427-7318**.

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This guidance is intended for use by infection preventionist, nursing personnel, and other relevant staff in long-term care facilities (LTCF) and builds on our [Infection Prevention and Control Preparation Guide for Long-Term Care and Other Residential Facilities in Kansas](#).

The Centers for Medicare & Medicaid Services (CMS) has implemented [guidance](#) that must be followed to focus on infection prevention and control in LTCFs for prevention of further spread of COVID-19. Prior to any confirmed COVID-19 cases present in a LTCF, adherence to current CMS requirements and the Centers for Disease Control and Prevention (CDC) recommendations should be in effect with the aim of preventing infections. The primary focus for facilities without any active COVID-19 cases should be preparing for cases. If and when cases occur in the facility, the focus should shift to containment. It is imperative that all facilities develop a realistic plan to care for COVID-19 patients within their facility. Drill your preparedness plan with frontline staff to ensure your facility knows how to respond when using the plan.

It is important to note that these recommendations are meant to help healthcare facilities of every type continue to provide assessment, testing, and treatment of patients no matter what disease processes are present. LTCFs are settings in which patients live long-term and in which healthcare personnel (HCP) are available for assistance with activities of daily living as well as for medical purposes (such as nursing homes, skilled nursing, and assisted-living facilities). These facilities should be able to; triage/assess, potentially test, care for residents who are well enough to stay home, and transfer residents to acute care settings when they need a higher acuity of care. Please note that given their congregate nature and populations served (e.g., older adults often with underlying chronic medical conditions), LTC residents are at the highest risk serious illness due to COVID-19.

## Monitoring for, Reporting, and Testing Cases

Your facility should already be assessing/monitoring both staff and residents. According to the plans you have in place, you should be prepared to respond when residents and staff exhibit signs/symptoms of COVID-19 (see our document). **Given the high risk of spread once COVID-19 enters a LTCF, facilities must act immediately to protect residents, families, and staff from serious illness, complications, and death.** When a person is suspected of having COVID-19 ([person under investigation \[PUI\]](#)), immediately implement infection control practices, notify infection preventionist, and local/state health departments.

K.A.R. 28-1-2 requires facilities to notify local/state health department within 4 hours regarding:

- Suspected or confirmed COVID-19 in any resident or HCP, or
- Identification, within 72 hours, of 2 or more cases of respiratory illness among residents and/or HCP

**KDHE 24/7 Epidemiology Hotline contact information:**

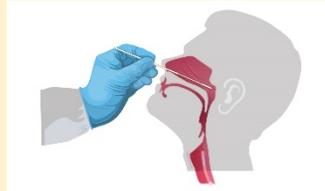
**Phone – 877427-7317**

**Fax – 877-427-7318**

These situations should prompt further investigation including testing for SARS-CoV-2 (the virus that causes COVID-19). Free testing (including testing supplies) of symptomatic HCP and residents is available through the Kansas Health and Environmental Laboratories (KHEL) and should be considered for testing patients based on local/state health department guidance. Testing is also available through many private laboratories. Residents and HCP with suspected COVID-19 (PUI) should be prioritized for testing. HCPs should cease patient care activities, notify infection preventionist, and be excluded from work.

### Facility:

#### Testing plans



- Follow your facility's plan for how to test and where to send specimens for COVID-19 testing: supplies (swabs, collection media), staff capable of testing, plans to deliver specimens
- If collecting specimens in-house, ensure staff are trained in appropriate PPE and follow [proper collection guidance](#)
- If the facility is unable to collect specimens in-house, consider working with nearby facilities to create agreements for testing as soon as possible while also minimizing exposures
- If testing is being done through KHEL, please fill out the [approval form](#) fax a copy to 877-427-7318, and send a copy with the specimen to KHEL
- If you are having testing done through a private laboratory – no approval is required; however a report of the suspicion of COVID-19 is mandatory so please send a [general reportable disease form](#) to 877-427-7318

## Infection Control and Personal Protective Equipment

Develop a realistic plan to care for COVID-19 patients within your facility. Drill your preparedness plan with frontline staff to ensure your facility knows how to respond when using the plan.

KDHE encourages all healthcare facilities to follow CDC's infection prevention and control (IPaC) measures as closely as possible:

### PREFERRED COVID-19 IPaC Guidelines

Place suspect and positive patients in an AIIR isolation room and follow Standard, Contact, and Airborne plus eye protection.

These measures are currently the ideal scenario for managing PUI and confirmed cases of COVID-19. However, KDHE and CDC are aware that the realities of our healthcare facilities might limit the ability to follow these guidelines. To that end, KDHE has created "alternative" guidance to assist in limited resource situations, aiming to ensure the safety of staff and patients with supplies on hand. CDC also [updated their recommendations](#) of acceptable alternatives, to be used in times of PPE shortages.

### Alternative Strategies for COVID-19 IPaC Measures

It is important to note that following these alternative strategies will place your HCPs in the **Low Risk Category** for the [KDHE Asymptomatic Healthcare Workers with Exposure to COVID-19](#).

#### AIIR unavailable:

- Put resident in a private room with their own bathroom – ideal to use a room with an air system that does not recirculate to other rooms without HEPA filtration – in the case of multiple PUIs or confirmed cases, rooms can be shared among residents ill with the same disease
- Keep a mask on the resident when HCP are in room, except during COVID-19 specimen collection procedure
- Keep door closed except to enter and exit
- Restrict staff presence in room to only those essential for care/procedures. Consideration will need to be given for contracted medical services that come onsite to deliver necessary care, but again, if these are not medical necessities (e.g., hair care, volunteers, non-essential staff) you should restrict their entry to the facility during this time of COVID-19 spread in communities.
- Do not allow in-person visitors, instead offer virtual/audio-visual methods for visits
- Place a facemask on the resident if they need to leave the room

### If N-95 or higher-level respirators are unavailable:

Observe Standard, Contact, and Droplet Precautions plus eye protection when coming into close contact ([See definition](#)):

**Cloth face coverings/masks are NOT considered PPE and should not be worn by HCP when PPE is indicated. Personal eyeglasses are NOT considered adequate eye protection.**

- Gown
- Gloves
- Facemask (i.e., surgical mask)
- Eye protection (e.g., face shield or goggles)
- Appropriate [donning](#), [doffing](#), and [hand hygiene](#) used throughout

### Steps for obtaining PPE from local/state Emergency Management:

#1 – Initially try to exhaust efforts with your primary contractor/vendor PPE suppliers

#2 – Check with all other vendors or contracted entities you have that might be able to find the product

#3 – Check with local/regional partners, organizations, or facilities who might be able to lend you some supplies (this includes going to parent organizations)

#4 – Call your local/county emergency management program (usually at the county level)

## Presence of Suspected or Confirmed Cases in Facility

Note – it is very likely that you will see COVID-19 in your facility at some point. **Early detection and implementation of mitigation strategies** are key in trying to better control the spread. It is crucial that you notify your local/state health departments so they can assist in finding the best strategies for your facility.

The presence of COVID-19 in a LTCF usually starts with introduction from an outside source (e.g. essential HCP). Recognition of COVID-19 usually begins with a single person (resident or staff) appearing ill. The faster these can be detected, and appropriate containment measures implemented, the chances are better that transmissions can be controlled.

Examples of single cases you might see in your facility:

**HCP with a laboratory-confirmed COVID-19 positive result worked while infectious (ill or during 48-hours prior to symptom onset).**

**Resident (PUI) tested and comes back with a laboratory-confirmed COVID-19 positive result.**

Exposure includes contact with PUI (unless ruled out with low suspicion), or COVID-19 exposure either while the infected was symptomatic OR had contact 48h prior to symptom onset. KDHE can assist with decisions about testing of asymptomatic residents.

If HCP in your facility are strongly suspicious of COVID-19 in a HCP or resident, a report should be made to your local/state health departments resulting in assistance with testing suspect person(s) and investigating for potential presence of COVID-19 in your facility. However, many times this notification does not happen until after confirmatory lab results are already in-hand at the facility. Once a single case is detected, a report should be made to your local/state health departments to start (or continue) the disease investigation.

## IN ADDITION TO STEPS DESCRIBED IN OUR PREPARATION GUIDE

### Residents:



#### Monitor

- Asymptomatic: vital signs (including measuring temperature and oxygen saturation levels) and ask or observe them for signs/symptoms of lower respiratory illness (e.g. cough, shortness of breath) for 14 days after exposure event
- Symptomatic (PUI)/Confirmed cases: immediately provide facemask, isolate according to plan, ensure facility's medical provider promptly assesses
  - If stable enough for continued facility care, keep resident isolated
  - If deemed unstable, call 911 or send them to the nearest hospital, ensure transport and receiving facility are [notified of potential PUI](#)

#### Source control – Isolation/Quarantine

- All: remain at least 6 feet away from others and cover nose/mouth when HCP in room and when outside of room
- Asymptomatic: remain in room to degree possible, cloth face covering can be used for source control, for 14 days after exposure event
- PUI/Confirmed case: isolate to single occupancy as available, facemask for source control

#### Track

- Continuing logging temp/symptom checks on all
- Start a [line list](#) of PUI/confirmed
  - Use for monitoring case
  - Use for identifying contacts
- Update daily and share with your local health department



For PUIs (residents) who have negative test results (note – negative test results do not ensure lack of transmission), consider continued use of all recommended PPE during the care of the resident. Roommates of residents with COVID-19 might already be exposed, use of all recommended PPE during the care of these residents is recommended. Also, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.

Your line list should contain information that helps you and your health department partners track the introduction and potential exposures in your facility. Contacts outside of the facility (e.g. household contacts) also need to be considered for appropriate quarantine measures.

**Do NOT refuse to receive new residents or residents being discharged from hospitals!** Acute care hospitals need to be reserved for patients who require admission for treatment and cannot hold residents who no longer need inpatient treatment. Accept residents as you normally would and quarantine/isolation the resident (as needed) for 14 days ensuring to perform temperature, oxygen saturation, and symptom checks and use appropriate PPE.

## IN ADDITION TO STEPS DESCRIBED IN OUR PREPARATION GUIDE

### Staff:

#### Source control

- Use of universal masks – all people inside of the healthcare facility will wear a mask at all times (exceptions for eating, etc.).
  - Prioritize medical masks (e.g., N95, surgical, procedure) to HCP who have close contact with patients
  - Staff who do not have close contact with patients can use cloth face coverings
- Universal use of [all recommended PPE](#) during the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community.
- If your facility is unable to follow this due to lack of PPE, please see the below alternative strategies as well as the Strategies for Optimizing Facemasks on our KDHE COVID-19 Resource Center.
  - Prioritize use of universal mask/PPE techniques to facilities in which active outbreaks are occurring.
  - Prioritize use of universal mask/PPE techniques to facilities within local areas with community transmission (e.g., counties, cities)

#### Monitor

- Encourage daily (prior to work) temperature checks, symptomatic checks and enforce staff policies **not to report to work when ill**
- Consider doing a temperature and symptoms (e.g. cough, shortness of breath) check at the **beginning and during** every shift.

#### Manage

- If staff displays signs/symptoms of COVID-19 immediately provide facemask, discontinue their shift, send home to self-isolate or to seek medical care
  - If staff feels they need medical care and testing, they should be instructed on seeking care from their PCP, or
  - If deemed unstable, call 911 for transfer to the local emergency department (ensure aware incoming potential PUI)
- If deemed safe for home monitoring: isolate for duration of illness a minimum of 7 days from symptom onset, at least 72 hours fever-free (off fever-reducing medications) *with* symptom improvement, **whichever is longer** ([releasing cases and contacts from isolation and quarantine](#)), further return to work guidance discussed in After Outbreak



## New Testing Strategy

KDHE would like to be more aggressive in testing of persons directly linked to these types of communal living settings, especially those serving populations who are at higher risk for severe illness due to COVID-19. If testing capacity is available, upon confirmation of one case, KDHE would like to work with the facility to determine a feasible plan for broad testing of staff and residents (both symptomatic and asymptomatic).

## Outbreak Response

If an **Outbreak of COVID-19** is Identified in the Facility  
(e.g. two or more cases within 14 days among HCP and/or residents)

NOTE – The incubation period can be up to 14 days and the **identification of new case within a week to 10 days of starting outbreak interventions DOES NOT necessarily represent a failure of the interventions to control transmission.**

1. Maintain all interventions from the above examples and build on those.
2. Maintain a [line list](#) of all positive staff and residents with documentation of minimum criteria and send **at least daily updates** to the local health department:
  - Name and date of birth
  - Specify staff or resident
  - Room number or unit staff assigned to
  - Symptom onset and type of symptoms
  - Hospitalization (admission and discharge dates, hospital name)
  - Date symptoms resolved
  - Date healthcare worker returned to work
3. Implement cohorting of staff and residents, if feasible\*
  - Testing strategy – if broad testing is available:
    - i. use testing of staff to ensure appropriate in-home isolation/quarantine
    - ii. use testing of residents to help with cohorting strategies
  - **\*Cohorting** = COVID-19 positive residents could share rooms with other COVID-19 positive residents. These residents should be cohorted together in a designated location with dedicated HCP providing their care (this is referred to as “cohorting of staff”).
  - For cohorting efforts to be effective, **consult the local/state health department** for guidance.
  - Roommates of COVID-19 patients should be considered potentially infected and not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure.
4. Enforce quarantine for all asymptomatic residents until no additional clinical cases for 28 days from last COVID-19 case onset date or until cases subside in community.
5. Increase frequency of cleaning high-touch surface areas.
6. Temporarily cease new admissions; until the situation can be addressed and interventions can be implemented OR if transmission is not controlled.

**Note:** Negative test results **do not** ensure lack of transmission. Use of PPE should continue for exposed residents for a min. of 14 days symptom-free.

**Do NOT refuse to receive previous residents being discharged from hospitals!** Acute care hospitals need to be reserved for patients who require admission for treatment and cannot hold residents who no longer need inpatient treatment. Accept residents back as you normally would and quarantine/isolation the resident (as needed) for 14 days ensuring to perform temperature, oxygen saturation, and symptom checks and use appropriate PPE.

**If additional cases persist beyond the initial 10 days from start of enhanced outbreak interventions, notify your local/state health department for further assistance and guidance.**

## Definitions

Close Contact:

You are a "**close contact**" if any of the following situations happened while you spent time with a person with COVID-19, even if they didn't have symptoms:

- Were within 6 feet of the person for 10 consecutive minutes or more
- Had contact with the person's respiratory secretions (for example, coughed or sneezed on; kissed; contact with a dirty tissue; shared a drinking glass, food, towels, or other personal items).
- Live with the person or stayed overnight for at least one night in a house with the person.

The chance of spreading the virus is greater the longer an infected person or persons are close to someone. It also matters if the infected person is coughing, sneezing, singing, shouting, or doing anything else that produces more respiratory droplets that contain virus or if there are exposures to more than one infected person. Under these higher risk situations, you may want to consider a close contact someone who has been within 6 feet of an infectious person or persons for 10 cumulative minutes or more in a 24-hour period.

The final decision on what constitutes close contact is made at the discretion of public health.

## Additional Resources and Guidance to Implement:

KDHE Guidance to Facilities: Coronavirus Disease 2019 (COVID-19) – Infection Prevention and Control Preparation Guide for Long-Term Care and Other Residential Facilities in Kansas

CMS Guidance: [Guidance for Infection Control and Prevention of Coronavirus Disease 2019 \(COVID-19\) in Nursing Homes \(REVISED\)](#)

CDC Guidance for LTCF (includes preparedness checklist and webinar, and sample family/resident notification letter):

<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>

CDC Return-to-Work for HCP with COVID-19 Guidance:

<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>

American Health Care Association COVID-19 Resources (include sample family and resident notification letters, staff symptom screening tool and more):

[https://www.ahcancal.org/facility\\_operations/disaster\\_planning/Pages/Coronavirus.aspx](https://www.ahcancal.org/facility_operations/disaster_planning/Pages/Coronavirus.aspx)

## References:

CDC. *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*. March 19, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>. March 26, 2020.

CDC. *Preparing for COVID-19: Long-Term Care Facilities, Nursing Homes*. March 21, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>. March 27, 2020.

Healthcare-Associated Infections  
& Antimicrobial Resistance Program

