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Welcome Nursing Facility Providers!

**COVID-19 Updates and Q&A
HHSC Long-Term Care Regulation
and
Department of State Health Services
May 11, 2022**

For more information:

Web: <https://hhs.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-provider-information>

Email: LTCRPolicy@hhs.texas.gov | Phone: (512) 438-3161

COVID-19, updates and Q&A

Panelist

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CMS to end COVID-19 Waivers for NFs, ICF/IIDs, Inpatient Hospices

[QSO-22-15-NH & NLTC & LSC](#): Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers issued on April 7, 2022

- COVID-19 emergency declaration blanket waivers ending for nursing facilities, skilled nursing facilities, ICF/IIDs, and inpatient hospices in two phases:
 - 30 days from April 7 (May 7)
 - 60 days from April 7 (June 6)
- Providers are expected to take immediate steps to return to compliance with the reinstated requirements according to the timeframes.
- Recommended providers continue following CDC guidance for preventing the spread of COVID-19, especially during activities that may increase resident contact.



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COVID-19 Waivers for NFs Ending May 7

[QSO-22-15-NH & NLTC & LSC](#): Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers

Emergency Declaration Blanket Waivers Ended for SNF/NFs May 7, 2022 (30 Days from Publication of the Memorandum):

- Resident Groups - 42 CFR §483.10(f)(5)
- Physician Delegation of Tasks in SNFs - 42 CFR §483.30(e)(4)
- Physician Visits - 42 CFR §483.30(c)(3)
- Physician Visits in Skilled Nursing Facilities/Nursing Facilities - 42 CFR §483.30
- Quality Assurance and Performance Improvement (QAPI) – 42 CFR §483.75(b)–(d) and (e)(3)
- Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities - 42 CFR §483.21(c)(1)(viii)
- Clinical Records - 42 CFR §483.10(g)(2)(ii)



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CMS to end COVID-19 Waivers for NFs ending June 6

[QSO-22-15-NH & NLTC & LSC:](#)

Emergency Declaration Blanket Waivers Ending for SNF/NFs June 6, 2022 (60 Days from Publication of the Memorandum):

- In-Service Training for LTC facilities – 42 CFR §483.95(g)(1)
- Training and Certification of Nurse Aides for SNF/NFs - 42 CFR §483.35(d) (Modification and Conditional Termination): a SNF or NF may not employ anyone for longer than four months unless they met specific training and certification requirements.
 - Nurse aides will have until [October 6, 2022](#) to successfully complete the required training and certification, regardless of the amount of time worked during the period the waiver was in effect.
 - Nurse aides who want to use SNF/NF work training and experience gained during the COVID-19 PHE to count toward certification must follow the process outlined in [Provider Letter 2021-19 - Certification Process for Nurse Aides Training and Working Under a Waiver.](#)



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CMS to end COVID-19 Waivers for NFs May 7 or June 6

[QSO-22-15-NH & NLTC & LSC:](#)

Emergency Declaration Blanket Waivers Ending for SNF/NFs **June 6, 2022 (60 Days from Publication of this Memorandum):**

- Physical Environment for SNF/NFs - 42 CFR §483.90
- Facility and Medical Equipment Inspection, Testing & Maintenance (ITM) for SNFs/NFs – 42 CFR §483.90
- Life Safety Code (LSC) and Health Care Facilities Code (HCFC) ITM for SNFs/NFs - 42 CFR §483.90(a)(1)(i) and (b)
- Outside Windows and Doors for SFNs/NFs – 42 CFR §483.90(a)(7)
- Life Safety Code for SNFs/NFs - 42 CFR §483.90(a)
- Paid Feeding Assistants for LTC facilities: 42 CFR §§483.60(h)(1)(i) and 483.160(a)

[Read the CMS memo details](#)



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HHSC Adopts Revised EMR Rules transferred to Title 26

04/26/2022

HHSC Long-term Care Regulation adopted Texas Administrative Code Title 26, [Chapter 561](#), Employee Misconduct Registry rules.

Effective as of April 21, 2022.

Key changes to the rule:

- Transfer from Title 40 to Title 26
- Replace references to legacy agencies
- Revise informal review process to reflect current practice



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NFs, NATCEPs Needed to Serve as Nurse Aide Testing Sites

5/5/2022 – HHSC Long-term Care Regulation seeking more NFs to serve as Nurse Aide Training and Competency Evaluation Program testing sites. Current NATCEPs that are not testing sites are urged to become testing sites.

- Becoming a testing site will help you recruit new nurse aides to your facility and/or new students to your training program.
- If interested in becoming a NATCEP testing site, [email Prometric inbox](#).
- See [Provider Letter 2021-19](#) for information on the certification process for nurse aides training and working under the waiver.



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Consent for Antipsychotic and Neuroleptic Medications

5/5/2022 – [PL 2022-11 Consent for Antipsychotic and Neuroleptic Medications](#)

- Guidance on requirements in Texas Health and Safety Code, [§242.505](#) and Texas Administrative Code, Title 26 (26 TAC), [§554.1207](#) for NFs to obtain written consent for treating a resident with antipsychotic or neuroleptic medication.
- Consent for antipsychotic and neuroleptic medications must be documented on HHSC [Form 3713, Consent for Antipsychotic or Neuroleptic Medication Treatment](#)



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State Long-Term Care Ombudsman Program

Statewide phone: 800-252-2412

Statewide email:

lrc.ombudsman@hhs.texas.gov

State Ombudsman: Patty Ducayet
512-438-4356 (or)

Patricia.Ducayet@hhs.texas.gov

Facebook:

https://apps.hhs.texas.gov/news_info/ombudsman/



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Centers for Disease Control and Prevention

Panelists

Abimbola Ogundimu, DrPH, RN, CIC, CPHQ

Heather Jones, DNP, NP-C

Centers for Disease Control and Prevention

Information: [Visit CDC-INFO](#)

Email: [CDC-INFO](#)

Phone: (800) 232-4636



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Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

COVID-19 Updates

Abimbola Ogundimu, DrPH, RN, CIC, CPHQ

Heather Jones, DNP, NP-C

Understanding COVID-19 Updates for Long-Term Care

We'll start out with case scenarios****

******Please note these scenarios are not
based on real-life examples**

Case Study #1

Scenario: You are a new healthcare-associated infection (HAI) epidemiologist working with the Texas Department of State Health Services (DSHS). You were recently hired to assist the program with investigating new suspected SARS-CoV-2 transmission (i.e., outbreak) within Nursing Homes A and B.

On your first day (2/11/22), you get a call from Nursing Home A, reporting 5 additional cases of suspected SARS-CoV-2 infections in 2 residents and 3 healthcare providers (HCPs). The facility is asking for your technical assistance with controlling this outbreak.

Case Study Facility

Nursing Home A is a 36-bed Skilled Nursing Facility (SNF) on one floor with 4 wings (North, South, East, West). The bed occupancy is at capacity. The facility is in a county with HIGH community transmission.

The facility has all single rooms on the SOUTH, EAST and WEST wings.

- The NORTH wing has 10 double-occupancy rooms for residents requiring tracheostomy care and most have complex wound care needs
- The SOUTH wing has 4 single-occupancy rooms at the end of the hallway – with 2 residents on Memory Care unit and 2 other residents requiring ventilator support
- The EAST wing has 2 single-occupancy rooms for newly admitted residents
- The WEST wing has 6 single-occupancy rooms dedicated to residents with confirmed SARS-CoV-2 infection who have not met criteria to discontinue Transmission-Based Precautions, regardless of vaccination status

Vaccination Status:

- 98% of residents are fully vaccinated and up to date with their COVID-19 vaccinations
- 51% of HCPs are fully vaccinated and 10% of HCPs are up to date with their COVID-19 vaccinations

Case Study Facility (Nursing Home A)

NORTH WING – for residents requiring trach care and complex wound care

Room 1	Room 2	Room 3	Room 4	Room 5	Room 6	Room 7	Room 8	Room 9	Room 10
Bed A	Bed A	Bed A	Bed A	Bed A	Bed A	Bed A	Bed A	Bed A	Bed A
Bed B	Bed B	Bed B	Bed B	Bed B	Bed B	Bed B	Bed B	Bed B	Bed B

WEST WING – for residents with confirmed SARS-CoV-2 infection

Room 1	Room 2	Room 3	Room 4	Room 5	Room 6

EAST WING – for newly admitted residents

Room 1	Room 2

SOUTH WING – with 2 residents on Memory Care unit and 2 other residents requiring vent support

Room 1	Room 2	Room 3	Room 4

First steps (for this facility):

Check in with your supervisor, the HAI/AR Program Coordinator, to confirm that your program should open an investigation into these cases at the request of the local health department

- If your supervisor agrees, investigations should be opened:
 - Confirm vaccination status of all residents and staff (including contracted staff)
- The steps for approaching **Nursing Home A** are not limited to only confirming the timeline of the COVID-19 test results

Case Study #1 - Question 1

What type of information will need to be captured/collected from Nursing Home A about this outbreak, in addition to case and facility information?

- Case demographics (e.g., date of birth, age, sex, race/ethnicity, weight, height)
- Hospitalization status and dates of admission and discharge
- Signs and symptoms of infection (e.g., fever, chills, cough, shortness of breath or difficulty breathing, fatigue, etc.)
- SARS-CoV-2 signs and symptoms timeline
- Updated COVID-19 vaccination status for residents and HCPs in Nursing Home A

Is there any other information you would need
to collect from **Nursing Home A**?




Case Study #2

Scenario: You are working in Nursing Home A and have been called to assist in the memory care unit for the week. There are currently no known SARS-CoV-2 infections on the unit. You are up-to-date with all recommended COVID-19 vaccinations. Due to the residents' significant cognitive deficits, many are unable to comply with recommended source control measures.

You are getting ready to start your day and need to determine what type of source control or PPE you are recommended to wear as well as what your fellow colleagues should be wearing.

Case Study #2 - Question 1

What type of information will need to be captured/collected from the nurse supervisor for this unit prior to beginning your first shift?

- Vaccination status of residents
 - Any residents with signs and symptoms of infection (e.g., fever, chills, cough, shortness of breath or difficulty breathing, fatigue, etc.)
 - Any residents requiring use of Transmission-Based Precautions or Enhanced Barrier Precautions
 - Any recent hospitalizations or new admissions
 - The county transmission rate
- 

Case Study #2 - Questions 2 and 3

You learn from the nurse supervisor that all the residents in the memory care unit have received and are up to date with recommended COVID-19 vaccine doses. However, there are two suspected cases (cough, fatigue) at the end of the hall (NORTH WING). The two residents are roommates and are awaiting results of testing. There have been no new admissions or recent readmissions. The county transmission rate is currently at “HIGH”.

- What PPE or source control should be used when providing care inside the room for the two suspected cases?
- What PPE or source control should be used when providing care inside the room the rest of the unit residents?

Case Study #2 - Question 2

What PPE or source control should be used when providing care inside the room for the two suspected cases?

- The residents should ideally be moved into single-occupancy rooms and be placed (if not already) on empiric Transmission-Based Precautions
- You should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) during any activities inside the room of the residents

Case Study #2 - Question 3

What PPE or source control should be used when providing care inside the room for the rest of the unit residents?

- You should follow Standard Precautions when providing care to the other unit residents
- It is recommended that you use source control during any encounter with the other residents on the unit, unless performing an activity that could result in higher risk for transmission (described on next slide)

Case Study #2 - Question 3

What PPE or source control should be used when providing care inside the room for the rest of the unit residents?

- NIOSH-approved N95 or equivalent or higher-level respirators should be used for:
 - All aerosol-generating procedures
 - All surgical procedures that might pose higher risk for transmission if the patient has SARS-CoV-2 infection
 - Other situations where additional risk factors for transmission are present such as
 - Resident is not up to date with all recommended COVID-19 vaccine doses
 - Resident is unable to use source control
 - Area is poorly ventilated
- Eye protection should be worn during all patient care encounters

COVID-19 Vaccine Guidance

Key Points

- COVID-19 vaccines currently approved or authorized by FDA are effective in preventing serious outcomes of coronavirus disease 2019 (COVID-19), including severe disease, hospitalization, and death
- COVID-19 primary series vaccination is recommended for everyone ages 5 years and older in the United States for the prevention of COVID-19
- A 3-dose primary mRNA COVID-19 vaccine series is recommended for people ages 5 years and older who are moderately or severely immunocompromised, followed by a booster dose in those ages 12 years and older

Key Points

- In most situations, Pfizer-BioNTech or Moderna COVID-19 vaccines are preferred over the Janssen COVID-19 vaccine for primary and booster vaccination
- A booster dose of COVID-19 vaccine is recommended for everyone ages 12 years and older. Timing of a booster dose varies based on COVID-19 vaccine product and immunocompetence

Key Points

- Efforts to increase the number of people in the United States who are up to date with their COVID-19 vaccines remain critical to preventing illness, hospitalizations, and deaths from COVID-19
- The clinical considerations (link below) provide additional information to healthcare professionals and public health officials on the use of COVID-19 vaccines

Recent Updates (as of 4/21/22)

Up To Date

- **A person has received all recommended COVID-19 vaccines**
 - Including any booster dose(s) when eligible

Fully Vaccinated

- **A person has received their primary series of COVID-19 vaccines**

Recent Updates (as of 4/21/22)

Second Booster

- People in certain groups or situations may receive a 2nd COVID-19 booster
- Second boosters can only be Moderna or Pfizer-BioNTech (and for 12 through 17-year-olds, only Pfizer-BioNTech)
- Make sure it has been at least 4 months since your 1st COVID-19 booster

Second Booster Considerations (as of 4/21/22)

Are you eligible?

- Are 50 years of age or older **and** got your first booster at least 4 months ago
- Are [moderately or severely immunocompromised](#), 12 years of age or older, **and** got your first booster at least 4 months ago
- Got 2 doses of J&J/Janssen vaccine at least 2 months ago

Second Booster Considerations

Are you (or is someone you live with) more likely to get very sick?

- If you are eligible for a second booster, it may be helpful to get a 2nd booster now if you are (or if someone you live with is)
 - Moderately or severely immunocompromised
 - More likely to get very sick from COVID-19
 - More likely to be exposed to COVID-19 through your job, where you live, or other factors (such as frequent travel or large gatherings)
 - In an area with medium to high COVID-19 community levels
 - Someone you live with is unvaccinated

Second Booster Considerations

Can you wait?

- Even if you are eligible for a second booster, you may consider waiting to get a 2nd booster if you:
 - Had COVID-19 within the past 3 months
 - Feel that getting a 2nd booster now would make you not want to get another booster in the future (a 2nd booster may be more important in fall of 2022, or if a new vaccine for a future COVID-19 variant becomes available)

Booster Dose Recommendations

Why is a booster dose recommended?

- COVID-19 vaccine boosters can further enhance or restore protection that might have waned over time after your primary vaccine series
- People are protected best from severe COVID-19 illness when they [stay up to date](#) with their COVID-19 vaccines, which includes a booster for many people
- There are different [COVID-19 vaccine recommendations for people who are moderately or severely immunocompromised](#)

Isolation Recommendations

From Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC

Patients/residents who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised

- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible
- Asymptomatic patients with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure

Patients/residents who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised

- In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these individuals, an antigen test, instead of a nucleic acid amplification test (NAAT) is recommended
- This is because some people may remain NAAT positive, but not be infectious during this period
- At least 10 days have passed since the date of their first positive viral test

Patients/residents with mild to moderate illness who are *not* moderately to severely immunocompromised

- Day 0 is the first day of symptoms
- Isolation can end when
 - At least 10 days have passed *since symptoms first appeared* and
 - At least 24 hours have passed *since last fever* without the use of fever-reducing medications and
 - Symptoms (e.g., cough, shortness of breath) have improved

Patients/residents with severe to critical illness and who are *not* moderately to severely immunocompromised

- At least 10 days and up to 20 days have passed *since symptoms first appeared* and
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved
- The test-based strategy as described for moderately to severely immunocompromised patients can be used to inform the duration of isolation

Patients/residents who are moderately or severely immunocompromised might have a longer infectious period

- Day 0 is the first day of symptoms or a positive viral test
- Extend isolation to 20 or more days
- Use a test-based strategy and consult with an infectious disease specialist to determine the appropriate duration for isolation and precautions

Patients/residents who are moderately or severely immunocompromised

- May produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test
- Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients
- Extending the duration of isolation and precautions to at least 10 days and up to 20 days after symptom onset and after fever ends (without the use of fever-reducing medication) and symptoms are improving, may be warranted

Criteria for Test-Based Strategy

- Residents/Patients who are **symptomatic**
 - Resolution of fever without the use of fever-reducing medications and
 - Symptoms (e.g., cough, shortness of breath) have improved, and
 - Results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) tested using an antigen test or NAAT
- Residents/Patients who are **not symptomatic**
 - Results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Caveats – Healthcare Personnel, Patients, and Residents

- Within 90 days of infection (for healthcare personnel, patients, and residents)
 - Testing and quarantine following exposure is not generally necessary
 - Could be considered in certain circumstances
- For healthcare visitors and outpatients
 - Follow the healthcare guidance for source control for healthcare settings and not the community guidance

Testing – Healthcare Settings

- Testing following exposure differs between the community and healthcare guidance
- In healthcare, *regardless of vaccination status*, testing is recommended following exposure
 - Two tests are recommended
 - Immediately, but not sooner than 24 hours after exposure
 - If negative, again at 5 to 7 days

Recent Updates (cont'd)

- **Patient Visitation**

- Indoor visitation (in single-person rooms; in multi-person rooms, when roommates are not present; or in designated visitation areas when others are not present)
 - The safest practice is for patients and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated
 - If the resident and all their visitor(s) are up to date with all recommended COVID-19 vaccine doses, they can choose not to wear source control and to have physical contact
 - Visitors should wear source control when around other residents or HCP, regardless of vaccination status

Recent Updates (cont'd)

- **Patient Visitation**

- Outdoor Visitation: Patients and their visitors should follow the source control and physical distancing recommendations for outdoor settings described on the page addressing [Your Guide to Masks](#)

Ultimately...

- The decision to discontinue empiric Transmission-Based Precautions (quarantine) by excluding the diagnosis of current SARS-CoV-2 infection for a patient/resident with suspected SARS-CoV-2 infection can be made based upon having negative results tested using an FDA-authorized COVID-19 viral test
- If a patient/resident is suspected of having SARS-CoV-2 infection and is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described above
- Clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions

Staffing Guidance Recommendations

Key Points

- Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and for safe patient care
- Maximizing interventions to protect HCP, residents, and visitors are critical at all times, including when considering strategies to address staffing shortages
- **CDC's mitigation strategies offer a continuum of options for addressing staffing shortages**
 - Contingency, followed by crisis capacity, strategies augment conventional strategies and are **meant to be considered and implemented sequentially** (i.e., implementing contingency strategies before crisis strategies)

Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

"Up to Date" with all recommended COVID-19 vaccine doses is defined in [Stay Up to Date with Your Vaccines | CDC](#)

For more details, including recommendations for healthcare personnel who are immunocompromised, have severe to critical illness, or are within 90 days of prior infection, refer to [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#) (conventional standards) and [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#) (contingency and crisis standards).

Work Restrictions for HCP With SARS-CoV-2 Infection

Vaccination Status	Conventional	Contingency	Crisis
Up to Date and Not Up to Date	10 days OR 7 days with negative test [†] , if asymptomatic or mild to moderate illness (with improving symptoms)	5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)	No work restriction, with prioritization considerations (e.g., types of patients they care for)

Work Restrictions for Asymptomatic HCP with SARS-CoV-2 Exposures

Vaccination Status	Conventional	Contingency	Crisis
Up to Date	No work restrictions, with negative test on days 1 [‡] and 5–7	No work restriction	No work restriction
Not Up to Date	10 days OR 7 days with negative test [†]	No work restriction with negative tests on days 1 [‡] , 2, 3, & 5–7 (if shortage of tests prioritize Day 1 to 2 and 5–7)	No work restrictions (test if possible)

[†]Negative test result within 48 hours before returning to work

[‡]For calculating day of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0



C3328856-A | 01/07/2022

cdc.gov/coronavirus

Healthcare Personnel (HCP) with SARS-CoV-2 Infection

- In general, *asymptomatic HCP* who have had a higher-risk exposure do not require work restriction if they are [up to date](#) with all recommended COVID-19 vaccine doses and do not develop symptoms or test positive for SARS-CoV-2
- HCP with even *mild symptoms* of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays; ensure that SARS-CoV-2 testing is performed with a test that is [capable of detecting](#) SARS-CoV-2 even with currently circulating variants in the United States

Healthcare Personnel (HCP) with SARS-CoV-2 Infection (cont'd)

- The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known
- Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP

Source Control and Personal Protective Equipment (PPE)

Implementing Source Control Measures

- [Source control](#) refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing
- Source control options for HCP include
 - A NIOSH-approved N95 or equivalent or higher-level respirator
 - A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated)
 - A well-fitting facemask

Source Control vs. PPE Use

for Suspected or Confirmed SARS-CoV-2 Infection

Source control is recommended for **everyone in a healthcare setting**

This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with **substantial to high community transmission** or who

- Are not up to date with all recommended COVID-19 vaccine doses
- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze)
- Have moderate to severe immunocompromise
- Have otherwise had source control recommended by public health authorities
- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection for 10 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission (i.e., outbreak)

Types of Masks and Respirators

- Masks are made to contain droplets and particles you breathe, cough, or sneeze out. If they fit closely to the face, they can also provide you some protection from particles spread by others, including the virus that causes COVID-19
- Respirators are made to protect you by filtering the air and fitting closely on the face to filter out particles, including the virus that causes COVID-19. They can also contain droplets and particles you breathe, cough, or sneeze out so you do not spread them to others

Types of Masks and Respirators (cont'd)

- Masks and respirators (i.e., specialized filtering masks such as “N95s”) can provide different levels of protection depending on the type of mask and how they are used
- Loosely woven cloth products provide the least protection, layered finely woven products offer more protection, well-fitting disposable surgical masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection

Types of Masks and Respirators (cont'd)

- Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to
- Learn how to improve how well your mask protects you by visiting CDC's [Improve How Your Mask Protects You](#)

Implementing Source Control Measures

- When used solely for source control, any of the options listed on the previous slides could be used for an entire shift unless they become soiled, damaged, or hard to breathe through
- If they are used during the care of a patient for which a NIOSH-approved respirator or facemask is indicated (e.g., NIOSH-approved N95 or equivalent or higher-level respirator) during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure, or during care of a patient on Droplet Precautions, they should be removed and discarded after the patient care encounter and a new one should be donned

Source Control vs. PPE Use for Suspected or Confirmed SARS-CoV-2 Infection

- If SARS-CoV-2 infection is not suspected in a resident you are providing care for (based on symptom and exposure history) and the resident does not require Transmission-Based Precautions or Enhanced Barrier Precautions, the HCP should
 - Follow **Standard Precautions** for all patient care
 - Perform Hand Hygiene
 - Use PPE whenever there is an expectation of possible exposure to infectious material
 - Follow respiratory hygiene/cough etiquette

Source Control vs. PPE Use for Suspected or Confirmed SARS-CoV-2 Infection (cont'd)

- HCP working in facilities located in [counties](#) with substantial or high transmission should also use PPE as described below
- All aerosol-generating procedures (refer to [Which procedures are considered aerosol generating procedures in healthcare settings?](#))
- All surgical procedures that might pose higher risk for transmission if the resident/patient has SARS-CoV-2 infection (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract)

Source Control vs. PPE Use for Suspected or Confirmed SARS-CoV-2 Infection (cont'd)

- NIOSH-approved N95 or equivalent or higher-level respirators can also be used by HCP working in other situations where additional risk factors for transmission are present, such as:
 - The resident is not up to date with all recommended COVID-19 vaccine doses
 - The resident is unable to use source control
 - The area is poorly ventilated
- NIOSH-approved N95s may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place

Source Control vs. PPE Use for Suspected or Confirmed SARS-CoV-2 Infection (cont'd)

- To simplify implementation, facilities in counties with substantial or high transmission may consider implementing universal use of NIOSH-approved N95s, an equivalent, or higher-level respirators for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission

Recent Updates

- **HCPs who are up to date with all recommended COVID-19 vaccine doses**
 - Could choose not to wear source control or physically distance when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen)
 - They should wear source control when they are in areas of the healthcare facility where they could encounter patients (e.g., cafeteria, common halls/corridors)

General Infection Prevention and Control (IPC)

Key Points

- Age is a strong risk factor for severe COVID-19 illness, complications, and death
- Among a cohort of more than 44,000 confirmed cases of COVID-19 in China, the case fatality ratio (CFR*) increased with advancing age, and was highest among the oldest cohort
- The CFR was also elevated for patients with comorbidities

*CFR: the proportion of individuals diagnosed with a disease who die from that disease and is therefore a measure of severity among detected cases

[Management of Patients with Confirmed 2019-nCoV | CDC](#)

Key Points

- Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2
- A strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP)
- Even as nursing homes resume normal practices, they must sustain core IPC practices and **remain vigilant for SARS-CoV-2 and other infections among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death**

Infection Prevention and Control (IPC) Measures

- Hand hygiene
- Appropriate use of personal protective equipment (PPE)
- Environmental Cleaning and Disinfecting
- Education and Communication

- Hand hygiene

- Appropriate use of personal protective equipment (PPE)

- Environmental Cleaning and Disinfecting

- Education and communication

Standard Precautions – Hand Hygiene

Use of Alcohol-Based Hand Sanitizer

- Immediately before touching a patient
- Before performing an aseptic task or handling an invasive medical device
- Before moving from work on a soiled body site to a clean body site on the same patient
- After touching a patient or the patient's immediate environment
- After contact with blood, body fluids, or contaminated surfaces
- Immediately after glove removal

Wash with Soap and Water

- When hands are visibly dirty
- After caring for a person with known or suspected infectious diarrhea
- After known or suspected exposure to spores (e.g., *B. anthracis*, *C. difficile* outbreaks)

Hand Hygiene

- Use Alcohol-Based Hand Sanitizer prior to and after performing any hands-on activity with resident
 - Including before and after donning and doffing gloves
- Recommendation to use soap and water if hands are visibly soiled, before eating, and after using the restroom

Barriers to Hand Hygiene (HH) adherence in NHs

Workload

Access

Guidelines

Confusion with gloves

Lack of Education

Barriers to Hand Hygiene (HH) adherence in NHs

Workload



Forgot HH because of workload

Access



27.5% lack of alcohol-based hand rub

Guidelines



Belief that HH guidelines aren't applicable in LTC

Confusion with gloves



No HH because of glove use

Lack of Education



55% never/rarely received personal feedback on HH practices

- Hand hygiene

- Appropriate use of personal protective equipment (PPE)

- Environmental Cleaning and Disinfecting

- Education and Communication



Standard Precautions

Used in all settings with all residents

- **Gloves**
 - Use when anticipating touching blood, body fluids, secretions, excretions, contaminated items, and touching mucous membranes and non-intact skin
- **Gowns**
 - Use during any procedure and resident care activity when contact anticipated with blood/body fluids, secretions, or excretions
- **Mask, goggles, or face shield**
 - Use during any activity likely to generate splashes or sprays with blood, body fluids, secretions, or excretions

Contact Precautions

Used in all settings with specific residents for all room entries

- Includes the use of **gowns** and **gloves**
- *C. difficile*, scabies, norovirus, and other conditions where Contact Precautions is recommended
- Presence of acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained
- On units where ongoing transmission is documented or suspected

Used in all settings with specific residents for all room entries

- Resident should be placed in a private room*
- Gowns and gloves are recommended for every entry into the room and for all activities being performed in the room
- Residents should be restricted to their room except for medically necessary movement
- Intended to be time-limited
 - to reduce transmission during a limited infectious period or period of high risk for transmission (e.g., acute care hospital stay)



*When a private room is unavailable, some residents may be cohorted

Enhanced Barrier Precautions (EBP)

Used in NH settings with specific resident situations and only during High-Contact Resident Care Activities

- Includes the use of **gowns** and **gloves**
- **Specific resident situations**
- Infection or colonization with a novel or targeted MDRO *when Contact Precautions do not apply*
- Wounds/and or indwelling medical devices *regardless of MDRO colonization status* who reside on a unit or wing where a resident known to be infected or colonized with a novel or targeted MDRO resides

Used in NH settings with specific resident situations and only during High-Contact Resident Care Activities

- Does not require a private room
- Gowns and gloves are recommended for High-Contact Resident Care Activities
- Residents are not restricted to their room
- Intended to be used for the resident's entire length of stay in the facility



PPE Use

- Understand when and what types of PPE are recommended during activities with residents requiring Transmission-Based Precautions (TBP) or Enhanced Barrier Precautions (EBP)
- Appropriate storage and accessibility of PPE at point of care locations
- Audit the practice of donning and doffing and provide real-time feedback

- Hand hygiene
- Appropriate use of personal protective equipment (PPE)
- Environmental Cleaning and Disinfecting
- Education and Communication

Environmental Cleaning and Disinfection

- Effective cleaning and disinfection of facility surfaces and shared resident care equipment is critical
- Focus on daily cleaning and disinfection of high touch surfaces
- Clean and disinfect non-disposable, non-dedicated (i.e., shared between patients) equipment after each use

Environmental Cleaning and Disinfection

- Ensure you are using the right cleaning/disinfection product for the correct contact time (dwell time)
 - Contact time: The amount of time a disinfectant must remain wet on a surface to be effective
- Know your facility and regional epidemiology
- Establish a “who cleans what” list for all staff

- Hand hygiene
- Appropriate use of personal protective equipment (PPE)
- Environmental Cleaning and Disinfecting
- Education and Communication

Educational Resources

- **Don't Reinvent the Wheel**
 - Use the resources available
 - Provide numerous options for learning (auditory, visual, tactile)
 - Give and receive feedback

Welcome to CDC TRAIN

CDC TRAIN is a gateway into the [TRAIN Learning Network](#), the most comprehensive catalog of public health training opportunities. TRAIN is a free service for learners from the Public Health Foundation.



**The right infection
control actions
help stop germs
from spreading.**

Learn more:
WWW.CDC.GOV/PROJECTFIRSTLINE



Auditing adherence to IPC practices and providing feedback to staff about adherence

- Consistently audit adherence to IPC practices (e.g., hand hygiene, PPE selection and use, including donning and doffing, environmental surface and shared equipment cleaning and disinfection)
- Can be either paper or electronic documentation
- Share your results and provide real-time feedback

Communication

- Ask the transferring unit, hall, facility for residents' infection status (i.e., MDRO, SARS-CoV-2) and what precautions are in place or recommended
- Use appropriate recommended signs for residents requiring Transmission-Based Precautions or Enhanced Barrier Precautions

Communication

- Health Departments (e.g., facility-to-health department and vice versa)
- Within your facility (e.g., floor-to-floor, shift-to-shift)
- Other healthcare providers and facilities
- Your residents, staff, and families (e.g., staff-to-resident, Residents' council)



Coordinated Approach *(Needed)*

- Public health departments track and **alert** health care facilities to antibiotic-resistant or *C. difficile* germs coming from other facilities and outbreaks in the area.
- Facilities and public health authorities share information and implement shared infection control actions to stop spread of germs from facility to facility.

Thank you for all you do!

**Please do not hesitate to contact us with questions or comments
at al2074@cdc.gov and qtt4@cdc.gov**



COVID-19, updates and Q&A

Panelist

Robert Ochoa

Senior Policy Specialist
Policy & Rules
Long-term Care Regulation



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Services

Reminders

GovDelivery Alerts

Don't forget to sign up for GovDelivery alerts <https://service.govdelivery.com/accounts/TXHHSC/subscriber/new>. Select "Nursing Facility Resources" as a topic option to receive webinar updates.

CMS/CDC COVID-19 Training

CMS is offering free online training for nursing facilities related to COVID-19.

[Click here](#) to view currently available pre-recorded trainings. Facilities also have access to the [CMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management](#).



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Next Webinar

NF Provider Webinars are held every other month. The next webinar will be held on Wednesday, July 13, 2022 at 2:30pm.

Registration information is sent at least two weeks before each webinar and is sent via [GovDelivery email](#). An alert is also posted to your [Nursing Facility Provider Portal](#) under the Communications section.

The recording and slides from today's webinar will also be posted to the [Nursing Facility Provider Portal](#) and sent out via [GovDelivery alerts](#).

Webinars are typically posted/sent out within a few days after the session.



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Questions?

For more information:

Web: [Coronavirus \(COVID-19\) Provider Information](#)

Web: [Provider Portal: LTC Providers - Nursing Facilities \(NF\)](#)

Email: LTCRPolicy@hhs.texas.gov | Phone: (512) 438-3161



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Thank you!

For more information:

Web: <https://hhs.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-provider-information>

Email: LTCRPolicy@hhs.Texas.gov | Phone: (512) 438-3161