This document has been archived. Please refer to PA-HAN-610 for updated information on the topic.

PENNSYLVANIA DEPARTMENT OF HEALTH

2021 – PAHAN – 599 – 09-24-UPD

UPDATE: Response to an Outbreak and Residents with Exposure to COVID-19 for Long-term Care Facilities

DATE:	09/24/21
TO:	Health Alert Network
FROM:	Alison Beam, JD, Acting Secretary of Health
SUBJECT:	**UPDATE: Response to an Outbreak and Residents with Exposure to COVID- 19 for Long-term Care Facilities**
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ZIP CODE:	n/a

This transmission is a Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL**; EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS**: PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF

This guidance has been updated to incorporate changes made by CDC on September 10, 2021.

This guidance is designed to supplement the core measures outlined in PA-HAN-568 with additional information to outline the facility's response to a new suspected, probable, or confirmed case of COVID-19 in facility healthcare personnel (HCP) or a resident, or when a resident has been exposed to COVID-19. Key changes include:

- Outbreak response options are presented including a contact tracing approach or a unit-based or facility-wide approach.
- Removed quarantine recommendations for fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection, in most circumstances. An emphasis remains on testing and source control for these patients for 14 days following exposure.
- Clarification of the recommended intervals for testing asymptomatic residents following exposure to someone with SARS-CoV-2 infection.
- Removed discussion of Zones for cohorting of residents by exposure status. Cohorting will have limited applications under the new guidance.

This guidance supersedes **PA-HAN-570**. Changes have been noted in red. If you have additional questions about this guidance or would benefit from discussion to support infection prevention and control decisions in your facility, please contact DOH at 1-877-PA- HEALTH (1-877-724-3258) or your local health department.

This guidance is specific for long-term care facilities (LTCF) but may also be applicable to other congregate and residential settings. **This guidance replaces PA-HAN-570**. Even as nursing homes resume more normal practices and begin relaxing restrictions, nursing homes must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death**.**

Core prevention measures for LTCFs are outlined separately in PA-HAN-568 and should be reviewed closely. This guidance is designed to supplement the core measures with additional information to outline the facility's response to a new suspected, probable, or confirmed case of COVID-19 in facility HCP or a resident, or when a resident has been exposed to COVID-19.

The guidance contains the following sections:

1. Key definitions
2. New resident admissions
3. Residents who leave the facility for medical or social reasons
4. Residents or HCP with signs and symptoms of COVID-19
5. Identification of exposure to residents
6. Managing residents with exposure
7. Testing residents for SARS-CoV-2
8. Response to an outbreak of COVID-19
9. Comment on the use of zones

1. KEY DEFINITIONS

Close contact: Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period, during their infectious period. The infectious period begins from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to specimen collection date of the positive test).

Healthcare personnel (HCP): Include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, other HCP providing direct care, contractual HCP not employed by the healthcare facility, and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the CDC Interim Clinical Considerations for Use of COVID-19 Vaccines.

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise and not clearly affect decisions about need for or duration of Transmission-Based Precautions if the individual had close contact with someone with SARS-CoV-2 infection. However, fully vaccinated people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility, even when not otherwise recommended for fully vaccinated individuals.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Isolation for residents: The term isolation refers to the implementation of measures for a resident with COVID-19 infection during their infectious period, to prevent transmission to other residents, HCP, or visitors. Isolation in LTCF residents includes:

- Use of standard and transmission-based precautions for COVID-19; and

- Private room with a private bathroom or with another resident with laboratory-confirmed COVID-19, preferably in a COVID Care Unit; and
- Restrict the resident to their room with the door closed. In some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway; and
- No visitation except for compassionate care considerations as outlined in QSO-20-39-NH; and
- Monitor by assessing symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam at least 3 times a day; and
- Follow the guidance in PA-HAN-554 to determine duration of isolation for residents.

Long-term Care Facility: For the purposes of this guidance, LTCF includes, but is not limited to, skilled nursing facilities (SNF), personal care homes (PCH), assisted living residences (ALRs), Community Residential Rehabilitation Services (CRR), Long-Term Structured Residence (LTSR), Residential Treatment Facility for Adults (RTFA), and Intermediate Care Facilities (ICF).

Nursing home-onset COVID-19: SARS-CoV-2 infection that originated in the nursing home. It does not refer to the following:

- Residents who were known to have COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
- Residents who were placed into quarantine on admission and developed SARS-CoV-2 infection within 14 days after admission.
- Residents with a known exposure to COVID-19 from a visitor or during an outing who later developed COVID-19 but who were under quarantine for *their entire infectious period*.

Outbreak: The occurrence of one or more cases of COVID-19 in a LTCF that meet the following criteria:

- New nursing home-onset of COVID-19 in a resident; or
- New onset of COVID-19 in an HCP who was working in the facility while infectious (during the 2 days prior to symptom onset or positive test if asymptomatic).

Source control: Use of well-fitting cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Cloth masks, facemasks, and respirators should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing a cloth mask, facemask, or respirator safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their cloth mask, facemask, or respirator without assistance. Face shields alone are not recommended for source control.

Testing or test: This term refers to authorized nucleic acid or antigen detection assays that have received an FDA Emergency Use Authorization for SARS-CoV-2.

Transmission-based precautions for COVID-19: HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. See PA-HAN-563 for additional details.

2. NEW RESIDENT ADMISSIONS

- Residents with **confirmed SARS-CoV-2 infection** who have **not met** criteria for discontinuation of Transmission-Based Precautions as per PA-HAN-554 should be placed

in isolation in the designated COVID Care Unit, regardless of vaccination status.

- Residents who meet the criteria as **fully vaccinated**, or residents within 90 days of a SARS-CoV-2 infection do **not** need to be quarantined upon admission or readmission.
- All other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission or during their 14-day quarantine. New admission quarantine would ideally occur in a separate unit from quarantine for residents with known exposure to COVID-19 (see Section 4).
    - Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which unvaccinated residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission.

3. RESIDENTS WHO LEAVE THE FACILITY FOR MEDICAL OR SOCIAL REASONS

Residents who leave the facility should be reminded to follow all recommended IPC practices including well-fitting source control, physical distancing, and hand hygiene and to encourage those around them to do the same. Individuals accompanying residents (e.g., transport personnel, family members) should also be educated on and adhere to these IPC practices and should assist the resident with adherence.

For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.

In most circumstances, quarantine is not recommended for unvaccinated residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) ***unless***:

- The resident, medical provider, or family report that the resident had close contact with someone with SARS-CoV-2 infection; or
- Based on an assessment of risk, uncertainty exists about the resident's adherence or the adherence of those around them to recommended IPC measures. The risk assessment should be documented by the facility in the resident's chart and outline the decision-making process.

Residents who leave the facility **for 24 hours or longer** should be managed as described in Section 2: New Resident Admissions. This includes for overnight hospitalizations greater than 24 hours.

4. RESIDENTS OR HCP WITH SIGNS AND SYMPTOMS OF COVID-19

a. Residents:

- At least daily, take the temperature of all residents and ask them if they have any COVID-19 symptoms, as outlined in PA-HAN-568.
- If signs and symptoms of COVID-19 develop:
    - Perform viral testing; and
    - Implement isolation while results are pending; and
    - Place unvaccinated roommate(s) under quarantine immediately. Remove roommate quarantine if an alternative diagnosis is identified and SARS-CoV-2 viral testing is negative (i.e. roommate quarantine does not need to be a full 14 days if the resident is determined to not have COVID-19 infection); and
    - Do **not** place a person with *suspected* COVID-19 into a COVID Care Unit prior to confirmation of infection by positive test result.

- Clinicians are encouraged to consider testing for other causes of respiratory illness, such as influenza, in addition to testing for SARS-CoV-2.
- If symptomatic residents test positive for COVID-19, follow guidance outlined in PA-HAN-597 Section 2.

b. HCP
- HCP with signs or symptoms of COVID-19 should be tested for SARS-CoV-2 and excluded from work pending results. They should follow recommendations in PA-HAN-535 while home and awaiting results. If viral testing results are negative, return to work should be based on the facility's policy. If positive, follow guidance for return-to-work in PA-HAN-595.

5. IDENTIFICATION OF EXPOSURE TO RESIDENTS

For residents in LTCFs, use the definition of a close contact as defined in Section 1 to identify exposures related to any of the following situations:
- By visitors outside or inside the facility; or
- At outside medical facilities or clinics; or
- During a social outing outside the facility that is either not hosted by the facility or involves only a small group of residents and staff.

Refer to Section 8 for guidance on response to a positive case in the facility that meets the definition of an outbreak. **Following identification that a close contact has occurred, manage resident(s) as outlined below.**

6. MANAGING RESIDENTS WITH EXPOSURE

Quarantine for residents with exposure is based on their vaccination status. Quarantine for residents includes:
- Use of standard and transmission-based precautions for COVID-19; and
- Maintain source control at all times while around others; and
- Test the resident for SARS-CoV-2 as described in the Section 7; and
- Place in a single-person room. If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location while being monitored for evidence of SARS-CoV-2 infection; and
- Restrict the resident to their room; and
- No visitation except for compassionate care considerations as outlined in QSO-20-39-NH; and
- Quarantine for residents should extend 14 days from the date of last exposure, regardless of the results of testing, unless the resident should become symptomatic or positive for SARS-CoV-2 during that period.

Unvaccinated residents should be placed in quarantine for 14 days after their exposure.

Fully vaccinated residents and residents with SARS-CoV-2 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, are moderately to severely immunocompromised, if the initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result or if the facility is directed to do so after consultation with the local public health department.

Fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection, or have an identified exposure using broad-based methods, should:
- Follow **testing** guidance in Section 7 for asymptomatic exposed persons; and

- **Implement Source control**: Universal use of source control while in the healthcare facility is recommended for 14 days following their higher-risk exposure, then they may default to routine source control recommendations for HCP outlined in PA-HAN-563 or its successor.

7. TESTING RESIDENTS FOR SARS-COV-2

- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.
- Asymptomatic residents who have had close contact with someone with SARS-CoV-2 infection, or have an identified exposure using broad-based methods, **regardless of vaccination status**, should have a series of two viral tests for SARS-CoV-2 infection.
    - **If the date of a discrete exposure is known:** testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure.
    - **If the date of a discrete exposure is NOT known** (for example, a positive roommate with an unclear symptom onset date): testing is recommended immediately and, if negative, again 5–7 days after the first test.
- Testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic, including if they have had close contact or a higher-risk exposure; this is because some people may be non-infectious but have detectable virus from their prior infection during this period (additional information is available).
- Expanded screening testing of asymptomatic HCP in nursing homes should follow guidance in CMS QSO-20-38-NH REVISED.
- Testing for outbreak response is described in the next section.

8. RESPONSE TO AN OUTBREAK OF COVID-19

A. Definition of an outbreak

A single new case of SARS-CoV-2 infection in any resident or HCP should be evaluated as a potential outbreak. Residents with confirmed COVID-19 infection should be placed in the COVID Care Unit under isolation as described in PA-HAN-563.HCP with confirmed COVID-19 infection should be excluded from work per PA-HAN-595.

An outbreak is defined as the occurrence of one or more cases of COVID-19 in a LTCF that meet the following criteria:

- New **nursing home-onset** of COVID-19 in a resident; or
- New onset of COVID-19 in an HCP who was working in the facility while infectious (during the 2 days prior to symptom onset or positive test, if asymptomatic).

Identification of a single new case 14 days after the last known case would meet the criteria for a new outbreak and prompt the need for an outbreak response**.**

B. Choosing an outbreak response method

Upon identification of one or more cases of COVID-19 meeting the definition of an outbreak above, the facility should carefully consider options to conduct **outbreak response**:

- Use of contact tracing to identify exposed residents, staff, and visitors; or
- Use of a unit-based approach to identify exposed residents, staff, and visitors; or
- Use of a facility-wide approach to identify exposed residents, staff, and visitors.

Choosing an outbreak response method is also described in Figure 1. The approach to an outbreak response should take into consideration whether the facility has the experience and resources to perform individual contact tracing, the vaccination acceptance rates of staff and residents, whether the index case is a healthcare worker or resident, whether there are other individuals with suspected or

confirmed SARS-CoV-2 infection identified at the same time as the index case, and the extent of potential exposures identified during the evaluation of the index case.

A contact tracing-based initial outbreak response may later need to be expanded, if transmission occurs within a wider range of areas within the facility, or per recommendations made by the local public health department. For example, if a contact tracing-based approach is used to initially respond, but additional cases develop in an area of the facility where epidemiologic links were not previously identified, a unit-based or facility-wide approach may then be warranted.

C. Response measures for all outbreak response methods

- Increase monitoring of all residents to every shift to rapidly detect those with new symptoms.
- If there is a suspect case, and test results for the suspect case are anticipated to take longer than 2-3 days, *do not wait* to implement outbreak response interventions. Begin planning and executing outbreak response as outlined below while awaiting test results.

D. Implementing a contact-tracing based approach to outbreak response:

Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-CoV-2 infection:

- All HCP who have had a higher-risk exposure and residents who have had close contacts, **regardless of vaccination status**, should be tested immediately (but not earlier than 2 days after the exposure) and 5–7 days after exposure, as described in the testing section.
    - Restriction from work, quarantine, and testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic. Potential exceptions are described here and here.
- Residents identified as close contacts should be treated as described in Section 6 according to their vaccination status.
- HCP identified as having high-risk exposure should be treated as described in PA-HAN-596.

- **If testing of close contacts does not reveal additional HCP or residents with SARS-CoV-2 infection,** continue to manage residents as outlined in Section 6 for 14 days following exposure. After the initial series of 2 viral tests, ongoing testing is not required if close contacts remain asymptomatic.
- **If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection**, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection.
    - A facility-wide or unit-level (e.g. unit, floor, or other specific area(s) of the facility) approach should be implemented if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
    - If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below.

E. Implementing a broad-based approach (unit-based or facility-wide) to outbreak response:

The unit-based or facility-wide approach may be the best option in certain outbreak situations. These methods are also outlined in Figures 2 and 3. We recommend consulting with the local public health department to determine how best to respond to an outbreak if needed.

- **Identify exposed residents by unit** within the following guidelines:
    - A resident *on the same unit* as another resident who was directly cared for (within 6 feet or less) for any duration of time, by an HCP positive for COVID-19 during the HCP's infectious period, *if this care occurred within the LTCF*; or
    - A resident on the same unit as another resident who has COVID-19 infection, if the infected resident was not on quarantine, or did not adhere to quarantine measures

during their infectious period.

- **Perform viral testing** for SARS-CoV-2 facility-wide for all residents and HCP, or for a unit-based approach, perform viral testing for:
  - All residents considered exposed by unit; and
  - All HCP working on the unit(s) during the exposure period, or who are regularly assigned to work on the affected unit(s).

  Test regardless of vaccination status, immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later**.**
- **Managing exposed residents and HCP as part of the unit-based or facility-wide response:**
  - **Residents and HCP with SARS-CoV-2 infection in the last 90 days:**
    - Do not need to be quarantined.
    - Testing is not recommended for these persons if they remain asymptomatic.
  - **Unvaccinated residents and HCP:**
    - Unvaccinated residents should be managed as described in Section 6. They should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.
    - For guidance about work restriction for unvaccinated HCP who are identified to have had higher-risk exposures, refer to PA-HAN-596.
  - **Fully vaccinated residents and HCP:**
    - Fully vaccinated residents should be managed as described in Section 6. They do not need to be restricted to their rooms or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the local public health department.
    - For guidance about work restriction for fully vaccinated HCP who are identified to have had higher-risk exposures, refer to PA-HAN-596.
- **If additional cases are identified**, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days.
  - If antigen testing is used, more frequent testing (every 3 days), should be considered.
  - **Ongoing transmission:** Evidence of ongoing transmission may include the detection of new cases in additional unit(s) or new cases being detected beyond the first 14-day period. In the event of ongoing transmission within a facility that is not controlled with initial interventions:
    - Strongly consider use of quarantine for fully vaccinated residents and work restriction of fully vaccinated HCP with higher-risk exposures.
    - Consider expanding testing to facility-wide, if not already done.
    - In addition, there might be other circumstances for which the jurisdiction's public health department recommends these and additional precautions.
- **If no additional cases** are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days. After the initial series of 2 viral tests, ongoing testing is not required if exposed residents and HCP remain asymptomatic.

F. Indoor visitation during an outbreak response:

- Facilities should follow guidance from CMS QSO-20-39-NH about visitation.
- Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility.
- Residents on quarantine or isolation should be limited to compassionate care visits per CMS QSO-20-39-NH.
- During visitation for residents who are not on quarantine or isolation during an outbreak, follow prevention measures outlined in PA-HAN-568 including wearing well-fitting source control (if

tolerated), maintaining physical distancing from others, and not lingering in common spaces when moving from their rooms to the visitation space.

9. COMMENT ON THE USE OF ZONES

Previous guidance in PA-HAN-570 outlined three zones to conceptualize the cohorting of residents in response to outbreak testing results. The Zones refer to units or in some cases, entire facilities where staff and residents were cohorted by whether they were unexposed or recovered from COVID-19 (Green zone), in quarantine (Yellow zone), or in isolation (Red zone).

Given changes to the approach to outbreak response outlined in this update, in combination with the recommendation that most fully vaccinated residents no longer need to be in quarantine following exposure, the Zones will have limited utility. Limited circumstances where units or facilities might be considered zones as outlined in PA-HAN-570 could include:

- For COVID-care units (Red zone); or
- For admission units designated for unvaccinated residents (Yellow zone); or
- A unit-based or facility-wide approach to outbreak response where all residents are undergoing quarantine (Yellow zone) because none are fully vaccinated, or the facility has been advised to do so to respond to an outbreak with ongoing transmission.

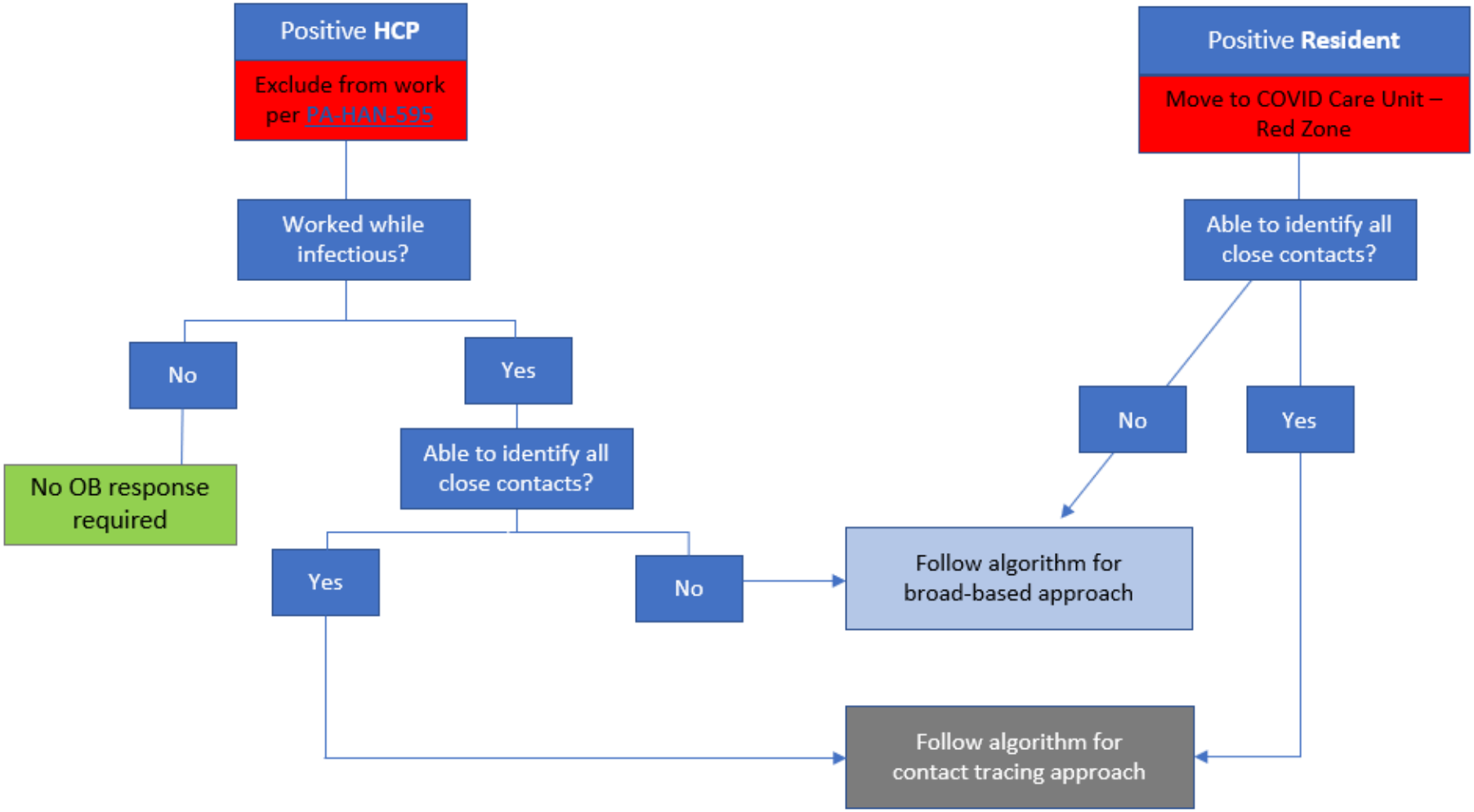
To implement Zone-based guidance in your facility, refer to guidance in PA-HAN-570. For all other outbreak response approaches where a mixture of quarantine and non-quarantine for residents might occur on a single unit, Transmission-Based Precautions, room restrictions, and other quarantine measures must be assigned to the care of each individual resident.

If you have questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877- 724-3258) or your local health department.

Categories of Health Alert messages:
Health Alert: conveys the highest level of importance; warrants immediate action or attention.
Health Advisory: provides important information for a specific incident or situation; may not require immediate action.
Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of September 22, 2021 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.

FIGURE 1: CHOOSING AN OUTBREAK RESPONSE METHOD

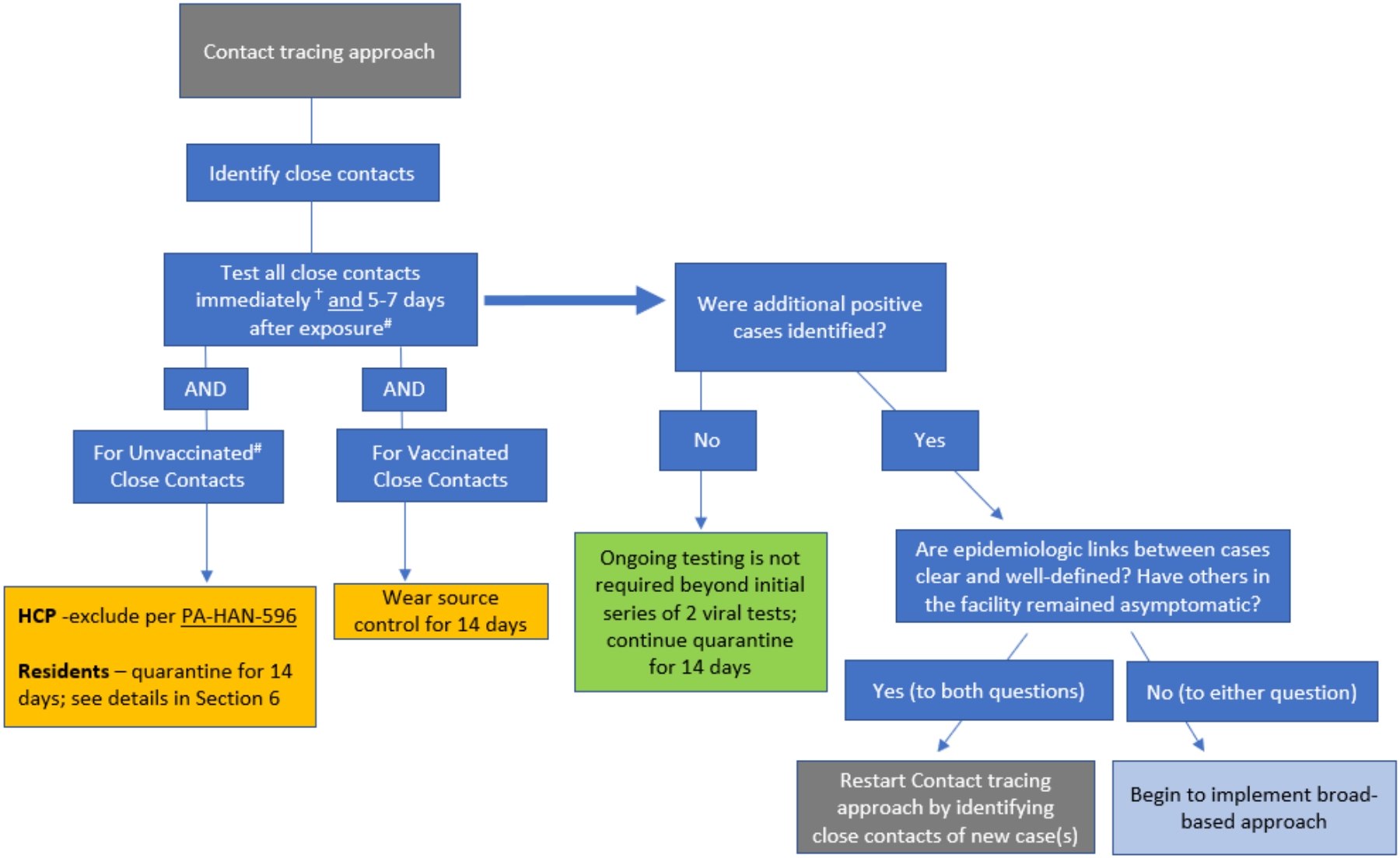


Footnotes:

† Immediately but not sooner than 2 days after the exposure if the date of a discrete exposure is known

#Generally testing and quarantine are not recommended for residents with SARS-CoV-2 infection in the prior 90 days if they remain asymptomatic. See Sections 6 and 7 for details.

FIGURE 2: IMPLEMENTING A CONTACT-TRACING BASED APPROACH TO OUTBREAK RESPONSE

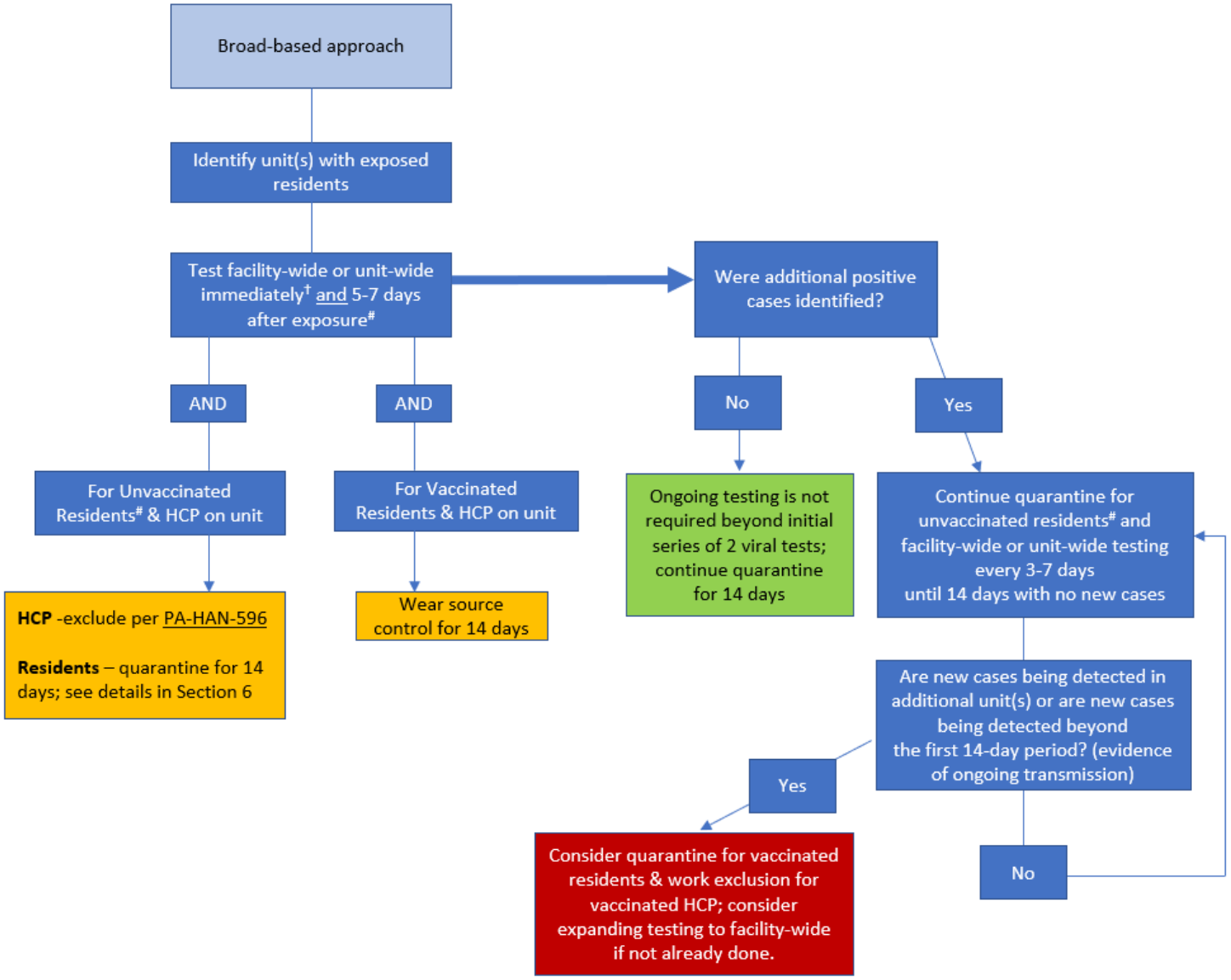


Footnotes:

† Immediately but not sooner than 2 days after the exposure if the date of a discrete exposure is known.

#Generally testing and quarantine are not recommended for residents with SARS-CoV-2 infection in the prior 90 days if they remain asymptomatic. See Sections 6 and 7 for details.

FIGURE 3: IMPLEMENTING A UNIT-BASED OR FACILITY-WIDE APPROACH TO OUTBREAK RESPONSE



Footnotes:

† Immediately but not sooner than 2 days after the exposure if the date of a discrete exposure is known

#Generally testing and quarantine are not recommended for residents with SARS-CoV-2 infection in the prior 90 days if they remain asymptomatic. See Sections 6 and 7 for details.