COVID-19 Testing & Outbreak Plan

Plan Statement

Coronavirus diseased 2019 (COVID-19) is a contagious, and at times fatal respiratory disease that is responsible for the novel coronavirus outbreak. On May 12, 2020 the State of NJ signed an executive order No. 20-013 that COVID-19 Testing at Licensed Long-term care facilities, Assisted Living residences, Comprehensive personal care homes, Residential Health Care Facilities and Dementia Care Homes. Pursuant to N.J.S.A. 26:13-17(a), access to medical information of individuals who have participated in medical testing programs or efforts by the Commissioner shall be limited to those persons having a legitimate need to acquire or use the information to, among other things, provide treatment to individuals and invest agate the cause of the transmission; and pursuant to N.J.S.A 26:2H-12.87(b) nursing homes, assisted living residences, comprehensive personal care homes, residential healthcare facilities, and dementia care homes (collectively, "long-term care facilities" or LTCs")must have outbreak response plans. The CDC and the New Jersey Department of Health have identified ley strategies to address COVID-19 in long-term facilities and congregate settings, including but not limited to identifying infection early; taking measures to prevent the spread of COVID-19 through asymptomatic, pre-symptomatic, and symptomatic transmission; and dedicating areas of a facility to care for residents with suspected or confirmed COVID-19. The New Jersey Department of Health recommends a cohorting plan for long-term care facilities; cohorting is only one element if infection prevention and control measures used for outbreak control. This plan considers resources including availability of testing, personal protective equipment (PPE) and staffing.

Policy Interpretation and Implementation

Testing of Nursing Home Staff and Residents

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, regardless of the vaccination status with signs andsymptoms must be tested	Residents, regardless of the vaccination status with signs andsymptoms must be tested
Newly identified COVID-19 positive staff or resident in a facility that can identify close contacts	Test all staff regardless of the vaccination status, that had a higher-risk exposure with a COVID-19 positive individual	Test all residents regardless of the vaccination status, that had close contact with a COVID-19 positive individual.
Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts	Test all staff regardless of the vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor or other specific area(s) of the facility).	Test all residents regardless of the vaccination status, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility).
Routine testing	Not generally recommended	Not generally recommended

Testing of Staff and Resident's with COVID-19 Symptoms or Signs

Staff with symptoms or signs of COVID-19, regardless of vaccination status, must be tested *as soon as possible* and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidance "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2." Staff who do not test positive for COVID-19 but have symptoms should follow facility policies to determine when they can return to work.
Residents who have signs or symptoms of COVID-19, regardless of vaccination status, must be tested *as soon as possible*. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance. Once test results are obtained, the facility must take the appropriate actions based on the results.

Testing of Staff with a Higher-Risk Exposure and Residents who had a Close Contact
For information on testing staff with a higher-risk exposure to COVID-19 and residents who had close contact with a COVID-19 positive individual, when the facility is not in an outbreak status, see the CDC's "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" and "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2." Examples may include exposures from a visitor, while on a leave of absence, or during care of a resident on the COVID-19 unit.

Testing of Staff and Residents During an Outbreak Investigation
An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP are discontinued. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission.
Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately *(but not earlier than 24 hours after the exposure, if known)*. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing.
If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.
For further information on contact tracing and broad-based testing, including frequency of repeat testing, see CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic"
For individuals who test positive for COVID-19, facilities should follow the CDC "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" guidance for *discontinuing TBP for* residents and the "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2." for staff.

Regional CALI Level	Regional Percent Positivity Rate in the past week	Minimum testing frequency
Low	<3%	Once a Week*
Moderate	3-10%	Once a Week*
High/Very High	>10%	Twice a Week**

*Testing at this frequency until the NJDOH changes testing cadence based on epidemiology and data about the circulation of virus in the community or new CMD guidance.

a. If the 48- hour turnaround time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments.
b. Testing should begin with all staff that are not up to date with their vaccinations at the frequency prescribed in the testing table above, based on the regional positivity rate reported in the past week.
c. WGCC will monitor our reginal CALI level every week and adjust the frequency of staff testing according to the table above
    - If the reginal CALI level increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met.
    - If the regional CALI level decrease to a lower level of activity, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency.

b. Retest staff who have previously tested positive according to CDC guidance:

Antigen Testing

Antigen testing is a form of viral testing and may be used as an alternative to molecular diagnostic PCR tests subject to the following:

- Antigen testing may be used to fulfill any testing requirements set forth in directive 20-026-1 and also may be used on asymptomatic individuals at the facilities discretion. If antigen testing is used, please refer to CDS: www.nj.gov/health/cd/documents/topics/NCOV/COVID-19AntigenTestinginLTC.pdf and CDC: www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html, guidance for test interpretation and to determine when RT-PCR confirmation testing is necessary.
- Only antigen tests that have received an Emergency Use Authorization or approval from the United States Food and Drug Administration (FDA) may be used to fulfill the requirements of the directive 20-026

- All facilities that perform COVID-19 point of care (POC)test such as antigen tests, in their facilities must possess a federal Clinical Laboratory Improvement Amendment (CLIA) Certificate

Test Results

1. Results for all weekly tests and retests relating to residents shall be reported back to the facilities Medical Director and his/her designee
2. Results for Staff shall be reported back to each individual Staff member and to the facility administrator.

Rapid Testing

1. Rapid testing will be offered to all staff, visitors, vendors physicians or any individual entering the building; All reporting of positive tests will done in accordance within the directive, and logs maintained.
2. Facility staff, regardless of their vaccination status, to report any of the following criteria to occupational health or another point of contact designated by the facility so they can be properly managed.
   - a positive viral test for SARS-CoV-2
   - symptoms of COVID-19 or

Staff Consent, Exclusion from work and return to work

3. Any individual Staff member who refuses to test when indicated shall be treated as if he/she tested positive for Covid-19.
4. Present facility is under contract with 2 certified labs that will process a PCR test when indicated. The administration of the test will be conducted by a healthcare professional.
5. Guidance from the CDC and NJ DOH will be followed for testing and retesting positive employees
6. Return to Work Criteria for HCP with Suspected or Confirmed COVID-19 with be determined with the CDC & NJDOH guidance.

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

- At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **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.

HCP who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

HCP with severe to critical illness and 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 HCP below can be used to inform the duration of isolation.

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. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)

HCP who are moderately to 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 (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to

Test-based strategy

HCP who are symptomatic could return to work after the following criteria are met:

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

HCP who are not symptomatic could return to work after the following criteria are met:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

Return To Work Criteria for HCP Exposure

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection[3] and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)[4]

- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

Following a higher-risk exposure, HCP should:

- Have a series of three viral tests for SARS-CoV-2 infection.
    - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
    - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

- Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include:

- HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure;
- HCP is moderately to severely immunocompromised;
- HCP cares for or works on a unit with patients who are moderately to severely immunocompromised;
- HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions;

If work restriction is recommended, HCP could return to work after either of the following time periods:

- HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following a higher-risk exposure is negative.
- If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

In addition to above:

- HCP should follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.

- Any HCP who develop fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

7. Return to Work Practices and Work Restrictions, after returning to work, HCP
   a. Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline.
   b. A face mask for source control does not replace the need to wear an N95 or higher-level respirator or other recommended PPE when indicated
   c. Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

8. If a staff member tests positive for COVID-19 (symptomatic or asymptomatic) the facility may permit them to return to work subject to CDC/DOH recommendations as to time frames and requirements that are incorporated.

Cohort

9. **SARS-CoV-2 positive patients/residents (i.e, COVID-19 care unit/area)** These individuals consist of both symptomatic and asymptomatic patients/residents who test positive for SARS-CoV-2, regardless of vaccination status, including any new or re-admitted patients/residents known to be positive who have not met the criteria for discontinuation of transmission-based precautions. If feasible, care for SARS-CoV-2 positive patients/residents on a separate closed unit. Patients/residents who test positive for SARS-CoV-2 are known to shed virus, regardless of symptoms; therefore, all newly positive* patients/residents would be placed in the COVID-19 care unit/area.

10. **Unvaccinated, SARS-CoV-2 negative, close contact patients/residents** These individuals consist of all symptomatic and asymptomatic unvaccinated patients/residents who test negative for SARS-CoV-2 with an identified exposure (i.e., close contact) to someone SARS-CoV-2 positive. All symptomatic patients/residents should be evaluated for causes of their symptoms. Patients/residents who test negative for SARS-CoV-2 could be incubating and later test positive. To the best of their ability, facilities should separate symptomatic and asymptomatic patients/residents, ideally having symptomatic housed in private rooms. Even though symptomatic SARS-CoV-2 negative patients/residents might not be a threat to transmit SARS-CoV-2, they still may have another illness, such as influenza. Asymptomatic patients/residents with close contact to a COVID-19 case should be closely monitored for symptom development. Unvaccinated patients/residents identified as close contacts should be quarantined for 14 days and have a series of twoCOVID-19 tests. In these situations, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure. If testing remains negative, unvaccinated close contact patients/residents should complete the remainder of their 14-day quarantine period. Testing at the end of this period could be considered to increase the certainty that the person is not infected

11. **Unvaccinated, new or readmission observation** These individuals consist of all unvaccinated new patients/residents from the community or other healthcare facilities and unvaccinated re-admitted patients/residents who left the facility for ≥24 hours. This cohort serves as an observation area where persons remain for 7 days. Testing at the end of this period could be considered to increase the certainty that the person is not infected. In most circumstances, quarantine is not recommended for unvaccinated patients/residents who leave the facility. Any unvaccinated or partially vaccinated resident will be permitted to go to the physical therapy gym after all other resident that are not on TBP have completed their therapies and if masking can be tolerated, and no symptoms of COVID-19 are indicated.

12. **Symptomatic patients/residents with suspected SARS-CoV-2 infection** All **symptomatic** patients/residents should be evaluated for causes of their symptoms. Patients/residents who test negative for SARS-CoV-2 could be incubating and later test positive. Ideally, a patient/resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2 or other pathogens. This is especially important for patients/residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of a designated space within the COVID-19 care unit/area. However, in some circumstances, keeping the door closed may pose patient/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. If limited single rooms are available, or if numerous patients/residents are simultaneously identified to have symptoms concerning for COVID-19, they should remain in their current location pending return of test results

13. **Asymptomatic patients/residents who are not up to date* with all recommended COVID-19 vaccine doses, have a viral test that is negative for SARS-CoV-2, and have had close contact with someone with SARS-CoV-2**
14. These patients/residents should be placed in quarantine after their exposure and cared for using full PPE (gowns, gloves, eye protection, and NIOSH-approved N95 or equivalent or higher-level respirator). Any unvaccinated or partially vaccinated resident will be permitted to go to the physical therapy gym after all other resident that are not on TBP have completed their therapies and if masking can be tolerated, and no symptoms of COVID-19 are indicated. Testing** is recommended **immediately** (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days **after the exposure.** Patients/residents can be removed from quarantine, either:

    a. After day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, facilities may consider testing for SARS-CoV-2 within 48 hours before the time of planned discontinuation of quarantine. OR
    b. After day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be **collected and tested within 48 hours** before the time of planned discontinuation of quarantine.

15. **Asymptomatic patients/residents who are up to date* with all recommended COVID-19 vaccine doses and have a viral test that is negative for SARS-CoV-2 OR had a viral test that was positive for SARS-CoV-2 in the past 90 days,** and have had close contact with someone with SARS-CoV-2*** These patients/residents should wear well-fitting source control based on CDC recommendations, and at minimum, for 10 days after their exposure. Testing** is

recommended **immediately** (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days **after the exposure.** In general, these patients/residents do not need to be quarantined, restricted to their room, or cared for by HCP using the full COVID-19 recommended PPE unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority. Quarantine might also be considered if the patient/resident is moderately to severely immunocompromised.

16. **New or readmitted asymptomatic patients/residents who are not up to date* with all recommended COVID-19 vaccine doses and have a viral test negative for SARS-CoV-2 upon admission or readmission** These patients/residents should be placed in quarantine and cared for using full PPE (gowns, gloves, eye protection that covers the front and sides of face, and NIOSH-approved N95 or equivalent or higher-level respirator), even if they have a negative test upon admission. Testing is recommended **immediately** (upon admission) and, if negative, again 5–7 days **after their admission**. **Quarantine may be discontinued after day 7 if a COVID-19 test is negative for SARS-CoV-2 and they do not develop symptoms.** The specimen should be collected and tested within 48 hours before the time of planned discontinuation of quarantine. In most circumstances, quarantine is not recommended for patients/residents who are **not up to date** with all recommended COVID-19 vaccine doses that routinely leave the facility for <24 hours and do not have close contact with a suspected or known COVID-19 positive person. Any unvaccinated or partially vaccinated resident will be permitted to go to the physical therapy gym after all other resident that are not on TBP have completed their therapies and if masking can be tolerated, and no symptoms of COVID-19 are indicated.

17. **New or readmitted asymptomatic patients/residents who are up to date* with all recommended COVID-19 vaccine doses and have a viral test that is negative for SARS-CoV-2 OR had a viral test positive for SARS-CoV-2 in the past 90 days*** ** Testing is recommended immediately (upon admission) and, if negative, again 5–7 days after their admission. In general, these patients/residents do not need to be quarantined, restricted to their room, or cared for by HCP using the full COVID-19 recommended PPE unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority. Quarantine might also be considered if the patient/resident is moderately to severely immunocompromised. Any unvaccinated or partially vaccinated resident will be permitted to go to the physical therapy gym after all other resident that are not on TBP have completed their therapies and if masking can be tolerated, and no symptoms of COVID-19 are indicated.

Staffing Shortages Created by Testing

18. It is the policy of this facility to ensure that we have adequate staffing during emergencies. Our employees are expected to report to their work site and provide services related to emergency response and recovery operations in addition to their normally assigned duties if requested to do so. Supervisors, co-workers, and residents share an expectation that medical services will proceed uninterrupted and that any medical needs generated by the incident impact will be addressed.
19. Preparedness planning in this facility is recognized as a shared responsibility between nursing and administration.
20. All staff in regular and temporary or contracted positions (appropriate with their role) should contact their immediate supervisor or manager if they are unable to report to duty as scheduled due to an emergency.

21. All approved Paid Time Off (PTO) days during an event may be cancelled. Employees should be available to report for duty if it is safe and feasible to do so.

Communication and notifications to residents, families and staff

22. Updates about any new facility outbreaks/ investagations/ COVID-19 vaccination clinics are communicated to the resident families via clinoclinex, website postings
    a. If the facility receives a positive resident or staff COVID-19 test result,
    b. sent to families and staff via a texting based system using eztext.com or cliniconex, no later than 5pm the next business day
    c. Our Communication Officer is assigned to Kristy Santana, Assistant Administrator for the families and staff to reach out to with any questions
    d. The facilities website will be updated at minimum a weekly basis to share the status of the facility and include information that helps families know what is happening in the facilities environment

Personal Protection Equipment (PPE)

Wedgewood Gardens will have and adequate emergency stockpile of PPE, essential cleaning and disinfection supplies so that the staff, residents and visitors can adhere to recommended infection prevention and control practices.

    a. Two months of a stock pile of PPE, will only be used in the event of an emergency and not daily use, if at anytime the facility is forced to use the stock pile due to an emergency it is required to restock the supply
    b. b. Essential cleaning products and disinfection supplies on hand in the event of a supply chain disruption

Reporting

23. The facility administrator and/or his/her designee shall submit the following reports:
    a. An attestation stating that the LTC has developed a plan in compliance with this policy shall be submitted by email to LTC Diseaseoutbreakplan@doh.nj.gov, no later than two months from the enactment of Directive NO.20-026
    b. NJDOH - COVID-19 Facility Outbreak Survey. (State) Frequency: Daily During an outbreak (until 28 days passes)
    c. Line list during an outbreak (Local)Frequency: whenever there's a new case listed
    d. CDC – NHSN (Federal)Frequency: Twice weekly
    e. Simple report will be used to report any positive cases

*CDC defines *up to date* as a person receiving all recommended COVID-19 vaccines (e.g., fully vaccinated) including any booster dose(s) **when eligible** based on CDC Stay Up to Date with Your Vaccines (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html).

**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 people, 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.

*** There may be circumstances when quarantine of asymptomatic patients/residents who are up to date with all recommended COVID-19 vaccine doses and have a viral test that is negative for SARS-CoV-2 OR have a viral test that is positive SARS-CoV-2 in the past 90 days might be recommended (e.g., patient is moderately to severely immunocompromised). In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for these patients/residents on affected units, **even if they are up to date with all recommended COVID-19 vaccine doses.** In addition, there might be other circumstances for which the jurisdiction's public health authority recommends these and additional precautions