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, with signs or symptoms must be tested regardless of the COVID-19 vaccination status.	Residents, with signs or symptoms must be tested, regardless of the COVID-19 vaccination status.
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, who 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, 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), regardless of the COVID-19 vaccination status	Test all residents, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility), regardless of the COVID-19 vaccination status

Routine testing	Test all covered workers in accordance with E.O. 252, E.O. 283, E.O. 290 and NJDOH E.D. 21-011. IF the covered workers (a) have not yet submitted	Not generally recommended

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.

**Any staff member or resident that refuses to be tested when indicated shall be treated as if he/she tested positive for COVID-19

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.

**If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later, day 7. Day 0 is the point of symptom onset or positive viral test for asymptomatic infection.

Work restrictions for HCP with SARS-CoV-2 exposure(s) Because of their extensive and close contact with vulnerable individuals in healthcare settings, a conservative approach to HCP monitoring and, in some instances, applying work restrictions is recommended to prevent transmission from potentially contagious HCP to patients/residents, other HCP, and visitors. When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. Occupational health programs should have a low threshold for evaluating symptoms and testing HCP. In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2. However, work restrictions may be considered when HCP are unable to be tested, unable to wear source control for 10 days following the exposure, are moderately to severely immunocompromised or care for patients/residents who are, or work on a unit experiencing ongoing transmission not controlled by initial interventions.

Asymptomatic HCP with a higher-risk exposure should:

• Be tested for SARS-CoV-2 no 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.

• Follow all recommended infection prevention and control practices, including use of well-fitting source control for 10 days following their exposure, not reporting to work when ill, and monitoring themselves for fever or symptoms consistent with COVID-19. Healthcare facilities should continue utilizing formal HCP risk assessments for exposure December 13, 2022 Page 2 of 4 to SARS-CoV-2 (See Appendix: NJDOH Healthcare Personnel Exposure to a Confirmed COVID-19 Case Risk Algorithm). 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.

HCP testing results guidance

HCP with even mild symptoms of COVID-19 should be prioritized for viral testing, regardless of vaccination status. Viral tests include antigen and Nucleic Acid Amplification Test (NAAT). Ensure the test is indicated for the intended use, is administered in accordance with the manufacturer's instructions for use, and has FDA approval or Emergency Use Authorization (EUA). Refer to FDA FAQs on Testing for SARS-CoV-2 https://www.fda.gov/medical-devices/coronaviruscovid-19-and-medical-devices/faqs-testing-sars-cov-2. 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. The use of self-tests might be considered in some situations. Facilities could also consider having HCP present for a proctored test to ensure appropriate collection and interpretation. If self-tests are used, refer to the FDA At-Home OTC COVID-19 Diagnostic Tests https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/home-otccovid-19-diagnostic-tests and CDC Self-Testing at Home or Anywhere https://www.cdc.gov/coronavirus/2019-ncov/testing/self-testing.html.

SARS-CoV-2 Viral Test Results

1. ***SARS-CoV-2 Positive HCP:*** Remove from work. Perform contact tracing. Implement the facility plan for how SARSCoV-2 exposures in a healthcare facility will be investigated and managed. Identification of close contacts should begin at 48 hours prior to symptom onset or specimen collection for asymptomatic cases. For asymptomatic cases with an identifiable date of exposure, contact tracing should focus on investigating the 48 hours after that date of exposure through the time they meet the discontinuation of isolation criteria.

Symptomatic HCP tested negative: Symptomatic HCP with a higher-risk exposure should be excluded from work (see Appendix for guidance). When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. If using NAAT, a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT. If using an antigen test, a negative result should be confirmed by either a negative NAAT or a second negative antigen test taken 48 hours after the first negative test.

Symptomatic HCP who test negative for COVID-19 may have another respiratory virus. Similar guidance on infection prevention and control should be followed in these circumstances (e.g., being isolated from others, practicing good hand hygiene, cleaning and disinfecting environmental surfaces). If HCP has an alternate diagnosis (e.g., tested positive for influenza), the criteria for returning to work should be based on that diagnosis. At a minimum, HCP should be excluded from work for at least 24 hours after symptoms resolve, including fever, without using fever-reducing medications, if applicable. Consult your facility's occupational health policy for return to work after illness criteria.

Work Restrictions*	**Additional Recommendations*****
EXCLUDE FROM WORK	• Perform SARS-CoV-2 testing no 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 if day 0), day 3, and day 5. HCP can return to work after day 7 following the exposure (day 0) if all viral testing is negative for SARS-CoV-2 and there is no alternate diagnosis that would restrict them from work. • If the HCP is never tested, the decision to return to work can be made based on time from symptom onset where HCP can return to work after a minimum of 10 days following symptom onset or higher-risk exposure, which ever was later.
TEST AND MONITOR**	• Perform SARS-CoV-2 testing no 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. • Follow the recommendations provided below.
NO WORK RESTRICTIONS	• Follow all recommended infection prevention and control practices, including use of well-fitting source control for 10 days following exposure, not reporting to work when ill, and monitoring for fever or symptoms consistent with COVID-19. • Any HCP who develops 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.

NOTE: 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.

^Procedures likely to generate aerosols or that might create uncontrolled respiratory secretions include but are not limited to cardiopulmonary resuscitation; endotracheal intubation and extubation; bronchoscopy; sputum induction; manual ventilation; open suctioning of airways; and non-invasive ventilation (e.g., BiPAP, CPAP). Refer to CDC Clinical Questions about COVID-19: Questions and Answers at https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control.

*In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.

**Work restrictions may be considered when HCP are unable to be tested, unable to wear source control for 10 days following the exposure, are moderately to severely immunocompromised or care for patients/residents who are, or work on a unit experiencing on-going transmission not controlled by initial interventions.

*** Licensed health care providers subject to DCA Administrative Order No. 2022-01 are required to follow NJDOH guidance.

Discontinuation of Transmission-based Precautions for Persons with COVID-19 in Healthcare Settings

Criteria for discontinuing transmission-based precautions are determined by the patient's immunocompromised status and illness severity. The highest level of illness severity experienced by the patient/resident at any point in their clinical course should be used when determining the duration of transmission-based precautions. Clinical judgment regarding the contribution of SARS-CoV-2 to clinical severity might also be necessary when applying these criteria to inform infection control decisions. In general, patients/residents hospitalized for SARS-CoV-2 infection should be maintained on transmission-based precautions for the period described for individuals with severe to critical illness. Patients with severe to critical illness who are not moderate to severely immunocompromised may use a test-based strategy (as described for moderate to severely immunocompromised patients) to inform the duration of isolation. The decision to extend transmission-based precautions should be made in consultation with a healthcare provider and/or public health professional and is subject to differences in disease course, symptoms, living situation, available resources, and clinical management. In general, patients/residents should continue to wear source control until symptoms resolve, or for those who never developed symptoms until they meet the criteria to end isolation. Then they should revert to the standard facility source control policy for patients/residents.

Symptom Based

Patients/residents who are not moderately to severely immunocompromised1 with mild2 to moderate3 illness should remain in isolation until 10 DAYS have passed since symptoms first appeared (for severe4 to critical5 illness, a minimum of 10 days, up to 20) AND at least 24 hours have passed since the resolution of fever without the use of fever-reducing medication AND improvement in symptoms.

TIME-BASED STRATEGY

Asymptomatic patients/residents who are not moderately to severely immunocompromised should remain on isolation until 10 DAYS have passed since the date of first positive SARS-CoV-2 viral diagnostic test AND have remained asymptomatic (if symptoms appear during this time refer to above).

TEST-BASED STRATEGY

Moderate to severely immunocompromised patients/residents should use a test-based strategy and (if available) consult with an infectious disease specialist to determine discontinuation of transmission based precautions with negative results from at least two consecutive specimens collected 48 hours apart using a viral test. When symptoms are present, there should be resolution of fever and improvement of symptoms as described in the symptom-based strategy above.

Illness severity definitions

1The treating provider determines the degree to which an individual is immunocompromised. For this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the Interim Clinical Considerations for Use of COVID-19 Vaccines.

2 Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache,muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

3 Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

4 Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300mmHg, or lung infiltrates >50%.

5Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Cohort

7. **Any new or re-admission regardless of their vaccination status is tested for COVID-19 on the day of admission, then day 3 & day 5.**
8. **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.

9. **Unvaccinated, new or readmission observation, close contact patients/residents** 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 on day of admission, then day 3 & 5, 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.

10. **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, either antigen and/or PCR.

11. **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 30 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.

12. **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 on precautions 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 3 and then 5 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.** 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.

Staffing Shortages Created by Testing

13. 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.

14. Preparedness planning in this facility is recognized as a shared responsibility between nursing and administration.
15. 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.
16. 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

17. Updates about any new facility outbreaks/ investigations/ 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

18. 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