



COVID-19 TESTING GUIDANCE FOR LONG-TERM CARE FACILITIES

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The following guidance is to be used for both nursing homes and assisted living facilities. These are the minimum requirements. All LTC facilities may increase testing frequency as needed.

Testing When a Staff Member or Resident Tests Positive/Outbreak (Hot Spot) Testing

An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any long-term care facility-onset COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident admitted to a facility with COVID-19 does not constitute a facility outbreak. Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents, regardless of vaccination status, should be tested immediately. Continue repeat viral testing of all previously negative staff and residents every 3 days to 7 days, regardless of vaccination status until the testing identifies no new cases of SARS-CoV-2 infection among residents or staff for a period of at least 14 days since the most recent positive result. Every facility will conduct at least 2 rounds of facility-wide testing.

For individuals who test positive for COVID-19, repeat testing is not recommended, **except when testing is used as part of a strategy to reduce work restrictions for healthcare personnel in accordance with the [CDC's January 21, 2022 Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#)**. A symptom-based strategy is intended to replace the need for repeated testing. **Facilities should follow the [CDC guidance Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 Infection in Healthcare Settings for residents](#) and [Criteria for Return to Work for Healthcare Personnel](#) with SARS-CoV2 Infection.**

Ongoing Routine Surveillance Testing of Staff

Staff who are up-to-date with all recommended vaccine doses do not have to be routinely tested.

If a staff member is exhibiting **even mild** symptoms, regardless of vaccination status, they should be tested and not permitted to work in any long-term care facility pending testing results.

Staff with an exposure should be tested in accordance with guidance in Table 3 below.

Resident Testing

Resident testing should occur in the following circumstances:

1. Resident is symptomatic;
2. Resident has had a known contact with a positive;

3. Unvaccinated residents who regularly leave the facility test according to Table 1 below.
4. The facility has a new positive test and is considered a 'hot spot'/outbreak requiring 100% testing of staff and residents, regardless of vaccination status for at least two consecutive weeks until there are no new positive tests identified.

Resident and Staff Exposures:

- Staff who are up-to-date with all recommended COVID-19 vaccine doses with **an exposure should be tested and restricted from work in accordance with guidance in Table 3 below**. If signs or symptoms develop at any time in the **10** days following exposure, staff should seek testing and isolate at home.
- Unvaccinated staff and those who are not up-to-date with all recommended COVID-19 vaccine doses are required to quarantine for **10** days following an exposure **in accordance with the guidance in Table 3 below**. If signs or symptoms develop at any time in the **10** days following exposure, staff should seek testing and continue isolating at home.
- Residents (regardless of vaccination status) with prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period, regardless of level of protection) with someone with SARS-CoV-2 infection should have a series of two viral PCR tests. In these situations, testing is recommended immediately, and **if negative, again 5–7 days after exposure**. **In general testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these individuals an antigen test instead of PCR is recommended.**
- Residents who are not up-to-date on with all recommended COVID-19 vaccinations who are newly admitted and readmitted to the facility should be placed in quarantine even if they have a negative test upon admission.
- Residents who are not up-to-date on with all recommended COVID-19 vaccinations and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine following their exposure, even if viral testing is negative.
- HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).
 - **Residents can be removed from Transmission-Based Precautions (quarantine) after day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, healthcare providers could consider testing for SARS-CoV-2 within 48 hours before the time of planned discontinuation of Transmission-Based Precautions.**
 - **Residents can be removed from Transmission-Based Precautions (quarantine) 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 Transmission-Based Precautions.**
- Residents up-to-date with all recommended COVID-19 vaccine doses and residents who have recovered SARS-CoV-2 infection in the prior 90 days who have close contact with someone with SARS-CoV-2 infection should wear source control and be tested as described in the testing section. In general, these residents 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, or the facility is directed to do so by the jurisdiction's public health authority.

TABLE 1: Routine Testing Intervals

	STAFF		RESIDENTS	
	Vaccinated and up-to-date with all recommended doses	Not up-to-date on all recommended doses of vaccine	Vaccinated and up-to-date with all recommended doses	Not up-to-date on all recommended doses of vaccine
New Positive (or Hot Spot)	➤ Test 100% once per week until no new positives identified in facility for 14 days	➤ Test 100% twice per week	➤ Test 100% once per week until no new positives identified in facility for 14 days	➤ Test 100% once per week until no new positives identified in facility for 14 days
All other facilities regardless of county positivity	<ul style="list-style-type: none"> ➤ No routine testing requirements ➤ When symptomatic ➤ Exposure 	<ul style="list-style-type: none"> ➤ Test 100% twice per week ➤ When symptomatic ➤ Exposure 	<ul style="list-style-type: none"> ➤ No routine testing requirements ➤ When symptomatic ➤ Exposure 	<ul style="list-style-type: none"> ➤ Test residents who leave the facility regularly who are not up-to-date with all recommended doses of vaccine ➤ When symptomatic ➤ Exposure

For purposes of testing “individuals providing services under arrangement and volunteers,” facilities should prioritize those regularly in the facility (*e.g.*, weekly) and have contact with residents or staff. Staff includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility’s nurse aide training programs or from affiliated academic institutions.



Rapid Antigen Testing Guidance

New Mexico recognizes the utility of antigen tests is limited for routine surveillance purposes in some settings and is directing facilities to use antigen tests in the following circumstances ONLY:

1. Immediate testing of a symptomatic staff or resident.
2. Immediate testing of an exposed staff or resident.
3. **As part of a strategy to reduce work restrictions for healthcare personnel in accordance with the CDC guidance, see Table 3 below.**
4. During outbreak/hotspot testing when access to PCR testing is limited by lack of supplies or a test turnaround time that exceeds 72 hours.
5. **To discontinue quarantine of a resident as described in the “Resident and Staff Exposures” section**

Reporting Requirements for SARS-CoV-2 Point of Care (POC) tests

Every COVID-19 testing site is [required to report](#) to the appropriate state or local public health department every diagnostic and screening test performed to detect SARS-CoV-2 or to diagnose a possible case of COVID-19. Point of Care (POC) testing may be performed with a [Clinical Laboratory Improvement Amendments \(CLIA\)](#) certificate of waiver but reporting of test results to state or local public health departments are mandated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Reference Guide.

Table 2 General Testing Guidance

Who	Testing Instructions	Type of Testing
New positive staff or resident (rapid response initiated, facility considered hot spot)	<ul style="list-style-type: none"> ➤ 100% testing of all residents, <u>regardless of vaccination status</u>, ➤ 100% testing of all vaccinated staff once per week, and ➤ 100% testing <u>twice per week</u> of all unvaccinated staff 	RT-PCR specimen for transport to laboratory or antigen test if access to PCR testing is limited by supplies, or test turnaround time exceeds 72 hours
Symptomatic staff or resident	<u>Staff or residents with symptoms or signs of COVID-19, regardless of vaccination status, must be tested immediately.</u> Perform test of symptomatic staff or resident. If the antigen test indicates positive no confirmatory test needed.	Antigen test if available and/or RT-PCR specimen for transport to laboratory if LTC facility does not have an antigen test or if the antigen test result is negative
Residents who are not up-to-date on vaccines who leave the facility regularly	Residents who are not up-to-date with all recommend vaccine doses who leave regularly: Test twice a month	RT-PCR specimen for transport to laboratory
Asymptomatic Staff	Test staff who are not up-to-date with all recommended doses of vaccine according to Table 1 above	RT-PCR specimen for transport to laboratory
Asymptomatic Residents	No testing unless resident leaves facility regularly, in response to an outbreak (rapid response, hot spot testing), or the resident had known close contact with someone infected with SARS-CoV-2	RT-PCR specimen for transport to laboratory
Exposed Staff or Residents	<p>Immediately test directly exposed staff or residents when a new confirmed case is identified. Immediate results can identify other infected individuals, to isolate earlier and prevent further spread in the facility.</p> <ul style="list-style-type: none"> - If the antigen test indicates a negative result, the person should do a confirmatory PCR test. This person should be treated as if they were positive pending receipt of the PCR test result. - If the antigen test indicates positive no confirmatory test needed. 	Antigen test and RT-PCR specimen for transport to laboratory

If a facility is experiencing a shortage in PCR testing supplies from Curative, facilities may supplement their testing with rapid antigen tests if available.



Return to Work Criteria for HCP with SARS-CoV-2 Infection

These mitigation strategies taken from the [CDC's January 21, 2022 Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#) and the January 5, 2022 New Mexico Department of Health's Health Alert Network "Guidance on Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2" offer a continuum of options for addressing staffing shortages. Contingency, followed by crisis capacity, strategies augment conventional strategies and are meant to be considered and implemented sequentially (*i.e.*, implementing contingency strategies before crisis strategies).

Employers and employees should make decisions based on the context of facility settings and strategies and use discretion whether to implement contingency operations. Further, for approval to use crisis standards of care, facilities should continue to use the [Processes for Utilizing COVID-19 Positive or Suspected Asymptomatic Staff When a Facility is Experiencing an Outbreak and a Staffing Crisis](#).

In general, asymptomatic HCP who have had a higher-risk exposure do not require work restrictions if they have received all COVID-19 vaccine doses, including booster dose, as recommended by the CDC and do not develop symptoms or test positive for SARS-CoV-2.

Maximizing interventions to protect HCP, patients, and visitors are critical at all times, including when considering strategies to address staffing shortages.

The following are criteria to determine when HCP with SARS-CoV-2 infection or exposure could return to work. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.

Either an antigen test or PCR test can be used. Some may be beyond the period of expected infectiousness but remain PCR positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than PCR. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.



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

- At least 7 days if a negative antigen or PCR 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) 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.

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

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

HCP with severe to critical illness and are *not* moderately to severely immunocompromised:

- In general, when 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.

- Table 3 Work Restrictions and Testing for HCP With SARS-CoV-2 Infection and Exposures

- Work Restrictions for HCP with SARS-CoV-2 Infection			
- Vaccination Status	- Conventional	- Contingency	- Crisis
- Boosted, Vaccinated or Unvaccinated	- 10 days OR 7 days with negative test, if asymptomatic or mildly symptomatic with improving symptoms	- 5 days with or without a negative test, if asymptomatic or mildly symptomatic with improving symptoms	- No work restriction, with prioritization considerations (asymptomatic or mildly symptomatic with improving symptoms).
- Work Restrictions for Asymptomatic HCP with Exposures			
- Vaccination Status	- Conventional	- Contingency	- Crisis
- Boosted	- No work restrictions, with negative test on day 1 and days 5-7	- No work restrictions	- No work restrictions
- Vaccinated or unvaccinated, even within 90 days of prior infection	- 10 days OR 7 days with negative test	- No work restriction with negative tests on days 1,2,3, and day 5-7	- No work restrictions, testing recommended



**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 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 work. Ultimately, the degree of immunocompromise for the HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.*

Definitions:

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious material, contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff 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 [Interim Clinical Considerations for Use of COVID-19 Vaccines](#). Severe immune suppression includes being on chemotherapy for cancer; having untreated HIV infection with CD4 T lymphocyte count <200; primary immunodeficiency disorder; and receipt of prednisone >20 mg a day for more than 14 days.

Other factors, such as advanced age, diabetes, or end-stage renal disease may pose a much lower degree of immunocompromise and not clearly affect decisions about need for work restriction. However, people in this category should still consider continuing to practice physical distancing and use of source control while in a healthcare facility, even if they have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC.

Ultimately, the degree of immunocompromise for the HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

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.

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.

Severe Illness: Severe illness is indicated by hospitalization in an intensive care unit (ICU) with or without mechanical ventilation