MANAGING RESPIRATORY ILLNESS IN MINNESOTA NURSING HOMES AND ASSISTED LIVING ORGANIZATIONS

LeadingAge Minnesota is driven to transform and enhance the experience of aging. Our members provide quality, compassionate care to older adults every day in all the places they call home, including adult day programs, independent senior housing, assisted living communities, in-home care, and skilled nursing facilities. LeadingAge Minnesota is a state partner of LeadingAge and a state affiliate of Argentum.

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Narcan Resources: Assisted Living

Managing Respiratory Illness in Minnesota Nursing Homes and Assisted Living Organizations

Managing respiratory illnesses such as influenza, COVID-19, and respiratory syncytial virus (RSV) in nursing homes requires a comprehensive, multi-layered approach that spans prevention, early detection, infection control, outbreak response, treatment, and ongoing education.

Prevention Through Immunization

Immunizations are a cornerstone of quality care in long-term care settings because they protect a highly vulnerable population from serious, potentially life-threatening respiratory and infectious diseases. Residents often have advanced age, chronic illnesses, or compromised immune systems that increase both the likelihood of severe complications and the risk of rapid transmission within the communal living environment. By ensuring high vaccination coverage among residents and staff—against influenza, COVID-19, RSV, pneumococcus, and other preventable diseases—facilities can significantly reduce hospitalizations, antibiotic use, and mortality rates, while minimizing disruptions to daily routines and care delivery. Moreover, robust immunization programs support regulatory compliance, demonstrate a commitment to patient safety, and foster confidence among families, staff, and surveyors that the facility is proactively safeguarding resident health.

Influenza	COVID	RSV
Annual Vaccination Offer influenza vaccine to all residents and staff each fall, aiming for completion by October 31. Early vaccination maximizes protection before peak circulation (CDC).	**Vaccine Updates** Provide the latest CDC-recommended COVID-19 vaccine as soon as available for all eligible residents and staff (CDC).	**Target Population** Offer a single dose of RSV vaccine to adults ≥ 75 years, and to those 60–74 years who have chronic cardiorespiratory conditions or reside in long-term care (CDC, CDC).
Logistics Coordinate on-site clinics with pharmacy partners. Use standardized consent forms and track refusals with documented counseling.	**Tracking & Storage** Maintain precise logs of lot numbers, expiration dates, and consent. Ensure cold-chain integrity with daily temperature monitoring.	**Immunization Planning** Align RSV vaccinations with influenza and COVID efforts to streamline staffing and resident education.

Infection Prevention & Control

Effective infection prevention in long-term care begins with universal application of Standard Precautions: every staff member must perform rigorous hand hygiene before and after each resident interaction—using either alcohol-based hand rub or soap and water—and don disposable gloves any time respiratory secretions might be encountered (adding a gown when heavy contamination is expected). When a known or suspected pathogen is present, Transmission-Based Precautions layer on additional safeguards: for droplet-transmitted viruses such as influenza and RSV, residents should be housed in

private rooms or cohorted with others infected by the same agent, while staff don surgical masks within six feet and replace them between rooms; for airborne risks—most notably during aerosol-generating procedures in COVID-19 cases—caregivers upgrade to fit-tested N95 respirators (or equivalent), eye protection, gowns, and gloves, ideally in negative-pressure environments . Finally, rigorous Environmental Cleaning underpins all precautions: high-touch surfaces such as bed rails, call buttons, and doorknobs must be disinfected at least twice daily with an EPA-registered, hospital-grade virucidal product, and any shared equipment—blood pressure cuffs, stethoscopes, walkers—cleaned between each use, ensuring that resident rooms and common areas remain as free of pathogens as possible.

Infection Control Precautions and Environmental Cleaning

Standard Precautions	All Residents	Rigorous hand hygiene before and after resident contact, using alcohol-based hand rub or soap and water. Gloves for any contact with respiratory secretions, gowns if heavy contamination is anticipated.
Transmission-Based Precautions	Droplet Precautions (Influenza, RSV)	Place resident in single room or cohort with the same pathogen. Staff wear surgical masks within 6 ft of the resident; change masks between rooms.
	Airborne Precautions (COVID-19	Use N95 respirators (or equivalent), eye protection, gown, and gloves (CDC).
Environmental Cleaning	Disinfect high-touch surfaces (bed rails, call buttons, doorknobs) at least twice daily with an EPA-registered, hospital-grade virucidal agent. Clean shared equipment (e.g., blood pressure cuffs) between each use.	

Outbreak Control Measures – Respiratory Illness

Symptomatic residents stay in their own rooms as much as possible

- Restrict them from common activities
- Have meals served in their rooms/apartments when possible.

Limit the number of large group activities in the facility

- Consider serving all meals in resident rooms if possible when the outbreak is widespread (involving multiple units of the facility).

Avoid new admissions or transfers to wards with symptomatic residents.

Careful visitation, including notification to visitors of infectious processes in the organization

- Exclude ill persons from visiting the facility via posted notices.
- Consider restricting visitation by children during community outbreaks of influenza.

Monitor healthcare personnel absenteeism due to respiratory symptoms

- Exclude those with influenza-like symptoms from work until at least 24 hours after they no longer have a fever.

Restrict healthcare personnel movement from areas of the facility having illness to areas not affected by the outbreak.

Influenza Outbreak

Definition	An influenza outbreak is defined by the CDC as two resident confirmed influenza cases within 72 hours.
Outbreak Control	Implementation of outbreak control measures can also be considered as soon as possible when one or more residents have acute respiratory illness with suspected influenza and the results of influenza molecular tests are not available the same day of specimen collection.
1sr confirmed case	Active surveillance for additional cases should be implemented as soon as possible once one case of laboratory-confirmed influenza is identified in a facility.

COVID – 19 Guidance for Health Care Workers

Return to Work Guidance			Test-Based Strategy
COVID + Mild/Moderate Symptoms (Illness)	• 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	**Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later* **NAAT – Day 7** **Antigen – Days 5 & 7**	• 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 tested using an antigen test or NAAT.
COVID+ Asymptomatic	• Testing: 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 **NAAT – Day 7 – or - Antigen – Days 5 & 7** • No Test / + Test: 10 days if testing is not performed or if a positive test at day.	**Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later*	• 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.
High-Risk Exposure	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.	Test Days 1 – 3 - 5	HCW can work if asymptomatic; they should wear source control for 10 days following exposure. Report to nurse if symptomatic.

*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. Use an antigen test instead of a NAAT. This is because some people may remain NAAT positive but not be infectious during this period.

*Date of positive test or symptom onset = DAY 0

Updated 05/21/2025

COVID – 19 Guidance for Residents

Symptomatic – Evaluating for COVID 19 Infection			

• One negative NAAT test.
  ○ If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
• A negative antigen test should
  ○ Must be confirmed by either a NAAT (molecular) or second antigen test taken 48 hours after the first negative test.
		**Either a NAAT (molecular) or antigen test may be used.*
		• *If using an antigen test, confirm a negative test with a NAAT or second antigen test.*
			Resident is never tested:
			• At least 10 days have passed *since symptoms first appeared* **and**
			• At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
			• Symptoms (e.g., cough, shortness of breath) have improved

Discontinue Transmission-Based Precautions			**Test-Based Strategy**
COVID+ Symptomatic	• At least 10 days have passed *since symptoms first appeared* **and** • At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and** • Symptoms (e.g., cough, shortness of breath) have improved	**Either a NAAT (molecular) or antigen test may be used.* • *If using an antigen test, confirm a negative test with a NAAT or second antigen test.*	• Resolution of fever without the use of fever-reducing medications **and** • Symptoms (e.g., cough, shortness of breath) have improved, **and** • Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT
COVID + Asymptomatic	At least 10 days have passed since the date of their first positive viral test.	**Either a NAAT (molecular) or antigen test may be used.* • *If using an antigen test, confirm a negative test with a NAAT or second antigen test.*	Results are negative from at least two consecutive tests collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT
High-Risk Exposure	Series of three viral tests : 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.	Test Days 1 – 3 - 5	Does not require quarantine if asymptomatic; they should wear source control for 10 days following exposure. If becomes symptomatic = quarantine

*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. Use an antigen test instead of a NAAT. This is because some people may remain NAAT positive but not be infectious during this period.

*Date of positive test or symptom onset = DAY 0

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New COVID + Resident or Staff

Complete contact tracing to determine close contacts

Close Contacts Determined	Unable to determine close contacts
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. Test days 1 – 3 - 5	If unable to determine close contacts, complete a broad-based testing approach. Test all residents and staff who lived and/or worked in the unit, floor, or other specific area of the organization.

Testing Results		
All Tests Negative	No further action is needed	
Someone tests positive	strong consideration should be given to shifting to the broad-based approach if not already being	
	testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.	If antigen testing is used, more frequent testing (every 3 days), should be considered.

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*Testing should be considered for those who have recovered in the prior 31-90 days. Use an antigen test instead of a NAAT. This is because some people may remain NAAT positive but not be infectious during this period.

*Date of positive test or symptom onset = DAY 0

In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures.