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Infection Prevention and Control Plan for Residential Facilities Coronavirus Disease 2019 (COVID-19) Response Best Practices

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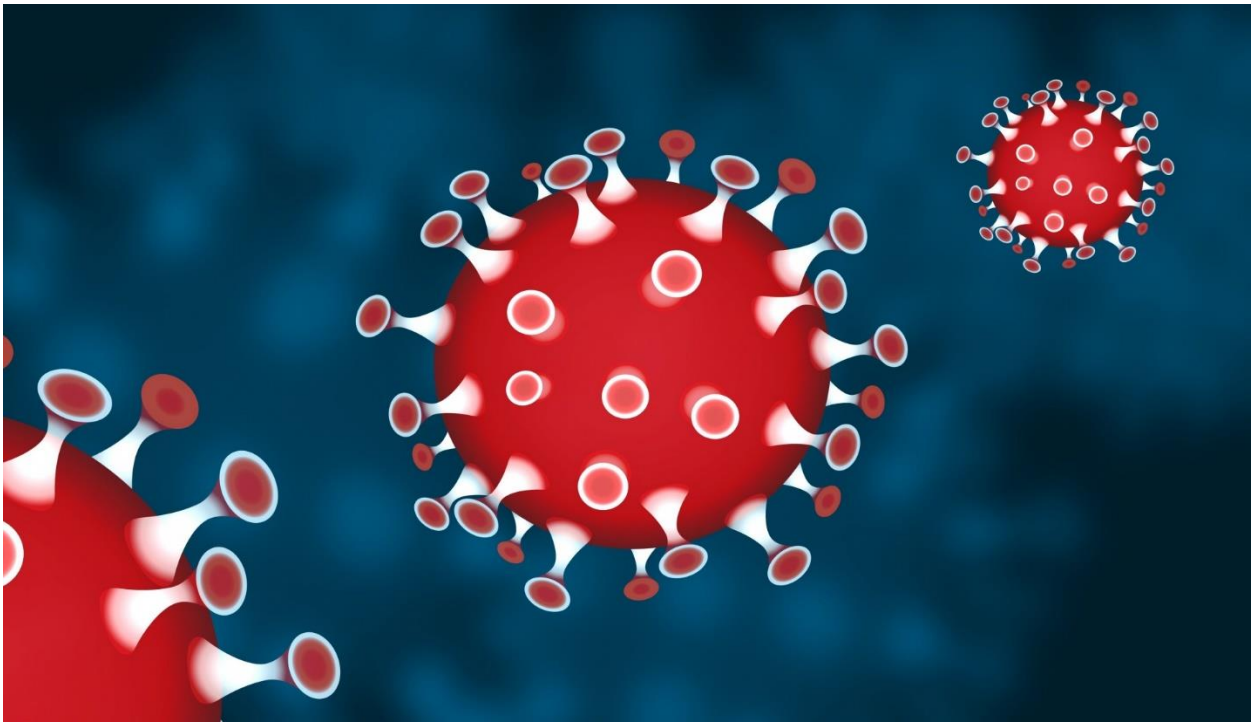

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Introduction

Because group homes involve different individuals living together and sharing activities (congregate living), group homes are at high risk of COVID-19 spreading and affecting residents as well as staff. If residents become infected with COVID-19 they may be at increased risk of developing a serious illness or dying since residents in group homes tend to be older, have physical, psychiatric or intellectual disabilities and may have underlying chronic medical conditions.

COVID-19 spreads mainly through close person-to-person contact in respiratory droplets from someone who is infected. People who are infected often have symptoms of illness, but even some people without symptoms may be able to spread the virus. Person-to-person spread occurs between people who are in close contact with one another such as within about six feet and through respiratory droplets produced when an infected person coughs, sneezes or talks. A person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose or possibly their eyes. However, this is not thought to be the main way the virus spreads.

Having an infection prevention and control plan individualized to your facility is important for the protection of your staff and residents**. COVID-19 may continue to present itself in the future and it is important to have your facility prepared to keep COVID-19 from entering your facility, if possible. If COVID-19 infection enters the facility, the key is recognizing and taking immediate action to rapidly contain the spread.**

This generic infection prevention and control plan for group homes is meant to assist each facility in developing its own individualized plan to meet the needs of the facility residents and staff.

The current recommendations from the Centers for Disease Control and Prevention (CDC) will continue to be the primary way that long-term care facility (LTCF) residents and health care personnel (HCP) are protected until vaccination is widespread. These recommendations are described in the Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC.

Currently, authorized vaccines in the United States are highly effective at protecting vaccinated people against symptomatic and severe COVID-19.

When Are You Up to Date?

You are **up to date** with your COVID-19 vaccines if you have completed a COVID-19 vaccine primary series and received the most recent booster dose recommended for you by CDC.

COVID-19 vaccine recommendations are based on three things:

1. Your age,
2. The vaccine you first received, and
3. The length of time since your last dose.

People who are moderately or severely immunocompromised have different recommendations for COVID-19 vaccines. Stay Up to Date with COVID-19 Vaccines Including Boosters | CDC.

Protective Measures / Mitigating the Risk of Spreading COVID-19

In general, long-term care settings (excluding nursing homes) whose staff provide non-skilled personal care* similar to that provided by family members in the home (e.g., many assisted livings, group homes) should follow community prevention strategies based on COVID-19 community levels, similar to independent living, retirement communities or other non-health care congregate settings.

Residents should also be counseled about strategies to protect themselves and others, including recommendations for source control if they are immunocompromised or at high risk for severe disease. CDC has information and resources for older adults and for people with disabilities.

Visiting or shared health care personnel who enter the setting to provide health care to one or more residents (e.g., physical therapy, wound care, intravenous injections or catheter care provided by home health agency nurses) should follow the health care infection prevention and control (IPC) recommendations in this guidance. In addition, if staff in a residential care setting are providing in-person services for a resident with SARS-CoV-2 infection, they should be familiar with recommended IPC practices to protect themselves and others from potential exposures, including the hand hygiene, personal protective equipment (PPE) and cleaning and disinfection practices outlined in this guidance.

*Non-skilled personal care consists of any non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing; it may also include the kind of health-related care that most people do themselves, such as taking oral medications. In some cases where care is received at home or a residential setting, care can also include help with household duties such as cooking and laundry.

Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC

Individual-Level Prevention Steps You Can Take Based on Your COVID-19 Community Level

A. **Low, Medium and High**

At all COVID-19 Community Levels:

- Stay up to date on vaccination, including recommended booster doses.
- Maintain ventilation improvements.
- Avoid contact with people who have suspected or confirmed COVID-19.
- Follow recommendations for isolation if you have suspected or confirmed COVID-19.
- Follow the recommendations for what to do if you are exposed to someone with COVID-19.
- If you are at high risk of getting very sick, talk with a health care provider about additional prevention actions.
- Use PPE
    - Caregivers who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to core practices and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves and eye protection (i.e. goggles or a face shield that covers the front and sides of the face).
    - Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134)

B. **Medium and High**

When the COVID-19 community level is Medium or High:

- If you are at high risk of getting very sick, wear a high-quality mask or respirator (e.g., N95) when indoors in public
- If you have household or social contact with someone at high risk for getting very sick, consider self-testing to detect infection before contact, and consider wearing a high-quality mask when indoors with them.

C. High

When the COVID-19 Community Level is High:

- Wear a high-quality mask or respirator.
- If you are at high risk of getting very sick, consider avoiding non-essential indoor activities in public where you could be exposed.

Visitation Guidance

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. Regardless of how visits are conducted, certain core principles and best practices reduce the risk of COVID-19 transmission.

Core Principles of COVID-19 Infection Prevention

- Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19 or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for health care settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC health care guidance (e.g., cannot wear source control).
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose) in accordance with CDC guidance community prevention strategies based on COVID-19 Community Levels.
- For suspected or known positive, visitors must follow appropriate PPE of mask, gown and gloves
- Instructional signage throughout the facility and proper visitor education on COVID- 19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting frequently-touched surfaces in the facility often, and designated visitation areas after each visit.
- Appropriate staff use of PPE.
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care).

These core principles are consistent with CDC guidance and should be adhered to at all times. Additionally, visitation should be person-centered, consider the residents' physical, mental and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear plexiglass dividers, curtains). Also, residential facilities should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred when the resident and/or visitor are not fully vaccinated against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios or parking lots, including the use of tents, if available. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor Visitation 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. To swiftly detect cases, we recommend facilities to adhere to CDC recommendations for COVID-19 testing of individuals with symptoms and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately (but not earlier than 24 hours after the exposure, if known) begin outbreak testing in accordance with CDC guidelines.

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If visitors are unwilling to follow appropriate core principles of infection control, visitation should not be allowed until outbreak is resolved. While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Also, visitors should physically distance themselves from other residents and staff, when possible. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

Compassionate Care Visits
Compassionate care visits and visits required under federal disability rights law should be **allowed at all times** for any resident (vaccinated or unvaccinated) while maintaining the core principles of COVID-19 infection prevention.

Family Home Visitation
Family member(s) should be notified of the precautions that should be taken while the resident is visiting their family and the importance of keeping the precautions in place to protect other facility residents from possible exposure to COVID-19 upon the resident's return to the facility. The high risk for serious complications of COVID-19, including but not limited to death, in residential facilities for group should also be explained. The family member(s) should acknowledge their understanding of the needed precautions to maintain while the resident is out of the facility visiting with their family.

Facilities should permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices, including wearing a face covering or mask, physical distancing and hand hygiene. Anyone who is around the resident should be encouraged to do the same.

Upon the resident's return, facilities should take the following actions:

- If the resident or family member reports possible close contact to a COVID-positive individual while outside of the nursing home, see the CDC's guidance for residents who have had close contact for next steps regarding testing and quarantine.
- If the resident develops signs or symptoms of COVID-19 after the outing, see the CDC's guidance for residents with symptoms of COVID-19.
- Follow Appendix B: Risk Assessment and Infection Control Recommendations for Returning Residents at the end of this document.

In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) except in certain situations, described in the CDC's empiric transmission-based precautions guidance. Residents who leave the facility for 24 hours or longer should generally be managed as a new admission, as recommended by the CDC in the "Managing admissions and residents who leave the facility" section of the aforementioned guidance.

During holidays, taking a person-centered approach while adhering to the core principles of COVID-19 infection prevention, it is important for the facility to evaluate each scenario in which a resident leaves the facility for family visitation to determine the best course of action to take upon the resident's return to the facility. Some scenarios are noted below:

Resident and family are following precautions. There will only be four family members present at the family gathering and resident will not spend the night. Resident returns to facility with no additional precautions.

Resident has a large family and there is a good chance that precautions will not be followed. Resident visits with 15 family members, spends the night and returns home the next day. In this case, the facility should follow the new admissions guideline of placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission.

It is impossible to go over every scenario but some things to consider helping you determine the precautions to take upon a resident's return to the facility include:

- Can the resident and family be trusted to follow the necessary precautions to limit their exposure to COVID-19?
- Will the resident be out of the facility for greater than 24 hours?
- How many family members will the resident be visiting?
- Will the family be taking the resident out to a public place such as a restaurant or other event? What is the nature of the event?

Note: Facilities should have their visitation plan available for review by surveyors during an on-site inspection. Facilities are ***not*** required to submit their plan to HCQC for prior approval.

Managing New Admissions

Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
Quarantine is based on facility risk assessment. Examples of when empiric transmission-based precautions may be considered include:

- Based on community transmission level.
- Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure.
- Patient is moderately to severely immunocompromised.
- Patient is residing on a unit with others who are moderately to severely immunocompromised.
- Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

Testing and required preventive measures of new admissions is recommended below:

- Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.
- They should also be advised to wear source control for the 10 days following their admission. Residents who leave the facility for 24 hours or longer should generally be managed as an admission.

Based on the availability of adequate testing resources, the following options to shorten quarantine can be acceptable alternatives:

- Quarantine can end after Day 10 without testing if no symptoms have been reported during daily monitoring.
- When testing resources are available, quarantine can end after Day 7 if a diagnostic specimen tests negative and no symptoms were reported during daily monitoring. The specimen should be collected and tested within 48 hours before the time of planned quarantine discontinuation (in anticipation of testing delays), but quarantine cannot be discontinued earlier than after Day 7.

In both options, additional criteria (e.g., continued symptom monitoring and masking through Day 14) must be met. Full information on this issue can be found in the technical bulletin, titled, *Quarantine new admits and readmissions regardless of vaccination status in nursing homes and residential facilities*, on the Division of Public and Behavioral Health website.

Screen All Staff and Visitors

1. Ensure everyone is aware of recommended IPC practices in the facility.
    a. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can let help ensure people know that they reflect current recommendations.
2. Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
    a. a positive viral test for SARS-CoV-2
    b. symptoms of COVID-19, or
    c. close contact with someone with SARS-CoV-2 infection (for residents and visitors)
3. Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
4. Staff who work in multiple locations may pose higher risks and should be asked about exposure to facilities with recognized COVID-19 cases. The risks should be weighed against the need to care for the residents.
5. Implement sick leave policies that are flexible and non-punitive.

Note: EMS personnel responding to an emergency do not need to be screened so they can attend to an emergency without delay.

Symptoms of COVID-19 may include:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Note: Older people with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 by the resident's physician.

Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have underlying medical conditions like heart or lung disease or diabetes are at higher risk for getting very sick from COVID-19.

Communal Activities and Social Distancing

- While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. The safest approach is for everyone, particularly those at high risk for severe illness, to wear a face covering or mask while in communal areas of the facility. For more information, see CDC guidance community prevention strategies based on COVID-19 Community Levels.

Maintaining a good social distance (at least 6 feet), particularly during an outbreak, is very important in preventing the spread of COVID-19. The following preventative measures should be considered:

- Arrange seating of chairs and tables to be least 6 feet (2 meters) apart during shared meals or other events.
- Alter schedules to reduce mixing and close contact, such as staggering meal and activity times and forming small groups that regularly participate at the same times and do not mix.
- Ensure that social distancing can be maintained in shared rooms, such as television, game or exercise rooms.
- Make sure that shared rooms in the facility have good air flow from an air conditioner or an opened window.
- Work with building maintenance staff to determine if the building ventilation system can be modified to increase ventilation rates. Improving ventilation helps remove respiratory droplets from the air.
- If possible, residents should have their own room and bathroom.

Note: Facilities should consider additional limitations based on status of COVID-19 infections in the facility. For example, if the facility is experiencing an outbreak consider temporarily canceling all non-essential group activities and events until the outbreak is fully contained. Guidance on when to restart communal activities and any recommended preventive measures should be obtained from the Division of Public and Behavioral Health's Office of Public Health Investigations and Epidemiology at DPBHHAI@health.nv.gov or Infection Prevention and control team with Bureau of Health Care Quality and Compliance at hcqcipcteam@health.nv.gov.

Considerations for Specific Communal Rooms in your Facility

Shared kitchens and dining rooms

While adhering to the core principles of COVID-19 infection prevention, communal dining may occur. While residents are eating in the same room the following guidelines should be followed:

- Restrict the number of people allowed in the kitchen and dining room at one time so that everyone can stay at least 6 feet (2 meters) apart from one another.
    - People who are sick, their roommates and those who have higher risk of severe illness from COVID-19 should eat or be fed in their room.
- Do not share dishes, drinking glasses, cups or eating utensils. Non-disposable food service items used should be handled with gloves and washed with dish soap and hot water or in a dishwasher. Wash hands after handling used food service items.
- Use gloves when removing garbage bags and handling and disposing of trash. Wash hands.
- All kitchen and dining room staff must be trained to the policies and procedures for infection control and prevention in the dining rooms, including but not limited to cleaning and disinfecting between meal services.

Note: Facilities should consider additional limitations based on status of COVID-19 infections in the facility. For example, if the facility is experiencing an outbreak consider temporarily closing the communal dining area and serving residents in their individual rooms.

Laundry rooms

- Maintain access and adequate supplies to laundry facilities to help prevent spread of COVID-19.
- Restrict the number of people allowed in laundry rooms at one time to ensure everyone can stay at least 6 feet (2 meters) apart.

- Provide disposable gloves, soap for washing hands, household cleaners and EPA-registered disinfectants for residents and staff to clean and disinfect buttons, knobs and handles of laundry machines, laundry baskets and shared laundry items.
- Post guidelines (such as washing instructions and handling of dirty laundry) for doing laundry. For example, the laundry of COVID-19-positive residents should be washed in the hottest tolerable water and dried at the highest temperature tolerated (see pages 2 and 3 of the guidance linked here).

Recreational areas such as activity rooms and exercise rooms during outbreak

- Consider closing activity rooms or restricting the number of people allowed in at one time to ensure everyone can stay at least 6 feet (2 meters) apart.
- Consider closing exercise rooms.
- Activities and sports (e.g., ping pong, basketball, chess) that require close contact are not recommended.

Pools and hot tubs during outbreak

- Consider closing pools and hot tubs or limiting access to pools for essential activities only, such as water therapy.
    - While proper operation, maintenance and disinfection (with chlorine or bromine) should kill COVID-19 in pools and hot tubs, they may become crowded and could easily exceed recommended guidance for gatherings. It can also be challenging to keep surfaces clean and disinfected.
    - Considerations for shared spaces (maintaining physical distance and cleaning and disinfecting surfaces) should be addressed for the pool and hot tub area and in locker rooms if they remain open.

Shared bathrooms

- Shared bathrooms should be cleaned regularly using EPA-registered disinfectants at least twice per day (e.g., in the morning and evening and after times of heavy use).
- Make sure bathrooms are continuously stocked with soap and paper towels or automated hand dryers. Hand sanitizer could also be made available.
- Make sure trash cans are emptied regularly.
- Provide information on how to wash hands properly. Hang hand hygiene signs (such as those provided on the CDC web page linked here) in bathrooms.
- Residents should be instructed that sinks could be an infection source and should avoid placing toothbrushes directly on counter surfaces. Totes could also be used for personal items to limit their contact with other surfaces in the bathroom.

Rapidly Identify and Properly Respond to Residents with Suspected or Confirmed COVID-19

1. Designate one or more facility employees to ensure all residents have been asked at least daily about fever and symptoms of COVID-19 (e.g., sore throat, new or worsening cough, shortness of breath, muscle aches, new loss of taste or smell and others listed in Symptoms of COVID-19 section).
2. Implement a process or facility point of contact whom residents can notify (e.g., call by phone) if they develop symptoms.
3. If COVID-19 is identified or suspected in a resident (i.e. resident reports fever or symptoms of COVID-19), immediately isolate the resident in their room and notify the resident's physician and health department.
4. Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
    - Identify caregivers who will be assigned to work only on the COVID-19 care unit when it is in use.
    - Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of transmission-based precautions, prioritize for testing, transfer to COVID-19 unit if positive).
    - Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting

results of testing, caregivers should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by caregivers for source control, not when PPE is indicated.

- Have a plan for how roommates, other residents and caregivers who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them).

5. An ill resident might be able to remain in the facility if the resident:
    - Can isolate in their room for the duration of their illness.
    - Can have meals delivered – use disposable food utensils, containers, cups, forks, etc. and discard in dedicated marked COVID trash bag. Remove unnecessary shared items.
    - There is a mechanism for staff to regularly check on the resident; visits by home health agency personnel who wear all recommended PPE if able to request assistance.

    It might also be possible for ill residents who require more assistance to remain in the facility if they can remain isolated in their room, and on-site or consultant personnel can provide the level of care needed with access to all recommended PPE and training on proper selection and use.

    If the ill resident requires more assistance than can be safely provided by on-site or consultant personnel (e.g., home health agency), they should be transferred (in consultation with public health) to another location (e.g., alternate care site, hospital) that is equipped to adhere to recommended infection prevention and control practices. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.
    - While awaiting transfer, symptomatic residents should wear a cloth face covering (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE, as described above, should be used by caregivers when coming in contact with the resident.

    - If residents are transferred to the hospital or another care setting, actively follow up with that facility and resident family members to determine if the resident was known or suspected to have COVID-19. This information will inform the need for contact tracing or implementation of additional infection prevention practices recommendations.
        - Implement processes to maintain social distancing (remaining at least 6 feet apart) between all residents and personnel while still providing necessary services.
    - If a resident is experiencing a medical emergency such as persistent pain or pressure in the chest, new confusion or inability to wake up, bluish lips or face, or difficulty breathing, call 911 and tell the dispatcher that the resident has or might have COVID-19.
      The items listed above are not the only reason to call 911. Call 911 for any and all medical emergencies a resident may be experiencing.

Resident/Family Notification

Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or two or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must:

(i) Not include personally identifiable information;

(ii) Include information on actions to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and

(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either. Each time a confirmed infection of COVID-

19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Local Health Authority Notification

Notify your local health authority if:

- COVID-19 is suspected or confirmed among residents or facility personnel.
- A resident develops severe respiratory infection.
- More than two residents or facility personnel develop fever or respiratory symptoms within 72 hours of each other.

Nevada Division of Public and Behavioral Health
- 24-hour phone: (775) 684-5911
- http://dpbh.nv.gov/

Carson City Health & Human Services
- Business hours: (775) 887-2190
- After hours: (775) 887-2190
- https://gethealthycarsoncity.org/

Southern Nevada Health District
- 24-hour phone: (702) 759-1300
- https://www.southernnevadahealthdistrict.org/

Washoe County Health District
- 24-hour phone: (775) 328-2447
- https://washoecounty.us/health/

Staff Testing

- If a staff member or resident is suspected of having COVID-19 consult with your health authority about having the staff member or resident tested.
- If one or more staff members or residents test positive for COVID-19, contact your health authority for consideration of facility wide testing for all residents and staff members.
    - If staff member refuses testing, consider implementing a policy requiring staff member to be tested prior to returning to work.
    - If resident refuses testing, explain to resident the importance of testing and how it can help protect the resident and others in the facility. If the resident continues to refuse, document refusal to be tested in resident's file.

Duration/Discontinuation of Isolation and Precautions for Adults with COVID-19

Symptoms-based strategy:

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

- 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

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

- At least 10 days have passed since the date of their first positive viral test.

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

Patients 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 (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.

For more information refer to Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC.

Monitor and Plan for Absenteeism Among Staff

- Develop plans to cover activities in the event of increased staff absences. Coordinate with other local residential facility for groups and reach out to substitutes to determine their anticipated availability if regular staff members need to stay home if they or their family members are sick.
- Require sick staff to stay home.
- Communicate to staff the importance of staying home when they are sick.
- Communicate to staff the importance of being vigilant for symptoms and staying in touch with facility management if or when they start to feel sick.
- Sick staff members should not return to work until they have met the criteria for Discontinuation of Isolation and Precautions for Adults with COVID-19 (please refer to CDC link https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html)

Strategies to Mitigate Staffing Shortages

Maintaining appropriate staffing in facilities is essential to providing a safe work environment for staff and safe resident care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to staff exposures, illness, or need to care for family members at home. Facilities must be prepared for staffing shortages and plan accordingly. Considerations for creating a staffing contingency plan include (but are not limited to):

- Not admitting new residents until staffing shortages are alleviated
- Use of a staffing agency
- Management or office staff to assist with residents (within their scope of practice)
- Implement sick leave policies that are flexible and non-punitive
- Bonus or overtime pay
- Closing the facility (may be an option for smaller facilities)

Other strategies could be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Educate Residents, Family Members and Personnel About COVID-19

- Have a plan and mechanism to regularly communicate with personnel, residents, and any family members specified by the resident.
- Provide information about COVID-19 (including information about signs and symptoms) and strategies for managing stress and anxiety.
- Describe actions the facility is taking to protect residents and personnel.
- Describe actions residents and personnel can take to protect themselves in the facility, emphasizing the importance of social (physical) distancing, hand hygiene, respiratory hygiene and cough etiquette, and face mask or alternate face covering source control (keeps respiratory droplets contained and from reaching other people).
- Remind residents and visitors that public health authorities have urged older adults and people of any age who have serious underlying medical conditions to remain home and limit their interactions with others.
- If residents leave their room or are around others, they should wear a cloth face covering (if tolerated), regardless of symptoms. If the resident does not have a cloth face cover, a facemask may be used for source control if supplies allow.

- Encourage residents, personnel, and visitors to remain vigilant for and immediately report fever or symptoms consistent with COVID-19 (e.g., sore throat, new or worsening cough, shortness of breath, muscle aches). Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.

Note: Cloth face coverings should not be worn or placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Additionally, they should not be placed on children under age 2.

Prevention

COVID-19 vaccine – Continue your efforts to sign up residents and staff for COVID-19 vaccination. Contact your assigned Infection Preventionist or Office of Public Health Investigations and Epidemiology (OPHIE) contact to get help setting up a clinic. Additional information regarding the COVID-19 vaccine can be found at dpbh.nv.gov/Programs/Immunization/COVID/COVID_Vaccine/

Flu shots – It is important that all residents receive the quadrivalent inactivated influenza vaccine unless there is a medical contraindication or the resident or legal representative refuses. Vaccines should be given before flu season starts if possible.

Pneumococcal vaccination – The CDC recommends the pneumococcal vaccination for all adults 65 years or older. Pneumococcal disease in older adults may place them at risk for serious illness and death.

Shingles vaccination is the only way to protect against shingles and postherpetic neuralgia (PHN), the most common complication from shingles. CDC recommends that healthy adults 50 years and older get two doses of the shingles vaccine called Shingrix (recombinant zoster vaccine), separated by two to six months, to prevent shingles and the complications from the disease. Two doses of Shingrix is more than 90% effective at preventing shingles and PHN. Protection stays above 85% for at least the first four years after you get vaccinated.
Discuss these four important vaccinations with residents and their physicians.

Hand hygiene
1) The facility should ensure that hand hygiene supplies are readily available to all personnel in every care location.
2) Wash your hands often with soap and water for at least 20 seconds. Tell everyone in the home to do the same, especially after being near the person who is sick.
3) If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry. If hands are visibly soiled, use soap and water before returning to an alcohol-based hand sanitizer.
4) Avoid touching your eyes, nose, and mouth with unwashed hands.

Handwashing should be done on the following occasions:
- Before, during, and after preparing food
- Before eating food
- Before and after providing care to a resident
- Before and after caring for someone at home who is sick with vomiting or diarrhea
- Before and after treating a cut or wound
- After using the toilet
- After changing incontinence briefs or cleaning up a resident who has used the toilet
- After blowing your nose, coughing or sneezing
- After touching an animal, animal feed, or animal waste

- After handling pet food or pet treats
- After touching garbage
- After contact with potentially infectious material,
- Before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

During the COVID-19 pandemic, handwashing should also be performed on the following occasions:

- After having been in a public place and touching an item or surface that may be frequently touched by other people, such as door handles, tables, gas pumps, shopping carts or electronic cashier registers/screens, etc.
- Before touching eyes, nose or mouth because that is how germs enter the body.

Five steps in handwashing

- Wet hands with clean, running water (warm or cold), turn off the tap and apply soap. Hand-washing posters can be found online at https://www.cdc.gov/handwashing/posters.html.
- Lather hands by rubbing them together with the soap. Lather the backs of hands, between fingers and under the nails.
- Scrub hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- Rinse hands well under clean, running water.
- Dry hands using a clean towel or air dry them.
- Turn off the tap water with a disposable towel to avoid re-contaminating your hands again.

Sanitizers can quickly reduce the number of germs on hands in many situations, however:

- Sanitizers do not get rid of all types of germs.
- Hand sanitizers may not be as effective when hands are visibly dirty or greasy.
- Hand sanitizers might not remove harmful chemicals from hands like pesticides and heavy metals.

How to use hand sanitizer

- Apply the gel product to the palm of one hand (read the label to learn the correct amount).
- Rub hands together.
- Rub the gel over all the surfaces of the hands and fingers until the hands are dry. This should take around 20 seconds.

Open the following link to access the video on handwashing:
https://www.cdc.gov/handwashing/

Personal Protective Equipment (PPE)

Caregivers providing care to residents with suspected COVID-19 (resident reports fever, shortness of breath or other symptoms consistent with COVID-19) or who are COVID-19 positive (both residents with symptoms and without symptoms) should, at a minimum, wear:

- Eye protection (goggles or face shield) and an N95 or higher-level respirator. **Face coverings are not PPE and should not be used when a respirator or facemask is indicated.**
- Gown and gloves

Important: If using PPE extended use/optimizing strategies, the facility should have a policy and procedure in place, based on CDC guidelines. Please see resource guide at the end of this document for links.

All caregivers must receive training on and demonstrate an understanding of:

- when to use PPE;
- what PPE is necessary;

- how to properly put on, use, and take off PPE in a manner to prevent self-contamination;
- how to properly dispose of or disinfect and maintain PPE; and
- the limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated and maintained after and between uses in accordance with the manufacturer's instructions. The PPE recommended when caring for a resident(s) with known or suspected COVID-19 includes:

- Respirator or face mask (cloth face coverings are ***not*** PPE and should not be worn for the care of residents with known or suspected COVID-19 or other situations where a respirator or face mask is warranted)
  - If the facility has any case of COVID-19 put on an N95 respirator (or higher-level respirator) or face mask (if a respirator is not available) before entry into ***all*** resident rooms or care areas, even those that do not have COVID-19.
  - Disposable respirators and face masks should be removed and discarded after exiting a resident's room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or face mask.
    - If reusable respirators (e.g., powered air-purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
  - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for residents with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for residents with pathogens for which a respirator is recommended, should implement a respiratory protection program. Components of a respiratory protection program include but are not limited to:
    - Documented respiratory protection plan
    - Respiratory protection program administrator
    - Staff medical evaluation and respirator test fitting
    - Staff training program

OSHA Respiratory Protection Program Guidelines: https://www.osha.gov/enforcement/directives/cpl-02-02-054

- Eye protection
  - Put on eye protection (i.e. goggles or a disposable face shield that covers the front and sides of the face) upon entry to the resident room or care area, if not already wearing as part of extended use or reuse strategies to optimize PPE supply. Personal eyeglasses and contact lenses are ***not*** considered adequate eye protection.
  - Remove eye protection after or when leaving the resident room or care area.
  - Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse.
- Gloves
  - Put on clean, non-sterile gloves upon entry into the resident room or care area.
    - Change gloves if they become torn or heavily contaminated.
  - Remove and discard gloves when leaving the resident room or care area, and immediately perform hand hygiene.
- Gowns
  - Put on a clean isolation gown upon entry into the resident room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the resident room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
  - If there are shortages of gowns, they should be prioritized for:
    - aerosol generating procedures
    - care activities where splashes and sprays are anticipated

        - high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of caregivers. Examples include:
            - dressing
            - bathing/showering
            - transferring
            - providing hygiene
            - changing linens
            - changing briefs or assisting with toileting
            - device care or use
            - wound care
    - Additional strategies for optimizing supply of gowns are available.
- Obtain a relationship/contract with a PPE vendor, track use of PPE and order before you run out. It is imperative that your facility has enough PPE to prevent the spread of COVID-19.

Open the following link to access the strategies to optimize the supply of PPE and equipment:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

How to put on (don) PPE:
More than one donning method may be acceptable. Training and practice using the facility's procedure is critical. Below is one example of donning.

a. Identify and gather the proper PPE to don. Ensure choice of gown size is correct.
b. Perform hand hygiene using hand sanitizer.
c. Put on isolation gown. Tie all the ties on the gown. Assistance may be needed by other health care personnel.
d. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a face mask if a respirator is not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/face mask should be extended under chin. Both the mouth and nose should be protected. Do not wear respirator/face mask under the chin or store in scrubs pocket between residents.*
    - Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
    - Face mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around the ears.
e. Put on face shield or goggles. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
f. Perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of gown.
g. Health care personnel/caregivers may now enter the resident room.

How to take off (doff) PPE:
More than one doffing method may be acceptable. Training and practice using the facility's procedure is critical. Below is one example of doffing.

a. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
b. Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
c. Health care personnel/caregivers may now exit the resident room.
d. Perform hand hygiene.
e. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.

f. Remove and discard respirator (or facemask if used instead of respirator). Do not touch the front of the respirator or face mask.*
    - Remove the bottom strap of the respirator by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
    - Carefully untie (or unhook from the ears) a face mask and pull away from face without touching the front.

g. Perform hand hygiene after removing the respirator/face mask and before putting it on again if your workplace is practicing reuse.*

** Facilities implementing reuse or extended use of PPE will need to adjust their donning (putting on) PPE and doffing (removing) PPE procedures to accommodate those practices.*

Open the following link to access the video on how to safely put on PPE:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

Cleaning and Disinfection of Facility

a. Clean and disinfect "high-touch" surfaces and items every day: This includes tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, and electronics.
b. Clean the area or item with soap and water if it is dirty. Then, use a household disinfectant.
    - Be sure to follow the instructions on the label to ensure safe and effective use of the product. Many products recommend keeping the surface wet for several minutes to kill germs. Many also recommend wearing gloves, making sure you have good air flow, and wiping or rinsing off the product after use.
    - Use EPA- registered disinfectants to clean.
    - To clean electronics, follow the manufacturer's instructions for all cleaning and disinfection products. If those directions are not available, use alcohol-based wipes or spray containing at least 70% alcohol.

Open the following link to access the list of EPA-registered disinfectants:
https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

Bedroom and bathroom:

a. If you are using a separate bedroom and bathroom: Only clean the area around the person who is sick when needed, such as when the area is soiled. This will help limit your contact with the sick person.
b. If sharing a bathroom: The person who is sick should clean and then disinfect after each use. If this is not possible, wear a mask and wait as long as possible after the sick person has used the bathroom before coming in to clean and use the bathroom.

Wash and dry laundry:

a. Do not shake dirty laundry.
b. Wear disposable gloves while handling dirty laundry.
c. Dirty laundry from a person who is sick can be washed with other people's items.
d. Wash items according to the label instructions. Use the warmest water setting you can.
e. Remove gloves, and wash hands right away.
f. Dry laundry, on hot if possible, completely.
g. Wash hands after putting clothes in the dryer.
h. Clean and disinfect clothes hampers. Wash hands afterwards.

Use lined trash can:

a. Place used disposable gloves and other contaminated items in a lined trash can.

b. Use gloves when removing garbage bags, and handling and disposing of trash. Wash hands afterwards.
c. Place all used disposable gloves, facemasks, and other contaminated items in a lined trash can.
d. If possible, dedicate a lined trash can for the person who is sick.

Cleaning and disinfection after persons suspected/confirmed to have COVID-19 have been in the facility

Timing and location of cleaning and disinfection of surfaces
Close off areas visited by the ill persons. Open outside doors and windows and use ventilating fans to increase air circulation in the area.

Cleaning staff should clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment (like tablets, touch screens, keyboards, remote controls, and ATM machines) used by the ill persons, focusing especially on frequently touched surfaces**.**

How to clean and disinfect:
Hard (non-porous) surfaces

- Wear disposable gloves when cleaning and disinfecting surfaces. Gloves should be discarded after each cleaning. If reusable gloves are used, those gloves should be dedicated for cleaning and disinfection of surfaces for COVID-19 and should not be used for other purposes. Consult the manufacturer's instructions for cleaning and disinfection products used. Clean hands immediately after gloves are removed.
- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
  Always read and follow the directions on the label to ensure safe and effective use.
- Wear skin protection and consider eye protection for potential splash hazards
- Ensure adequate ventilation
- Use no more than the amount recommended on the label
- Use water at room temperature for dilution (unless stated otherwise on the label)
- Avoid mixing chemical products
- Label diluted cleaning solutions
- Store and use chemicals out of the reach of children and pets

You should never eat, drink, breathe or inject these products into your body or apply directly to your skin as they can cause serious harm. Do not wipe or bathe pets with these products or any other products that are not approved for animal use.
Click here to see the EPA's 6 steps for Safe and Effective Disinfectant Use.
Special considerations should be made for people with asthma and they should not be present when cleaning and disinfecting is happening as this can trigger asthma exacerbations.

- Disinfect with a household disinfectant on the EPA's List N to kill COVID-19. Follow the manufacturer's instructions for all cleaning and disinfection products. Read the product label for the correct concentration to use, application method and contact time.
- Diluted household bleach solutions can be used if appropriate for the surface. Unexpired household bleach will be effective against coronaviruses when properly diluted:
  - Use bleach containing 5.25%-8.25% sodium hypochlorite. Do not use a bleach product if the percentage is not in this range or is not specified.
  - Follow the manufacturer's application instructions for the surface, ensuring a contact time of at least 1 minute.
  - Ensure proper ventilation during and after application.
  - Check to ensure the product is not past its expiration date.
  - Never mix household bleach with ammonia or any other cleanser. This can cause fumes that may be very dangerous to breathe in.
- Prepare a bleach solution by mixing:

- 5 tablespoons (1/3 cup) of 5.25%-8.25% bleach per gallon of room temperature water, or
- 4 teaspoons of 5.25%-8.25% bleach per quart of room temperature water

- Bleach solutions will be effective for disinfection up to 24 hours.
- Alcohol solutions with at least 70% alcohol may also be used.
- Cleaning staff and others should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Always read and follow the directions on the label to ensure safe and effective use.
- Keep hand sanitizers away from fire or flame
- For children under 6 years of age, hand sanitizer should be used with adult supervision
- Always store hand sanitizer out of reach of children and pets
- Follow normal preventive actions while at work and home, including cleaning hands and avoiding touching eyes, nose, or mouth with unwashed hands.
    - Additional key times to clean hands include:
        - After blowing one's nose, coughing, or sneezing.
        - After using the restroom.
        - Before eating or preparing food.
        - After contact with animals or pets.
        - Before and after providing routine care for another person who needs assistance such as a child.

Soft (porous) surfaces such as carpeted floor, rugs and drapes — Remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:

- If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
    - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces

Electronics such as tablets, touch screens, keyboards, remote controls and ATM machines — Remove visible contamination if present.

- Follow the manufacturer's instructions for all cleaning and disinfection products.
- Consider use of wipeable covers for electronics.
- If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Linens, clothing and other items that go in the laundry

- Do not shake dirty laundry to minimize the possibility of dispersing virus through the air.
- Wash items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
- Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

The risk of exposure to cleaning staff is inherently low. Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash.

- Gloves and gowns should be compatible with the disinfectant products being used.
- Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk of splash.
- Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area. Be sure to clean hands after removing gloves.

    - If gowns are not available, coveralls, aprons or work uniforms can be worn during cleaning and disinfecting. Reusable (washable) clothing should be laundered afterwards. Clean hands after handling dirty laundry.
- Gloves should be removed after cleaning a room or area occupied by ill persons. Clean hands immediately after gloves are removed.
- Cleaning staff should immediately report breaches in PPE, such as a tear in gloves or any other potential exposures, to their supervisor.
- Cleaning staff and others should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Follow normal preventive actions while at work and home, including cleaning hands and avoiding touching eyes, nose, or mouth with unwashed hands.
    - Additional key times to clean hands include:
        - After blowing one's nose, coughing, or sneezing.
        - After using the restroom.
        - Before eating or preparing food.
        - After contact with animals or pets.
        - Before and after providing routine care for another person who needs assistance such as a child.

Additional considerations for employers

- Employers should work with their local and state health departments to ensure appropriate local protocols and guidelines, such as updated/additional guidance for cleaning and disinfection, are followed, including for identification of new potential cases of COVID-19.
- Employers should educate staff and workers performing cleaning, laundry, and trash pick-up activities to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms within 14 days after their last possible exposure to the virus. At a minimum, any staff should immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.
- Employers should develop policies for worker protection and provide training to all cleaning staff on site prior to providing cleaning tasks. Training should include when to use PPE, what PPE is necessary, how to properly don, use and doff PPE, and how to properly dispose of PPE.
- Employers must ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication standard.
- Employers must comply with OSHA's standards on Bloodborne Pathogens, including proper disposal of regulated waste, and PPE.

https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html#Cleaning

Transporting Residents

Facilities may provide transportation for residents to and from the facility. The following guidelines are recommended for safe resident transportation in facility vehicles:

- The driver should screen all passengers for fever (temperature) and COVID-19 symptoms and exposure before entering the vehicle. If fever or COVID-19 symptoms are present or exposure has occurred or resident is positive for COVID, the passenger should not be allowed entry into the transportation vehicle, unless leaving the facility to receive essential medical care. Other residents or non-essential staff should not be allowed in the vehicle.
- Provide EPA approved hand sanitizer in the vehicle.
- Reduce vehicle occupancy to accommodate social distancing.
- Identify or mark seats available in the vehicle that are at least 6 feet apart.
- Passengers should wear a face mask.

- Occupants of these vehicles should avoid or limit close contact (within 6 feet) with others. The use of larger vehicles such as vans is recommended when feasible to allow greater social (physical) distance between vehicle occupants.
- Clean and disinfect surfaces in the vehicle with EPA-approved chemicals and disinfectants after each use.
- Avoid, if possible, to transport suspected or confirmed COVID-19 residents.
- In the event a resident suspected or confirmed with COVID-19 must be transported using facility vehicles, it is recommended the driver wear an N95 respirator or face mask (if a respirator is not available) and eye protection such as a face shield or goggles (as long as they do not create a driving hazard), and the passenger should wear a face mask or cloth face covering.
- Drivers should wear a mask, practice regular hand hygiene, and avoid touching their nose, mouth, or eyes.

Cleaning and disinfection for non-emergency transport vehicles

The following are general guidelines for cleaning and disinfecting transportation vehicles.

- At a minimum, clean and disinfect commonly touched surfaces in the vehicle at the beginning and end of each shift and between transporting passengers. Ensure that cleaning and disinfection procedures are followed consistently and correctly, including the provision of adequate ventilation when chemicals are in use. Doors and windows should remain open when cleaning the vehicle. When cleaning and disinfecting, individuals should wear disposable gloves compatible with the products being used as well as any other PPE required according to the product manufacturer's instructions. Use of a disposable gown is also recommended, if available.
- For hard non-porous surfaces within the interior of the vehicle such as hard seats, arm rests, door handles, seat belt buckles, light and air controls, doors and windows, and grab handles, clean with detergent or soap and water if the surfaces are visibly dirty, prior to disinfectant application. For disinfection of hard, non-porous surfaces, appropriate disinfectants include:
    - EPA's Registered Antimicrobial Products for Use Against Novel Coronavirus SARS-CoV-2. Follow the manufacturer's instructions for concentration, application method, and contact time for all cleaning and disinfection products.
    - Diluted household bleach solutions prepared according to the manufacturer's label for disinfection, if appropriate for the surface. Follow manufacturer's instructions for application and proper ventilation. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser.
    - Alcohol solutions with at least 70% alcohol.
- For soft or porous surfaces such as fabric seats, remove any visible contamination, if present, and clean with appropriate cleaners indicated for use on these surfaces. After cleaning, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces.
- For frequently touched electronic surfaces, such as tablets or touch screens used in the vehicle, remove visible dirt, then disinfect following the manufacturer's instructions for all cleaning and disinfection products. If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect.
- Gloves and any other disposable PPE used for cleaning and disinfecting the vehicle should be removed and disposed of after cleaning; wash hands immediately after removal of gloves and PPE with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer with at least 60% to 95% alcohol if soap and water are not available. If a disposable gown was not worn, work uniforms/clothes worn during cleaning and disinfecting should be laundered afterwards using the warmest appropriate water setting and dry items completely. Wash hands after handling laundry.

Definitions

Source control: Use of respirators, well-fitting facemasks or well-fitting cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing one safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control. At a minimum, source control devices should be changed if they become visibly soiled, damaged, or hard to breathe through. Further information about source control options is available at Masks and Respirators (cdc.gov)

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by health care personnel. Guidance on design, use and maintenance of cloth masks is available.

Face mask: OSHA defines face masks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Face masks may also be referred to as 'medical procedure masks.'" Face masks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other face masks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in health care.

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

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise. However, people in this category should still consider continuing to use of source control while in a healthcare facility.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)
The studies used to inform this guidance did not clearly define "severe" or "critical" illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the National Institutes of Health (NIH) COVID-19 Treatment Guidelines are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions. Clinical judgement regarding the contribution of SARS-CoV-2 to clinical severity might also be necessary when applying these criteria to inform infection control decisions.

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: 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) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

Resources

- CDC website: www.cdc.gov
- Updated Health care Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html
- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
- Nursing Home Visitation - COVID-19 (REVISED) https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf
- What you should know about COVID-19 to protect yourself and others: https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html
- Cleaning and Disinfecting Your Home: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/disinfecting-your-home.html https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
- Preventing the Spread of COVID-19 in Retirement Communities and Independent Living Facilities (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-retirement-communities.pdf
- Considerations When Preparing for COVID-19 in Assisted Living Facilities https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- Hand Hygiene: https://www.cdc.gov/handwashing/
- PPE:
    - https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
    - https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
- Discontinuation of Isolation for Persons with COVID-19 Not in Health care Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-residents.html
- Return to Work: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- Cleaning and Disinfection for Non-emergency Transport Vehicles: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html
- CDC cloth face covering poster: https://www.cdc.gov/coronavirus/2019-ncov/downloads/DIY-cloth-face-covering-instructions.pdf
- CDC/APIC PPE posters:
    - https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf
    - https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
    - http://www.apic.org/Resource_/TinyMceFileManager/consumers_professionals/APIC_DosDontsofMasks_hiq.pdf
- CDC poster - What you should know about COVID-19 to protect yourself and others: https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf

- Monitoring residents and staff during suspected respiratory illness cluster/outbreak tool: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf
- CDC's Strategies to Mitigate Health Care Personnel Staffing Shortages: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
- Additional information about cohorting residents and establishing a designated COVID-19 care unit is available in the Considerations for the Public Health Response to COVID-19 in Nursing Homes (can tailor to group homes): https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html
- Strategies for Optimizing the Supply of N95 Respirators: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
- OSHA Respiratory Protection Program Guidelines: https://www.osha.gov/enforcement/directives/cpl-02-02-054
- Nursing Home Visitation - COVID-19 https://www.cms.gov/files/document/qso-20-39-nh.pdf

Note: CDC guidelines are subject to change as more is learned about COVID-19. Visit the CDC website regularly to check for updated information.

Appendix A - COVID-19 Admission Intake Screening Tool

Name of Resident/Resident: _____

Date of Referral: _____

Date of Admission: _____

Date of COVID-19 Diagnosis: _____

Use this screening tool for residents/residents who have had a confirmed COVID-19 test to determine if the resident/resident has met the CDC's Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19 in Health Care Settings for the purposes of admitting residents/residents into your facility. A test-based strategy is no longer recommended by the CDC as the majority of cases who meet the CDC's criteria for the discontinuation of transmission-based precautions are no longer infectious.

1. **Does the resident/resident have symptoms at time of referral?**
   a. No _____ (asymptomatic – does not have symptoms)
      For residents who were **asymptomatic** throughout their infection, transmission-based precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test (For asymptomatic residents that have severe to critical illness or immunodeficiency, transmission-based precautions may be discontinued when at least 20 days have passed).
   b. Yes _____ (symptomatic – has symptoms)

2. **Symptoms:**
   a. Date of onset *(per acute care hospital):* _____
   b. Description of symptoms: _____
   _____
   _____
   c. Have the symptoms improved?
      Yes _____
      No _____
      (If symptoms have not improved transmission-based precautions must continue)

3. **Date of last fever** (without use of fever reducing medication): _____
   (If date of last fever is within the last 24 hours transmission-based precautions must continue)

4. **Is the resident/resident severely immunocompromised?**
   Yes _____
   No _____

5. **Severity of illness:** (Circle A or B)
   a. Mild to moderate illness (*not severely immunocompromised*):
      - 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

   b. Severe to critical illness ***or*** *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 patients below can be used to inform the duration of isolation.

Note: Facilities must only admit residents/residents that are within the level of care appropriate for their facility type.

6. **Discharge summary received** *(within 24 hours of admission)*

_____Yes _____No

Admission of residents/residents to a nursing home or other long-term care facility such as a residential facility for groups/assisted living

- If transmission-based precautions *are still required*, the resident should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with SARS-CoV-2 infection. The resident should be placed in a location designated to care for residents with SARS-CoV-2 infection.
- If transmission-based precautions *have been discontinued*, the resident does not require further restrictions, based upon their history of SARS-CoV-2 infection.

Resource

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

Appendix B: Risk Assessment and Infection Control Recommendations for Returning Residents:

Visitation in residential facilities can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. The Centers for Disease Control and Prevention (CDC) continues to emphasize the importance of maintaining infection prevention practices, given the continued risk of COVID-19 transmission.

Risk Assessment and Infection Control Recommendations for Returning Residents:

This risk assessment template should be used as a framework to guide COVID-19 infection prevention policy and practices for resident outings into the community.

This guidance can be used for non-medical community activities (e.g., therapeutic home visits, shopping, etc.) and for medical visits (e.g., dentist, outpatient clinic visit, outpatient dialysis, etc.). For each visit utilize the risk assessment tool on page two to determine if the visit was low, medium, or high risk, so you may implement the appropriate interventions, based on the risk score, to keep residents safe.

Fully vaccinated residents are equal to or greater than 2 weeks following receipt of the second dose in a 2-dose series, or equal to or greater than 4 weeks following receipt of one dose of a single-dose vaccine.

Up to date vaccinated residents is having received a primary series and the newest booster available.

During visits in the community, residents (whether vaccinated or unvaccinated) should adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene, and use of face-coverings as source control. Facilities should:

- Screen and increase monitoring for signs and symptoms of COVID-19.
- Test a resident for COVID-19 if signs or symptoms are present or if a resident or their family reports possible exposure to COVID-19 while outside the facility. A facility may also opt to test residents without signs or symptoms if they leave the facility frequently or for a prolonged length of time, such as over 24 hours. For more information on testing guidelines see CMS memorandum QSO-20-38-NH.
- Place the resident on transmission-based precautions (TBP) if the resident or family member reports possible exposure to COVID-19 while outside of the facility, or if the resident has signs or symptoms of COVID-19 upon return. Please note that residents and loved ones should report to facility staff if they have had any exposure to COVID-19 while outside of the facility.

In addition to the above interventions, on a resident's return to the facility from a leave of absence, facilities should use the following risk assessment template to guide COVID-19 infection prevention policy and practices.

For the questions below regarding vaccination status; **"up to date"** means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.

Risk Assessment Template for All Residents, Regardless of Vaccination Status:

A. Prolonged contact with a person who has COVID-19 ☐ Yes ☐ No
   - If "yes," consider high risk.
   - If the above question is "no," go to next set of questions.

B. Is the family and/or persons that the resident is visiting up to date on their COVID-19 vaccines?
   ☐ Yes ☐ No

C. Is the resident up to date on their COVID-19 vaccines? ☐ Yes ☐ No

- If the response to question B and/or C above is "Yes," consider low risk and the risk assessment is complete.
- If the response to both of the questions (B and C) above is "No," proceed to the risk assessment below.

Risk Assessment Template for Unvaccinated or Not Fully Vaccinated Residents

Unvaccinated or Not Fully Vaccinated Residents:

Assign 1 point to each "Yes"	**Yes or No?**	**Points**
14 days prior to visit, family participated in activity with greater than 5 people	☐ Yes ☐ No	
Took resident out of home to high-risk area (ex: crowded areas, shopping mall, another home, etc.)	☐ Yes ☐ No	
During visit, gathering at home or any indoor activity with greater than 5 people	☐ Yes ☐ No	
Duration of activity more than 1 hour with any unvaccinated person	☐ Yes ☐ No	
Persons in contact with resident that are unmasked and/or do not maintain physical distancing of at least 6 feet for any portion of the visit	☐ Yes ☐ No	
Contact with someone who is having COVID like symptoms or tests positive for COVID.	☐ Yes ☐ No	
	Total Points:	

Based on the results of the above risk assessment, facilities should implement the following actions based on the level of risk determined:

Score	**Risk Level**	**Example Activities**	**Recommended Actions for Facility**
0 - 1	**Low**	• Walk in an uncrowded park • Doctor's appointment where universal masking is required • Home visits with fully vaccinated extended family/people present.	Educate on infection prevention, hand hygiene and respiratory/cough etiquette. Actively screen residents daily for symptoms, before leaving and after returning.
2 - 3	**Medium**	• Retail shopping with social distance maintained	Implement all low-risk actions ***and*** refrain from group activities for 14 days since most recent outing.
4 - 6	**High**	• Eating in a crowded restaurant • Social public gatherings • Home visits with unvaccinated or not fully vaccinated extended family/ people present • Casino visits	Implement all low and medium risk actions ***and*** place in quarantine for 10 days with no testing or 7 days with testing on day 5 from most recent outing.

- Quarantine can end after Day 10 without testing and if no symptoms have been reported during daily monitoring.
    - With this strategy, residual post-quarantine transmission risk is estimated to be about 1% with an upper limit of about 10%.

- *When diagnostic testing resources are sufficient and available (see bullet 3, below),* then quarantine can end after Day 7 if a diagnostic specimen tests negative and if no symptoms were reported during daily monitoring. The specimen may be collected and tested within 48 hours before the time of planned quarantine discontinuation (e.g., in anticipation of testing delays), but quarantine cannot be discontinued earlier than after Day 7.
    - With this strategy, the residual post-quarantine transmission risk is estimated to be about 5% with an upper limit of about 12%.

In both cases, additional criteria (e.g., continued symptom monitoring and masking through Day 14) must be met and are outlined in the full text.

Note: Please have your visitation plan available at your facility for review by surveyors during an inspection. You are **not** required to submit your plan to the Bureau of Health Care Quality and Compliance (HCQC) for prior approval.

References:

- CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- CDC: When to Quarantine
- Stay Up to Date with Your Vaccines | CDC