Recommended Infection Prevention and Control Plan for Group Homes
Coronavirus Disease 2019 (COVID-19) Response
Best Practices as of November 4, 2020

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 their 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 as residents in group homes tend to be older, or have physical, psychiatric or intellectual disabilities and may have underlying chronic medical conditions.

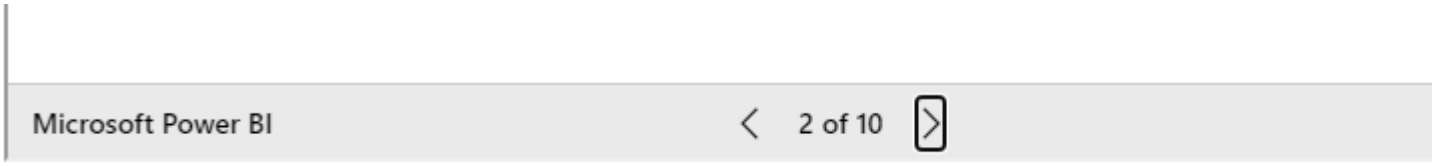
COVID-19 spreads mainly through close contact from person-to-person in respiratory droplets from someone who is infected. People who are infected often have symptoms of illness. Some people without symptoms may be able to spread virus. Person-to-person spread occurs between people who are in close contact 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 possibly 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 patients**. 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, and if not, recognizing and taking immediate action to prevent and rapidly contain the spread.**

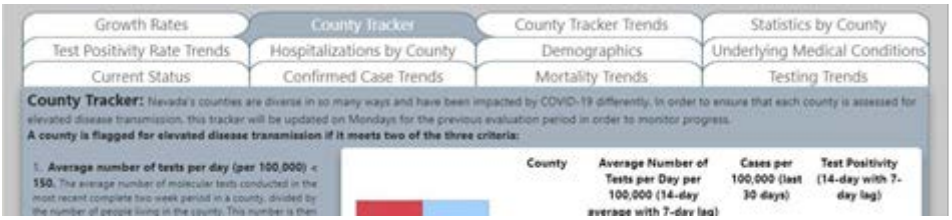
This generic infection prevention and control plan for group homes is meant to assist each facility in developing its own individualized plan to meet the need of the facility, its residents and staff.

Keep COVID-19 From Entering your Facility
Know your county's COVID-19 positivity rate, which can be found online at https://nvhealthresponse.nv.gov/. You will see the COVID-19 (coronavirus) dashboard on the first page, then click the arrow at the bottom of the dashboard to page 2 (screen shot 1); or click the "County Tracker" tab 9 (screen shot 2).

Screen Shot 1



Screen Shot 2



Your county's COVID-19 positivity rate may change, so it should be monitored regularly in order to adjust your facility's current visitation procedures with your county's positivity rate.

Indoor Visitation Restrictions for All Visitors with Limited Exceptions in Counties with a high COVID-19 positivity rate or in a facility that is having an outbreak

If facility is having an outbreak or is in a county with a high (>10%) COVID-19 county positivity rate the following guidelines are recommended.

1. Limit visitors to the facility to only those essential for the resident's physical or emotional well-being and care (e.g., contract service providers, home health agency staff, hospice staff, and health inspectors, etc.)
    - Examples of support for emotional well-being include:
    - A resident, who was living with their family before recently being admitted to a facility, is struggling with the change in environment and lack of physical family support.
    - A resident who is grieving after a friend or family member recently passed away.
    - A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
    - A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).
2. Restrict all volunteers and non-essential personnel including consultant services (e.g., entertainers, barber, nail care).
3. Encourage use of alternative mechanisms for resident interactions such as video-call applications on cell phones or tablets.
4. Limit points of entry to the facility to allow screening of all potential visitors.
5. Create or review an inventory of all volunteers and staff who provide care in the facility. Use that inventory to determine which staff are non-essential and whose services can be delayed. This inventory can also be used to notify staff if COVID-19 is identified in the facility.
6. Establish procedures for monitoring, managing, and training all visitors, which should include:
    - All visitors should be instructed to wear a facemask or cloth face covering at all times while in the facility, perform frequent hand hygiene, and restrict their access to the area designated by the facility.

- Informing visitors about appropriate PPE use according to current facility visitor policy.

7. Post signage at all entrances to alert everyone entering the facility (visitors, residents and staff) regarding screening and restrictions. Signs should remind visitors, residents and staff not to enter the building if they have fever or symptoms of COVID-19.

Indoor Visitation for Counties with a low or medium COVID-19 county positivity rate

If a facility is not having an outbreak or is in a county with a low (<5%) *or medium* (5% – 10%) COVID-19 county positivity rate allow indoor visitations according to the core principles of COVID-19 infection prevention and facility policies. The following indoor visitation guidelines are recommended.

Facilities should accommodate and support indoor visitation to the best of their abilities while also keeping the residents and staff safe, including visits for reasons beyond emotional wellbeing support, based on the following guidelines:

a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;

b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;

c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and

d) Facilities should limit 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. Visits for residents who share a room should not be conducted in the resident's room.

e) Facilities should define a visitation space at the front of their facility for visitation to occur for residents that are mobile and not bed-bound so as not to have visitors walking throughout the facility.

f) For bed-bound residents, visitation will be held in the resident's room with an employee checking on the visit regularly to verify that all policies are being followed. The visitor will be escorted by an employee to the resident's room following symptom screening and will be escorted out once the visit has concluded.

NOTE: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-Like Illness visits to the emergency department or the positivity rate of a county adjacent to the county where the facility is located.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred and can also be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident's health status (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status, outdoor visitation should be facilitated routinely. 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. When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). Reasonable limits on the number of individuals visiting with any one resident at the same time should also be considered.
Note: County positivity rate does not need to be considered for outdoor visitation.

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 the resident and other residents, upon the resident's return to the facility, from possible exposure to COVID-19. 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.

With the holidays in mind and taking a person-centered approach also 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 can be trusted to follow precautions. There will only be 4 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 to help you determine the precautions to take upon a resident's return to the facility includes:

- 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:
If your facility has more than 10 beds, please submit your facility's visitation plan to the Bureau of Health Care Quality and Compliance prior to allowing visitations by emailing: pbhlicensing@health.nv.gov.

If your facility has 10 or few beds, please have your visitation plan available at your facility for review by surveyors during an inspection.

Screen All Staff & Visitors

1. Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms of COVID-19 before starting each shift/when they enter the building. Send visitors and personnel home if they are ill or have a fever of 100.0°F or greater. Ill personnel should be prioritized for testing. Encourage or coordinate testing for COVID-19 where appropriate.
2. 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.
3. 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:

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell
- Persistent pain or pressure in the chest

- New confusion or inability to wake up
- Bluish lips or face

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.

Resident Restrictions

1. Ask residents not to leave the facility except for medically necessary purposes. Cancel all group field trips.
2. Ensure residents who must leave the facility (e.g., residents receiving hemodialysis) wear their cloth face covering whenever leaving the facility.

Communal Activities & Social Distancing

Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering. Facilities may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.

Maintaining a good social distance (at least 6 feet) 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.
- Consider working 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 the facility should consider temporarily canceling all non-essential group activities and events, until such time that the outbreak

is fully contained. Guidance on when to restart communal activities should be obtained from the Division of Public and Behavioral Health's Office of Public Health Investigations and Epidemiology by email at DPBHHAI@health.nv.gov or The Bureau of Health Care Quality and Compliance by email at dphlicensing@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 the facility should 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, and household cleaners and EPA-registered disinfectants (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19) for residents and staff to clean and disinfect buttons, knobs, and handles of laundry machines, laundry baskets, and shared laundry items.
- Post guidelines for doing laundry such as washing instructions and handling of dirty 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 as well. (http://nsla.nv.gov/ld.php?content_id=54777857 page 2 of 3)

Recreational areas such as activity rooms and exercise rooms

- 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

- 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 (https://www.cdc.gov/handwashing/posters.html) 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 that 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
    - Is 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.

New Admissions or Readmissions with an unknown COVID-19 status

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. 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.

Resident/Family Notification

Inform residents, their representatives, and families of those residing in facilities by 5:00 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 department notification

Notify your local health department if:

- COVID-19 is suspected or confirmed among residents or facility personnel
- A resident develops severe respiratory infection
- More than 2 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/

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.

Visitor Testing

While not required, facilities in medium or high-positivity counties are encouraged to test visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test.

Tracking residents & staff during a suspected respiratory illness cluster/outbreak

The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home or other long-term care facility. This template was developed to help with data collection for common respiratory illness outbreaks. The data fields can be modified to reflect the needs of the individual facility during other outbreaks. Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

Respiratory Surveillance Line List:

https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf

Duration/Discontinuation of Isolation and Precautions for Adults with COVID-19
(https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)
Recommendations:

1. **Duration of Isolation and Precautions**

- For most persons with COVID-19 illness, isolation and precautions can generally be discontinued 10 days *after symptom onset*[1] **and** resolution of fever for at least 24 hours, without the use of fever-reducing medications, **and** with improvement of other symptoms.
  - A limited number of persons with severe illness may produce the virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; consider consultation with infection control experts.
- For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days *after the date of their first positive RT-PCR test (COVID-19 diagnostic test) for SARS-CoV-2 RNA.*

2. **Role of PCR testing (a COVID-19 Diagnostic Test) to Discontinue Isolation or Precautions**
   - For persons who are severely immunocompromised, a test-based strategy could be considered in consultation with infectious diseases experts.
   - For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strategy outlined in Part 1, above.

   For more information refer to the CDC's Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance). Found at:
   https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

3. **Role of PCR Testing (a COVID-19 Diagnostic Test) After Discontinuation of Isolation or Precautions**
   - For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection.
   - For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended. Isolation may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.
   - For persons who never developed symptoms, the date of first positive RT-PCR test for SARS-CoV-2 RNA (a COVID-19 Diagnostic Test) should be used in place of the date of symptom onset.
4. **Role of Serologic Testing**
   - Serologic testing should not be used to establish the presence or absence of SARS-CoV-2 infection or reinfection.

Monitor and Plan for Absenteeism Among Your 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 this section on page 10 of this document)

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
- 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)

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

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.

Discuss these two 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) Hand sanitizer: 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) Hands off: 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 bodies.

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 here: (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 (or a facemask if respirators are not available). **Cloth face coverings are not PPE and should not be used when a respirator or facemask is indicated.**
- A KN95 is not approved as a National Institute for Occupational Safety and Health (NIOSH) certified respirator and therefore should not be used in place of an N95 when a N95 or higher-level respirator is indicated. KN95's are not tight-fitting respirators and therefore do not require fit testing. *
- If personnel have direct contact with the resident, they should also wear gloves. If available, gowns are also recommended but should be prioritized for activities where splashes or sprays are anticipated or high-contact resident-care activities that provide opportunities for transfer of pathogens to hands and clothing of personnel (e.g., dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care).

*The below recommendations are to be followed <u>for crisis situations when no other NIOSH- approved N95 respirators are available:</u>

- **Scenario 1: Facility only has KN95 masks and has proof of attempt to attain N95 masks**
- In this scenario, the CDC guidance allows the next step down for PPE (mask, gown, gloves and face shield). The mask is the real difference. The CDC states a step-down mask such as a surgical mask be utilized, since the facility has KN95's, they could be utilized as well. If KN95's are used, it is suggested the individual also wear a surgical mask over the top. A KN95 is not considered a full protective barrier like a fitted N95. With KN95's, it is unknown what filtering guidelines have been met. We know that the surgical masks have been cleared to a certain level. We would not suggest a KN95 be worn alone though.
- **Scenario 2:**
  Facility has the available PPE (mask, gown, gloves and face shield) – Use of surgical mask as an alternative to fitted N95 respirator mask.

  Personnel who do not interact with residents (e.g., not within 6 feet) and do not clean patient environments or equipment do not need to wear PPE. Consistent with the guidance for the general public, however, they should wear a cloth face covering for source control.

Personnel who are expected to use PPE should receive training on selection and use of PPE, including demonstrating competency with putting on and removing PPE in a manner to prevent self-contamination.

CDC has provided strategies for optimizing personal protective equipment (PPE) supply that describe actions facilities can take to extend their supply if, despite efforts to obtain additional PPE, there are shortages. These include strategies such as extended use or reuse of respirators, facemasks, and disposable eye protection.

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 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
- 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 Facemask (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 facemask is warranted)
  - If the facility has any case of COVID-19 put on an N95 respirator (or higher-level respirator) or facemask (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 facemasks 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 facemask.
    - 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 patients with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for patients 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 & 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 patient 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 patient 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 Gear:
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 healthcare personnel.

d. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask 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/facemask should be extended under chin. Both the mouth and nose should be protected. Do not wear respirator/facemask under the chin or store in scrubs pocket between residents. *
    - Respirator: 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.
    - Facemask: 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. Healthcare personnel/caregivers may now enter the resident room.

How to Take Off (Doff) PPE Gear:

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. Healthcare 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 facemask. *
    - Respirator: Remove the bottom strap 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.
    - Facemask: Carefully untie (or unhook from the ears) and pull away from face without touching the front.
g. Perform hand hygiene after removing the respirator/facemask 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 & 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. Wait 24 hours or as long as practical before beginning cleaning and disinfection.

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.
See EPA's 6 steps for Safe and Effective Disinfectant Use by going to:
https://www.epa.gov/sites/production/files/2020-04/documents/disinfectants-onepager.pdf

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 found at: https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-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 (1/3rd 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 six 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 for 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 For 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

- In order to minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
- 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 (put on), use, and doff (take off) 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 facemask.
- 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 facemask (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, the virus that causes COVID-19. 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:

Cloth face covering: Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer**.** Guidance on design, use, and maintenance of cloth face coverings is included in the list of resources in Section J.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks 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. Facemasks that are not regulated by FDA, 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 the CDC/NIOSH, including those intended for use in healthcare. Refer to the Appendix for a summary of different types of respirators.

Resources

- CDC website: www.cdc.gov
- 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 Healthcare Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.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 Poster cloth face covering: https://www.cdc.gov/coronavirus/2019-ncov/downloads/DIY-cloth-face-covering-instructions.pdf
- CDC/APIC Poster PPE: 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 Healthcare 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. Please visit the CDC website regularly to check for updated information.

Appendix A – Guidelines for Residential Facilities for Groups with Greater than 10 Beds

Cohorting Plan for Residential Facilities for Groups with greater than 10 Beds (to be implemented when a COVID-19 infection is suspected or identified)

Residential facilities for groups with greater than 10 beds should implement a cohorting plan when a case of COVID-19 infection is suspected or identified in the facility.

Facilities with the capacity to do so should identify red (Isolation), yellow (Quarantine) and green (COVID-19-free) zones where residents can be cohorted based on their symptoms and exposure risks to COVID-19. Facilities are also recommended to establish a transitional zone (gray zone) for Newly admitted/readmitted residents with no symptoms of COVID-19 with an undetermined exposure history.

The residents will be placed in different zones based on meeting certain criteria as follows:

- Residents belonging to Red (Isolation) zone:
  - Confirmed COVID-19 Cohort/Unit for residents
  - Both asymptomatic & symptomatic residents with confirmed SARS-CoV-2
  - All residents in the red zone should be on isolation precautions per CDC guidelines and healthcare workers should wear personal protective equipment as per the CDC.
- Residents belonging to Yellow (Quarantine) Zone:
  - All residents who may have been exposed to confirmed COVID-19.
  - Several factors have to be taken into consideration in order to determine the risk of exposure. These factors include (but are not limited to) suspected mode of COVID-19 acquisition (for the positive resident), movement of the resident with COVID-19 infection within the facility prior to the diagnosis, a facility's policies on universal masking and visitation, compliance of staff with infection control protocols and the number of residents with suspected or confirmed COVID-19 infection in a unit.
  - Example of residents who may qualify for being in the yellow zone: All exposed residents of a single unit/hallway/neighborhood where residents tested positive for COVID-19.
  - All residents in the yellow zone should be on precautions per CDC guidelines and healthcare workers should wear personal protective equipment as per CDC.
- Residents belonging to Green (COVID-free) Zone:
  - Residents with no known exposure to COVID-19

- Residents that have met the CDC Criteria for Discontinuation of Transmission-Based Precautions or who have completed their 14-day quarantine from the last date of known exposure and have shown no symptoms throughout the quarantine period.
- All residents without symptoms who are not considered to be exposed.

Note: If there are confirmed COVID-19 residents in many different units/hallways/neighborhoods, then there may not be a true green zone in that residential facilities for group (at least at that point of time), as everyone is going to be considered exposed.

- Residents belonging to Gray (Transitional) Zone:
  - Newly admitted/readmitted residents with no symptoms of COVID-19 with an undetermined exposure history.
  - Full PPE, including the use of N95 masks, should be worn by caregivers providing care to residents in the transitional zone.

If the resident remains without symptoms at the end of day 14, the resident may be moved to the green zone. All residential facilities for groups (if able to) should consider establishing a transitional zone for new admissions, readmissions even regardless of facility COVID status.

Strategies to establish red, yellow and green zones.

Scenario 1:

If residential facilities for group has space/rooms available then it will be preferred to establish red, yellow and green zones in geographically distinct areas within the facilities.

- For example, if a facility has an empty unit, then the confirmed COVID-19 positive residents will be transferred immediately to that area for isolation which will be considered the red zone.
- Depending on exposure risk assessment the unit from where the residents were moved from will now be considered a yellow zone.
- The rest of the facility will be considered a green zone if it is established that residents in those units/areas have not been exposed.

Scenario 2:

If space is limited, red and yellow zones can be established within the same unit/hallway/neighborhood.

- For example, initially when a resident is diagnosed with confirmed COVID-19 and there is no isolation area available in the facility, the resident room will be considered the red zone and the resident will stay in his/her own room.
- As much as possible, this confirmed case should be moved to the end of that hallway.
- The rest of the shared hallway/neighborhood may become the yellow zone (depending on exposure risk assessment).

- All other units in the facility will be considered a green zone if it is established that residents in those units have not been exposed.
- If the resident in the above example has a roommate, the roommate should be stay within the yellow zone. (Note: Do not transfer the roommate to green zone).

If confirmed COVID-19 cases are identified in more than one unit/hallway/neighborhood or in both north and south hallways. The best strategy will be to move all COVID-19 positive residents into one hallway (cohort confirmed positive residents at one end of that hallway this will be considered the red zone).

Similarly, move all quarantine/exposed residents to the other hallway, which will now be considered a yellow zone. This is appliable only during surge outbreak in the yellow and red zones since all residents in this area will consider exposed.

If the facility has additional hallways or units that are geographically distinct from the north and south hallway (and no exposure is suspected), then those units/hallways will be considered the green zone. However, if everyone is considered exposed then there is no true green zone in the facility at that point.

Staffing Strategies:

The facility should implement a plan to control transmission of COVID-19 by dedicating health care personnel (HCP) to residents that are confirmed COVID-19 positive.

The facility should demonstrate an effort to limit rotations of HCP to different cohorts/units.

HCP must be educated on the facility's cohorting action plan in response to a COVID-19 positive resident or a resident becoming symptomatic.

The facility should follow their COVID-19 specific infection control plan when moving residents from the red zone to the yellow zone or from the yellow zone to the green zone. Follow infection prevention and control procedures very strictly to avoid transmission between zones.

Figure: Cohorting Residents in the Long-Term Care Facilities

Red Zone (Isolation zone) Confirmed COVID-19 Cohort/Unit for residents	Both asymptomatic & symptomatic residents with confirmed SARS-CoV-2
Yellow Zone (Quarantine zone) Quarantine Cohort/Unit for residents with known exposure	Residents had Contact with confirmed COVID-19 cases
Green Zone (COVID-19 free zone) COVID-19 Free Cohort/Unit for asymptomatic residents that tested negative SARS-CoV-2	Residents with no known exposure to COVID-19 Residents that have met the CDC Criteria for Discontinuation of Transmission-Based Precautions or who have completed their 14-day quarantine from the last date of known exposure

	and have shown no symptoms throughout the quarantine period.
COVID19 Gray Zone (Transitional zone) New admission / readmission	Residents who are Newly admitted/readmitted with no symptoms of COVID-19 with an undetermined exposure history. are kept in this zone for 14 days and if the resident remains asymptomatic at the end of 14 day, the resident maybe moved to Green zone

Appendix B - COVID-19 Admission Intake Screening Tool

Name of Patient/Resident: _____

Date of Referral: _____

Date of Admission: _____

Date of COVID-19 Diagnosis: _____

Use this screening tool for residents/patients who have had a confirmed COVID-19 test to determine if the resident/patient has met the CDC's Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings for the purposes of admitting patients/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/patient have symptoms at time of referral?

No _____ (Asymptomatic – does not have symptoms)

For patients 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 patients that have severe to critical illness or immunodeficiency, Transmission-Based Precautions may be discontinued when at least 20 days have passed).

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 patient/resident severely immunocompromised?

Yes _____
No _____

5. Severity of illness: (Circle one, if applicable. If not applicable, do not circle)
a. Mild to Moderate Illness (*not severely immunocompromised*):
At least 10 days have passed since symptoms first appeared
b. Severe to Critical Illness ***OR*** *Severely Immunocompromised:*
At least 20 days have passed since symptoms first appeared
(If either of the above criteria is not met transmission-based precautions must continue)
Discontinuation of Transmission-Based Precautions
If symptoms have improved **AND** at least 24 hours have passed *since last* fever without the use of fever-reducing medications **AND** either 10 days or 20 days have passed, regarding severity of illness, the transmission-based precautions can be discontinued.
Note: Facilities must only admit residents/patients 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 patients/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 patient 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 patient should be placed in a location designated to care for residents with SARS-CoV-2 infection.
• If Transmission-Based Precautions *have been discontinued*, the patient does not require further restrictions, based upon their history of SARS-CoV-2 infection.

Resource
Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html