



Date	Summary of Changes
06.01.21 06.22.21 07.01.21	FDA and CDC update on 05.21.21 for facilities to "transition supplies" from approved KN95 masks back to NIOSH-approved N 95 respirators. Recommends not to procure these masks and transition to approved N95. Continues to support conventional use of PPE. PPE updates for fully vaccinated HCP regarding eye protection and masks when with fully vaccinated residents. Changes to daily COVID-19 assessments for fully vaccinated residents. Due to increase in outbreaks of vaccinated residents' masks should be worn indoors when delivering resident care for all fully vaccinated and unvaccinated HCP.

WHAT IS COVID-19?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. Residents with COVID-19 have experienced mild to severe respiratory illness, including fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. The virus that causes COVID-19 is a novel (new) coronavirus. It is not the same as other types of coronaviruses that commonly circulate among people and cause mild illness, like the common cold. The risk for severe illness from COVID-19 increases with age, with older adults at highest risk.

HOW DOES COVID-19 SPREAD?

The virus that causes COVID-19 is thought to spread mainly from person-to-person, between people who are in close contact with one another (within about 6 feet for a total of more than a cumulative total of 15 minutes or longer over a 24-hour period) through respiratory droplets when an infected person coughs or sneezes. It may be possible that 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, but this is not thought to be the main way the virus spreads. There is new evidence that under certain conditions, people with COVID-19 seem to have infected others who were more than 6 feet away. These transmissions occurred within enclosed spaces that had inadequate ventilation. Sometimes the infected person was breathing heavily, for example while singing or exercising. (<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>)

- Under these circumstances, scientists believe that the amount of infectious smaller droplet and particles produced by the people with COVID-19 became concentrated enough to spread the virus to other people. The people who were infected were in the same space during the same time or shortly after the person with COVID-19 had left.



- Available data indicate that it is much more common for the virus that causes COVID-19 to spread through close contact with a person who has COVID-19 than through airborne transmission.
- The best way to protect yourself and to help reduce the spread of the virus that causes COVID-19 is to limit your interactions with other people as much as possible and take precautions to prevent getting COVID-19 when you do interact with others. Those steps include wearing a face covering, maintaining social distance of 6 feet, and sanitizing your hands frequently.

If you start feeling sick and think you may have COVID-19, get in touch with your healthcare provider within 24 hours and do not report to work with any symptoms of COVID even if you have a negative COVID test. A fever is one criterion whereby HCP should not report to the facility for work, facilities should be vigilant to not allow staff with runny nose and sore throats, as one example to work without first testing for COVID-19 and have those symptoms improve.

PREVENT THE INTRODUCTION OF COVID-19 INTO YOUR FACILITY

Long-term care centers should take everyday preventive measures to help contain the spread of COVID-19.

- Actively screen all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any history of being a close contact or exposed to COVID 19 positive or symptomatic person.
- Post signs at the entrance instructing visitors not to visit if they have symptoms of COVID 19 infection.
- Ensure sick leave policies allow employees to stay home if they have symptoms of COVID 19 infection.
- Assess residents' symptoms of COVID 19 infection upon admission to the facility, and daily during this pandemic and implement appropriate infection prevention practices for incoming symptomatic residents.

Daily Covid-19 Assessments -

- Unvaccinated residents require once-daily assessment for COVID-19.
- Residents with symptomatic COVID-19 require three-times-per-day assessment for COVID-19.
- Fully vaccinated residents' assessment can be limited to whether they have symptoms for COVID-19.
 - Screen all nursing homes residents or residential facilities' residents who are not fully functional or have dementia in person.
 - Residential facilities' fully functional and non-dementia patients: screening by phone is acceptable, but screen at least once a week in person.
 - Symptomatic resident from any location: do comprehensive evaluation.
 - Examination frequency can be decreased to pre-pandemic levels if asymptomatic.



Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms may have COVID-19:

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

PREVENT THE SPREAD OF COVID-19 WITHIN YOUR FACILITY

- Keep residents and employees informed.
- Monitor residents and employees for fever or respiratory symptoms.
- Support hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees.
- Identify dedicated employees to care for COVID-19 resident and provide infection control training.
- Provide the right supplies to ensure easy and correct use of PPE.
- Report any possible COVID-19 illness in residents and employees to the local health department.
- Cohort, if possible, direct care providers caring for confirmed or presumed COVID-19 residents into one area of the building.
- Other strategies to decrease spread can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

MASKS AND EYE PROTECTION

There is emerging evidence that many persons with COVID-19 may only have mild symptoms or no symptoms at all. These persons, however, can still be infectious. In addition, CDC notes that transmission risks can be airborne for those infected with COVID 19. To prevent the spread of COVID-19 in your facilities among providers with no or mild symptoms, we recommend the following:

- All LTC facilities should limit confirmed or presumed COVID-19 positive resident contact to essential direct care providers (Nurse, CNA, QMA, hospice, EMS, healthcare providers, dedicated Environmental Services staff who have been trained in proper PPE for TBP)
- Direct care providers should wear a surgical mask for the duration of their shifts. Indirect care providers should wear a mask during their shifts. N95 (transition away from the approved KN95) masks should be worn in COVID units and with any resident who is symptomatic or awaiting testing in transmission-based precautions (red or yellow zone). While supplies are limited, masks should be conserved and only a single mask should be worn by staff each shift. They should be changed when visibly soiled or wet. When possible, by supply and lower transmission in the facility, mask use can return to conventional usage and NIOSH-approved N95 respirators.
 - **FDA update:** Facilities should transition away from the use of imported KN95-approved masks and use NIOSH-approved N95 respirators: <https://www.fda.gov/medical-devices/letters-health-care->



[providers/update-fda-recommends-transition-use-non-niosh-approved-and-decontaminated-disposable-respirators](#).

- **CDC situational update as of May 2021:** The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices. Check the [NIOSH Certified Equipment List](#) to identify all NIOSH-approved respirators.
 - Fully vaccinated HCP may choose to unmask during outdoor activities.
- To align with updated Centers for Disease Control and Prevention (CDC) updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who **provide essential direct care within 6 feet of the resident** in all levels of care in all long-term care facilities and assisted living. https://www.coronavirus.in.gov/files/IN_COVID-19%20eye%20protection%2010.19.20.pdf
- Fully vaccinated HCP may choose to not wear eye protection in green zones and in yellow zones when residents are being monitored for new admission quarantine--irrespective of county positivity rates. HCP must keep on eye protection for any symptomatic or positive COVID-19 resident in transmission-based precautions (TBP).
- Cohort confirmed or presumed COVID-19 positive residents.
- Cohort, if possible, direct care providers caring for confirmed or presumed COVID-19 residents into one area of the building. Staff should be dedicated for the COVID unit.
- **Conserving PPE:** Should supplies become critically low, this may mean wearing a single mask on multiple days. While googles and face shields can be cleaned and sterilized, we are not aware, at this time, of any methods that can clean and sterilize surgical masks. Continue to check the CDC website for additional strategies to conserve PPE - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>
- Other strategies to decrease spread can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

GENERAL COVID-19 INFECTION CONTROL FOR LONG-TERM CARE FACILITIES

1. All LTC facilities who have not already done so, need to use this CDC checklist to prevent the spread of coronavirus in their facilities. https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-HomesPreparedness-Checklist_3_13.pdf
2. All LTC facilities should use this sheet to track their infection control activities and to track employees and residents with respiratory illness. <https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf>
3. All LTC facilities should have a plan to rapidly implement, or implement now, how they will cohort confirmed or presumed COVID-19 residents in their facilities. This can be by wing, floor, or if available, by building. This should be done with expediency. Residents should be cohorted depending on COVID-19 status. Colors can be used on facility maps to help visualize testing results to facilitate moving of residents.
4. All LTC facilities should limit confirmed or suspected COVID-19 positive resident contact to essential direct care providers (Nurse, CNA, QMA, hospice, EMS, healthcare providers, dedicated Environmental Services staff who have

been trained in proper PPE for TBP etc.) https://www.coronavirus.in.gov/files/IN_COVID-19_out_of_hospital_08.17.20.pdf

COVID-19 Positive (Red) – These are residents who are confirmed COVID-19 positive and who, based on [CDC criteria](#), still warrant TBP. HCP will wear single gown with each resident, glove, N95 **(transition away from the approved KN95)** mask and eye protection (faceshield/or goggles). Gowns and gloves should be changed after every resident encounter followed by hand hygiene:

1. Masks and eye protection may be used for the entire shift if not wet or visibly soiled.
2. Gowns and gloves should be changed after every resident encounter followed by hand hygiene. This is conventional gown use for each resident encounter. It is expected that facilities will follow conventional use (new gown for every encounter) unless absolutely necessary to do gown conservation. Staff should batch tasks (medication and food delivery, cleaning, vital checks) to maximize single gown use.
 - a. IF gown conservation is necessary; then extended gown use may be used in the COVID (RED) zone for all resident's care as part of crisis capacity gown use.
 - b. Single gown use is prioritized during gown conservation times for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of the staff, including dressing, changing linens, bathing, wound care, changing briefs or assisting with toileting, and device care or use.
 3. Gowns should always be doffed (removed) prior to leaving unit/or resident room (hot zone) when working in the nurse's stations and break rooms (cold zone). Hand Hygiene and a new clean gown is required when returning to the COVID unit from the cold zone.
 4. Residents should be wearing masks when within 6 feet of the HCP.
 - o **When supply and lower transmission in the facility allow, gown use can return to conventional usage.** Conventional use of a single gown for each resident encounter is preferred.
 - o **Source:** <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html>
 - o These residents should be placed in TBP (droplet and contact) and cohorted into a COVID-19 wing, floor, or building. If facilities have dedicated COVID-19 memory units, residents may continue to socialize so long as there are no COVID-19 negative residents or residents with unknown COVID-19 status in these units.

Unknown COVID-19 status (Yellow): All residents in this category warrant TBP (droplet and contact.) HCP will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed.

1. **Masks and eye protection may be used for the entire shift if not wet or visibly soiled.**
2. Gowns and gloves should be changed after every resident encounter.
3. Residents should be wearing masks when within 6 feet of the HCP
4. IF gown conservation is necessary; then gowns may be hung on the inside of the resident's door and used for 1 shift by the same HCP, for the same resident. It is suggested to use a cloth re-washable



gown for this type of extended wear when possible. If gown is contaminated, visible soiled or wet it must be changed for a new gown.

5. When residents are sheltering in place and awaiting test results and become symptomatic then single use gowns should be used in this zone.
6. When supply and lower transmission in the facility allow, facemask use can return to conventional usage.

- **Waiting for test results** – These are residents whose COVID-19 status is unknown. This can include residents who have been tested and are waiting on results, or residents who are admitted, or readmitted, to a facility where they are likely to have been exposed to COVID-19 (e.g., transferred from a facility with an outbreak). Residents in this category should, if possible, be isolated from residents with a known COVID-19 status (both positive and negative). Residents in this category are to remain in TBP for full 14 days.
- If an asymptomatic resident test positive on an antigen test, they are to be placed in TBP but should not be moved to a COVID RED UNIT unless they have a confirmatory positive on a PCR test. This includes when the facility is in outbreak testing or the resident is a close contact. If the PCR test is negative, then they remain in TBP for 14 days if the facility is in outbreak testing or the resident is a close contact and continue to monitor for symptoms but do not move to the red unit. If they test positive on PCR then move to a red unit.
- For any resident who tests negative for COVID-19, but has had a roommate who is positive, it is not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test. They should be placed in TBP Contact Droplet and the positive resident moved to the COVID unit.
- **Symptom Observation** – Residents in yellow status who do not undergo testing can be transferred to the COVID-19 negative areas of the facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period can be done by the facility to increase the certainty that the resident is not infected. Residents who develop symptoms while being observed should be tested and moved accordingly.

COVID-19 Negative (Green) – These include residents who are asymptomatic and not suspected to have

- COVID-19, asymptomatic residents who have had a negative test, and residents who have recovered from COVID-19 and meet CDC criteria for removing transmission-based precautions. HCP will wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is **moderate to substantial (high) community transmission**.
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
- **If the county positivity rates are < 5% with low community transmission and the facility is not in outbreak testing**, then eye protection **will not be required** when providing essential direct care within 6 feet to residents who are not in TBP for COVID-19 or quarantined for COVID-19 positive exposures.



- This would include residents in the general population (green zones) who are not suspected to have COVID-19.
- **IF the county positivity rates increase to moderate or high substantial community transmission** then eye protection **should be used** for all residents within 6 feet when delivering essential direct care regardless of COVID 19 status.
- **Fully vaccinated HCP may choose to not wear eye protection in green zones and in yellow zones when residents are being monitored for new admission quarantine irrespective of county positivity rates. HCP must keep on eye protection for any symptomatic or positive COVID-19 resident in TBP.**

2. PPE includes:

- a. Masks and face shield may be used for the entire shift if not wet or visibly soiled.
- b. Staff may only remove mask to eat or drink and it is expected that they are more than 6 feet away from other staff and residents while the mask is removed.
- c. Standard precautions (wearing of gown and other PPE as needed per individual resident needs) should be followed.
- d. For gown crisis capacity they should be prioritized for care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures. These may also include high-contact patient care activities that provide opportunities for transfer of MDRO pathogens to the hands and clothing of healthcare providers, such as: dressing bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, wound care.
- e. **When supply and lower transmission in the facility allow, mask and gown use can return to conventional usage.**

3. If despite negative testing there remains clinical uncertainty around a resident's COVID-19 status and they are symptomatic, the symptomatic resident should be placed in TBP (may shelter in place if they do not have a roommate during testing) and moved to the yellow zone if symptomatic and remain negative for testing.

4. If symptomatic and testing is positive for COVID-19 then this resident should move to the COVID unit. If the resident has a roommate, the resident should be moved to the yellow zone during testing if symptomatic, and the roommate may shelter in place in TBP during the 14-day full quarantine period due to exposure.

5. Residents should be wearing masks when within 6 feet of the HCP.

6. Fully vaccinated residents may choose to have physical contact and not wear facemasks during group activities. Fully vaccinated residents can participate in communal dining without facemask or maintaining physical distance of > 6 feet.



7. If any **one person congregates** in group activity or communal dining area is **not fully vaccinated**, all residents should wear facemask while not eating and the **unvaccinated persons must physically distance > 6 feet**.
5. All LTC facilities should require those involved in direct resident care and indirect resident care to wear a facemask during their entire shift.
 - o Fully vaccinated HCP should continue to wear mask while at work. However, fully vaccinated HCP could dine and socialize together in conference and breakrooms without mask or physical distancing. If **any residents or unvaccinated HCP are present**, all HCP in the room should wear mask and physically distance:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>
 - o If national and local supplies are at conventional capacity then all staff in LTC facilities should wear a facemask per standard recommendations.
 - If national and local supplies are at contingency levels, only direct care staff should wear a mask and they should use one mask per shift.
 - If national and local supplies are scarce <1 week supply, then only direct care staff should wear a mask and they should use the same mask for multiple days
 - If national and local supplies are at crisis capacity, then direct resident care staff should wear a mask if available. If masks are not available, they should use alternative methods to cover their mouth and nose and decrease respiratory droplet spread.
6. All LTC facilities need to have updated lists of all residents' code status and preferences for hospitalization. Plans should be in place for how to provide hospice and comfort care to those residents who do not want hospitalization who develop critical symptoms from COVID-19.

INFECTION CONTROL STEPS WHEN HEALTHCARE WORKER OR RESIDENT TEST POSITIVE FOR COVID-19

1. Immediately place all residents that have tested positive for COVID-19 in **Contact-Droplet Precautions** in a single room, when possible and limit movement around the building, including memory care units to the degree that is possible.
 - o Facilities should follow the CDC guidelines for health care workers and positive protective equipment:
<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>
 - o Place a sign on the door indicating **Droplet- Contact Precautions**.
 - o Single resident room placement to minimize exposures and adherence to PPE and hand hygiene compliance.
 - o Minimize resident's movement around the building, confined to room or as in memory care consider placement in single room with dedicated staff to care for this resident.
 - o Cohort staff and equipment for COVID-19 residents to minimize transmission in the building
2. **Mask** all HCW who are ill and remove from duty.
3. **Mask** all direct care staff and conserve PPE as directed.
4. Increase **hand hygiene** with all staff, residents, and essential care givers in the building.



5. Assure hand hygiene and alcohol-based hand rub is at point of care for all HCP and handwashing is performed frequently during COVID- 19 resident care.
6. Increase **Environmental cleaning on all high touch surfaces** in building with approved disinfectants
 - o Cleaning and disinfection: Follow CDC cleaning and disinfection guidance for EVS personnel with proper PPE for cleaning COVID-19 rooms https://www.cdc.gov/coronavirus/2019-ncov/prepare/cleaningdisinfection.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019ncov%2Fcommunity%2Fhome%2Fcleaning-disinfection.html
 - o Use approved cleaning agents from List N: <https://www.epa.gov/pesticide-registration/list-n-disinfectants-useagainst-sars-cov-2>
 - o For shortage of approved disinfecting solutions: consider the following
 - Use of resident dedicated glucometers
 - Bleach 1:10 mixture (must be changed and remixed every 24 hours) which is 1 ½ cups of bleach per gallon.
7. **HCW scrubs** should be changed into street clothes each day before leaving facility.
 - o HCW should perform hand washing upon entry to the building before work and prior to exit after changing into street clothes.
 - o HCW should refrain from wearing scrubs home or the next day without being laundered, this includes jackets.
8. **Glove Hygiene:** Perform hand hygiene before use of non-sterile gloves upon entry into the resident room for direct care area.
 - o Change gloves if they become torn or heavily contaminated.
 - o Remove and discard gloves when leaving the resident room or care area
 - o Immediately perform hand hygiene after removal of gloves.
9. **Gown Conservation:** Conventional use of a single gown for each resident encounter is preferred. For crisis capacity, the same gown can be used in the COVID-19 positive units for droplet-contact precautions for all positive COVID residents, one gown per HCP, until soiled or wet. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html>

If there are shortages of gowns, a crisis capacity for single use of gowns should be prioritized for:

- **AGPs in Red/ Yellow zones:** Limit performance of aerosol-generating procedures (AGPs) on confirmed or presumed COVID-19 positive residents unless medically necessary. For any AGP that is performed on a resident with COVID or suspected COVID they should be performed in a **private room** with full TBP with the door closed for duration of procedure and 1 hour after the procedure ends. This includes N-95 mask, eye protection, gown and gloves and keeping the door closed throughout the procedure and disinfecting all surfaces following the procedure.
- o **AGPs in Green zones:** Make every effort to not place an unvaccinated resident in the same room when a resident is expected to need AGP in semi- private rooms. During low community positivity (under 5%), and the facility is not in outbreak testing: While fully vaccinated resident is receiving AGP, room door may be left open if the roommate also is fully vaccinated. If the roommate is unvaccinated, curtain must be closed.
 - Staff providing direct care within six feet of the resident while AGP is in progress should wear full PPE including N-95 mask and eye protection for all types of scenarios.



- For unvaccinated residents or AGP on anyone during moderate or high community positivity; > 5% or if facility is in outbreak testing: CDC guidance for aerosol-generating procedures should be followed for infection control measures for the duration of the AGP and one (1) hour after the procedure in positive pressure rooms. Resident is placed on TBP: both contact and droplet precautions for the duration of the procedure and 1 hour post procedure. This includes N-95 mask, eye protection, gown and gloves and keeping the door closed throughout the procedure and one hour after, and disinfecting all surfaces following the procedure.
 - When possible, a private room is preferred with AGPs with the door shut for the duration of the procedure including 1 hour after the procedure ends.
 - When possible, with semi-private rooms, cohort green zone residents who use CPAP/BIPAP or nebulizers.
 - Otherwise, for use of CPAP/BIPAP/nebulizers with COVID naïve residents (green zone) the roommates can continue to stay in the same room with the curtains closed and doors closed.
- SOURCE: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Transmission>
- Use appropriate levels of PPE, mask, eye protection, gown, and gloves when splashes and sprays are anticipated.
- Continue to use Standard precautions (all residents) and/ or Enhanced Barrier precautions (EBP) for residents with novel MDROs or emerging pathogens when high-contact resident care activities occur that provide opportunities for transfer of pathogens to the hands and clothing of HCP.
- EBP Examples include:
 - dressing
 - bathing/showering
 - providing hygiene
 - changing briefs or assisting with toileting
 - changing linens
 - wound care
 - transferring
 - device care or use
- **Masks:** Universal use of facemasks should continue for all HCP, residents, and visitors that come into the facility. All HCP are asked to wear a clean procedure/surgical mask for delivery of care and an N 95 (transition away from the approved KN95) for anyone who is in TBP, including symptomatic or tests positive for COVID 19, or is a new admission to the facility that is placed in 14-day quarantine due to not being vaccinated.

<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>. Cloth masks are still acceptable for residents for general social distancing. Cloth masks should be laundered on a schedule to assure that they remain a clean barrier for prevention of COVID-19 transmission. A clean procedure/surgical mask should be used for residents in the salon and any COVID PUI or + resident who is transferred to a new room or facility.

11. Use of Face shields or protective eyewear/goggles: (CDC updated 10/5/20 <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>) To align with updated CDC's updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident in all levels of care in all LTC and AL. Fully vaccinated HCP may choose to not wear eye protection/faceshield when residents are not in TBP.

Examples include:



- The delivery of direct care for COVID 19 residents in any type of TBP throughout the facility- both COVID positive and those being tested or monitored for unknown COVID status.
- The delivery of care for non-COVID residents in all facilities and those who are quarantined in COVID positive, symptomatic, or quarantined residents who are already in TBP Droplet Contact.
- They should be used for any resident regardless of COVID status when < 6 ft. spray or splash is anticipated: High-risk examples include assistance in showers, tub rooms, salons, and assistance in toileting, hygiene, changing linens, and environmental cleaning.

12. Preservation of protective eyewear/goggles or face shield:

- Do not touch eye or face protection during use. Hand Hygiene must be performed after any touching
- Hand hygiene must be performed before and after donning and doffing eye or face protection
- Eye protection should be disinfected when removed and prior to storage or when visibly soiled.

13. Equipment Dedicated to Resident Rooms:

- a. Isolation carts or bins should be outside each individual room, or just inside the contained COVID red zone for donning and doffing
- b. Trash cans should be near the door or exit of the zone for doffing. An isolation cart and trash can may exist in the hallway in the contained COVID zone, otherwise trash cans should be used inside each individual resident room that is in TBP
 - o Cohort supplies, do not share room to room
 - o Use disposable or single B/P cuff and stethoscopes/ no mobile units
 - o Use pitchers for each resident and disposable cup -Do not use ice coolers to take inside the resident's room for filling cups
 - o Single use B/P, O2 Sat per resident as much as possible, and proper disinfection for any reuse
 - o Single use bedpans or bathroom supplies for all residents

14. Visitors and Community dining:

- Refer to current IDOH Long term care visitation guidance and community activities based on current CDC and CMS guidance.

15. Routine testing:

- Consider postponing non-urgent testing for routine labs, chest X-rays, across your facility during an outbreak.
- Consider changing aerosolizing treatments moving to metered dose inhalers during this outbreak, especially when N95 is not available.



ISOLATION (TRANSMISSION-BASED PRECAUTIONS) REMOVAL RECOMMENDATIONS

New in this update on Aug. 10:

- Change TBP guidance
 - [Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19 in Healthcare Settings \(Interim Guidance\)](#)

Long-term care facility residents with COVID-19 should remain on standard contact and droplet precaution until at least 10 days and up to 20 days (residents with severe to critical illness or who are severely immunocompromised) after symptom onset and 24 hours after resolution of fever, without use of antipyretic medication, and improvement in symptoms (e.g., cough, shortness of breath), whichever is longer. Shedding may persist after symptom resolution, but it is unclear what transmission risks this presents, and prolonged isolation based on negative PCR testing as described below may not be feasible based on access to laboratory testing, availability of appropriate PPE, staffing shortages, and concern for resident quality of life. Consideration should be given to discontinuing standard contact and droplet precaution when respiratory symptoms are resolving, oxygen saturation has stabilized or improved and they have had no measured fever without use of antipyretic medication for 24 hours, and it has been at least 10 days **and up to 20 days (residents with severe to critical illness or who are severely immunocompromised)** since illness onset:

Removal from TBP for COVID residents will be based on following CDC COVID Healthcare IPC guidance: Discontinuation of Transmission-Based Precautions (*updated Aug. 10*):

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>.

- **Residents with mild to moderate illness who are 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
- Note: For residents who are not severely immunocompromised and who were **asymptomatic** throughout their infection, TBP may be discontinued when at least **10 days have passed since the date of their first positive viral diagnostic test.**
- **Residents with severe to critical illness or who are 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
 - Consider consultation with infection control experts
 - Note: For severely immunocompromised residents who were **asymptomatic** throughout their infection, TBP may be discontinued when at least **10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.**

Return to Work Guidance for Healthcare Personnel (HCP) will use symptom based strategy per CDC guidance updated 2/16/20; <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>.



- **HCP with *mild to moderate illness* who are 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
 - **Note:** HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.
- **HCP WITH *severe to critical illness* OR WHO ARE SEVERELY IMMUNOCOMPROMISED:**
 - At least 10 days and up to 20 days have passed SINCE SYMPTOMS FIRST APPEARED
 - At least 24 hours have passed SINCE LAST fever without the use of fever-reducing medications **and**
 - Symptoms (e.g., cough, shortness of breath) have improved
 - HCP who are severely immunocompromised, could remain infectious more than 20 days after symptom onset. Consultation with infectious diseases specialists is recommended; use of a test-based strategy for determining when these HCP may return to work could be considered.
 - **Note:** HCP who are **severely immunocompromised**¹ but who were **asymptomatic** throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.
- **Test-based strategy for discontinuing TBP for residents or HCP.**
 - In some instances, a test-based strategy could be considered for discontinuing TBP earlier than if the symptom-based strategy were used.
However, as described in the CDC's Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/durationisolation.html>.
 - A test-based strategy could also be considered for some residents (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the resident being infectious for more than 20 days.

ADDITIONAL INFORMATION

Additional information and resources for COVID-19 are available at the links below.

- CDC COVID-19 guidance for long-term care facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>
- Guidance on release from isolation: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>
- CDC COVID-19 print materials (posters and fact sheets in English, Spanish, and Chinese):
<https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc>
- CDC health promotion materials (handwashing posters): <https://www.cdc.gov/handwashing/materials.html>
- ISDH COVID-19 webpage: <https://coronavirus.in.gov>