COVID-19 RESPONSE FOR NURSING FACILITIES

Abstract
This document provides guidance to Nursing Facilities on Response Actions in the event of a COVID-19 exposure.
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# TABLE OF CHANGES

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I. Purpose:

The purpose of this document is to provide NFs with response guidance in the event of a positive COVID-19 case associated with the facility.

II. Goals:

- Rapid identification of COVID-19 situation in a NF
- Prevention of spread within the facility
- Protection of residents, staff and visitors
- Provision of care for an infected resident(s)
- Recovery from an in-house NF COVID-19 event

III. Summary:

Residents of NFs are more susceptible to COVID-19 infection and the detrimental impact of the virus than the general population. In addition to the susceptibility of residents, a LTC environment presents challenges to infection control and the ability to contain an outbreak, resulting in potentially rapid spread among a highly vulnerable population.

This document provides NFs immediate actions to consider and actions for extended periods after a facility is made aware of potential infection of a resident, provider or visitor.

IV. Description of a Nursing Facility:

A NF provides institutional care to people whose medical condition regularly requires the skills of licensed nurses. NF services are available to people who receive Medicaid assistance or those who wish to private pay for their care. The NF must provide for the needs of each resident, including room and board, social services, over-the-counter medications, medical supplies and equipment, and personal needs items.

A SNF is a special facility or part of a hospital that provides medically necessary professional services from nurses, physical and occupational therapists, speech pathologists, and audiologists. SNFs provide round-the-clock assistance with health care and activities of daily living. SNFs are used for short-term rehabilitative stays after a resident is released from a hospital.
A hospital-based SNF is located in a hospital and provides skilled nursing care and rehabilitation services for people who have been discharged from that hospital but who are unable to return home right away. They do not accept general admissions.

V. NFs and COVID-19

Environment:

A NF is typically a mix of semi-private and private resident bedrooms; the majority of the bedrooms are semi-private, housing two to four people. The bedrooms usually do not have physical barriers like walls or partitions separating the space allotted for each resident inside the room. Rules require a minimum of 100 square feet for a private (one person) bedroom, 80 square feet per person in multiple occupant rooms, and a minimum dimension of 10 feet. Many of the common areas in a NF are intended for use by groups of people. These areas include dining and living room spaces, activity and therapy areas, and common bathing units, which are provided at a ratio of one tub or shower for every 20 residents.

Impact of environment on COVID-19 response:

A typical NF is not physically designed to effectively support social distancing measures, while at the same time housing numerous residents who might require quarantine measures including isolation. The limitations of the physical environment mean many of the protective measures required to limit potential exposure and spread must be accomplished by staff who are already working under extreme conditions.

NFs can promote social distancing in a variety of ways. For example, dining and activities can take place in resident rooms and when able, residents can participate in medication passes while remaining in their doorways. Current CMS and state guidance for NFs state that communal activities, including dining, should be canceled, and no more than 10 people, maintaining at least 6 feet of separation, can be in a room at any time. Meals can be served in the dining room for residents who require assistance with feeding if social distancing is practiced.

Facility Demographics:

NFs are located in metropolitan, urban, and rural locales. Each locale has specific characteristics that affect workforce availability, health care system support, and interactions with public health, emergency care, and
jurisdictional administration. Texas currently has 1,220 NFs and nine hospital-based SNF units.

**Impact of facility demographics on COVID-19 response:**

NFs in more densely populated locations are likely to experience higher risk for exposure among staff and visitors. As a result, these facilities have a higher risk of infection and face more challenges controlling spread when infection occurs. They are also more likely to face staffing shortages because of competitive job markets.

NFs in more rural locations have less health care system support, might not have local health authorities, and have smaller staffing pools, making it harder to cover shortages that result from suspected exposure. Facilities in rural areas might also be more challenged to find equipment, such as personal protective equipment (PPE) and ventilators, necessary to care for COVID-19 positive residents.

**Facility Considerations:**

Facilities might have small, medium, or large bed capacity within buildings differing in age, size, available space, and equipment. Available services also differ by facility, affecting the level of available care; ventilator support might not be present, and the types of health care providers on site will also vary.

**Impact of facility considerations on COVID-19 response:**

There are NFs with limited or no isolation rooms available. Statewide, approximately 30 NFs are equipped to care for residents on ventilators. Bed capacity (along with staff and PPE availability) also affects the number of residents for which each facility can provide care. COVID-19 positive residents will increase the staff and resources required to provide care, further limiting the number of residents that a facility can serve.

**Resident Demographics:**

All NF residents must meet medical necessity to reside in a NF. While all have medical needs, each resident is unique and might require rehabilitation services, minimal supportive care, or significant medical care. Resident conditions will vary physically and mentally, affecting mobility and intellectual capacity.
Impact of resident demographics on COVID-19 response

All NF residents require care from medical professionals who are in increasingly short supply as the pandemic continues. Also, the subpopulation of residents with dementia and Alzheimer’s disease are often unable to express when they experience symptoms and could unknowingly (and without staff knowing) spread the virus if infected. This population is also less likely to understand why social distancing and quarantine are necessary and can present challenging behaviors when staff attempt to enforce such restrictions.

Other subpopulations require specialized medical care, including specialized diets, ventilator care, gastronomy (feeding) tubes, and wound care for pressure sores. These specialized needs require a combination of skilled and non-skilled caregivers. Having COVID-19 infections in a facility will increase the demands on and for staff.

NF Staffing Considerations:

The NF workforce is made up of medical professionals and direct care staff including: registered nurses (RNs), licensed vocational nurses (LVNs), certified nurse aides (CNAs), medication aides, respiratory therapists, facility support staff, and other skilled and non-skilled workers. Rules require NFs to provide nursing services at a ratio of not less than one licensed nurse for every 20 residents, or a minimum of 0.4 licensed-care hours per resident per day.

Impact of NF staffing considerations on COVID-19 response:

Many NF residents’ daily activities, such as dining, bathing, grooming and ambulating, require partial or total assistance from facility staff. Caring for someone with COVID-19 requires additional time and resources, including PPE, to maintain infection control and protect other residents and staff. As staff are exposed, become symptomatic or test positive for COVID-19, the available workforce will decline making it even more challenging for NFs to provide care.

Additionally, NFs don’t normally have a physician on-site. Typically, there is an RN and several LVNs and CNAs on staff. Staffing shortages resulting from possible exposure could lead to NFs refusing to admit residents because they cannot provide care. It is also common for NF staff to work in more than one NF, so if an employee is exposed, it is likely he or she will expose residents and staff in more than one NF, making it difficult to contain spread. A NF should follow CMS guidance (released April 2, 2020) related to NF staffing.
Visitors:
During routine NF operations, visitors including family members, volunteers, consultants, external providers, and contractors regularly enter facilities. Many perform services essential for facility function, or in the case of service providers such as hospice and dialysis staff, they provide services critical to resident care. It is important to note current CMS and state guidance to NFs requires they limit visitors to only those who are providing critical assistance and only if these essential visitors are properly screened.

Impact of visitors on COVID-19 response:

Despite efforts to screen visitors prior to allowing them to enter the facility, every person allowed inside the building increases the risk of infection. Some people will present as asymptomatic during screening but will have COVID-19 and unknowingly spread the virus. Some visitors will not follow standard precautions such as proper hand-washing, use of hand sanitizer, use of PPE, isolation protocols, and limiting the number of areas in the building that they access – all of which increases the risk of infection for residents and staff.

VI. To Do’s for Nursing Facilities:

- Review the CDC’s Key Strategies to Prepare for COVID-19 in Long-term Care Facilities.
- Review resident isolation and quarantine plans with staff.
- Review handwashing, surface-cleaning, and other environmental hygiene precautions with staff.
- Report a confirmed COVID-19 case to the local health department or DSHS and to HHSC.
- Obtain and properly use PPE.
- Comply with all CMS and CDC guidance related to infection control. (NFs need to frequently monitor CDC and CMS guidance, as it is being updated often.)
- For the duration of the state of emergency, all NF personnel should wear a facemask while in the facility. Staff who are have been appropriately trained and fit-tested can use N95 respirators.
- Actively screen, monitor, and surveil everyone who comes into the facility.
- To avoid transmission within facilities, NFs should use separate staffing teams for COVID-19-positive residents to the best of their ability, designate separate facilities or units within a facility to separate residents who are COVID-19-negative from residents who are COVID-19-positive and people with unknown COVID-19 status.
- Quarantine residents with exposure or symptoms.
- Isolate residents with positive cases.
• Upon the first positive test result of a NF staff member or resident, the facility shall work with local health authorities, DSHS, and HHSC to coordinate testing of all NF staff and residents.
• Clean and sanitize the facility when a positive case occurs.
• Coordinate resident diagnoses and symptoms with transferring and receiving hospitals and other NFs.
• Communicate with residents, staff, and family when exposure, suspected, or confirmed cases occur in the facility.
• Keep an up-to-date list of all staff who work in other facilities.
• Require staff self-monitoring on days they work and on days they don’t work.
• Require staff to report via phone prior to reporting for work if they have known exposure or symptoms.
• Follow the guidance beginning on page 25 of this document to determine when staff can return to work after recovering from an illness.
• Post a list of state contacts where it is visible on all shifts. The list should at least include phone numbers for the local health authority or DSHS office and the regional HHSC LTCR office.
• Follow physician’s plan for immediate care of any resident with a positive case. Orders can include increased assessment frequency, increased monitoring of fluid intake and output, supportive care, a treatment plan, and what to do in case of a change in the resident’s status.
• Inform the resident of treatment or supportive care plans; residents have the right to participate in care planning.
• Utilize the ASPR TRACIE workforce virtual toolkit.
• If needed, request deployment of the Rapid Assessment Quick Response Force.

VII. S.P.I.C.E.

Recognizing notification of a potential COVID-19 situation in a facility can result in disorientation, questions, and confusion; this document suggests NFs focus on the following five basic actions (S.P.I.C.E.) to anchor activities:

• Surveillance – Monitor for symptoms – fever, cough, shortness of breath, or difficulty breathing – for each resident at least once each shift.
• Protection/PPE – Protect workforce and residents through soap/water; hand sanitizer; facemask. If coughing or potential splash precautions are needed, wear a gown and face/eye shields. Refer to DSHS guidance.
• Isolate – Residents with suspected and confirmed cases need to be isolated.
• Communicate – Call local health department/authority or DSHS and
HHSC Long-term Care Regulatory to report confirmed cases.

- **Evaluate** – Infection control processes, spread of infection and mitigation efforts, and staffing availability need to be assessed.

S.P.I.C.E. is not meant to be all-encompassing. It is suggested to assist initial actions and be a reminder of necessary activities.

VIII. **HHSC Long-term Care Regulatory Activities with NFs that have Positive COVID-19 Cases**

For a report of a positive COVID-19 test (resident or staff) in a NF, HHSC will take the following steps:

- Verify the NF is prohibiting non-essential visitors.
- Generate a priority 1 intake (must be investigated within 24 hours).
- Conduct a focused review of facility infection control processes.
- Communicate with the local health department/local health authority and DSHS.
- Determine the number of residents suspected or positive for COVID-19.
- Determine the number of staff suspected or positive for COVID-19.
- Review facility isolation precautions and determine how residents are isolated in the facility (dedicated wing, private room) to ensure compliance with requirements.
- Verify that upon the first positive test result of a NF staff member or resident, the facility worked with local health authorities, DSHS, and HHSC to coordinate testing of all NF staff and residents.
- Determine that all staff suspected or positive for COVID-19 have been sent home and the facility knows to coordinate any return to work with the local health department.
- Determine if facilities have sufficient PPE.
- Determine if facilities are screening residents and staff, and at what frequency.
- Determine if others (contract staff, family members) are also being tested.
- Determine if there is a control or quarantine order.
- Ensure the control/quarantine orders are followed.
- Perform a call-down to all other facilities in the county when staff at one facility tests positive for COVID-19.
- Determine if facilities are following rules and regulations related to admission and discharge and are readmitting residents when appropriate.
- Determine if staff, residents, and families are notified of positive COVID-19 cases in the facility.
• Track facilities by program type and number of positive and suspected cases.
• Track hospitalizations of COVID-19 positive NF residents.
• Track deaths of COVID-19 positive NF residents.
• Maintain communication with facilities after investigations are complete.

IX. Facility Activities Required for LTC COVID-19 Response

In Advance (actions focused on response)
• Review/create cohort plans for residents
• Review Health Care Associated Infection (HAI) plan
• Determine/review who is responsible for specific facility plans
• Identify desired applicable waivers
• Develop communication plan (external and internal)
• Conduct supply/resource evaluation
• Enact MORE resident/staff/visitor screening

Immediate (0-24 hours)
• Activate resident isolation/facility cohort plan, including establishing a unit, wing, or group of rooms for any positive residents.
• Supply PPE to care for residents positive for COVID-19
• Screen residents for signs and symptoms
• Screen staff for signs and symptoms
• Enact HAI procedures
• Clean and disinfect facility
• Confirm case definitions
• Identify health care worker (HCW) outside activities
• Activate resident transport protocols (for transporting residents out)
• Establish contact with receiving agencies (hospitals, other facilities)
• Identify lead at facility and determine stakeholders involved external to facility
• Engage with community partners (public health, health care, organizational leadership, local/state administrators)
• Review/establish testing plan
• Activate all communication plans
• Determine need for facility restrictions/lock-down
• Supply resource evaluations
• Maintain patient care
• Upon the first positive test result of a NF staff member or resident, work with local health authorities, DSHS, and HHSC to coordinate testing of all NF staff and residents.
• Report a confirmed COVID-19 case to the local health department or DSHS and to HHSC.
• If needed, request deployment of the Rapid Assessment Quick
Response Force.

Extended (24-72 hours)
• Supply PPE for health care workers and staff
• Screen residents for signs and symptoms
• Continue specialized HAI procedures
• Activate resident transport protocols (for transporting residents out/in)
• Establish contact with transporting/receiving agencies (hospitals, other facilities)
• Engage with external partners
• Testing
• Determine need for facility restrictions/lock-down
• Consider occupational medicine needs
• Maintain resident care
• Work with your LHD or DSHS to establish a resident recovery plan, including when a resident is considered recovered and next steps for care.

Long Term (72 hours plus)
• Screen patient for signs and symptoms
• Continue cleaning and disinfecting procedures
• Activate transport (residents in) protocols
• Establish contact with transporting/receiving agencies (hospitals, other facilities)
• Lift of facility restrictions/lock-down
• Consider occupational medicine needs
• Maintain resident care

X. State\Regional\Local Support

Texas Health and Human Services Commission (HHSC) will serve as the lead state agency in the state’s response to an LTC COVID-19 event. HHSC actions will include:

• Developing recommendations in consultation with DSHS
• Ensuring appropriate/assistance with resident movement
• Providing subject matter experts (SME): LTC, HAI, epidemiology
• Coordination of HHSC, DSHS, emergency management and local actions

Texas COVID-19 Assistance Team - LTC

In addition to the activities of Section VI of this response and those above, HHSC will coordinate formation of a Texas COVID-19 Assistance Team – LTC (TCAT-LTC). This team will include representatives from HHSC, DSHS, local
This team will assist NFs with management of a COVID-19 event by providing subject matter expertise, resource request management, and other support to facility actions through initial response activities. The TCAT-LTC will remain available for a maximum of 48 hours from activation. State and local entities will provide SMEs and continued assistance after TCAT-LTC deactivation.

To activate TCAT-NF assistance, contact the LTCR Associate Commissioner.

Rapid Assessment Quick Response Force

In addition to the activities of Section VI of this response and those above, HHSC and DSHS will coordinate formation of a Rapid Assessment Quick Response Force.

The team will assist NFs by providing a rapid response and medical triage team that can be deployed by DSHS through the Emergency Medical Task Force upon notification of a positive COVID-19 resident. If needed, an additional team can be sent to assist the facility with immediate needs.

To activate Rapid Assessment Quick Response Force assistance, contact the LTCR Associate Commissioner and DSHS.
ATTACHMENT 1: Immediate Response Guidelines

IMMEDIATE ACTIONS (0-24 hours)

FACILITY ACTIONS

REVIEW SPICE ACTIVITIES

Prevent further disease spread
- Determine number of residents potentially infected
- Determine number of staff potentially infected
- Invoke isolation precautions/plans
- Determine who has been tested
- If applicable, invoke quarantine or control order
- Identify if exposed staff are working in other facilities
- Upon the first positive test result of a NF staff member or resident, work with local health authorities, DSHS, and HHSC to coordinate testing of all NF staff and residents.
- Report a confirmed COVID-19 case to the local health department or DSHS and to HHSC.

Create an isolation wing/unit
- Identify a separate, well-ventilated area to use as an isolation area. This NF area should be an isolated wing, unit, or floor that provides meaningful separation between COVID-19 positive residents and the space where the facility cares for residents who are COVID-19 negative or untested and asymptomatic. A curtain or a moveable screen does not provide meaningful separation.
- When possible, use an area with an entrance separated from the rest of building. The isolation space should be separated so the essential NF personnel maintaining the building or providing services to residents in the isolation space are not required to go through areas where negative or asymptomatic residents are receiving care.
- Provide hand hygiene areas as needed, including inside and outside of the entrance to isolation area when possible.
- Use a private bedroom with its own bathroom for each resident when possible.
- Use a semi-private bedroom and cohort COVID-19 positive residents if necessary. If a resident with COVID-19 has another infectious disease that requires transmission-based precautions, they need to be in a single occupancy room.
- House a resident in the same bedroom for their entire stay while in the isolation unit/wing when possible.
- Limit resident transport and movement to medically essential purposes
• Use dedicated HCW and staff for the isolation area,
• Minimize traffic in and out of the isolation area,
• Provide dedicated areas within the isolation area for HCW and staff use, including break rooms, medication rooms, and supply rooms.
• Provide adequate staff with training, skills, and competencies for COVID-19 care.
• Provide dedicated and adequate PPE, supplies and equipment for use in the isolation area.
• Train HCW and staff on proper use and maintenance of PPE per CDC guidance.
• Use dedicated staff to provide meal service and cleaning in the isolation area.
• Transfer all of a resident’s personal belongings to the new bedroom in the isolation area, and ensure all belongings are disinfected before they are moved out of the isolation area.

HCW/staff leaving and entering isolation wing/unit
• Directly after entering the isolation area and prior to donning PPE, perform hand hygiene
• Put on proper PPE
• Perform hand hygiene before and after performing resident care
• Directly before exiting the isolation area, remove PPE
• Perform hand hygiene
• Exit isolation area, and directly after leaving the isolation area, perform hygiene

Protect from infection
• Enact PPE plans
• Determine PPE supplies
• Screen residents/essential visitors
• Contact other facilities where exposed individuals might have visited/worked
• Consult with local health department (LHD) or DSHS regarding testing
• Limit staff in contact with infected or exposed

Care for residents who are infected
• Isolate residents who are infected
• Identify cohorts (exposed, infected)
• Determine level of required care
• Determine if hospitalization and transport are required
• Notify local health care/EMS
• Track signs/symptoms
• Work with your LHD or DSHS to establish a resident recovery plan, including when a resident is considered recovered and next steps for care.
Other
- Contact LHD/DSHS regional office/health authority (HA)
- Ensure all relevant regulations/rules are followed
- Notify families, staff, residents
- Track tested, suspected, positive, isolated, quarantined, hospitalized, and deaths
- Activate emergency response command structure
- Identify specific points of contact (POCs) for communication with HHSC, local government, clinical staff, and press
- Maintain central database of external contacts and phone numbers

Creating a voluntary isolation NF
- Identify NF location to use as an isolation facility
- Identify service and supply vendors and notify them of anticipated operations start date. Example: Transportation, Oxygen Supply, Laundry, Hospice Agencies, ESRDs
- Arrange for PPE supplies and HCW/staff training.
- Discharge current residents to other NFs in the area if needed, working with residents and families, guardians, and local LTC Ombudsman.
- Standard discharge requirements apply, and a resident’s rights are still protected. If current residents do not want to move to another NF, they are not required to move, and the facility should take all actions necessary to protect them from possible COVID-19 exposure.
- Follow steps for establishing an isolation wing or unit if residents do not want to move.
- When residents move, transfer all personal belongings to limit the risk of contamination.
- Work with the LHD or DSHS to test residents per the testing strategy prior to moving them to other NFs.
- Staffing considerations:
  - Provide additional training specific to caring for persons with COVID-19
  - Provide additional PPE training
  - Provide meals to all employees to limit items brought into the facility and to limit them exiting the facility
  - Provide showers and changing area for the start and end of each shift
  - Increase housekeeping and laundry to accommodate increased needs in a COVID-19 positive environment
  - Use an off-site location for interviewing, and orientation of additional employees
  - Conduct twice daily COVID-19 conference calls 7 days a week to hear staff concerns and provide immediate support
HHSC ACTIONS

Prevent further disease spread
- Conduct Priority 1 Intake investigation
- Review facility Infection Control Practices
- Determine if staff work at other facilities

Protect Others from infection
- Review isolation precautions/plans
- Determine if facility has sufficient PPE
- Determine if facility has enacted screening for residents/staff
- Determine if local quarantine order is in effect
- Ensure contact of other facilities where exposed individuals are working

Care for infected
- Ensure appropriate isolation and quarantine
- Ensure timely resident care
- Ensure clinical support

Other
- Review all relevant rules/regulations with facility
- Track tested, suspected, positive, isolated, quarantined, hospitalized, and deaths
- Identify POCs and maintain communication
- Contact DSHS to review response activities
- Perform focused COVID-19 ICAR onsite or tele-visit to provide support and enhance the NF’s ability to prevent or suppress any COVID-19 cases

EXTERNAL ACTIONS

Texas COVID-19 Assistance Team - NF
- Testing
- Patient Movement
- Emergency Management
- HAI
- LHD
- Resource Requests

DSHS
- Assessment
- Initial Response
- Onsite Coordination
- Monitoring
SPICE for COVID-19

Surveillance
- Sign and Symptoms
- Temperature Checks
- Residents/Staff/Visitors
- Testing

Protection/Personal Protective Equipment
- Clinical Staff
- Support Staff
- Resident
- Supply/Burn-rate

Isolate
- Resident(s) isolated
- Staff Isolated
- Others Isolated

Communicate
- Administrator Contact #:
- Local Health Department #:
- Department of State Health Services #:
- HHSC (TCAT)#:
- Hospital Contact #:

Evaluate
- Review 0-24-hour checklist
- Prevent delay of critical actions
- Communication plan
Purpose
This document provides guidance to NFs, including nursing homes, SNF, long-term acute care hospitals, and other communal living settings such as assisted living, group homes, and other institutions for the prevention, management, and reporting of Coronavirus Disease 2019 (COVID-19) outbreaks. Prompt recognition and immediate isolation of suspected cases is critical to prevent outbreaks in residential facilities.

Background
Because of their congregate nature and residents served (older adults often with underlying medical conditions), NF populations are at the highest risk of serious illness caused by COVID-19. Every effort must be made to prevent the introduction and spread of disease within these facilities.

People at high risk for developing severe COVID-19 include those who are 65 or older, immunocompromised (including cancer treatment), and have other high-risk conditions such as chronic lung disease, moderate to severe asthma and heart conditions.

People of any age with severe obesity or certain underlying medical conditions, particularly if not well controlled, such as diabetes, renal failure, or liver disease might also be at risk.

COVID-19 is most likely to be introduced into a facility by ill health care personnel (HCP) or visitors. Long-term care facilities should implement aggressive visitor restrictions and enforce sick leave policies for ill staff. Facilities must take the extreme action of restricting visitors except in compassionate care, such as end-of-life situations. Facilities must also restrict entry of non-essential personnel, and essential personnel should be screened for fever and symptoms before they enter the facility to begin their shift.

Immediate Prevention Measures
Visitor restriction – On March 13, 2020, the Centers for Medicare and Medicaid Services (CMS) released a memorandum directing all NFs to restrict visitors except those deemed medically necessary. This is an important measure to prevent the introduction of the virus that causes COVID-19 into NFs. DSHS recommends all NFs restrict all non-essential
visitation except in end-of-life care.

End-of-life care is the care given to people who have stopped treatment for their disease and whose death is imminent.

1. For people allowed in the facility (in end-of-life situations when death is imminent), instruct visitors before they enter the facility and residents’ rooms on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident’s room. Screen visitors and exclude those with fever and/or symptoms. Decisions about visitation during an end-of-life situation should be made on a case-by-case basis.

2. Visitors who are allowed in the facility must wear a facemask while in the building and restrict their visit to the resident’s room or other location designated by the facility. Visitors who are not providing care to residents, such as visitors in end-of-life scenarios, can wear a cloth face cover instead of a facemask if no facemasks are available.

3. Facilities should communicate through multiple channels to inform people and non-essential health care personnel of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls.

4. In lieu of visits, facilities should consider offering alternative means of communication for people who would otherwise visit.

5. When visitation is necessary or allowable (in end-of-life scenarios), facilities should make efforts to allow for safe visitation for residents and loved ones.
   a. Remind visitors to refrain from physical contact with residents and others while in the facility. Practice social distancing by not shaking hands or hugging and remaining 6 feet apart.
   b. If possible (pending design of building), create dedicated visiting areas near the entrance to the facility where residents can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.

Advise visitors, and any person who entered the facility (hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms happen, advise them to self-isolate at home and immediately notify the facility of the date they were in the facility, the people they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the people of reported contact and take all necessary actions based on findings.

**Restrict non-essential personnel** – Review and revise how the facility
interacts with vendors and delivery personnel, agency staff, EMS personnel and equipment, transportation providers (when taking residents to offsite appointments, etc.), and other non-health care providers (food delivery, etc.). This should include taking necessary actions to prevent any potential transmission. For example, do not have supply vendors bring supplies inside the facility. Instead, have vendors drop off supplies at a dedicated location, such as a loading dock.

Restrict non-essential personnel including volunteers and non-essential consultant personnel (barbers, delivery personnel) from entering the building.

Essential services such as dialysis, interdisciplinary hospice care, organ procurement, or home health personnel should still be permitted to enter the facility provided they are wearing all appropriate PPE and undergo the same fever and symptom screening process as facility staff. Facilities can allow entry of these essential visitors after screening.

Surveyors should not be restricted. CMS and state survey agencies are constantly evaluating their surveyors to ensure they don’t pose a transmission risk when entering a facility. For example, surveyors might have been in a facility with COVID-19 cases in the previous 14 days, but because they were wearing PPE effectively per CDC guidelines, they pose a low risk to transmission in the next facility and must be allowed to enter. However, there are circumstances under which surveyors should still not enter, such as if they have a fever or any additional signs or symptoms of illness.

**Active screening** – The CDC and CMS recommend NFs screen all staff entering the facility at the beginning of their shift for fever and symptoms consistent with COVID-19. Actively take their temperature and document absence of or shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask, immediately leave the NF, and self-isolate at home.

DSHS has created a [template screening log](#) for facility staff that is available on the DSHS website. Facilities should also screen any visitors who are permitted to enter the building, including visiting health care providers. Maintain a log of all visitors who enter the building that at minimum includes name, current contact information, and fever and presence/absence of symptoms.

**Education** – Share the latest information about COVID-19 and review CDC’s [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare](#)
Settings.

Educate residents and families about COVID-19, actions the facility is taking to protect them and their loved ones (including visitor restrictions) and actions residents and families can take to protect themselves in the facility. Educate and train health care personnel (HCP) and reinforce sick leave policies and adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE. Have HCP demonstrate competency with putting on and removing PPE. Remind HCP not to report to work when ill.

Educate facility-based and consultant personnel (wound care, podiatry, barber) and volunteers. Including consultants is important because they often provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.

Coordinate with your long-term care ombudsman to assist with education to residents and family members. To request help from an ombudsman statewide, call 1-800-252-2412 or email ltc.ombudsman@hhsc.state.tx.us.

Provide Supplies for Recommended Infection Prevention and Control Practices

- Hand hygiene supplies:
  - Put alcohol-based hand sanitizer with 60–95 percent alcohol in every resident room (ideally inside and outside of the room) and other resident care and common areas (outside dining hall, in therapy gym).
  - Make sure sinks are well-stocked with soap and paper towels for handwashing.

- Respiratory hygiene and cough etiquette:
  - Make tissues and facemasks available for people who are coughing.
  - Consider designating staff to steward those supplies and encourage appropriate use by residents, visitors, and staff.

- Make necessary PPE available in areas where resident care is provided. Put a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. Facilities should have supplies of:
  - Facemasks
  - N95 respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP)
  - Gowns
• Gloves
• Eye protection (face shield or goggles).

• Consider implementing a respiratory protection program compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training and fit testing.

• Environmental cleaning and disinfection:
  o Make sure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
  o Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA’s emerging viral pathogens program for use against SARS-CoV-2.

Control Measures for Residents

Most of the actions that can be taken to prevent or control COVID-19 outbreaks in NFs are not new and include increasing hand hygiene compliance among staff, residents, and their families through education and on the spot coaching, as well as providing facemasks and hand hygiene supplies at the entrance to the facility. Additional critical control measures are listed below:

Monitoring - Ask residents to report if they feel feverish or have symptoms of respiratory infection. Actively monitor all residents upon admission and at least three times daily for fever and respiratory symptoms (including shortness of breath, new or change in cough, sore throat, and oxygen saturation). If the resident has fever or symptoms, implement recommended infection prevention and control (IPC) measures.

Isolation - Once a case of COVID-19 is identified in the facility, immediate action must be taken to isolate the resident who is positive for COVID-19 away from other residents.

Symptoms of COVID-19 can vary in severity. Initially, symptoms can be mild and not require transfer to a hospital if the facility can follow the infection prevention and control practices recommended by CDC. Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should be placed in a private room with their own bathroom.

If a resident requires a higher level of care or the facility cannot fully implement all recommended precautions, the resident should be transferred to another facility capable of implementation. Transport personnel and the
receiving facility should be notified about the suspected diagnosis prior to transfer. While awaiting transfer, symptomatic residents should wear a facemask (if tolerated) and be separated from others (kept in their room with the door closed). Appropriate PPE should be used by health care personnel when encountering the resident.

Any roommates should be moved and monitored for fever and symptoms twice daily for 14 days. Room-sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.

Create a plan for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units. If the case is transferred to a higher level of care, perform a final, full clean of the room, and use an EPA-registered disinfectant that has qualified under EPA's emerging viral pathogens program for use against COVID-19. These products can be found on EPA’s List N.

**Source control** - Ill residents should wear a surgical mask when health care or other essential personnel enter the resident’s room. If the resident cannot tolerate a surgical mask, personnel who enter the room must wear N95 respirators, if available and staff are fit-tested. If they are not available or staff are not trained or fit-tested, facemasks should be worn. Respiratory protection should be worn in addition to gown, gloves and face shield. Ensure staff have been appropriately trained and fit-tested before using N95 respirators.

All residents who are not ill should wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments.

All residents who are ill should wear a facemask at all times as tolerated, except for when they are eating or drinking, taking medications, or performing personal hygiene like bathing or oral care.

If COVID-19 is identified in the facility, restrict all residents to their rooms and have HCP wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide, depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use, including putting it on and taking it off.

**Social distancing** - Remind residents to practice social distancing and
perform frequent hand hygiene. Social distancing means avoiding unnecessary physical contact and keeping a distance of at least 6 feet from other people. Cancel communal dining and all group activities, such as internal and external activities.

**Resident education** - Educate residents and any visitors regarding the importance of handwashing. Assist residents in performing hand hygiene if they are unable to do so themselves. Education should also be provided to residents to cover their coughs and sneezes with a tissue, then throw the tissue away in the trash and wash their hands.

**Recovery** - Work with your LHD or DSHS to establish a resident recovery plan, including when a resident is considered recovered and next steps for care. A recovery plan is the guidance for determining when to discontinue transmission-based precautions and continued are of a resident. The recovery plan may be different depending on whether a test-based or non-test-based strategy is used. Criteria should include:
- Discontinuation of transmission-based precautions without testing.
- Discontinuation of transmission-based precautions with testing.
- Whether using a testing-based strategy for discontinuation of transmission-based precautions is preferred.

**Control Measures for Staff**

**Hand hygiene** - Reinforce the importance of hand hygiene among all facility staff, including any contract staff. Facilities can increase the frequency of hand hygiene audits and implement short in-service sessions on the proper technique for hand hygiene.

Ensure that supplies for performing hand hygiene are readily available and easily accessible by staff. Advise staff not to keep hand sanitizer bottles in their pockets. This practice causes hands and sanitizer bottles to become contaminated. Instead, consider keeping alcohol-based hand rub (ABHR) bottles in easily accessible areas, and mounting ABHR to the sides of carts (dining tray carts, wound care carts, medication carts, etc.).

**Personal protective equipment (PPE)** - Ensure the facility maintains an adequate supply of PPE and that all required PPE is easily accessible to staff entering resident rooms. For COVID-19 patients, CDC recommends staff adhere to standard and transmission-based precautions. If the facility does not have a supply of N95 respirators, or does not have any fit-tested staff, facemasks must be worn. Follow the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, which includes detailed information regarding recommended PPE.
Consider designating staff to steward these supplies and encourage appropriate use by staff and residents.

**Dedicated staff/COVID-19 response teams** - Facilities can consider establishing COVID-19 care teams dedicated to the care of positive cases. These teams should be fit-tested for N95 respirators and prepared to provide an advanced level of care for cases if necessary, or until cases can be transferred to a higher level of care. COVID-19 care teams can be implemented if not all staff can be trained and fit-tested for N95 respirators, or if supplies of N95 respirators are insufficient to equip the entire staff.

**Restrict staff movement between facilities** - Facilities should restrict the movement of staff between facilities to the extent possible.

**Sick leave** - Review and potentially revise sick leave policies. Staff who are ill should not come to work. Sick leave policies that do not penalize staff with loss of status, wages, or benefits will encourage staff who are ill to stay home.

**Work exclusion** – Staff who are confirmed or suspected to have COVID-19 must stay at home. See below for guidance on when they may return to work.

**Staff return to work** – After being diagnosed with COVID-19, an employee can return to work per [DSHS guidance](#).

Use the test-based strategy as the preferred method for determining when HCP can return to work in health-care settings:

- **Test-based strategy.** Exclude from work until:
  - Resolution of fever without the use of fever-reducing medications and
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
  - Negative results of an FDA emergency use authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens) [1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

If the test-based strategy cannot be used, the non-test-based strategy can be used for determining when HCP may return to work in healthcare settings.
Exclude from work until:

- At least 7 days have passed since symptoms first appeared; AND
- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications. AND
- Improvement in respiratory symptoms (e.g., cough, shortness of breath).

**FOR ASYMPTOMATIC HCP with CONFIRMED COVID-19**

HCP with laboratory-confirmed COVID-19 who have not had any symptoms should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test. After the 10 days, these asymptomatic HCP will still need to be cleared using the test-based strategy (preferred) or the non-test-based strategy.

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the facility. A facemask instead of a cloth face covering should be used by these HCP for source control while in the facility.
- A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Both the provider and the employee must take all necessary measures to ensure the safety of everyone in the facility, including adhering to all infection control procedures such as hand hygiene, respiratory hygiene, and cough etiquette.
- Be restricted from contact with severely immunocompromised residents (e.g., transplant, hematology-oncology) until 14 days after illness onset.
- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.

Note: If the employee was diagnosed with a different illness (e.g., influenza) and was never tested for COVID-19, base their return to work on the criteria associated with that diagnosis.

**Environmental cleaning and disinfection** – Increase environmental cleaning. **Clean and disinfect** all frequently touched surfaces such as doorknobs/handles, elevator buttons, bathroom surfaces/fixtures, remote
controls and wheelchairs. Limit the sharing of personal items and equipment between residents. Provide additional work supplies to avoid sharing (pens, pads) and disinfect workplace areas (nurse’s stations, phones, internal radios, etc.).

Make sure EPA-registered hospital-grade disinfectants are available to allow for frequent disinfection of high-touch surfaces and shared resident care equipment. Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility. Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA’s emerging viral pathogens program for use against COVID-19.

**Reporting COVID-19**

All confirmed cases of COVID-19 must be reported to the local health department (LHD) or public health region (PHR) in jurisdictions where the PHR serves as the LHD. If you suspect your facility is experiencing an outbreak of COVID-19, immediately notify your local health authority by phone.

You can find contact information for your local/regional health department on the [DSHS Local Health Entities](#) website. Work with your local health department to complete the COVID-19 Case Report form if and when necessary.

NFs are also required to notify HHSC Long-term Care Regulatory of a confirmed case in either residents or staff as a self-reported incident.

Submit an incident report to HHSC Complaint and Incident intake through [TULIP](#) or by calling 1-800-458-9858.

In addition, [CMS now requires NF providers to report to the CDC](#) all confirmed COVID-19 cases and persons under investigation for COVID-19 among residents and staff.

CMS also requires NFs to keep all residents’ and their representatives up to date on the conditions inside the facility, such as when new cases of COVID-19 occur.

**Outbreak Management**

If an outbreak of COVID-19 is suspected or identified in your facility, strict measures must be put in place to halt disease transmission.
**Outbreak definitions** – A confirmed outbreak of COVID-19 is defined as one or more laboratory confirmed cases of COVID-19 identified in either a resident or paid/unpaid staff. All confirmed outbreaks will be reported to the LHD or PHR immediately, as well as to HHSC.

A suspected outbreak is defined as one or more cases of respiratory illness within a one-week period without a positive test for COVID-19. Use the suspected outbreak definition if your facility is awaiting test results from either a resident or paid/unpaid staff. You are required to report suspected outbreaks to your local health department, local health authority or DSHS pending COVID-19 test results. If you suspect a resident or staff member might have COVID-19, do not wait for test results to implement outbreak control measures.

If you have two or more residents or staff with similar symptoms, report to your local health authority as you would for any other cluster of illness. Maintain a low threshold of suspicion for COVID-19 as early symptoms can be non-specific and include atypical presentations such as diarrhea, nausea, and vomiting, among others.

Implement universal use of facemask for HCP while inside the facility. Follow the CDC’s guidance for optimizing the supply of PPE when deciding how long staff should wear one facemask. Masks should be discarded upon exit, and a new mask should be worn upon reentry.

Homemade facemasks should only be used when all other options have been entirely exhausted and should only be used as source control. These masks are not considered protective.

Consider having HCP wear all recommended PPE for COVID-19 (gown, gloves, eye protection, a facemask or N95 respirator) for the care of all residents, regardless of presence of symptoms. Implement protocols for extended use of eye protection and facemasks. Refer to DSHS’ strategies for optimizing the supply of PPE.

Restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room, residents should wear a facemask, perform hand hygiene, limit their movement in the facility, and keep a distance of 6 feet between themselves and other residents.

Implement protocols for cohorting positive COVID-19 cases with dedicated HCP. These HCP should be appropriately trained and fit-tested for N95 masks if at all possible. If staff cannot be fit-tested for N95 respirators, they should NOT use them and use facemasks instead. Consider designating
entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 cases.

Movement and monitoring decisions for HCP with exposure to COVID-19 should be made in consultation with local public health authorities. To learn more, refer to the CDC *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).*

Maintain a line list of all confirmed and suspected COVID-19 cases within your facility. Include details such as name, date of birth, age, gender, whether staff or resident, room number or job description, date of symptom onset, fever, symptoms, and others. If your facility does not already have a line list template, you can find one on the DSHS website.
Glossary of Acronyms in Alphabetical Order

1. ABHR – Alcohol-based hand rub
2. AIIR – Airborne infection isolation room
3. CDC – The Centers for Disease Control and Prevention
4. CMS – The Centers for Medicare and Medicaid Services
5. CNA – Certified nursing aide
6. DSHS – Texas Department of State Health Services
7. EMS – Emergency medical services
8. EPA – Environmental Protection Agency
9. HA – Health authority
10. HAI – Health care associated infection
11. HCP – Health care personnel
12. HCW – Healthcare worker
13. HHSC – Texas Health and Human Service Commission
14. ICAR – Infection control assessment and response tool
15. IPC – Infection prevention and control
16. LHA – Local health authority
17. LHD – Local health department
18. LTC – Long-term care
19. LTCF – Long-term care facility
20. LTCR – Long-term Care Regulatory
21. LVN – Licensed vocational nurse
22. NF – Nursing facility
23. OSHA – Occupational Safety and Health Administration
24. POC – Point of contact
25. PPE – Personal protective equipment
26. RN – Registered nurse
27. SME – Subject matter expert
28. SNF – Skilled nursing facility
29. TCAT – Texas COVID-19 Assistance Team
List of Referenced Resources

ASPR TRACIE

COVID-19 Workforce Virtual Toolkit

CDC

Cleaning and Disinfecting Your Facility

Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings - Includes PPE Recommendations


Key Strategies to Prepare for COVID-19 in Long-term Care Facilities

Strategies for Optimizing the Supply of Facemasks

CMS

CMS’ April 2, 2020 Guidance

QSO 20-14 Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes

QSO 20-26 Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes

EPA

List N: Disinfectants for Use Against SARS-CoV-2
DSHS

**DSHS COVID-19 LTC Facility Staff Symptom Monitoring Log**

**DSHS Local Health Entities**

**Information on PPE**

**Line List Template**

**Strategies for Optimizing the Supply of PPE**

**Strategies for HCP Return to Work**

HHS

**The Difference Between Isolation and Quarantine**

HHSC

**CII – Reporting to HHSC**

**LTCR Regional Contact Information**

**TULIP**

OOG

**Governor Abbot’s Executive Orders**
**Long-Term Care Facilities**

**Coronavirus Disease 2019 (COVID-19) Symptom Monitoring Log**

Instructions:
Screen all healthcare personnel (HCP) at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. Mark the symptoms below with 'Y' for Yes and 'N' for No. Don’t leave any spaces blank. If any HCP are ill, have them put on a facemask and leave the workplace. As part of a routine practice, ask HCP to regularly monitor themselves for fever and symptoms of respiratory infection.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Temperature</th>
<th>Signs and Symptoms (Y/N)</th>
<th>Exposure to facilities with confirmed COVID-19 cases (Y/N)</th>
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<td>Time °F</td>
<td>Shortness of breath</td>
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<td>Reporting Facility</td>
<td>Administrator / POC</td>
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<th>Case Status</th>
<th>Case Initials or other ID</th>
<th>Age</th>
<th>Gender</th>
<th>Staff or Resident</th>
<th>Unit/Room (or assigned area if staff)</th>
<th>Onset date</th>
<th>Cough</th>
<th>Sore throat</th>
<th>Fever</th>
<th>Shortness of breath</th>
<th>Pneumonia</th>
<th>Patient date of admission</th>
<th>Date Symptoms resolved</th>
<th>Duration of illness</th>
<th>Other respiratory illness testing</th>
<th>Other testing result</th>
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**Definitions**

**Case Definition**
- Confirmed (C): confirmed case meets COVID-19 definition AND has a positive COVID-19 test (includes rapid test)

**Covid-19 Definition**
- An illness usually characterized by a fever, cough, and/or shortness of breath. Other symptoms might include muscle aches, fatigue, sore throat, headache, runny nose, chills, abdominal pain/discomfort, nausea, vomiting, or diarrhea. If COVID-19 test results are pending and the resident’s symptoms are consistent with COVID-19 or the resident has a relevant epidemiological link, assume the resident is positive and isolate them accordingly.
ATTACHMENT 6: Comprehensive Mitigation Plan

Comprehensive Mitigation Plan - NF Without COVID-19 Positive Cases

1. Keep COVID-19 from entering your facility:
   • Restrict all visitors except for compassionate care situations (end-of-life).
   • Restrict all volunteers and non-essential HCP, including consultant services (e.g., barber, hairdresser).
   • Implement universal use of source control for everyone in the facility.
   • Actively screen anyone entering the building.
   • Cancel all group activities.

2. Identify infections early:
   • Actively screen all residents daily for fever and symptoms of COVID-19
   • If symptomatic, immediately isolate and implement appropriate Transmission-Based Precautions.
     o Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms.
     o 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.
   • Notify LHD or DSHS immediately (<24 hours) if these occur:
     o Severe respiratory infection causing hospitalization or sudden death
     o Clusters (≥3 residents and/or HCP) of respiratory infection
     o Individuals with suspected or confirmed COVID-19

3. Prevent spread of COVID-19:
   • Actions to take now:
     o Cancel all group activities and communal dining.
     o Enforce social distancing among residents.
     o Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments.
     o Ensure all HCP wear a facemask while in the facility.

4. Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:
   • If you anticipate or are experiencing PPE shortages, reach out to the LHD or DSHS.
   • Consider extended use of respirators, facemasks, and eye protection or prioritization of gowns for certain resident care activities.

5. Identify and manage severe illness.
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Determine exactly what level of infection exists at the NF and implement a comprehensive mitigation plan. Work with LHD or DSHS to ensure that test kits are available, and that testing is conducted quickly and efficiently. After the first positive test of a NF staff member or resident, test all residents and staff of the facility for COVID-19. NFs with current positive cases and that have not done comprehensive testing must conduct an assessment of their current infection levels. Test all NF staff and residents who were either not previously tested or were tested previously but are now exhibiting symptoms of COVID-19.

Design and implement a comprehensive mitigation plan. The mitigation plan must address the specific level of infection that is discovered in the NF and include specific actions to accomplish the following:

- Upon the first positive test result of a NF staff member or resident, work with local health authorities, DSHS, and HHSC to coordinate testing of nursing facility staff and residents.
- Isolate residents who are COVID-19 positive in the most effective manner available. Consider a transfer to a different facility (possibly a COVID Positive dedicated facility) or move them to a COVID isolation wing of the facility.
- Limit transport and movement of residents who are COVID-19 positive to isolation or medically essential purposes only.
- Move residents who are not COVID-19 positive to areas within the NF designated for their care.
- Staff who are confirmed to have COVID-19 must stay at home and may only return to work in accordance with the CDC Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 guidance.
- Require facility staff to only work in one facility at a time.
- Take immediate measures to inform all who interact (or may have recently interacted) with the NF of the positive result(s) so that further limitations can be enacted to control the spread of infection to family or other service providers. Follow CDC, CMS and DSHS guidance, and this NF COVID-19 Response Plan.
- Implement enhanced cleaning and disinfection techniques.
- Limit all unnecessary visitation.
- To assist in controlling infection, limit access to the facility to designated entrances only.
- Implement enhanced screening techniques.
TEST-BASED STRATEGY FOR HEALTHCARE PERSONNEL
RETURN TO WORK (Preferred)
Adapted from the Tennessee Department of Health

SYMPTOMATIC CASES
Must be isolated and excluded from work until afebrile (without the use of fever reducing medications) and with improvement of respiratory symptoms, and after receiving negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).

Asymptomatic Cases
Must be excluded from work until 10 days have passed since the date of the first positive test, assuming they have not subsequently developed symptoms since the positive result.

If the HCP develops symptoms, they should self-isolate and use follow instructions above for "symptomatic cases."

ADDITIONAL INFORMATION
There may be additional requirements for HCP to be cleared to return to work at their healthcare facility.

After returning to work, symptomatic and asymptomatic HCP should:
• Wear a medical facemask (and not a cloth face covering) for source control at all times while in the healthcare facility until all symptoms are completely resolved OR until 14 days after illness onset or positive result, whichever is longer.
• Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset or positive result.
• Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms occur, recur, or worsen.
SYMPTOMATIC CASES

Must be isolated and excluded from work for a minimum of 7 days after symptom onset and can be released after afebrile (without the use of fever reducing medications) for at least 72 hours and with improvement of respiratory symptoms.

Examples:
• A case that is well on day 2 and afebrile and feeling well for 72 hours must remain isolated and excluded from work until day 7.
• A case that is well on day 4 and afebrile and feeling well for 72 hours can be released on day 7 and may return to work.
• A case that is well on day 7 and afebrile and feeling well for 72 hours can be released on day 10 and may return to work.

Onset date
(or specimen collection date if onset unclear)

Minimum 7 days

Case released from isolation and may return to work

+ Afebrile with improved symptoms for at least 72 hours

ASYMPTOMATIC CASES

Must be excluded from work until 10 days have passed since the date of the first positive test, assuming they have not subsequently developed symptoms since the positive result.

If the HCP develops symptoms, they should self-isolate and use follow instructions above for “symptomatic cases.”

Date of positive result

10 days

No symptoms develop

Case released to return to work

ADDITIONAL INFORMATION

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• Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset or positive result.
• Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms occur, recur, or worsen.

The Centers for Disease Control and Prevention (CDC) recommends healthcare personnel follow the test-based strategy to return to work. This information can be found on the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
ATTACHMENT 8: Extended Response Guidelines (To Be Developed)
ATTACHMENT 9: Recovery Guidelines (To Be Developed)