COVID-19 RESPONSE FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS

Abstract

This document provides guidance to Intermediate Care Facilities on Response Actions in the event of a COVID-19 exposure.

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1. Purpose

This document provides Intermediate Care Facilities for People with an Intellectual Disability or Related Conditions (ICFs) with guidance in the event of a positive COVID-19 case associated with the facility.
2. Goals

- Rapid identification of COVID-19 situation in an ICF
- 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 ICF COVID-19 event
3. To Do’s for Intermediate Care Facilities:

- Review the CDC’s Key Strategies to Prepare for COVID-19 in Long-term Care Facilities.
- Review the CDC’s Preparing for COVID-19: Long-term Care Facilities, Nursing Homes.
- Review the CDC’s Strategies to Mitigate Healthcare Personnel Staffing Shortages.
- Review the CDC’s Guidance for Group Homes for Individuals with Disabilities.
- Review the CDC’s Guidance for Direct Service Providers.
- Review the CDC’s Guidance for Direct Service Providers, Caregivers, Parents, and People with Developmental and Behavioral Disorders.
- Review the WHO’s Visual Tools.
- Review CMS blanket (1135) waivers, which include:
  - Resident Care and Program Requirements
    - staffing flexibilities
    - suspension of community outings
    - suspend mandatory training requirements
    - modification of adult training programs and active treatment
  - Physical Environment and LSC
    - inspection, testing, and maintenance of systems and equipment
    - resident bedroom outside window or door
    - ABHR dispensers
    - fire drills
    - temporary construction, including temporary walls or barriers between residents

Note: Temporary walls or barriers or plastic sheeting must not impede or obstruct the means of egress, fire safety components, or fire safety systems (e.g., corridors, exit doors, smoke barrier doors, fire alarm pulls, fire sprinklers, smoke detectors, fire alarm panels, or fire extinguishers).

- Review resident isolation and quarantine plans with staff.
- Review handwashing, surface-cleaning, and other environmental hygiene precautions with staff.
- Develop a staffing contingency plan in case a large number of staff must self-quarantine or isolate because of potential exposure, being suspected of, or positive for COVID-19.
- Report a confirmed COVID-19 case to the local health department (LHD) or DSHS and to HHSC.
- Obtain and properly use PPE.
- Review the CDC’s LTC Webinar Series, including:
  - Clean Hands
  - Closely Monitor Residents
  - Keep COVID-19 Out
  - PPE Lessons
  - Sparkling Surfaces
• Utilize the ASPR TRACIE workforce virtual toolkit
• Comply with all CMS and CDC guidance related to infection control. ICFs need to frequently monitor CDC and CMS guidance as it is being updated often. This will ensure the ICF is operating off the most current guidance.
• For the duration of the state of emergency, all ICF personnel should wear a facemask while in the facility. Staff who are have been appropriately trained and fit-tested can use N95 respirators. Staff who are caring for residents with COVID-19 or caring for residents in a building with widespread COVID-19 infection, should wear an N95 respirator and all suggested PPE. See guidance in the section related to PPE use when caring for residents with COVID-19.
• If N95 or other respirators are used, review OSHA’s Respiratory Protection Training Videos.
• Actively screen, monitor, and surveil everyone who comes into the facility.
• To avoid transmission within facilities, ICFs to the best of their ability should use separate staffing teams for COVID-19-positive residents and designate separate ICFs or units within an ICF to separate COVID-19-negative residents from COVID-19-positive residents and people with unknown COVID-19 status.
• Quarantine residents with exposure or symptoms:
• Isolate residents with positive cases:
• Clean and disinfect the facility there is a positive case.
• Coordinate resident diagnoses and symptoms with transferring and receiving hospitals and other ICFs.
• Communicate with residents, staff, and family when there is exposure, suspected, or confirmed cases in the facility.
• Keep an up-to-date list of all staff who work in other facilities. The list does not have to include the names or locations of the other facilities, just whether the staff member works at other facilities.
• Minimize the movement of staff between facilities as much as possible.
• Require staff self-monitoring on days they work. Ask staff to self-monitor 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 32 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 healthcare plans; residents have the right to participate in their own care.
• Upon the first positive test result of an ICF staff member or resident, consider testing of all ICF staff and residents.
• If needed, request deployment of the TCAT-ICF team.
Recognizing notification of a potential COVID-19 situation in a facility can result in disorientation, questions, and confusion; this document suggests ICFs 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.
5. HHSC Long-term Care Regulatory Activities with ICFs that have Positive COVID-19 Cases

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

- Verify the ICF 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 to ensure compliance with requirements.
- 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 ICF residents.
- Track deaths of COVID-19 positive ICF residents.
- Maintain communication with facilities after investigations are complete.
6. Facility Activities Required for LTC COVID-19 Response

In Advance (actions focused on response)

- Review/create cohort plans for residents. A cohort plan is a plan to group people together, such as people who were exposed to coronavirus.
- Review infection control plan
- Determine/review who is responsible for specific facility plans
- Identify desired 1135 waivers
- Develop communication plan (external and internal)
- Evaluate supplies/resources
- Enact MORE resident/staff/visitor screening
- Review the CDC’s LTC Webinar Series.
- Review the CDC’s Guidance for Group Homes for Individuals with Disabilities
- Review OSHA’s Respiratory Protection Training Videos.
- Review HHSC’s Helping Individuals with Intellectual Disabilities and Related Conditions Prevent the Spread of COVID-19
- Review the WHO’s Visual Tools
- Develop a staffing contingency plan in case a large number of staff must self-quarantine or isolate because of potential exposure, being suspected of, or positive for COVID-19.

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. See attachment 8 about donning (putting on) and doffing (taking off) PPE, and attachment 7 about optimizing the use of facemasks and do’s and don’ts for facemask use.
- Screen residents for signs and symptoms at least once each shift.
- Screen staff for signs and symptoms at least at the beginning of their shift.
- Clean and disinfect facility
- Confirm case definitions
- Identify DSP 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
- Evaluate supply resources
- Maintain resident care
- 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 at least once each shift
• Screen staff for signs and symptoms at least at the beginning of their shift
• Continue specialized infection control procedures
• Activate resident transport protocols (for transporting residents out/in)
• Establish contact with transporting/receiving agencies (hospitals, other facilities)
• Engage with external partners
• Continue testing
• Determine need for facility restrictions/lock-down
• Consider additional healthcare needs
• Maintain resident care
• Establish a resident recovery plan, including when a resident is considered recovered and next steps for care.

**Long Term (72 hours plus)**

• Screen resident for signs and symptoms at least once each shift
• Screen staff for signs and symptoms at least at the beginning of their shift
• [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 additional healthcare needs
• Maintain resident care
Texas HHSC will serve as the lead state agency in the state’s response to an LTC COVID-19 event. HHSC actions will include:

- Developing testing recommendations, in consultation with DSHS
- Ensuring appropriate/assistance with resident movement
- Providing subject matter experts (SME): LTC, epidemiology, etc.
- 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 – ICF (TCAT-ICF). This team will include representatives from HHSC, DSHS, local health department (as applicable) and emergency management (as applicable.)

This team will assist ICFs 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-ICF will remain available for a maximum of 48 hours from activation. State and local entities will provide SMEs and continued assistance after TCAT-ICF deactivation.

To activate TCAT-ICF assistance, contact the [LTCR Associate Commissioner](mailto:LTCR_Associate_Commissioner).
8. Summary

Residents of ICFs 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, an ICF environment presents challenges to infection control and the ability to contain an outbreak, partly due to residents living in close proximity to others, which could result in potentially rapid spread among a highly vulnerable population.

This document provides ICFs immediate actions to consider and actions for extended periods after a facility is made aware of potential infection of a resident, provider or visitor.
9. Description of an Intermediate Care Facility

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions provide residential and habilitation services to people with intellectual disabilities or a related condition.
10. ICFs and COVID-19

Environment

A small ICF home is often integrated into the community and is typical of other residences in the community. These residential settings include a mix of semi-private and private individual bedrooms; many of the bedrooms are shared, accommodating two to three 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 80 square feet for a private (one person) bedroom, 60 square feet per person in multiple occupant rooms, and a minimum dimension of 8 feet for a private room and 10 feet for a shared room. The common areas in an ICF are intended for use by the residents of the facility. These areas include dining and living room spaces, activity areas, and common bathing units, which are provided at a ratio of one tub or shower for every 8 residents.

A large ICF might be made up several cottages similar to a small ICF home, a larger building more similar in design to a nursing facility, or both. A large ICF is also typically a mix of semi-private and private resident bedrooms; many of the bedrooms are semi-private, accommodating two to three 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 80 square feet for a private (one person) bedroom, 60 square feet per person in multiple occupant rooms, and a minimum dimension of 8 feet. Many of the common areas in a large ICF 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 15 residents.

Impact of environment on COVID-19 response:

The relatively small size of a typical ICF residence makes it challenging for providers to effectively support social distancing measures or accommodate quarantine or isolation measures. A single shared kitchen can pose infection control challenges when both residents and staff access the kitchen throughout the day.

The following section is new:

Quarantine of an individual who might have been exposed to COVID-19, including individuals whose status is unknown:

- Quarantine means keeping the individual separate from the other individuals in the home;
- Quarantine in a private bedroom with the use of a private bathroom, if possible;
- Consider if other rooms in the ICF could be used as a bedroom;
- Consider if a bathroom can be reserved only for the use of the individual being quarantined, possibly the one closest to the bedroom;
• Consider cohorting an individual who might have been exposed with another individual who also might have been exposed;

• Consider cohorting an individual whose status is unknown with another individual whose status is unknown;

• Do not cohort with another individual who has COVID-19;

• Maintain at least 6 feet distance between individual’s beds, or more if possible, for individuals who are cohorting in the same room;

• Increase cleaning and disinfection of the bedroom, including commonly touched surfaces and equipment;

• Increase cleaning and disinfection of the bathroom, including after each use by the individual being quarantined if a bathroom cannot be dedicated for the individual’s use only;

• Have each individual who might have been exposed to COVID-19 or whose status is unknown wear a cloth face covering at all times when they are not in their bedroom, as tolerated; and

• Educate individuals about hand hygiene, covering coughs and sneezes, and properly discarding used tissues.

The following section is new:

Isolation of an individual who has COVID-19:

• Isolate in a private bedroom with the use of a private bathroom if at all possible;

• Consider whether other rooms in the ICF could be used as a bedroom during an isolation emergency;

• Consider whether a bathroom can be reserved only for the use of the individual with COVID-19, possibly the one closest to the bedroom;

• Consider cohorting (accommodating in same bedroom) with another individual who also has COVID-19;

• Do not cohort with another individual who does not have COVID-19 or whose status is unknown;

• Maintain at least 6 feet distance between individual’s beds, or more if possible, for individuals who are cohorting in the same room;

• Increase cleaning and disinfection of the bedroom, including commonly touched surfaces and equipment;

• Increase cleaning and disinfection of the bathroom, including after each use by the individual with COVID-19, if a bathroom cannot be dedicated only for use by the individual with COVID-19;

• Keep the bedroom door closed at all times when possible;

• Have each individual with COVID-19 wear a facemask or cloth face covering at all times, if tolerated; and/or

• Educate individuals about hand hygiene, covering coughs and sneezes, and properly discarding used tissues.
Smaller ICFs can still 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 in the privacy of their own room. CMS and HHSC guidance for ICFs 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, but social distancing of at least 6 feet apart must be practiced.

**Facility Demographics**

ICFs are located in metropolitan, urban, and rural locales. Each locale has specific characteristics that impact workforce availability, health care system support, and interactions with public health, emergency care, and jurisdictional administration. Texas currently has 786 community ICFs and 13 State Supported Living Centers (SSLCs).

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

ICFs in more densely populated locations are likely to experience higher risk for exposure among staff and visitors. As a result, facilities in metropolitan and urban areas have a higher risk of infection and face more challenges controlling spread when infection occurs. ICFs 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 both metropolitan and rural areas are likely to face staffing shortages because of competitive job markets and have challenges finding personal protective equipment (PPE).

**Facility Considerations**

Facilities have small or large bed capacity and differ 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 available or on-site will also vary.

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

Most ICFs have limited or no isolation rooms available. Most small ICFs are not equipped to care for resident with fragile medical conditions. 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 for which a facility can care.

**Resident Demographics**

All ICF residents must have an intellectual disability (IDD) or related condition. While all have an IDD or related condition, each resident is unique and might require habilitation services, minimal supportive care, or significant medical care. Resident conditions will vary physically and mentally, impacting mobility and intellectual capacity.
Impact of resident demographics on COVID-19 response:

In addition to having an IDD or related condition, many ICF residents need care from medical professionals who are in increasingly short supply as the pandemic continues. Also, the population of residents with IDD and related conditions 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. Having COVID-19 infections in a facility will increase the demands on and for staff.

ICF Staffing Considerations

The ICF workforce includes qualified intellectual disability professionals (QIDPs), house managers, medical professionals, and direct care staff including: registered nurses (RNs), licensed vocational nurses (LVNs), facility support staff and other skilled and non-skilled workers. Rules require ICFs to provide nursing services as needed, and most small ICFs use contract medical providers rather than staff providers to do so.

Impact of ICF staffing considerations on COVID-19 response:

Many ICF 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 ICFs to provide care.

Additionally, ICFs don’t normally have a physician on-site. Typically, direct care staff are in the facility and health care professionals are available by phone. Staffing shortages resulting from possible exposure could lead to ICFs refusing to admit residents because they won’t have the ability to provide care. It is also common for ICF staff to work in more than one ICF, so if an employee is exposed, it is likely they will expose residents and staff in more than one ICF, making it difficult to contain spread.

Visitors

During routine ICF operations, visitors including family members, volunteers, consultants, external providers, and contractors routinely enter facilities. Many perform essential services necessary for facility function. It is important to note current CMS and state guidance to ICFs requires they limit visitors to only those who are providing critical assistance.

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 including 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 increase the risk of infection for residents and staff.
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
- Report a confirmed COVID-19 case to the local health department or DSHS and to HHSC.

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 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
- Establish a resident recovery plan, including when a resident is considered recovered and next steps for care.
- Upon the first positive test result of an ICF staff member or resident, consider testing of all ICF staff and residents.

Other

- Contact HHSC, 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

**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 residents who are 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

**EXTERNAL ACTIONS**

Texas COVID-19 Assistance Team - ICF

• Testing
• Resident Movement
• Emergency Management
• Infection control plan
• LHD
• Resource Requests
ATTACHMENT 2: SPICE Graphic

**SPICE**
for COVID-19

**S**urveillance
- Sign and Symptoms
- Temperature Checks
- Residents/Staff/Visitors
- Testing

**P**rotection/Personal Protective Equipment
- Clinical Staff
- Support Staff
- Resident
- Supply/Burn-rate

**I**solate
- Resident(s) isolated
- Staff Isolated
- Others Isolated

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

**E**valuate
- Review 0-24-hour checklist
- Prevent delay of critical actions
- Communication plan
Purpose

This document provides guidance to ICFs 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 (adults with IDD or a related condition, often with underlying medical conditions), ICF populations are one of the most at 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), or 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 DSP or visitors. ICFs should implement aggressive visitor restrictions and strictly enforce sick leave policies for ill DSP. Facilities must take the extreme action of restricting visitors except in compassionate care situations, such as end-of-life. Facilities must also restrict entry of non-essential personnel, and essential personnel should be screened for fever and other symptoms before they enter the facility to begin their shift.

Immediate Prevention Measures

Visitor restriction – On March 30, 2020, CMS released a memorandum directing all ICFs 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 LTCFs. DSHS recommends all LTCFs restrict all non-essential visitation except in end-of-life situations.

End-of-life care is the care given to people who have stopped treatment for their disease and are near the end of life.

1. For people allowed in the facility (in end-of-life situations only when death is imminent), provide instruction before visitors enter the facility and residents’ rooms on hand hygiene, limiting surfaces touched, and use of personal protective equipment (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 visiation 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 where death is imminent), facilities should make efforts to allow for safe visitation for residents and loved ones:
   a. Remind visitors to refrain from physical contact with residents other than their loved ones 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 a dedicated visiting room 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 to monitor for signs and symptoms of respiratory infection and coronavirus for at least 14 days after exiting the facility. If symptoms occur, 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 who were in 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 front or back patio.

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

Essential services such as therapists of different disciplines, behavior support staff, or direct support professionals 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 staff only after screening.

HHSC surveyors should not be restricted. HHSC surveyors are conducting surveys and investigations remotely, by regional offsite review, or through the use of telecommunications to the extent practicable, as well as limiting surveys and investigations to essential activities only. 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 LTCFs screen all staff prior to 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, immediately send them home to self-isolate. For the SSLCs, HHSC recognizes that documenting the absence of symptoms on all staff daily might pose a challenge and will educate surveyors accordingly.

DHHS has created a template screening log for facility. Facilities should also screen any essential visitors who are permitted to enter the building, including health care providers. Maintain a log of all visitors who enter the building that at minimum includes name, current contact information, and presence/absence of symptoms such as fever.

**Education** – Share the latest information about COVID-19 and review CDC guidance, including:

- [CDC LTC Webinar Series](#)
- [Interim Infection Prevention and Control Recommendations for Residents with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings](#)
- [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#)
- [Strategies for Optimizing the Supply of Facemasks](#)
- [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)

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 DSP and reinforce sick leave policies and adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE. Have DSPs demonstrate competency with putting on and removing PPE. Remind DSPs not to report to work when ill.

Educate consultant personnel (therapists of different disciplines, behavior support specialists, etc.). 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.

**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 room, in living room).
  - Make sure sinks are well-stocked with soap and paper towels for handwashing.
• Respiratory hygiene and cough etiquette:
  o Make tissues and facemasks available for people who are coughing.
  o Consider designating staff to steward those supplies and encourage appropriate use by residents, essential 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:
  o Facemasks
  o N95 respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested DSP)
  o Gowns
  o Gloves
  o Eye protection (face shield or goggles).

• See guidance in the section related to PPE use when caring for residents with COVID-19.
• 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 and disinfection 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.
  o High-touch surfaces include items like doorknobs, light switches, handrails, countertops - clean and disinfect frequently
  o Workstations include items like computers, chairs, keypads, common-use items - clean and disinfect frequently
  o Equipment includes items like blood pressure cuffs, hoyer lifts and other shared equipment used for resident care - clean and disinfect after each use

Control Measures for Residents

Most of the actions to prevent or control COVID-19 outbreaks in ICFs are not new and include increasing hand hygiene compliance among staff, residents, and essential visitors 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 and coronavirus. Actively monitor all residents upon admission and at least three times daily for fever and respiratory symptoms and coronavirus (including shortness of breath, new or change in cough, and sore throat). If the resident has fever or symptoms, implement recommended infection prevention and control measures. For the SSLCs, HHSC recognizes that daily fever checks for every resident might pose a challenge and will educate surveyors accordingly.
People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. 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 difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

**Isolation** - If 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 the CDC. Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room but should be placed in a private room with their own bathroom if possible.

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 staff when encountering the resident.

Any roommates should be moved and monitored for fever and symptoms three times a day (once each shift) 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 and coronavirus, including dedicating DSP to work only on affected units. If the resident 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](https://www.epa.gov/). This section is new.

Consider the following when isolating an individual with COVID-19:

- Isolate in a private bedroom with the use of a private bathroom if possible;
• Consider whether other rooms in the ICF can be used as a bedroom during an isolation emergency;

• Consider whether a bathroom can be reserved only for the use of the individual with COVID-19, possibly the one closest to the bedroom;

• Consider cohorting (accommodating in same bedroom) with another individual who also has COVID-19;

• Do not cohort with another individual who does not have COVID-19 or whose status is unknown;

• Maintain at least 6 feet distance between individual’s beds, or more if possible, for individuals who are cohorting in the same room;

• Increase cleaning and disinfection of the bedroom, including commonly touched surfaces and equipment;

• Increase cleaning and disinfection of the bathroom, including after each use by the individual with COVID-19 if a bathroom cannot be dedicated only for use by the individual with COVID-19;

• Keep the bedroom door closed when at all possible;

• Have each individual with COVID-19 wear a facemask at all times, as tolerated; and

• Educate individuals about hand hygiene, covering coughs and sneezes, and properly discarding used tissues.

Source control - 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 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 masks. See guidance in the section related to PPE use when caring for residents with COVID-19.

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.

If COVID-19 is identified in the facility, restrict all residents to their rooms and have DSP 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. DSP 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.

This section is new.

**Returning from home visits:** The [CDC guidance](https://www.cdc.gov/coronavirus/2019-ncov/community/restricting-activities.html) recommends that individuals be restricted to their bedroom if they are confirmed or suspected of having COVID-19. It does not recommend restricting individuals to their bedroom while they are in quarantine. Quarantine, specifically, means keeping the individual separate from the other individuals in the home. Being in quarantine after returning from a home visit does not automatically mean an individual is confirmed or suspected of having COVID-19; rather, it means they had the potential for being exposed to COVID-19, are considered to have unknown COVID-19 status, and should be kept away from others while they are under observation for 14 days.

This section is new.

**Quarantine of an individual who might have been exposed to COVID-19, including individuals whose status is unknown:**

- Quarantine means keeping the individual separate from the other individuals in the home;
- Quarantine in a private bedroom with the use of a private bathroom if possible;
- Consider whether other rooms in the ICF could be used as a bedroom;
- Consider whether a bathroom can be reserved only for the use of the individual being quarantined, possibly the one closest to the bedroom;
- Consider cohorting an individual who might have been exposed with another individual who also might have been exposed;
- Consider cohorting an individual whose status is unknown with another individual whose status is unknown;
- Do not cohort with an individual who has COVID-19;
- Maintain at least 6 feet distance between individuals’ beds, or more if possible, for individuals who are cohorting in the same room;
- increase cleaning and disinfection of the bedroom, including commonly touched surfaces and equipment;
- Increase cleaning and disinfection of the bathroom, including after each use by the individual being quarantined if a bathroom cannot be dedicated only for that individual’s use;
- Have each individual who might have been exposed to COVID-19 or whose status is unknown wear a facemask or cloth face covering at all times when they are not in their bedroom, as tolerated; and
- Educate individuals about hand hygiene, covering coughs and sneezes, and properly discarding used tissues.

This section is new.
The individual in quarantine can visit common areas, but the ICF will have to determine how to accomplish this safely. Some issues to consider:

- Can the individual visit the common areas and still be separate from other individuals who are not under quarantine?
- Can at least 6 feet of distance be maintained between the individual under quarantine and the other individuals?
- Are all individuals, including the individual in quarantine, wearing a facemask or cloth face covering when out of their bedrooms?
- Are all individuals practicing hand hygiene, covering coughs and sneezes, and properly discarding used tissues?
- Is the facility frequently cleaning and disinfecting high-touch surfaces and equipment?
- Is the facility monitoring for signs and symptoms at least three times a day (once per shift)?
- Does the facility have a plan for what to do if the individual starts having signs or symptoms of respiratory illness?

**Bathing and showering** - Residents with active signs and symptoms of respiratory illness and coronavirus should remain in their bedroom while being evaluated and treated. However, care and services for other residents should continue with appropriate precautions.

Ideally, residents with COVID-19 should be accommodated in a private bedroom with a private bathroom if at all possible. If a private bathroom is not available, the ICF should at least designate a bathroom that is separate from the ones used for residents who do not have COVID-19.

Alternately, the ICF could use other strategies for ensuring resident safety while delivering care, including staggering schedules for resident showering or bathing for residents with COVID-19 so there would be less overlap with residents who do not have COVID-19.

ICFs should continue to follow existing CDC recommendations for cleaning and disinfection of equipment and surfaces in shared spaces, like bathrooms or equipment that must be shared between residents, between every resident use, using the appropriate EPA-approved products for COVID-19 prevention.

DSPs should also be able to wear and maintain safe use of all recommended PPE while assisting residents with personal hygiene. Some PPE, including respirators and facemasks, could be compromised if they get wet.

**Residents who can bathe independently** - If a resident is able to bathe independently, they should continue to do so.

**Residents who need assistance to bathe** - If a resident needs assistance with bathing and:
• the resident has COVID-19 and is symptomatic or asymptomatic, DSP must also be able to wear and maintain safe use of all recommended PPE while assisting residents with personal hygiene; or
• the resident has recovered from COVID-19, per the test-based or non-test-based strategy (or otherwise), OR the resident has consistently tested negative and is asymptomatic, follow established policies and procedures for other care that requires close contact for bathing and showering.

Cleaning and disinfecting the bathing or shower area - If residents with COVID-19 have access to a private bathroom or only share a bathroom with other residents who have the same COVID-19 status, the ICF should clean and sanitize the bathroom frequently.

If the bathroom is shared by both residents who have COVID-19 and those who don’t, clean and disinfect the area between every resident use.

Resident education - Educate residents and any essential 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. If individuals are unable to understand or perform the appropriate hygiene, DSPs should assist as necessary.

This section is new

Medical Appointments – A resident leaving regularly for necessary medical appointments outside the facility does not have to be quarantined each time they return. However, they cannot be cohorted with residents who do not go into the community or with those who are either COVID-19 positive or COVID-19 negative.

Per CDC guidance, residents who must regularly leave the facility for medically necessary purposes should wear a facemask whenever they leave their bedroom, including for procedures outside of the facility. They also should continue to practice social distancing in the facility.

Recovery - 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

Active screening – The CDC and CMS recommend ICFs screen all staff prior to entering the facility at the beginning of their shift for fever and other symptoms consistent with COVID-19. Actively take their temperature and document shortness of breath, new or change in cough, and
sore throat. If they are ill, immediately send them home to self-isolate. For the SSLCs, HHSC recognizes that documenting the absence of symptoms on all staff daily might pose a challenge and will educate surveyors accordingly.

**Staffing contingency plan** – Develop a staffing contingency plan in case a large number of staff must self-quarantine or isolate because of potential exposure, being suspected of, or positive for COVID-19. ICFs must:

- have sufficient direct care staff to manage and supervise residents in accordance with their individual program plans - 42 CFR §483.430(d)(1)
- have an active program for the prevention, control, and investigation of infection and communicable diseases - 42 CFR §483.470(l)(1)
- develop and maintain an emergency preparedness plan that is based on a facility-based and community-based risk assessment, utilizing an all-hazards approach, and includes emerging infectious disease - 42 CFR §483.475(a)

**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 in different rooms throughout the facility.

**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 residents with COVID-19, 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 should be worn for droplet protection. Follow the CDC [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings](https://www.cdc.gov/mmwr/mmwrhtml/rr6903a1.htm), which includes detailed information regarding recommended PPE.

Consider designating staff to steward these supplies and encourage appropriate use by staff and residents.

**PPE and Infection Control Education and Training** - Ensure staff are educated and trained on which PPE they should use, proper procedure for donning (putting on) and doffing (taking off) PPE, and how to determine if the PPE is contaminated or damaged.

ICFs must identify whether the following concerns exist and specifically address them through education and training:

- Improper use of PPE
  - lack of understanding of proper use of each type of PPE
  - lack of fit-testing (see [PPE Use When Caring for Residents with COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-use-care-residents-hcp.html))
  - lack of user seal check
• Improper donning and doffing procedures
  o lack of understanding of appropriate donning and doffing sequence
  o safety and quality control measures
  o lack of appropriate donning and doffing locations
• Cross contamination
  o lack of understanding of cold, warm, and hot zones within a facility
  o cold zone - area with no COVID-19 infection present
  o warm zones - area used to monitor residents suspected of COVID-19 infection
  o hot zones - area where COVID-19 infection is present

If the ICF is following the CDC's or DHS's guidance for optimizing the supply of PPE, inform staff of the expectations specific to the type of PPE they are using. PPE education and training for staff should include at least the following information:

• PPE – simple, easy to understand training that includes:
  o use of PPE in an ICF without a known positive case of COVID-19
  o use of PPE in an ICF with a suspected or positive case of COVID-19
  o donning and doffing sequence and procedures
  o procedures, if any, for optimizing the use of PPE
  o procedures for determining if the PPE is contaminated or soiled
  o procedures for disposal of PPE (contaminated or uncontaminated)
• Infection Control – simple, easy to understand training that includes:
  o Concept of infection control zones including:
    ▪ cold - clean or uncontaminated area
    ▪ warm - potentially contaminated area
    ▪ hot - contaminated area
    ▪ understanding of how cross contamination occurs
  o Protocols, policies, and procedures for use during:
    ▪ monitoring for COVID-19
    ▪ suspected COVID-19
    ▪ confirmed COVID-19

Note: See attachment 8 about donning (putting on) and doffing (taking off) PPE, and attachment 7 about optimizing the use of facemasks and do’s and don’ts for facemask use.

**Dedicated staff/Covid-19 response teams** - Facilities can consider establishing COVID-19 care teams dedicated to the care of residents with COVID-19. These teams should be fit-tested for N95 respirators and prepared to provide an advanced level of care for cases if necessary, or until residents with COVID-19 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 masks, or if supplies of them are insufficient to equip the entire staff. See guidance in the section related to PPE use when caring for residents with COVID-19.

**Restrict staff movement between facilities** - Facilities should restrict the movement of staff between facilities to the extent possible.
**Sick leave** - Facilities should review and potentially revise their 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 or non-test-based strategy for determining when staff can return to work in an ICF:

**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).

If the test-based strategy cannot be used, the *non-test-based* strategy can be used for determining when staff may return to work in an ICF.

**Non-test-based strategy. Exclude from work until:**

- At least 10 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 Staff with CONFIRMED COVID-19**

Staff 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 staff will still need to cleared using the test-based strategy or the non-test-based strategy.

After returning to work, staff 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 staff 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 residents 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, adaptive equipment 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 (staff desks, phones, 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 HHSC and to the LHD, or 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.

Work with your LHD to complete the COVID-19 case report form if and when necessary. If you are in a location that does not have a local/regional health department, all confirmed cases of COVID-19 must be reported to DSHS.

You can find contact information for your local/regional health department on the [DSHS Local Health Entities](#) website.

You can find information about reporting to HHSC on the [CII website](#).

ICFs 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. As long as the intake generated by the first positive case of COVID-19 is open, addendums can be added. Once the intake is closed, it is not necessary to report additional
cases of COVID-19 unless the specific circumstances of a case would be reportable – for example if neglect were suspected.

**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, or DSHS when a LHD or PHR are not available in that region.

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 can contact your local health authority for assistance during this period but are not required to report suspected outbreaks. 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 (or DSHS when there is no 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 facemasks for DSP while inside the facility. Follow the CDC’s guidance for optimizing the supply of facemasks when deciding how long staff should wear one facemask. Masks should be discarded upon exit, and a new mask should be worn upon reentry.

Note that 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 DSP wear all recommended PPE for COVID-19 (gown, gloves, eye protection, a facemask or N95) 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 DSP. These DSP should be appropriately trained and fit-tested for N95 masks if at all possible. If staff cannot be fit-tested for N95s, they should NOT use them and use facemasks instead. Consider designating
entire units within the facility, with dedicated DSP, to care for known or suspected COVID-19 cases. See guidance in section related to PPE use when caring for residents with COVID-19.

Movement and monitoring decisions for DSP with exposure to COVID-19 should be made in consultation with local public health authorities. To learn more, refer to the CDC’s 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.

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 (shared or private) 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.

**PPE Use When Caring for Residents with COVID-19**

DSP should wear an N95 respirator and all suggested PPE when caring for residents with COVID-19. If there is widespread COVID-19 infection in the building, staff should wear an N95 respirator and all suggested PPE when caring for residents.

Per the CDC, “all suggested PPE” includes:

- N95 respirator
- eye protection
- gloves
- gown

**Cloth gowns** - Follow manufacturer’s recommendations for cleaning and laundering, including the number of times the gown can be laundered and re-worn. This might differ by manufacturer and type of cloth gown. Immediately remove the gown to be laundered if it becomes soiled.

Certain types of gowns, sometimes called Level 1 or “minimal risk” gowns, do not provide protection from splashes/sprays of blood or body fluids, depending on the material the gown is made of. For these situations:

- Use a disposable, impervious isolation gown when a splash, spray, or cough might be expected.
- If an ICF does not have disposable, impervious isolation gowns, use a disposable plastic apron over the cloth gown in these situations.

The ICF also should train staff on how to correctly don/doff any cloth or other alternative isolation gown; include a competency check.

Review the CDC’s Strategies for Optimizing the Supply of Isolation Gowns for more information.

**N95 respirator fit testing** - Under serious outbreak conditions in which respirator supplies are severely limited, DSP may not have the opportunity to be fit-tested on a respirator before using it. ICFs should make every effort to ensure DSPs who need to use tight-fitting respirators are fit-tested to identify the right respirator for the DSP. Under serious outbreak conditions, there may be limited availability of respirators or fit-test kits.
If ICFs cannot fit-test DSPs for N95 respirators, they should follow the NIOSH guidance for respirator use in a serious outbreak.

While it is not ideal, even without fit-testing, a respirator will provide better protection than a facemask or using no respirator at all. ICFs should assist the DSP in choosing a respirator that fits best.

Even if DSPs begin using respirators without proper fit-testing, ICFs should make every effort to perform fit-testing as respirator supplies allow. ICFs should always perform fit-testing for workers who cannot successfully seal check their own respirators.

DSPs should review the following OSHA Respiratory Protection Training Videos:

- Respiratory Protection for Healthcare Workers
- The Differences Between Respirators and Surgical Masks
- Respirator Safety: Donning & Doffing
- Respirator Types
- Respirator Fit Testing
- Maintenance and Care of Respirators
- Medical Evaluations
- Respiratory Protection Training Requirements
- Voluntary Use of Respirators
- Counterfeit and Altered Respirators: The Importance of NIOSH Certification

Review attachment 10, the “Three Key Factors Required for a Respirator to be Effective” infographic.

ICFs should document that the DSP has reviewed the OSHA respiratory protection training videos.

**User Seal Check** - DSPs wearing tight-fitting respiratory protection should perform a user seal check each time they put on their respirator. A fit test ensures that the respirator fits and provides a secure seal. A user seal check ensures that it’s being worn right each time.

DSPs can either perform a positive-pressure or negative-pressure seal check:

- A positive-pressure check is accomplished by covering the respirator surface on a filtering facepiece (N95) and trying to breathe out. Cover the surface using your hands. If slight pressure builds up, that means air isn’t leaking around the edges of the respirator.
- A negative-pressure check is accomplished by covering the respirator surface on a filtering facepiece (N95) and trying to breathe in. Cover the surface using your hands. If no air enters, the seal is tight.

The seal check method may vary by manufacturer and model and will be described in the user instructions. DSPs should follow the PPE manufacturer’s instructions and recommendations for the proper use, donning, doffing, and user seal check of the N95 respirator.

Review attachment 9, the “User Seal Check” infographic.
People who live in long-term care facilities are at higher risk for severe illness. There are actions that an ICF program provider can take to identify a COVID-19 situation, help prevent the spread within facility, and care for residents who have COVID-19.

**PREPARE**

- **COMMUNICATION PLAN**: Who? When? How? What?
- **SUPPLIES**: Do you have enough? Stock up.
- **SCREEN**: Screen staff, residents, and essential visitors.
- **ISOLATION PLAN**: How will you isolate a sick resident?
- **INFECTION CONTROL** policies & procedures: Review, revise, reflect CDC, DSHS & HHSC.
- **EMERGENCY PLAN**: Review; adapt to COVID-19.

**REACT**

- **ACTIVATE** response plans
- **CLEAN & SANITIZE**
- **DEPLOY PPE** for staff & residents
- **REPORT** to local health department/DSHS & to HHSC
- **ENHANCED MONITORING** of signs & symptoms (daily for well residents; 3x daily for sick residents)
- **EVALUATE RESTRICTIONS**: Is a lock-down needed?

**PROTECT**

- **SUSTAIN** supplies of PPE
- **EVALUATE RESTRICTIONS**: Are they working?
- **MAINTAIN** care & services
- **CONSIDER** medical needs
- **CONTINUE** enhanced monitoring signs & symptoms; cleaning & sanitizing; rigorous infection control

**TRANSITION**

- **SUSTAIN** your response
- **EVALUATE**: What is/isn't working?
- **LOOK AHEAD**: How will you lift restrictions safely?
ATTACHMENT 5: DSHS Healthcare Personnel Return to Work Strategies - Updated May 4, 2020

TEST-BASED STRATEGY FOR HEALTHCARE PERSONNEL RETURN TO WORK

Adapted from the Tennessee Department of Health Guidance applies to both confirmed and probable cases

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 respiratory specimens collected ≥24 hours apart (total of two negative specimens).

- Onset date
- Afebrile with improvement of symptoms
- Second negative specimen collected at least 24 hours after first
- Case released from isolation and may return to work

ASYMPTOMATIC CASES

Must be isolated and excluded from work until after receiving negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens).1

If the HCP develops symptoms, they should follow instructions above for “symptomatic cases.”

- Date of positive result
- No symptoms develop
- Second negative specimen collected at least 24 hours after first
- Case released from isolation and may return to work

1Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

ADDITIONAL INFORMATION

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

After returning to work, 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 at baseline.
- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms occur, recur, or worsen.
NON-TEST-BASED STRATEGIES FOR HEALTHCARE PERSONNEL RETURN TO WORK

Adapted from the Tennessee Department of Health Guidance applies to both confirmed and probable cases

SYMPTOMATIC CASES
Symptom-Based Strategy
Must be isolated and excluded from work for a minimum of 10 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 10.
- 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.
- A case that is well on day 10 and afebrile and feeling well for 72 hours can be released on day 13 and may return to work.

ASYMPTOMATIC CASES
Time-Based Strategy
Must be isolated and 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 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, 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 at baseline.
- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms occur, recur, or worsen.

Version 2.2 - Released 5/19/2020
ATTACHMENT 6: Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19

TEST-BASED STRATEGY: DISCONTINUATION OF TRANSMISSION-BASED PRECAUTIONS AND DISPOSITION OF RESIDENTS WITH COVID-19 (Preferred)

Must be isolated 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).

Onset date

Afebrile with improvement of symptoms

Second negative specimen collected at least 24 hours after first

First negative specimen

Case released from isolation

NON-TEST-BASED STRATEGY: DISCONTINUATION OF TRANSMISSION-BASED PRECAUTIONS AND DISPOSITION OF RESIDENTS WITH COVID-19

Must be isolated for a minimum of 10 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 until day 10.
- A case that is well on day 7 and afebrile and feeling well for 72 hours can be released on day 10.
- A case that is well on day 9 and afebrile and feeling well for 72 hours can be released on day 12.

Onset date

10 days

Case released from isolation

+ Afebrile and feeling well for at least 72 hours
The practice of wearing the same facemask for repeated close contact with several different residents, without removing the facemask between resident encounters.

- Staff should take care not to touch their facemask.
- If staff touch or adjust their facemask, they must immediately perform hand hygiene.

- Staff should leave the resident care area if they need to remove the facemask.

- Carefully fold so the outer surface is held inward and against itself to reduce contact with the outer surface during storage.
- Folded facemask can be stored between uses in a clean sealable paper bag or breathable container.

- Remove and discard if facemask is soiled, damaged, or hard to breathe through.
Example of a damaged facemask.
HOW TO WEAR A MEDICAL MASK SAFELY

**Do's**

- Wash your hands before touching the mask
- Inspect the mask for tears or holes
- Find the top side, where the metal piece or stiff edge is
- Ensure the colored-side faces outwards
- Place the metal piece or stiff edge over your nose
- Cover your mouth, nose, and chin
- Adjust the mask to your face without leaving gaps on the sides
- Avoid touching the mask
- Remove the mask from behind the ears or head
- Keep the mask away from you and surfaces while removing it
- Discard the mask immediately after use preferably into a closed bin
- Wash your hands after discarding the mask

**Don’ts**

- Do not use a ripped or damp mask
- Do not wear the mask only over mouth or nose
- Do not wear a loose mask
- Do not touch the front of the mask
- Do not remove the mask to talk to someone or do other things that would require touching the mask
- Do not leave your used mask within the reach of others
- Do not re-use the mask

Remember that masks alone cannot protect you from COVID-19. Maintain at least 1 metre distance from others and wash your hands frequently and thoroughly, even while wearing a mask.
ATTACHMENT 8: PPE Donning and Doffing Infographic

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN
   • Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
   • Fasten in back of neck and waist

2. MASK OR RESPIRATOR
   • Secure ties or elastic bands at middle of head and neck
   • Fit flexible band to nose bridge
   • Fit snug to face and below chin
   • Fit-check respirator

3. GOGGLES OR FACE SHIELD
   • Place over face and eyes and adjust to fit

4. GLOVES
   • Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

• Keep hands away from face
• Limit surfaces touched
• Change gloves when torn or heavily contaminated
• Perform hand hygiene
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)

EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES
   - Outside of gloves are contaminated!
   - If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
   - Hold removed glove in gloved hand
   - Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
   - Discard gloves in a waste container

2. GOGGLES OR FACE SHIELD
   - Outside of goggles or face shield are contaminated!
   - If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Remove goggles or face shield from the back by lifting head band or ear pieces
   - If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. GOWN
   - Gown front and sleeves are contaminated!
   - If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Unfasten gown ties, taking care that sleeves don’t contact your body when reaching for ties
   - Pull gown away from neck and shoulders, touching inside of gown only
   - Turn gown inside out
   - Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR
   - Front of mask/respirator is contaminated — DO NOT TOUCH!
   - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
   - Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)
EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. **GOWN AND GLOVES**
   - Gown front and sleeves and the outside of gloves are contaminated!
   - If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
   - While removing the gown, fold or roll the gown inside-out into a bundle
   - As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

2. **GOGBLES OR FACE SHIELD**
   - Outside of goggles or face shield are contaminated!
   - If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Remove gogles or face shield from the back by lifting head band and without touching the front of the gogles or face shield
   - If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. **MASK OR RESPIRATOR**
   - Front of mask/respirator is contaminated — **DO NOT TOUCH!**
   - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
   - Discard in a waste container

4. **WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE**

**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE**
ATTACHMENT 9: User Seal Check – Infographic

Filtering out Confusion:
Frequently Asked Questions about Respiratory Protection

User Seal Check

Over 5 million United States employees in approximately 1.5 million workplaces are required to wear respiratory protection. The Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires an annual fit test to confirm the fit of any respirator that forms a tight seal on the wearer’s face before it is used in the workplace. Once a fit test has been done to determine the best respirator model and size for a particular user, a user seal check should be done every time the respirator is to be worn to ensure an adequate seal is achieved.

What is a User Seal Check?

A user seal check is a procedure conducted by the respirator wearer to determine if the respirator is being properly worn. The user seal check can either be a positive pressure or negative pressure check.

During a positive pressure user seal check, the respirator user exhales gently while blocking the paths for air to exit the facepiece. A successful check is when the facepiece is slightly pressurized before increased pressure causes outward leakage.

During a negative pressure user seal check, the respirator user inhales sharply while blocking the paths for air to enter the facepiece. A successful check is when the facepiece collapses slightly under the negative pressure that is created with this procedure.

A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual.

How do I do a User Seal Check while Wearing a Filtering Facepiece Respirator?

Not every respirator can be checked using both positive and negative pressure. Refer to the manufacturer’s instructions for conducting user seal checks on any specific respirator. This information can be found on the box or individual respirator packaging.

The following positive and negative user seal check procedures for filtering facepiece respirators are provided as examples of how to perform these procedures.

[Image: CDC NIOSH logo]
How to do a positive pressure user seal check

Once the particulate respirator is properly donned, place your hands over the facepiece, covering as much surface area as possible. Exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure is being built up inside the facepiece without any evidence of outward leakage of air at the seal. Examples of such evidence would be the feeling of air movement on your face along the seal of the facepiece, fogging of your glasses, or a lack of pressure being built up inside the facepiece.

If the particulate respirator has an exhalation valve, then performing a positive pressure check may be impossible. In such cases, a negative pressure check should be performed.

How to do a negative pressure user seal check

Negative pressure seal checks are typically conducted on particulate respirators that have exhalation valves. To conduct a negative pressure user seal check, cover the filter surface with your hands as much as possible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece.

In the case of either type of seal check, if air leaks around the nose, use both hands to readjust the nosepiece by placing your fingertips at the top of the metal nose clip. Slide your fingertips down both sides of the metal strip to more efficiently mold the nose area to the shape of your nose. Readjust the straps along the sides of your head until a proper seal is achieved.\(^2\)

If you cannot achieve a proper seal due to air leakage, you may need to be fit tested for a different respirator model or size.

Can a user seal check be considered a substitute for a fit testing?

No. The user seal check does not have the sensitivity and specificity to replace either fit test methods, qualitative or quantitative, that are accepted by OSHA (29 CFR 1910.134). A user should only wear respirator models with which they have achieved a successful fit test within the last year. NIOSH data suggests that the added care from performing a user seal check leads to higher quality donnings (e.g., reduces the chances of a donning with a poor fit).\(^3\)

Where can I Find More Information?

This information and more is available on the NIOSH Respirator Trusted-Source webpage.

References
3. This document is in the public domain and may be freely copied or reprinted.

References

To locating NIOSH documents or more information about occupational safety and health topics, please contact NIOSH at:

Telephone: 1-800-35-NIOSH (1-800-356-4674) or 1-800-356-4674. NIOSH@cdc.gov. www.cdc.gov/niosh. www.osha.gov/niosh. For more information, go to the NIOSH website (www.cdc.gov/niosh).
ATTACHMENT 10: Three Key Factors Required for a Respirator to be Effective - Infographic

Three Key Factors Required for a Respirator to be Effective

1. The respirator must be put on correctly and worn during the exposure.

2. The respirator must fit snugly against the user’s face to ensure that there are no gaps between the user’s skin and respirator seal.

3. The respirator filter must capture more than 95% of the particles from the air that passes through it.

*If your respirator has a metal bar or a molded nose cushion, it should rest over the nose and not the chin area.
ATTACHMENT 11: Isolation Planning in ICF Homes

 PRIOR TO
 COVID-19 Diagnosis

The time to begin planning is BEFORE a resident is diagnosed with COVID-19.

 WHERE
 will you isolate
 a COVID + individual?

• Is there a room you can repurpose?
• Can you make an arrangement with another ICF?

 WHO
 will provide care?

• Can you dedicate certain staff to provide care?
• Keep staff who provide care to resident with COVID-19 from working at other ICFs if possible.

 HOW
 will you ensure infection control?

• Train staff on infection control.
• Provide hygiene supplies and PPE.
Upon COVID-19 Diagnosis

**MOVE** resident’s personal belongings to designated area

**TRANSFER** resident to designated area

**NOTIFY** local health department or DHSS; notify HHSC

**TEST** all residents and staff
After Recovery

Clean & Disinfect resident's personal belongings

Transfer resident & belongings out of isolation

Monitor resident for signs/symptoms

Clean & Disinfect isolation room
ATTACHMENT 12: List of Referenced Resources

ASPR TRACIE

COVID-19 Workforce Virtual Toolkit

CDC

CDC LTC Webinar Series:

- Clean Hands
- Closely Monitor Residents
- Keep COVID-19 Out
- PPE Lessons
- Sparkling Surfaces
- Cleaning and Disinfecting Your Facility

Interim Infection Prevention and Control Recommendations for Residents with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings


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

Preparing for COVID-19: Long-term Care Facilities

Strategies for Optimizing the Supply of Facemasks

Strategies to Optimize the Supply of PPE and Equipment

Strategies for Optimizing the Supply of Isolation Gowns

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Symptoms of Coronavirus

<added> Guidance for Group Homes for Individuals with Disabilities <added>

<added> Guidance for Direct Service Providers <added>

<added> Guidance for Direct Service Providers, Caregivers, Parents, and People with Developmental and Behavioral Disorders <added>
CMS

1135 Waivers


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

EPA

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

HHSC

CII – Reporting to HHSC

LTCR Regional Contact Information

PL 20-18 Guidance on COVID-19 Response in Intermediate Care Facilities

NIOSH

Proper N95 Respirator Use for Respiratory Protection Preparedness - includes respirator use during a serious outbreak condition

User Seal Check - N95 respirator

OOG

Governor Abbott’s Executive Orders

OSHA

OSHA Respiratory Protection Training Videos, including:

- Respiratory Protection for Healthcare Workers
- The Differences Between Respirators and Surgical Masks
- Respirator Safety: Donning & Doffing
- Respirator Types
• Respirator Fit Testing
• Maintenance and Care of Respirators
• Medical Evaluations
• Respiratory Protection Training Requirements
• Voluntary Use of Respirators
• Counterfeit and Altered Respirators: The Importance of NIOSH Certification
• OSHA Respiratory Protection Standard (29 CFR §1910.134)

**U.S. HHS**

The Difference Between Isolation and Quarantine

This section is new.

**WHO**

• Visual Tools
ATTACHMENT 13: 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. DSP – Direct Support Staff
8. EMS – Emergency medical services
9. EPA – Environmental Protection Agency
10. HA – Health authority
11. HHSC – Texas Health and Human Service Commission
12. IPC – Infection prevention and control
13. ICF – Intermediate Care Facility
14. IDD – Intellectual or Developmental Disability
15. LHA – Local health authority
16. LHD – Local health department
17. LTC – Long-term care
18. LTCF – Long-term care facility
19. LTCR – Long-term Care Regulatory
20. LVN – Licensed vocational nurse
21. OSHA – Occupational Safety and Health Administration
22. POC – Point of contact
23. PPE – Personal protective equipment
24. QIDP – Qualified Intellectual Disability Professional
25. RN – Registered nurse
26. SME – Subject Matter Expert
27. SSLC – State Supported Living Center
28. TCAT – Texas COVID-19 Assistance Team
29. <added> W.H.O – World Health Organization <added>