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.
Contents

POINTS OF CONTACT FOR THIS DOCUMENT ................................................................. 3
TABLE OF CHANGES ....................................................................................................... 4
I. Purpose: ....................................................................................................................... 5
II. Goals: ......................................................................................................................... 5
III. To Do’s for ICFs: ..................................................................................................... 5
IV. S.P.I.C.E. .................................................................................................................. 7
V. HHSC Long-term Care Regulatory Activities with ICFs that Have Positive COVID-19 Cases .................................................. 7
VI. Facility Activities Required for LTC COVID-19 Response ...................................... 8
VII. State\Regional\Local Support ................................................................................ 10
Texas COVID-19 Assistance Team - LTC................................................................... 10
ATTACHMENT 1: Immediate Response Guidelines ...................................................... 11
FACILITY ACTIONS ...................................................................................................... 11
HHSC ACTIONS .......................................................................................................... 12
EXTERNAL ACTIONS .................................................................................................... 12
ATTACHMENT 2: SPICE Graphic ................................................................................ 13
ATTACHMENT 3: Interim Guidance for Prevention, Management, and Reporting of Coronavirus Disease 2019 (COVID-19) Outbreaks in Long-Term Care Facilities and Other Communal Living Settings ........................................... 14
Purpose ..................................................................................................................... 14
Background .............................................................................................................. 14
Immediate Prevention Measures ................................................................................ 14
Provide Supplies for Recommended Infection Prevention and Control Practices ........... 17
Control Measures for Residents .............................................................................. 18
Control Measures for Staff ....................................................................................... 20
Reporting COVID-19 ............................................................................................... 23
Outbreak Management ............................................................................................. 23
ATTACHMENT 4: Facility Actions for COVID-19 Response - Infographic ...................... 26
ATTACHMENT 5: DSHS Healthcare Personnel Return to Work Strategies - Updated May 4, 2020 .................................................. 27
ATTACHMENT 6: Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19 29
ATTACHMENT 7: Isolation Planning in ICF Homes ....................................................... 31
ATTACHMENT 8: List of Referenced Resources ............................................................ 34
ASPR TRACIE .............................................................................................................. 34
CDC .............................................................................................................................. 34
CMS ............................................................................................................................ 34
DSHS .......................................................................................................................... 35
EPA ............................................................................................................................. 35
POINTS OF CONTACT FOR THIS DOCUMENT

Texas Health and Human Services Commission
Regulatory Services Division

Michelle Dionne-Vahalik, DNP, RN
Associate Commissioner, LTCR
To activate SWAT assistance
Michelle.dionne-vahalik@hhsc.state.tx.us
Phone: 512-962-3260

Renee Blanch-Haley, BSN, RN
Director of Survey Operations,
LTCR Survey Operations
Renee.Blanch-Haley@hhsc.state.tx.us
Phone: 512-571-2163

Cecilia Cavuto
Intermediate Care Facility, Policy
Manager Contact for Policy and Rule
Cecilia.Cavuto@hhsc.state.tx.us
Phone: 512-650-6401
# TABLE OF CHANGES

<table>
<thead>
<tr>
<th>Document Version</th>
<th>Date</th>
<th>Change</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td>05/06/2020</td>
<td>5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 25,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>guidance in attachments 4, 5, 6, 7, 8, 9 and 10 added, and contents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>reorganized for clarity</td>
<td></td>
</tr>
</tbody>
</table>


I. 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.

II. 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

III. To Do’s for ICFs:

- 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 resident isolation or quarantine plans with staff.
- Review handwashing, surface cleaning, and other environmental hygiene precautions with staff.
- Report a confirmed COVID-19 case to the local health department or DSHS and 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.
- 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 to the best of their ability.
- Clean and disinfect the facility when 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 21 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.

IV. S.P.I.C.E.

Recognizing notification of a potential COVID-19 situation in a facility can result in disorientation, questions, and confusion; this document suggests 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.

V. 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 amounts of 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 test 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.

VI. 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

Immediate (0-24 hours)

- Activate resident Isolation/facility cohort plan, including establishing a unit, wing, group of rooms, room or area for any positive residents.
- Supply PPE to care for residents positive for COVID-19
- Screen residents for signs and symptoms
- Screen staff for signs and symptoms
• Enact infection control procedures
• Conduct cleaning and sanitization
• Confirm case definitions
• Identify direct support professional (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
• Notify HHSC and 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
• 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 residents for symptoms
• Continue cleaning and disinfection procedures
• Activate resident 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

VII. State\Regional\Local Support

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

• Developing 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 departments (as applicable) and emergency management (as applicable). This team will assist ICFs with management of a COVID-19 event through provision of subject matter expertise, resource request management, and 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.
ATTACHMENT 1: Immediate Response Guidelines

IMMEDIATE ACTIONS (0-24 hours)

FACILITY ACTIONS

РЕVIEW 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
SPICE for COVID-19

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

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

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

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

**Evaluate**
- Review 0-24-hour checklist
- Prevent delay of critical actions
- Communication plan
ATTACHMENT 3: Interim Guidance for Prevention, Management, and Reporting of Coronavirus Disease 2019 (COVID-19) Outbreaks in Long-Term Care Facilities and Other Communal Living Settings

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 direct support staff (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, the CMS released a memorandum directing all ICFs to restrict visitors except those 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 visitation except in certain end-of-life situations.
End-of-life care is provided 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.

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

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

5. When visitation is necessary or allowable (in end-of-life scenarios 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 one and others while in the facility. Practice social distancing by not shaking hands or hugging and remaining 6 feet apart.
   b. If possible (pending design of building), create 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 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 the Centers for Disease Control and Prevention (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 entering the facility before their shift for fever or other symptoms consistent with COVID-19. Actively take their temperature and document the absence of or indication of shortness of breath, new or change in cough, or 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.

DSHS has created a [screening log template](#) for facility staff. Facilities should also screen any 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:
  o 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).
  o 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 door 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 Respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested DSP)
  - Gowns
  - Gloves
  - Eye protection (face shield or goggles).
• Consider implementing a respiratory protection program compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
• Environmental cleaning and disinfection:
  - Make sure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
  - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA’s emerging viral pathogens program for use against SARS-CoV-2.

Control Measures for Residents

Most of the actions 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. Actively monitor all residents upon admission and at least daily for fever and respiratory symptoms (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.

**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 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 personnel when encountering the resident.

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

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

**Source control** - 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.

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). 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.

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.

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 care of a resident. The recovery plan may be different depending on whether a test-based or non-test-based strategy is used. Criteria should include:

- Discontinuation of transmission-based precautions without testing.
- Discontinuation of transmission-based precautions with testing.
- Whether using a testing-based strategy for discontinuation of transmission-based precautions is preferred.

Control Measures for Staff

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

Ensure that supplies for performing hand hygiene are readily available and easily accessible by staff. Advise staff not to keep hand sanitizer bottles in their pockets. This practice causes hands and sanitizer bottles to become contaminated. Instead, consider keeping alcohol-based hand rub (ABHR) bottles in easily accessible areas and 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, the CDC recommends staff adhere to standard and transmission-based precautions. If the facility does not have a supply of N95 masks, or does not have any fit-tested staff,
alternative facemasks must be worn. Follow the CDC Interim Infection Prevention and Control Recommendations for Residents with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings, which includes detailed information regarding recommended PPE.

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

**Dedicated staff/COVID-19 response teams** - Facilities can consider establishing COVID-19 care teams to dedicate 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 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.

**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 strategy as the preferred method 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 ICF settings.

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 (preferred) 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, 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.

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 appropriate use of facemask 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 respirators 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.


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 information (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.
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.

**Activities Required for COVID-19 Response**

**BEFORE THE FIRST CASE**
- **PREPARE**
  - 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.

**IMMEDIATELY 0-24 HOURS**
- **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?

**EXTENDED 24-72 HOURS**
- **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

**LONG-TERM 72 HOURS+**
- **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

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

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 excluded from work until 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). If the HCP develops symptoms, they should self-isolate and follow instructions above for "symptomatic cases."

Date of positive result → No symptoms develop → First negative specimen → Second negative specimen collected at least 24 hours after first → Case 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.

Version 2.0 - Released 5/4/2020
NON-TEST-BASED STRATEGIES FOR HEALTHCARE PERSONNEL RETURN TO WORK
Adapted from the Tennessee Department of Health

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.

Case released from isolation and may return to work

+ Afebrile with improved symptoms for at least 72 hours

Onset date

Minimum 10 days

(or specimen collection date if onset unclear)

ASYMPTOMATIC CASES
Time-Based Strategy

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

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

Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

Case released to return to work

Date of positive result

10 days

No symptoms develop

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.
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).

**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.
ATTACHMENT 7: Isolation Planning in ICF Homes

**PRIOR TO COVID-19 Diagnosis**

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

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

**WHERE will you isolate a COVID + individual?**

- 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.

**WHO will provide care?**

- Train staff on infection control.
- Provide hygiene supplies and PPE.

**HOW will you ensure infection control?**
Upon COVID-19 Diagnosis

MOVE resident's personal belongings to designated area

TRANSFER resident to designated area

NOTIFY local health department or DSHS; 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 8: 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


Preparing for COVID-19: Long-term Care Facilities, Nursing Homes

Strategies for Optimizing the Supply of Facemasks

Strategies to Mitigate Healthcare Personnel Staffing Shortages

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

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
ATTACHMENT 9: 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 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. SSLC – State Supported Living Center
26. SME – Subject Matter Expert
27. RN – Registered nurse
28. SME – Subject matter expert
29. TCAT – Texas COVID-19 Assistance Team
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.

IV. 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.

V. 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.

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 11: Extended Response Guidelines (To Be Developed)
ATTACHMENT 12: Recovery Guidelines (To Be Developed)