RESOURCES FOR A LONG-TERM CARE COMMUNITY IN CRISIS
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*This toolkit will be updated as new resources become available.*
Coronavirus Disease 2019 (COVID-19) FAQs

What is coronavirus disease 2019?
Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China. The virus that causes COVID-19 is known as SARS-CoV-2. The virus originated from an animal source but is now transferring from person to person.

Can I get COVID-19?
Yes. COVID-19 is spreading from person to person. Risk of infection from the virus that causes COVID-19 is higher for people who have been exposed to someone known to have COVID-19, for example healthcare workers or household members who are living or working in close proximity to infected people. Other people at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.

Learn more about places with ongoing spread by clicking here. COVID-19 cases have been reported in all 50 states, the District of Columbia, and multiple U.S. territories; many having wide-spread community transmission (the VDH Updates on Virginia cases). Based on available data, older adults and people of any age who have a serious underlying medical condition might be at higher risk for severe illness from COVID-19 (especially those with immunocompromising conditions or respiratory conditions). Given the high risk of spread once COVID-19 enters a long term care, facilities must act immediately to protect residents, families, and staff from serious illness, complications, and death.

How does COVID-19 spread?
The virus is spreading easily and sustainably between people. It is thought to spread mainly between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs, talks or sneezes. It also may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. The virus is thought to live on surfaces for at minimum a few hours and up to a few days if not disinfected properly. Some people without symptoms may be able to spread the virus. Learn what is known about the spread of newly emerged coronaviruses by clicking here.
Coronavirus Disease 2019 (COVID-19) Resources

Symptoms of COVID-19

Prevent the Illness

Steps to help prevent the spread of COVID-19 if you are sick

What should I do if I recently traveled from an area with ongoing spread of COVID-19?

Is there a vaccine?
There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to take everyday preventive actions, like avoiding close contact with people who are sick and washing your hands often.

Is there a treatment?
To date, there is no vaccine and no specific antiviral medicine to prevent or treat COVID-19. Most people (about 80%) recover from the disease without needing special treatment. Patients infected with COVID-19 should receive supportive care to relieve symptoms, while patients with serious illness should be hospitalized. Currently, possible vaccines and some specific drug treatments are under investigation.

How can we keep LTCF residents social engaged while social distancing?
AARP has compiled a list of resources, tool and guidance related to mental health, having fun at in place, educational resources, using technology to stay connected, health and fitness, and food and nutrition.

- VDH COVID-19 FAQs for Long-Term Care Facilities
- VDH printable Resources and Infographics

Preparing for COVID-19: Long-term Care Facilities, Nursing Homes
A new respiratory disease – coronavirus disease 2019 (COVID-19) – is spreading globally and there have been instances of COVID-19 community spread in the United States. The general strategies CDC recommends to prevent the spread of COVID-19 in LTC are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza.

- Preparedness Checklist
- Key Strategies to Prepare for COVID-19 in LTC
- Interim Guidance for Nursing Homes
- Things Facilities Should Do Now
- When There Are Cases in the Community

Symptoms of respiratory infection, including COVID-19:
- Fever
- Cough
- Shortness of breath

Long-term care facilities concerned that a resident, visitor, or employee may be a COVID-2019 patient under evaluation should contact their local health department immediately for consultation and guidance.

**Preparation Checklist for COVID-19 in Nursing Homes and other Long-Term Care Settings**

Nursing homes and other long-term care facilities can take steps to assess and improve their preparedness for responding to coronavirus disease 2019 (COVID-19). This CDC Checklist should be used as one tool to develop a comprehensive COVID-19 response plan, including plans for:

- Rapid identification and management of ill residents
- Considerations for visitors and consultant staff
- Supplies and resources
- Sick leave policies and other occupational health considerations
- Education and training
- Surge capacity for staffing, equipment and supplies, and postmortem care

The checklist identifies key areas that long-term care facilities should consider in their COVID-19 planning. Long-term care facilities can use this tool to self-assess the strengths and weaknesses of current preparedness efforts. This checklist does not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19.

**Key Strategies to Prepare for COVID-19 in LTCF (4/15/2020)**

COVID-19 cases have been reported in all 50 states, the District of Columbia, and multiple U.S. territories: many having wide-spread community transmission.
Given the high risk of spread once COVID-19 enters a LTCF, facilities must act immediately to protect residents, families, and staff from serious illness, complications, and death.

1. **Keep COVID-19 from entering your facility:**
   - Restrict all visitors except for compassionate care situations (e.g., end-of-life).
   - Restrict all volunteers and non-essential healthcare personnel (HCP), including consultant services (e.g., barber, hairdresser).
   - Implement universal use of source control for everyone in the facility.
   - Actively screen anyone entering the building (HCP, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift; send ill personnel home. Sick leave policies should be flexible and non-punitive.
   - Cancel all field trips outside of the facility.

2. **Identify infections early:**
   - Actively screen all residents daily for fever and symptoms of COVID-19; if symptomatic, immediately isolate and implement appropriate Transmission-Based Precautions.
     - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
   - Notify your local health department immediately (<24 hours) if these occur:
     - Severe respiratory infection causing hospitalization or sudden death
     - Clusters (≥3 residents and/or HCP) of respiratory infection
     - Individuals with suspected or confirmed COVID-19

3. **Prevent spread of COVID-19:**
   - Actions to take now:
     - Cancel all group activities and communal dining.
     - Enforce social distancing among residents.
     - Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments.
     - Ensure all HCP wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.
   - If COVID-19 is identified in the facility, restrict all residents to their rooms and have HCP wear all recommended PPE for care of all residents.
(regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off.

- This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop.
- When a case is identified, public health can help inform decisions about testing asymptomatic residents on the unit or in the facility.

4. **Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:**

   - Access [CDC Personal Protective Equipment (PPE) Burn Rate Calculator](https://www.cdc.gov/)
   - If you anticipate or are experiencing PPE shortages, reach out to your local healthcare coalition.
   - Consider extended use of respirators, facemasks, and eye protection or prioritization of gowns for certain resident care activities.

5. **Identify and manage severe illness:**

   - Designate a location to care for residents with suspected or confirmed COVID-19, separate from other residents.
   - Monitor ill residents (including documentation of temperature and oxygen saturation) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.

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**Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes**

4/2020 Summary of Changes to the Guidance:
• Act now to implement ALL COVID-19 preparedness recommendations, even before cases are identified in their community
• Address asymptomatic and pre-symptomatic transmission, implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms.
  o Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Facemasks, if available, should be reserved for HCP.
  o For visitors and residents, a cloth face covering may be appropriate. If a visitor or resident arrives to the facility without a cloth face covering, a facemask may be used for source control if supplies are available.
• Dedicate an area of the facility to care for residents with suspected or confirmed COVID-19; consider creating a staffing plan for that specific location

COVID-19 cases have now been reported in all 50 states and DC; with many areas having wide-spread community transmission, including in many communities in Virginia. Given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from severe infections, hospitalizations, and death. It is likely that the virus will be identified in more communities, including areas where cases have not yet been reported. As such, nursing homes should assume it could already be in their community and follow the above recommendations.

**Background**
Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at the highest risk of being affected by COVID-19. If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness.

**Visitor Restrictions**
Ill visitors and healthcare personnel (HCP) are the most likely sources of introduction of COVID-19 into a facility. CDC recommends aggressive visitor restrictions and enforcing sick leave policies for ill HCP, even before COVID-19 is identified in a community or facility.

**These recommendations supplement** CDC’s [Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-prevention-control-patients.html). These recommendations are specific for nursing homes, including skilled nursing facilities. Much of this information could also be applied in assisted living facilities. This information complements, but does not replace, the general [infection prevention and control recommendations](https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html) for COVID-19.

This guidance is based on the currently available information about COVID-19. It will be refined and updated as more information becomes available and as response needs change in the United States. It is important to understand transmission dynamics in your
community to inform strategies to prevent introduction or spread of COVID-19 in your facility. Consultation with public health authorities can help you better understand if transmission of COVID-19 is occurring in your community.

**Things facilities should do now:**

*Educate Residents, Healthcare Personnel, and Visitors*

- Review CDC's *Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings*.
- Educate and train HCP.
  - Reinforce sick leave policies. Remind HCP not to report to work when ill.
  - Educate them about new policies for source control while in the facility.
  - Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE.
- Educate both facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers. Including consultants is important because they often provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.
- Educate residents and families including:
  - information about COVID-19
  - actions the facility is taking to protect them and their loved ones, including visitor restrictions
  - actions residents and families can take to protect themselves in the facility emphasizing the importance of social distancing, hand hygiene, respiratory hygiene and cough etiquette, and wearing a cloth face covering.

*Provide Supplies for Recommended Infection Prevention and Control Practices*

- Hand Hygiene Supplies:
  - Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory Hygiene and Cough Etiquette:
  - Tissues and trash cans are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
- Personal Protective Equipment (PPE):
  - Assess the CDC PPE Burn Rate Calculator.
Identify your health department or healthcare coalition contacts for getting assistance during PPE shortages.

Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.

- Implement strategies to optimize current PPE supply even before shortages occur
  - Bundling resident care and treatment activities to minimize entries into resident room (e.g., having clinical staff clean and disinfect high-touch surfaces when in the room)
  - Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
    - Extreme care must be taken to avoid touching the respirator, facemask or eye protection. If this must occur, HCP should perform hand hygiene immediately before and after contact to prevent contaminating themselves or others.
  - Prioritizing gowns for activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP.
  - Developing a process for decontamination and reuse of PPE such as face shields and goggles

- Make necessary PPE available in areas where resident care is provided.
  - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.
  - Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).

- Position 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.

Environmental Cleaning and Disinfection:

- Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas;
- Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- Refer to List Nexternal icon on the EPA website for EPA-registered disinfectants that have qualified under EPA’s emerging viral pathogens program for use against SARS-CoV-2.

Assessing Risk & Possible Restrictions for HCP

**Evaluate and Manage HCP with Symptoms of Respiratory Illness**

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill HCP to stay home.
- As part of routine practice, ask HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection.
  - Remind HCP to stay home when they are ill.
  - If HCP develop fever or symptoms of respiratory infection while at work, they should keep their facemask on, inform their supervisor, and leave the workplace.
  - HCP with suspected COVID-19 should be prioritized for testing.
- Screen all HCP at the beginning of their shift for fever and respiratory symptoms.
  - Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and leave the workplace.
  - HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.
- Facilities should develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
  - CDC has created guidance to assist facilities with mitigating staffing shortages.
  - For guidance on when HCP with suspected or confirmed COVID-19 may return to work refer to Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance).
- Restrict nonessential healthcare personnel (including consultant personnel) and volunteers for entering the building.
  - Consider implementing telehealth to offer remote access to care activities.
- As part of source control efforts, HCP should wear a facemask or cloth face covering at all times while they are in the healthcare facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of COVID-19 (as supply allows). Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.
  - All HCP should be reminded to practice social distancing when in break rooms or common areas.

**When to End Transmission-Based Precautions**
Refer to the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19.

**Policies and Procedures for Visitors**
- Because of the ease of spread in a long-term care setting and the severity of illness that occurs in residents with COVID-19, facilities should immediately restrict all visitation to their facilities except certain compassionate care situations, such as end of life situations.
  - Send letters or emails to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations. Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.
  - Post signs at the entrances to the facility advising that no visitors may enter the facility.
  - Decisions about visitation during an end of life situation should be made on a case by case basis, which should include careful screening of the visitor for fever or respiratory symptoms. Those with symptoms should not be permitted to enter the facility. Those visitors that are permitted must wear a facemask while in the building and restrict their visit to the resident’s room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.
    - Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.

**Resources for Confirmed or Suspected COVID-19**
- Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19)
- Evaluating and Reporting Persons Under Investigation (PUI)
- Respiratory infection surveillance in long-term care facilities during an outbreak

**Evaluate and Manage Residents with Symptoms of Respiratory Infection**
- 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 (T≥100.0°F) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, implement Transmission-Based Precautions as described below.
  - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or clusters (≥ 3 residents or HCP) with new-onset respiratory symptoms within 72 hours of each other.
- Contact information for the healthcare-associated infections program in each state health department is available – Virginia Contact: Sarah Lineberger, MPH Sarah.Lineberger@vdh.virginia.gov

- In general, when caring for residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis). This includes restricting residents with respiratory infection to their rooms. If they leave the room, residents should wear a facemask (if tolerated) or use tissues to cover their mouth and nose.
  - Continue to assess the need for Transmission-Based Precautions as more information about the resident’s suspected diagnosis becomes available.

- If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community,
  - Facilities should notify the local health department immediately and follow the Interim Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings, which includes detailed information regarding recommended PPE. Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated.
  - Residents with suspected COVID-19 should be prioritized for testing
  - Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
    - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
    - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
  - 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 that is capable of implementation. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.
  - While awaiting transfer, residents should wear a cloth face covering or facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed)
  - All recommended PPE should be used by healthcare personnel when coming in contact with the resident.

Additional Measures

- Cancel communal dining and all group activities, such as internal and external activities.
• Remind residents to practice social distancing and perform frequent hand hygiene.
• Create a plan for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units.

In addition to the actions described above, these are things facilities should do when there are cases in their facility or sustained transmission in the community.

Healthcare Personnel Monitoring and Restrictions:

• Implement universal use of facemask for HCP while in the facility.
• Consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator or, if not available, a facemask) for the care of all residents, regardless of presence of symptoms. Implement protocols for extended use of eye protection and facemasks.

Resident Monitoring and Restrictions:

• Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes.
  o If they leave their room, residents should wear a facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others).
• Implement protocols for cohorting ill residents with dedicated HCP.
Healthcare Professional Preparedness Checklist for Transport and Arrival of
Patients with Confirmed or Possible COVID-19:

Front-line healthcare personnel in the United States should be prepared to evaluate
patients for coronavirus disease 2019 (COVID-19). The following checklist highlights
key steps for healthcare personnel in preparation for transport and arrival of patients
with confirmed or possible COVID-19.

Stay up to date on the latest information about signs and symptoms, diagnostic testing,
and case definitions for coronavirus disease 2019.

Review your infection prevention and control policies and CDC infection control
recommendations for COVID-19 for:
  o Know who, when, and how to seek evaluation by occupational health following
    an unprotected exposure (i.e., not wearing recommended PPE) to a suspected or
    confirmed coronavirus disease 2019 patient.
  o Assessment and triage of patients with acute respiratory symptoms
  o Patient placement
  o Implementation of Standard, Contact, and Airborne Precautions, including the
    use of eye protection
  o Visitor management and exclusion
  o Source control measures for patients (e.g., put facemask on suspect patients)
  o Requirements for performing aerosol generating procedures
  o Be alert for patients who meet the persons under investigation (PUI) definition
  o Know how to report a potential COVID-19 case or exposure to facility infection
    control leads and public health officials.
  o Remain at home, and notify occupational health services, if you are ill.
  o Know how to contact and receive information from your state or local public
    health agency.
Virginia Updated Guidance on Testing for COVID-19

The Virginia Department of Health (VDH) continues to update its guidance in response to this emerging, rapidly evolving situation.

In the setting of limited availability of tests, testing performed at DCLS, Virginia’s state lab, is reserved for patients who meet VDH’s four priority investigation criteria below. If you have a patient who meets VDH criteria, please request testing via the [online COVID-19 Testing Request Form](https://example.com). If you are unable to submit your request online, please contact your [local health department](https://example.com).

1. Healthcare worker or first responder with fever OR signs/symptoms of a lower respiratory illness.
2. Potential cluster of unknown respiratory illness, with priority for healthcare facility outbreaks. All suspected clusters or outbreaks should be reported to the local health department immediately.
3. Person hospitalized with fever OR signs of lower respiratory illness. Priority will be given to patients where circumstances require a confirmed COVID-19 diagnosis for compassionate use treatment with antivirals.
4. Person who resides or works in a congregate setting (e.g., homeless shelter, assisted living facility, group home, prison, detention center, jail, or nursing home) AND who has fever or signs/symptoms of a lower respiratory illness.

For other patients who need COVID-19 testing, please contact a private laboratory to ask about how to submit specimens for testing. VDH approval is not needed for testing at private labs.

If a clinician suspects COVID-19 and public health resources are not available for testing, clinicians should:

- Take appropriate [infection control precautions](https://example.com) in the healthcare setting.
- Advise patients with mild illness to isolate at home, according to [CDC recommendations](https://example.com).
- Advise the patient to call the healthcare provider if symptoms worsen.
- Advise the patient to get medical attention immediately if the patient develops emergency warning signs, which include, but are not limited to, trouble breathing, persistent pain or pressure in the chest, new confusion or inability to arouse, or bluish lips or face.

Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Even if testing is being pursued at a private laboratory, VDH strongly recommends that clinicians use the priority investigation criteria listed above to conserve resources (e.g., personal protective equipment and specimen collection supplies). Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). There are epidemiologic factors that may also help guide decisions about COVID-19 testing. Documented COVID-19 infections in a jurisdiction and known community transmission may contribute to an epidemiologic risk.
assessment to inform testing decisions. Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).

Clinical diagnosis of COVID-19 is a reportable condition, regardless of whether testing is pursued or not. Clinicians should utilize the VDH Online Morbidity Report Portal to report individual cases that do not meet the criteria for DCLS testing noted above.

**OLC Facility Reported Incident Form:** Nursing Homes are required to report COVID-19 cases to the local health department. The OLC is also requesting that facilities submit a Facility Reported Incident (FRI) form when either a resident or staff tests positive for COVID-19.

For more information, refer to the CDC guidance about evaluating and testing persons for COVID-19. Virginia’s local health departments do not provide primary care and thus are not equipped to clinically evaluate patients with respiratory symptoms.

**Planning for a COVID-19 Outbreak in Your Community**

**Overview:** Communication specific to coronavirus, caregiving, and older adults is a dynamic situation. The points below provide a framework for organizations developing messaging for media consumption and/or responding to press queries about diagnosed cases of COVID-19 in their organization. Tailor the content below, as needed, to your setting.

**Guiding principles:** The spread of coronavirus is a public health emergency. Transparency and open communication are crucial to establishing your organization’s credibility and ensuring that each of your audiences (i.e., the older adults living in your community and their families, your staff and your larger community, local public health officials and the general public), know the facts and view your organization as a trusted source of information. **It is crucial to tell the truth, tell it first, tell it fully, and tell it fast.**

**Prepare.** Anticipate what you will need should reporters call. Answer the following:

- Who will be your spokesperson? (Pick only one.)
- What is your message?
- What audiences need to be addressed, and in what order? (i.e., patients, patient families, board members, staff, public, media, etc.)
- What will the process be to create and approve messaging, and then distributed?
- Who will have approval to create and distribute messaging; who in your organization must approve the message prior to it being made public?
- What channels will be used to distribute (email, social media, website)?
- If you intend to push your message out to the media, what outlets and reporters can be tapped? (if you have time and the desire to proactively reach out to media with whom you have established relationships)
• Plan to inform staff that any queries about the case must be directed to your organization’s designated media spokesperson when word of a diagnosed case is shared with residents/clients, families, staff and others in your community. You want to maintain control of the message.

• Anticipate follow up questions that may be asked after the diagnosed case is announced and develop a Frequently Asked Questions (FAQ) document.

NOTE:

○ While you do not have to disclose ALL details of the situation (i.e., where/how the person became infected, the person’s state of health, etc.) in your public statement, you should be prepared to respond to any question, and those responses should have the same approvals as the statement.

○ If you do not know the answer to an anticipated question, it is appropriate to say, “At this time, we do not have the answer to your question. We will provide updates as we learn more,” and then be sure to provide updates when you have them.

Execute:

• **Message:** Keep the language simple and straightforward. Provide facts without violating privacy. Explain the steps your organization is taking to care for the sick person and to contain the virus’ spread amongst each of your audiences (i.e. other residents/clients; families and visitors; your staff; vendors; etc.). Emphasize your organization’s collaboration with public health organizations.

○ **SAMPLE:** “A [resident/client we serve/staff member] of [insert organization name] has been diagnosed with COVID-19. The [resident/client we serve/staff member] is in [what: quarantined at home/in the hospital]. We have notified public health officials as required and are following procedures recommended by the Centers for Disease Control & Prevention.”

• **Timing:** News spreads fast. You can anticipate a call moments after learning about the diagnosis yourself. Prepare a short statement for use in the event of a diagnosed case; have approvals in place so that you can take action if necessary. When a case is diagnosed, proactive media outreach is not necessary, however you should be prepared to make a statement and be transparent. Make it easy to find information about the situation on your website with the name of your spokesperson.

Follow-up: Prepare to update your statement as the situation changes. (E.g., new cases, no more cases, etc.). You can also reasonably expect that a reporter will follow-up with you regularly. If you have promised to provide updates to reporters, do so.

Re-group: After the situation has passed, plan a time to regroup with your team to assess how the plan was executed including how to improve your processes for a future crisis event.
CDC Resources

- CDC: Preparing for COVID-19: Long-term Care Facilities, Nursing Homes
- Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings
- CDC Coronavirus Disease 2019 (COVID-19) Situation Summary
- CDC in Action: Preparing Communities for Potential Spread of COVID-19
- CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings
- CDC Printable Fact Sheets for the Public

Virginia Department of Health (VDH) & State Resources

- VDH Clinician Memos
- COVID-19 in Virginia
- COVID-19 in Long-Term Care Facilities
- Confidential Morbidity Report
- Electronic Death Registration System
- Facility Reported Incident (FRI) Form
- Guidance on Testing for COVID-19
- Health Department Locator
- Local Health Districts
- Health Districts Directors Contact Information
- Health Professions Guidance (including guidance documents and tools)
- Outbreak Reporting Requirements for Facilities and Programs
- Out-of-State Licensed Provider Reporting
- Testing Capability at Private Laboratories
- Virginia Healthcare Alerting & Status System (VHASS)
- Virginia Regional Healthcare Coalition Contact Information
- Virginia State Board of Health: Rules & Regulations of the Board of Health
- Virginia Volunteer Health System

LeadingAge National Provider or Setting-Specific Resources

- Affordable Housing
- Assisted Living Communities
- Home Health
- Hospice
- Life Plan Communities
- Nursing Homes
TEN INITIAL STEPS for Long-term Care Facilities with a confirmed Case of COVID-19

1. BREATHE
   Take a deep breath and stay calm; remind staff to do the same and to not spread fear or confidential information.

2. ISOLATE
   Place positive resident in an airborne isolation room with a private bathroom if available. If one isn’t available, use a private room and keep the door closed.

3. PROTECT
   Ideally, wear gown, gloves, goggles or face shield and an N95 or higher respirator for all resident care. If respirator supply is limited, wear facemasks for routine care and implement contingency capacity strategies as per CDC.¹

4. CONTAIN
   Restrict all residents to their room. No visitation.

5. NOTIFY
   Contact your regulatory agency and your local health department or call 1-877-PA-HEALTH.

6. INFORM
   Communicate to all staff, residents and family members. A sample letter is available². Identify a person who will be taking inquiry calls.

7. TRACK
   Use the COVID-19 Symptomatic Line List Template², or similar tool, to track symptomatic residents and staff.

8. SCREEN
   Begin active screening of all residents every 8 hours. Use the guidance for Active Screening².

9. ASSESS
   Assess current supply of PPE, hand hygiene products, and environmental cleaning products. Report immediate needs to your healthcare coalition.

10. PLAN
    Activate your incident command structure and identify an Incident Commander; post contact information in nursing station and be ready to share with DOH.

² https://paltc.org/COVID-19
Dear Residents, Families, Friends, Volunteers:

We are committed to keeping our residents safe and we need your help. The virus causing Coronavirus Disease 2019 (abbreviated COVID-19) can cause outbreaks in nursing homes. Many of our residents are elderly and may have medical conditions putting them at a very high risk of becoming sick, or even severely ill, with COVID-19. Visitors and healthcare personnel (HCP) are the most likely sources of introduction of the virus that causes COVID-19 into a facility.

To protect our vulnerable residents, even before COVID-19 is seen in our community, we are immediately taking the following aggressive actions to reduce the risk of COVID-19 in our residents and staff:

1. **Effective immediately: We are restricting all visitation.** All visitation is being restricted except for certain compassionate care situations, such as end of life situations. These visitors will first be screened for fever and respiratory symptoms. We know that your presence is important for your loved one but, per guidance from the Centers for Disease Control and Prevention (CDC), this is a necessary action to protect their health. We are introducing alternative methods of visitation (such as Skype and FaceTime) so that you can continue to communicate with your loved ones. Visitors who are permitted to enter the building will be required to frequently clean their hands, limit their visit to a designated area within the building, and wear a facemask. As the situation with COVID-19 is rapidly changing, we will continue to keep you updated.

2. **We are monitoring healthcare personnel and residents for symptoms of respiratory illness.** Non-essential healthcare personnel and volunteers are now restricted from entering the facility. Healthcare personnel will be actively monitored for fever and symptoms of respiratory infection. Ill healthcare personnel will be asked to stay home. You may see healthcare personnel wearing facemasks, eye protection, gown, and gloves in order to prevent germs from spreading and help keep residents safe. Healthcare personnel will clean their hands frequently.

   We are assessing residents daily for fevers and symptoms of respiratory infection in order to quickly identify ill residents and implement additional infection prevention activities. When ill residents are identified, they will be monitored closely, asked to stay in their rooms or wear a mask.

3. **We are limiting activities within the facility.** We are cancelling all group activities within the building and all community outings. We will be helping residents to practice social distancing, including during meals, and to frequently clean their hands.
We encourage you to review the CDC website for information about COVID-19, including its symptoms, how it spreads, and actions you can take to protect your health.

Thank you very much for everything you are doing to keep our residents and facility staff safe and healthy. We continue to monitor the situation in our community; we will keep you informed about any new precautions we think are necessary to keep your loved one safe.

Please contact us with additional questions at …Sincerely, …

SAMPLE TEMPLATE: Letter to Families Following Positive Diagnosis

Insert Facility Name/Logo
Insert Date

Dear Resident & Family,

Insert Facility Name is concerned for the ongoing welfare, safety, and health of our residents. The Virginia Department of Health, the Centers for Disease Control and Prevention (CDC), and local health departments are monitoring the outbreak of a new virus, COVID-19. The people most likely to become severely ill from COVID-19 are older adults and those with underlying medical conditions.

This letter is to alert you that on Insert Date we learned that one or more of our staff members/one or more of our residents developed COVID-19. We are actively monitoring our residents for signs and symptoms of COVID-19 and are working with our local and state health departments.

All of our staff members continue to follow public health recommendations to reduce the risk of spreading COVID-19. These include strict handwashing procedures, and in many circumstances, wearing facemasks, gowns, and gloves when interacting with residents who are sick.

To minimize the risk of our residents becoming sick with COVID-19, we are suspending all visits to Insert Facility Name. This decision is being made in accordance with recommendations from the Centers for Medicare & Medicaid Services (CMS). We understand that connecting with family members is important. Other ways to connect include telephone, email, text, or through Skype or Facebook.

For the most up-to-date information on this topic, please visit the CDC website at http://www.cdc.gov/covid19.

Thank you for your patience and understanding.

Sincerely, Administrator
SAMPLE TEMPLATE: GENERAL FACEBOOK ANNOUNCEMENT

The news is full of stories about coronavirus or COVID-19. Westminster Canterbury Richmond wants to assure you that we are proactively preparing should the coronavirus COVID-19 reach our region. In the meantime, you can help limit the spread by following these steps from the World Health Organization. If you’re sick, please stay home, rest up and plan to visit us when you’re all better. *(include image of the above recommendations)*
Policy Statement
[facility name’s] Infection Control Program (ICP), includes policies and procedures to assist in preventing transmission of COVID-19 into the [facility name] campus. In the event a transmission occurs, prompt detection and effective triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among additional residents, employees, and visitors.

[facility name] recognizes its high-risk population and, as such, the actions listed below will be implemented, and [facility name] will further coordinate the ICP and Emergency Preparedness (EP) plans to address COVID-19. These policies and practices are based on Infection Prevention and Control recommendations from the Centers for Disease Control (CDC), Iowa Department of Public Health (IDPH) and the World Health Organization (WHO) and is based on the currently limited information available about coronavirus disease 2019 (COVID-19) related to disease severity, transmission efficiency, and shedding duration. According to the CDC, their guidance is applicable to all U.S. healthcare settings and subject to change as more information becomes available. [facility name] will monitor the CDC website routinely and update this policy as needed.

Background
Coronavirus disease 2019 (COVID-19) is a respiratory disease first detected in China. Early on, many of the patients in the epicenter of the outbreak in Wuhan, Hubei Province, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside of Hubei and in countries outside China, including the United States (US). To date, imported, person-to-person, and community spread cases have been identified in the US.

Community spread means some people have been infected and it is not known how or where they became exposed. The virus that causes COVID-19 seems to be spreading easily and sustainably in the community (“community spread”). Current symptoms reported for patients with COVID-19 have included mild to severe respiratory illness with fever, cough, and difficulty breathing. It has also been determined older adults and individuals with severe chronic medical conditions, such as heart, lung or kidney disease, are higher risk for more serious COVID-19 (Control, 2020).

Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the
mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely.

Some spread might be possible before people show symptoms; there have been reports of this occurring with this new coronavirus, but this is not thought to be the main way the virus spreads. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. The virus that causes COVID-19 seems to be spreading easily and sustainably in the community (“community spread”) in some affected geographic areas.

**Definitions**

**Airborne precautions** refer to actions taken to prevent or minimize the transmission of infections agents/organisms that remain infections over long distances when suspended in the air. These particles can remain suspended in the air for prolonged periods of time and can be carried on normal air currents in a room or beyond, to adjacent spaces or areas receiving exhaust air.

**Close contact** for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the resident; or sitting within 6 feet of the resident in a healthcare common area or room); or b) having unprotected direct contact with infectious secretions or excretions of the resident (e.g., being coughed on, touching used tissues with a bare hand).

**Cohorting** is the practice of grouping residents infected with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. During outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission.

**Droplet precautions** refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.

**Healthcare Personnel (HCP):** For the purposes of this document HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to residents or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

**Isolation** means the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease.
Personal protective equipment (PPE) are protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. This includes but is not limited to gloves, gowns, goggles, facemasks, or respirators.

Standard precautions are infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infections agents.

Transmission based precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission.

Defining HCP Exposure Risk Categories and Appropriate PPE
While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit, and urine, might put HCP at risk of COVID-19. According to CDC guidance, high-risk exposures refer to HCP who performed or were present in the room for treatments or procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, nebulizer therapy, sputum induction) on residents with COVID-19 when the healthcare providers’ eyes, nose, or mouth were not protected. When high-risk treatments or procedures are completed by a [facility name] staff member, the following PPE will be required: gloves, gown, goggles and respirator. While a respirator is preferred in high-risk exposure situations, if a respirator is not available, a facemask may be used.

Medium-risk exposures generally include HCP who had prolonged close contact with residents with COVID-19 where HCP mucous membranes were exposed to material potentially infectious with the virus causing COVID-19. These scenarios involve interactions with symptomatic residents who were not wearing a facemask for source control. Because these exposures do not involve treatments or procedures that generate aerosols, they pose less than that described under high-risk. When a [facility name] staff member is involved in medium-risk exposure situations, the following PPE will be required: gloves, gown, goggles and respirator. While a respirator is preferred in medium-risk exposure situations, if a respirator is not available, a facemask may be used.

Low-risk exposures generally refer to brief interactions with residents with COVID-19 or prolonged close contact with residents who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to
a facemask or respirator would further lower the risk of exposure. When a [facility name] staff member is involved in low-risk exposure situations, the following PPE will be required: gloves, gown, goggles and facemask.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with residents infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures HCP should still perform self-monitoring with delegated supervision.

HCP with no direct resident contact and no entry into active resident management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have no identifiable risk.)

**Preventing the Introduction of COVID-19 into our Campus**

I. The primary goal of [facility name] is to prevent COVID-19 from being introduced within our campus. Prevention efforts include:

a. Following **Standard Precautions**, which are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where health care is delivered. These practices are designed to both protect HCP; and prevent HCP from spreading infections among residents. Standard Precautions include —

   i. Hand hygiene - washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand rub that contains at least 60% alcohol before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.

      - Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

      - If hands are visibly soiled, staff will use soap and water before returning to alcohol-based hand rub.

   ii. Use of personal protective equipment (e.g., gloves, gowns, masks, eyewear) when there is an expectation of possible exposure to infectious material.

   iii. Respiratory hygiene/cough etiquette principles.

   iv. Properly handle and properly clean and disinfect patient care equipment and instruments/devices.

   v. Clean and disinfect the environment appropriately; and in accordance with [facility name’s] environmental services policy.

   vi. Handle textiles and laundry carefully; and in accordance with [facility name’s] linen handling policy.

b. Providing training and education for staff, residents, and visitors on COVID-19 to include prevalence, signs and symptoms, standard
precautions, and the [facility name] Infection Control and Emergency Preparedness plans. Additionally, on:
   i. Avoiding touching eyes, nose, and mouth with unwashed hands.
   ii. Avoiding close contact with people who are sick; and
   iii. Maintaining social distances, when possible, of 6 feet or greater.

c. Following CMS’ recommendations for restricting visitors.
d. Reminding employees to stay home if they are experiencing fever and respiratory symptoms.
e. Ongoing communication with residents, employees, and resident representatives/families.
f. Monitoring residents (current and new admissions) and employees for fever or respiratory symptoms, such as, cough, or shortness of breath.
   i. If symptoms are identified, move to action steps to prevent the spread of respiratory germs within the [facility name] campus to include restricting residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask, if tolerated.

Preventing the Spread of COVID-19 Within our Campus

II. In the event COVID-19 is introduced within the [facility name] campus, our efforts will transition to preventing the COVID-19 from spreading. Prevention efforts will include:

   a. Following Standard Precautions for all residents, which are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where health care is delivered. These practices are designed to both protect HCP and prevent HCP from spreading infections among residents. Standard Precautions include —

      i. Hand hygiene - washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand rub that contains at least 60% alcohol before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.
         - Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
         - If hands are visibly soiled, staff will use soap and water before returning to alcohol-based hand rub.

t. Use of personal protective equipment (e.g., gloves, gowns, masks, eyewear) when there is an expectation of possible exposure to infectious material.

   iii. Respiratory hygiene/cough etiquette principles.
   iv. Properly handle and properly clean and disinfect patient care equipment and instruments/devices.
   v. Clean and disinfect the environment appropriately; and in accordance with [facility name’s] environmental services policy.
vi. Handle textiles and laundry carefully; and in accordance with [facility name's] linen handling policy.

AND

b. Following **Transmission Based Precautions**, which are the second tier of basic infection control and are to be used in addition to Standard Precautions for **residents who are suspected or confirmed to have COVID-19**, for which additional precautions are needed to prevent infection transmission. There are three types of transmission-based precautions--contact, droplet, and airborne. The CDC is documenting the COVID-19 as droplet, however, the contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. Therefore, [facility name] will implement all three types of Transmission Based Precautions with resident's who are suspected or confirmed with COVID-19. Specifically, respirators will be used when available and resident room doors will be closed as able. Transmission Based Precautions include -

i. **[facility name] will ensure appropriate resident placement (isolation)** in a single resident space/private room if available. If private rooms are unavailable, the IDT will make room placement decisions balancing risks to other residents; and by cohorting impacted residents.
   - Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with the Infection Preventionist and the local health department
     a. Factors that should be considered include presence of symptoms related to COVID-19 infection, date symptoms resolved, other conditions that would require specific precautions (e.g., MRSA, *Clostridioides difficile*), other laboratory information reflecting clinical status.

ii. **[facility name] will use personal protective equipment (PPE) appropriately.** Donning PPE upon room entry and properly discarding before exiting the resident room is done to contain pathogens. In the event there is a shortage of PPE, [facility name] will contact the VDH by calling 877-ASK-VDH3 for assistance and guidance. PPE use will include:
   - Donning clean, non-sterile gloves upon entry into the resident room or care area.
   - Changing gloves if they become torn or heavily contaminated.
   - Removing and discarding gloves when leaving the resident room or care area, and immediately performing hand hygiene.
- Donning a clean isolation gown upon entry into the resident room or care area.
- Changing the gown if it becomes soiled.
- Removing and discarding the gown in a dedicated container for waste or linen before leaving the resident room or care area.
- Disposable gowns will be discarded after use.
- If there are shortages of gowns, they will be prioritized for:
  a. aerosol-generating procedures
  b. care activities where splashes and sprays are anticipated
  c. high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
     i. dressing
     ii. bathing/showering
     iii. transferring
     iv. providing hygiene
     v. changing linens
     vi. changing briefs or assisting with toileting
     vii. device care or use
     viii. wound care
- Donning a respirator or facemask (if a respirator is not available) before entry into the patient room or care area.
  a. N95 respirators or respirators that offer a higher level of protection will be used instead of a facemask when performing or present for an aerosol-generating/high-risk procedure.
- Disposable respirators and facemasks will be removed and discarded after exiting the resident’s room or care area.
- Resident doors will be closed unless there are safety considerations (the IDT will determine safety exclusions to closing the resident’s door).
- Performing hand hygiene after discarding the respirator or facemask.
- If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they will be cleaned and disinfected according to manufacturer’s reprocessing instructions prior to re-use.
- [facility name] will refer to the following guidance on extended use of respirators: Strategies to Optimize the Current Supply of N95 Respirators.
- Donning eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the resident room or care area.
a. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- Removing eye protection before leaving the resident room or care area.
- Reusable eye protection (e.g., goggles) will be cleaned and disinfected according to manufacturer’s reprocessing instructions prior to re-use.
- Disposable eye protection will be discarded after use.

iii. [facility name] will limit the transport and movement of residents who are suspected or confirmed with COVID-19 outside of their room to medically necessary purposes. When transport or movement is necessary, the following steps will occur:
- The resident will use a facemask (as tolerated). If the resident cannot tolerate a facemask, they should use tissues to cover their mouth and nose.
- Staff will remove and dispose of contaminated PPE and perform hand hygiene prior to transporting residents on Transmission Based Precautions.
- Staff will don clean PPE to handle the resident at the transport location.
- In the event a resident requires transfer to the hospital, the EMS and Hospital ED will be notified of the resident’s COVID-19 status.

iv. [facility name] will use disposable or dedicated resident-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple residents is unavoidable, the equipment will be cleaned and disinfected before use on another resident.

v. [facility name] will prioritize cleaning and disinfection of the rooms of residents on Transmission Based Precautions ensuring rooms are frequently cleaned and disinfected (e.g., at least daily focusing on frequently touched surfaces and equipment in the immediate vicinity of the resident).

vi. [facility name] will ensure only essential personnel should enter the room and will implement staffing policies to minimize the number of HCP who enter the room (dedicated staff assignments).

vii. [facility name] will keep a log of all persons who care for or enter the rooms or care areas of impacted residents.

Postmortem Care

III. In the event a resident with suspected or confirmed COVID-19 expires while at [facility name],
a. The [facility name] Administrator, Infection Preventionist or designee will notify the resident’s physician and the VDH by calling 877-ASK-VDH3
i. All recommendations from the IDPH will be implemented.
b. The following PPE will be worn during post-mortem care.
i. Gloves, gown, facemask, and goggles
   - The goal is to protect the face, eyes, nose, and mouth from splashes of potentially infectious body fluids. Additionally, if the staff member has cuts or wounds on their hands, double gloving is recommended.

c. Upon receiving the order to transfer the resident’s body to the mortuary, [facility name] staff will inform the mortuary of the resident’s suspected or confirmed COVID-19 status and provide the mortuary with VDH by calling 877-ASK-VDH3 to allow the mortuary to seek guidance.
   i. The staff will greet the mortuary at the [facility name] entrance to screen the mortuary staff for potential COVID-19 and to ensure they perform hand hygiene and to provide them with necessary PPE.

References

Sample COVID-19 Infection Control Policy

Policy Statement

[facility name’s] Infection Control Program (ICP), includes policies and procedures to assist in preventing transmission of COVID-19 into the [facility name] campus. In the event a transmission occurs, prompt detection and effective triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among additional residents, employees, and visitors. [facility name] recognizes its high-risk population and, as such, the actions listed below will be implemented, and [facility name] will further coordinate the ICP and Emergency Preparedness (EP) plans to address COVID-19. These policies and practices are based on Infection Prevention and Control recommendations from the Centers for Disease Control (CDC), Iowa Department of Public Health (IDPH) and the World Health Organization (WHO) and is based on the currently limited information available about coronavirus disease 2019 (COVID-19) related to disease severity, transmission efficiency, and shedding duration. According to the CDC, their guidance is applicable to all U.S. healthcare settings and subject to change as more information becomes available. [facility name] will monitor the CDC website routinely and update this policy as needed.

Background

Coronavirus disease 2019 (COVID-19) is a respiratory disease first detected in China. Early on, many of the patients in the epicenter of the outbreak in Wuhan, Hubei Province, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside of Hubei and in countries outside China,
including the United States (US). To date, imported, person-to-person, and community spread cases have been identified in the US. **Community spread** means some people have been infected and it is not known how or where they became exposed. The virus that causes COVID-19 seems to be spreading easily and sustainably in the community (“community spread”). Current symptoms reported for patients with COVID-19 have included mild to severe respiratory illness with fever, cough, and difficulty breathing. It has also been determined older adults and individuals with severe chronic medical conditions, such as heart, lung or kidney disease, are higher risk for more serious COVID-19 (Control, 2020).

Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely.

Some spread might be possible before people show symptoms; there have been reports of this occurring with this new coronavirus, but this is not thought to be the main way the virus spreads. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. The virus that causes COVID-19 seems to be spreading easily and sustainably in the community (“community spread”) in some affected geographic areas.

**Definitions**

**Airborne precautions** refer to actions taken to prevent or minimize the transmission of infectious agents/organisms that remain infectious over long distances when suspended in the air. These particles can remain suspended in the air for prolonged periods of time and can be carried on normal air currents in a room or beyond, to adjacent spaces or areas receiving exhaust air.

**Close contact** for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the resident; or sitting within 6 feet of the resident in a healthcare common area or room); or b) having unprotected direct contact with infectious secretions or excretions of the resident (e.g., being coughed on, touching used tissues with a bare hand).

**Cohorting** is the practice of grouping residents infected with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. During outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission.
**Droplet precautions** refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.

**Essential Staff** refer to staff needed to ensure the health and safety of all individuals under the care or services of the organization. This should include all staff as any staff can assist critical care staff with non-nursing duties.

**Healthcare Personnel (HCP):** For the purposes of this document HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to residents or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

**Isolation** means the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease.

**Personal protective equipment (PPE)** are protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. This includes but is not limited to gloves, gowns, goggles, facemasks, or respirators.

**Standard precautions** are infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infections agents.

**Transmission based precautions** are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission.

**Defining HCP Exposure Risk Categories and Appropriate PPE**

While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit, and urine, might put HCP at risk of COVID-19.

According to CDC guidance, **high-risk** exposures refer to HCP who performed or were present in the room for treatments or procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, nebulizer therapy, sputum induction) on residents with COVID-19 when the healthcare providers’ eyes, nose, or mouth were not protected. When high-risk
treatments or procedures are completed by a [facility name] staff member, the following PPE will be required: gloves, gown, goggles and respirator. While a respirator is preferred in high-risk exposure situations, and respirators should be prioritized for high-risk treatments and procedures that are likely to generate respiratory aerosols, a facemask is an acceptable alternative and may be used in the event respirator supply is unavailable.

Medium-risk exposures generally include HCP who had prolonged close contact with residents with COVID-19 where HCP mucous membranes were exposed to material potentially infectious with the virus causing COVID-19. These scenarios involve interactions with symptomatic residents who were not wearing a facemask for source control. Because these exposures do not involve treatments or procedures that generate aerosols, they pose less than that described under high-risk. When a [facility name] staff member is involved in medium-risk exposure situations, the following PPE will be required: gloves, gown, goggles and respirator. While a respirator is preferred in medium-risk exposure situations, if a respirator is not available, a facemask may be used.

Low-risk exposures generally refer to brief interactions with residents with COVID-19 or prolonged close contact with residents who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure. When a [facility name] staff member is involved in low-risk exposure situations, the following PPE will be required: gloves, gown, goggles and facemask.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with residents infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures HCP should still perform self-monitoring with delegated supervision.

HCP with no direct resident contact and no entry into active resident management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have no identifiable risk.)

Preventing the Introduction of COVID-19 into our Campus

1. The primary goal of [facility name] is to prevent COVID-19 from being introduced within our campus. Prevention efforts include:
   a. Following Standard Precautions, which are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where health care is delivered. These practices are designed to both protect HCP; and prevent HCP from spreading infections among residents. Standard Precautions include —
i. Hand hygiene - washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand rub that contains at least 60% alcohol before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.
   - Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
   - If hands are visibly soiled, staff will use soap and water before returning to alcohol-based hand rub.

ii. Use of personal protective equipment (e.g., gloves, gowns, masks, eyewear) when there is an expectation of possible exposure to infectious material.

iii. Respiratory hygiene/cough etiquette principles.

iv. Properly handle and properly clean and disinfect patient care equipment and instruments/devices.

v. Clean and disinfect the environment appropriately; and in accordance with [facility name’s] environmental services policy.

vi. Handle textiles and laundry carefully; and in accordance with [facility name’s] linen handling policy.

b. Providing training and education for staff, residents, and visitors on COVID-19 to include prevalence, signs and symptoms, standard precautions, and the [facility name] Infection Control and Emergency Preparedness plans. Additionally, on:
   i. Avoiding touching eyes, nose, and mouth with unwashed hands.
   ii. Avoiding close contact with people who are sick; and
   iii. Maintaining social distances, when possible, of 6 feet or greater.

c. Following CMS’ recommendations for restricting visitors.

d. Reminding employees to stay home if they are experiencing fever and respiratory symptoms, and follow the CDC guidance on staff to return to work as indicated.

e. Ongoing communication with residents, employees, and resident representatives/families.

f. Monitoring residents (current and new admissions) and employees for fever or respiratory symptoms, such as, cough, or shortness of breath.
   i. If symptoms are identified, move to action steps to prevent the spread of respiratory germs within the [facility name] campus to include restricting residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask, if tolerated.
Preventing the *Spread* of COVID-19 Within our Campus

II. In the event COVID-19 is introduced within the [facility name] campus, our efforts will transition to preventing the COVID-19 from spreading. Prevention efforts will include:

a. Following **Standard Precautions for all residents**, which are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where health care is delivered. These practices are designed to both protect HCP and prevent HCP from spreading infections among residents. Standard Precautions include —
   i. **Hand hygiene** - washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand rub that contains at least 60% alcohol before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.
      - Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
      - If hands are visibly soiled, staff will use soap and water before returning to alcohol-based hand rub.
   ii. Use of personal protective equipment (e.g., gloves, gowns, masks, eyewear) when there is an expectation of possible exposure to infectious material.
   iii. Respiratory hygiene/cough etiquette principles.
   iv. Properly handle and properly clean and disinfect patient care equipment and instruments/devices.
   v. Clean and disinfect the environment appropriately; and in accordance with [facility name's] environmental services policy.
   vi. Handle textiles and laundry carefully; and in accordance with [facility name's] linen handling policy.

**AND**

b. Following **Transmission Based Precautions**, which are the second tier of basic infection control and are to be used in addition to Standard Precautions for **residents who are suspected or confirmed to have COVID-19**, for which additional precautions are needed to prevent infection transmission. There are three types of transmission-based precautions—contact, droplet, and airborne. The CDC is documenting the COVID-19 as droplet, however, the contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. Therefore, [facility name] will implement all three types of Transmission Based Precautions with resident’s who are suspected or confirmed with COVID-19. Specifically,
respirators will be used when available and resident room doors will be closed as able. Transmission Based Precautions include -

i. **[facility name] will ensure appropriate resident placement (isolation)** in a single resident space/private room if available. If private rooms are unavailable, the IDT will make room placement decisions balancing risks to other residents; and by cohorting impacted residents.

   - Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with the Infection Preventionist and the Nebraska Department of Health and Human Services by calling [insert number].

   a. Factors that should be considered include presence of symptoms related to COVID-19 infection, date symptoms resolved, other conditions that would require specific precautions (e.g., MRSA, *Clostridioides difficile*), other laboratory information reflecting clinical status.

ii. **[facility name] will use personal protective equipment (PPE) appropriately.** Donning PPE upon room entry and properly discarding before exiting the resident room is done to contain pathogens. In the event there is a shortage of PPE, [facility name] will contact the Local Department of Public Health by calling [insert number] for assistance and guidance. PPE use will include:

   - Donning clean, non-sterile gloves upon entry into the resident room or care area.
   - Changing gloves if they become torn or heavily contaminated.
   - Removing and discarding gloves when leaving the resident room or care area, and immediately performing hand hygiene.
   - Donning a clean isolation gown upon entry into the resident room or care area.
   - Changing the gown if it becomes soiled.
   - Removing and discarding the gown in a dedicated container for waste or linen before leaving the resident room or care area.
   - Disposable gowns will be discarded after use.
   - If there are shortages of gowns, they will be prioritized for:
     a. aerosol-generating procedures
     b. care activities where splashes and sprays are anticipated
     c. high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
i. dressing
ii. bathing/showering
iii. transferring
iv. providing hygiene
v. changing linens
vi. changing briefs or assisting with toileting
vii. device care or use
viii. wound care

- Donning a respirator or facemask (if a respirator is not available) before entry into the patient room or care area.
  a. N95 respirators or respirators that offer a higher level of protection will be used instead of a facemask when performing or present for an aerosol-generating/high-risk procedure.

- Disposable respirators and facemasks will be removed and discarded after exiting the resident’s room or care area.

- Resident doors will be closed unless there are safety considerations (the IDT will determine safety exclusions to closing the resident’s door).

- Performing hand hygiene after discarding the respirator or facemask.

- If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they will be cleaned and disinfected according to manufacturer’s reprocessing instructions prior to re-use.

- [facility name] will refer to the following guidance on extended use of respirators: Strategies to Optimize the Current Supply of N95 Respirators.

- Donning eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the resident room or care area.
  a. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.

- Removing eye protection before leaving the resident room or care area.

- Reusable eye protection (e.g., goggles) will be cleaned and disinfected according to manufacturer’s reprocessing instructions prior to re-use.

- Disposable eye protection will be discarded after use.


iii. [facility name] will limit the transport and movement of residents who are suspected or confirmed with COVID-19 outside of their room to medically necessary purposes. When transport or movement is necessary, the following steps will occur:
- The resident will use a facemask (as tolerated). If the resident cannot tolerate a facemask, they should use tissues to cover their mouth and nose.
- Staff will remove and dispose of contaminated PPE and perform hand hygiene prior to transporting residents on Transmission Based Precautions.
- Staff will don clean PPE to handle the resident at the transport location.
- In the event a resident requires transfer to the hospital, the EMS and Hospital ED will be notified of the resident’s COVID-19 status.

iv. [facility name] will use disposable or dedicated resident-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple residents is unavoidable, the equipment will be cleaned and disinfected before use on another resident.

v. [facility name] will prioritize cleaning and disinfection of the rooms of residents on Transmission Based Precautions ensuring rooms are frequently cleaned and disinfected (e.g., at least daily focusing on frequently touched surfaces and equipment in the immediate vicinity of the resident).

vi. [facility name] will ensure only essential personnel should enter the room and will implement staffing policies to minimize the number of HCP who enter the room (dedicated staff assignments).

vii. [facility name] will keep a log of all persons who care for or enter the rooms or care areas of impacted residents.

Postmortem Care

III. In the event a resident with suspected or confirmed COVID-19 expires while at [facility name],
   a. The [facility name] Administrator, Infection Preventionist or designee will notify the resident’s physician and the Nebraska Department of Health and Human Services, Division of Public Health by calling [insert number].
      i. All recommendations from the Nebraska Department of Health and Human Services, Division of Public Health.
   b. The following PPE will be worn during post-mortem care.
      i. Gloves, gown, facemask, and goggles
         - The goal is to protect the face, eyes, nose, and mouth from splashes of potentially infectious body fluids. Additionally, if the staff member has cuts or wounds on their hands, double gloving is recommended.
      ii. Upon receiving the order to transfer the resident’s body to the mortuary, [facility name] staff will inform the mortuary of the resident’s suspected or confirmed COVID-19 status and provide the mortuary with the Nebraska Department of Health and Human
Services, Division of Public Health [insert number] to allow the mortuary to seek guidance.

iii. The staff will greet the mortuary at the [facility name] entrance to screen the mortuary staff for potential COVID-19 and to ensure they perform hand hygiene and to provide them with necessary PPE.
SAMPLE POLICIES: CONTAINMENT STRATEGIES IN AN INFLUENZA PANDEMIC

A. CONTAINMENT STRATEGIES

A.1 General Infection Control
In general, facilities shall be kept clean and sanitized. Steps will be taken to educate residents, staff and visitors about fundamental control measures. Reminders about such measures will be posted in visible locations throughout our facilities.

Hand Hygiene
Hand washing and sanitizing are critical. Staff, residents and all visitors are encouraged to wash their hands frequently, especially when they are visibly soiled or have come in contact with mucous or other bodily secretions. When soap and water are not readily available, use an alcohol-based (60-percent alcohol) hand sanitizer when hands are not visibly soiled. If hands are visibly soiled, they must be washed with soap and water.

Respiratory Etiquette
Staff, visitors and residents will be educated on proper respiratory etiquette. All will be reminded to about the “sleeve sneeze” and coughing into the elbow. Signs shall be posted throughout our facilities and tissues and wastebaskets will be provided.

If someone is in a group and cannot be removed, the individual shall use a surgical mask (unless the individual cannot tolerate it or it interferes with the person’s breathing). This will help decrease the spread of droplets to others by coughing.

Social Distancing
Influenza is transmitted by droplets from the respiratory system, especially when you cough or sneeze, but can even be transmitted through speaking or singing. These droplets usually do not travel more than three feet from the person coughing, sneezing, etc., and therefore, keeping a “social distance” of three feet among the residents can reduce the spread of influenza.

Rotating times in common areas will be established so they are not as crowded. Residents shall be placed at least three feet apart at mealtimes or during therapy.

Contaminated Surfaces:
It is critical to clean all surfaces that are suspected to be contaminated by a pandemic strain of influenza. Frequently touched surfaces such as counters,
tabletops, doorknobs, telephones, TV knobs, computer keyboards, etc., shall be wiped down and disinfected frequently.

Some routine cleaning procedures may be temporarily discontinued because they might help spread the Influenza virus (like vacuuming or dusting) or due to staffing limitations. See Appendix B for additional cleaning tasks and other measures for reducing the spread of the disease.

A.2 Non-Pharmaceutical Interventions (NPI) and Containment during a Pandemic

A.2.1. Reduction of Social Interactions
During a pandemic, staff will be reminded that they conduct a vital service for others and therefore should reduce their exposure to other persons, whether they are known to be sick or not, wherever possible.

Steps will be taken to limit our residents’ exposure, including the following:

- The resident Admission Agreement provisions for advance notification of discharge will be waived for residents wishing to move home with families or friends.
- Unnecessary travel by residents will be cancelled.
- Trips for nonessential medical appointments will be cancelled.
- Activity trips may be cancelled.
- Group activities may be cancelled.
- The Dining Room may be closed thereby requiring all meals to be served in the resident rooms. When residents must be taken out of the facility, they may be required to wear a surgical mask and latex gloves during the entire time they are away.

A.2.2. Self-Isolation
Our goal will be that sick visitors, staff and volunteers must be kept out. Signs and placards will be posted at all entrances. Families, friends, delivery and repair personnel, volunteers and staff must understand and respect this goal.

Persons who have been exposed to flu or who reasonably suspect that they have been exposed should also stay out of the facility. The following message will shall be communicated to all visitors and staff:

“If you have the flu or if you think you might have the flu or if you have been exposed to someone who has the flu (or even if you have been exposed to someone who became ill within two days of your exposure to them), PLEASE STAY OUT. If you MUST enter, please wear a mask, wash your hands frequently and avoid breathing or coughing/sneezing near anyone else. Please leave as soon as possible.”
Additional procedures that may be implemented include:

- We will request that there be no visitation by children under age 12.
- Signs will be posted urging visitors to not enter if they are sick or have been exposed to flu. Visitors will be screened for influenza like illness.
- Visitation may be restricted to essential visitors only.
- Essential visitors will be required to wash their hands upon entry and don a surgical mask.
- People who enter the facility and find they are sick after arriving or within two days of leaving should let the facility know that the exposure has occurred.

A.2.3. Isolation of Residents
Residents who have a confirmed, probable, or suspected case of novel H1N1 should be kept in their rooms and the door should be kept closed. The following guidelines should be followed:

- Isolation precautions shall be implemented. A sign indicating isolation precautions have been implemented within the room shall be mounted on, or by, the room door.
- Only essential personnel or visitors should enter the room.
- All individuals entering the resident’s room should take standard and contact precautions plus eye protection. Gloves, gowns and masks along with eye protection should be donned when entering the resident’s room. If the resident must be transported out of the room, he or she should wear a surgical mask to contain secretions when outside of the room and should be encouraged to perform hand hygiene frequently and follow respiratory etiquette.

A.2.4. Quarantine
If a definite exposure has occurred in a limited part of the facility, those individuals should be kept apart from the rest of the population as effectively as possible. Residents should be kept in their rooms; roommates who would have been exposed to the quarantined residents should also be quarantined.

The quarantine period would be 7 days. If the individual who was exposed receives antiviral medications following the exposure, the quarantine period would end when the person remains well for 72 hours after receiving the medication.
SAMPLE POLICIES: ADMISSIONS IN AN INFLUENZA PANDEMIC

B. ADMISSIONS
All admission applicants, to all levels of care, must be screened for signs and symptoms of pandemic influenza prior to acceptance into our facilities. Guidelines on laboratory testing from the PA Department of Health and the CDC will be followed as part of the screening of applicants.

Priority for nursing home or Personal Care Home admissions will be given to existing residents in other levels of care. Independent Living residents who are ill with the H1N1 flu should be admitted only if other care arrangements (care from family members or friends, temporarily moving to a loved one’s home, etc.) are not possible.

Depending on the circumstances (the availability of staff and essential supplies, the severity of the strain, etc.), the decision may be made to close our facilities to new admissions except for residents from other levels of care. The decision to close our facilities to admission will be made in consultation with the Board of Directors, Executive Director, X County Emergency Management Office and the PA Department of Health.
SAMPLE POLICIES: HUMAN RESOURCES AND OCCUPATIONAL HEALTH IN AN INFLUENZA PANDEMIC

C. HUMAN RESOURCES AND OCCUPATIONAL HEALTH

C.1 Attendance Policy
It is expected that during a flu pandemic, many personnel may become sick or may have dependent family members who become ill and need our employee to care for them at home. It is our belief that all employees know the important roles they have in caring for our elderly residents and will make good faith efforts to attend work except when it may place other individuals’ health and safety at risk.

We wish to establish the following:

- Our residents and our coworkers count on all of us to do our best to avoid contracting the flu by following good infection control practices.
- Employees should assess themselves for Influenza-Like Illness prior to leaving home for work. If you have Influenza like symptoms, please do not report for work. Please notify your supervisor immediately.
- If you develop Influenza like symptoms while at work, please report to your supervisor immediately.
- If you are exposed to the H1N1 flu at home, do not report to work without calling your supervisor or the designee for direction first.
- It is our desire to create a non-punitive and safe work environment. We do not wish to deter employees who are ill from being absent. Therefore, unless specific circumstances suggest otherwise, enforcement of customary attendance policies on excessive absences will be waived when the absences relate to the pandemic flu.
- Extraordinary measures may be needed due to staffing shortages. Healthy staff members may be called on to work many extra hours or to supervise volunteer workers or employees who are temporarily assigned to new positions. Everyone’s patience and cooperation will be vitally important.

C.2 Training and Education
Depending on the infectiousness of the influenza strain, the services of 20 percent to 50 percent of the staff could be lost during an outbreak. Staff, families and residents shall be educated about our pandemic planning to ease their fears and to become better prepared.

The PI Planning Committee shall develop and carry out training programs appropriate for all personnel. Educational materials shall be distributed to families and residents. The materials shall be reviewed with residents at Council meetings, luncheons, quarterly town-hall meetings, and special purposes informational sessions.
Staff shall be trained and assess for competency in implementing the facility's infection control measures, including:

- Respiratory hygiene measures
- Cohorting of residents and consistent staff assignments Posting of visual reminders
- Verbal reminders/in-services
- PPE, vaccine and antiviral distribution Restriction of visitors
- Decisions on how to handle (and perhaps decline) new admissions and/or transfers Evaluation and management of ill staff

C.3 Emergency Staffing Shortages

C.3.1 Use of Retired Health Care Professionals, Reassignment of Existing Personnel, and Volunteers
During a pandemic, severe staffing shortages may be experienced, and under emergency conditions, we may need to use volunteers, retired health care professionals and existing personnel who are reassigned from non-caregiving positions to provide essential services.

Permission from the PA Department of Health (Nursing Home care) and/or the PA Department of Public Welfare (Personal Care) should be obtained before deviating from the staffing standards specified in the licensure regulations.

Refer to Appendix E for a description of training topics and materials.

C.3.2 Retired Health Care Professionals
Retired health care professionals (RNs, LPNs, CNAs, et al) may be assigned to perform caregiving and other services appropriate for their experience and current abilities after an assessment of their skills conducted by a member of the PI Planning Committee or other personnel designated by the Executive Director or Administrator (e.g., RNAC or RN Supervisor).

Retired health care professionals may serve as volunteers or be temporarily hired. They should undergo the training and described in Appendix E.

C.3.3 Reassignment of Existing Personnel
We will strive to train two staff members for every one staff who will be needed to perform the following:

- Essential resident care (see core skills described in 10.3)
- Food Service
- Housekeeping Laundry
- Essential administrative procedures, such as billing and payroll
See Appendix F for a listing of alternative personnel (i.e. staff reassignments) during a pandemic.

C.3.4 Volunteers
1. After training, volunteers may be assigned to a variety tasks, including but not limited to:
   - Security at entrances and supply storage areas
   - Childcare at on-campus temporary day care facilities
   - Food Service
   - Laundry Housekeeping/Cleaning Feeding
   - One to One Visits

2. Under extreme emergency conditions, with the permission of the PA Department of Health or DPW, volunteers may be assigned to assist with essential resident care. Volunteers should be recruited as part of the advance planning and preparation. Measures to screen and supervise volunteer personnel shall include the following:
   - Criminal record check or, at a minimum, a reference check
   - Infectious disease screening
   - Verification of credentials if the volunteer is to be utilized in a clinical capacity (i.e., nursing or medical license)
   - Training and supervision by a “buddy-up” with experienced staff until trained. Determination of competency through demonstration, observation and/or formal testing
   - Pairing volunteers with experienced staff, at least initially, to determine their competency and reliability and oversee their work.

C.3.5 Basic Resident Care Skills
The following is a list of core skills for basic resident care that should be covered in the “just in time” training of reassigned or newly recruited staff/volunteers who will be providing basic care.

   - Infection control, including airborne precautions and respiratory hygiene techniques
   - Donning and doffing of personal protective equipment
   - Positioning a resident in bed
   - Moving residents from bed to chair
   - Assisting ambulation
   - Making both an unoccupied and an occupied bed
   - Brushing a resident’s teeth/dentures
   - Mouth care for the unconscious resident
   - Giving a resident a bed bath
   - Assisting a resident with eating
• Assisting a resident with a bedpan/urinal
• Assisting a resident with using the bathroom
• Incontinence care
• Taking a resident’s temperature (oral and electronic)
• Taking a resident’s pulse
• Counting a resident’s respirations
• Post-mortem care.

C.4 Temporary Changes in Personnel Policies
We will implement temporary changes in employment policies to help protect
the health of the staff. The changes must be approved by the Executive
Director or the senior person in command.

C.4.1 Working from Home
For administrative jobs and duties that could be adequately performed outside
of the work place (possible examples – payroll, billing), we will permit
employees to work at home.

C.4.2 Employees at Increased Risk for Influenza Complications
During an Influenza Pandemic, employees who are immunocompromised or
pregnant, may be placed on a leave of absence. Employees must submit
their requests to their Department Head or supervisor.

Leave requests must be approved by the Executive Director.
Employees may use available PTO. Benefits would continue, subject to
the requirements of our health insurer.

C. 5 Management of Ill Employees
Employees should not report to work if they have an Influenza-Like Illness (see
Screening Form). The following procedures should be followed when an
employee shows up for work and is suspected of being infected with an
Influenza-Like Illness:
• The employee should don a surgical mask.
• The employee should be isolated in a room with the door shut.
• The employee should contact his/her healthcare provider and leave the
  facility immediately via private transportation if at all possible.
• Any areas that the employee was in should be decontaminated.

C.5.1 Ill Employees’ Return to Work
Employees who are suspected of having an Influenza-Like Illness should
excluded from work for 7 days from the onset or symptoms, or until the
symptoms have resolved, whichever is longer.

C.6 Staffing Practices
Experienced Staff
Experienced caregiving employees will be directed to supervise newly recruited and/or reassigned staff or volunteers as they carry out the basic care described in section 10.2.5. Experienced personnel should help organize resident care in the most efficient manner possible. Experienced staff should be paired with new staff in dietary, laundry, payroll and housekeeping as well if at all possible.

Consistent Staff Assignments
To the best of our ability, we will cohort sick residents, and we will assign consistent staff to care for them. We will minimize the floating of staff in all departments but especially with staff who are caring for contagious residents. Ideally, the staff assigned to care for sick residents will be:

- Licensed/Certified.
- The most experienced.
- Vaccinated or given antiviral treatment or have recovered from the illness themselves so they are not at a high risk of infection.

Altered Shifts
Shortages of personnel may require the adoption of different work shifts (for example, scheduling employees to work four 12-hour shifts instead of five 8-hour shifts).

10.7 Staff Dependents
If necessary, and if feasible, we will organize a safe place at the retirement community for staff to bring their dependent family members who would otherwise be left unsupervised while staff members are at work as a result of school closures, etc. An unoccupied cottage, apartment, activity room, lounge or other appropriate area would be possible locations. The dependent family members would be supervised by volunteers.
# CALL LOG for Family/Resident Questions and Concerns

<table>
<thead>
<tr>
<th>Date of Call</th>
<th>Time of Call</th>
<th>Name (Family Member or Resident)</th>
<th>Resident Room #</th>
<th>Question/Comment</th>
<th>Resolved?</th>
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<th>Name</th>
<th>Shift</th>
<th>Temperature</th>
<th>Symptoms of COVID-19? (Cough, Sore Throat, Shortness of Breath?)</th>
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Checklist for Temporary Living Quarters for Staff

Inventory of vacant/model apartments available for temporary housing

Cots

Pillows

Bedding

Basic Toiletry Needs

Extra food available

Plan for serving food for employees (time, place, etc.)
COVID-19 Resource Links

Please visit the sponsor page on our website www.leadingagevirginia.org. Our sponsors are thought leaders in the industry and their combined expertise across a broad range of fields in these unprecedented times is a valuable resource to all of our members. Many of our sponsors have dedicated COVID-19 resources centers and all are happy to address any questions and be of service as unique situations occur.

- Centers for Disease Control and Prevention: Long-Term Care (LTC) Respiratory Surveillance Line List https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf


• American Medical Directors Association https://paltc.org/covid-19


• Communications Skills for Clinicians https://www.vitaltalk.org/guides/covid-19-communication-skills/


Please visit www.leadingagevirginia.org for more information and resources

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