Long Term Care Facility Check-In List

☐ **Monitoring of Residents (COVID-19 Line List)**

- All residents are to be screened by obtaining a full set of vitals **AND** pulse oximetry every 8 hours
- Residents positive for COVID-19 **OR** showing sign/symptoms of respiratory viral infection:
  - Full Vitals **AND** pulse oximetry every 4 hours (twice a shift)
  - Identify additional isolation rooms limiting to single unit if possible, cohort like cases if necessary (e.g., influenza with influenza, COVID-19 with COVID-19, etc).
  - Maintain standard, contact, and droplet precautions (including eye protection)
  - Provide surgical mask to positive or symptomatic patients
  - Serve meals in resident rooms
- COVID-19-like-illness line list **must** be completed for all residents showing signs and symptoms (fever, cough, or shortness of breath)
- Assign designated employees for symptomatic and non-symptomatic residents to prevent transmission between residents
- Facilities should be able to accept COVID-19 residents from the hospital if clinically stable
- New admissions (residents and families) should be notified if the facility has COVID-19 in the building

☐ **Monitoring of Staff (IDPH Interim HCP Screening Guidance)**

- Screen staff for COVID-19-like symptoms
  - Signs and symptoms of respiratory infection – should not work and be sent home
  - No COVID-19 symptoms & with mild respiratory illness – can work only if 72 hours fever free and symptoms improving. Must wear a facemask
  - If develops sign and symptoms of a respiratory infection during shift, must stop immediately, put on a facemask and self-isolate at home.
    - Inform facility IP
    - Contact the Kane County Health Department for next steps
- **Return to Work Criteria for HCP with Confirmed or Suspected COVID-19**
  - Non-Test based strategy:
    - Resolution of fever without the use of fever reducing medication **AND** improvement in respiratory symptoms (e.g. cough, shortness of breath), **AND** at least 3 days (72 hours) have passed
    - At least 7 days have passed since symptoms first appeared
    - IF HCP were never tested for COVID-19 but has an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.
  - Test-based strategy: Exclude from work until
    - Resolution of fever without the use of fever –reducing medication AND improvement in respiratory symptoms (e.g. cough, shortness of breath) AND negative results of an FDA EUA molecular assay for COVID-19 from at least two consecutive NP swab specimens collected ≥24 hours apart (total of 2 negative specimen)
- **Return to Work Practices and Work Restrictions**
  - After returning to work HCP should:
    - Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer

- Be restricted from contact with severely immunocompromised patients (e.g. transplant, hematology-oncology) until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g. cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

☐ **Visitors**

- Visitor restriction sign posted at entry
  - All visitors are restricted except those visiting end-of-life residents
  - Permit (1) visitor per day
- All visitors under 18 years of age are restricted until further notice
- Visitors **must** be screened for illness prior to visiting. Post screening questionnaire at entrances of building.
- Other avenues of communication with family should be explored (i.e., FaceTime, skype, etc.)

☐ **Infection Control**

- Post respiratory hygiene & cough etiquette signs on all doors and in lobby areas
- Provide respiratory hygiene & cough etiquette supplies at all entry locations
  - Supplies include: alcohol-based hand rub, tissues, masks, and a waste receptacle for disposal of tissues.
- Designate an employee entrance
- Educate and communicate with employees, residents, and visitors on basic infection prevention measures (e.g. clean hands, cough etiquette, and disinfection of surfaces)
- Ensure staff are educated on and correctly performing hand hygiene, donning and doffing of PPE
- Ensure adequate supplies of PPE are easily accessible to staff
- Ensure adequate testing supplies and masks are available for staff collecting specimen (for first resident being tested).
- Avoid aerosol generating procedures. If necessary, use face and eye protection, N95 or respirator, close door and pull curtain. Wipe horizontal surfaces with EPA registered and approved products (List N products) after procedure. If supplies are scarce follow CDC recommendations for crisis capacity use.
- Ensure cleaning and disinfection of frequently touched surfaces with EPA registered disinfectant effective against human coronavirus

Outbreak Definition:

One lab confirmed case of COVID-19 and at least one case of COVID-like illness (CLI) with onsets within 14 days of each other

NOTE: Once one positive case is identified, no additional testing is needed in either residents or staff.

COVID-19-Like-Illness Line List

Submit to Kane County Health Department Daily for monitoring of residents with CLI

Fax (630)897-8128 Secure Email: Kanecophd@securemail.countyofkane.org

LTCF Tool Kit (attached)

IDPH Interim Guidance for LTCF

LTCF Resident Line List for COVID-19-Like-Illness

Resident Monitoring Protocol

IDPH Interim HCP Screening Guidance

HCP Assessment Form

LTCF Employee Line List for COVID-19-Like-Illness

Self-Monitoring of Asymptomatic Healthcare Personnel (HCP)

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19

PPE Strategies for LTCFs during Cluster of COVID-19 Infections

PPE donning/doffing options for LTCFs during Cluster of COVID-19 Infections

Guidelines for cleaning and disinfection for SARS-CoV2

Visitor Restrictions

Communal Dinning

Sample Letter

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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COVID-19 Control Measures for Long Term Care

Interim Guidance (subject to change) March 20, 2020

Outbreak definition:
One lab confirmed case of COVID19 and at least one case of COVID-like illness (CLI) with onsets within 14 days of each other
NOTE: Once one positive case is identified, no additional testing is needed in either residents or staff

Residents:

- All residents should be screened by obtaining full set of vitals AND pulse oximetry every 8 hours (Q8 hours)
- If patients have been screened and their testing is POSITIVE for COVID-19 OR if patients have signs/symptoms of a respiratory viral infection:
  a) Full Vitals AND pulse oximetry every 4 hours (Q4hours) {twice a shift}
  b) Private Room or Cohort with another symptomatic/positive patient
  c) Maintain Standard, Contact and Droplet Precautions (including eye protection)
  d) Consider that staff caring for positive or symptomatic patients do NOT care for negative or asymptomatic patients.
  e) Positive or symptomatic patients should be given a surgical mask and encouraged to wear at all times. These patients should be wearing a surgical mask when close contact with others is anticipated.
- Any resident identified with symptoms of fever and lower respiratory illness (cough, shortness of breath, sore throat) should be immediately placed in both Contact and Droplet transmission-based precautions.
- The isolation should be implemented by the healthcare member who discovers the symptoms pending a physician order.
- Residents with confirmed COVID-19 or displaying respiratory symptoms should receive all services in room with door closed (meals, physical and occupational therapy, activities, and personal hygiene, etc.)
- Symptomatic residents should only leave their room as required for medical procedures not available on site (i.e., dialysis, medical specialist appointment, and critical testing not available at the facility). If the resident is to leave room for these purposes the shortest route should be utilized and the immediate are/route to the exit/treatment areas should be cleared of all residents and unnecessary staff.
- Testing to rule out routine pathogens may be completed via rapid influenza testing and respiratory viral panels (Rhinovirus, RSV, etc.).
- Determination to send the resident to the hospital should be based on the same criteria used for other illnesses.
- Those residents with severe illness requiring hospitalization should be transferred to the hospital with notification to EMS and the receiving hospital.

Facilities:

- Should communicate with physician, local health department, regulatory agency, families, staff and residents.
- Processes and activities which increase residents' risk should be modified or suspended.
- Immediately inform the local health department and IDPH of symptomatic residents to determine if COVID-19 testing is indicated. Once a positive case is identified in a facility, no additional testing is needed in either residents or staff.
- Stop large group congregate activities and provide alternatives (arrange in room dining or dining that maintains social distancing and activities, stop bingo, beauty shop, outside volunteer presentations, church, etc.)
- If not already being performed begin screening all residents and staff including temperature checks and use of checklists to identify symptomatic individuals.
- Inform staff to stay home when sick insuring non-punitive practices during this period. Screen all staff prior to shift for temperature and respiratory symptoms. If present staff member should be sent home until symptoms resolve.
- Focus on decreased staff rotation and cohort staff to work with symptomatic residents whenever possible.
- Ensure staff are educated on and correctly performing hand hygiene, donning and doffing of PPE, and using appropriate products for environmental cleansing/disinfection.
- Ensure adequate supplies of PPE are easily accessible to staff.
- Post signage for Hand hygiene and cough etiquette, ensure necessary supplies to accomplish these tasks are present at all entries and patient care areas. Notify all residents, staff, visitor and families of current situation.
- Visitation should be restricted to essential individuals. All visitors should be informed of risk and instructed on proper PPE use prior to entering unit. Other avenues of communication with family should be explored (i.e., face time, skype, etc.).
- Identify additional isolation rooms limiting to single unit if possible, cohort like cases if necessary (e.g., influenza with influenza, COVID-19 with COVID-19, etc.).
- Ensure adequate testing supplies and masks are available for staff collecting specimens (for first resident being tested). Avoid aerosol generating procedures. If necessary, use face and eye protection, N95 or respirator, close door and pull curtain. Wipe horizontal surfaces with EPA registered and approved product (List N products) after procedure. If supplies become scarce, follow CDC recommendations for crisis capacity use.
- Facilities should be able to accept COVID-19 residents from the hospital if clinically stable.
- New admissions (residents and families) should be notified if the facility has COVID-19 in the building.

Environmental Services/controls:

- Disinfect frequently touch surfaces **every two hours or as frequently as possible** with EPA registered and approved product (List N products).

- Educate and observe practice on appropriate disinfection (clean to dirty, appropriate dwell time, when to switch clothes and wipes, etc.). Ensure cleaning and disinfection policies and procedures are being followed consistently and correctly.
- Ensure appropriate PPE is worn during cleaning and disinfection work.
- Limit access to facility and post signage reading rationale. Only essential visitors, employees and contract staff should be allowed to entrance.
- Ensure adequate facilities for completion of hand hygiene-hand washing sink or alcohol-based hand rub. Alcohol-based hand rub should ideally be both inside and outside of patient rooms, at all entrances, and throughout the clinical areas. Ensure all dispensers contain product within expiration date.

Employees:

- All employees should promptly notify supervisor of any symptoms of illness in themselves or individual in their care.
- Employee who are ill will exclude themselves from work environments and will seek the advice of their health care provider.
- Provide symptoms report and allow temperature monitoring upon entry to work.
- Symptomatic staff do not require testing but, should considered possible cases and work restriction and isolated at home for a minimum of 7 days after onset and can be released after afebrile and feeling well (without fever reducing medications for at least 72 hours.
- Asymptomatic staff do not need to be tested for SARS-CoV2.
- Employees may utilize extended use techniques with masks and eye protection when caring for residents.
- Mask should be worn when entering unit. Change mask if touched soiled or moist. Remove when leaving isolation rooms.
- Agencies of contract employees should be notified of risk and screen their staff to prevent transmission from facility to facility. Use limited and or consistent agency staff during the COVID-19 pandemic if possible.
- Perform hand hygiene on arrival at the facility, during the 5 moment so of patient care activities, and prior to going home.
- PPE should not be worn off affected units or areas unless approved as enhanced control measure.
- All employees should be pre-screened for fever and symptoms prior to shift.
- If employee has been tested and has a negative COVID-19 test and does NOT have symptoms, they may continue to work. Symptom screening is done pre-shift and every 4 hours during shift.
- All asymptomatic employees must wear a mask during their shift to protect residents.

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19

Use one of the below strategies to determine when HCP may return to work in healthcare setting:

1. Non-test-based strategy:
    - Resolution of fever without the use of fever-reducing medications and

- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **AND**
- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**
- At least 7 days have passed since symptoms first appeared
- If HCP were never tested for COVID-19 but have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

2. Test-based strategy. Exclude from work until

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

- **Return to Work Practices and Work Restrictions**
  After returning to work, HCP should:
  - Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
  - Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
  - Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
  - Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Guidance for Communal Dining (update March 25, 2020)

Residents identified as being positive for COVID-19 or who are displaying symptoms of COVID-19-like illness (fever, cough, sore throat, shortness of breath) should have meals in their rooms (dine-in meals).

If residents are not displaying ANY symptoms of COVID-19, the facility should consider the following measures to balance the directive to eliminate communal dining and the need to provide nutritional meals to residents in a safe manner.

- Stagger dining periods, so fewer residents dine at a time.

- Utilize all available dining halls in the facility (providing additional space to separate residents)
- Those residents that can feed themselves without any issues or concerns should dine in their room (this decreases the number of residents in the dining hall).
- Those residents needing assistance to eat should be separated by at least six feet. Depending on the size of the dining table, only 1 to 2 residents per table. Tables need to be at least six feet apart as well.
- The facility should consider utilizing resident attendants and speech therapists to assist nursing assistants in feeding residents.
- Staff should wear a facemask when feeding residents.
- Hand hygiene is to be performed between resident care (feeding).
- Only ONE resident should be transported (pushed) at a time to the dining room. Do not attempt to push more than one wheelchair at a time. The same process is used for return trips to resident rooms---only ONE resident at a time.
- Ensure cleaning and disinfection of environmental surfaces between dining periods. Only use EPA registered disinfectants. Ideally, use a product from List N. Refer to CDC/EPA website for List N products. If your current disinfectant is not listed on the List N products, check the label and ensure the product is at least effective against human coronavirus.

Line List for COVID-19 Outbreaks in Long Term Care Facilities

Please list all residents ill with COVID respiratory symptoms.

Name	DOB	Unit Or Room	Onset Date	Cough (Y/N)	Fever Y/N)	Measured (degrees F)	Shortness of Breath (Y/N)	SARS CoV-2 test result (+/-)	Respiratory Panel Test Result (+/-)	Hospitalized (Y/N)	Died (Y/N)	Notes

Adapted from Washington State Department of Health 3/15/2020

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INTERIM GUIDANCE FOR COVID-19*
(updated 3/18/2020, subject to change)

Resident Monitoring Protocol

Long-Term Care Facilities

Long-Term Care Facility Residents/Patients
All Patients
Full Vitals AND pulse oximetry every 8 hours (Q8 hours)
Symptom screening to be performed every shift (Q8H) and should include questions about and/or observations of the following: 1) Fever 2) Shortness of Breath (SOB) 3) Cough 4) Sore Throat
Contact Clinical Supervisor for any of the following: new-onset fever, SOB, cough, sore throat or for any decrease in pulse oximetry
If patients have been screened and their testing is NEGATIVE for COVID-19: a) Avoid placing with COVID-19 or symptomatic[1] patients b) Consider discharge to home of post-acute/rehabilitation patients who can be home quarantined
If patients have been screened and their testing is POSITIVE for COVID-19 OR if patients have signs/symptoms of a respiratory viral infection: a) Full Vitals AND pulse oximetry every 4 hours (Q4hours) b) Private Room or Cohort with another symptomatic/positive patient c) Maintain standard, contact and droplet precautions (including eye protection) d) Consider that staff caring for positive or symptomatic patients do NOT care for negative or asymptomatic patients. e) Positive or symptomatic patients should be given a surgical mask and encouraged to wear it at all times. These patients should be wearing a surgical mask when close contact with others is anticipated.

[1]Signs/symptoms consistent with respiratory viral infection

*Interim guidance developed by Illinois Department of Public Health and DuPage County Health Department based on an Illinois long-term care COVID-19 experience and in consultation with University of Washington.

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Interim Guidance for Work Exclusion and Monitoring Recommendations for Healthcare Settings and EMS

3/19/20

Work Exclusion and Monitoring Determinations

Once a COVID-19 case has been confirmed in a facility, work exclusions and home monitoring plans should be implemented. In general, staff (including providers, nurses, EMS, medical assistants, patient care techs, EVS, dietary services, radiology staff, contracting staff (who removes sharps containers, etc), security officers, chaplains, behavioral therapists, clerks, other ancillary staff with access to patients.) with the following risk factors should be excluded from work and monitored for fever or respiratory symptoms (see Table 1):

- Patient interaction that did not include aerosol-generating procedures without a regular facemask or respirator and eye protection (goggles or face shield).
- Patient interaction that involves extensive contact with the patient and their immediate environment (e.g., logrolling, toileting) without using gown and gloves in addition to facemask or respirator and eye protection.
- Patient interaction that did include aerosol-generating procedures without all elements of full PPE requirements (respirator, eye protection, gown, and gloves).

Facilities could consider allowing asymptomatic staff who have had an exposure to a COVID-19 patient to continue to work after consultation with their occupational health program. The decision to allow continued work should be made on an individual basis, with a thorough risk assessment. (See footnote f in Table 1 for more information.) The risk assessment should include the staff's level of exposure, ability to reliably undergo daily active monitoring, and the constraints that work restrictions would place on the facility's workforce. Re-assignment of the staff to non-patient care duties during the monitoring period should also be considered. These staff should still undergo daily active monitoring prior to starting work and mid-shift.

If staff develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.

The following table provides considerations for sample staff activities to aid in decision making regarding exclusion and monitoring plans. Examples are generally limited to those that involve patient care. Other factors may alter risk determination, including but not limited to patient symptoms, ability to comply with source control, and duration of exposure. (See Table 1, next page. HCP refers to all staff as noted above.)

Table 1: Work Exclusion and Monitoring Plan Considerations for HCP Activities by PPE and Source Control Utilization

Sample Activity	Personal Protective Equipment Used by HCP					Source Control	Work Restriction	Follow up and Monitoring Plan
	Respirator[a]	Regular Mask	Goggles or Face Shield	Gown	Gloves	Patient Masked		
HCP walks by patient, but has no direct contact with patient or their secretions	–	–	–	–	–	–/+	None	Standard respiratory illness precautions[b]
Brief check-in interactions or brief entrance into patient room without contact with patient secretions	–	–	–	–	–	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
Patient care with no aerosol- generating procedures[e]	+	–	+	+	+	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	–	+	+	+	+	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	–	+	+	–	–	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	+	–	–	–	–	+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	–	+	–	–	–	+	None	HCP self-monitoring for 14 days after last exposure[b,c]
Patient care with aerosol- generating procedures (Appendix I)	+	–	+	+	+	N/A	None	HCP self-monitoring for 14 days after last exposure[b,c]
Patient care with no aerosol- generating procedures	–	–	–	–	–	–/+	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
	–	–	+	+	+	–/+	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
	+	–	–	+	+	–	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
	–	+	–	+	+	–	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
Patient care with aerosol- generating procedures (Appendix I)	Any variation that does not include the full recommended PPE (respirator, eye protection, gown, and gloves)					N/A	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]

Green: no identifiable risk; **Yellow**: low-risk exposure; **Blue**: medium-risk exposure **Red**: high-risk exposure
+ designated PPE category used throughout the activity, assumes appropriate donning, doffing, and hand hygiene
– designated PPE category not used;
+/– designated PPE category either used or not used, action steps not contingent on this item.

[a] Respirator: Refers to respiratory protection at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator, including NIOSH-approved powered air-purifying respirators (PAPRs).

[b] Standard respiratory illness precautions: All HCP with fever or respiratory symptoms should stay home if ill for 7 days from illness onset or 72 hours after symptoms resolved, whichever is longer.

[c] HCP self-monitoring: HCP perform self-monitoring for fever or respiratory symptoms for 14 days from last exposure under the supervision of a healthcare facility's occupational health or infection control program.

[d] Active monitoring: Daily communication to assess for the presence of fever or respiratory symptoms (cough, sore throat, or shortness of breath) conducted by healthcare facility's occupational health or infection control program, if excluded from work.

[e] Provision of patient care that requires extensive direct contact with the patient and their immediate environment (e.g. logrolling, toileting) should include use of gown, gloves, and appropriate hand hygiene. Failure to use gown and gloves in addition to specified PPE would elevate exposure risk and may warrant work exclusion and active monitoring.

[f] Work exclusion period should be 14 days from date of last exposure. **Facilities could consider allowing asymptomatic HCP who have had any medium- or high- risk exposure to a COVID-19 patient to continue to work after consultation with their occupational health program**. The decision to allow continued work should be made on an individual basis. The healthcare facility should evaluate the HCP prior to each shift and at mid- shift by taking the HCP's temperature and assessing for symptoms. Exposed HCP should be asked to wear a facemask while at work for the 14 days after the exposure event, if there is a sufficient supply of facemasks. It is recommended that HCPs be restricted from working with severely immunocompromised patients until 14 days after illness onset. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work. See: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html and https://www.cdc.gov/coonavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Tracking Form for Asymptomatic Healthcare Personnel Potentially Exposed to nCoV[1]
(e.g. nurses, physicians, respiratory therapists, environmental services, others)

v4 03/17/2020

REDCap ID:

Complete column (or new form) for each date worked

Date interviewed: _____

Facilty Name:

Facility Location:

Which Case Number is the contact associated with?

Name:	
Address (street, city, county, state):	
Preferred Phone number(s):	
Preferred email:	
County:	

Sex: M F

Date of Birth:

Age (years):

Employee position:

Race:
[ ]African American/Black
[ ]White
[ ]Asian
[ ]Other

Ethnicity
[ ] Hispanic
[ ] Non-Hispanic

Interviewer name: _____

Since seeing the patient for the first time, have you had any of the following symptoms - please answer yes or no?

	Y	N
No symptoms		
Fever		
Chills		
Sore throat		
Productive cough		
Dry cough		
SOB		
Headache		
Muscle aches		
Diarrhoea		
Vomiting		
Other	Specify	

SEE OTHER SIDE FOR ADDITIONAL QUESTIONS

Date, at beginning of shift		3/17	3/18	3/19	3/20	3/21	3/22	3/23	3/24	3/25	3/26	3/27	Notes
		Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	
Did you work on this shift on this day? (Y/N)													
	If yes, was this shift overnight? (Y/N)												
Did you enter the patient's room/same enclosed area[3]? (Y/N) If yes, list room/care locations by date													
	Can you estimate the cumulative duration in minutes?												
Did you touch the patient? (Y/N) If yes, list room/care locations by date													
Did you have contact with patient's secretions, excretions, surfaces in the room, surfaces in transit, or used medical equipment (even if patient not present)? (Y/N) If yes, describe in notes													
Was the patient in an Airborne Infection Isolation Room (AIIR) when contact occurred? (Y/N) If No, describe in notes.													
Was the patient wearing a facemask if contact occurred outside an AIIR? (Y/N/Not Applicable)													
Did you always wear the following PPE:													
	Gloves (Y/N)												
	Gown? (Y/N)												
	N95 respirator? (Y/N)												
	If wore N95, fit-tested in last year? (Y/N)												
	Mask? (Y/N)												
	PAPR & hood? (Y/N)												
	Goggles or Disposable Faceshield that covers the front and sides of the face? (Y/N)												
Did you ave any issues with PPE (e.g. tears, needing change or replace PPE while in the room)? (Y/N; if yes, explain in notes)													
Did you conduct or were you present for any aerosol generating procedures (e.g., cough-generating procedures, collection of respiratory specimens, bronchoscopy, sputum induction, intubation, extubation)? (Y/N - If yes, list which procedures)													
Did you have any percutaneous exposures (i.e. needle sticks, cuts)? (Y/N; if yes, explain in notes)													
Did you have any known direct exposures to <u>your</u> mucous membranes/skin with patient's respiratory secretions/other body fluids/blood?													
Did you have any known direct skin-skin exposure to patient? (Y/N; if yes, explain in notes)													
Was anyone else in the same room with you? (Y/N; if yes, explain in notes)													
Do you work in any other healthcare settings? If Yes, summarize locations in notes													
Exposure Category (High, Some, Low but not zero, No identifiable risk)[2]													
Employee's initials													

[1]For the purposes of risk exposure to nCoV, HCP refers to all people, paid and unpaid, working in healthcare settings whose activities potentially place them at risk for exposures to a patient with nCoV. Examples of such activities include:

- those that require direct contact with patients or their respiratory secretions
- presence in the patient's room or immediate patient-care environment, such as in a triage or examination room, or other potentially contaminated areas
- handling respiratory secretions, including soiled medical supplies and medical waste, or potentially contaminated equipment or environmental surfaces

[2]Refer to Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Exposure for the Exposure Categories

[3]This refers to entering the room or care area in any of the following situations: while the patient was present or within 2 hours of the patient leaving the room or care. The time period may be shorter depending on the number of air changes per hour.

Self-Monitoring of Asymptomatic Healthcare Personnel (HCP)

Instructions: HCP should check their temperature and complete this form twice daily for 14 days after the date of the last exposure. If temperature is above o equal to 38.0°C/100.0°F, HCP report subjective fevers or any of the following symptoms, they should separate yourself from others and call their local or state public health authority or healthcare facility. They should ensure their temperature is below 38.0°C/100.0°F and that they don't have any of the following symptoms before they leave home and report to work.

Name			Employee ID #			Phone		Email		Job Title			Supervisor		Date of last exposure		
Day # After Exposure	Date	Time	Temp	Symptoms (check if you have any of the following)													
				Subjective Fever	Cough	Sore throat	Shortness of breath	Runny Nose	Chills	Muscle aches	Headache	Fatigue	Abdominal Pain	Nausea or Vomiting	Diarrhea	None	Other
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
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Evaluation of Asymptomatic Healthcare Personnel (HCP)

Instructions: HCP can start work if temperature is below 38.0°C/100.0°F, and no subjective fever or any of the following symptoms are reported.

Name	Employee ID #	Phone	Email	Job Title	Supervisor	Date of last exposure	Screening Personnel Name

Day # After Exposure	Date	Time	Temperature	Symptoms (check if you have any of the following)														Screening Personnel Name and Signature
				Subjective Fever	Cough	Sore throat	Shortness of breath	Runny Nose	Chills	Muscle aches	Headache	Fatigue	Abdominal Pain	Nausea or Vomiting	Diarrhea	None	Other	
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Return to Work Criteria for HCP with Confirmed or Suspected COVID-19

(3.20.2020, subject to change)

Use one of the below strategies to determine when HCP may return to work in healthcare settings:

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

2. *Non-test-based strategy.* Exclude from work until
    - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and,**
    - At least 7 days have passed *since symptoms first appeared*

If HCP were never tested for COVID-19 but have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational healthif respiratory symptoms recur or worsen

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Line List for COVID-19 Outbreaks in Long Term Care Facilities

Employees ill with COVID-like symptoms

Name	DOB	Onset Date	Cough (Y/N)	Fever Y/N)	Measured (degrees F)	Shortness of Breath (Y/N)	SARS CoV-2 test result (+/-)	Respiratory Panel Test Result (+/-)	Unit Worked	Date last worked at Facility	Died (Y/N)	Notes

Adapted from Washington State Department of Health 3/15/2020

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PPE Strategies for LTCFs during Cluster of COVID-19 Infections

When there are cases if the facility:

- Universal masking of HCP while in the facility
  - Consider changing every 2 hours or if it become visibly soiled or wet (see further guidance below for extended use).
- Consider using all recommend PPE (mask/respirator, eye protection, gowns, gloves) for the care of any resident if available.

For any contact with residents with respiratory infections, healthcare personnel (HCP) MUST wear all of the following if gowns are not readily available:

- Respirator (or Facemask if Respirator is not available or HCP are not fit-tested)
  - A respirator must be used if performing an aerosol-generating procedure (e.g., nebulizer therapy)
- Eye protection (Goggles or Face shield); Any eye protection that is not immediately discarded after use must be dedicated to each provider
- Gloves

Gowns MUST be added in the following situations:

- Performing an aerosol-generating procedure (e.g., nebulizer therapy);
- During care activities where splashes and sprays are anticipated;
- During the following high-contact resident care activities:
  - Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

The following PPE must NEVER be used for more than one resident:

- Gloves
- Gown

Using the same respirator (or facemask if used) and eye protection is permitted for repeated close contact encounters with several residents, without removing between resident encounters (Extended Use).

- This should only be done between roommate pairs or residents in different rooms who are symptomatic
  - In units where illness is wide-spread, HCP could continue use of same respirator (or facemask if used) and eye protection for 2 hours before changing
- **HCP should avoid touching their face protection**.
- Hand hygiene must be performed after the HCP touches their face protection at any point.
- The respirator (or facemask if used) MUST be discarded and the eye protection must be replaced (can be reused after cleaning and disinfection) in the following scenarios:
  - If damp, damaged, or hard to breathe through.
  - If used during aerosol generating procedures.
  - If contaminated with blood, respiratory or nasal secretions, or other bodily fluids from residents.
- The face shield MUST be discarded if it becomes damaged such that it can no longer fasten securely to the provider or become even slightly difficult to see through.

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PPE donning/doffing options for LTCFs during Cluster of COVID-19 Infections

Donning Steps When All PPE is Being Put on at the Same Time

1. **Identify and gather the proper PPE to don.**
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Ensure that the gown fits. Tie all of the ties on the gown.
4. **Put on respirator (use a facemask if a respirator is not available or HCP are not fit-tested).** Nosepiece should be fitted to the nose, not bent or tented. Mask should be extended under chin. Both mouth and nose should be protected. Do not store under the chin between uses. If using a respirator, perform a seal check.
5. **Put on face shield or goggles.**
6. **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **Enter resident room.**

Doffing Steps When All PPE is Being Removed at the Same Time

1. **Remove and discard gloves.** Ensure glove removal does not cause additional contamination. Gloves can be removed using more than one technique, e.g., glove-in-glove, and duckbill.
2. **Remove and discard gown.** Untie all ties (or unsnap all buttons). Reach up to the shoulders and carefully put gown down and away from the body. Rolling the gown down is an acceptable approach.
3. **Perform hand hygiene.**
4. **Exit resident room.**
5. **Perform hand hygiene. Go to area where reprocessing of face shield or goggles will be performed.**
6. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing by the strap and pull upwards and away from head. *Do not touch the front of face shield or goggles.*
7. **Place the face shield or goggles on a designated surface for reprocessing that should be in same area where they will be stored.**
8. **Remove and discard respirator (or facemask if used instead of respirator).** Do not touch the front of the respirator or surgical mask.

   a. **Respirator:** Carefully grasp bottom elastics, then the ones at the top, pull away from face without touching the front.
   b. **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.
9. **Perform hand hygiene and put on gloves.**
10. **Clean the exterior facing surface of the goggles or face shield with an EPA-registered disinfectant wipe (ADD PRODUCT USED IN FACILITY) after exiting each resident care area.**
11. **After it is dry, the goggles or face shield should be placed in a secure area where no other persons should need to interact with them until they are needed again.**
12. **Clean the designated reprocessing surface with an EPA-registered disinfectant wipe (ADD PRODUCT USED IN FACILITY)**
13. **Remove and discard gloves**

Donning Steps When Only New Gown and Gloves are Being Put On (Extending use of Respirators/Facemasks and Eye Protection):

1. **Identify and gather the gown and gloves to don.**
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Ensure that the gown fits. Tie all of the ties on the gown. Care must be taken to avoid touching face and eye protection while putting on gown.
4. **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
5. **Enter resident room.**

Doffing Steps When Only Gown and Gloves are Being Removed:

1. **Remove gloves.** Ensure glove removal does not cause additional contamination. Gloves can be removed using a more than one technique, e.g., glove-in-glove, and duckbill.
2. **Remove gown.** Untie all ties (or unsnap all buttons). Reach up to the shoulders and carefully put gown down and away from the body. Rolling the gown down is an acceptable approach.
3. **Perform hand hygiene.**
4. **Exit resident room.**
5. **Perform hand hygiene.**

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Guidelines for cleaning and disinfection for SARS-CoV-2

- Dedicated medical equipment should be used for patient care.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Use EPA-approved disinfection products listed on this website: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
- Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE) for use.
- Clean the surface first, and then apply the disinfectant as instructed on the disinfectant manufacturer's label. Ensure adequate contact time for effective disinfection.
- Adhere to any safety precautions or other label recommendations as directed (e.g., allowing adequate ventilation in confined areas, proper disposal of unused product or used containers and donning appropriate PPE).
- After cleaning and removal and disposal of gloves, staff should perform hand hygiene by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol. Soap and water should be used if the hands are visibly soiled.

Best practices for long-term care facilities:

- Avoid using product application methods that cause splashing or generate aerosols.
- Cleaning activities should be supervised and inspected periodically to ensure correct procedures are followed.
- Review cleaning and disinfection products and protocols with floor staff and housekeeping
  - Ensure they understand the necessary contact time
  - Differences between porous and non-porous surfaces
- Room cleaning
  - Daily cleaning
  - High touch surfaces every shift (door handles, bedside tables, bed rails, TV remote, call button, light switches
- Facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the patient.
- Shared equipment: clean and disinfect after every resident use
- Dedicated equipment: clean and disinfect prior to storage

Resources:

- This document contains those disinfectants already registered with EPA for coronavirus effectiveness, at the link here https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 .
- Overall IPC guidance for COVID-19 can be found on CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- Detailed information on environmental infection control in healthcare settings can be found in CDC's Guidelines for Environmental Infection Control in Health-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [section IV.F. Care of the environment].

Long Term Care Facility Guidance for Coronavirus (COVID19)

VISITOR RESTRICTIONS

As we continue to closely monitor the coronavirus, also known as COVID-19, the health and safety of our residents, families, and team members remain our top priority.

To prevent the possible spread of the coronavirus (COVID-19), facilities need to restrict visitors younger than 18 years of age.

All other visitors need to screen themselves by reviewing the screening questionnaire. If you have any of the symptoms listed or answered "yes" to any of the questions, you need to postpone your visit for 14 days.

THANK YOU FOR YOUR UNDERSTANDING

Long Term Care Facility Guidance for Coronavirus (COVID19)

Visitor Screening Questionnaire Notice to be posted at all building entrances

In an effort to protect our residents, clients, and patients, from illness we are screening visitors and volunteers. Please answer the following questions:

Within the past 14 days, I have traveled to a location Where COVID-19 has been diagnosed or suspected.	Yes□	No□
Within the past 14 days, I have been in close contact with persons who have traveled to a location where COVID19 has been diagnosed or suspected.	Yes□	No□
Within the past 14 days, I have been sick with a cold or the flu.	Yes□	No□
Within the last 7 days, I have had a fever.	Yes□	No□
Within the last 7 days, I have had a sore throat.	Yes□	No□
Within the last 7 days, I have had nausea and vomiting.	Yes□	No□
Within the last 7 days, I have had diarrhea.	Yes□	No□
I now have symptoms of a cold or flu.	Yes□	No□
I now have a fever.	Yes□	No□
Within the past 14 days, I have been around people who have been or are sick with colds or flu.	Yes□	No□
Within the past 14 days, I have been around people who were sick with colds or flu.	Yes□	No□

IF YOU HAVE MARKED "YES" TO ANY OF THESE QUESTIONS, PLEASE POSTPONE YOUR VISIT FOR AT LEAST 14 DAYS FROM THE DAY YOUR SYMPTOMS BEGAN

Thank you for your understanding

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Long Term Care
Guidance for Communal Dining

Residents identified as being positive for COVID-19 or who are displaying symptoms of COVID-19-like illness (fever, cough, sore throat, shortness of breath) should have meals in their rooms (dine-in meals).

If residents are not displaying ANY symptoms of COVID-19, the facility should consider the following measures to balance the directive to eliminate communal dining and the need to provide nutritional meals to residents in a safe manner.

- Stagger dining periods, so fewer residents dine at a time.
- Utilize all available dining halls in the facility (providing additional space to separate residents)
- Those residents that can feed themselves without any issues or concerns should dine in their room (this decreases the number of residents in the dining hall).
- Those residents needing assistance to eat should be separated by at least six feet. Depending on the size of the dining table, only 1 to 2 residents per table. Tables need to be at least six feet apart as well.
- The facility should consider utilizing resident attendants and speech therapists to assist nursing assistants in feeding residents.
- Staff should wear a facemask when feeding residents.
- Hand hygiene is to be performed between resident care (feeding).
- Only ONE resident should be transported (pushed) at a time to the dining room. Do not attempt to push more than one wheelchair at a time. The same process is used for return trips to resident rooms---only ONE resident at a time.
- Ensure cleaning and disinfection of environmental surfaces between dining periods. Only use EPA registered disinfectants. Ideally, use a product from List N. Refer to CDC/EPA website for List N products. If your current disinfectant is not listed on the List N products, check the label and ensure the product is at least effective against human coronavirus.

(Date)

Dear Residents, Families, and Staff:

The health and safety of the *(facility name's)* community is our highest priority, and we recognize the uncertainty and concern regarding the evolving coronavirus (COVID-19) outbreak. We would like to inform you that one of our residents at *(facility name)* has tested positive for COVID-19. We are following guidance from the Centers for Disease Control and Prevention (CDC) as well as the state and local health departments for best practices and procedures to protect everyone's health.

To prevent further spread of the disease, *(facility name)* has taken the following steps:

- Facilitating a deep clean of the entire facility, including all common areas
- Restricting visitor access to the center
- Screening all visitors and staff members for symptoms such as fever daily before entering the building

We are coordinating our efforts with *(name of local/state health department)* to promptly identify and monitor individuals who have had recent contact with our COVID-19 positive individual to prevent further spread within our facility and community.

We are committed to providing you with a safe and healthy environment. For any questions or concerns, please contact us at *(phone number)*.

(Name)

(title)