COLORADO
Department of Public Health & Environment

COVID-19 GUIDANCE

Residential Care Facility (RCF) Comprehensive Mitigation Guidance

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Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

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Summary of Recent Changes

Updates as of 5/31/2021

- Updated language regarding vaccinated vs. unvaccinated individuals:
  - Updates to communal dining, group activities and facility outings.
  - Changes to SARS-CoV-2 (COVID-19) testing recommendations for fully vaccinated individuals (staff and residents).
  - Updates to source control requirements for fully vaccinated individuals (staff and residents)
  - Updated visitation guidance to include circumstances when source control and physical distancing are not required during visitation.
- Changes to EMResource reporting frequency.
- New requirements for an ongoing facility vaccination plan.
- Removed the social distancing space calculator.
- New section with supplemental resources, including:
  - Required Isolation Plans
  - When Creating a COVID-19 Care Area Within the Facility
  - Strategies for Memory Care or Facilities Serving People with Developmental Disabilities
  - Strategies for Small Residential Settings (13 or Fewer Residents)
  - PPE FAQ

Guidance Document Alignment

CDPHE guidance no longer is in complete alignment with guidance issued by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC). We understand that this may cause confusion for facilities but feel it is important to issue guidance specifically for Colorado facilities. All licensed residential care facilities are required to follow this guidance per Public Health Order 20-20. Additionally, federally certified facilities must follow CMS guidance. Other facility types may also choose to follow more restrictive guidance. The table below may help facilities determine which guidance to follow.

Facility type	Required Guidance	Recommended Guidance
Skilled nursing facilities	CDPHE* CMS*	CDC
Assisted living residences (ALFs & ALRs)	CDPHE	CDC
Group homes	CDPHE	CDC
Intermediate care facilities (ICFs)	CDPHE*	CDC

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	CMS*	

* In cases where CDPHE and CMS guidance do not align, the facility must follow the more restrictive guidance.

Example:
CDPHE guidance does not require vaccinated visitors to wear a face covering when in the facility. CMS guidance requires vaccinated visitors to wear a face covering during their visit in the facility. Skilled nursing facilities and intermediate care facilities must follow both sets of guidance and must require their visitors to wear a face covering during their visit. The CMS guidance is more conservative and must be followed.

The specific areas in which CDPHE differs from federal guidance includes:

- Fully vaccinated staff are no longer required to wear PPE unless required for standard and/or transmission-based precautions.
- Fully vaccinated visitors are allowed to participate in visitation without restrictions and without wearing a mask.
- Fully vaccinated residents are no longer required to wear masks while inside of the facility.

Guidance document links:

CMS nursing home visitation guidance - QSO-20-39
CMS nursing home regulatory revisions in response to COVID-19 - QSO-20-38
CDC Updated Health care Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination

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COVID-19 in Residential Care Facilities

Scope

The purpose of this document is to provide guidance to residential care facilities (RCF) when a resident or staff member is suspected or confirmed to have COVID-19 and to provide recommendations to prevent transmission of COVID-19 within the facility. These recommendations are specific for RCFs. Guidance provided in this document is based on currently available information at the time it was drafted and is subject to change. Updated case counts are available on the CDPHE website: Coronavirus Disease 2019 (COVID-19) in Colorado.

RCFs (skilled nursing facilities, assisted living residences, group homes, and intermediate care facilities) are licensed by the Colorado Department of Public Health and Environment (CDPHE). Some of these facilities are also federally certified by the Centers for Medicare and Medicaid Services (CMS). **In instances where state and federal guidance do not align, federally certified facilities are required to follow the more restrictive guidance.**

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like SARS-CoV-2 and other pathogens, including multidrug-resistant organisms (e.g., carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and health care personnel (HCP). Even as nursing homes resume more normal practices and begin relaxing restrictions, **nursing homes must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.**

The information in this document applies regardless of vaccination status and level of vaccine coverage in the facility unless specifically stated.

Key Information about COVID-19

- **Agent**
  - SARS-CoV-2
- **Incubation Period**
  - Range 2 to 14 days
- **Transmission/Communicability**
  - The virus is thought to spread mainly from person-to-person.
  - Between people who are in close contact with one another (within about 6 feet).
  - Through respiratory droplets produced when an infected person talks, coughs, or sneezes.
  - These droplets can land in the eyes, mouths, or noses of people who are nearby or possibly be inhaled into the lungs.
  - There is evidence that the virus can also be spread via airborne transmission, when smaller droplets and particles containing the virus remain suspended in the air for minutes to hours.
  - 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.
- **Symptoms**
  - Symptoms associated with COVID-19 include: Fever (measured at >100.0°F or subjective), chills, cough, shortness or breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose. Consider also diarrhea, nausea or vomiting.

Definitions

For the purpose of this document, definitions are as follows:

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Adult Day Services

- Adult Day Services Centers (ADSCs) are professional care settings where community-dwelling adults receive social or health services for some part of the day. ADSCs often serve adults age 65 years or older who may require supervised care and adults (of any age) living with dementia, cognitive decline, or disability. ADSCs are designed to provide a safe, community-based group setting where specific needs are addressed and individualized therapeutic, social, or health services are delivered.

Ancillary Non-Medical Services

- Ancillary non-medical services are such as those provided by hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists not employed by the facility, but who enter the building to provide services to residents. Ancillary service providers must either participate in the facility's surveillance testing or provide proof of COVID-19 PCR testing in accordance with these requirements.

Close Contact

- Close contact refers to someone who has been within 6 feet of an infected person (laboratory-confirmed or a clinically compatible illness) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes in one day).

Core Infection Prevention Principles

- Screening of all who enter the facility for signs and symptoms consistent with COVID-19, including a temperature check and questions about risk (e.g., close contact with someone with COVID-19 infection in the prior 14 days).
- Denying entry to those with signs or symptoms of COVID-19 or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status).
- Hand hygiene (use of alcohol-based hand rub is preferred).
- Face coverings or masks (covering mouth and nose) for unvaccinated individuals (staff, residents and visitors) and those caring for suspected or confirmed COVID-19 residents.
- Physical distancing of at least six feet between unvaccinated persons and others.
- Instructional signage throughout the facility and proper visitor education on COVID-19, including the signs and symptoms, infection control precautions, and other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene).
- Increased cleaning and disinfecting of high-frequency touched surfaces throughout the facility, including designated visitation areas and shared medical equipment.
- Appropriate staff use of Personal Protective Equipment (PPE) including when caring for a suspected or confirmed COVID-19 resident regardless of HCP vaccination status.
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care).
- Resident and staff testing as required per the Seventh Amended PHO 20-20.

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Essential Health Care Service Providers

- Essential Health Care Service Providers (not staff) include but are not limited to physicians, hospice, and home health staff of all disciplines, along with other types of both medical and nonmedical health care and services. They must be screened and tested in accordance with the surveillance and outbreak testing prescribed in the Seventh Amended PHO 20-20.

Fully Vaccinated

- "Fully vaccinated" refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose vaccine series or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons, and has provided verification of vaccination status to the facility.

Health Care Personnel (HCP)

- Includes staff and essential service providers and providers of healthcare.

Isolation

- Isolation is for someone who has developed illness (i.e., COVID-19 like symptoms) or who has tested positive for COVID-19. Individuals with COVID-19 are infectious and can transmit COVID-19 to others. Individuals who have illness and/or who test positive for COVID-19 should remain in isolation until at least 10 days have passed since their illness began or from the date of test if asymptomatic. For more information go to CDC: COVID-19: Quarantine vs. Isolation.

Medical Appointments

- Medical appointments (e.g., clinic visits, emergency department, outpatient surgical procedures, dialysis) are medical visits that are assumed to have occurred in a controlled environment in which proper infection control measures were maintained. See New Admissions.

Outbreak Definition

- Outbreaks have been standardized across outbreak settings. An outbreak in a residential setting is defined as:
    - Two or more confirmed cases of COVID-19 among residents and/or staff in a facility with onset in a 14-day period
      [OR]
    - One confirmed case and two or more probable cases of COVID-19 among residents and/or staff in a facility with onset in a 14-day period.
- When determining if an outbreak has occurred in a facility, exclude residents with a diagnosis known at the time of admission to the facility. Exclude residents who test positive for COVID-19 in the 14 days after admission **AND** are in observation for

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signs/symptoms of COVID-19 and following appropriate Transmission-Based Precautions.

Outbreak Testing

- Upon notification of a single positive COVID-19 case (staff or resident), the facility must immediately implement facility-wide testing (outbreak testing) of **ALL** staff and **ALL** residents (regardless of vaccination status) to identify additional asymptomatic, pre-symptomatic, or symptomatic infections. Outbreak testing specimens must be collected on all individuals (who have not already tested PCR positive in the previous 90 days) and received by the testing lab within 48 hours of identifying the COVID-19 positive staff or resident.

Physical Distancing

- Physical distancing refers to maintaining physical distance of at least 6 feet whenever possible and is an important strategy to prevent SARS-CoV-2 transmission.

Providers of Health Care Services

- Providers of health care services include those individuals providing medical services (such as podiatrists, dentists, physical or occupational therapists, or hospice nurses), not employed by the facility, but who enter the building to provide care or services to residents. Healthcare service providers must either participate in the facility's surveillance testing or provide proof of COVID-19 PCR testing in accordance with these requirements.

Quarantine

- Quarantine is for someone who was possibly exposed to COVID-19 and needs to stay away from others for a certain period of time to determine whether they develop infection. This is to limit transmission in the event the exposed individual develops COVID-19. Because the incubation period for COVID-19 is 2-14 days, individuals should remain in quarantine until 14 days have passed since their last possible exposure. Testing during this time will not rule out incubating disease and therefore cannot be used to shorten quarantine.
    - Of note: The options to shorten quarantine that CDC published do not apply to high-risk settings such as residential care facilities. The quarantine period for residential settings will remain 14 days after exposure.

Residential Care Facilities (RCF)

- Residential Care Facilities (RCF) are skilled nursing facilities, assisted living residences, intermediate care facilities, and group homes. This does not include non-residential settings such as Adult Day Services.

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Service Repair Technicians, Delivery Persons, and Suppliers

- Service repair technicians, delivery persons, and suppliers (e.g., oxygen delivery suppliers) are not included in required facility testing but should follow core infection prevention practices to prevent COVID-19 including screening for illness prior to admission.

Source Control

- Source control refers to the use of well-fitting cloth masks, medical face masks, or respirators that cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.
    - In addition to providing source control, these devices also offer varying levels of protection against exposure to infectious droplets and particles produced by infected people. Fit-tested respirators (e.g. N95s) are most protective for the wearer. Ensuring a proper fit is important to optimize both the source control and protection offered.

Staff

- Staff are defined as employees (e.g., nurses, licensed independent practitioners, students and trainees, therapists, environmental services) whether employed, contracted, consulting, or volunteer.

Unvaccinated and Partially Vaccinated Individuals

- These include persons who do not yet meet the definition of fully vaccinated, including persons who have never received a vaccine (unvaccinated) and persons who have received one or two doses but have not yet met the complete criteria for full vaccination (partially vaccinated). This includes individuals whose vaccination status is unknown for the purpose of this document. These populations are treated the same for disease control purposes.

Vaccine Breakthrough Case

- Vaccine breakthrough case refers to a person who tests positive for SARS-CoV-2 (regardless of symptoms) and more than ≥2 weeks has passed following receipt of the second dose in a 2-dose vaccine series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons. Vaccine breakthrough cases are treated the same as all individuals who test positive for COVID-19.

Visitor

- A visitor does not meet the criteria of staff. Visitors may include musicians and other performers that provide group activities to more than one resident at a time or a family member or friend visiting one resident. Visitors do not typically participate in

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orientation or training programs. Visitors are not included in surveillance and outbreak testing nor are they offered vaccination. See visitation section for more information.

Volunteer

- Volunteers are unpaid staff members who provide routine services, generally have a recurrent role within the facility, and have received structured training and orientation on resident rights and infection prevention practices. Volunteers generally are 18 and older and have an ongoing relationship with a contract, role, and/or schedule. Volunteers are not infrequent visitors (e.g., Girl Scout troops, musicians, individuals seeking community service hours). Volunteers should be treated as staff and should be included in surveillance and outbreak testing and offered vaccination (e.g., influenza, COVID-19).

Infection Prevention and Control (IPC) Program

Infection Control Training

- Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities. This should be a full-time role for at least one person in facilities that have more than 100 residents. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment. Staff members who are managing the IPC program should complete the CDCs online training modules or complete/have documentation of other comparable infection prevention training education.

Provide Necessary Supplies

Provide supplies necessary to adhere to recommended infection prevention and control practices:

- **Hand Hygiene Supplies**
  - Put FDA-approved 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 the dining hall, in the therapy gym).
  - Unless hands are visibly soiled, performing hand hygiene using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands.
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.

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- **Personal Protective Equipment (PPE)**
    - Employers should select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration (OSHA) PPE standards (29 CFR 1910 Subpart I).
    - Facilities should have supplies of face masks, N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles that cover the front and sides of the face).
        - Make necessary PPE available in areas where resident care is provided.
    - Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard (29 CFR 1910.134) for employees if not already in place. The program should include medical evaluations, training, and fit testing.
    - Perform and maintain an inventory of PPE in the facility including: face masks, respirators (if available and the facility has a respiratory protection program with trained medically cleared, and fit-tested providers) gowns, gloves, and eye protection (i.e., face shield or goggles that covers the front and sides of the face).
        - Consider designating staff responsible for stewarding those supplies,monitoring and providing timely feedback, and promoting appropriate use by staff.
        - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.
        - For PPE resource requests, facilities should notify their local public health agency or refer to Concept of Operations (CONOPS) for Coronavirus Disease (COVID-19) Personal Protection Equipment Shortage (CDPHE).
    - Unvaccinated staff working in facilities located in counties with >10% two-week average test positivity rate ("Colorado Covid Dial"), should wear eye protection (i.e., face shields or goggles that cover the front and the sides of the face) during all resident care activities to protect against viral spread from asymptomatic individuals.
    - N95 respirators should be prioritized for use as PPE versus source control.
    - For more on PPE, to include CDCs Optimization Strategies and how to implement them safely, go to CDPHE PPE FAQ.
- **Environmental Cleaning and Disinfection**
    - Develop a schedule for regular cleaning and disinfection of frequently touched surfaces in resident rooms and common areas.
    - Shared equipment (e.g., thermometers, pulse ox, blood pressure cuffs, resident lifts) should be cleaned and disinfected according to manufacturer instructions in between residents.
    - Equipment utilized to care for individuals on transmission-based precautions should be disposable or dedicated to an individual resident whenever possible.

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If disposable or dedicated equipment is not possible, all equipment must be cleaned and disinfected prior to use on additional residents.
    - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
    - Use an EPA-registered disinfectant from List N:disinfectants for coronavirus (COVID-19) on the EPA website to disinfect surfaces that are frequently touched and those that might be contaminated with SARS-CoV-2.
    - Ensure HCP are appropriately trained on use and follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).

Education

Educate residents, health care personnel, and visitors about SARS-CoV-2, current precautions being taken in the facility, and actions they should take to protect themselves.

- Provide culturally and linguistically tailored information about SARS-CoV-2 infection, including the signs and symptoms that could signal infection.
- Provide information about strategies for managing stress and anxiety.
- Regularly review CDC's Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic for current information and ensure staff and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., rehabilitation therapy, wound care, podiatry, barber), ombudsman, and volunteers who provide care or services in the facility. Including consultants is important since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of SARS-CoV-2. Training should occur prior to providing any care or contact with residents.
- Educate HCP about any new policies or procedures.
- Reinforce sick leave policies and remind HCP not to report to work when ill.
- Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of PPE. Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities. Keep a written record of these observations and provide feedback to staff on their performance.
- CDC has created training resources for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
    - At minimum observe and record staff adherence to the following practices:
        - Hand hygiene (HH) observations
        - PPE use, to include proper glove use
        - Shared medical equipment cleaning and disinfection
        - Isolation precautions and cohorting

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        - Environmental decontamination, to include isolation rooms
        - Surveillance
- Educate residents and families through educational sessions and written materials on topics including information about SARS-CoV-2, actions the facility is taking to protect them and their loved ones, any visitor restrictions that are in place, and actions they should take to protect themselves in the facility, emphasizing the importance of source control, physical distancing and hand hygiene.
- Have a plan and mechanism to regularly communicate with residents, families and HCP, including if cases of SARS-CoV-2 infection are identified among residents or HCP.

Vaccinate Residents and HCP against SARS-CoV-2

- Receiving a COVID-19 vaccination is an important step to prevent getting sick with COVID-19 disease.
- Encourage residents and HCP to receive and complete a COVID-19 vaccination series. Provide accurate information to persons with questions, and support practices that allow residents and HCP to receive vaccination (e.g., time off to receive a vaccine, no penalties for time off if there are side effects after vaccination).
- Facilities should maintain a record of vaccination status for all residents and staff and any visitors who wish to follow guidance for fully vaccinated individuals.
- Language in this document has been updated to address vaccinated vs. unvaccinated given the increased protection offered for fully vaccinated individuals.
- The Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility provides resources including information on preparing for vaccination, vaccination safety monitoring and reporting, frequently asked questions, and printable tools.
- How do I get more vaccines? Visit the strike team website for ongoing COVID-19 vaccination.

Ongoing Vaccination Plans

Each facility must establish and maintain a COVID-19 mitigation plan that promotes vaccine confidence and acceptance and must continue to offer vaccinations to all consenting staff and residents. Each facility shall submit to CDPHE a plan which details how the facility ensures vaccinations are offered and provided to all consenting staff and residents. A template for this plan is available on the CDPHE webpage. Minimally, this information must include:

1. How the facility assesses and addresses the vaccination status of new staff and residents;
2. The identification of designated staff who coordinate vaccination information, administration and tracking of the vaccination status of staff and residents on an ongoing basis,
3. Ongoing measures to promote vaccine confidence and acceptance, and;
4. The vaccination status of all current staff and residents.

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Submission of this information may be completed utilizing this form and must be submitted via email to residentialcarestriketeam@state.co.us on or before Monday, June 14, 2021. This plan must be kept current by the facility and be presented for review during health facility inspections.

Implement Source Control Measures

- **All Who Enter the Facility**
    - **EVERYONE who enters the facility is required to either wear a face covering that covers both their nose and mouth at all times or provide documentation to the facility that they are fully vaccinated.**

CDPHE guidance related to fully vaccinated visitors and those that enter the facility differs from CMS requirements and CDC recommendations. For full guidance and requirements please consult CMS guidance and CDC recommendations.
• CMS requires/CDC recommends: Visitors, regardless of their vaccination status, should wear a well-fitting cloth mask, face mask, or respirator (N95 or a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators) for source control, except as described in the scenarios below. • CMS requires/CDC recommends: In general, fully vaccinated HCP should continue to wear source control while at work. However, fully vaccinated HCP could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If unvaccinated HCP are present, everyone should wear source control and unvaccinated HCP should physically distance themselves from others.

        - Individuals who are not fully vaccinated and cannot wear appropriate source control must be excluded from the facility. These individuals may visit with fully vaccinated staff and/or residents outdoors as an alternative. Information specific to indoor and outdoor visitation can be found here.
- **Unvaccinated Health Care Personnel**
    - HCP that are not fully vaccinated should arrive at the facility wearing their community source control (i.e. face covering or cloth mask). Staff that do not provide resident care (e.g. clerical personnel) may continue to wear their community source control throughout their shift.
    - HCP that are not fully vaccinated and providing resident care should remove their community source control upon arriving to work and don a well-fitting medical grade face mask or respirator. This should remain in place for the duration of the time in the facility except for the examples listed below.
    - To reduce the number of times HCP must touch their face, and the potential risk for self-contamination, HCP should consider extended use of masks and respirators as outlined in the PPE FAQ.

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    - When leaving the facility at the end of their shift, HCP that are not fully vaccinated should remove and dispose of their medical grade face mask or respirator (do not store for later use), perform hand hygiene, and put on their community source control. For additional guidance on recommended source control or PPE use, refer to CDPHEs PPE FAQ or CDCs Interim for Infection Prevention and Control Recommendations.
    - HCP that are not fully vaccinated should wear a mask and socially distance themselves from others whenever possible while in the facility, including but not limited to breakrooms, meeting rooms, and offices.
- **Fully Vaccinated Health Care Personnel**
    - Fully vaccinated HCP are no longer required to wear masks while in the facility unless required as part of standard or transmission-based precautions (including the care of COVID-19 residents).
    - Fully vaccinated HCP can dine and socialize together in employee break rooms with their mask removed.
    - Fully vaccinated HCP can participate in in-person meetings with their mask removed.
    - Fully vaccinated HCP must provide verification of vaccination status.

CDPHE guidance related to fully vaccinated HCP differs from CMS requirements and CDC recommendations. For full guidance and requirements please consult: CMS guidance and CDC recommendations.
CDC and CMS Guidance on HCP Mask Use • In general, fully vaccinated HCP should continue to wear source control while at work. However, fully vaccinated HCP could dine and socialize together in break rooms and conduct in- person meetings without source control or physical distancing. If unvaccinated HCP are present, everyone should wear source control and unvaccinated HCP should physically distance themselves from others.

- **Unvaccinated Residents**
    - Residents that are not fully vaccinated, if tolerated, should wear a well-fitting form of source control whenever they leave their room, including in common areas or outside of the facility.
    - Source control should not be placed on anyone who cannot wear a mask safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask or who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
    - Ensure residents that are not fully vaccinated are educated on how to safely remove their masks (should they need to do so) while out of the facility.
    - Residents that are not fully vaccinated should continue to wear a mask and practice social distancing during activities and facility outings.
    - Residents that are not fully vaccinated should wear a mask until seated in the dining room for a communal meal and should be socially distanced from other residents. The mask should be replaced once the meal has ended.

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- **Fully Vaccinated Residents**
    - Fully vaccinated residents are no longer required to wear masks while in the facility.
    - Fully vaccinated residents may share a table with other fully vaccinated residents.
    - Fully vaccinated residents do not need to wear masks while participating in group activities and facility outings.
    - Fully vaccinated residents must provide verification of vaccination status.

Implement Physical Distancing Measures

- Although most care activities require close physical contact between residents and HCP, when possible, maintaining physical distance between unvaccinated people (at least 6 feet) is an important strategy to prevent SARS-CoV-2 transmission.
- Remind unvaccinated HCP to practice physical distancing when in break rooms or common areas (as outlined above). Wearing a mask does not negate the need for social distancing but serves as another infection control measure to prevent disease transmission. The more infection control measures consistently implemented and maintained, the more successful we will be at preventing disease transmission.

Surveillance for Respiratory Illness in Residents during COVID-19

- Assess resident vital signs including temperature and pulse oximetry daily.
- Routinely monitor residents for possible COVID-19 symptoms, including:
    - Cough
    - Shortness of breath, difficulty breathing, or signs of new hypoxemia
    - Fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)
    - Other symptoms in the setting of a suspected or confirmed COVID-19 outbreak (e.g., rhinorrhea, diarrhea, nausea or vomiting)
    - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include changes in cognition, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, or loss of taste or smell. Additionally, more than two temperatures >99.0˚F might also be a sign of fever in this population.
- Identification of any one symptom should prompt facilities to follow the guidance below Respiratory Illness or a Positive Test is Identified.
- Ensure residents have been educated on the signs and symptoms of COVID-19 and how to report if they develop illness.

Respiratory Illness or a Positive Test is Identified (Isolation)

Residents with Illness or a Positive Test

Residents that test positive (regardless of symptoms) and those with signs or symptoms of COVID-19 should be cared for in the following manner (regardless of vaccination status):

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- Residents with newly identified signs or symptoms of COVID-19 should be tested immediately if not already completed.
- Residents should be cared for following transmission-based precautions in a single person room with a private bathroom (i.e. isolated).
    - Staff caring for these individuals should follow transmission-based precautions.
    - If single person rooms are not available, or numerous residents are simultaneously identified as having signs or symptoms of COVID-19, residents should shelter in place while awaiting testing results.
    - Residents with suspected or confirmed COVID-19 do not need to be cared for in a negative airborne isolation room (AIIR) but should be cared for using an N95 or higher level respirator, eye protection, gloves, and a gown.
    - The door to the room should be closed whenever possible. If the door being closed creates a safety concern (e.g. memory care unit), work with facility engineers to minimize airflow into the hallway (e.g. running the bathroom exhaust fan).
    - A COVID-19 care area can be used if available, but should only house individuals who have a positive PCR test confirming COVID-19.
- Avoid moving ill residents both inside and outside of the facility. If an ill resident requires care outside of the facility, notify EMS and/or the receiving facility of known or suspected COVID-19 prior to arrival.
- Only essential personnel should enter the room of residents being cared for following transmission based precautions. Consider having designated staff care for ill residents and/or bundle care activities to limit the number of interactions and PPE utilized.
- Increase monitoring of all residents (regardless of vaccination status) for signs and symptoms of COVID-19 to at least 3 times per day.
- Consult the Discontinuation of Isolation for Residents and Staff section in this document to determine when isolation is no longer necessary.

Staff with Illness or a Positive Test

- Facilities should have a process in place to ensure all staff (including consultant and ancillary personnel) are screened at the beginning of their shift for fever or respiratory symptoms, regardless of vaccination status. A sample form can be found here.
    - Screening should ask about close contact with a person infected with COVID-19 and any ill household member.
    - Facilities can choose to actively screen their staff or allow staff to self-screen but must ensure screening occurs and responses monitored to promptly respond to staff who report illness or close contact exposures.
    - As part of routine practice, ask staff to regularly monitor themselves for fever and symptoms of respiratory infection. Remind staff to report illness promptly.
    - Remind staff to stay home when they are ill. Staff should not report to the facility if they are feeling ill.
    - Prioritize testing if it has not already been done.
        - POC testing can be used (in addition to the required PCR testing but not as a replacement) to assist with prompt identification of COVID-19. See antigen testing section for additional information.
- Discourage staff from working in multiple facilities, as this can increase the risk of transmission and an outbreak among multiple facilities. If such limitations cannot be

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

maintained, keep a record of other healthcare facilities where your staff are working and ask about exposure to facilities with recognized COVID-19 cases.
- Consult the Discontinuation of Isolation for Staff section in this document to determine when isolation is no longer necessary.

Alternate Diagnosis

- If staff or residents have COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work/discontinuation of transmission based precautions should be based on that diagnosis. However, if concurrent COVID-19 infection is suspected based on association with a suspected or confirmed outbreak, return to work criteria should follow the strategies above.

Management of Asymptomatic Residents and HCP who had Close Contact with Someone with SARS-CoV-2 Infection (Quarantine)

The following recommendations are based on what is known about currently available COVID-19 vaccines. These recommendations will be updated as additional information becomes available, including information regarding vaccine effectiveness to prevent against infection with novel variants. This could result in additional circumstances when work restrictions for fully vaccinated HCP are recommended.

Fully Vaccinated Health Care Personnel

- Fully vaccinated HCP with higher-risk exposures who are asymptomatic **do not** need to be restricted from work for 14 days following their exposure. Work restrictions with higher-risk exposures should still be considered:
    - HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact the level of protection provided by the COVID-19 vaccine. However, data on which immunocompromising conditions might affect response to the COVID-19 vaccine and the magnitude of risk are not available.
- Asymptomatic HCP with a higher-risk exposure with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5–7 days after exposure.

All Residents in Health Care Settings

- All residents (regardless of vaccination status) who reside in a health care setting should quarantine for 14 days following prolonged close contact (roommates and those within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with SARS-CoV-2 infection.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

    - Residents in quarantine should be placed in a single-person room with a private bathroom whenever possible. If single rooms are not available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location while being monitored for evidence of SARS-CoV-2 infection.
        - If at any time during the quarantine period a resident tests positive for or has symptoms concerning for COVID-19, the resident starts isolation and remains in isolation until Discontinuation of Isolation Criteria is met. For more information on isolation, refer to Respiratory Illness or a Positive Test is Identified (Isolation).
        - Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection (i.e. positive PCR test). Placing a resident without confirmed SARS-CoV-2 infection (e.g. with symptoms concerning for COVID-19 pending testing or with known exposure) in a dedicated COVID-19 care unit could put them at higher risk of exposure to SARS-CoV-2.
- Asymptomatic residents with a higher-risk exposure with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5–7 days after exposure.

Newly Admitted Residents

Unvaccinated Residents

In general, all new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. Exceptions are listed below. Residents who leave the facility for 24 hours or longer should generally be managed as a new admission.

- Unvaccinated new admissions should be included in surveillance and outbreak testing.
- HCP should wear an N95 or higher-level respirator, eye protection (i.e. goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for residents on transmission-based precautions (e.g. isolation and quarantine).

Fully Vaccinated Residents

- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility **if they are fully vaccinated and have not had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days**. Facilities should have a process in place to assess for such risk upon admission.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Considerations for Residents Who are Within 3 Months of Prior Infection

- CDC recommendations indicate that asymptomatic residents who have recovered from COVID-19 and are within 3 months of their positive PCR test may not need to quarantine or test following re-exposure to someone with SARS-CoV-2 infection. However, there might be clinical scenarios for which providers could consider testing for SARS-CoV-2 and quarantine. Examples could include:
    - Residents with underlying immunocompromising conditions (e.g. patient after organ transplantation) or who become immune compromised (e.g. receive chemotherapy) in the 3 months following SARS-CoV-2 infection and who might have an increased risk for reinfection. However, data on which specific conditions may lead to higher risk and the magnitude of risk are not available.
    - Residents for whom their initial diagnosis of SARS-CoV-2 infection might have been based on an antigen test, and a confirmatory nucleic acid amplification test (NAAT) was not performed.
    - Residents for whom there is evidence that they were exposed to a novel SARS-CoV-2 variant (e.g. exposed to a person known to be infected with a novel variant) for which the risk of reinfection might be higher.

Discontinuation of Isolation (Residents and Staff)

Residents or staff requiring isolation due to suspected or confirmed COVID-19 infection may be released from isolation and/or return to work when the following are true:

Individuals with Mild to Moderate Illness Who are Not Severely Immunocompromised

- At least 10 days have passed since symptoms first appeared.
  [AND]
- At least 24 hours have passed since last fever without the use of fever-reducing medications.
  [AND]
- Symptoms (e.g., cough, shortness of breath) have improved.
- Patients who were asymptomatic throughout their infection and are not severely immunocompromised should wait at least 10 days have passed since the date of their first positive viral test.

Individuals with Severe to Critical Illness or Who are Severely Immunocompromised

- At least 10 days and up to 20 days have passed since symptoms first appeared.
  [AND]
- At least 24 hours have passed since last fever without the use of fever-reducing medications.
  [AND]

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Symptoms (e.g., cough, shortness of breath) have improved.
- For severely immunocompromised residents who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.
- Patients who are severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when Transmission-Based Precautions may be discontinued could be considered.

When SARS-CoV-2 and Influenza Viruses are Co-circulating

- When SARS-CoV-2 and influenza viruses are found to be co-circulating based upon local public health surveillance data and/or testing at local health care facilities, facilities should implement the following:
    - Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for COVID-19 and test for both viruses (COVID-19 and influenza).
    - Because some of the symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two infections based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in the current room, pending results of viral testing. **They should not be placed in the COVID-19 care unit unless influenza is ruled out and they are confirmed to have COVID-19 by SARS-CoV-2 (PCR) testing.**
    - Facilities should promptly contact public health for consultation and further investigation if co-circulating viruses are suspected.
    - Additional CDC guidance for influenza can be found here. The CDPHE guidelines for influenza outbreaks in long-term care facilities can be found here.
- CDPHE provides a basic tracking tool: Line List Template to Monitor Residents and Staff. Collection of additional variables may be recommended in the setting of a suspected or confirmed COVID-19 outbreak.

Return to Work After Travel

Travel may increase an individual's risk of getting and potentially spreading SARS-COV-2. Those living in a residential care facility are at an increased risk of poor outcomes if they become infected. Facilities should consider the following when assessing risk of those who have recently traveled and will be coming into contact with residents.

Fully Vaccinated Travelers

- Domestic travelers that are fully vaccinated do not need to get a SARS-CoV-2 viral test or self-quarantine after travel.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- International travelers that are fully vaccinated should get tested with a viral test 3-5 days after travel and isolate if positive.
    - Travelers do not need to self-quarantine after international travel.
- In either scenario, the traveler should continue to self monitor for signs and symptoms for a full 14 days.

Unvaccinated or Partially Vaccinated Travelers

- In general, CDC recommends people delay travel (domestically or internationally) until they are fully vaccinated.
    - Unvaccinated or partially vaccinated travelers should notify the facility of their travel plans prior to departure whenever possible. Facilities should have processes in place to assess traveler risk prior to travelers being allowed to return to work.
- Domestic travelers are recommended to get tested with a viral test 3-5 days after travel and isolate if positive. HCP should self-quarantine for a full 7 days if testing negative. If testing does not occur, the traveler should be quarantined for 10 days after travel.
- International travelers should get tested with a viral test 3-5 days after travel AND stay home and self-quarantine for a full 7 days after travel. Even if they test negative, travelers should stay home and self-quarantine for the full 7 days. If they test positive, travelers should isolate themselves to protect others from getting infected.
    - If they don't get tested, travelers should stay home and self-quarantine for 10 days after travel.
    - International travelers should avoid being around people who are at increased risk for severe illness for 14 days after return, whether they get tested or not.
    - International travelers should self-monitor for COVID-19 symptoms for 14 days, and isolate and get tested if they develop symptoms.

Considerations for completing a risk assessment should include at minimum: location of travel, method of travel (e.g. air, bus, car), and activities during travel (e.g. camping vs amusement park or large indoor gathering). The goal of a risk assessment is to determine if the risk of being exposed to COVID-19 is greater during travel than the risk within the community. If risk is greater, travelers should quarantine for 14 days in addition to the other CDC travel recommendations.

Testing Requirements

CDPHE guidance related to the routine testing of staff differs from CMS requirements. For full guidance and requirements please consult CMS guidance. In this example CDPHE guidance is more strict than CMS, therefore Facilities should follow CDPHE guidance.		
• The CMS guidance represents the minimum testing expected. Facilities may consider other factors, such as the positivity rate in an adjacent county to test at a frequency that is higher than required.		
Community COVID-19 Activity	County Positivity Rate in the past week	Minimum Testing Frequency of Unvaccinated Staff

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Low	<5%	Once a month
Medium	5% - 10%	Once a week
High	>10%	Twice a week

Public Health Order 20-20 requires facilities to participate in surveillance and outbreak testing as described in this guidance document.

Residents and staff with asymptomatic and presymptomatic COVID-19 infection, who likely play a significant role in transmission of COVID-19, cannot be identified without testing. Cohorting residents within a facility is difficult without expanded testing. Residents without illness and those with an unknown COVID-19 status should not be cohorted with COVID-19-positive residents. Without routine surveillance testing of unvaccinated staff and residents, residential care settings might implement cohorting strategies that could contribute to increased transmission within the facility because of others who may be infected and are either at the early stage of infection or are infected with COVID-19 but are asymptomatic.

CDPHE will provide testing supplies for all facilities to implement surveillance and outbreak testing, or facilities may choose to procure their own resources for laboratory based PCR testing that meets or exceeds the testing services provided by CDPHE, as outlined in this document and required by the PHO.

Surveillance Testing

- All facilities must implement surveillance testing for COVID-19 utilizing laboratory based PCR testing.
- Surveillance testing should be based on the extent of the virus in the community (as outlined in this section) and the vaccination status of the individual being tested.

Fully Vaccinated HCP and Residents

- Fully vaccinated HCP and residents who remain asymptomatic **DO NOT** need to participate in routine surveillance testing.

HCP and Residents Who Recovered from COVID-19 in the Previous 90 days.

- Residents and HCP who have tested positive for COVID-19 (by PCR) in the previous 90 days **SHOULD NOT** be included in routine surveillance testing.

HCP That Are Not Fully Vaccinated

- Unvaccinated HCP (employees, consultants, agency staff, contractors, volunteers, students, caregivers, and others who provide care and services to residents) should be included in routine surveillance testing.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Residents That Are Not Fully Vaccinated

- Residents who are not fully vaccinated **DO NOT** need to participate in routine surveillance testing **UNLESS** they have left the facility in the past 14 days.

Testing Frequency

Facilities should monitor their county's two-week test positivity rate every other week (e.g. first and third Monday of each month) using the Colorado COVID-19 dashboard and adjust the frequency of testing as outlined below. The facility should test all required staff and residents at the frequency indicated in the routine testing interval table below.

Routine Testing Interval Table

Individuals that should participate in routine surveillance testing	County Positivity Rate using CO COVID-19 dashboard	Minimum Testing Frequency utilizing PCR testing
• HCP that are not fully vaccinated. • Residents that are not fully vaccinated and have left the facility in the past 14 days. *Exclude those that tested positive in the past 90 days.	< 10% two-week test positivity.	Once a week.
• HCP that are not fully vaccinated • Residents that are not fully vaccinated and have left the facility in the past 14 days. *Exclude those that tested positive in the past 90 days.	>10% two-week test positivity.	Twice a week.

- Providers of health care or ancillary non-medical services for residents of the facility must either provide proof that they are fully vaccinated, participate in the facility's surveillance testing, or bring evidence of negative PCR test results to the facility within the preceding week.
    - Facilities should have a process in place that ensures and maintains the required documentation (i.e. a copy of the individual's vaccination record or a copy of PCR negative test results) prior to exemption.
- Facilities may choose to expand testing beyond these minimum requirements, such as testing all unvaccinated residents on a more frequent basis.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- POC testing may be offered to visitors; visitors may be excluded from visiting if they test positive, but cannot be denied entry if testing is refused. Facilities should not use state funded/state provided testing resources outside the scope of surveillance and outbreak testing (i.e. do not use to test visitors).
- Facilities may not restrict Ombudsman, Adult Protective Services workers, or Emergency Medical Services workers from entering their building for any reason, including the absence of proof of testing.

Individuals that Refuse Testing When Indicated

Facilities must have procedures in place to address residents, staff, and others who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return-to-work criteria are met.

- Staff and residents (or resident guardians/representatives) may exercise their right to decline COVID-19 testing. Facilities must have written infection control policies and procedures in place to address staff and residents who refuse COVID-19 testing.
- If outbreak testing has been triggered (identification of a positive resident or staff member) and an asymptomatic staff member refuses testing, the staff member should be restricted from the facility building for 14 days following each round of refused testing or until the procedures for outbreak testing have been completed (e.g., outbreak resolved).
- Symptomatic residents, regardless of vaccination status, that refuse testing should be placed on transmission based precautions in a private room until symptom based criteria for the discontinuation of isolation precautions have been met.
- Asymptomatic residents that refuse testing should be quarantined and staff shall use PPE effective against COVID-19 until the outbreak resolves.

Implement Outbreak Testing

When one or more positive tests are identified in a resident or a staff member (regardless of vaccination status), the facility moves to outbreak testing and follows additional response measures.

Outbreak Testing Interval Table

Individuals that should participate in outbreak testing	Testing Frequency Utilizing PCR Testing
• All HCP-regardless of vaccination status. • All residents, regardless of vaccination status. *Exclude those that tested positive in the past 90 days and remain asymptomatic.	Twice a week.

After the positive test(s), do the following next steps:

- Initiate outbreak testing immediately. Perform round 1 of outbreak testing, including all staff and residents regardless of vaccination status, except those who have tested

positive in the previous 90 days and remain asymptomatic. Testing must be initiated immediately with specimens collected and sent to the testing laboratory within 48 hours of identifying the positive test result. This is to promptly identify other asymptomatic, presymptomatic, and symptomatic infections.

- The results for each round of testing will determine the next step in responding to the outbreak, as outlined in the Outbreak Testing Results and Response section.
- Conduct contact tracing to identify individuals (staff and residents) with prolonged exposure and quarantine accordingly.
- Facilities may continue admissions regardless of residents' COVID-19 status while awaiting results from the initial round of testing . Facilities may also continue communal dining, group activities, and indoor visitation. However, residents on transmission based precautions (i.e. isolation or quarantine) should be excluded.
- Facilities must immediately report an outbreak of COVID-19 to public health. Review Reporting Test Results to Public Health within this document for additional information.

Outbreak Testing Results and Response (See decision tree)

- **Facilities that Identify No Positives in Residents or Staff**
  - Move to OB Exit Testing.
    - Facilities must ensure testing of ALL staff and residents except those that have tested positive in the previous 90 days in order to move to OB Exit Testing.
  - Testing frequency is every 7 days until the outbreak is closed.
  - Facilities may resume or continue admissions, communal dining and group activities, and indoor visitation for all residents regardless of vaccination status.
- **Facilities that Identify Positive Residents Only**
  - Continue to follow OB testing protocol.
  - Testing frequency is every 3-4 days.
  - Facilities should stop admissions, communal dining, group activities, and indoor visitation for unvaccinated persons.
  - The facility may continue **outdoor** visitation for all residents (regardless of vaccination status) as long as the resident otherwise meets the criteria for visitation.
- **Facilities that Identify Positive Staff and Residents**
  - Continue to follow OB testing protocol.
  - Testing frequency is every 3-4 days.
  - Facilities should stop admissions, communal dining, group activities, and indoor visitation for unvaccinated persons.
  - The facility may continue with **outdoor** visitation for all residents (regardless of vaccination status) as long as the resident otherwise meets the criteria for visitation.
- **Facilities that Identify Positive Staff Only**
  - Continue to follow OB testing protocol.
  - Testing frequency is every 7 days.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

    - Facilities may resume or continue admissions, communal dining, group activities, and indoor visitation (regardless of vaccination status).
- **Outbreak Exit Testing**
    - Outbreak exit testing is done when a round of testing identifies no positive residents or staff. Facilities must ensure testing of ALL eligible staff and residents (i.e., individuals who have not tested PCR positive in the previous 90 days) in order to move to OB Exit Testing.
    - Frequency of testing is at least 7 days from the previous round of testing and continues until two additional rounds of testing (three consecutive rounds) identifies no positive residents or staff.
    - If at any point a round of testing identifies a new positive, the facility returns to OB testing.
    - Facilities may resume or continue admissions (regardless of resident COVID-19 status), communal dining and group activities, and indoor visitation.

Testing Previous Positives

- CDPHE does not recommend repeat testing of persons who previously tested positive for COVID-19 in the past 90 days. This includes those who are asymptomatic and identified during outbreak testing. **Repeated testing of any positive individual cannot be used to release someone from isolation or resolve an outbreak.** For adults who have recovered from SARS-CoV-2 infection, a positive SARS-CoV-2 RT-PCR result without new symptoms during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.
- If such a person becomes symptomatic during this 90-day period and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the person may warrant evaluation for SARS-CoV-2 reinfection in consultation with an infectious disease or infection control expert.
    - Quarantine may be warranted during this evaluation, particularly if symptoms developed after close contact with an infected person.
    - Serologic testing should not be used to establish the presence or absence of SARS-CoV-2 infection or reinfection. See Duration of Isolation and Precautions for Adults with COVID-19.

Point of Care (POC) Antigen Testing

Antigen tests are available as point-of-care (POC) diagnostics for SARS-CoV-2, offering a rapid turnaround time. Although specificity for SARS-CoV-2 is similar to RT-PCR, it has a lower sensitivity. It is recommended that antigen tests be reserved and used with symptomatic individuals as a supplement to PCR testing to test for the presence of COVID-19 in the residential care setting.

Considerations for use are outlined below:

- POC tests can be used in addition to the required PCR testing (outlined above) but not as a replacement. POC testing **DOES NOT** meet the testing requirements.
- In order for a facility to conduct POC testing, the facility must have a CLIA Certificate of Waiver. Information on obtaining a CLIA Certificate of Waiver can be found here.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- If using POC testing, the facility should be familiar with the instructions for use of the specific test being utilized including the FDA EUA for antigen tests.
- Considerations for interpreting antigen test results in nursing homes can be found here.
- Facilities that choose to use POC testing need to report results (positive, negative and inconclusive) to CDPHE as the performing laboratory (as outlined below in Reporting Test Results to Public Health).
- If the facility is utilizing rapid antigen tests for expansion of these testing requirements and timeframes, and encounters a negative result among symptomatic residents or staff, the facility must conduct a PCR test to confirm the results.
- POC testing should be used to isolate in a private room but facilities should not make cohorting decisions until PCR confirmation.

Specimen Collection

- The type of specimen collected when testing for current or past infection with SARS-CoV-2 is based on the test being performed and its manufacturer's instructions. Some of the specimen types will not be appropriate for all tests.
- For initial diagnostic testing for current SARS-CoV-2 infections, CDC recommends collecting and testing an upper respiratory specimen.
- CDC interim guidelines for collecting and handling of clinical specimens for COVID-19 testing should be followed.

Reporting Requirements

Reporting Test Results to Public Health

- COVID-19 (SARS-CoV-2) is a reportable communicable disease in Colorado requiring both the ordering provider and laboratory to report SARS-CoV-2 test results. Your facility is responsible for reporting all results (positive, negative, and inconclusive) for specimens that are collected and tested by your facility (e.g., rapid point-of-care tests) as described below. Additionally, your facility is responsible for reporting positive results from laboratory-based testing directly to CDPHE. **Your facility is exempt from this rule only if you are currently participating in state-funded surveillance and outbreak testing via your assigned laboratory.**
- **For additional questions about reporting SARS-CoV-2 results, please email the team in PHIRR:** cdphe_covidreporting@state.co.us.
- Facilities performing POC testing must report all SARS-CoV-2 results (positive, negative and inconclusive) to CDPHE directly.
- All tests whether submitted to a laboratory or conducted as a point of care test MUST include all of the required information necessary to process the tests by the provider and testing lab and should include:
    - Full name of the individual being tested.
    - Date of birth.
    - Sex.
    - Ethnicity and race.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

    - Complete street address (only residents may utilize the facility address -- the address should be where the individual resides).
    - Phone number (only residents may use the facility phone number).
    - Collection date
    - Specimen type
- Any suspected or confirmed case **or** outbreak (e.g., one or more cases) of COVID-19 among residents or staff shall immediately be reported to the local or state public health agency using the COVID-19 Outbreak report form.
    - Facilities can send this form to their local public health agency OR to CDPHE by securely emailing the completed form to cdphe_covid_outbreak@state.co.us. Facilities may also contact CDPHE at 303-692-2700 (8:30 - 5:00, Monday - Friday) or 303-370-9395 (after-hours, holidays and weekends).
    - Additionally, facilities should promptly notify public health for any of the following: Suspected or confirmed case of influenza in a resident or HCP (may indicate co-circulation); a resident with severe respiratory infection resulting in hospitalization or death; or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of one another.

EMResource

- ALL residential care facilities should report COVID-19 information weekly, using the CDPHE EMResource.

NHSN

- CMS nursing homes must report COVID-19 data to NSHN at least once weekly. CDPHE does not currently have NHSN reporting requirements for Nursing Homes. You may view the required reporting information for CMS here.
- Reporting information to NHSN does not fulfill state COVID-19 reporting requirements.

Communal Dining/Group Activities/Facility Outings

For communal dining/group activities and facility outings, the following CMS requirements and CDC recommendations differ from CDPHE. For full guidance and requirements please consult the following links. CMS guidance and CDC recommendations.
Specifically for communal dining, group activities, and facility outings: • CMS requirements and CDC recommendations: If unvaccinated patients/residents are dining in a communal area (e.g., dining room), all patients/residents should use source control when not eating, and unvaccinated patients/residents should continue to remain at least 6 feet from others.

Facilities may participate in communal dining, group activities and facility outings as outlined below:

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Documented proof of vaccination status is required and must be maintained by the facility for all staff, residents and any visitors participating in group activities.
- Residents with symptoms of illness, including signs and symptoms of COVID-19, or those that require isolation or quarantine (regardless of the reason) should be excluded from participating in communal dining, group activities, and facility outings.
- Facilities that are conducting outbreak testing related to the identification of one or more positive COVID-19 cases should follow the OB testing guidance and decision tree to determine when communal dining and group activities should be stopped, or resumed.
- Pets other than ADA service animals should not be included in communal dining or group activities. See visitation for individual pet visits.
- Hand hygiene should occur before and after all communal dining, group activities, and outings.

Communal Meals

- **Fully Vaccinated Residents**
  - Can participate in communal dining and share a table with other fully vaccinated residents without source control or physical distancing.
- **Residents Not Fully Vaccinated**
  - Should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated.
  - Should wear masks at all times when outside of their room and until seated at a table to consume a meal.
  - Meals should be consumed while socially distanced from other residents or in the resident's room.

Group Activities

- **Fully Vaccinated Residents**
  - May choose to participate in group activities without using a mask or social distancing.
  - The consumption of food and drink can occur during group activities.
- **Residents Not Fully Vaccinated**
  - Should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated.
  - Should wear masks at all times when outside of their room, including while participating in group activities and facility outings.
  - While participating in group activities, residents should socially distance themselves from other residents and staff.
  - Food and drink should not be consumed during group activities and facility outings unless food and drink are consumed outdoors and residents are socially distanced from other residents and staff.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- **Fully Vaccinated Visitors**
    - Fully vaccinated visitors (i.e., family members, musicians, entertainers) may participate in group activities, facility outings and communal meals. Visitors must provide proof of vaccination.
    - Visitors that are unable to provide proof of vaccination are restricted from participating in group activities, facility outings and communal dining and should follow visitation guidance.

Facility Outings

It may not be possible to social distance from others while riding in shared transportation required for facility outings. This should be considered prior to allowing unvaccinated residents to participate in such activity. If residents who are not fully vaccinated are sharing transportation to/from an activity, all unvaccinated individuals in the vehicle should wear masks and vehicle ventilation should be increased.

Residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces. They should be encouraged and assisted with adherence to all recommended infection prevention and control measures, including source control, physical distancing, and hand hygiene.

Documented proof of vaccination status is required and must be maintained by the facility for all visitors participating in dining, group activities, and visitation intended for vaccinated individuals.

- **Fully Vaccinated Residents**
    - May choose to participate in facility outings without using a mask or social distancing.
- **Residents Not Fully Vaccinated**
    - Unvaccinated residents should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated.
    - Unvaccinated residents should wear masks and physically distance themselves from others.
    - Food and drink should not be consumed during facility outings unless food and drink are consumed outdoors and socially distanced from other residents and staff.

Visitation

While COVID-19 continues to present a substantially increased risk of mortality among older adults and individuals with underlying medical conditions in the state of Colorado, social isolation of individuals in nursing homes, group homes, assisted living communities, intermediate care facilities, and other congregate settings imposes substantial physical and mental health consequences for these residents. Visitation should be person-centered;

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consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.

The facility must be in compliance with all public health orders as part of the implementation for this guidance. Residential care providers must routinely evaluate and update their visitation policies and procedures as guidance, facility resources, and the degree of community spread changes. Individual facilities may be required to enact stricter requirements based on their local COVID-19 community transmission levels, but may not waive any of these requirements.

General Visitation Guidance

The following guidance outlines requirements for all indoor and outdoor visitation, as well as circumstances when visitation should be limited. Visitation can be conducted through different means based on a facility's structure and residents' needs such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Visitation is offered as a means for families and friends to have an opportunity to have personal interactions with one or two residents in the case of an established relationship (e.g., siblings, married couple, life partners); in general visits should be limited to a single resident unless all participants are fully vaccinated.

For all visitation, the facility shall:

- Have adequate staffing and personal protective equipment (PPE), as reported into EMResource. The facility may cease visitation if it does not have necessary staff or PPE to perform infection control practices. **The facility must contact CDPHE (residentialcarestriketeam@state.co.us) if it wishes to cease visitation due to a lack of staffing or PPE.**
- Unvaccinated residents should wear a well-fitting mask which covers their nose and mouth unless it is medically contraindicated.
- Require unvaccinated visitors to schedule an appointment for the visit to ensure the facility can safely accommodate the number of people and have enough staff to monitor compliance with required infection prevention activities.
- Appropriately schedule visits for unvaccinated visitors, so that staff have sufficient time to ensure rooms and/or surfaces can be properly cleaned and disinfected according to manufacturer's instructions between each visit.
- Require unvaccinated visitors to remain in their cars or outside the building until their scheduled visit time.
- Require unvaccinated visitors to wear a well-fitting mask which covers their nose and mouth during the entirety of the visit.
- Deny entry to visitors, regardless of vaccination status, who do not pass screening or who refuse to comply with any of the indoor visitation requirements set forth in this guidance.
- Cease visitation for visitors and residents, regardless of vaccination status, who do not adhere to the core principles of COVID-19 infection prevention during the visit.
- If a visitor is participating in activities reserved for only those that are fully vaccinated, the visitor must share a copy of their vaccination record with the facility prior to the visit. The facility is required to maintain a copy of such records.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Who May Visit

All residential care facilities, including those which do not meet the criteria for indoor visitation, must allow entry and may not deny entrance for the following services. The following service providers must wear a mask when entering the facility unless they are able to provide a copy of their vaccination record to the facility prior to the visit.

- **Essential Health Care Service Providers**
  - This includes but is not limited to physicians, hospice, and home health staff of all disciplines, along with other types of both medical and nonmedical health care and services.
  - Essential health care services providers must be screened and tested in accordance with the surveillance and outbreak testing prescribed in the Seventh Amended PHO 20-20.
  - Essential health care service providers must either produce a negative COVID-19 test within the prescribed testing frequency the facility is following or submit to facility testing.
- **Religious Exercise**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Adult Protective Services**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Long Term Care Ombudsman**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Designated Support Persons**
  - Support service providers must be screened and may be offered testing in accordance with the surveillance and outbreak testing prescribed in the Seventh Amended PHO 20-20.
- **Compassionate Care Visits Should be Permitted at All Times**
  - Screening is required.
- **Emergency Medical Service Personnel**
  - Neither screening nor testing is required.
  - Emergency medical and service personnel shall not be delayed from response or access in relation to responding and carrying out their duties.
- **Ancillary Non-Medical Services**
  - Includes hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists.
  - Ancillary services must be provided in the resident's room or in a separate room that is appropriately disinfected between uses.
  - Must wear appropriate PPE and follow appropriate infection control measures prior to, during, and after each resident encounter.
  - Comply with the policy and procedures regarding infection control, and abide by all other precautions and restrictions imposed on their profession that would be required in any setting.

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Visitation Restrictions

Facilities may NOT offer or allow general visitation (as opposed to other types of required visitation) on the premises if:

- The resident participating in the visit has symptoms of COVID-19 or an active COVID-19 infection and requires transmission-based precautions.
- The resident participating in the visit is on transmission-based precautions (e.g., COVID-19 isolation, droplet or contact precautions). This includes residents required to quarantine following admission.
- Statewide restrictions are implemented due to increased cases of COVID-19.
- Facilities should allow for indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times).
- Indoor visitation for unvaccinated residents should be limited to compassionate care visits only IF any of the following are true:
    - The facility has a two-week COVID-19 positivity rate of more than 10%, and fewer than 70% of residents in the facility are fully vaccinated. The facility shall utilize the COVID-19 Colorado Dial Dashboard to determine their county's average two-week positivity rate.
    - The facility has an outbreak of COVID-19 among the residential population.
    - Refer to the outbreak testing and response (or decision tree) to determine when indoor visitation for unvaccinated residents may resume.
    - Visitation during an outbreak may occur under certain circumstances as outlined here.

Prior to Implementing Visitation

- Notify residents' families and friends that general visitation is occurring in the facility. The notification should include:
    - Requirements, expectations, and limitations of visitation.
    - Instructions for self-screening along with information about when the results of the screening would require a cancellation of the visit.
    - Information on minimizing the spread of COVID-19.
    - Instructions for physical distancing and requirements for wearing a mask.
    - Instructions for scheduling visits, arriving, checking in for the visit, and screening with staff prior to entry.

Outdoor Visitation

Outdoor visitation is preferred even when the resident and visitor are fully vaccinated against COVID-19, as these visits generally pose a lower risk of transmission due to increased space and airflow. Visits should be held outdoors whenever possible. However, poor weather conditions or an individual resident's health status may hinder the possibility of an outdoor visit. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate core infection control and prevention practices should be adhered to, and the following practices should be followed:

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- The designated meeting area should be isolated. The facility should ensure that residents not participating in visits continue to have access to separate outdoor space.
    - The meeting area should be monitored by facility staff to ensure it remains separated from the facility population and from facility staff.
- The allowable number of persons (resident, staff, and visitors) will depend on the size of the space and should allow for social distance of at least 6 feet for residents and visitors that are unvaccinated.
    - Any codes, regulations, or ordinances requiring a smaller number of people must be followed.
    - This number of maximum visitors allowed must be documented in the visitation plan.
- Furniture used for external visits should be appropriately disinfected between visits.

Indoor Visitation

Facilities should allow indoor visitation at all times and for all residents, as outlined in this document. Ensuring the following:

- Visitation can still occur when there is an outbreak but under certain circumstances, as outlined in Outbreak Testing Results and Response (or decision tree below).
- The facility should restrict the total number of unvaccinated visitors according to the size of the facility in order to maintain core principles of infection prevention as well as the number of unvaccinated visitors allowed per resident at one time. CDPHE generally recommends allowing no more than two visitors per resident per room.
- Visitors are not required to be vaccinated or show proof of COVID-19 vaccination unless they are participating in activities requiring vaccination. To participate in these activities, the facility must:
    - Ensure visitors are aware of this requirement when scheduling their visit.
    - The facility must maintain documentation of the visitor vaccination status as outlined in the group activities section.
- Facilities may choose to offer rapid testing of visitors; however, it cannot be a contingency for visitation. Facilities should deny entry to visitors who test positive.
    - Facilities should have a process in place to respond to positive results. Should a potential visitor test positive, the visitor's positive test will not impact the facility's outbreak status even if the visitor has been in the facility during the prior 14 days. The visitor could be counted towards the facility's outbreak status if an epidemiological link is identified.
    - If the facility arranges, suggests, or performs COVID-19 testing for visitors, the test results must be obtained in a reasonable amount of time and visitation cannot be denied as a result of prolonged turnaround time.
- All visitors must be screened for COVID-19 symptoms, regardless of vaccination status, and facilities should limit visitor movement in the facility by following these procedures:
    - Greet visitors at a designated area at the entrance of the facility where a staff

member must:
    - Perform temperature check and symptom screening.
    - Document the visitor's contact information and the results of the screening. This example form may be used to document the information.
    - Deny entry to visitors who have a positive test or display symptoms during the screening.
    - Ensure the unvaccinated visitor has a face mask and ensure the mask covers the visitor's nose and mouth.
    - Have the visitor clean their hands with alcohol-based hand sanitizer.
    - Escort the unvaccinated visitor to the designated visitation area.
  - Indoor visitation for unvaccinated residents and visitors should occur in dedicated visitation spaces that allow for appropriate physical distancing if required and increased ventilation (open windows, etc.), and cleaning and disinfection between visitors.

Visitation During an Outbreak

Visitation can still occur when there is an outbreak but under certain circumstances, as outlined in Outbreak Testing Results and Response (or decision tree below):

- If outbreak testing reveals no additional COVID-19 cases in residents, then indoor visitation can continue regardless of resident vaccination status. Follow testing recommendations in the testing decision tree to determine next steps.
- If outbreak testing reveals one or more additional COVID-19 cases in residents, then facilities should stop indoor visitation, communal dining, and group activities for unvaccinated residents.
- The facility may continue with **outdoor** visitation for all residents (regardless of vaccination status) as long as the resident meets the criteria for visitation.
- In all cases:
  - Residents in isolation or quarantine are not eligible for visitation until transmission-based precautions are discontinued.
  - Visitors should be notified about the potential for COVID-19 exposure in the facility.
  - Refer to Visitation Restrictions if the facility's COVID-19 county positivity rate is more than 10% and fewer than 70% of residents in the facility are fully vaccinated.

Note: Compassionate care visits and visits required under federal disability rights law should be allowed at all times, for any resident and regardless of vaccination status.

Visitation: Miscellaneous Considerations

- With pre-notice and facility permission, pets may accompany a visitor for a visit with a single resident. Pets can aid in the transmission of COVID-19 and therefore the pet must be kept away from other staff and residents during the visit (inside or outside).

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The facility should have policies and procedures regarding the safety and parameters for pet visitation, including criteria for vaccinations and infection control.

- Remind visitors that they should refrain from visiting for at least 14 days if they have been in close contact with anyone who has tested positive for or has symptoms consistent with COVID-19. Visitors should alert the facility if they develop fever or other symptoms consistent with COVID-19, or if they are diagnosed with COVID-19 in the 14 days following visitation. Promptly notify public health if such notification occurs.

Supplemental Resources

Required Isolation Plans

Facilities must have and maintain an isolation plan that allows for prompt isolation of residents with COVID-19 (suspected or confirmed) to limit transmission.

- Residents testing positive for COVID-19 should be isolated in a private room with a private bathroom away from others (as outlined here) or in a COVID-19 care area.

When Creating a COVID-19 Care Area Within the Facility

- Identify a location within the facility that can be separate from healthy residents. This could potentially be a hall, wing, group of rooms, etc. that can house COVID-19-positive residents and allow for staffing and other resources to be separated from other residents and staff. Identifying a location and developing a staff plan to allow for dedicated staff ahead of time allows facilities to rapidly move residents if identified as positive for COVID-19.
    - Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care area should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g. the majority of residents in the facility are already infected).
- If residents are being moved to another area of the facility in order to create space for COVID-19-positive residents, ensure testing results are available for ALL residents before moves occur (results preferably have been collected 24-48 hours prior to the move or utilizing a point of care antigen test if significant lab delays are being experienced).
    - Residents testing positive for a COVID-19 infection should only be placed in a single room with a private bathroom or a room with another COVID-19-confirmed individual, assuming neither resident has other transmissible diseases (e.g., multi-drug resistant organisms, Clostridioides difficile, etc.).

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- Ideally the space should be physically separated from other rooms or units housing residents without confirmed COVID-19.
    - Whenever possible, the area within the facility dedicated to care for COVID-19 residents should be located on a separate floor, wing, or cluster of rooms.
- Assign dedicated health care providers (HCPs) to work only in the COVID-19 care area. This should occur consistently and across multiple shifts to limit the number of HCPs exposed. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.
- HCPs working in the COVID-19 care area should ideally have a restroom, breakroom, and work area that are separate from HCPs working in other areas of the facility. Consider only allowing one person at a time to utilize breakroom areas to allow appropriate physical distancing until the outbreak is resolved.
- Consider excluding health care personnel that are at higher risk for severe illness from caring for residents with confirmed or suspected COVID-19 infection.
- To the extent possible, restrict access of non-essential ancillary personnel (e.g., dietary, housekeeping) from working in an area designated for care of the COVID-19 residents.
    - Bundle care activities whenever possible; this allows less resident/staff contact and reduced use of personal protective equipment.
    - Dietary, housekeeping, and other staff not directly involved in nursing care of residents should not be allowed in the COVID-19 designated area. Consider having staff deliver supplies, meals etc. to the entrance of the area without entering the area and risking exposure or further spread to other areas of the facility.
    - Nursing staff should utilize dedicated or disposable supplies and equipment whenever possible.
    - Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N should be utilized to perform environmental surface disinfection.
    - Ensure that high-touch surfaces (e.g. light switch, doorknob, bedside table) in staff break rooms and work areas are frequently cleaned and disinfected utilizing an Environmental Protection Agency (EPA)-registered disinfectant from List N. Place signage at the entrance to the dedicated COVID-19 area that instructs health care providers that they must wear eye protection and an N95 or higher level respirator (or face mask if a respirator is not available) at all times while in the area. Gowns and gloves should be worn prior to entering resident rooms. Gloves should be removed and disposed of and HCPs should immediately perform hand hygiene upon exit and prior to assisting additional residents.
- If PPE shortages exist, notify public health for assistance and implement CDC's strategies to optimize PPE. Once PPE supplies are restored facilities should return to standard PPE usage.
- Bundle care activities to minimize the number of health care providers entries into a room whenever possible.
    - CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency and then crisis capacity strategies augment conventional capacity measures and are meant to be considered and implemented sequentially. When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to health care providers before they carry out

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patient care activities. As PPE availability returns to normal, health care facilities should promptly resume standard practices.

Strategies for Memory Care or Facilities Serving People with Developmental Disabilities

- **COVID-19 Care Area in Memory Care**
  - Because isolation amongst memory care residents or individuals with developmental disabilities can be challenging, facilities should consider additional measures to prevent COVID-19 from entering the facility and rapidly responding once illness is identified.
- **Limit Staff Movement as Much as Possible**
  - Assign dedicated health care providers (HCPs) to work only with individuals who have tested positive for COVID-19. This should occur consistently and across multiple shifts to limit the number of HCPs exposed. At a minimum, this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.
  - To prevent dietary staff from entering the unit and/or resident rooms, consider having dietary staff deliver meals or meal carts to the unit and allow the designated HCP to deliver the meal trays to the residents.
  - To prevent housekeeping staff from entering the unit and/or resident rooms, consider having the designated HCP place bagged laundry in a hamper outside the unit or resident room to allow housekeeping staff to collect these items. This similar practice can be used when returning clean linens back to the unit.
  - Consider having the designated HCP clean and disinfect common areas and high touch surfaces more frequently to limit the frequency of environmental staff in the unit or resident room.
  - Discourage staff from visiting other units and from interacting with other staff outside of their designated unit.
- **Miscellaneous Considerations for Memory Care Residents**
  - To the extent possible, consider cohorting residents to the smallest area/unit possible, depending on the facility layout.
  - Consider closing fire doors or placing temporary barriers at the end of hallways or neighborhoods while allowing for Life Safety Requirements. This consideration is an attempt to limit the movement of residents interacting with each other by limiting movement throughout the facility.
  - Consider re-arranging furniture to provide places for residents to sit that are spaced at least six feet apart.
  - Activities should be provided in a cohorted neighborhood or POD while maintaining physical distancing.
  - If activities or dining occur in common spaces shared by multiple neighborhoods, consider staggering the times when residents in cohorted neighborhoods would access the common space such as two neighborhoods that are not in the shared space at the same time.
  - Consider alternate activities that residents can participate in while in their rooms (hallway Bingo, television, music, arts, making their own masks, etc).

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- If space allows, consider designating a location to care for residents with confirmed COVID-19, separating them from other residents promptly to mitigate spread.

Strategies for Small Residential Settings (13 or Fewer Residents)

These strategies have been developed to meet the needs of small assisted living residences, intermediate care facilities (ICFs), and group homes typically operating in single-family homes which typically have 13 or fewer residents. These settings operate similarly to a single family residence due to the smaller spaces and congregate setting between residents and staff and therefore may need to consider additional strategies when trying to implement IPC recommendations.

- **Dining**
  - If it is not always possible to stop communal dining (e.g. during outbreak testing when new positive residents are being identified) due to space restraints or if the resident requires assistance (as outlined in their care plan), dining should be limited to 2 residents at a time in order to maintain social distances.
  - Unvaccinated residents should remain at least 6 feet away from each other during meal times. Four (4) foot tables can only seat one resident in this case. The facility may consider adding an additional four foot table to accommodate additional residents during meals, but should adhere to residents remaining at least 6-feet away from each other. Consider scheduling times and locations for meals to allow for social distancing for unvaccinated residents.
  - Maintain physical distances of at least 6 feet for unvaccinated residents and staff at all times and while residents are entering and leaving the dining room.
  - Keep hand sanitizer on each table for use before and after mealtime.
  - Disinfect all surfaces in between each resident.
  - Consider using disposable plates, napkins, and silverware.
  - Implement universal masking for source control of unvaccinated staff. Unvaccinated residents should wear masks that cover their nose and mouth when entering and leaving the dining room and anytime they are out of their room.
- **Feeding Sick Residents**
  - Stay separated: The person who is sick should eat (or be fed) in their room, if possible.
  - Sick residents should not participate in communal meals or group activities.
  - It is strongly recommended to stop all communal dining and group activities within the home while an ill resident resides there. If you have no other option to care for residents, limit meals and activities to no more than two people in a shared room at the same time and provide as much space between individuals as possible.

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    - Handle any dishes, cups/glasses, or silverware used by the person who is sick with gloves. Wash them with soap and hot water or in a dishwasher.
    - Clean hands after taking off gloves or handling used items.
    - Do not share dishes, cups/glasses, silverware, towels, bedding, or electronics (like a cell phone) with the person who is sick.
- **Self-Isolation**
    - The sick person, their roommates, and close contacts within the house need to self-isolate and limit their use of shared spaces as much as possible until public health determines your outbreak is over.
    - A mask helps prevent a person who is sick from spreading the virus to others. It keeps respiratory droplets contained and prevents them from reaching other people.
- **Bedrooms and Bathrooms**
    - If possible, have the person who is sick use a separate bedroom and bathroom and keep the door closed as much as possible. If possible, have the person who is sick stay in their own "sick room" or area and away from others. Try to keep yourself and others at least 6 feet away from the sick person.
    - If a sick person must share a bedroom, make sure the room has good airflow. Open the window to increase air circulation if possible. Caution should be utilized if considering the use of an individual room fan; consult CDPHE's COVID-19 Ventilation Guidance for more information. Improving ventilation within a room or home helps remove respiratory droplets from the air and works to dilute the amount of virus present. Space beds in a shared room at least 6 feet from one another; consider placing heads of beds at opposite ends of the room.
    - Disinfect shared bathrooms after each use and leave the exhaust fan running. Wear a mask and wait as long as possible after the sick person has used the bathroom before coming in to clean and use the bathroom.
    - If a sick person is using a separate bedroom and bathroom: Only clean the area around the person who is sick when needed, such as when the area is soiled. This will help limit your contact with the sick person.
- **Avoid Sharing Personal Items**
    - Everyone should avoid placing toothbrushes directly on counter surfaces. Totes can be used for personal items so they do not touch the bathroom countertop.
- **Washing and Drying Laundry Items**
    - Do not shake dirty laundry or hold it close to you.
    - Wear disposable gloves while handling dirty laundry.
    - Dirty laundry from a person who is sick can be washed with other people's items.
    - Wash items according to the label instructions. Use the warmest water setting you can.
    - Remove gloves and wash hands right away.
    - Dry laundry completely on hot or high if possible.
    - Wash hands after putting clothes in the dryer.
    - Clean and disinfect clothes hampers. Wash hands afterwards.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Personal Protective Equipment: FAQ

Eye protection | Face masks | General guidance | Gloves | Gowns | N95 respirators

The information below is to assist healthcare settings with proper use of personal protective equipment (PPE) during COVID-19 and when implementing CDC's Strategies to Optimize the Supply of PPE and Equipment. This may not answer all questions pertaining to PPE usage, and facilities are encouraged to contact their local or state health departments or consult CDC guidance (Information for Healthcare Professionals about Coronavirus (COVID-19)) if they have questions that are not answered in this FAQ. This FAQ does not replace guidance but serves as a tool to answer frequently asked questions and/or clarify misinterpreted guidance.

PPE general guidance

What is the recommended PPE when caring for COVID-19 patients?

- When caring for a patient with suspected or confirmed COVID-19, health care personnel (HCP) should wear an N95 respirator (to obtain a higher level of protection), gowns, gloves, and eye protection (i.e., face shield or goggles). Of note: prescription glasses and trauma glasses do not provide adequate protection as they do not cover the sides of the face and therefore do not qualify as PPE.

Are hair coverings or shoe covers needed as PPE for the care of patients with suspected or confirmed COVID-19?

- No, neither of these are required for the care of patients with suspected or confirmed COVID-19.

What manufacturer of PPE should we use?

- CDC does not recommend a specific manufacturer of PPE. You should select PPE from any manufacturer that meets the specifications outlined in the PPE guidance document.

What are CDC's optimization strategies for PPE?

- CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency and crisis strategies are intended to be temporary with facilities promptly resuming conventional capacity strategies when PPE availability returns to normal. There are three capacity strategies:
    - Conventional capacity: Measures consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in health care settings.

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- Contingency capacity: Measures that may be used temporarily during periods of expected shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility's current or anticipated utilization rate, there may be uncertainty if future supply will be adequate and therefore, contingency capacity strategies may be needed.
- Crisis capacity: Strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity when the supply is not able to meet the facility's current or anticipated utilization rate.

When would it be appropriate to implement CDCs optimization strategies?

- Conventional capacity strategies should already be implemented and maintained. Contingency capacity strategies can help stretch PPE supplies when shortages are anticipated, for example if facilities have sufficient supplies now but are likely to run out soon or there may be uncertainty in future supply. Crisis strategies can be considered during **severe PPE shortages** and should be used with the contingency options to help stretch available supplies for the most critical needs. Contingency and then crisis capacity measures augment conventional capacity measures and are meant to be considered and implemented sequentially. **As PPE availability returns to normal, healthcare facilities should promptly resume conventional practices.**

- When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to HCP before they carry out patient care activities.

Can we use crisis capacity strategies to help limit the financial impact on our facility?

- No, PPE expense should **not** be a determining factor and should not interfere with use of conventional capacity. CDCs strategies are available to assist facilities when supply availability is uncertain or during severe PPE shortages. Facilities should implement administrative controls and prioritization of PPE to further limit PPE use.

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Do we need to seek public health approval prior to implementing CDCs optimization strategies?

- No, public health approval is not required. Facilities should, however, ensure the following:
    - The employer has made a good faith effort to obtain other alternative filtering facepiece respirators, reusable elastomeric respirators, or PAPRs appropriate to protect workers;
    - The employer has monitored their PPE supply/burn rate and is making every attempt to maintain adequate supply and prioritize their use according to CDC guidance.
    - Facilities should maintain documentation which supports their efforts and the optimization strategy being used.
    - Surgical masks and eye protection (e.g., face shields, goggles) were provided as an interim measure to protect against splashes and large droplets (note: surgical masks are ***not*** respirators and do not provide protection against aerosol-generating procedures); and
    - Other feasible measures, such as using partitions, restricting access, cohorting patients (healthcare), or using other engineering controls, work practices, or administrative controls that reduce the need for respiratory protection, were implemented to protect employees.
    - When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to HCP before they carry out patient care activities.

https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus

What does extended use of PPE mean?

- Extended use refers to the practice of wearing the same PPE for repeated close contact encounters with several patients, without removing the PPE between patient encounters. The capacity strategy depends on the PPE being used.
    - Extended use of respirators is a contingency capacity strategy whereas extended use of a gown is a crisis capacity strategy. Crisis capacity strategies can only be considered during **severe PPE shortages.**

What does reuse of PPE mean?

- Reuse is a crisis capacity strategy and refers to the practice of using the same PPE (e.g., facemasks, eye protection, and reusable gowns) for multiple patient encounters but involves the HCP doffing (taking off) the PPE after use, storing it, and redonning it

(putting on) to use again. Crisis strategies can only be considered during **severe PPE shortages.**

N95 respirators

My N95 has a valve on it. Is that ok?

- Although previous guidance discouraged the use of N95 filtering facepiece respirators with exhalation valves, CDC recently updated its guidance to allow for their use.
    - A NIOSH-approved N95 filtering facepiece respirator with an exhalation valve offers the same protection to the wearer as one that does not have a valve. As source control, findings from NIOSH research suggest that, even without covering the valve, N95 respirators with exhalation valves provide the same or better source control than surgical masks, procedure masks, cloth masks, or fabric coverings.
- In general, individuals wearing NIOSH-approved N95s with an exhalation valve should not be asked to use one without an exhalation valve or to cover it with a face covering or mask. However, NIOSH-approved N95 respirators with an exhalation valve are not fluid resistant. Therefore, in situations where a fluid resistant respirator is indicated (e.g., in surgical settings), individuals should wear a surgical N95 or, if a surgical N95 is not available, cover their respirator with a surgical mask or a face shield. Be careful not to compromise the fit of the respirator when placing a facemask over the respirator.

Can I use an N95 respirator if I have not been fit tested?

- During times of extreme supply constraints, when there may be limited availability of respirators or fit test kits, employers may face challenges in fit testing workers.
- While this is not ideal, you should work with your employer to choose the respirator that fits you best, as, even without fit testing, a respirator would provide better protection than a facemask when a higher level of protection is needed.
- Users should always perform a seal check when donning a respirator to ensure a tight fit. Without an adequate seal, air and small particles leak around the edges of the respirator and into the wearer's breathing zone. For additional information, consult the following CDC resource.
- With PPE supply availability returning to normal, to include fit testing supplies and kits, facilities should make every effort to ensure that staff who need to use tight-fitting respirators are fit tested to identify the right respirator for each staff member. It is important to note that OSHA requires an initial respirator fit test to identify the right model, style, and size respirator for each person and annually thereafter.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

https://www.cdc.gov/niosh/docs/2018-129/pdfs/2018-129.pdf?id=10.26616/NIOSHPUB2018129

Can I use an N95 respirator if I have facial hair?

- It depends. The OSHA Respiratory Protection standard specifically requires employers not to permit respirators with tight-fitting facepieces to be worn by employees who have facial hair that comes between the sealing surface of the facepiece and the face. See 29 CFR 1910.134(g)(1)(i). Therefore, healthcare workers must be fit tested to ensure that facial hair will not interfere with the safe use of an N95 or other tight-fitting respirators. CDC has created a visual aid to help health care providers determine if their facial hair is compatible with respirator use.

I have prescription glasses; can I wear those with an N95 respirator?

- Yes, however, HCP should be fit tested while wearing their prescription glasses to ensure that the glasses will not interfere with the safe use of an N95 or other tight-fitting respirators. Of note: prescription glasses do not provide adequate eye protection as they do not cover the sides of the face and therefore do not qualify as eye protection for PPE. Prescription glasses will need to be covered with approved PPE for eye protection (i.e., goggles or face shields).

What is a fit test?

- A "fit test" tests the seal between the respirator's facepiece and your face. It takes about fifteen to twenty minutes to complete and is performed at least annually by trained personnel using a qualitative fit test method accepted by OSHA. A fit test should not be confused with a user seal check.

Where can I get fit tested?

- Some facilities that do not already have a respiratory program that includes fit testing have been able to make arrangements with local hospitals or health departments for fit testing. The Hospital Respiratory Protection Program Toolkit contains more information about fit testing.
- Information about respiratory fit in crisis situations may be found at *Fit Under Fire: Situational Strategies to Achieve the Best Respirator Fit During Crisis*: Proper N95 Respirator Use for Respiratory Protection Preparedness.

Can I wear any respirator once I am fit tested?

- No, after passing a fit test with a respirator, personnel must use the exact same make, model, style, and size respirator on the job.

I was fit tested by my previous employer. Do I need to be fit tested again?

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- That depends on when you were last fitted for the N95 respirator. Fit testing is recommended annually or more frequently if there have been changes that may interfere with respirator seal (e.g., weight gain, weight loss, facial hair, etc.). If the new employer does not stock the same make, model, style, and size respirator for which you were fit tested, you should be fit tested again using the respirators your new employer uses.

What is a user seal check?

- A user seal check is a quick check performed by the wearer each time the respirator is put on. It determines if the respirator is properly seated to the face or needs to be readjusted. A seal check should not be confused with a fit test. More information is available here.

Can I implement extended use of my N95 respirator?

- Yes, this is a contingency capacity strategy that allows respirator use to be prolonged, using one respirator per staff per day/eight-hour shift. This strategy allows staff to wear the same respirator for multiple patient encounters. However, extended use of respirators should only be implemented after conventional capacity strategies have been considered and implemented.
- Generally, extended use is best implemented when multiple patients are infected with the same pathogen (e.g., a COVID-19-positive unit); however, during the current COVID-19 pandemic response, implementation of extended use of N95 respirators across multiple patients with positive, negative, and unknown COVID-19 status may be considered when there may be uncertainty if future supply will be adequate. If extended use of N95 respirators is permitted, HCP should dispose of respirators immediately if:
    - Respirators are removed (doffed) at any time, to include at the end of their shift, when doffing for breaks, and/or to eat/drink.
    - Performing aerosol generating procedures (as outlined above).
    - Contaminated with blood, respiratory, or nasal secretions, or other bodily fluids.
    - Caring for patients co-infected with an infectious disease requiring contact precautions (e.g., methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococci, *Clostridium difficil*e, norovirus, etc.).
    - A respirator is obviously damaged or becomes hard to breathe through.
- Consider use of a cleanable face shield over an N95 respirator and/or other steps (e.g., masking patients for source control, use of engineering controls) to reduce surface contamination of the N95 respirator.
- Staff must take care not to touch their respirator. They should perform hand hygiene before and after touching or adjusting their respirator. Avoid touching the inside of

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene.

Can I wear a face shield or surgical mask over my N95 respirator to prevent contamination during aerosol-generating procedures?

- During contingency or crisis settings (respirator shortages), the IDSA guideline panel suggests that health care personnel involved with aerosol-generating procedures on suspected or known COVID-19 patients add a face shield or surgical mask as a cover for the N95 respirator to allow for REUSE as part of appropriate PPE. Note that this is not considered to be a conventional capacity strategy.
- Following the aerosol-generating procedure, the face shield should be discarded or reprocessed according to the manufacturer's guidance and the surgical mask discarded. Of note: a cloth mask or homemade mask (handkerchief) should not be used as personal protective equipment.

  Infectious Diseases Society of America Guidelines on Infection Prevention in Patients with Suspected or Known COVID-19 (IDSA)

Does my N95 respirator still provide adequate protection if extended use is implemented?

- Extended use alone is unlikely to degrade respiratory protection. However, healthcare facilities should develop clearly written procedures to advise staff to discard any respirator that is obviously damaged or becomes hard to breathe through. https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html#risksextended
- N95 respirators used outside of the manufacturer's guidance (extended use and/or reuse) cannot be assured to maintain fit and function. Repeated donning and doffing will result in the straps no longer being able to generate enough force to create a tight seal with the face. Users should perform a user seal check immediately after they don the N95 respirator and should not use a N95 respirator on which they cannot perform a successful user seal check.
- More information on extended use and/or reuse of N95s, to include when capacity strategies can be implemented, are further outlined in this (N95 Respirator) section.

Can I reuse my N95 respirator for multiple shifts?

- Limited reuse is listed as a crisis capacity strategy that should only be considered during periods of known shortages. It is important to consult with the respirator manufacturer regarding the maximum number of donnings or uses they recommend for the N95 respirator model. This practice is often referred to as "limited reuse" because restrictions are in place to limit the number of times the respirator can be reused. If no manufacturer guidance is available, data suggests limiting the number of reuses to

five donnings (eight hours of continuous or intermittent use each time) per device per healthcare worker to ensure an adequate safety margin. Users should always perform a user seal check immediately after they don the N95 respirator and should not use a N95 respirator on which they cannot perform a successful user seal check. N95 and other disposable respirators should not be shared by multiple HCP.

- If reuse of N95 respirators is permitted, respiratory protection program administrators should ensure adherence to administrative and engineering controls to limit potential N95 respirator surface contamination (e.g., use of barriers to prevent droplet spray contamination) and consider additional training and/or reminders (e.g., posters) for staff to reinforce the need to minimize unnecessary contact with the respirator surface, strict adherence to hand hygiene practices, and proper PPE donning and doffing technique, including physical inspection and performing a user seal check.
- Please see Risks of Extended Use and Reuse of Respirators for more information about contact transmission and other risks involved in these practices.

Is it safe to reuse my N95 respirator?

- Reuse of respirators was a common practice for many health care settings due to respirator shortages and often involved facilities assigning multiple respirators (five respirators and five paper bags) to each staff member in an attempt to reduce risk associated with reuse. With the PPE supply availability (including respirators) returning to normal, this is now a crisis capacity strategy and should ONLY be considered during periods of known shortages. Reuse of respirators should not be implemented unless the facility can clearly document crisis capacity.
- Although extended use and reuse of respirators have the potential benefit of conserving limited supplies of disposable N95 respirators, concerns about these practices have been raised. While contact transmission caused by touching a contaminated respirator has been identified as the primary hazard of extended use and reuse of respirators, other concerns have been assessed, such as a reduction in the respirator's ability to protect the wearer caused by rough handling or excessive reuse. Extended use can cause additional discomfort to wearers from wearing the respirator longer than usual.
- The risks of contact transmission when implementing extended use and reuse can be affected by the types of medical procedures being performed and the use of effective engineering and administrative controls, which affect how much a respirator becomes contaminated by droplet sprays or deposition of aerosolized particles. For example, aerosol generating medical procedures such as bronchoscopies, sputum induction, or endotracheal intubation, are likely to cause higher levels of respirator surface contamination, while source control of patients (e.g. asking patients to wear facemasks), use of a face shield over the disposable N95 respirator, or use of engineering controls such as local exhaust ventilation are likely to reduce the levels of respirator surface contamination.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

How can I safely reuse my N95?

- Reuse of N95s is considered a crisis standard of care and should only be considered during periods of known shortages and when other strategies have been exhausted. As supplies of N95s become available, facilities should promptly resume contingency and/or conventional capacity strategies.
- Per a recent CDC review of potential fomite transmission of SARS-CoV-2, on porous surfaces, studies report inability to detect viable virus within minutes to hours; on non-porous surfaces, viable virus can be detected for days to weeks. One strategy to mitigate the contact transfer of pathogens from the respirator to the wearer during reuse is to **issue five respirators to each healthcare worker** who may care for patients with suspected or confirmed COVID-19. The health care worker will wear one respirator each day (no more than an eight-hour shift) and store it in a breathable paper bag at the end of each shift. The order of use should be repeated with a **minimum of five days between each respirator use**. This will provide some time for pathogens on it to "die off" during storage. This strategy requires a minimum of five N95 respirators per staff member, provided that healthcare personnel don, doff, and store them properly each day.
- Respirators should be stored in a designated/centralized location, away from the patient care area. HCP should not take these masks home. Healthcare workers should treat the respirators as though they are still contaminated and follow the precautions outlined in our reuse recommendations.

How do I safely store my N95 respirator for later use?

- When utilizing crisis capacity strategies (during times of extreme PPE shortages),which includes the reuse of respirators, store respirators between uses so that they do not become damaged or deformed. Store respirators in a designated storage area or in a labeled paper bag or breathable container to minimize potential cross-contamination. Storage containers should be disposed of or cleaned regularly.
- Ensure respirators do not touch each other and the person using the respirator is clearly identified. Secondary exposures can occur from respirator reuse if respirators are shared among users. Thus, N95 respirators must only be used by a single wearer. To prevent inadvertent sharing of respirators, healthcare facilities should develop clearly written procedures to inform users to label breathable containers/bags used for storing respirators or label the respirator itself (**on the straps only**) between uses with the user's name to reduce accidental usage of another person's respirator.
- N95 respirators should never be stored below the chin or on top of the head, as the outside of the respirator is contaminated and can lead to HCP exposure. Ensure N95 respirators are properly removed and safely stored or discarded, even during breaks.

How do I safely put on (don) my used N95 respirator?

- Limited reuse is now considered a crisis capacity strategy. If reuse is permitted (during times of extreme shortages), use a pair of clean (non-sterile) gloves when donning a

used N95 respirator and performing a user seal check (to ensure the respirator is sitting comfortably on your face with a good seal). Discard gloves (and perform hand hygiene) after the N95 respirator is donned and when any adjustments are made. https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html#risksextended

- Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator.
- Management should consider additional training and/or reminders for users to reinforce the need for proper respirator donning techniques including inspection of the device for physical damage (e.g., are the straps stretched out so much that they no longer provide enough tension for the respirator to seal to the face? Is the nosepiece or other fit enhancements broken? etc.).

Can I use expired N95s respirators?

- The use of expired N95s is a crisis capacity strategy and generally must *not* be used when HCP:
    - Perform surgical procedures on patients infected with, or potentially infected with, SARS-CoV-2, or perform or are present for procedures expected to generate aerosols or procedures where respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, sputum induction).
    - In accordance with CDC guidance for optimizing the supply of respirators, employers should prioritize the use of N95 respirators by activity type. When HCP perform or are present for aerosol-generating procedures or procedures where respiratory secretions are likely to be poorly controlled, use respirators (including N95 respirators; other respirators; non-disposable, elastomeric respirators; and PAPRs) that are still within their manufacturer's recommended shelf life, if available, before using respirators that are beyond their manufacturer's recommended shelf life.

Can I disinfect my N95 respirator for reuse?

- No, previous options for decontamination are no longer recommended. According to CDC, there are no manufacturer-authorized methods for N95 respirator decontamination.

Should N95 respirators be used for ALL aerosol-generating procedures or just when caring for patients with COVID-19 (suspected or confirmed)?

- The use of a NIOSH approved respirator is recommended (regardless of vaccination status) when:

    - Patient-care activities are likely to generate splashes or sprays of blood, body fluids, or secretions (e.g., suctioning, endotracheal intubation, etc.), regardless of COVID-19 infection.
    - During aerosol-generating procedures (AGPs) performed on patients with suspected or proven infections transmitted by respiratory aerosols, including patients with COVID-19 (suspected or confirmed).
        - The use of a N95 or higher-level respirator is also recommended for all AGPs performed (regardless of patient SARS-CoV-2 infection status) in facilities located in areas of moderate to substantial community transmission as these HCP would be more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection.
        - HCP working in areas with minimal to no community transmission should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures and suspected or confirmed diagnoses.

Refer to Appendix A and the interim IPC guidance for HCP (sections on "HCP working in facilities located in areas with moderate to substantial community transmission" and "Recommended infection prevention and control practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection") for more information.

Discard N95 respirators following use during aerosol-generating procedures. Extended use should not be employed for an N95 respirator following an aerosol-generating procedure, and N95 respirators should not be re-used following an aerosol-generating procedure.

What procedures are considered to be aerosol-generating?

- Development of a comprehensive list of AGPs for healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining if reported transmissions during AGPs are due to aerosols or other exposures.
- There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for health care settings.
- Commonly performed medical procedures that are often considered aerosol-generating procedures, or that create uncontrolled respiratory secretions, include:
    - Open suctioning of airways.
    - Sputum induction.
    - Cardiopulmonary resuscitation.
    - Endotracheal intubation and extubation.
    - Non-invasive ventilation (e.g., BiPAP, CPAP).
    - Bronchoscopy.
    - Manual ventilation.
- Based on limited available data, it is uncertain whether aerosols generated from some procedures may be infectious, such as:

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Nebulizer administration.*
- High flow O2 delivery.**

*Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.

**Based on limited data, high-flow oxygen use is not considered an aerosol-generating procedure for respirator prioritization during shortages over procedures more likely to generate higher concentrations of infectious respiratory aerosols (such as bronchoscopy, intubation, and open suctioning). For more information please see: Healthcare Infection Prevention and Control FAQs

Can we use KN95s?

- Although the FDA has approved the use of certain N95-equivalent respirators (via EUA) for health care providers (including many models of KN95s), this should only be implemented as a crisis capacity strategy when supplies of N95s are unavailable.
- It is important to note that the EUA was put in place for when the N95 supply chain was depleted. With the N95 supply returning to normal, KN95's should only be used if facilities cannot get a NIOSH-certified N95.
- Prioritize N95 surgical respirators for healthcare workers who have exposure to airborne and fluid risks/hazards.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/checklist-n95-strategy.html

Face Masks

Can we implement extended use of face masks?

- Yes, this is a contingency capacity strategy that allows face mask use to be prolonged, using one mask per staff per day/eight-hour shift. This strategy should only be employed under contingency capacity conditions. This strategy allows staff to wear the same face mask for multiple patient encounters. If extended use of face masks is permitted, HCP should dispose of masks immediately if:
  - Face masks that are removed (doffed) at any time, to include at the end of their shift, when doffing for breaks, and/or to eat/drink.
  - Contaminated with blood, respiratory or nasal secretions, or other bodily fluids.
  - Caring for patients co-infected with an infectious disease requiring contact precautions (e.g., methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococci, *Clostridium difficil*e, norovirus, etc.).

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

    - Any face mask is obviously damaged or becomes hard to breathe through.
- The most significant risk is of contact transmission from touching the surface of the contaminated face mask. Respiratory pathogens on the face mask surface can potentially be transferred by touch, contaminating the hands of the wearer, and in turn be transmitted via self-inoculation or to others via direct or indirect contact transmission. HCP must take care not to touch or adjust their face mask. If they do, they must immediately perform hand hygiene. HCP should remove and discard the face mask if soiled, damaged, or hard to breathe through. Ensure HCP leave patient care areas before removing their mask.

Can HCP reuse their face masks?

- Limited reuse is a crisis capacity strategy that should only be implemented during periods of known shortages. When used, pairing limited re-use of face masks with extended use is the practice of using the same face mask by one HCP for multiple patient encounters but removing it after several encounters, storing it, and redonning it for further patient encounters. As it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, care should be taken to ensure that HCP do not touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.
    - At this time, there is not known a maximum number of uses (donnings) the same face mask could be reused.
    - The face mask should be removed and discarded if soiled, damaged, or hard to breathe through.
    - Not all face masks can be reused.
        - Face masks that fasten to the provider via ties may not be able to be undone without tearing and should be considered only for extended use, rather than reuse.
        - Face masks with elastic ear hooks may be more suitable for reuse.
- HCP should leave the patient care area if they need to remove the face mask. Face masks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

Can we use face masks that tie?

- Yes, however, ensure both ties are secured and that the mask is tight fitting. This is to ensure adequate protection for both the wearer and others. Ensure tie masks are doffed and disposed of appropriately, following each use, as these masks are not appropriate for reuse, even when implementing CDCs crisis capacity strategy (as outlined above).

How do I safely store my face mask for later use?

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Storing a face mask for later use, otherwise known as re-use, is a crisis capacity strategy and should only be used under crisis capacity. Ensure that mask removal is done in a careful and deliberate manner. Face masks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can then be stored between uses in a paper bag or breathable container. Refer to CDC's strategies to optimize the use of PPE. Note that at this time, there is not known a maximum number of uses (donnings) the same facemask could be reused.
- Masks should never be worn below the chin or on top of the head, as the outside of the mask is contaminated and can lead to HCP exposure. Ensure masks are properly removed and safely stored or discarded, even during breaks.
- Masks should be placed in breathable paper bags and stored in a centralized location, away from the patient care area. HCP should not take their masks home. Health care workers should treat the masks as though they are still contaminated and follow the precautions outlined in the reuse recommendations.

Can HCP wear cloth face coverings or homemade masks (e.g., bandana, scarf)?

- No, cloth face coverings and/or homemade masks are not considered PPE, since their capability to protect HCP is unknown. Cloth face coverings are intended for community source control and are not approved PPE and therefore should not be worn by HCP interacting with patients. However, if staff do not have any interactions with patients nor work in parts of the building where patients are located, cloth face coverings could be considered.

Can HCP wear cloth face coverings or homemade masks (e.g., bandana, scarf) if face masks are no longer available?

- Only as part of crisis capacity strategies; however, the masks should be worn in combination with a face shield that covers the entire front (extends to the chin or below) and sides of the face. Extreme caution should be used when considering this option, and it should be reserved as a last resort.

If I am wearing a face shield, do I still need to wear a face mask?

- Face shields function as eye protection and are not an adequate substitute for a face mask. COVID-19 spreads primarily from person to person via close contact through respiratory droplets that are produced when we talk, sing, shout, or even breathe. By design, a face shield is not able to stop these respiratory droplets from escaping or entering when worn alone.

Can I wear a face mask while caring for a suspected or confirmed SARS CoV-2 resident if no respirators are available to me?

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- A tight fitting face mask can be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection but only as a last resort if respirators are severely limited or unavailable.

Eye protection

Why do we need to follow universal use of eye protection when our facility is in an area with >10% two-week average positivity rate?

- As we learn more about COVID-19, we are able to develop better strategies and interventions for preventing transmission. Universal eye protection during direct patient care is one such intervention. Continuously protecting our eyes from respiratory droplets in a patient-care setting is an added step to keep our unvaccinated HCPs safe from infection. When infection rates might be high, adding eye protection to routine care adds additional protection for HCP.

Who needs to follow universal use of eye protection?

- In addition to masks, unvaccinated staff working in facilities located in counties with >10% two-week average positivity rate should wear eye protection (i.e., face shields or goggles) during **all patient care activities** to protect against viral spread from asymptomatic and presymptomatic individuals.
- Staff include anyone with potential for patient contact including, but not limited to: nursing staff, physical and occupational therapy staff, housekeepers going inside patient rooms to clean. Staff who do not encounter patients during their time at the facility may not need to wear eye protection..
- However, staff should always follow standard, contact, and droplet precautions (gown, gloves, N95, and eye protection) for any resident with fever, respiratory symptoms, or when COVID-19 is suspected.

Do we need to follow universal use of eye protection at all times while in the facility?

- If your facility is in a county with >10% two-week average positivity rate, unvaccinated HCP should wear eye protection during any direct patient care activity. It is not required for unvaccinated HCP to wear eye protection outside of patient rooms/in areas without patients in them. Consider following CDC's PPE optimization guidance for eye protection by keeping the eye protection in place during multiple patient encounters (extended use), and/or reprocessing the eye protection after use to use again later (reuse).
- If your facility is experiencing a shortage of eye protection, prioritize wearing eyewear when caring for patients who are symptomatic, are positive for COVID-19, or when COVID-19 is suspected.

What is considered acceptable eye protection?

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Goggles or a face shield are recommended to ensure appropriate protection. Eye protection should cover the front and sides of the eyes (i.e., goggles or a face shield). There should not be gaps in between the eye protection and the face, unless you are using a face shield. Protective eyewear (safety glasses, trauma glasses) or corrective glasses with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
- Protective eyewear (e.g., safety glasses and trauma glasses) that have extensions to cover the side of the eyes can be considered under CDC's Crisis Capacity Strategies for Optimization of Protective Eyewear.

Can I implement extended use of my eye protection?

- Yes, this is a contingency capacity strategy that allows for extended use of eye protection and can be applied to disposable and reusable devices. Eye protection should be removed and replaced if it becomes visibly soiled, damaged, or difficult to see through. Eye protection worn during aerosol-generating procedures should be considered soiled. Staff must take care to not touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.

Can I reprocess a disposable face shield or goggles for reuse?

- Follow manufacturer instructions for cleaning and disinfection. When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields or goggles, consider:
    - While wearing a clean pair of gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with a neutral detergent solution or cleaner wipe.
    - Carefully wipe the **outside** of the face shield or goggles using a wipe or clean cloth saturated with an EPA-registered **hospital disinfectant solution**.
    - Wipe the outside of the face shield or goggles with clean water or alcohol to remove residue.
    - Fully dry (air dry or use clean absorbent towels).
    - Remove gloves and perform hand hygiene.
    - Cleaned and disinfected eye protection can be stored onsite, in a designated clean area within the facility.

Strategies for Optimizing the Supply of Eye Protection

Do I need to change or wipe down my eye protection in between patients?

- When using conventional capacity strategies, disposable eye protection should be removed and discarded. Reusable eye protection should be cleaned and disinfected after each patient encounter according to manufacturer instructions.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- When it is necessary to use contingency capacity strategies (i.e., implementing extended use of eye protection), it is acceptable to wear the same eye protection for multiple patients without cleaning and disinfecting your eyewear in between patients unless it is being removed, or if it is visibly soiled or comes in direct contact with respiratory secretions (e.g., worn during aerosol-generating procedures). Eye protection should be removed and discarded if damaged or difficult to see through. Staff must take care not to touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.

Gowns

Can I store and reuse my disposable gown?

- Reuse and extended use of isolation gowns is considered a crisis standard of care and should only be considered during periods of known shortage and when all other strategies have been exhausted. As supplies of isolation gowns become available facilities should promptly resume conventional strategies.
- The risks to HCP and patient safety must be carefully considered before implementing a gown reuse strategy. Disposable gowns generally should NOT be re-used, and reusable cloth gowns should NOT be reused before laundering, because reuse poses risks for possible transmission among HCP and patients that likely outweigh any potential benefits.
- Similar to extended gown use, gown reuse has the potential to facilitate transmission of organisms (e.g., *C. auris*) among patients. However, unlike extended use, repeatedly donning and doffing a contaminated gown may increase risk for HCP self-contamination. If reuse is considered, gowns should be dedicated to care of individual patients. Any gown that becomes visibly soiled during patient care should be disposed of or, if reusable, laundered.

Can I reuse my disposable gown if I disinfect it?

- No, disposable gowns are intended for single use. Cloth isolation gowns could potentially be reused under crisis capacity only.

Can I use disposable gowns that are expired?

- Only as a contingency capacity strategy. The majority of isolation gowns do not have a manufacturer-designated shelf life. However, if a shelf life is designated, considerations can be made to use gowns beyond the designated shelf life when PPE shortages exist.

Can I use coveralls?

- Only as a contingency capacity strategy, which can be used if your facility falls into

the contingency category for gowns. Coveralls are less convenient to use in most healthcare settings. Their one-piece design covers the back and lower legs, in addition to arms and the front of the body, making them useful for situations in which vigorous physical mobility is anticipated (e.g., emergency medical services).
- If coveralls are used, the material and seams should be appropriate to serve the intended barrier function effectively. Facilities should anticipate challenges and potential hazards to staff related to doffing coveralls and should provide training and practice in their safe use and designated places for donning and doffing, before providing them for patient care.

Can I implement extended use of gowns in a COVID-19 positive care area?

- Only as a crisis capacity strategy when your facility falls into the crisis category for gowns. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies.
- Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (e.g., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no co-infections transmitted by contact (such as *Clostridioides difficile*) among patients.
- Ensure gowns are removed and discarded if they become visibly soiled or damaged and before leaving the isolation cohort.

Can I implement extended use of gowns for COVID-19 positive patients if they are in different units?

- Extended use can only be considered as a contingency capacity strategy when patients known to be infected with COVID-19 are housed in the same location (e.g., COVID-19 patients residing in an isolation cohort) presuming they do not have another condition that requires contact precautions. Gowns should be removed and discarded before leaving the unit.

Can I implement extended use of gowns for non-COVID-19 cohorts or units with mixed COVID-19 status (e.g., negatives, unknowns, positives)?

- No, extended use of isolation gowns should not be implemented under any strategy if caring for multiple patients with positive, negative, and unknown COVID-19 status. Extended use of isolation gowns should be limited to COVID-19-positive cohorts only, assuming there are no other conditions that require contact precautions. Extended use of gowns should NOT be implemented on COVID-negative or COVID observation units.

Can I prioritize gowns to be used only during high-risk activities?

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Only as a crisis capacity strategy when your facility falls into the crisis category for gowns. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies.
- Gowns should be prioritized for care activities where splashes and sprays are anticipated (which typically includes aerosol generating procedures), and for high-contact patient care activities (such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care).

Gloves

Can I implement extended use of gloves for COVID-19-positive cohorts?

- No, do not use the same pair of gloves for the care of more than one patient. Gloves become contaminated and a source of transmission. Proper glove use and hand hygiene should always be maintained and in accordance with CDC guidelines.
- Ensure staff understand that wearing gloves is not a substitute for hand hygiene. Gloves should always be doffed (removed) following patient care and before leaving the patient room. Contact public health immediately should your facility have concerns about their glove supply.

Is it okay to extend the use of gloves if they are cleaned between uses?

- No, CDC does not recommend that gloves be cleaned and reused, even if caring for the same patient. Gloves do not negate the need for hand hygiene. Ensure that all HCP are following appropriate glove use, including:
    - Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur,
    - Performing hand hygiene immediately prior to donning gloves and immediately after doffing gloves,
    - Ensuring staff understand that wearing gloves is not a substitute for hand hygiene,
    - Removing gloves upon completing a task or when soiled during the process of care, even if caring for the same resident,
    - Gloves should be changed and hand hygiene performed when moving from dirty to clean activities (e.g., after patient care activities, before handling clean supplies)
    - Always remove gloves and perform hand hygiene before leaving the resident's room or care areas,
    - Do not use the same pair of gloves for the care of more than one resident.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

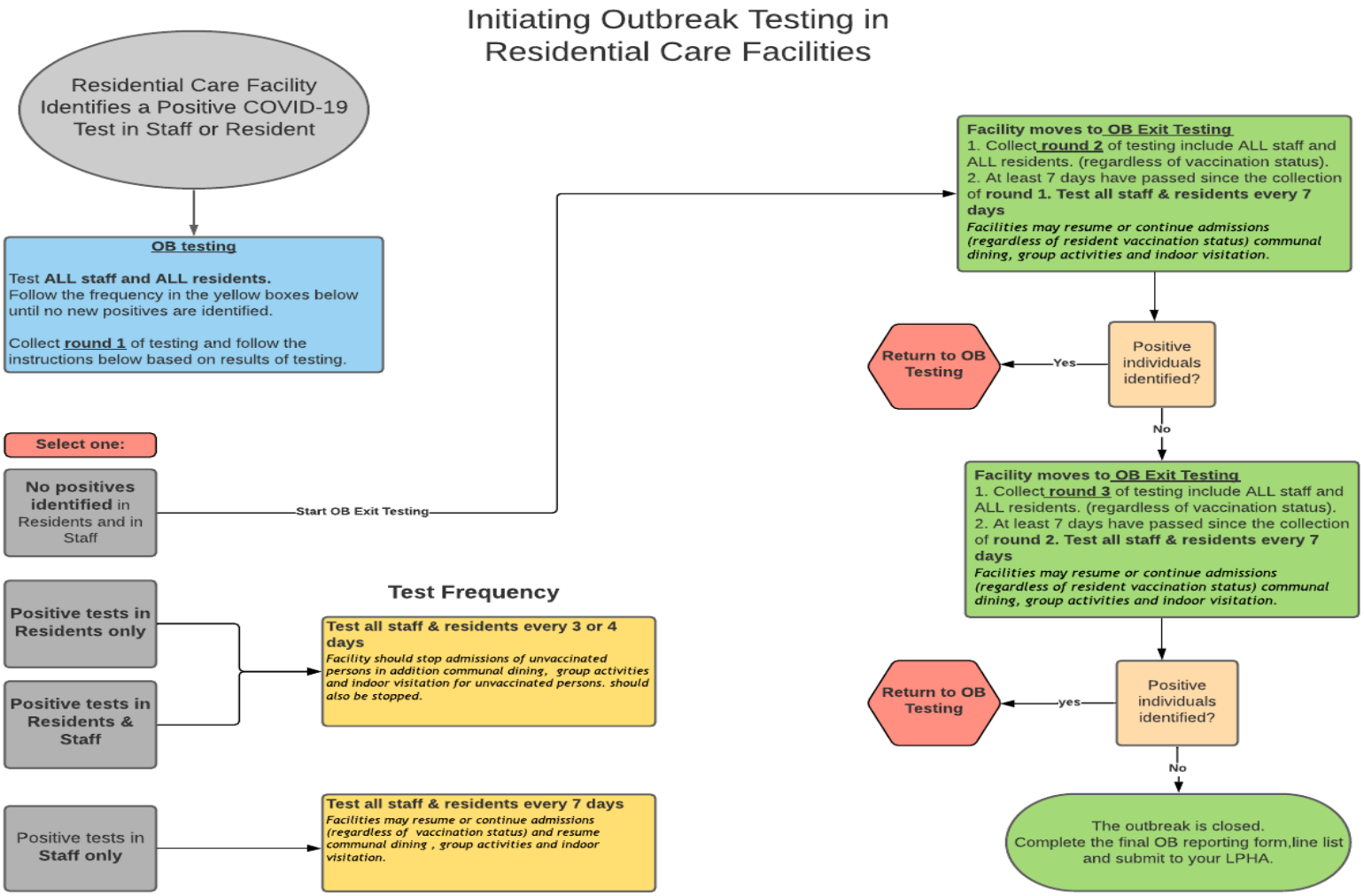
Hand Hygiene in Healthcare Settings: http://www.cdc.gov/handhygiene OR https://www.cdc.gov/handhygiene/providers/guideline.html

Is it OK to double-glove (i.e., wear more than one pair of gloves)?

- No, CDC guidance does not recommend double gloves when providing care to suspected or confirmed 2019-COVID patients.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Outbreak Testing and Response Decision Tree



Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.