

WLC MANAGEMENT FIRM, LLC

CORONAVIRUS PREVENTION & CONTROL
(COVID 19)

(Based on IDPH 10/20/2021 Guidance & CMS QSO-20-39-NH Rev. 11.12.21)
Reviewed & Revised 11.22.21 – Visitation

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Coronavirus Disease 2019 (COVID-19)

This facility follows current guidelines and recommendations for the prevention and control of Coronavirus (COVID-19).

Prevention or Limited Transmission

Strategies to prevent or limit transmission in this facility will include the following:

1. Ensuring triage, early recognition, and source control (isolating residents with suspected COVID-19 infection);
2. Immediate notification of the Administrator, Director of Nursing, Medical Director, and Infection Preventionist of suspected respiratory infections.
3. Maintaining standard precautions for all residents.
4. Implementing empiric additional precautions (droplet and contact and, when ever applicable airborne precautions for suspected cases of COVID-19 infection).
5. Implementing administrative controls;
6. Using environmental and engineering controls.
7. The promotion of hand hygiene and respiratory hygiene.
8. Implementing surveillance testing and symptomatic testing per guidance provided by IDPH, CMS, CDC and LHD.
9. Ensuring Core Principles of Covid 19 Infection Prevention are followed including: Offering and highly encouraging Covid 19 Vaccination of all residents and staff; screening all who enter the facility for signs and symptoms of Covid 19, rejecting entry for those symptomatic or who have had close contact with someone with Covid 19 in the past 14 days regardless of vaccination status; Performing hand hygiene with the use of ABHR which is preferred to soap and water, unless hands are visibly soiled; require face covering in accordance with CDC guidance and FDA Guidance; employ physical distancing; provide instructional signage; clean and disinfect high touch surfaces in the facility often, and designated visitation areas after each visit; ensure appropriate staff use of PPE; Effective cohorting of residents (e.g. separate areas dedicated to Covid 19 care); Resident and staff testing as required and visitor testing highly recommended as a precaution.

Core Principles of COVID-19 Infection Prevention (Updated)

*Vaccination for COVID-19 has been shown to be safe and highly effective. LTC facilities are urged to require vaccination for all staff.

- Screening-All persons (staff and visitors) who enter the facility must self-screen for COVID-19.

Facility screening tools:

- Assess for signs and symptoms of COVID-19. Temperature can be included as one of the COVID-19 symptoms but can be self-reported and does not need to be taken by the facility.
- Inquire if the person has had close contact with someone with known COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status).
- Inform the person if they are experiencing any symptoms of COVID-19 or have had close contact with someone with COVID-19 that they are not allowed to enter the facility.

*Facilities should maintain signage on doors instructing visitors not to visit if ill or exhibiting any signs and symptoms of COVID-19.

- Perform hand hygiene with the use of alcohol-based hand rub, which is preferred to soap and water, unless hands are visibly soiled.
- Require source control (as defined above), in accordance with CDC guidance and FDA guidance. All residents must wear a cloth face mask or face covering, when outside of their rooms unless actively eating or drinking, and when staff or other visitors enter their rooms. Residents who cannot tolerate masks (e.g. persons with dementia or other medical conditions) must physically distance from others to reduce their risk of transmission. Visitors must wear source control at all times while in the facility.
- Employ physical distancing at least 6 feet between unvaccinated persons, in accordance with CDC guidance.
- Provide instructional signage throughout the facility and visitor education on COVID-19 signs and symptoms, infection control precautions, and other applicable facility practices (e.g., use of cloth face mask or face covering, specified entries, exits and routes to designated areas, hand hygiene).
- Clean and disinfect high-touch surfaces in the facility often, and designated visitation areas after each visit.
- Ventilation – CDC recommends improving building ventilation, to reduce the spread of disease and lower the risk of exposure .
- Ensure appropriate staff use of PPE.
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care).
- Resident and staff testing as required. Visitor testing is highly recommended as a precaution.

Symptoms

Clinical features are fever, or sign/symptoms of lower respiratory illnesses. Symptoms may include:

- Fever (100 degrees or above) or Chills, Repeated Shaking with Chills.
- New or Worsening Cough
- Shortness of Breath or Difficulty Breathing
- Fatigue
- Muscle or body aches
- Headache (new or unusual onset). Not related to caffeine, dietary reasons (hunger), or history of migraines, cluster, or tension headaches or HA typical for the individual.
- New loss of taste or smell
- Sore Throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

(Per CDC, list does not include all possible symptoms and they continue to update list as they learn more.)

Transmission

Human coronavirus most commonly spread from an infected person to others through:

- The air by coughing and sneezing;
- Close personal contact, such as touching or shaking hands;
- Touching an object or surface with the virus on it, then touching your mouth, nose, or eyes before washing your hands; an
- Rarely, fecal contamination.

Prevention

The following can help prevent the spread of coronavirus and protect your from becoming infected:

- Wash your hands often with soap and water for at least 20 seconds;
- Use Alcohol Based Hand Rub (ABHR)
- Avoid touching your eyes, nose, or mouth with unwashed hands; and
- Avoid close contact with people who are sick.

Prevent the introduction of respiratory germs INTO the facility

- Post signs at the entrance instructing facility employees, vendors and necessary medical staff not to enter the facility if they are experiencing new or worsening respiratory infection symptoms.
- Facility Staff, Essential Ancillary Staff and Visitors will be screened for symptoms of respiratory infection, including taking temperature, immediately upon entering facility at established entry utilizing electronic screening or a written screening form. Individuals showing symptoms shall be provided a mask and asked to return home to self-isolate and contact their medical provider. Screening will include inquiry of diagnosis of Covid-19 within past 14 days as well as any close contact with someone with Covid 19 infection in the prior 14 days (regardless of the visitor's vaccination status). Individuals answering yes to these questions will be denied entry to facility pending completion of 14 day quarantine period. Screenings shall be completed prior to beginning of shift for direct facility staff and prior to entering facility for other Essential Ancillary Staff. Mid-Shift Screenings are no longer required.
- All Individuals will don an isolation/procedural face mask prior to entering facility. Facility can provide.
- Indoor visits will be allowed in the facility, as authorized by IDPH / CMS Guidance. All Indoor Visitors will enter and exit through designated entrance, and are required to complete the Covid 19 Screening Tool, sanitize hands with ABHR, and utilize appropriate mask. Visitors will be highly encouraged to test for Covid 19. A Visitor Guidance Form will be reviewed with the visitor and will be signed in acknowledgement by the visitor.
- Outdoor visits will be allowed as authorized by IDPH / CMS, and are preferred. Visitors are required to complete the Covid 19 Screening Tool, sanitize hands with ABHR, and utilize the appropriate mask. A Visitor Guidance Form will be reviewed with the visitor and will be signed in acknowledgement by the visitor.
- Ensure sick leave policies allow employees to stay home if they have symptoms of respiratory infection.
- An unvaccinated resident who is newly admitted or readmitted, even if asymptomatic, shall be immediately placed on contact and droplet precautions, and remain in isolation for up to 14 days. Fully vaccinated residents do not have to be isolated /quarantined upon admission or readmission unless symptomatic. All appropriate PPE shall be utilized and appropriate infection prevention practices shall be followed. If there are no private rooms available when a current resident returns from a hospital stay, a risk assessment should be completed, and the resident may return to their normally assigned room on quarantine with TBP and ensure that the privacy curtain remains pulled between the beds. If the individual is a high risk exposure / symptomatic, facility will work with a sister facility to attempt to place temporarily until isolation / quarantine period has exhausted.
- Residents within 90 days of confirmed Covid 19 infection, and who have not had prolonged close contact with someone with Covid 19 infection in the prior days, are not required to quarantine / isolate unless symptomatic.
- Residents transferring from one WLC Management Firm facility to another WLC Management Firm facility, are not required to be isolated for 14 days, provided they were not on isolation at the transferring facility, regardless of vaccination status..
- An unvaccinated resident that spends overnight out of building, regardless of setting, shall be placed in transmission-based precautions for 14 days upon return.

- A resident returning from a trip outside of the facility (not gone overnight) will be observed and monitored closely for development of symptoms during the following 14-day period following the outing. Decisions on whether to place such resident into transmission-based precautions, should be made by assessing the potential for exposure while away using the IDPH Risk Assessment:
http://dph.illinois.gov/sites/default/files/COVID-19_LTC.FacilityRiskAssessment.pdf
- All residents shall be screened for symptoms AND temperature, heart rate, respirations (Vital signs) AND pulse oximetry at least daily. Blood pressure may be taken once a day. NOTE: Contact Clinical Supervisor for any of the following: new-onset fever, SOB, cough, sore throat or for any decrease in pulse oximetry from resident baseline level or any pulse oximetry reading < 92%. The clinical supervisor should alert the medical provider for orders. Monitoring every 4 hours is appropriate for patients with evidence of clinical deterioration with blood pressure taken every 8 hours.
- Resident transportation may be provided by the facility, resident family, or transportation service that transports 1 individual at a time (such as VA Vans). The facility transport vehicle will be cleaned prior to and between each transportation episode.
- If no other transportation is available, fully vaccinated residents may use Mass Transit if the resident is able and willing to wear source control throughout the transport. Facility should verify the Covid Safety precautions being provided by the Mass Transit System.
- All non-emergency leave of absences outside of the facility for non-vaccinated residents is discouraged, utilizing tele health when possible.
- Employees who travel out of community, will follow CDC Vacation Guidance/Directives. If facility has a need for an unvaccinated individual to return to work prior to any quarantine recommendation, the individual must Covid Test prior to returning and will test 5-7 days (or more frequently based on facility testing requirements) after returning. Employee shall wear an N95 and a Face Shield until 14 days has passed.
- Staff, Essential Ancillary Staff and Visitors must honestly answer all screening questions, sanitize hands with ABHR, and utilize proper PPE prior to entering the facility.

Prevent the spread of respiratory germs WITHIN the facility

- When possible, residents should cover mouth/nose with a cloth facemask, tissue or other cloth when staff are in the room and providing direct care.
- Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, unless actively eating/drinking, including whenever they leave the facility for essential medical appointments. Whenever a resident is outside their room, they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others). Residents who refuse to wear a mask or social distance, or are cognitively incapable of understanding the directive, will have such documented in resident record and care plan. Staff will provide education and reminders to all residents regarding mask usage and social distancing. If all residents participating in dining / activity are vaccinated, please see guidance under Activities later in this document.
- Monitor residents at least daily for elevated temperature (100 degrees or above) and objective symptoms of respiratory infection. Blood pressure may be taken once a day.
- If POSITIVE for Covid-19 OR if residents have signs/symptoms of a respiratory viral infection:
 - a) Obtain Vitals (temperature, heart rate, respirations) AND pulse oximetry every 4 hours (Q4 hours). Blood pressure can be taken every eight hours (Q8 hours).
 - b) Private Room or Cohort with another symptomatic/positive patient.

- c) Maintain Standard, Contact and Droplet Precautions (including eye protection)
 - d) Consider that staff caring for positive or symptomatic patients do NOT care for negative or asymptomatic residents, when possible.
 - e) Positive or symptomatic residents should be given a surgical mask and encouraged to wear at all times. These residents should be wearing a surgical mask when close contact with other is anticipated.
 - Any resident identified with symptoms of fever and lower respiratory illness (cough, shortness of breath, sore throat) will be placed in both Contact and Droplet transmission-based precautions.
 - Residents with confirmed Covid-19 or displaying respiratory symptoms should receive all services in room with door closed (meals, physical and occupational therapy, activities, and personal hygiene, etc.). Residents who may feel claustrophobic in their room, may have a sheet of plastic placed over the door rather than closing the door.
 - Symptomatic residents should only leave their room as required for medical procedures not available on site (i.e., dialysis, medical specialist appointment, and critical testing not available at the facility).
- *If the resident is to leave for these purposes the shortest route should be utilized and the immediate Area/route to the exit/treatment areas should be cleared of all residents and unnecessary staff.
- Testing to rule out routine pathogens may be completed via rapid influenza testing and respiratory pathogen panels (Rhinovirus, RSV, etc.).
 - Determination to send the resident to the hospital should be based on the same criteria used for other illnesses.
 - Every effort will be made to keep residents at least 6 feet apart.
 - Pause of group activities and dining based on outbreak status of facility and outcome of contact tracing and follow up testing.
 - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask.
 - Employees shall utilize face mask at all times while in the facility, utilizing authorized face mask for their job classification/assignment of duties, as directed in Use of Face Mask Policy as directed by WLC Management Firm, LLC.
 - If an employee becomes sick at work, they should immediately stop working, and report directly to the Administrator/Director of Nursing or Nurse if management is not available. POC Rapid test employee. Collect information from the employee regarding individuals, equipment and locations the employee came into contact with and follow current guidance about returning to work (this can be completed via telephone after employee leaves the facility).
 - An Employee who has had a direct exposure to an individual testing positive for Covid 19 will isolate / quarantine based on IDPH Guidance and direction of Infection Preventionist, DON, and/or from the Local Health Department.
 - Standard Contact and Droplet Precautions with eye protection will be used for residents with undiagnosed respiratory infections. Airborne precautions may be needed for some diagnosed respiratory infections.
 - Facilities should monitor their local and state public health sources to understand COVID-19 activity in their community and implement precautions as updates are available.
 - Post signs throughout the facility describing ways to prevent the spread of germs.
 - Support hand and respiratory hygiene as well as cough etiquette by residents, visitors, and employees.
 - Ensure employees clean their hands according to CDC guidelines, including before / after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment.

- Alcohol based hand rub will be made available to all staff entering and exiting a resident's room. Staff will carry alcohol based hand rub with them at all times.
- Tissues will be made available and sinks will be well-stocked with soap and paper towels for hand washing.
- Identify dedicated employees to care for COVID-19 residents and provide infection control training as possible.
- Post signs on the door or wall outside of the resident's room that clearly describes the type of precautions needed and required PPE.
- Make PPE, including facemasks, eye protection, gowns, and gloves available immediately outside of the resident room when it's determined PPE is needed for the resident. Facility administrator or designee, will ensure that ample supplies of PPE are available in the facility. (Note: PPE back-up supplies are available at the WLC Office.)
- Position a trash can/linen bin near the exit inside any resident room to make it easy for employees to discard PPE. Note: Bio Hazard bags are not required as trash and linen do not have to be treated any differently than non-isolation room. This does secure the items prior to transport through facility.
- Perform hand hygiene upon exiting resident's rooms.
- Covid Test staff, essential ancillary staff, residents as directed by IDPH/CMS Guidance. Symptom onset will require testing for Covid 19 via Lab PCR Test or POC Antigen Test. A single facility-onset of Covid 19 infection in a resident or a staff member will require testing of previously negative residents and staff (regardless of vaccination status) per IDPH/CMS Guidance.
- Indoor Visitors will be highly encouraged to test for Covid 19 prior to visits.
- General Visits, or visitors for an end of life or compassionate care situation, shall be screened upon entering at designated location, including temperature and shall receive education including: proper hand sanitizing (ABHR), utilizing appropriate PPE, and once in the designated visiting area or resident room, must remain in that location, until exiting the facility. Visitors are not authorized to walk throughout the facility and may not enter the facility multiple times a day. Number of visitors at any given time is dependent upon the space of the visiting area being utilized. Individuals must be able to socially distance and they must wear appropriate facemask. Visitors under the age of 18 must be under the direct control of an adult visitor and must be able to abide by the core principles and best practices to reduce the risk of Covid 19 Transmission.
- Facility shall provide notification to staff members, residents, residents' family, residents' guardians, conservators, or representatives (collectively "representative"), DPH and local health department (LHD) when persons working or resident in the facility are confirmed with Covid 19 Infection. Such notification shall identify whether the individual was a staff member or resident. The facility shall not, however, reveal personally identifying information about the individual, including name, except as necessary to notify the resident's family or representative and to ensure staff members take sufficient safety precautions. Notification will comply with IDPH guidance, with revisions to guidance as received from IDPH.

Prevent the spread of respiratory germs BETWEEN facilities

- Alert transportation entities and team members of respiratory illness, suspected or confirmed COVID-19.
- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- Report possible COVID-19 illness in residents and employees to the local health department, including your state Healthcare associated Infections and Antimicrobial Resistance (HAI/AR) coordinator.

Training for Facilities and Staff

- Facilities should provide education and training on proper hand hygiene and donning and doffing of personal protective equipment.
- Training should include information on cleaning and disinfection practices.
- Staff should complete online CMS Targeted Training for Nursing Home Management or Frontline Staff
- Admin, DON and Infection Preventionist should complete online CDC Infection Preventionist Training. Training is recommended for other licensed nursing staff as well.
- Facilities should provide education on importance of vaccination for Covid 19, and strongly encourage staff to accept the vaccination. A 90 minute training on the importance of Covid 19 Vaccination is required for all unvaccinated staff.

Vaccinations

Facility complies with [Executive Order 2021-22](#) and the Illinois Administrative Codes applicable to each respective licensure in regards to vaccination and testing. Facility also complies with the CMS – Medicare and Medicaid Programs: Omnibus COVID-19 Health Care Staff Vaccination Final Rule, mandating Covid19 Vaccination.

FACILITY VACCINATION PROCESS/PLAN:

Who is required to be vaccinated: Facility staff; Licensed Practitioners (Phys, PA, NP...), Students, Trainees, Volunteers, Contracted Staff (Beautician, Therapy, Dietitian, Act/SS Consult...).

Facility works with contracted pharmacy and local health department to provide Covid 19 Vaccination, Additional Doses, and Boosters to residents and staff that consent to the vaccine. There is no charge to the individuals for the vaccination, and facility can request the vaccine from pharmacy at any time.

Vaccination Clinics have been offered/provided to all facility staff. Education on the importance of the Covid Vaccination has been provided to all staff. For those individuals who remain unvaccinated as of the date of the CMS Final Rule, facility will take the following steps:

- 1) Discuss with each individual employee, the requirement that our health care personnel be vaccinated, based on the CMS Final Rule, unless they qualify for a Medical or Religious Exemption. Employee will be required to sign a Covid Vaccination Mandation Acknowledgement.
- 2) Request appropriate vaccine from facility pharmacy if the employee consents to vaccination through the facility. Individuals also have the option to obtain the

- vaccination(s) through another authorized provider, but must provide the facility with documentation of receipt of the vaccination(s).
- 3) Upon notification of a Medical or Religious Exemption, the appropriate Exemption form will be provided to the employee for completion. Facility Administration will review each request and authorize as appropriate.
 - 4) Individuals that qualify for a Medical or Religious Exemption, and are not vaccinated for COVID 19, shall: be Covid 19 Tested at the frequency required by CMS for unvaccinated HCP; physically distance from all other individuals (unless providing direct care to a resident); and must wear a well fitting mask and face shield at all times when in the facility.
 - 5) Facility will track all vaccination information for active employees, licensed practioners, contracted staff, students, volunteers, trainees, on a Tracking Log which will contain:
 - *Employee Name
 - *Manufacturer Name of Vaccine Received
 - *Date(s) of each dose received – including booster/additional dose
 - *Exemption Type (if applicable)
 - *Exemption Approval Date (if applicable)
 - 6) Vaccination Verification Card/Physician Documentation will be scanned into each employee's individual file.
 - 7) Staff refusing Covid 19 vaccination, that are not eligible for a Medical or Religious Exemption, will be terminated from employment if they have not received their first dose or One-Dose Vaccine by December 6, 2021
 - 8) Staff that have not completed the 2nd dose of a 2 dose series by January 4, 2022, will be terminated from employment.
 - 9) New Staff will be required to have received the 1st dose of a 2 dose series vaccine (i.e. Pfizer or Moderna), or a 1 dose vaccine (i.e. Janssen), prior to providing care or services in the facility.

Vaccination for visitors is always preferred and should be encouraged.

Reporting of Staff and Resident COVID-19 Vaccinations and Testing - New

Facilities that are not required to report COVID-19 aggregate vaccination and testing data into the National Healthcare Safety Network (NHSN) shall report this data to the Department weekly utilizing the online form at [LTC Weekly Reporting COVID-19 Vaccinations and Testing](#).

The required information matches that submitted by CMS-certified facilities to NHSN.

Monoclonal Antibody Therapy – New

Treatment with monoclonal antibodies (mAb) may reduce the risk of severe COVID-19

disease and hospitalization. As soon as a resident is diagnosed with COVID-19 or determined to be a close contact of someone with COVID-19, contact the resident's provider and the pharmacy to assess whether monoclonal antibodies should be administered.

Treatment: Persons who are older or who have chronic respiratory, cardiac, or renal disease, obesity, immunosuppressive disease, diabetes, and other medical conditions or factors, including race and ethnicity associated with increased risk of severe COVID-19 disease, may benefit from mAb treatment, regardless of vaccination status.

Post-exposure prophylaxis: Monoclonal antibody treatment may also be used to prevent the development of COVID-19 for close contacts who are at high risk for progression to severe COVID-19, including hospitalization or death, and are not fully vaccinated or who are not expected to develop immunity from vaccination (for example, people with immunocompromising conditions, including those taking immunosuppressive medications).

More information about mAb treatment is available from [IDPH](#), [CDC](#), [CMS](#), and from the [U.S. Department of Health and Human Services](#) (HHS).

Allocation and distribution process

Long-term care facilities should contact your usual pharmacy provider for more information on residents receiving monoclonal antibodies.

New providers or sites for mAb administration, please provide initial account information to AmeriSource Bergen.

Current mAb providers can submit requests for monoclonal antibody treatment to the [State](#).

Source control and physical distancing recommendations - Updated

The safest practice is for residents and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated.

Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a health care setting. HCP must wear at a minimum a well fitted face mask while working. Other PPE may be required based on outbreak status or community transmission; see the section on Universal PPE for HCP.

In accordance with Governor Pritzker's August 4, 2021 Executive Order Number 18 ([COVID-19 Executive Order No. 85](#)), "all nursing homes and long-term care facilities in Illinois must continue to follow the guidance issued by the CDC and IDPH that

requires the use of face coverings in congregate facilities for those over the age of 2 and able to medically tolerate a face covering, regardless of vaccination status.”

Universal PPE for HCP – New

- If a resident is suspected or confirmed to have COVID-19, or is an unvaccinated resident identified to be a close contact, HCP must wear an N95 respirator, eye protection, gown, and gloves.
- If a resident is identified to be a close contact and is vaccinated, HCP must wear PPE according to community transmission levels listed below.
- For those residents not suspected to have COVID-19, HCP should use community transmission levels to determine the appropriate PPE to wear
 - When community transmission levels are substantial or high:
 - HCP must wear a well-fitted face mask and eye protection.
 - HCP working in non-patient care areas are not required to wear eye protection with substantial or high community transmission levels, except when entering the patient care areas (e.g., dietary aide, maintenance, etc.).
 - When community transmission levels are low-to-moderate HCP must wear a well-fitted face mask.
- For COVID-19 specimen collection: HCP must wear N95 respirator, eye protection, gown, and gloves
- Guidance for CPAP/BIPAP for asymptomatic residents, who are not suspected to have COVID-19 (regardless of vaccination status).
 - In areas with substantial-to-high community transmission levels, HCP must wear N95 respirator and eye protection.
 - In areas with moderate-to-low community transmission levels, HCP must wear a well-fitted face mask.

Continued Monitoring of Essential Measures - Updated

Facilities will continue to monitor essential criteria to ensure they can provide safe care and respond to outbreak situations.

Case Status in the Community: New Focus on County Level COVID-19 Transmission
How to implement several of the IPC measures (e.g., vaccination, use of source control,

screening testing) depends on levels of SARS-CoV-2 transmission in the community.

KEY POINTS:

County test positivity rates for COVID-19 are no longer available on the CMS website.

- Facilities must use the [CDC COVID-19 Data Tracker](#).
- Facilities must carefully monitor the color-coding, which depicts county community transmission levels.
- Facilities must contact their local health department with questions pertaining to community transmission levels.

Factors CDC uses to calculate the COVID-19 county level of community transmission. The CDC uses two different indicators (identified in the table below) to determine the level of SARS-CoV-2 transmission for the county where the LTC facility is located. If the two indicators suggest different transmission levels, CDC will use the higher level to determine community transmission risk. Facilities do not need to calculate county community transmission levels.

Table 1: Determining County Level of Community Transmission

	LOW	MODERATE	SUBSTANTIAL	HIGH
New cases per 100,000 persons in the past 7 days*	<10	10-49.99	50-99.99	>100
Percentage of positive NAATS tests during the past 7 days*	<5%	5-7.99%	8-9.99%	>10.0%

*See footnotes from CDC guidance: <https://covid.cdc.gov/covid-data-tracker/#county-view>

Community transmission levels dictate facility testing of unvaccinated HCP, PPE use, and facility response to a positive case(s).

- The facility must test unvaccinated staff according to the community transmission level or more frequently if required by local or state authorities. See Table: Routine Testing Intervals by County COVID-19 Level of Community Transmission (below).
- Facilities must monitor their community transmission level every other week (e.g., first and third Monday of every month) and adjust the frequency of staff testing accordingly.
- If the community transmission level increases to a higher level of activity, the facility must begin testing staff at the frequency shown in the table below as soon as the criteria for the higher activity level are met.

- If the community transmission level decreases, the facility must continue testing staff at the higher frequency until the level of community transmission has remained at the lower level for at least two weeks before reducing testing frequency as shown in the table below.
- For HCPs who work infrequently (less than weekly), test within 72 hours of the next scheduled shift.
- The local health department may have a more stringent testing requirements that facilities must follow.

Table 2: **Testing Intervals of Unvaccinated HCP by Community Transmission Level**

Community Transmission Level	Minimum Testing Frequency of Unvaccinated Staff*
LOW	Per Illinois COVID-19 Executive Order No. 85 testing is required at a minimum of weekly
MODERATE	Once a week
SUBSTANTIAL	Twice a week
HIGH	Twice a week

*While fully vaccinated staff are not required to be routinely tested based on IDPH Guidance, as a precaution, facility may test fully vaccinated staff as directed by the WLC Management Firm Covid Coordinator. Testing is not required of HCP within 90 days of a prior COVID-19 infection, if the staff member remains asymptomatic.

Case status in the facility

A facility must continue to test and to monitor for new facility-onset and facility-associated cases and implement facility-wide testing per testing plan.

Staffing level

IDPH does not support staff working while ill. However, should shortages occur, facilities should utilize mitigation strategies as defined by CDC.² Refer to CDC website "[Mitigation Strategies for Staffing Shortages](#)." Facility will follow the Staffing Emergencies Plan in this case.

Hand hygiene

The facility must train and validate competencies of all staff on hand hygiene. Everyone entering the facility must perform hand hygiene.³

Cleaning and disinfection supplies

Ensure that any disinfectants used in the facility are included on the U.S. Environmental Protection Agency (EPA) "[List N](#)"⁴ as effective against coronavirus (COVID-19). Cleaning and disinfecting products should be readily available for use at the point of care.

PPE supply

- Conventional (normal operations without shortages),
- Contingency capacity (measures used temporarily during periods of anticipated PPE shortages), and
- Crisis capacity (strategies implemented during periods of shortages even though they do not meet U.S. standards of care).

The supply and availability of NIOSH-approved respirators and other PPE has increased significantly. Health care facilities should not be using crisis capacity strategies at this time.

Facilities that extend the use of N95 respirators, face masks, and eye protection are operating at a contingency level of PPE utilization. If PPE is reused, the facility is operating at a crisis level.

Based upon availability, facilities should not be operating at a crisis level for PPE utilization⁵.

[Utilize CDC PPE optimization strategies](#)

[Screening & Monitoring](#)

All individuals entering facility will self screen for Covid like symptoms and recent exposures,, regardless of vaccination status, Facility utilizes Accu Shield electronic screenings. Individuals who have answered yes to any of the screening questions, will not be allowed to print an "Access Sticker". These individuals will be further screened by Admin / DON / IP, utilizing a paper screening. An example of an individual that may answer yes to an exposure questions, could include a State Surveyor or a Mobile X Ray representative who has been in other facilities. If they indicate that they utilized appropriate PPE, individual will be allowed into facility. Individuals who will not be allowed to enter include those with:

- 1) a positive viral test for SARS-CoV-2,
 - 2) symptoms of COVID-19, or
 - 3) person who meets criteria for quarantine, isolation, or exclusion from work.
- Health care personnel (HCP), even if fully vaccinated, should report any of the above criteria. Symptomatic HCP will be restricted from work until they have been evaluated.
 - Visitors meeting any of the above criteria will be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively⁶.

Testing Plan and Response Strategy - Updated
(Appendix A has a table summarizing this
information)

Facility shall follow testing guidelines as established by CMS & IDPH.

Facility utilizes AIM Laboratories for PCR Testing as well as POC Rapid Covid Antigen Testing Analyzers and BinaxNOW Ag Cards for Covid Antigen Testing. The Laboratory reports all results directly to the State of Illinois. All POC Testing is reported through NHSN by WLC Covid Coordinator or facility. NHSN reports results to local health departments as well.

All residents and staff have been tested via facility-wide testing on multiple occasions throughout the pandemic.

Routine testing will be conducted based on CMS & IDPH guidelines. Fully vaccinated staff does not have to be routinely tested. However, based on high community positivity rates, facility may require full vaccinated staff to test.

Facility will immediately test residents or staff with signs/symptoms of COVID-19 with a POC Antigen test, regardless of vaccination status.

Asymptomatic staff with a higher-risk exposure and resident with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral (antigen or Nucleic Acid Amplification Test (NAAT) tests for SARS-CoV-2 infection in these situation, testing is recommended immediately and 5-7 days after exposure.

Individuals with SARS-CoV-2 infection in the last 90 days do not need to be tested if they remain asymptomatic, including those with a known contact.

New Admissions and individuals re-admitting to the facility shall be tested upon arriving at the facility, and 5-7 days following admission /re-admission.

New Employees and employees returning from vacation will be tested at beginning of shift upon return to work and day 5-7 and 2x week until 14 days from return has passed.

Residents that refuse testing shall have a risk assessment completed to determine possible risk of exposure and need to be placed in quarantine with TBP for a 14 day period for monitoring purposes, regardless of symptomatic or asymptomatic status.

Staff that refuse testing, regardless of symptomatic or asymptomatic status, will be barred from the facility for a 14 day quarantine period. Continuing failure shall result in loss of position with facility.

Facility will report positive testing results to the local health department in a timely/routine manner. Facility will report positive resident and staff test results to IDPH in a timely manner. Test results shall be scanned into resident chart or

employee medical personnel file. Visitor testing results will be maintained for a minimum of 1 month for contact tracing purposes.

Visitor Testing and Vaccination

While regulatory agencies do not require testing of visitors, they do encourage facilities in medium- or high-positivity counties to offer testing to visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days). Similarly, visitors are encouraged to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, CMS has indicated that visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation.

Visitors who are willing to be tested, for the protection of the residents in the facility, may choose to test with a POC Antigen Test at the facility or through another testing provider. Individuals who visit routinely throughout the week, may test through our laboratory testing, should they wish to do so, on the facility testing days.

Facility will place symptomatic or Covid 19 Positive residents in a designated isolation room with dedicated staff, as possible.

The facility will submit its testing and response plan to IDPH, CMS, or local health department personnel upon request. Although PCR Testing remains the gold standard for testing, point of care antigen testing is acceptable.

Although a laboratory RT-PCR test remains the gold standard for testing, point-of-care (POC) antigen testing is acceptable. Facility has a CLIA Certificate of Waiver.

Newly Identified Positive Case in an HCP or Resident – Updated

Because of the risk of unrecognized infections among HCP or residents, a single new case of COVID-19 in any HCP or resident should be evaluated as a potential outbreak.

- Increase monitoring and screening of all residents and HCP for signs and symptoms of COVID-19 from daily to each shift, to more rapidly detect those with new symptoms.
- Determine which approach to use for the outbreak investigation. Facilities have the option to choose either a Unit (or department)-based approach or a broad-based approach
 - Either contact tracing or broad-based approaches are recommended by the CDC for outbreak investigations in long-term care facilities. In order to assure that all potential close contacts are tested, IDPH will require at a minimum a unit-based approach in addition to contact tracing.

- It is up to the facility to determine which approach to use. If the facility has the resources and experience to investigate the outbreak at a unit-level [e.g., unit, floor, or other specific area(s) of the facility], and identify higher risk exposures and close contacts, they can choose the unit-level approach. Otherwise, the facility should use a broad-based approach.
- A broad-based approach is required in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.
- LTC facilities responding to COVID-19 cases must always notify and follow the recommendations of the local health department.

Unit (or department level)-based approach

This is a more focused approach and starts the outbreak investigation on the unit or department where the positive COVID-19 case was identified (affected unit).

- If the unit-based approach is used, the facility must test all residents and HCP on the unit (or department) where the HCP worked or the resident resided immediately (but not earlier than two days after exposure), regardless of vaccination status. Continue to test every 3-7 days until there are no more positive cases for 14 days.
- There is no need to test individuals who have had COVID-19 in the prior 90 days if they remain asymptomatic. PCR testing is preferred, but POC antigen tests are also acceptable.
- Perform contact tracing on the unit or department where the new case was identified, by investigating to determine if during the prior 48 hours there were any higher risk exposures to other HCP or close contacts with residents.
- Also determine if there were any higher risk exposures of HCP or close contacts of residents beyond the affected unit (e.g., other units, departments).
- Those identified to be higher risk exposures or close contacts must be tested every 3-7 days until there are no more positive cases for 14 days.
- Pause all visitation (except compassionate care, end-of-life, essential caregivers) on the affected unit until the first round of testing is performed and results are obtained.
- Once the initial tests are completed and the results are obtained, the facility must determine if the outbreak investigation should be expanded to other areas of the

facility.

- When the positive case is a staff member who rotates on multiple units, facilities must determine which units may be affected based upon the infectious period or 48 hours prior to the positive test. Multiple units may need to be tested. If more than one unit is indicated, follow the broad-based approach below.
- In general, individuals who have had a COVID-19 infection within the past 90 days are exempt from testing unless they become symptomatic.

Broad-based Approach

This approach is broad from the start or onset and requires testing of all residents and HCP regardless of vaccination status when a single case of COVID-19 is identified in the facility.

- Conduct facility-wide testing of all residents and HCP immediately (but not earlier than two days after exposure), regardless of vaccination status.
- Pause all visitation (except compassionate care, end-of-life, essential caregivers) until the first round of testing is performed and results are obtained.
- Continue to test every 3-7 days until there are no more positive cases for 14 days.
- In general, individuals who have had a COVID-19 infection within the past 90 days are exempt from testing unless they become symptomatic.

HCP Higher-risk Exposure – Updated

The specific factors associated with these exposures should be evaluated on a case-by-case basis to determine if a higher-risk exposure occurred; interventions, including restriction from work, can be applied if the risk for transmission is deemed substantial ([evaluating an exposure](#)).⁹

Testing of HCP with higher risk exposures is conducted in addition to the routine serial testing of unvaccinated HCP required by CMS and the [COVID-19 Executive Order No. 85](#).

- Unvaccinated HCP should be excluded from work for 14 days after their last exposure and have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than two days after the exposure) and, if negative, again 5–7 days after the exposure. The HCP should be referred to their health care provider for possible post-exposure prophylaxis with monoclonal antibodies.

- Fully vaccinated asymptomatic HCP should have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than two days after the exposure) and, if negative, again 5–7 days after the exposure. Work restriction is not necessary unless the HCP develops symptoms or tests positive for COVID-19.
- Asymptomatic HCP who have recovered from COVID-19 in the past 90 days, do not need to be restricted from work or have testing performed following exposure to a confirmed or probable COVID-19 case if they remain asymptomatic.
- HCP who are moderately to severely immunocompromised might be at increased risk for infection. Facilities should consult with their local health department for any work restriction that may be required after a higher risk exposure.

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- Note: Fully vaccinated HCP with prolonged, continued exposure in the home (e.g. children, spouse or other household member positive for COVID-19 who cannot be isolated from others in the home) must test at least two days after first exposure, between days 5-7, and weekly for two weeks after the last exposure date (or more frequently based on community transmission rates).
 - Restriction from work, quarantine, and testing is not recommended for people who have had COVID-19 in the last 90 days if they remain asymptomatic.

Management of Residents –

Updated Residents with Confirmed COVID-19

- Resident placement
 - Single room
 - Door closed (if safe to do so). Plastic over the door is a good option for individuals if door closure is an issue.
- Designate a separate area or unit as a COVID-19 unit, if possible.
- Isolate using transmission-based precautions
- Monitor the resident every four hours
- Use dedicated medical equipment
- Dedicate HCP to the COVID-19 unit as possible (including environmental services or housekeeping staff)
- Staff wear full PPE (N95 respirator, gown, gloves, eye protection)
- Visitation - Updated
 - While not recommended, resident may receive visitors. Visitors must be counseled on risks of visiting an individual in isolation with TBP including

- potential for severe illness or death.
- Communal dining - not allowed in communal areas. Dining should occur in resident room.
- Group activities - resident should not participate in group activities until recovered.
- Transmission-based precautions (TBP)
 - Symptom-based strategy is preferred over testing strategy
 - Mild-to-moderate illness
 - A minimum of 10 days since symptoms first appeared or first diagnostic test
 - Fever free for 24 hours without fever-reducing medications
 - Symptoms improving (e.g., shortness of breath, cough)
 - Severe-to-critical illness or moderate-to-severely immunocompromised
 - A minimum of 10 days (or up to 20 days) since symptoms first appeared
 - Fever free for 24 hours without fever-reducing medications
 - Symptoms improving (e.g., shortness of breath, cough)
 - Consider consultation with infectious disease expert
- Environmental cleaning
 - Routine cleaning and disinfection of surfaces and equipment.
 - After discharge, leave the room empty (do not occupy or enter) for a period of one hour(60 minutes). Environmental services or housekeeping must not enter to terminally clean the room before 60 minutes has elapsed, unless they are wearing full PPE. After 60 minutes, they can wear a well-fitted face mask.

Residents Suspected to have COVID-19 - Updated

- Test symptomatic residents regardless of vaccination status
- Patient placement
 - Single room (if feasible)
 - Door closed (if safe to do so). Plastic over door is acceptable if door closure is not safe.
 - Private bathroom if possible
- Isolate using transmission-based precautions until results of tests are known
- Evaluate residents at least daily
- Use dedicated medical equipment
- Staff wear full PPE (N95 respirator, gown, gloves, eye protection)
- Visitation-Updated
 - While not recommended, resident may receive visitors. Visitors must be counseled on risks of visiting an individual in isolation with TBP including potential for severe illness or death.
- Communal dining – not allowed in communal areas. Dining must occur in resident room.
- Group activities – resident must not participate in group activities until recovered.
- Routine cleaning and disinfection of surfaces and equipment.
- After discharge, leave the room empty for a period of 60 minutes. Environmental services or housekeeping must not enter to terminally clean the room before 60 minutes has elapsed, unless they are wearing full PPE. After 60 minutes, they can wear a well-fitted face mask.

- If limited single rooms are available, or if numerous residents are simultaneously identified to have COVID-19 exposures or symptoms concerning for COVID-19, residents should remain in their current location, draw privacy curtain between beds, and wait for test results.

Resident identified as a Close Contact of someone with COVID-19 (e.g., roommates or other close contacts) - Updated

- Restriction from quarantine, and testing is not recommended for people who have had COVID-19 in the last 90 days if they remain asymptomatic.
- Regardless of vaccination status, should have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than two days after the exposure) and, if negative, again 5–7 days after the exposure.
- Isolation, quarantine, and PPE requirements for residents identified to be a close contact of a positive COVID-19 case:
 - If the resident is symptomatic, regardless of vaccination status, isolate using transmission-based precautions and test as above. HCP should wear full PPE — treat as suspected COVID-19 case (see above guidance).
 - If resident is asymptomatic and fully vaccinated, no need to quarantine or restrict resident to their rooms, but resident should wear source control for 14 days post exposure.
 - If the resident is asymptomatic and unvaccinated, quarantine for 14 days even if testing negative. HCP should wear full PPE.
 - If the resident is asymptomatic and has had COVID-19 within last 90 days, no need to quarantine; resident should wear source control for 14 days post exposure.
 - If the resident is moderate-to-severely immunocompromised, consider quarantine. Consult with resident's health care provider to determine if quarantine is necessary.
- Visitation
 - Unvaccinated residents identified to have had a close contact that are in quarantine are allowed indoor visits in their room only. Both the resident and the visitor should wear source control and maintain physical distancing. Visitor should be counseled on potential risk of exposure to Covid 19 including severe illness or death.
 - Vaccinated residents identified to have had a close contact can participate in indoor visits in their rooms, in common areas, or in designated visitation spaces. Outdoor visits are allowed. Both the resident and the visitor should wear source control and maintain physical distancing for both indoor and outdoor visits.
- Dining
 - Unvaccinated residents identified to have had a close contact that are in quarantine must not participate in communal dining and should dine in their room.
 - Vaccinated residents identified to have had a close contact may participate in

communal dining but should wear source control to and from the dining hall and when not eating or drinking.

- Group activities
 - Unvaccinated residents identified to have had a close contact that are in quarantine must not participate in group activities.
 - Vaccinated residents identified to have had a close contact may participate in group activities but should wear source control during the activity.

New Admissions or Readmissions – Updated

- Hospitalized residents with confirmed COVID-19 must complete transmission-based precautions (isolation) requirements (minimum of 10 days or up to 20 days if immunocompromised or severe illness).
- Because of the risk of unrecognized COVID-19 infections among residents, facilities must conduct testing at the time of admission to the facility (if not done in the past 72 hours). See testing requirements listed below.
- New Admissions or Readmissions
 - When community transmission levels are substantial or high, asymptomatic new admissions and readmissions, regardless of vaccination status, must be tested on admission if not tested in the past 72 hours. If negative, test again 5 – 7 days after admission.
 - If community transmission levels are low-to-moderate, asymptomatic new admissions and readmissions will be tested upon admission, but if negative, do not need to be re-tested at 5-7 days after admission.
- PCR testing is the preferred testing method. POC antigen testing is acceptable.
- New admissions or readmissions that are unvaccinated need to quarantine for 14 days and complete testing as noted above.
- New admissions or readmissions that are fully vaccinated do not need to quarantine as long as they remain asymptomatic but must complete testing listed above.
- Visitation – follow the same guidance as residents who are close contacts.
- Facilities in an outbreak may admit new residents if they have met the following criteria: have adequate staffing (HCP) to provide care to all residents (current residents and new admissions), are not in crisis staffing, have adequate PPE inventory to meet the care needs of all residents (those currently residing in the building and new admissions), and have appropriate room placement for residents. Facilities in outbreak must consider the criteria listed above, the extent of the outbreak, and must consult with their local health department before accepting new admissions.

Residents who leave the facility – Updated

- Remind residents to follow core infection control measures when out of the building (e.g., hand hygiene, source control in crowded settings, physical distancing when feasible, etc.)
- Quarantine is not recommended for unvaccinated residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with COVID-19. A Risk Assessment can be completed to assist in making this determination.
- Residents who leave the facility for 24 hours or longer should generally be managed as described in New Admissions and Readmissions.

Resident vaccination status	Is quarantine of resident necessary?	Is testing of the resident necessary?	
		Low-to-moderate community transmission	Substantial-to-high community transmission
Unvaccinated resident out for less than 24 hours	No	No	No
Unvaccinated resident out for 24 hours or more	Yes	No	Yes, test as readmission
Vaccinated resident out for less than 24 hours	No	No	No
Vaccinated resident out for 24 hours or more	No	No	Yes, test as readmission

Visitation - Updated

Facility will allow outdoor and indoor visits, as authorized by CMS QSO-20-39-NH with a revision date of 11/12/2021. *Please note that a mask is required at all times based on the Illinois Governor's Indoor Mask Mandate.

Visitation can be conducted through different means based on facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. Regardless of how visits are conducted, core principles and best practices reduce the risk of Covid 19 Transmission:

Core Principles of COVID-19 Infection Prevention

- Visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or currently meet the criteria for quarantine, should not enter the facility. Facilities should screen all who enter for these visitation exclusions.
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose) and physical distancing at least six feet between people, in accordance with CDC guidance
- Instructional signage throughout the facility and proper visitor education on COVID19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO20- 38-NH)

Visitors who are unable to adhere to the core principles of Covid19 infection prevention will not be permitted to visit or will be asked to leave.

Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred when the resident and/or visitor are not fully vaccinated against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor Visitation

Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits. Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. Facilities should ensure that physical distancing can still be maintained during peak times of visitation (e.g., lunch time, after business hours, etc.). Also, facilities should avoid large gatherings (e.g., parties, events) where large numbers of visitors are in the same space at the same time and physical distancing cannot be maintained. During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated

visitation area. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission.

If a resident's roommate is unvaccinated or immunocompromised (regardless of vaccination status), visits should not be conducted in the resident's room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of infection prevention.

If the nursing home's county COVID-19 community level of transmission is substantial to high, all residents and visitors, regardless of vaccination status, should wear face coverings or masks and physically distance, at all times. In areas of low to moderate transmission, the safest practice is for residents and visitors to wear face coverings or masks and physically distance, particularly if either of them is at increased risk for severe disease or are unvaccinated. If the resident and all their visitor(s) are fully vaccinated and the resident is not moderately or severely immunocompromised, they may choose not to wear face coverings or masks and to have physical contact. Visitors should wear face coverings or masks when around other residents or healthcare personnel, regardless of vaccination status. Additional information on levels of community transmission is available on the CDC's COVID-19 Integrated County View webpage.

While not recommended, residents who are on transmission-based precautions (TBP) or quarantine can still receive visitors. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated). Before visiting residents, who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention. Facilities may offer well-fitting facemasks or other appropriate PPE, if available; however, facilities are not required to provide PPE for visitors.

NOTE: CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection. This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor in accordance with the CDC's "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic." Unvaccinated residents may also choose to have physical touch based on their preferences and needs, such as with support persons for individuals with disabilities and visitors participating in certain religious practices, including in end-of-life situations. In these situations, unvaccinated residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit. Visitors should also physically distance from other residents and staff in the facility.

Indoor Visitation during an Outbreak Investigation

An outbreak investigation is initiated when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). To swiftly detect cases, we remind facilities to adhere to CMS regulations and guidance for COVID-19 testing, including routine unvaccinated staff testing, testing of individuals with symptoms, and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing in accordance with CMS QSO 20-38-NH REVISED and CDC guidelines (immediately, but not sooner than 2 days).

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

Visitor Testing and Vaccination

While not required, we encourage facilities in counties with substantial or high levels of community transmission to offer testing to visitors, if feasible. If facilities do not offer testing, they should encourage visitors to be tested on their own before coming to the facility (e.g., within 2–3 days).

CMS strongly encourages all visitors to become vaccinated and facilities should educate and also encourage visitors to become vaccinated. Visitor testing and vaccination can help prevent the spread of COVID-19 and facilities may ask about a visitors' vaccination status, however, visitors are not required to be tested or vaccinated (or show proof of such) as a condition of visitation. If the visitor declines to disclose their vaccination status, the visitor should wear a face covering or mask at all times. This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below.

Compassionate Care Visits

Compassionate care visits are allowed at all times. Previously during the PHE, there were some scenarios where residents should only have compassionate care visits. However, visitation is now allowed at all times for all residents, in accordance with CMS regulations. Therefore, we believe there are few scenarios when visitation should be limited only to compassionate care visits. In the event a scenario arises that would limit visitation for a resident (e.g., a resident is severely immunocompromised and the number of visitors the resident is exposed to needs to be kept to a minimum), compassionate care visits would still be allowed at all times. CMS expects these scenarios to be rare events.

Required Visitation

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f)(4)(v). In previous nursing home visitation guidance during the PHE, CMS outlined some scenarios related to COVID-19 that would constitute a clinical or safety reason for limited visitation. However, there are no longer scenarios related to COVID-19 where visitation should be limited, except for certain situations when the visit is limited to being conducted in the resident's room or the rare event that visitation is limited to

compassionate care. Therefore, a nursing home must facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, per 42 CFR § 483.10(f)(4), which states “The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident,” would constitute a potential violation and the facility would be subject to citation and enforcement actions.

As stated above, we acknowledge that there are still risks associated with visitation and COVID-19. However, the risks are reduced by adhering to the core principles of COVID-19 infection prevention. Furthermore, we remind facilities and all stakeholders that, per 42 CFR §483.10(f)(2), residents have the right to make choices about aspects of his or her life in the facility that are significant to the resident. Visitors, residents, or their representative should be made aware of the potential risk of visiting and necessary precautions related to COVID-19 in order to visit the resident. However, if a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk (e.g., in the resident’s room), the resident must be allowed to receive visitors as he/she chooses.

Access to the Long-Term Care Ombudsman As stated in previous CMS guidance QSO-20-28-NH (revised), regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid-certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. If an ombudsman is planning to visit a resident who is in TBP or quarantine, or an unvaccinated resident in a nursing home in a county where the level of community transmission is 7 substantial or high in the past 7 days, the resident and ombudsman should be made aware of the potential risk of visiting, and the visit should take place in the resident’s room. We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID19 infection prevention as described above. If the resident or the Ombudsman program requests alternative communication in lieu of an in-person visit, facilities must, at a minimum, facilitate alternative resident communication with the Ombudsman program, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident’s medical, social, and administrative records as otherwise authorized by State law.

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

42 CFR § 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to “investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred.” 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes “the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person.” 42 CFR § 51.42(c); 45 CFR § 1326.27.

If the P&A is planning to visit a resident who is in TBP or quarantine, or an unvaccinated resident in a county where the level of community transmission is substantial or high in the past 7 days, the resident and P&A representative should be made aware of the potential risk of visiting and the visit should take place in the resident's room.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (Section 504) and the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 et seq. (ADA).

For example, if communicating with individuals who are deaf or hard of hearing, it is recommended to use a clear mask or mask with a clear panel. Face coverings should not be placed on anyone who has trouble breathing or is unable to wear a mask due to a disability, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

In addition, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention. Any questions about or issues related to enforcement or oversight of the non-CMS requirements and citations referenced above under this section subject heading should be referred to the HHS Office for Civil Rights (Toll-free: 800-368- 8 1019) (TDD toll-free: 800-537-7697), the Administration for Community Living (202-401-4634), or other appropriate oversight agency.

Entry of Healthcare Workers and Other Providers of Services

All healthcare workers must be permitted to come into the facility as long as they are not subject to a work exclusion or showing signs or symptoms of COVID-19. In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance. We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.

Essential Caregivers

Refer to the [IDPH Essential Caregiver Guidance for Long-term Care Facilities Guidance](#)

Communal Dining and Group Activities

Communal Dining

- Residents must wear a mask to and from dining hall or activity room.
- Consistent with the Illinois-COVID-19 Executive Order No. 85 residents, regardless of vaccination status or community transmission levels should wear source control when not eating or drinking unless they are in their own room or apartment.

Live Music, Vocal Performances and Sing-alongs, or Worship Services

- Outdoor performances are preferred
 - Residents regardless of vaccination status are not required to wear source control when outdoors. Unvaccinated residents should physically distance from one another when outdoors.
 - Performers are not required to wear source control while performing outdoors but must maintain at least 6-9 feet from audience. If unable to maintain 6-9 feet separation, the performer must wear source control.
 - Performing groups with more than five performers must perform outdoors. Facilities should not allow indoor performances of large groups.
 - Instruments should be fitted with bell covers consisting of a minimum of two layers of dense fabric. Bell covers should be made of a non-stretchy material with a MERV-13 rating (Minimum Efficiency Reporting Value) to protect against bacteria and virus particles.
 - Performers who play wind instruments can use face coverings with a slit.
 - Communion. Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.
- Indoor Performances and Sing-alongs or Worship services are allowed using the following guidance.
 - Illinois Executive Order Number 18 ([COVID-19 EXECUTIVE ORDER NO. 85](#)), requires residents, visitors, and HCP to wear source control while indoors in all areas of the facility other than their room(s) or apartments.
 - Vaccinated residents do not have to physically distance from one another.
 - Unvaccinated residents should physically distance from one another.
 - Individuals (e.g., clergy, pastors, etc.), conducting the worship service, regardless of vaccination status, are required to wear source control and maintain a physical distance of 6-9 feet from the audience or congregation.
 - Instruments should be fitted with bell covers consisting of a minimum of two layers of dense fabric. Bell covers should be made of a non-stretchy material with a MERV-13 rating to protect against bacteria and virus particles.
 - Individuals who play wind instruments can use face coverings with a slit.
 - Communion. Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.
 - If required, individuals providing pastoral care visits must wear source control and

- otherPPE (e.g., eye protection, gown and gloves).
- Communion. Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.

Resident Outings

Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices including wearing a face covering or mask, physical distancing, and hand hygiene and to encourage those around them to do the same.

Upon the resident's return, nursing homes should take the following actions:

- Screen residents upon return for signs or symptoms of COVID-19.
 - If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, test the resident for COVID-19, regardless of vaccination status. Place the resident on quarantine if the resident has not been fully vaccinated.
 - If the resident develops signs or symptoms of COVID-19 after the outing, test the resident for COVID-19 and place the resident on Transmission-Based Precautions, regardless of vaccination status.
- Facility will test unvaccinated residents without signs or symptoms if they leave the nursing home frequently or for a prolonged length of time, such as over 24 hours.
- Facilities might consider quarantining unvaccinated residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention measures.
- Monitor residents for signs and symptoms of COVID-19 daily.

Residents who leave the facility for 24 hours or longer should generally be managed as a new admission or readmission, as recommended by the CDC's "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes." Please note that there are exceptions to quarantine, including for fully vaccinated residents

Group Outings

Group outings beyond the facility grounds may be considered provided all the above precautions are observed, along with precautions listed below for trips that are not medically necessary.

- Outdoor outings, such as a stroll in the park, are strongly preferable to outings to indoor destinations, weather permitting.
- Avoid mass events like festivals, fairs, and parades.
- Avoid other locations where it may be difficult to maintain 6-foot separation.

Beauty Salons and Barber shops

To operate facility-based beauty salons and barber shops:

- Allow services in beauty salons and barber shops only for residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- All residents must wear source control to and from and in the beauty salon.
- The beautician or barber, regardless of vaccination status, must wear source control at all times while in the beauty salon.
- Hand-held blow dryers are now allowed to be used in salons.
- Observe restrictions and precautions in Personal Care Services Guidelines for Restore Illinois except if IDPH guidelines in this document are more stringent, the IDPH guidance applies.

Assisted living facilities and other similar arrangements

For Assisted Living Facilities (ALF), Shared Housing Establishments (SHE), Sheltered Care Facilities, and Supportive Living Facilities (SLF), visits can be in common areas or in residents' apartments, following guidance listed above.

State-Authorized Personnel. IDPH grants authorization for entry to state-authorized personnel. They should not be classified as visitors. All such individuals must promptly notify facility staff upon arrival, follow all screening protocols established by the facility, and wear appropriate source control while onsite. State-authorized personnel are required to bring their own PPE and sufficient additional PPE for donning and doffing while entering and exiting COVID-19 units. State-authorized personnel will follow the COVID-19 rules and policies set forth by their respective state agencies. (For additional guidance, see this IDPH guidance document: "Access to Hospital Patients and Residents of Long-Term Care Facilities by Essential State- Authorized Personnel," April 17, 2020). Failure to allow entry by state-authorized personnel may lead to penalties and sanctions pursuant to applicable state and federal law.

Long-Term Care Ombudsman

As stated in previous CMS guidance QSO-20-28-NH, regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid-certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. During this public health emergency, in-person access may be limited due to infection control concerns and/or transmission of COVID-19, such as the scenarios stated above for limiting indoor visitation; however, in-person access may not be limited without reasonable cause.

Representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If in-person access is deemed inadvisable (e.g., the ombudsman has signs or symptoms of COVID-19), facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or

throughout use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by state law.

Surveyors

Federal and state surveyors are not required to be vaccinated and must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19. Surveyors should also adhere to the core principles of COVID-19 infection prevention.

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 42 CFR § 483.10(b), F550.
- For concerns related to a facility limiting visitors without a reasonable clinical and safety cause, surveyors should investigate for non-compliance at 42 CFR § 483.10(f)(4), F563.
- For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at 42 CFR §§ 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.
- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance at 42 CFR § 483.80(a), F880.

Definitions

Facility-onset case: Following the definition from [CMS \(QSO-20-30-NH\)](#): "A COVID-19 case that originated in the facility; not a case where the facility admitted an individual from a hospital with known COVID-19 positive status, or an individual with unknown COVID-19 status that became COVID-19 positive within 14 days after admission."

Facility-associated case of COVID-19 infection in a staff member: "A staff member who worked at the facility for any length of time two calendar days before the onset of symptoms (for a symptomatic person) or two calendar days before the positive sample was obtained (for an asymptomatic person) until the day that the positive staff member was excluded from work." (CDC Contact Tracing for COVID-19, found at: <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact>).

Fully Vaccinated: The vaccination status of a person who is \geq two weeks following receipt of thesecond dose in a valid two-dose series, or \geq two weeks following receipt of one dose of a single dose vaccine.

Higher-risk Exposure: An exposure of a staff member to a person with COVID-19 in any of thefollowing circumstances:

- Staff member not wearing a respirator or face mask.
- Staff not wearing eye protection if the person with COVID-19 was not wearing a cloth maskor face mask.
- Staff member not wearing full personal protective equipment (PPE) (gown, gloves, eyeprotection, respirator) while performing an aerosol-generating procedure.

Staff: (CDC) “[Staff] include, but are not limited to, emergency medical service personnel, nurses,nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).”

State-authorized personnel: State-authorized personnel include, but are not limited to, representatives of the Office of the State Long-Term Care Ombudsman Program, the Office ofState Guardian, IDPH Office of Health Care Regulation, and the Legal Advocacy Service; and community-service providers, social-service organizations, prime agencies, or third parties serving as agents of the state for purposes of providing telemedicine, transitional services to community-based living, and any other supports related to existing consent decrees and courtmandated actions, including, but not limited to, the prime agencies and sub-contractors of theComprehensive Program serving the Williams and Colbert Consent Decree Class Members.

Source Control (e.g., Cloth Face Covering, Face Mask, or Respirator): Source control refersto the use of a well-fitting face covering, face masks, or respirators to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing,or coughing. Source control offers varying levels of protection for the wearer against exposure to infectious droplets and particles produced by infected people.

- o Resident Source Control = cloth face covering, surgical mask, or procedure mask.
- o HCP Source Control = surgical mask, procedure mask, or respirator, as applicable.

Appendix A: COVID-19 Testing Summary (New)		
Testing Trigger	Staff (HCP)	Residents
Symptomatic individual identified.	Vaccinated and unvaccinated staff with signs or symptoms must be tested.	Vaccinated and unvaccinated residents with signs or symptoms must be tested.
Higher risk exposure or close contact with individual who tested positive for COVID-19 that occurs within the facility	<p>Asymptomatic HCP with higher-risk exposure to someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection.</p> <p>Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule</p>	<p>Asymptomatic residents with prolonged close contact with someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection.</p> <p>Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule</p>
Higher risk exposure or close contact with individual positive with COVID-19 that occurs outside the facility	<p>Asymptomatic HCP with higher-risk exposure to someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection.</p> <p>Test two days post-exposure. If negative, test again between day 5-7 post-exposure.</p> <p>Note: Fully vaccinated HCP with prolonged, continued exposure in the home must test at two days, between days 5-7, and weekly for two weeks after the last exposure date.</p>	<p>Asymptomatic residents with prolonged close contact with someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection.</p> <p>Test two days post-exposure. If negative, test again between day 5-7 post-exposure</p>
New admissions, readmissions or those out of the facility for more than 24 hours.		<p>If community transmission levels are substantial or high, regardless of vaccination status, must be tested on admission if not tested in the past 72 hours. If negative, test again 5 – 7 days after admission. PCR testing is preferred.</p> <p>If community transmission levels are low to moderate, do not need to be tested on admission.</p>

Appendix A: COVID-19 Testing Summary Continued (New)

Testing Trigger	Testing Trigger	Testing Trigger
<p>Newly identified COVID-19 positive HCP or resident in a facility.</p> <p>If the facility has the ability to investigate the outbreak at a unit-level (e.g., unit, floor, or other specific area(s) of the facility), and identify higher risk exposures and close contacts, they can choose the unit-level approach. Otherwise, the facility should use a broad-based approach.</p>	<p><u>Unit approach:</u> Test all HCP on the unit (or department) where the case was identified immediately (but not earlier than two days after exposure), regardless of vaccination status, Continue to test every 3-7 days until there are no more positive cases for 14 days. No need to test individuals who have had COVID-19 in the prior 90 days.</p> <p>Identify any asymptomatic higher risk exposures in HCP and close contacts in residents not on that unit. Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule. <u>Broad-based approach:</u> Test all HCP facility-wide immediately (but not earlier than two days after exposure) regardless of vaccination status. Continue to test every 3-7 days until there are no more positive cases for 14 days.. No need to test individuals who have had COVID-19 in the prior 90 days.</p>	<p><u>Unit approach:</u> Test all residents on the unit (or department) where the case was identified immediately (but not earlier than two days after exposure), regardless of vaccination status Continue to test every 3-7 days until there are no more positive cases for 14 days. No need to test individuals who have had COVID-19 in the prior 90 days.</p> <p>Identify any asymptomatic higher risk exposures in HCP and close contacts in residents not on that unit. Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule.</p> <p><u>Broad-based approach:</u> Test all residents facility-wide immediately (but not earlier than two days after exposure), regardless of vaccination status. Continue to test every 3-7 days until there are no more positive cases for 14 days.. No need to test individuals who have had COVID-19 in the prior 90 days.</p>
<p>Routine testing</p>	<p>Follow Table 2: Testing Intervals of Unvaccinated HCP by Community Transmission Level</p>	<p>Not generally recommended.</p>