Preparing for and Responding to COVID-19 in Nursing Homes and Assisted Living Facilities

Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), nursing home and assisted living facility populations are at high risk of being affected by coronavirus disease 2019 (COVID-19). If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness. The following recommendations from Maryland Department of Health (MDH) supplement MDH Secretary's Orders, MDH Guidance for Relaxation of Restrictions Implemented During the COVID-19 Pandemic – Nursing Homes, MDH Guidance for Relaxation of Restrictions Implemented During the COVID-19 Pandemic — Assisted Living, CDC's general infection prevention and control recommendations for COVID-19 and CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes. The following recommendations should continue until otherwise determined by public health.

COVID-19 Description

Typical COVID-19 symptoms include fever, cough, and shortness of breath. Other symptoms can be very mild and might include fatigue, muscle or body aches, headache, loss of sensation of smell and/or taste, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea. Additionally, experience with outbreaks in nursing homes and assisted living facilities has reinforced that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms.

Case Definitions for the Purposes of this Guidance

Suspect COVID-19 case: an individual with clinical illness as described above

Confirmed COVID-19 case: an individual with a positive SARS-CoV-2 PCR or, for the purposes of this guidance, a positive SARS-CoV-2 antigen test, regardless of signs and symptoms

Testing/Laboratory Diagnosis:

Facilities should:

- Establish a relationship with a CLIA-certified lab that can provide adequate COVID-19 testing to meet the projected needs of the facility for both resident and staff testing. The chosen laboratory should be able to provide results within 48 hours of receiving the specimen.
- Ensure capacity to safely collect specimens for COVID-19 testing. In assisted living facilities, testing for staff might be provided in the facility or at outpatient or urgent care settings, including by individual primary care providers.
- Develop written procedures for addressing residents or staff that decline required testing or are unable to be tested.

- Ensure access to tests for other respiratory viruses that can cause symptoms similar to COVID-19, as appropriate, e.g. rapid flu and influenza PCR and multiplex respiratory viral panels.
- Test staff and residents in accordance with MDH Secretary's Orders.

Pneumonia cases:

In addition to testing for COVID-19, run the following tests simultaneously, as appropriate:

- Rapid flu or influenza PCR or respiratory panel
- Sputum culture, including for *Legionella*
- *Legionella* and *Streptococcus pneumoniae* urinary antigen tests

Outbreak definitions:

COVID-19 outbreak: One or more confirmed cases of COVID-19 in a resident or staff member.

A single COVID-19 case in a resident admitted <3 days will NOT be considered an outbreak, unless otherwise determined by the local or state health department.

Other respiratory outbreaks (see respiratory illness guidelines for managing these outbreaks):

- Influenza-like illness (ILI) outbreak: 3 or more ILI cases in 7 days
- Influenza outbreak: 2 residents and/or staff with ILI or pneumonia within 3 days and at least one has a positive influenza test
- Pneumonia outbreak: 2 or more cases of pneumonia in a unit within 7 days
- A combination of ILI, influenza, and pneumonia cases

The following scenarios must be reported to LHD within 24 hours:

- One or more confirmed COVID-19 cases among residents and/or staff
- Two or more cases of suspect COVID-19 cases within 14 days
- Three or more residents or staff with new-onset respiratory symptoms that occur within 72 hours.
- Respiratory outbreaks as defined in the respiratory outbreak guidelines

Preventive Measures Against COVID-19

Share the latest general information about COVID-19 with staff, residents, and families

Personal protective equipment (PPE) use and infection control:

- As part of source control efforts, healthcare personnel (HCP) and essential visitors should wear a facemask or cloth face covering at all times while they are in the facility. Consider use of eye protection by all staff members at all times to reduce risk for unrecognized exposures.
- If tolerated, residents should wear masks or cloth face coverings if they leave their rooms and when they are within 6 feet of anyone else, including staff members.
- When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of COVID-19 (as supply allows). Guidance on extended use and reuse of facemasks is available.
- All staff should wear appropriate PPE, to the extent PPE is available. In nursing homes and assisted-living facilities, N95 respirators are not generally required because aerosol-generating procedures (APGs) are not generally performed. Use of a facemask is adequate, including for the routine care of suspected and confirmed COVID-19 residents. Ensure that use of PPE is consistent with CDC guidance on optimization of PPE:
    - Residents on COVID-19 observation/quarantine unit (if available) – gloves, gown, facemask, eye protection.
    - Residents with suspect or confirmed COVID-19 – gloves, gown, facemask, eye protection.
    - Residents in the general population – Facemasks and Standard Precautions and Transmission-based Precautions based on underlying diagnoses and presence of colonization or infection with multidrug-resistant organisms
    - Use of a fit-tested N95 respirator is recommended if an APG must be performed
    - Non fit-tested N95 respirators can be substituted for facemasks if the supply of facemasks is limited, but staff should understand that they are not being used as N95 respirator in such circumstances.
- Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of the appropriate PPE for Standard and Transmission-based Precautions.
- Educate staff on the appropriate and safe use of PPE.
- Review Strategies to Optimize the Supply of PPE and Equipment, but be aware that Crisis Capacity Standards are not allowed for facilities attempting to enter the re-opening process.
- Have HCP demonstrate competency with putting on and removing PPE.
- Instruct staff to perform hand hygiene before and after touching their masks and eye protection and to handle only by the sides, elastic, or ties.
- Implement or continue program for observing and monitoring adherence to hand hygiene and PPE, all days and shifts.
- Dedicate equipment (e.g. blood pressure cuffs, pulse oximetry sensors, etc.) to each resident, particularly those on transmission-based precautions, as much as possible. Clean and disinfect shared equipment between residents.

Ensure adequate supplies for infection prevention and control practices:

- Assess supply of PPE and initiate measures to optimize current supply.
- If a facility anticipates shortages of PPE supplies, they should notify their local health department.
- PPE should be readily available and kept well-stocked in areas where resident care is provided.
- Alcohol-based hand sanitizer should be available inside and outside of every resident room and other resident care and common areas, as available and appropriate.
- Sinks should be kept well-stocked with soap and paper towels for handwashing.

Management of staff:

- Staff with symptoms should not report to work. Signs and symptoms of COVID-19 can be very mild, so even mild signs of illness should result in HCP exclusion. Sick leave policies should be non-punitive and allow staff to stay home while symptomatic or under other circumstances necessary to prevent the transmission of COVID-19, such as having unprotected close contact with a case. See CDC guidance regarding risk assessments following potential exposures to COVID-19.
- Observe and enforce social distancing among staff, including in hallways, break rooms, and outdoors. Ensure staff are wearing masks and consider eye protection when interacting with each other. Encourage staff to not share items, and ensure that surfaces and objects shared by staff are cleaned appropriately.
- Facilities must continue to screen all staff at the beginning of each shift, including performance of temperature checks, observing for signs and symptoms of COVID-19, asking questions about signs and symptoms of COVID-19, and ensuring staff have a facemask. Staff who screen positive should be excluded from work and counseled to seek testing.
- Any staff that develop signs and symptoms consistent with COVID-19, including temperature ≥100.0^{o}F (individual facilities may consider using a lower cutoff), while working should keep their facemask on, inform their supervisor, and leave the workplace as soon as possible. Symptomatic staff members should be encouraged to get tested for COVID-19.
- Staff with negative COVID-19 molecular amplification tests (e.g. PCR) can generally return 3 days after the resolution of symptoms. If there is an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. However, judgement should be used, as false negative and positive tests and coinfections are possible. Staff should also consult with their own healthcare providers for guidance in this situation.
- Facilities should use the CDC return-to-work guidance when deciding when staff with suspected or confirmed COVID-19 should be allowed to return to work.
- Facilities should prepare for staff shortages. All nursing homes are required to register with the Chesapeake Registry Program http://www.chesapeakeregistry.com/ which may be a source of staffing. Hospitals, staffing agencies, and other arrangements should be considered.

Enhance surveillance to identify infections early:

- Actively screen all residents for fever and new or worsening symptoms of COVID-19; immediately isolate anyone who is symptomatic in a single-person room, if available, on

contact and droplet precautions. Dedicate blood pressure cuffs and pulse oximeters as much as possible. Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Additional symptoms may include new or worsening fatigue, muscle or body aches, headache, loss of sensation of smell and/or taste, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.
    - Nursing homes must screen all residents at least daily, including performance of temperature checks, pulse oximetry checks, observing for signs and symptoms of COVID19, and asking questions about signs and symptoms of COVID-19.
    - Assisted living facilities must screen all residents daily, including observing for signs and symptoms of COVID-19; asking questions about signs and symptoms of COVID-19; and where appropriate, temperature and pulse oximetry checks.
- All residents with suspect COVID-19 should be cared for using all recommended PPE (i.e., gown, gloves, facemask, and face shield or goggles), at least until diagnosis is clarified.
- Maintain a line list of all residents and staff with possible symptoms of COVID-19. Use the template provided by the local health department or posted on the MDH website.

Prepare to house COVID-19 cases, residents exposed to COVID-19 cases, and suspect COVID-19 cases:

- Determine the location(s) of the COVID-19 care unit(s) and create a staffing plan
- Desirable characteristics include:
    - Physical separation from other rooms or units housing residents without confirmed COVID-19. Can be a separate floor, wing, or cluster of rooms.
    - Separate entrance and a door that can be closed, if possible.
    - Separate PPE donning and doffing area.
    - Separate staff restroom, break room, and work area, as available.
    - Dedicated equipment such as vitals machines and carts for the unit.
- Staffing:
    - Plan for dedicated staff to work only on the COVID-19 care unit, especially nursing staff, but also environmental staff, therapy staff, and other staff if possible.
    - Train these staff members on infection control, donning and doffing of PPE, extended use and limited re-use of PPE (when allowed), cleaning and disinfection of surfaces in resident rooms, hallways, and staff areas, and cleaning and disinfection of equipment between uses.

Admissions and readmissions:

- Create a dedicated observation/quarantine area (this could be a separate unit/wing if possible or dedicated rooms in one area) to house new non-COVID-19-positive residents being admitted, or current residents being re-admitted from an outside facility where the resident spent 24 hours or longer, or after leaving for 24 hours or longer. Ideally, this area would have private rooms with private bathrooms.
- Staff should not float between the observation unit and other units.
- Residents should be screened for COVID-19 symptoms prior to admission or re-admission using at least the following methods:
    - Verbal report received from the transferring facility
    - Temperature taken (cutoff for fever is $\geq 100.0^{o}F$)
    - Questions asked about symptoms, e.g. fever, cough, shortness of breath, fatigue, muscle or body aches, headache, loss of sensation of smell and/or taste, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea

- If a new or re-admitted resident screens negative for COVID-19 symptoms, they should be admitted to the observation unit/area for 14 days. COVID-19 testing may be considered for asymptomatic residents being admitted to this area, but it is not required.
- Residents in the observation unit should be placed in isolation using contact and droplet precautions with eye protection.
- Residents in the observation unit should be monitored daily with temperature and symptom checks.
- If a new or re-admitted resident screens positive for COVID-19 symptoms, they should be moved to an area dedicated to the care of suspect COVID-19 patients or isolated to a private room and promptly tested for COVID-19. If the test result is positive, the patient should be transferred to the COVID-19 unit. If the test result if negative, the resident should be transferred back to and/or remain in the observation unit/area for 14 days; a negative test result does not mean that the resident was not exposed, and it is still possible that they could develop symptoms.
- After 14 days on the observation/quarantine unit, if the resident does not ever screen positive for COVID-19 symptoms, they can be relocated to the general population.
- All residents of nursing homes and assisted living facilities that are in pre-Phase 1 of relaxation of restrictions implemented during the COVID-19 pandemic should be restricted to their rooms as much as possible, except for medically necessary purposes. It is particularly important that residents in the observation area not mix with residents from other parts of the facility. For details on relaxing these restrictions, see MDH guidance for nursing homes or assisted living facilities.
- Patients who have been hospitalized for suspect or confirmed COVID-19 can be discharged from the hospital whenever it is clinically indicated. They do NOT require re-testing to be discharged. Patients with suspect COVID-19 should be admitted to an area dedicated to the care of suspect COVID-19 patients or isolated in a private room and promptly tested for COVID-19. Patients with confirmed COVID-19 should be admitted to the COVID-19 unit.
- A nursing home can accept a resident diagnosed with COVID-19 and who is still on Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions.
- See Frequently Asked Questions (FAQs) on Managing New Admissions and Readmissions for Maryland Nursing Homes.

Visitor restrictions (unless otherwise allowed based on a facility entering a reopening phase as specified in MDH guidance nursing homes or assisted living facilities):

- All visitors should be restricted from entering the facility except for in extenuating circumstances (e.g., a resident is at the end of life).
- Facilities shall screen all persons who enter the facility (e.g., staff, volunteers, vendors, and visitors when permitted) for signs and symptoms of COVID-19, including temperature checks. Facilities shall refuse entrance to anyone screening positive for symptoms of COVID-19.
- Visitors to the facility should be instructed to report the onset of fever or any COVID-19 symptoms to the facility in the 14 days after visitation.
- Visitors that are permitted inside must wear a facemask or cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. Visitors should perform frequent hand hygiene.
- Limited outdoor visitation may be permitted in certain circumstances:

- See Maryland Department of Health Guidance for Relaxation of Restrictions Implemented During the COVID-19 Pandemic – Nursing Homes
- See Guidance for Outdoor Visits at Assisted Living Facilities in Maryland

Movement restrictions:

- Residents:
  - Cancel communal dining and all group activities in the facility, unless otherwise allowed based on a facility's phase in the relaxation of restrictions.
  - Residents who have signs or symptoms of illness, are on a COVID-19 observation unit, or with suspected or confirmed COVID-19 (including those without symptoms) must remain in their room with the door shut if possible until they have been cleared from observation or Transmission-Based Precautions.
  - Other residents should remain in their room to the extent possible, except for medically necessary purposes. Well residents can be allowed outside on a limited basis, if the following conditions are met:
    - There is adequate staffing to escort and supervise residents outside. More than one resident can be outside at a time but they must be supervised, appropriate social distancing must be maintained, and they should not congregate in or near doorways
    - Residents must be masked anytime they are out of their room, as feasible; escorts must also be wearing appropriate PPE
    - Residents must stay at least 6 ft apart from others
    - Residents must perform hand hygiene before leaving the room and after returning
  - Have all residents who leave their rooms, including those who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis) wear a facemask or cloth face covering if tolerated when outside of their room, including for procedures outside of the facility.
  - Avoid transferring residents between units, except as needed for proper cohorting.
  - Remind residents not to congregate in hallways or other areas such as outdoors for smoking. Offer nicotine replacement. Remind residents not to share food, drinks, cigarettes, or personal items.
- Staff:
  - Avoid the floating of staff between units. Dedicate staff to a single unit as much as possible.
  - Cohort staff who care for COVID-positive residents. They should not also provide care for other residents in the facility.
  - Employ strategies to limit traffic between units. For example, have dietary staff deliver food to the entrance of the unit and have unit staff deliver trays.
  - Have in-room therapy and activities only, unless otherwise allowed based on MDH relaxation of restrictions guidance for nursing homes or assisted living facilities.
  - Non-nursing staff that enter the rooms of residents should follow the appropriate Standard and Transmission-based Precautions as described in other parts of this guidance.

Communication:

- Prepare facility internal and external communications in the event of a COVID-19 case being identified in your facility.

- Provide frequent education about COVID-19 to facility-based and consultant personnel (e.g. wound care, podiatry, barber) and volunteers who provide care or services in the facility. Inclusion of consultants is important, since they commonly provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.
- Brief leadership team on priority activities in the event of a suspected or confirmed case (e.g. ensuring vigilant infection control).
- Have an updated phone tree with public health communicable disease contacts and leadership contacts readily accessible.
- Ensure frequent and ongoing communication with all staff.

Memory Care:

Caring for residents with dementia presents a formidable challenge to maintaining social distancing, movement restrictions, and other infection prevention measures. Changes in routines, environments, and caregivers can result in anxiety and behavioral changes.

- Try to maintain routines while reminding and assisting residents to perform frequent hand hygiene and to wear face masks or face coverings as tolerated.
- Provide activities that can be conducted in residents' rooms or at staggered times to maintain social distancing.
- Attempt to redirect and remind residents not to congregate if they walk around the unit.
- Clean and disinfect frequently touched surfaces regularly.

When You Have Suspected COVID-19 Case(s)

Activities implemented before a suspected/confirmed case still apply.

Admissions and transfers:

- Facilities should remain open to new admissions unless specifically instructed otherwise by public health officials.
- Transport personnel and any facility receiving residents with suspect COVID-19 must be verbally notified about the suspected diagnosis prior to transfer.
- While awaiting transfer, symptomatic residents should wear a facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE should be used by HCP when coming in contact with the resident.

Environmental cleaning:

- In general, only essential personnel should enter the room of patients with COVID-19. Healthcare facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the patient.
- Frequently touched surfaces (e.g. tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones) should be disinfected frequently and as needed with an EPA-registered disinfectant on List N with an emerging pathogens or human coronavirus claim or a 1:10 bleach solution.
- Environmental services staff should use Standard Precautions and any appropriate Transmission-based Precautions while performing daily and terminal cleaning of resident rooms; if this includes rooms of residents with suspect or confirmed COVID-19, PPE should include eye protection. PPE should be removed upon leaving the room, immediately followed by performance of hand hygiene.
- To the extent possible, use dedicated medical equipment for residents with fever or signs or symptoms of COVID-19. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to the manufacturer's instructions and facility policies.

Care of residents:

- Place the suspect case in a private room with a private bathroom, if possible. If the suspect case had a roommate, the roommate should also be kept in a separate room without a roommate. Unless COVID-19 and observation units or units for suspect cases have been set up, do not move the residents between units. Do not move a resident to the COVID-19 unit unless they test positive.
- Your local health department can assist with resident placement decisions.
- Use Standard, Contact and Droplet precautions with eye protection (i.e., gown, gloves, face mask, and face shield or goggles) for residents with signs or symptoms consistent with COVID-19.
- To rapidly identify deteriorating residents with worsening clinical conditions, assess for symptoms and take vital signs, including pulse oximetry, on symptomatic residents at least three times daily.
- Aerosol-generating procedures should be avoided. If unavoidable, they should ideally be performed in an airborne infection isolation room (AIIR) or if not possible, in a private,

closed room with a closed door while wearing appropriate PPE (i.e., gown, gloves, N95 or higher-level respirator, and eye protection).

When you have suspect staff case(s):

- Arrange for testing for any symptomatic staff members.
- Conduct contact tracing to identify residents and staff who had close contact with the suspect or confirmed case. For any staff who had possible close contact with the suspect or confirmed case, in consultation with your local health department, follow CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.
    - For staff who had close contact with a suspect case that is awaiting test results, the work exclusions described in this document should be applied if the test results will be delayed beyond 48-72 hours.

When You Have a Confirmed COVID-19 Case

Activities implemented before confirming a COVID-19 case still apply.

When a COVID-19 case is confirmed:

- If the new case is in a resident, move the resident to the unit dedicated to the care of COVID-positive residents.
- If the new case is in a staff member, ensure the staff member is excluded from work and, in consultation with the local health department, follows CDC's Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19.
- Quickly perform an investigation to identify other potentially exposed individuals:
    - For any staff who had possible close contact with the confirmed case, in consultation with the local health department, follow CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.
    - Residents who had close contact with a confirmed case within 48 hours of the case's symptom onset should be moved to the observation/quarantine unit (if asymptomatic), or if available, a unit for persons under investigation for COVID-19 (if symptomatic). If such a unit is not available, isolate the resident in a private room.
    - As part of an outbreak investigation and in consultation with public health, the facility should consider additional interventions for residents with unknown levels of exposure to the case or who are at risk for exposures* to the case that do not meet the strict definition of a close contact, e.g.:
        - Increase use of PPE by staff caring for these residents to include gloves, gowns, N95 respirator or facemask if N95 respirator is unavailable, and eye protection for all encounters for 14 days after the last possible exposure.
        - Quarantine these residents for 14 days after the last possible exposure, with increased monitoring of residents for new symptoms of COVID-19, dedicated staff, and dedicated equipment.
- Increase monitoring of all residents in the facility. Assess for new or worsening symptoms, take vital signs and oxygen saturation via pulse oximetry at least 3 times daily for all residents. Dedicate blood pressure cuffs and pulse oximeters as much as possible; if not possible, clean and disinfect equipment between residents.
- Dedicate staff to each resident care area and avoid floating of nursing staff between resident care areas to avoid spreading COVID-19 to different areas of the facility. Employ strategies to minimize movement of other staff between resident care areas.
- Ensure universal mask use and consider universal eye protection for staff. Residents should wear masks when outside of their rooms or within 6 feet of another person.
- Reinforce hand hygiene practices and respiratory etiquette for staff and residents.
- Re-educate staff about and observe the correct donning and doffing of PPE.
- Enforce social distancing among staff in hallways, breakrooms, and outdoors.
- Conduct enhanced environmental cleaning of frequently touched surfaces frequently.
- Conduct additional staff and resident testing as described below.
- Ensure ongoing compliance with strict visitor restrictions.
- Communicate frequently and transparently with public health.

- Facilities that are currently relaxing COVID-19 restrictions (i.e. are in the process of "re-opening") should consult with their local health department to discuss any different or additional recommendations than those outlined here, including the need to temporarily disallow visitation, group activities, group dining, and outings.

*Risk for exposure among residents will vary in each individual situation and might depend on how well staff have been adhering to infection control guidance. Examples of residents who might be at risk for exposure without having close contact with a confirmed case might include the following: roommates of a case, residents cared for by the same nursing staff as a case, or residents housed on the same hallway or wing as a case.

Testing

- Implement COVID-19 testing of residents and staff in accordance with relevant MDH Secretary's Orders regarding testing at nursing homes and assisted living facilities and CDC's Testing Guidance for Nursing Homes.
- If testing asymptomatic residents or staff, plan in advance for what will happen in response to the results. For example, create a plan for cohorting and moving residents; start the process for obtaining additional staff in case large numbers of asymptomatic staff test positive; and/or seek contracts with specialist physicians to round on positive residents, if needed.

Staff exclusion

- CDC recommends staff with COVID-19 be excluded from work. Facility leadership should work with the local health department, the Chesapeake Registry, hospitals, staffing agencies and other available resources to plan for meeting staffing needs to provide safe care to residents while infected staff are excluded from work. If the facility is in Crisis Capacity and facing staffing shortages, see CDC's Strategies to Mitigate Healthcare Personnel Staffing Shortages.

Personal protective equipment (PPE):

- All staff should wear appropriate PPE, including use of procedure or surgical facemasks (i.e. not cloth face coverings) when they are interacting with residents, to the extent PPE is available and consistent with CDC guidance on optimization of PPE:
    - Residents on COVID-19 observation/quarantine unit (if available) – gloves, gown, N95 respirator or facemask if N95 respirator is unavailable, eye protection.
    - Residents with suspect or confirmed COVID-19 – gloves, gown, N95 respirator or facemask if N95 respirator is unavailable, eye protection.
    - Residents in the general population – Facemasks and Standard Precautions and Transmission-based Precautions based on underlying diagnoses and presence of colonization or infection with multidrug-resistant organisms. MDH or the local health department might provide alternate recommendations in an outbreak setting.
- When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of COVID-19 (as supply allows). Guidance on extended use and reuse of facemasks is available.
- Other essential visitors must wear a facemask or cloth face covering at all times while they are in the facility.

Discontinuation of Transmission-based Precautions and Staff Return-to-Work:

- Please see CDC guidance for Discontinuation of Transmission-Based Precautions for Residents with Suspected or Confirmed COVID-19 and for Criteria for Return to Work for Healthcare Personnel.
- Any of the three strategies (test-, symptom-, and time-based) included in these guidance documents is reasonable and appropriate; MDH does not require use of CDC's test-based strategy. Facilities choosing to use the test-based strategy should be aware that individuals can test positive for multiple weeks without remaining infectious, and recommended restrictions would still need to be maintained for those individuals.

Communication:

- Inform residents (and family members or other persons who serve as designated decision-makers for residents) and staff of confirmed case(s) with prepared communication materials. Informational updates must be provided within 12 hours of the occurrence of a single confirmed infection of COVID-19 or when three or more residents or staff have new onset of respiratory symptoms within 72 hours of each other. Potential new residents must be informed of the outbreak and receive the same communications.
- Discuss response to confirmed case(s) with public health authorities. Update the line list and send to the LHD at least daily.
- Staff/leadership rounds at the facility on every shift to ensure staff have an opportunity to discuss concerns with leadership might be beneficial.
- Coordinate public communications with state and local authorities.

In Memory care:

- Consider relocating suspect and confirmed cases out of the unit. If these residents will not be moved, dedicate staff to the cases as much as possible and use all recommended PPE.
- If a resident is moved, bring familiar objects and maintain the current routine to the extent possible.
- As with all outbreaks, test all residents in order to cohort positive and negative residents into physically separate areas with dedicated staff.
- Attempt to keep all residents in their rooms at all times through the use of reminders, barriers, redirection and other means. Meals should be served in rooms if possible.