COVID-19 RESPONSE for Assisted Living Facilities

Abstract

This document provides guidance to Assisted Living Facilities on Response Actions in the event of a COVID-19 exposure.
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1. Points of Contact for this Document

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## 2. Table of Changes

<table>
<thead>
<tr>
<th>Document Version</th>
<th>Date</th>
<th>Change</th>
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<tr>
<td>Version 3.0</td>
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<td>Added new HHSC Reporting Requirements</td>
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<td>New CDC Return to Work Exposure Guidance</td>
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<td>New Graphics for CDC Symptom Based Strategy</td>
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<td>Added Attachment 9 LTCR Provider Letter PL 20-24 pp 60-64</td>
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<td>Deleted ALF Outbreak Data (obsolete)</td>
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3. Introduction

Purpose

This document provides assisted living facilities (ALFs) with response guidance in the event of a positive COVID-19 case associated with the facility. A facility must develop a written COVID-19 Response Plan in accordance with 26 TAC §553.2001.

Goals

- Rapid identification of COVID-19 situation in an ALF
- Prevention of spread within the facility
- Protection of residents, staff, and visitors
- Provision of care for an infected resident(s)
- Recovery from an in-house COVID-19 event

Overview

Residents of long-term care (LTC) facilities are more susceptible to COVID-19 infection and the detrimental impact of the virus than the general population. In addition to the susceptibility of residents, a LTC environment presents challenges to infection control and the ability to contain an outbreak with potentially rapid spread among a highly vulnerable population.

This document provides LTC facilities’ immediate actions to consider and actions for extended periods after a facility is made aware of potential infection of a resident, provider, or visitor.
4. Required Screening

An ALF must screen all individuals who enter the facility prior to entry in accordance with the rules at 26 TAC §553.2003 (except for services personnel in an emergency), including staff at the start of their shift, visitors, new residents, and residents returning to the facility for:

- fever, defined as a temperature of 100.4 Fahrenheit and above;
- signs and symptoms of COVID-19, including chills, cough, shortness of breath or difficulty breathing; fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea; and
- any other signs and symptoms as outlined by the CDC in Symptoms of Coronavirus at cdc.gov; or
- contact in the previous 14 days with someone who has a confirmed diagnosis of COVID-19, is under investigation for COVID-19, or is ill with a respiratory illness regardless of whether the person is fully vaccinated (unless the individual is seeking entry to provide essential services such as doctors, nurses, home health and hospice staff).
- a positive COVID-19 test result from a test performed in the last 10 days.

Post signage at all entrances of the facility reminding individuals not to enter the facility prior to being screened.

Prohibit a visitor who meets any of the screening criteria from entering the facility and reschedule the visit.

Quarantine a resident who meets any of the screening criteria and monitor for symptoms of COVID-19 according to guidance.

Document in writing all persons who enter the building in a log kept at the entrance to the facility. Include, at least, the date, the person’s name, current contact information, and the data from the screening (presence/absence of fever and symptoms).

The screening log might contain protected health information and must be protected in accordance with applicable state and federal law.

An assisted living facility is not required to screen emergency services personnel entering the facility in an emergency or a visitor participating in a vehicle parade or a closed window visit.

Do not restrict surveyors. HHSC is constantly evaluating their surveyors to ensure they don’t pose a transmission risk when entering a facility. For example, surveyors might have been in a facility with COVID-19 cases in the previous 10 days, but because they were wearing PPE effectively per the CDC guidelines, they pose a low risk to transmission in the next facility and must be allowed to enter. However, there are circumstances under which surveyors should not enter, such as if they have a fever or any additional signs or symptoms of illness.
5. Visitors

Providers of Critical Assistance

In accordance with the Expansion of Opening Visitation rules at 26 Texas Administrative Code (TAC) §553.2003(a), the persons listed below are defined as persons providing critical assistance and must be allowed to enter the facility, provided they are wearing all necessary PPE as appropriate to the current COVID-19 status in the facility regardless of whether the ALF meets the criteria for a visitation designation. These include:

Persons with Legal Authority to Enter

- Government personnel performing their official duties, including HHSC surveyors whose presence is necessary to ensure the ALF is protecting the health safety of residents and providing appropriate care
- Law enforcement officers
- Representatives of the Long-term Care Ombudsman's Office and representatives of Disability Rights Texas

Providers of Essential Services

- Contract doctors, contract nurses, home health and hospice workers, health care professionals, contract professionals, and clergy members and spiritual counselors, whose services are necessary to ensure resident health and safety
- Family members and loved ones of residents at the end-of-life
- Essential caregivers
- Emergency responders
- This list is not exhaustive. A facility must use its best judgment to determine which persons are "essential" to protect the health and safety of a resident.

New Mask Guidance

On May 21, 2021 HHSC posted the following guidance for long-term care facilities on masks:

On Wednesday, Governor Abbott issued Executive Order GA-36, which prohibits governmental entities, such as HHSC, from mandating face coverings in response to the COVID-19 disaster.

Effective immediately, long-term care providers, including home and community support services agencies, are not required to comply with any requirement in HHSC rule that mandates face coverings in response to the COVID-19 disaster. Providers must continue to comply with applicable infection control rules, including those addressing compliance with CDC and CMS guidance.

Note that this order does not take the place of Executive Order GA-34, paragraph 4. Businesses, including long-term care providers, may require employees or customers to follow additional hygiene measures, including wearing face coverings.
HHSC continues to strongly encourage the use of face coverings to prevent the spread of COVID-19, particularly in settings involving vulnerable populations or individuals who are unvaccinated or of unknown vaccination status.

HHSC is developing new emergency rules in response to this order and will notify long-term care providers by provider letter when the new rules are adopted.

**COVID-19 Visitation Rules**

See [26 TAC §553.2003 ALF COVID-19 Visitation](#) rule for all requirements.

See Attachment 8 Provider Letter PL 2021-12 and Attestation Form 2196.

On March 24, 2021, as part of the continued reopening of the State of Texas, HHSC published The current rule allows for less stringent visitation guidelines if an ALF has *"offered"* a complete series of COVID vaccines to residents and staff and documented each resident’s choice to vaccinate, or not to vaccinate.

There are more stringent visitation guidelines for ALFs that have **not** offered a complete series of COVID vaccines to residents and staff and documented each resident’s choice to vaccinate, or not to vaccinate. If the facility has **NOT** offered a complete series of a one- or two-dose COVID-19 vaccine to residents, the facility must allow limited personal visitation including, but not limited to, the following requirements:

*"Offer" in this context means to administer, arrange, or give information about the COVID-19 vaccine. If this is done, the facility can follow the less restrictive rules, as long as documentation of each resident’s choice to vaccinate or not is maintained.

**ALFs that have "offered" vaccines:**

- No attestation form for visitation is required.
- A resident may choose to have close or personal contact with their visitor during the visit. (Any personal visitor, not just essential caregivers.)
- There may be up to two permanently designated essential caregivers per resident, and up to two. Both of the resident’s designated essential caregivers may visit the resident at the same time.

**ALFs that have NOT "offered" vaccines:**

- Must submit LTCR Form 2196 to the Regional Director where the facility is located to receive approved visitation designation from HHSC. Once approved, the facility must allow for outdoor visits, open window visits, vehicle parades, and plexiglass indoor visits involving residents and personal visitors.
- A resident may have only **one of their two** designated essential caregivers may visit at a time.
permanently designated essential caregivers per resident and <deleted>

All ALFs Regardless of offering vaccines

- ALFs must allow outdoor visits, open window visits, vehicle parades, and plexiglass indoor visits involving residents and personal visitors. The only exception is if the Region or visitation rules at 26 TAC §553.2003 require a temporary pause on personal visitors in an area with an active COVID-19 infection that has not yet met end of isolation criteria.
- ALFs must schedule visitation appointments to allow time for cleaning and sanitization of the visitation area between visits.
- ALFs must not require a visitor to provide documentation of COVID-19 negative test or COVID-19 vaccination status as a condition of visitation or to enter the facility.
- The facility must screen all visitors according to the requirements in the rule.
- Visitors who meet any of the screening criteria must leave the facility and reschedule the visit.
- The essential caregiver does not have to maintain physical distance between themselves and the resident they are visiting but must maintain physical distancing between themselves and all other residents and staff. In addition, the facility must develop and enforce essential caregiver visitation policies and procedures, as detailed in the emergency rule.

Additionally, all facilities must provide instructional signage throughout the facility and proper visitor education regarding the following:
- Signs and symptoms of COVID-19;
- Infection control precautions;
- Other applicable facility practices (e.g., use of facemasks and other appropriate PPE; specified entries and exits; routes to designated visitation; and hand hygiene).

Essential caregiver Visits

Essential caregiver visits must be allowed in all facilities for all residents with any COVID-19 status.

Essential caregiver--A family member or other outside caregiver, including a friend, volunteer, clergy member, private personal caregiver, or court-appointed guardian, who is at least 18 years old and has been designated by the resident or legal representative.

Up to two essential caregiver visitors can be designated by each resident or their legally authorized representative. Facilities that have offered a complete vaccine series to residents and documented each resident’s choice may allow up to two designated essential caregivers to visit the resident at the same time.

Facilities that have not offered a complete vaccine series to residents may only allow one-designated essential caregiver to visit the resident at a time.

The visit can occur outdoors, in the resident’s bedroom, or in another area in the facility that limits visitor movement through the facility and interaction with other residents. For example, an
activity room or library could be used as a designated area for visits. Essential caregiver visitors do not have to maintain physical distancing between themselves, the resident they are visiting but must maintain physical distancing between themselves and all other residents and staff.

The resident must wear a facemask or face covering over both the mouth and nose (if tolerated) throughout the visit.

The ALF must develop and enforce essential caregiver visitation policies and procedures, and document that the essential caregiver was informed of the policies and procedures and agrees to follow them. The ALF has to inform the essential caregiver of applicable policies, procedures, and requirements.

**Differences Between Essential Caregivers and Visitors:**

- Essential caregiver visits are allowed for all residents with any COVID-19 status. Other visits (indoor, outdoor, salon services) are allowed only for residents with COVID-negative status.
- Essential caregivers are required to be at least 18 years old.
- Essential caregivers must sign a written agreement to follow the ALF’s applicable policies, procedures, and requirements.
- Essential caregivers must be trained on proper PPE usage and infection control measures, hand hygiene, and cough and sneeze etiquette.

**Salon Visits**

Salon services visitor--A barber, beautician, or cosmetologist providing hair care or personal grooming services to a resident.

An ALF can allow a salon services visitor to enter the facility to provide hair care or personal grooming services to COVID-19 negative residents. Salon visits do not require an HHSC designation for general visitation. The rules in 553.2003 detail the requirements for salon visits.

Requirements include:

- More than one resident can be in the salon at the same time, as long as they are physically distanced.
- Salon services visitors do not have to maintain physical distancing between themselves and the resident they are serving but must maintain physical distancing from others in the facility.
- The facility must maintain a record of each salon services visit according to the rules at §553.2003.

See Attachment 9 for all requirements.
**Decision Tree for Allowed Visitation**

The types of visits and visitors allowed depend on whether or not the ALF has offered a complete series of COVID-19 vaccine to residents and documented each resident’s choice to vaccinate or not to vaccinate. Remember that “offer” in this context means to administer, arrange, or give information about the COVID-19 vaccine.

The table below compares the types of visits allowed:

<table>
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<th>Offered vaccine and documented resident’s choice</th>
<th>Has not offered vaccine and documented choice</th>
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<tr>
<td><strong>Essential Caregiver Visits</strong></td>
<td>Allowed for all residents with any COVID status.</td>
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<tr>
<td><strong>Number of EC Visitors</strong></td>
<td>Up to 2 EC can visit a resident at the same time.</td>
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<tr>
<td><strong>End-of-Life Visits</strong></td>
<td>Allowed for all residents with any COVID status.</td>
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<tr>
<td><strong>Screening</strong></td>
<td>Screen all visitors except emergency personnel in an emergency situation.</td>
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<td><strong>Facemask</strong></td>
<td>All visitors must wear facemask at all times while in the facility. Per the CDC, children 2 years of age or younger do not need to wear facemasks, if tolerated. Document if not tolerated.</td>
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<td><strong>Indoor and Outdoor Visits</strong></td>
<td>Must be Allowed for residents with COVID-negative status.</td>
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<tr>
<td><strong>Physical Contact between residents and visitors</strong></td>
<td>Allowed for all visitors if a resident chooses</td>
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<tr>
<td><strong>Salon Services</strong></td>
<td>Only for residents with COVID-negative status.</td>
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Visitation Definitions

The definitions below are also in the expansion of opening visitation rules at 26 TAC §553.2003(a).

(1) Closed window visit—A personal visit between a personal visitor and a resident during which the resident and personal visitor are separated by a closed window and the personal visitor does not enter the facility.

(2) COVID-19 negative—The status of a person who has either tested negative for COVID-19, is not exhibiting symptoms of COVID-19, and has had no known exposure to the virus in the last 14 days.

(3) COVID-19 positive—The status of a person who has tested positive for COVID-19 and does not yet meet the Centers for Disease Control and Prevention (CDC) guidance for the discontinuation of transmission-based precautions.

(4) End-of-life visit—A personal visit between a personal visitor and a resident who is receiving hospice services or who is at or near the end of life, with or without receiving hospice services, or whose prognosis does not indicate recovery. An end-of-life visit is permitted for all residents at or near the end of life.

(5) Essential caregiver—A family member or other outside caregiver, including a friend, volunteer, clergy member, private personal caregiver, or court-appointed guardian, who is at least 18 years old and has been designated by the resident or legal representative.

(6) Essential caregiver visit—A personal visit between a resident and an essential caregiver. An essential caregiver visit is permitted for all residents with any COVID-19 status.

(7) Facility-acquired COVID-19 infection—COVID-19 infection that is acquired after admission in a facility and was not present at the end of the 14-day quarantine period following admission or readmission.

(8) Indoor visit—A personal visit between a resident and one or more personal visitors that occurs in-person in a dedicated indoor space.

(9) Open window visit—A personal visit between a resident and a personal visitor during which the resident and personal visitor are separated by an open window.

(10) Outbreak—One or more laboratory-confirmed cases of COVID-19 identified in either a resident or paid or unpaid staff.

(11) Outdoor visit—A personal visit between a resident and one or more personal visitors that occurs in-person in a dedicated outdoor space.

(12) Persons providing critical assistance—Providers of essential services, persons with legal authority to enter, and family members or friends of residents at the end of life, and designated essential caregivers.

(13) Persons with legal authority to enter—Law enforcement officers, representatives of the long-term care ombudsman’s office, and government personnel performing their official duties.

(14) Physical distancing—Maintaining a minimum of six feet between persons, avoiding gathering in groups in accordance with state and local orders, and avoiding unnecessary physical contact.

(15) Plexiglass indoor visit—A personal visit between a resident and one or more personal visitors, during which the resident and the personal visitor are both inside the facility but within a booth separated by a plexiglass barrier.

(16) PPE—Personal protective equipment.
(17) Providers of essential services—Contract doctors or nurses, home-health and hospice workers, health care professionals, contract professionals, and clergy members and spiritual counselors, whose services are necessary to ensure resident health and safety.

(18) Salon services visit—A personal visit between a resident and a salon services visitor. Salon services visitor—A barber, beautician, or cosmetologist providing hair care or personal grooming services to a resident.

(19) Unknown COVID-19 status—The status of a person who is a new admission or readmission, has spent one or more nights away from the facility, has had known exposure or close contact with a person who is COVID-19 positive, or who is exhibiting symptoms of COVID-19 while awaiting test results.

(20) Vehicle parade—A personal visit between a resident and one or more personal visitors, during which the resident remains outdoors on the facility’s property and a personal visitor drives past in a vehicle.
6. Infection Control

Infection Control <delete> Prevent COVID-19

See Attachment 1: ALF COVID-19 Response Infographics & Flowcharts, for visual aids outlining ALF response activities. Comply with all CDC guidance related to infection control.

Zones

Establish infection control zones to keep resident cohort groups separate from each other and to limit movement of staff between the separate zones:

- Cold Zones for COVID-19 negative residents
- Warm Zones for monitoring residents with unknown COVID-19 status
- Hot Zones for COVID-19 positive residents

An ALF must have spaces for staff to doff and dispose of PPE used in a warm zone or hot zone, and wash hands or use hand sanitizer before entering a cold zone in the facility

Educate

Educate residents and families about COVID-19 actions that the facility is taking to protect them and their loved ones (including visitor restrictions), as well as actions residents can take to protect themselves in the facility.

Encourage residents to consider their level of risk before deciding to go out and educate them about steps they should take to protect themselves from infection.

Educate residents about the new physical distancing requirements as-applicable by the revised visitation rules because physical distancing will be different based on if the facility can follow the less restrictive or more restrictive visitation. <deleted>

Educate residents and any visitors regarding the importance of handwashing. Assist residents in performing proper hand hygiene if they are unable to do so themselves. Educate residents to cover their coughs and sneezes with a tissue, then throw the tissue away in the trash, and wash their hands.

See Attachment 2: S.P.I.C.E. graphic and focus on the following five basic actions (S.P.I.C.E.) to anchor your activities. SPICE is not intended to be all-encompassing.

- **Surveillance**—monitor each resident at least twice daily (if well) or three times a day (if sick)
- **Protection/PPE**—protect workforce and residents through the use of soap and water; hand sanitizer; facemask. If coughing or potential splash precautions are needed, wear a gown and face/eye shields. Refer to DSHS guidance and see Attachment 3, Use of PPE.
- **Isolate**—isolate residents with confirmed cases to the extent possible.
- **Communicate**—notify appropriate parties of a positive case.
- **Evaluate**—assess infection control processes, spread of infection and mitigation efforts, staffing availability.

<delete redundant info>
Educate and train staff on adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE. Have staff demonstrate competency with donning and doffing (putting on and removing) PPE. See Use of PPE for graphics demonstrating the proper way for donning and doffing PPE.

Review isolation/quarantine plans and use of PPE with staff.

Monitor CDC guidance on infection control, as it is updated frequently.

**PPE Plan**

Personal protective equipment (PPE) is specialized clothing or equipment worn by assisted living facility staff for protection against transmission of infectious diseases such as COVID-19, including masks, goggles, face shields, gloves, and disposable gowns. See CDC PPE Recommendations.

Plans for supplies should focus on ensuring that the facility maintains a two-week supply of PPE in accordance with 26 TAC 553.2001(c)(4) and that all required PPE is easily accessible to staff. It is not reasonable for all ALFs to have the same amount of PPE, which will vary depending on the facility size, type, and resident and staff needs.

Obtain PPE through your normal supply chain or through other resources available to you first. Some resources are sister facilities, local partners or stakeholders, Public Health Region, Healthcare Coalition, or Regional Advisory Councils. If you can’t get PPE from vendor(s) and have exhausted all other options, reference the State of Texas Assistance Request (STAR) User Guide for instructions on submitting a request for supplies. Please note that this is not a guarantee of receiving PPE. Supplies of PPE may be insufficient to meet demand.

Make necessary PPE available in areas where resident care is provided. Put a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.

**Cleaning and Disinfecting**

Increase environmental cleaning. Clean and disinfect all frequently touched surfaces such as doorknobs/handles, elevator buttons, bathroom surfaces/fixture, remote controls, and wheelchairs. Limit the sharing of personal items and equipment between residents. Provide additional work supplies to avoid sharing (pens, pads) and disinfect workplace areas (nurse’s stations, phones, internal radios, etc.).

Make sure EPA-registered hospital-grade disinfectants are available to allow for frequent disinfection of high-touch surfaces and shared resident-care equipment. Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility. Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA’s emerging viral pathogens program for use against COVID-19.
Provide supplies for recommended hand hygiene. Have alcohol-based hand sanitizer with 60–95 percent alcohol easily accessible. <deleted>outside of residents' rooms and in common areas. Advise staff not to keep hand sanitizer bottles in their pockets. This practice causes hands and sanitizer bottles to become contaminated. <deleted>Make sure sinks are well-stocked with soap and paper towels for handwashing.

Implement universal use of source control (face masks or, as applicable, cloth face coverings) for everyone in the facility. <deleted>

Review your infection control policies and procedures. Review your emergency preparedness and response plan required by 26 TAC §553.44. Update as needed. Ensure that any emergency plans specific to hurricanes or other natural disasters account for COVID-19.

Staff

Staff must always wear the proper PPE when caring for residents with COVID-19 or unknown COVID status. See attachment 3. Staff must wear a facemask while inside the facility. Staff should not use cloth face coverings while inside the facility. The CDC does not consider cloth face coverings to be PPE, nor adequate to prevent the spread of COVID-19.

Assisted living facilities should develop a staffing contingency plan to implement if a significant number of staff are unavailable to work.

In accordance with GA-34, Minimize the movement of staff between facilities wherever possible.

Enforce sick leave policies for ill staff and health care providers. Sick leave policies that do not penalize staff with loss of status, wages, or benefits will encourage staff who are ill to stay home.

Require staff to report via phone if they have symptoms of COVID-19 or had prolonged close contact with someone who has COVID-19. <deleted> (except if the staff member is fully vaccinated or had COVID-19 within the previous 3 months).<deleted> Staff should not report to work until the end of a 14-day quarantine period. If asymptomatic and no symptoms develop during daily monitoring, quarantine can end after day 10 without testing; or day 7 with a negative COVID-19 test result (test must occur on day 5 or later).

If a staff member has a confirmed case of COVID-19 they must not enter the facility until they meet the current CDC return to work criteria. See Attachment 4, Return-to-Work and End-of-Isolation Flowcharts.

Per CDC guidance, asymptomatic staff who are fully vaccinated or were COVID-19 positive within the previous three months and have a higher-risk exposure do not need to be restricted from work. Review Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2 for possible exceptions and additional information.

Residents
Definitions Related to Resident COVID-19 Status per 553.2001

1. Cohort—A group of residents placed in rooms, halls, or sections of an assisted living facility with others who have the same COVID-19 status or the act of grouping residents with other residents who have the same COVID-19 status.

2. COVID-19 negative—A person who has tested negative for COVID-19, is not exhibiting symptoms of COVID-19, and has had no known exposure to the virus since the negative test.

3. COVID-19 positive—A person who has tested positive for COVID-19 and does not yet meet Centers for Disease Control and Prevention (CDC) guidance for the discontinuation of transmission-based precautions.

4. COVID-19 status—The status of a person based on COVID-19 test results, symptoms, or other factors that consider the person’s potential for having the virus.

5. Isolation—The separation of people who are COVID-19 positive from those who are COVID-19 negative and those whose COVID-19 status is unknown.

6. Quarantine—The separation of a person with unknown COVID-19 status from those who are COVID-19 positive and those who are COVID-19 negative.

7. Unknown COVID-19 status—A resident who is a new admission, readmission, or has spent one or more nights away from the facility, has had known exposure or close contact with a person who is COVID-19 positive, or who is exhibiting symptoms of COVID-19 while awaiting test results.

Ask residents to report if they feel feverish or have symptoms of respiratory infection and coronavirus. Actively monitor all residents upon admission and at least daily for fever and symptoms of COVID-19 in accordance with HHSC guidance. or chills, respiratory symptoms (including shortness of breath, difficulty breathing, new or change in cough, sore throat, and oxygen saturation), fatigue, muscle or body aches, headaches, new loss of taste or smell, congestion or runny nose, nausea or vomiting, and diarrhea. If a resident has fever or symptoms, implement increased infection control measures.

Encourage residents to wear a facemask or cloth face covering (as tolerated) for source control whenever they leave their room or come around others, including whenever they leave the facility.

Residents have the right to leave and return to the facility for any reason, and the facility cannot restrict residents from exercising this right. The facility has a responsibility to ensure the resident is making an informed decision. Specifically, the facility must educate a resident on the risks and benefits of spending time in the community, including the potential risk of being exposed to or contracting COVID-19. If the resident makes an informed decision and chooses to leave the facility, the facility must also educate the resident and family member about infection control and prevention procedures, including:

- avoiding crowds;
● wearing a facemask or face covering, if tolerated for the resident, but necessary for the family member and medical provider; performing hand hygiene; cough and sneeze etiquette; physical distancing (maintaining at least six feet of distance between themselves and people they don't know besides the family member and medical provider); being aware of others who may potentially or actually have COVID-19; and reporting any contact with another person who may potentially or actually have COVID-19 to the facility

Upon the resident’s return to the facility, practice the following infection control procedures and provide staff assistance if needed:

• The facemask or cloth face covering the resident wore outside the facility should be replaced with a fresh one; Ensure that the resident's hands are washed thoroughly, or alcohol-based hand sanitizer is used; Suggest the resident changes into clean clothes; Ensure that all hard surface items the resident brings back into the facility are disinfected appropriately; and Ensure that the resident is screened, as is required for anyone entering the facility

In March 2021, the CDC updated their guidance on quarantine for residents who have been fully vaccinated. For asymptomatic residents, quarantine is no longer recommended for residents who are being admitted to an ALF if they are:

• fully vaccinated and
• have NOT had prolonged close contact with someone with COVID-19 in the prior 14 days.

This updated quarantine guidance applies to:

• new admissions,
• readmissions, and
• residents who have gone overnight as long as the resident DID NOT have prolonged close contact with someone with a COVID-19 infection.

For residents who are not fully vaccinated: A resident who leaves the facility does not require quarantine upon return, even if the resident is gone overnight, if the resident is asymptomatic and did not have contact with others who may potentially or actually have COVID-19. does not have to be quarantined upon returning to the facility, even if the resident leaves with someone other than an essential caregiver or facility staff. The resident's COVID-19 status would remain the same as it was before leaving the facility as long as all infection prevention protocols are followed.
If resident returns on the same day, the facility should discuss with the resident (or their visit companion) what activities occurred while the resident was outside the facility, using the following questions as a guide:

- Were you in any crowded spaces whether that be in public or at a large household gathering?
- Were you unable to maintain a physical distance of at least 6 feet from someone who was not wearing a facemask (excluding mealtimes) when you were in out in public or visiting with others in a household?
- Did you encounter anyone who tested positive for COVID-19 within the last 14 days? or, or who does not yet meet CDC end of isolation criteria?
- Did you encounter anyone who was exhibiting any symptoms related to COVID-19? whether that be in public or at a household gathering?

A “yes” to any of these questions should be further investigated. Ask the resident or their visit companion the following questions to help determine if exposure occurred:

- If you attended a gathering at a family member or friend’s household, how many others attended? Was the gathering mostly indoors or mostly outdoors? Did attendees maintain social distancing, wear face masks, or practice other infection control measures such as proper hand hygiene?
- If you came in close contact with someone at a household gathering who was not wearing a face mask or practicing other infection control procedures, how long did that close contact occur?
- Did attendees at the household gathering maintain social distancing during mealtimes, when they were unable to wear a face mask?

If the facility determines that a resident who left the facility and returned the same day requires a quarantine period, the facility must document the decision and its rationale. If a resident is gone overnight, they will return with unknown COVID status and require a quarantine period.

Keep in mind that quarantine does not mean the resident must remain in their room for the duration of the quarantine period. Consistent and continual monitoring is a must, as well as following infection control protocols and using facemasks.

The CDC recommends a quarantine period of 14 days for persons who might have been exposed to COVID-19.

On December 8, 2020, the CDC released guidance to shorten quarantine periods for individuals who might have been exposed to COVID-19. If no symptoms develop during daily monitoring, quarantine can end after day 10 without testing; or after day 7 with a negative COVID-19 test result (test must occur on day 5 or later). Continue to monitor the resident for a total of 14 days after potential exposure, even if the quarantine period ended early.
Activities, Dining, and Volunteers

Group activities, including group dining, are no longer limited to groups of 10, but the facility must provide sufficient staff to ensure physical distancing of at least six feet between individuals.

HHSC posted Long-Term Care Regulation Provider Letter Number PL 20-53, which provides guidance and outlines provider responsibilities for resident activities, including communal dining and holiday related activities. See Attachment 14 for the full content and link to PL 20-53.

Entertainers are allowed to perform in the facility if they adhere to the following:

- Pass screening prior to entry.
- Wear a facemask at all times in the facility.
- Maintain physical distance of 6-10 ft from audience.

COVID cohorts cannot mingle together for the entertainer. In other words, only residents who are COVID-19 negative can be together as the audience, COVID-19 unknown can be together as an audience and COVID-19 positive can be together as an audience. The area used for the performance must be sanitized after use and if used for different cohorts, between each performance. <deleted>

Memory Care Units and Alzheimer's Certified Units

Infection prevention strategies to prevent the spread of COVID-19 are especially challenging to implement in dedicated memory care units and Alzheimer's certified units where numerous residents with cognitive impairment reside together. These residents can have a difficult time following recommended infection prevention practices. <deleted>such as physical distancing, washing hands, avoiding touching their face, and wearing a cloth face covering for source control. <deleted>

Changes to resident routines, disruptions in daily schedules, use of unfamiliar equipment, or working with unfamiliar caregivers can lead to fear and anxiety, resulting in increased depression and behavioral changes such as agitation, aggression, or wandering.

Follow recommended guidance below from the CDC for considerations regarding residents with dementia, in memory care or Alzheimer's certified units. Considerations for Memory Care Units in Long-term Care Facilities
7. Vaccines

Availability

As of Wednesday, May 12, 2021, everyone 12 years old and older is eligible to receive a COVID-19 vaccine in Texas.

All vaccines are authorized for people 18 years old and older. The Pfizer vaccine is authorized for people 12 years old and older.

Large Vaccination Hub List
Check the COVID-19 Vaccination Hub Providers page to find a hub near you and learn how to register.

Retail Pharmacies List
Check your local pharmacy’s website to see if vaccine appointments are available. You can also check CDC’s Federal Retail Pharmacy Program website.

Texas Public Health Vaccine Scheduler
The Texas Vaccine Scheduler helps Texans get scheduled for a COVID-19 vaccine at clinics hosted by participating Texas public health entities.

Register online at GetTheVaccine.dshs.texas.gov. You will be notified by email or text when and where to get the vaccine. If there’s not an available clinic near you, you will be directed to other places to get your vaccine.

Call (833) 832-7067 if you don’t have internet or need help signing up. Call center support is available Monday–Friday from 8am–6pm and Saturday from 8am–5pm. Spanish language and other translators are available to help callers.

Find Vaccine by Phone
Texas businesses or civic organizations can call 844-90-TEXAS (844-908-3927) and select Option 3 to schedule a visit from a state mobile vaccine team to vaccinate employees, visitors, or members.

To qualify for a visit, a business or civic organization must have five or more employees, visitors, or members who voluntarily choose to be vaccinated. Homebound Texans are also encouraged to call the hotline and select Option 1 to request a state mobile vaccination team to visit their home.

Americans can now text their ZIP code to GETVAX (438829) in English or VACUNA (822862) in Spanish to immediately receive addresses of nearby available vaccination centers.

Residents
Vaccination is voluntary. You cannot require residents to be vaccinated. A resident or the resident's legally authorized legal representative has the right to refuse the resident's vaccination.

Staff
An ALF that wishes to impose a requirement for staff to be vaccinated for COVID-19 should consult their legal counsel and human resource professionals.

**Essential Caregivers**
If adequate doses are left over after a round of vaccines has been administered to all ALF residents and staff who want to be vaccinated, an ALF or pharmacy partner can vaccinate an essential caregiver, if the individual meets the criteria for the current Phase of COVID-19 availability.

<added>
**Side Effects & Allergic Reactions**
Mild side effects are normal signs your body is building protection, and they usually go away after a few days. Severe reactions from the vaccine are rare. To be safe, your provider will have you wait on-site for 15-30 minutes after your shot. There's no evidence that the vaccines cause long-term health problems.

People who have received the Johnson & Johnson vaccine who develop severe headache, abdominal pain, leg pain or shortness of breath within three weeks after vaccination should contact their healthcare provider.

V-safe: Register with CDC's [V-safe After Vaccination Health Checker](https://v-safe.hhs.gov/) on your smartphone to report any side effects after getting the COVID-19 vaccine. You'll also get reminders for your second vaccine dose.

**Vaccine Impact on COVID-19 Prevention Measures**
The CDC has updated [select healthcare infection prevention and control recommendations](https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html) in response to COVID-19 vaccination. People are considered fully vaccinated:

- 2 weeks after their second dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or
- 2 weeks after a single-dose vaccine, such as Johnson & Johnson’s Janssen vaccine.

If you do not meet these requirements, you are not fully vaccinated. Keep taking all CDC recommended [precautions until fully vaccinated](https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/precautions.html).

**Vaccine Provider**
To become a COVID-19 vaccine provider, you must register through [EnrollTexasIZ.dshs.texas.gov](https://EnrollTexasIZ.dshs.texas.gov). Only providers registered through this site can receive and administer COVID-19 vaccine in Texas.
8. Outbreaks

An outbreak of COVID-19 is defined as one or more laboratory confirmed cases of COVID-19 identified in either a resident or paid or unpaid staff.

<deleted>Confirmed cases of COVID-19 must be reported to HHSC. <deleted> Please see the Required Reporting section in this document for details about how, when, and what to report regarding confirmed cases of COVID-19.

<deleted redundant>If an outbreak of COVID-19 is suspected or identified in your facility, strict measures must be put in place to halt disease transmission. If you suspect a resident or staff member might have COVID-19, do not wait for test results to implement outbreak control measures for residents and staff.<deleted>

Outbreak Testing

Any time an ALF experiences an outbreak of COVID-19, it must immediately notify the Regional Director in the LTCR Region where the facility is located. The Region will investigate, make an assessment, and may implement a testing strategy based on the specific situation.

While testing is not currently mandated for ALF residents or staff, the CDC recommends testing all individuals with symptoms and all individuals who were in close contact* with an infected person whenever outbreak occurs in a community where older adults or individuals with disabilities reside.

*Close contact, per the CDC--a person who was within 6 feet of a person with confirmed COVID-19, anytime between the 2 days before symptom onset or date of testing (if the person was asymptomatic), and the time the person is isolated, that lasts for a cumulative total of 15 minutes, over a 24-hour period.

<deleted redundant>Depending on available resources, close contacts should be tested immediately after identification as a contact, and if negative, could be tested again about 5-7 days after last exposure or immediately if symptoms develop during quarantine. For more information see CDC Overview of Testing for COVID-19. <deleted>

Limiting Visits During an Outbreak

Whenever an ALF with approved general visitation designation experiences an outbreak of COVID-19 in an area accommodating COVID-19 negative residents (or facility-wide for a small ALF), all visit types authorized under the facility’s visitation designation, including outdoor visits, open window visits, vehicle parades, and indoor visits must be cancelled for that area of the facility, or facility-wide for a small ALF, until there have been no confirmed COVID-19 cases for at least 14 consecutive days in residents and staff working in the area accommodating COVID-19 negative residents (or facility-wide if it is a small ALF).

The facility must continue to allow closed window visits and visits by persons providing critical assistance, including essential caregiver visits and end-of-life visits. These visit types do not require an HHSC approved general visitation
designation, and ALFs cannot be exempt from allowing these visit types.

An ALF with previous approval for general visitation does not have to submit LTCR Form 2196 or other documentation unless the previous visitation approval has been withdrawn, rescinded, or canceled.

<deleted>HHSC LTCR can conduct a verification survey to confirm the following:

- all staff and residents in the facility or specified areas have fully recovered;
- the ALF has adequate staffing to continue to care for all residents and visits permitted in expansion of reopening visitation; and
- the ALF is in full compliance with infection control requirements and emergency rules related to COVID-19. <deleted>

**Care for Residents who have COVID-19**

An ALF can provide care to resident(s) with COVID-19 if:

- the resident is asymptomatic or has mild to moderate symptoms that do not require hospitalization or a higher level of care than the ALF can provide;
- the ALF can isolate the resident in their own separate living quarters or in a separate, well-ventilated area that provides meaningful separation between the resident and the rest of the facility (a curtain or a moveable screen does not provide meaningful separation); and
- the ALF has sufficient staff capable of providing the level of care required without sacrificing the care of other residents in the facility.

Staff must wear all <added>PPE recommended by the CDC<added> when caring for residents who are COVID-19 positive and residents with unknown COVID status, regardless of symptoms.<deleted> This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown.<deleted>.

To prevent transmission, ALFs should use separate staffing teams for COVID-19-positive residents. They also should work with state and local leaders to designate alternative facilities or units within a facility to separate COVID-19-negative residents from COVID-19-positive residents, as well as those with unknown COVID-19 status. This might be difficult for smaller facilities, but the ability to separate COVID negative and COVID positive is vital in the prevention of transmission.

**Transfer Residents**

If a resident requires a higher level of care or the facility cannot fully implement all recommended precautions, the facility must, in accordance with 26 TAC §553.2001(b):

- Transfer the resident to an alternate facility that has agreed to accept and care for the facility's COVID-19 positive residents until they are fully recovered;
- Assist the resident and family members to transfer the resident to the alternate facility; and
• Isolate the resident in an area that is separate from other residents until the resident is transferred.

Please see HHSC Long-Term Care Regulation Provider Letter Number PL 20-48, for guidance about developing a written process for transferring a resident with an active COVID-19 infection to a facility or higher level of care if the ALF is unable to provide appropriate care.

If the resident is transferred to an alternate facility or higher level of care, perform a final, full clean of the room and use an EPA-registered disinfectant that has qualified under its emerging viral pathogens program for use against COVID-19.

• Quarantine residents with exposure or symptoms.
• Isolate residents with positive cases.
• Different ALFs may have limited space capability to do so, but a facility should, to the best of its ability, group (or cohort) residents into separate groups: infected, negative and unknown COVID-19 status.
• Increase cleaning and sanitizing.
• Increase resident monitoring and screening.
• Ensure adequate supply of PPE to care for COVID-19 positive residents.
• Maintain enough PPE for a two-week period
• Document efforts to obtain PPE if a facility is having difficulty obtaining PPE from their Regional Advisory Council (RAC).
• Designate spaces for staff to don and doff PPE that minimizes the movement of staff through other areas of the facility. <deleted>
9. Reporting Requirements

Confirmed Cases of COVID-19

ALFs must report to HHSC:

- the first confirmed case of COVID-19 in staff or residents as a self-reported incident; and
- the first new case of COVID-19 after a facility has been without cases for 14 days or more as a self-reported incident.

Notify HHSC of these incidents through TULIP or by calling Complaint and Incident Intake (CII) at 1-800-458-9858 within 24 hours of the positive test.

Form 3613-A Provider Investigation Report should also be completed and submitted within five days from the day a confirmed case is reported to CII. The provider investigation report may be submitted:

- via TULIP
- by email at ciiprovder@hhsc.state.tx.us
- by fax at 1-877-438-5827

Do not report subsequent cases and addendums to HHSC.

ALFs are required to report communicable diseases, including all confirmed cases of COVID-19, to the local health authority with jurisdiction over their facility. This is in accordance with the Communicable Disease and Prevention Act, Texas Health and Safety Code, Chapter 81. It is also specified in Title 25 of the Texas Administrative Code, Chapter 97.

If you suspect your facility is experiencing an outbreak of COVID-19, immediately notify your local health authority by phone. Find contact information for your local/regional health department here: https://www.dshs.state.tx.us/regions/2019-nCoV-Local-Health-Entities/

Work with your LHD to complete the COVID-19 case report form as necessary. Post a list of state contacts where it is visible on all shifts. Please Attachment 10 for full guidance on reporting COVID-19 cases. <deleted>: PL 20-46 Reporting Guidance for Long-term Providers (revised). <deleted>

Test Results

Facilities offering POC antigen testing related to COVID-19 must report data:

- for all testing completed;
- for all test results (positive, negative, or indeterminate); and
- for each individual tested (residents and staff).
A facility must report COVID-19 test results within 24 hours of the results being known or determined. On days when a facility does not conduct any tests, the facility would not have to submit a report.

Please see Attachment 16: PL 20-46 Reporting Guidance for Long-term Providers for full guidance on reporting COVID-19 testing data (Revised).

**Vaccination Data**

**As of January 11, 2021, ALFs are required to report COVID-19 vaccinations administered in the facility to residents and staff, either by the facility or a pharmacy partner, and Do not include vaccinations of residents and staff that occurred outside of the facility, such as at a pharmacy, doctor’s office, or local vaccination clinic. Do not include data for vaccinations administered to essential caregivers.**

ALFs must submit this data to HHSC within 24 hours after each round of vaccinations is administered or within 24 hours after learning of the data.

This data is necessary to assist the Texas Department of State Health Services and the Texas Department of Emergency Management in ensuring the vaccination of long-term care provider staff and residents who choose to be vaccinated.

HHSC has developed a Survey Monkey tool to collect the data listed below: [https://www.surveymonkey.com/r/SRDM2GY](https://www.surveymonkey.com/r/SRDM2GY).

- The total number of staff who received their first dose of a two-dose vaccine
- The total number of staff who received their second dose of a two-dose vaccine
- The total number of staff who received a one-dose vaccine
- The total number of residents who received their first dose of a two-dose vaccine
- The total number of residents who received their second dose of a two-dose vaccine
- The total number of residents who received a one-dose vaccine

Do not provide cumulative numbers. In other words, do not include in a new report totals from previous reports.

Please see 26 TAC §553.2004 ALF COVID-19 Vaccination Data Reporting for the emergency rule.

Please see Long-Term Care Regulation Provider Letter PL 2021-01 for full guidance on reporting vaccinations of staff and residents.
VAERS Adverse Reactions to COVID-19 vaccines

ALFs are required to report any adverse reactions to COVID-19 vaccines administered in the facility to: Vaccine Adverse Event Reporting System (VAERS) (hhs.gov) (VAERS).
10. HHSC LTCR Activities with ALFs that have COVID-19 Cases

For a report of a positive COVID-19 test (resident or staff) in an ALF, LTCR will take the following actions:

- Verify that the ALF is prohibiting general visitation visits (outdoor visits, open window visits, vehicle parades, and indoor plexiglass visits).
- Verify that the ALF is continuing to allow visits that do not require visitation designation (essential caregiver visits for residents who are COVID-negative or status unknown, and end of life visits, and closed window visits).
- Generate an incident intake for potential investigation.
- Conduct a focused review of facility infection control processes.
- Communicate with the local health department/local health authority and DSHS.
- Determine the number of residents positive for COVID-19.
- Determine the number of staff positive for COVID-19.
- Review facility isolation precautions and determine how residents are isolated in the facility (dedicated wing/unit, private room) to ensure compliance with requirements.
- Determine whether ALFs have implemented a testing strategy when a facility has a confirmed case.
- Determine that all staff who test positive for COVID-19 have been sent home and the facility knows to coordinate any return to work with the local health department.
- Determine if ALFs have sufficient amounts of PPE.
- Determine if ALFs are screening residents and staff, and at what frequency.
- Determine if others (contract staff, family members) are also being tested.
- Determine if there is a local control or quarantine order.
- Ensure the control/quarantine orders are followed.
- Perform a call-down to all other ALFs in a county that is in a COVID-19 hot spot when staff at one facility tests positive for COVID-19.
- Determine whether ALFs are following rules and regulations related to admission and discharge and are readmitting residents when appropriate.
- Determine whether staff, residents, and families are notified of positive COVID-19 cases in the facility.
- Track ALFs by program type and number of positive cases.
- Track hospitalizations of COVID-19-positive ALF residents.
- Track deaths of COVID-19-positive ALF residents.
- Maintain communication with ALFs after investigations are complete to obtain updates.
11. End of Isolation and Staff Return to Work

See Return-to-Work and End-of-Isolation Flowcharts.

**Resident End of Isolation**

Follow current CDC guidance on when and how to end isolation of a resident who has recovered from Covid-19.

<deleted>Work with your LHD or DSHS to establish a resident recovery plan, including when a resident is considered recovered and next steps for care. A recovery plan is the guidance for determining when to discontinue transmission-based precautions and continued care of a resident. The recovery plan may be different depending on whether a test-based or non-test-based strategy is used. Criteria includes:

- Discontinuation of transmission-based precautions without testing.
- Discontinuation of transmission-based precautions with testing.
- Whether using a testing-based strategy for discontinuation of transmission-based precautions is preferred. <deleted>

**Staff Return to Work**

Follow current CDC guidance on when and how staff recovering from COVID-19 can return to work and mitigating staff shortages.

Note: If the employee was diagnosed with a different illness (e.g., influenza) and was never tested for COVID-19, base their return to work on the criteria associated with that diagnosis.
12. State/Regional/Local Support

HHSC will serve as the lead state agency in the state’s response to an LTC COVID-19 event and take the following actions:

- Develop testing recommendations in consultation with DSHS
- Assist with and ensuring appropriate movement of residents from one facility to another
- Provide subject matter experts (SME)
- Coordinate with local emergency management
- Contact providers to ensure they have the most current information issued on COVID-19

HHSC also has a Texas COVID-19 Assistance Team – ALF (TCAT-ALF), which includes representatives from HHSC, DSHS, local health department (as applicable), and emergency management (as applicable.) This team assists ALFs with management of a COVID-19 event through provision of subject matter expertise, resource request management, and support through initial response activities. The TCAT-ALF will remain available for a maximum of 48 hours from activation. State and local entities will provide SMEs and continued assistance after TCAT-ALF deactivation.

To activate TCAT-ALF assistance, contact the LTCR Associate Commissioner.

Vulnerable Populations Rapid Response Team
In addition to the activities above, HHSC and DSHS will coordinate formation of a Rapid Assessment Quick Response Force. The team will assist ALFs by providing a rapid response and medical triage team that can be deployed by DSHS through the Emergency Medical Task Force upon notification of a positive COVID-19 resident. If needed, an additional team can be sent to assist the facility with immediate needs.

To activate Rapid Assessment Quick Response Force assistance, contact the LTCR Associate Commissioner and DSHS.
## 13. Resources

### List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>ALF</td>
<td>Assisted living facility</td>
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<tr>
<td>CDC</td>
<td>The Centers for Disease Control and Prevention</td>
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<tr>
<td>DSHS</td>
<td>Texas Department of State Health Services</td>
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<tr>
<td>EMS</td>
<td>Emergency medical services</td>
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<td>EPA</td>
<td>Environmental Protection Agency</td>
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<td>HA</td>
<td>Health authority</td>
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<td>HCP</td>
<td>Healthcare personnel</td>
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<td>HHSC</td>
<td>Texas Health and Human Service Commission</td>
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<tr>
<td>LHA</td>
<td>Local health authority</td>
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<tr>
<td>LHD</td>
<td>Local health department</td>
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<tr>
<td>LTC</td>
<td>Long-term care</td>
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<tr>
<td>LTCF</td>
<td>Long-term care facility</td>
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<tr>
<td>LTCR</td>
<td>Long-term Care Regulation</td>
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<tr>
<td>LVN</td>
<td>Licensed vocational nurse</td>
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<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
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<tr>
<td>POC</td>
<td>Point of Contact</td>
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<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
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<td>RN</td>
<td>Registered nurse</td>
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<tr>
<td>SME</td>
<td>Subject matter expert</td>
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<tr>
<td>TCAT</td>
<td>Texas COVID-19 Assistance Team</td>
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<tr>
<td>TDEM</td>
<td>Texas Division of Emergency Management</td>
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</tbody>
</table>
Links

EPA:
- List N: Disinfectants for Use Against SARS-CoV-2

FEMA:
- COVID-19 Pandemic Operational Guidance All-Hazards.

CDC:
- Cleaning and Disinfecting Your Facility
- Considerations for Memory Care Units in Long-term Care Facilities
- Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities
- COVID-19 Travel Recommendations by Destination
- Donning and Doffing PPE Graphic
- Healthcare Workers: Information on COVID-19
- PPE Burn Rate Calculator
- Proper N95 Respirator Use for Respiratory Protection Preparedness
- Strategies for Optimizing the Supply of Facemasks
- Stress and Coping
- Symptoms of Coronavirus

DSHS:
- Coronavirus Disease 2019 (COVID-19)
- Local Health Entities
- Public Health Regions
- Regional Advisory Councils
- State of Texas Assistance Request (STAR)
- Template Screening Log
• Texas Local Public Health Organizations

HHS (Federal):
• Difference Between Isolation and Quarantine
• Vaccine Adverse Event Reporting System (VAERS)

HHSC (Texas):
• Complaint and Incident Intake
• COVID-19: Facemasks & Respirators Questions and Answers
• Helping Residents with Dementia Prevent the Spread of COVID-19 in LTC Communities
• TULIP
• Vaccine Reporting Survey Monkey
• Executive Orders by Governor Greg Abbott

OSHA
• Counterfeit and Altered Respirators: The Importance of NIOSH Certification
• Maintenance and Care of Respirators
• OSHA Respiratory Protection Standard (29 CFR §1910.134)
• Respirator Fit Testing
• Respirator Safety: Donning & Doffing
• Respirator Types
• Respiratory Protection for Healthcare Workers
• Respiratory Protection Training Requirements
• The Differences Between Respirators and Surgical Masks
• Voluntary Use of Respirators

TDEM
• COVID-19 Testing Locations.
Attachment 01: Facility Activities Required for ALF COVID-19 Response

What can you do to identify a COVID-19 situation, help prevent the spread within the facility, and care for infected residents?

**Prepare before a positive case (actions focused on response)**

- Review/create a COVID-19 plan for residents
- Determine/review who is responsible for specific functions under the facility plans
- Identify desired or applicable waivers
- Develop a communication plan (external and internal)
- Evaluate supplies/resources including PPE
- Enact resident/staff/visitor screening
- Determine what community sources are available for COVID testing and how residents, staff and visitors, if applicable, can be tested (a “testing plan”)
- Evaluate supply chains and other resources for essential materials including PPE

**Immediately 0-24 Hours React**

- Activate resident isolation/facility cohort plan, including establishing a unit, wing, or group of rooms for any COVID-19 positive residents
- Supply PPE to care for COVID-19 positive residents
- Screen residents for signs and symptoms
- Screen staff for signs and symptoms
- Clean and disinfect the facility
- Determine if HCP are providing services in other ALFs
- Establish contact with receiving agencies (hospitals, other ALFs)
- Identify lead at facility and determine stakeholders involved external to facility
- Engage with community partners (public health, health care, organizational leadership, local/state administrators)
- Activate all communication plans
- Determine need for facility restrictions/lock-down
- Maintain resident care
- Work with the local health department/authority or DSHS to activate a testing strategy
Extended 24-72 Hours Protect

- Supply PPE for HCP and staff
- Screen residents for signs and symptoms
- Screen staff for signs and symptoms
- Activate resident transport (resident out/in) protocols
- Establish contact with transporting/receiving agencies (hospitals, other ALFs)
- Continue engagement with community partners
- Determine need for facility restrictions/lock-down
- Maintain resident care

Long-Term 72 Hours+ Transition

- Screen residents for signs and symptoms
- Screen staff for signs and symptoms
- Continue decontamination procedures
- Establish contact with transporting/receiving agencies (hospitals, other ALFs)
- Maintain resident care
Attachment 02: Use of PPE in ALFs

- To address asymptomatic transmission, the CDC recommends that providers consider implementing policies requiring everyone entering the facility to wear a face mask (if tolerated) while in the building. **EXCEPTION:** Face masks and cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- Residents who are COVID-negative can wear a cloth face covering or a facemask while outside their room in the facility, or when other individuals are in the resident’s room.
- Cloth face coverings should be laundered daily or when they become soiled, damp, or hard to breathe through. Proper hand hygiene should be performed immediately before and after any contact with a cloth face covering.
- Residents with unknown COVID status should wear a facemask when they are outside their room in the facility (unless contraindicated), except for when they are eating or drinking.

**PPE for COVID-19 positive residents**

Staff should:
- Follow standard precautions.
- Use an N95 facemask or respirator (if available and if they have been trained and appropriately fit tested) rather than a cloth face covering or facemask.
- Use eye protection.
- Use nonsterile, disposable gloves and isolation gowns, which are used for routine care in healthcare settings.

**CDC: Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19)**

**CDC: Using Personal Protective Equipment (PPE)**

- After leaving the room of a resident with COVID-19, staff can remove a facemask and store it for reuse. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean paper bag or breathable container. <deleted>
SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN
   • Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
   • Fasten in back of neck and waist

2. MASK OR RESPIRATOR
   • Secure ties or elastic bands at middle of head and neck
   • Fit flexible band to nose bridge
   • Fit snug to face and below chin
   • Fit-check respirator

3. GOGGLES OR FACE SHIELD
   • Place over face and eyes and adjust to fit

4. GLOVES
   • Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

• Keep hands away from face
• Limit surfaces touched
• Change gloves when torn or heavily contaminated
• Perform hand hygiene
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)

EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES
   - Outside of gloves are contaminated!
   - If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
   - Hold removed glove in gloved hand
   - Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
   - Discard gloves in a waste container

2. GOGGLES OR FACE SHIELD
   - Outside of goggles or face shield are contaminated!
   - If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Remove goggles or face shield from the back by lifting head band or ear pieces
   - If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. GOWN
   - Gown front and sleeves are contaminated!
   - If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Unfasten gown ties, taking care that sleeves don’t contact your body when reaching for ties
   - Pull gown away from neck and shoulders, touching inside of gown only
   - Turn gown inside out
   - Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR
   - Front of mask/respirator is contaminated — DO NOT TOUCH!
   - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
   - Grasp bottom ties or elasticities of the mask/respirator, then the ones at the top, and remove without touching the front
   - Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)

EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES
   - Gown front and sleeves and the outside of gloves are contaminated!
   - If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands.
   - While removing the gown, fold or roll the gown inside-out into a bundle.
   - As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container.

2. GOGGLES OR FACE SHIELD
   - Outside of goggles or face shield are contaminated!
   - If your hands get contaminated during goggles or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield.
   - If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container.

3. MASK OR RESPIRATOR
   - Front of mask/respirator is contaminated — DO NOT TOUCH!
   - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front.
   - Discard in a waste container.

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE.
How to Wear a Medical Mask Safely

Dos

● Wash your hands before touching the mask
● Inspect the mask for tears or holes
● Find the top side, where the metal piece or stiff edge is
● Ensure the colored-side faces outwards
● Place the metal piece or stiff edge over your nose
● Cover your mouth, nose, and chin
● Adjust the mask to your face without leaving gaps on the sides
● Avoid touching the mask
● Remove the mask from behind the ears or head
● Keep the mask away from you and surfaces while removing it
● Discard the mask immediately after use preferably into a closed bin
● Wash your hands after discarding the mask

Don’ts:

● Do not Use a ripped or damp mask
● Do not wear the mask only over mouth or nose
● Do not wear a loose mask
● Do not touch the front of the mask
● Do not remove the mask to talk to someone or do other things that would require touching the mask
● Do not leave your used mask within reach of others
● Do not re-use the mask

Remember that masks alone cannot protect you from COVID-19. Maintain at least a 6-foot distance from others and wash your hands frequently and thoroughly, even while wearing a mask.
HOW TO WEAR A MEDICAL MASK SAFELY

Do's

- Wash your hands before touching the mask
- Inspect the mask for tears or holes
- Find the top side, where the metal piece or stiff edge is
- Ensure the colored-side faces outwards
- Place the metal piece or stiff edge over your nose
- Cover your mouth, nose, and chin
- Adjust the mask to your face without leaving gaps on the sides
- Avoid touching the mask
- Remove the mask from behind the ears or head
- Keep the mask away from you and surfaces while removing it
- Discard the mask immediately after use preferably into a closed bin
- Wash your hands after discarding the mask

Don’ts

- Do not use a ripped or damp mask
- Do not wear the mask only over mouth or nose
- Do not wear a loose mask
- Do not touch the front of the mask
- Do not remove the mask to talk to someone or do other things that would require touching the mask
- Do not leave your used mask within the reach of others
- Do not re-use the mask

Remember that masks alone cannot protect you from COVID-19. Maintain at least 1 metre distance from others and wash your hands frequently and thoroughly, even while wearing a mask.
Reusing Facemasks
To extend your supplies of PPE, staff may need to reuse facemasks in accordance with CDC guidelines.

- Don’t touch! If you touch or adjust the mask, wash/sanitize your hands.
- Handle with Care! Fold so that the outside surfaces touch; store in paper bag between uses.
- Toss it! Discard when soiled, damaged or hard to breathe through.
- Leave! Go outside the resident’s room to remove PPE.
Staff Return-to-Work Flowchart

When can staff return to work? CDC recommends a symptom-based strategy.

**Mild-Moderate Illness and not severely immunocompromised**
- AT LEAST 10 days since symptoms first appeared AND
- AT LEAST 24 hours since last fever without use of fever-reducing medications AND
- Symptoms have improved

**Severe-Critical Illness or Severely Immunocompromised**
- AT LEAST 20 days since symptoms first appeared AND
- AT LEAST 24 hours since last fever without use of fever-reducing medications AND
- Symptoms have improved

**Asymptomatic and not severely immunocompromised**
- AT LEAST 10 days since date of first positive viral diagnostic test

**Mild-Moderate Illness and not severely immunocompromised**
- At least 10 days since symptoms first appeared and
- At least 24 hours since last fever without use of fever-reducing medications and
- Symptoms have improved

**Severe-Critical Illness or Severely Immunocompromised**
- At least 20 days since symptoms first appeared and
- At least 24 hours since last fever without use of fever-reducing medications and
- Symptoms have improved
Asymptomatic and Not Severely Immunocompromised

- At least 10 days since date of first positive viral diagnostic test

After returning to work, staff should:

- <deleted>Wear a facemask (not a cloth face covering) at all times in the facility until all symptoms are completely resolved or at baseline. <deleted>
- <deleted redundant>Wear an N95 or equivalent when warranted, including when caring for residents with COVID-19 <deleted>
- self-monitor for symptoms and
- immediately stop work, leave the facility, and seek immediate care if Symptoms recur or worsen.

Resident End of Isolation Flowchart

When can residents end isolation? The CDC recommends a symptom-based strategy.

Mild-Moderate Illness and Not Severely Immunocompromised
- At least 10 days since symptoms first appeared and
- At least 24 hours since last fever without use of fever-reducing medications and
- Symptoms have improved

Severe-Critical Illness OR Severely Immunocompromised
- At least 20 days since symptoms first appeared and
- At least 24 hours since last fever without use of fever-reducing medications and
- Symptoms have improved

Asymptomatic
- If not severely immunocompromised, at least 10 days since date of first positive viral diagnostic test
- If severely immunocompromised, at least 20 days since date of first positive viral diagnostic test

Mild-Moderate Illness and Not Severely Immunocompromised
- At least 10 days since symptoms first appeared and
- At least 24 hours since last fever without use of fever-reducing medications
and

- Symptoms have improved

**Severe-Critical Illness or Severely Immunocompromised**

- **At least** 20 days since symptoms first appeared and
- **At least** 24 hours since last fever without use of fever-reducing medications and
- Symptoms have improved

**Asymptomatic**

- **If not severely immunocompromised**, **at least** 10 days since date of first positive viral diagnostic test
- **If severely immunocompromised**, **At least** 20 days since date of first positive viral diagnostic test
Attachment 04: Sample ALF Screening Symptom Monitoring Log

ALFs can use this template to screen individuals for COVID-19.

Instructions: Screen all staff at the beginning of their shift. Mark the symptoms below with ‘Y’ for Yes if present and ‘N’ for No if absent. Don’t leave any spaces blank. If temperature is greater than 100.4°F or any symptom is marked Y, direct staff to put on a facemask and leave the workplace.

DATE:

<table>
<thead>
<tr>
<th>NAME</th>
<th>TIME</th>
<th>°F</th>
<th>cough shortness of breath or difficulty breathing?</th>
<th>sore throat fatigue chills muscle or body aches?</th>
<th>headache new loss of taste or smell?</th>
<th>Congestion or runny nose?</th>
<th>Nausea or vomiting or diarrhea?</th>
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Attachment 05: ALF Infection Control Checklist for COVID-19

Entering the facility

Prior to entering the facility:

- Is signage posted at facility entrances with visitation restrictions and screening procedures?

- Are signs posted at entrances with instructions to individuals to cover their mouth and nose when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after contact with respiratory secretions and soiled surfaces?

- Did staff follow procedures to process surveyor screening prior to entry?

Triage/Registration/Visitor Handling

After screening and upon entry to the facility, ask if the facility has any residents who have a laboratory-tested positive case of COVID-19.

Upon entering the facility:

- Are staff trained on appropriate processes (e.g., questions to ask and actions to take) to rapidly identify and isolate probable COVID-19 cases?

- Is there a process that occurs after a probable case is identified to include immediate notification of facility leadership for infection control?

- What is the facility’s current visitor policy in response to COVID-19?

Resident Observations and Interviews

Observe and interview every resident.

What information has the facility given to residents regarding?

- hand hygiene
- reporting symptoms of respiratory illness
- leaving the facility
- limitations on visitors

Hand Hygiene
Interview appropriate staff to determine if hand hygiene supplies such as hand sanitizer, soap, paper towels, garbage bags for disposal, and bleach wipes are readily available and who they contact for replacement supplies.

Are staff performing hand hygiene (even if gloves are used) whenever indicated, including in the following situations? Before and after contact with the resident

- After contact with blood, body fluids, or visibly contaminated surfaces
- After contact with objects and surfaces in the resident’s environment and common areas

After removing personal protective equipment (e.g., gloves, gown, facemask) and before performing a procedure such as a sterile task (e.g., wound dressing care, feeding tube maintenance)

Is alcohol-based sanitizer available and readily accessible for staff?

**PPE**

What is the facility's status on available PPE?

If the facility is experiencing shortages, what methods are they using to conserve available supplies?

- Are staff using N95 respirators, or if not available, masks?
- Have staff been fit tested, if applicable to the type of mask?
- Are staff wearing gloves?
- Are gloves worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin?
- Are gloves removed after contact with blood or body fluids, mucous membranes, or non-intact skin?
- Are gloves changed and hand hygiene performed before moving from a contaminated body site to a clean body site during resident care?
- Are staff using isolation gowns?
- Are staff using goggles?
- Are staff using face shields?

In what situation are each being used? *Interview staff to determine their understanding of the use and conservation of PPE.*
Evaluate how the facility staff dons and doffs PPE.

- If PPE use is extended/reused, is it done according to national, state, and local guidelines?
- If the facility is using reusable PPE, how is it sanitized, decontaminated, and maintained between uses?

Education, Monitoring, and Screening of Staff

- Is there evidence that the facility staff has been educated on COVID-19 (symptoms, how it is transmitted, screening criteria, work exclusions)?
- Do all staff have access to the facility administrator or manager?
- Do staff have access to contact information for the Local Health Department, (or if there is no Local Health Department, the Department of State Health Services), and local hospital for emergencies and medical guidance?
- How has the provider conveyed updates on COVID-19 to all staff?

Shift Change

*The facility must document staff, resident and visitor screening. The screening log must at a minimum include the following: name, date, temperature and time taken, signs and symptoms (shortness of breath, new or change in cough, sore throat), exposure to a facility with confirmed COVID-19 cases.*

- Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness?
- Is the facility actively taking their temperature and documenting absence of illness (or signs/symptoms of COVID-19 as more information becomes available)?

Where and how is the screening documented?

If a resident has a temperature above normal ranges, but below the CDC-recommended COVID-19 criterion, how is this communicated during shift change to facilitate monitoring of possible symptoms?

Staff Monitoring

If staff develop symptoms at work, does the facility:

- have a process for staff to report their illness or developing symptoms?
- <deleted>ensure they have a facemask and have them return home for appropriate medical evaluation? <deleted>
• inform the facility’s administrator and include information on residents, equipment, and locations of the persons they came in contact with?

• Follow current CDC return to work guidance and current CDC risk assessment guidance about returning to work.

**Resident Service Plans**

*Review resident service plans and information for current resident health conditions.*

• Did the facility conduct a review of all resident service plans to establish a baseline for health conditions and symptoms of illness?

• What actions were taken to update resident service plans if necessary, and to inform residents about changes in facility policy? 26 TAC §553.41(c)(2).

**Medication Administration**

*Review the medication list and medication administration record for each resident.* 26 TAC §553.41(m) If medications were changed recently or in response to COVID-19 policy implementation, were the residents aware of the changes?

• Were legally authorized representatives informed?

• Were doctor’s instructions followed for medication administration and transportation for testing relating to drug regimen?

<deleted>Hydroxychloroquine:

• Are there residents in the facility taking a Hydroxychloroquine regimen prescribed in response to a COVID-19 diagnosis?

• If so, are the residents being monitored for signs and symptoms of toxicity?

• Who is monitoring signs and symptoms for those residents?

• Have any residents taking the drug showed signs of improvement as reported by the physician?

• Have any residents taking the drug showed signs of improvement as observed by staff?

• Have any residents died while taking hydroxychloroquine? <deleted>

**Meal Preparation and Service, Activities**

• For meals taken in the dining room or common areas, has the facility allowed for physical distancing <added>when appropriate</added>
during mealtime

- Is the facility practicing physical distancing for activities when they are appropriate during the response to COVID-19?

**Sanitation and Housekeeping**

*Interview housekeeping staff.*

What additional cleaning and disinfection procedures are in place to mitigate spread of illness?

- Does the facility have adequate housekeeping staff to clean and disinfect resident rooms and common areas as frequently as necessary to ensure appropriate infection control?
- Does the facility have adequate supply of housekeeping equipment and supplies?
- Does housekeeping staff know whom to contact if supplies are getting low?

**Emergency Preparedness- Staffing Levels in Emergencies**

26 TAC §553.62(d)

- Does the ALF have a policy and procedures for ensuring staffing to meet the needs of the residents when needed during an emergency, such as the COVID-19 outbreak?
- Does the ALF have adequate staffing to care for residents based on current census and resident needs?
- Does staff know how to report inadequate staffing needs to the administrator or manager?
- In an emergency, did the ALF implement its planned strategy for ensuring staffing to meet the needs of the patient? (N/A if emergency staff was not needed)

**Reporting and Response after a Positive COVID-19 Case**

*Determine the following for each onsite visit positive COVID case reported or discovered onsite.*

Review ALF isolation precautions and determine how residents are isolated in the ALF (dedicated wing, private room) to ensure compliance with requirements.

- If the ALF has known positive cases of COVID-19, were they appropriately reported to HHSC (cases after April 1, 2020) and to local health department or DSHS? Texas Health and Safety Code Chapter 81
• Is there a local control or quarantine order?
• Is the ALF aware of the order?
• Are the control or quarantine orders being followed as appropriate?
• Where the staff work for multiple facilities and or agencies, did the ALF track such employment?
• If a staff member tested positive for COVID-19, did the ALF contact other facilities where the employee is currently working?

What is the number of residents positive for COVID-19?

What is the number of staff positive for COVID-19? Determine if others (contract staff, family members, vendors) are also being tested.

After a positive COVID-19 case has been identified in the ALF, what are ALF procedures for admission and discharge?

Regional office staff must perform a call-down to all other facilities in when staff at one ALF tested positive for COVID-19.

Determine whether staff, residents, and families are notified of positive COVID-19 cases in the ALF. How is the ALF tracking hospitalization of COVID-19-positive ALF residents?

How is the ALF tracking deaths of COVID-19-positive ALF residents?

How is the ALF tracking quarantine periods for COVID-19-positive residents and staff?
Attachment 06 26 TAC §553.2001 Covid-19
Emergency Rule
Action Memorandum for the Executive Commissioner (texas.gov)

TITLE 26          HEALTH AND HUMAN SERVICES
PART 1            HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 553       LICENSING STANDARDS FOR ASSISTED LIVING
FACILITIES
SUBCHAPTER K      COVID-19 RESPONSE


<added>Revised 8/6/2021

(a) The following words and terms, when used in this section, have the following meanings.

(1) Cohort--A group of residents placed in rooms, halls, or sections of an assisted living facility with others who have the same COVID-19 status or the act of grouping residents with other residents who have the same COVID-19 status.

(2) COVID-19 negative--The status of a person who has tested negative for COVID-19, is not exhibiting symptoms of COVID-19, and has had no known exposure to the virus since the negative test.

(3) COVID-19 positive--The status of a person who has tested positive for COVID-19 and does not yet meet Centers for Disease Control and Prevention (CDC) guidance for the discontinuation of transmission-based precautions.

(4) COVID-19 status--The status of a person based on COVID-19 test results, symptoms, or other factors that consider the person’s potential for having the virus.

(5) Fully vaccinated person--A person who received the second dose in a two-dose series or a single-dose of a one-dose COVID-19 vaccine and 14 days have passed since this dose was received.

(6) Isolation--The separation of people who have COVID-19 positive status from those who have COVID-19 negative status and those whose COVID-19 status is unknown.

(7) PPE--Personal protective equipment means specialized clothing or equipment worn by assisted living facility staff for protection against transmission of infectious diseases such as COVID-19, including masks, goggles, face shields, gloves, and disposable gowns.

(8) Quarantine--The practice of keeping someone who might have been exposed to COVID-19 away from others. Quarantine helps prevent spread of
the disease that can occur before a person knows they are sick or if they are infected with the virus without experiencing symptoms.

(9) Unknown COVID-19 status--The status of a person, except as provided by the CDC for fully-vaccinated residents or residents who have recovered from COVID-19, who:
   (A) is a new admission or readmission;
   (B) has spent one or more nights away from the facility;
   (C) has had known exposure or close contact with a person who is COVID-19 positive; or
   (D) is exhibiting symptoms of COVID-19 while awaiting test results.

(b) An assisted living facility must have a protocol in place included in its COVID-19 response plan that describes how, if the facility cannot successfully isolate the individual, the facility will transfer a COVID-19 positive resident to another facility capable of isolating and caring for the COVID-19 positive resident.

(1) An assisted living facility must have contracts or agreements with alternative appropriate facilities for caring for COVID-19 positive residents.

(2) An assisted living facility must assist the resident and family members to transfer the resident to the alternate facility.

(c) An assisted living facility must have a COVID-19 response plan that includes:
   (1) designated space for:
       (A) COVID-19 negative residents;
       (B) residents with unknown COVID-19 status; and
       (C) COVID-19 positive residents, when the facility is able to care for a resident at this level or until arrangements can be made to transfer the resident to a higher level of care;
   (2) spaces for staff to don and doff PPE that minimize the movement of staff through other areas of the facility;
   (3) resident transport protocols;
   (4) plans for obtaining and maintaining a two-week supply of PPE, including surgical facemasks, gowns, gloves, and goggles or face shields; and
   (5) if the facility cares for or houses COVID-19 positive residents, a resident recovery plan for continuing care when a resident is recovering from COVID-19.

(d) An assisted living facility must screen all residents, staff, and people who come to the facility, in accordance with HHSC guidance.

(e) An assisted living facility must screen residents according to HHSC guidance:
   (1) upon admission or readmission to the facility; and
   (2) at least once a day in accordance with HHSC guidance.
(f) An assisted living facility must screen each employee or contractor for the criteria in subsection (d) of this section before entering the facility at the start of their shift. Staff screenings must be documented in a log kept at the facility entrance and must include the name of each person screened, the date and time of the evaluation, and the results of the evaluation. Staff who meet any of the criteria must not be permitted to enter the facility.

(g) An assisted living facility must assign each resident to the appropriate cohort based on the resident’s COVID-19 status.

(h) A resident with unknown COVID-19 status must be quarantined and monitored for fever and symptoms of COVID-19 in accordance with CDC guidance.

(i) A resident with COVID-19 positive status must be isolated until the resident meets CDC guidelines for the discontinuation of transmission-based precautions, if cared for in the facility.

(j) If a resident with COVID-19 positive status must be transferred for a higher level of care, the facility must isolate the resident until the resident can be transferred.

(k) An assisted living facility must implement a staffing policy requiring the following:

1. Staff must inform the facility per facility policy prior to reporting for work if they have known exposure or symptoms;

2. Staff must perform self-monitoring on days they do not work; and

3. The facility must develop and implement a policy regarding staff working with other long-term care (LTC) providers that limits the sharing of staff with other LTC providers and facilities, unless required in order to maintain adequate staffing at a facility.

(l) The facility must develop and enforce policies and procedures for infection control. The written standards, policies, and procedures for the facility’s infection prevention and control program must include standard and transmission-based precautions to prevent the spread of COVID-19, including the appropriate use of PPE. All facemasks and N95 masks must be in good functional condition as described in the COVID Response Plan for Assisted Living Facilities.

1. An assisted living facility must comply with CDC guidance on the optimization of PPE when supply limitations require PPE to be reused.

2. An assisted living facility must document all efforts made to obtain PPE, including each organization contacted and the date of each attempt.

(m) An assisted living facility must report COVID-19 activity as required by 26 TAC §553.41(n)(3) (relating to Standards for Type A and Type B Assisted Living Facilities). COVID-19 activity must be reported to HHSC Complaint and Incident Intake as described below.
(1) A facility must report the first confirmed case of COVID-19 in staff or residents, and the first confirmed case of COVID-19 after a facility has been without cases for 14 days or more, to HHSC Complaint and Incident Intake through Texas Unified Licensure Information Portal (TULIP), or by calling 1-800-458-9858 within 24 hours of the positive confirmation.

(2) A facility must submit Form 3613-A, Provider Investigation Report, to HHSC Complaint and Incident Intake through TULIP or by calling 1-800-458-9858 within five working days from the day a confirmed case is reported.

(n) If an executive order or other direction is issued by the Governor of Texas, the President of the United States, or another applicable authority, that is more restrictive than this rule or any minimum standard relating to an assisted living facility, the assisted living facility must comply. <added>


(a) The following words and terms, when used in this section, have the following meanings:

(1) Cohort--A group of residents placed in rooms, halls, or sections of an assisted living facility with others who have the same COVID-19 status or the act of grouping residents with other residents who have the same COVID-19 status.

(2) COVID-19 negative--A person who has tested negative for COVID-19, is not exhibiting symptoms of COVID-19, and has had no known exposure to the virus since the negative test.

(3) COVID-19 positive--A person who has tested positive for COVID-19, and does not yet meet Centers for Disease Control and Prevention (CDC) guidance for the discontinuation of transmission-based precautions.

(4) COVID-19 status--The status of a person based on COVID-19 test results, symptoms, or other factors that consider the person’s potential for having the virus.

(5) Isolation--The separation of people who are COVID-19 positive from those who are COVID-19 negative and those whose COVID-19 status is unknown.

(6) PPE--Personal protective equipment. PPE is specialized clothing or equipment worn by assisted living facility staff for protection against transmission of infectious diseases such as COVID-19, including masks, goggles, face shields, gloves, and disposable gowns.

(7) Quarantine--The separation of a people with unknown COVID-19 status from those who are COVID-19 positive and those who are COVID-19 negative.
(8) Unknown COVID-19 status—A person who is a new admission, readmission, or has spent one or more nights away from the facility, has had known exposure or close contact with a person who is COVID-19 positive, or who is exhibiting symptoms of COVID-19 while awaiting test results.

(b) An assisted living facility must have a protocol in place included in their COVID-19 response plan that describes how the facility will transfer a COVID-19 positive resident to another facility capable of isolating and caring for the COVID-19 positive resident, if the facility cannot successfully isolate the resident.

(1) An assisted living facility must have contracts or agreements with alternative appropriate facilities for caring for COVID-19 positive residents.

(2) An assisted living facility must assist the resident and family members to transfer the resident to the alternate facility.

(c) An assisted living facility must have a COVID-19 response plan that includes:

(1) Designated space for

   (A) COVID-19 negative residents;

   (B) residents with unknown COVID-19 status; and

   (C) COVID-19 positive residents, when the facility is able to care for a resident at this level or until arrangements can be made to transfer the resident to a higher level of care.

(2) Spaces for staff to don and doff PPE that minimize the movement of staff through other areas of the facility.

(3) Resident transport protocols.

(4) Plans for obtaining and maintaining a two-week supply of PPE, including surgical facemasks, gowns, gloves, and goggles or face shields.

(5) If the facility cares for or houses COVID-19 positive residents, a resident recovery plan for continuing care when a resident is recovering from COVID-19.

(d) An assisted living facility must screen all residents, staff, and people who come to the facility, in accordance with the following criteria:

(1) fever, defined as a temperature of 100.4 Fahrenheit and above, or signs or symptoms of a respiratory infection, such as cough, shortness of breath, or sore throat;

(2) signs or symptoms of COVID-19, including chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss-
of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea;

(3) additional signs and symptoms as outlined by the CDC in Symptoms or Coronavirus at cdc.gov;

(4) contact in the last 14 days with someone who has a confirmed diagnosis of COVID-19, is under investigation for COVID-19, or is ill with a respiratory illness, unless the person is entering the facility to provide critical assistance; and

(e) An assisted living facility must screen residents according to the following timeframes:

(1) for the criteria in subsection (d)(1)–(4) of this section upon admission or readmission to the facility; and

(2) for the criteria in subsection (d)(1)–(3) of this section at least twice a day.

(f) An assisted living facility must screen each employee or contractor for the criteria in subsection (d)(1)–(4) of this section before entering the facility at the start of their shift. Staff screenings must be documented in a log kept at the facility entrance and must include the name of each person screened, the date and time of the evaluation, and the results of the evaluation. Staff who meet any of the criteria must not be permitted to enter the facility and must be sent home.

(g) An assisted living facility must assign each resident to the appropriate cohort based on the resident’s COVID-19 status.

(h) A resident with unknown COVID-19 status must be quarantined and monitored for fever and symptoms of COVID-19 per CDC guidance.

(i) A COVID-19 positive resident must be isolated until the resident meets CDC guidelines for the discontinuation of transmission-based precautions, if cared for in the facility.

(j) If a COVID-19 positive resident must be transferred for a higher level of care, the facility must isolate the resident until the resident can be transferred.

(k) An assisted living facility must implement a staffing policy requiring the following:

(1) the facility must designate staff to work with each cohort and not change designation from one day to another, unless required in order to maintain adequate staffing for a cohort;

(2) staff must wear appropriate PPE based on the cohort with which they...
work;

3. Staff must inform the facility per facility policy prior to reporting for work if they have known exposure or symptoms;

4. Staff must perform self-monitoring on days they do not work; and

5. The facility must develop and implement a policy regarding staff working with other long-term care (LTC) providers that:

   A. Limits the sharing of staff with other LTC providers and facilities, unless required in order to maintain adequate staffing at a facility;

   B. Maintains a list of staff who work for other LTC providers or facilities that includes the names and addresses of the other employers;

   C. Requires all staff to inform the facility immediately, if there are COVID-19 positive cases at the staff’s other place of employment;

   D. Requires the facility to notify the staff’s other place of employment, if the staff member is diagnosed with COVID-19; and

   E. Requires staff to inform the facility which cohort they are assigned to at the staff’s other place of employment. The facility must maintain the same cohort designation for that employee in all facilities in which the staff member is working, unless required in order to maintain adequate staffing for a cohort.

1. All assisted living facility staff must wear a facemask while in the facility. Staff who are caring for COVID-19 positive residents and those caring for residents with unknown COVID-19 status must wear an N95 mask, gown, gloves, and goggles or a face shield. All facemasks and N95 masks must be in good functional condition as described in COVID-19 Response Plan for Assisted Living Facilities, and worn appropriately, completely covering the nose and mouth, at all times.

   1. A facility must comply with CDC guidance on the optimization of PPE when supply limitations require PPE to be reused.

   2. A facility must document all efforts made to obtain PPE, including the organization contacted and the date of each attempt.

m. An assisted living facility must report COVID-19 activity as required by 26 TAC §553.41(n)(3) (relating to Standards for Type A and Type B Assisted Living Facilities). COVID-19 activity must be reported to HHSC Complaint and Incident Intake as described below:

   1. Report the first confirmed case of COVID-19 in staff or residents, and the first confirmed case of COVID-19 after a facility has been
without cases for 14 days or more, to HHSC Complaint and Incident Intake through Texas Unified Licensure Information Portal (TULIP), or by calling 1-800-458-9858 within 24 hours of the positive confirmation.

(2) Submit Form 3613-A, Provider Investigation Report, to HHSC Complaint and Incident Intake through TULIP or by calling 1-800-458-9858 within five days from the day a confirmed case is reported.

(n) If an executive order or other direction is issued by the Governor of Texas, the President of the United States, or another applicable authority, that is more restrictive than this rule or any minimum standard relating to an assisted living facility, the assisted living facility must comply with the executive order or other direction. <deleted>
Attachment 07 26 TAC §553.2003
Expansion of Reopening Visitation

ALF Expansion of Reopening Visitation Emergency Rules 04.23.21 (texas.gov)

TITLE 26       HEALTH AND HUMAN SERVICES
PART 1         HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 553    LICENSING STANDARDS FOR ASSISTED LIVING FACILITIES
SUBCHAPTER K   COVID-19 EMERGENCY RULE


(a) The following words and terms, when used in this subchapter, have the following meanings.

(1) Closed window visit--A personal visit between a personal visitor and a resident during which the resident and personal visitor are separated by a closed window and the personal visitor does not enter the facility.

(2) COVID-19 negative--The status of a person who has either tested negative for COVID-19, is not exhibiting symptoms of COVID-19, and has had no known exposure to the virus in the last 14 days.

(3) COVID-19 positive--The status of a person who has tested positive for COVID-19 and does not yet meet the Centers for Disease Control and Prevention (CDC) guidance for the discontinuation of transmission-based precautions.

(4) End-of-life visit--A personal visit between a personal visitor and a resident who is receiving hospice services or who is at or near the end of life, with or without receiving hospice services, or whose prognosis does not indicate recovery. An end-of-life visit is permitted for all residents at or near the end of life.

(5) Essential caregiver--A family member or other outside caregiver, including a friend, volunteer, clergy member, private personal caregiver, or court-appointed guardian, who is at least 18 years old and has been designated by the resident or legal representative.

(6) Essential caregiver visit--A personal visit between a resident and an essential caregiver. An essential caregiver visit is permitted for all residents with any COVID-19 status.

(7) Facility-acquired COVID-19 infection--COVID-19 infection that is acquired after admission in a facility and was not present at the end of the 14-day quarantine period following admission or readmission.
(8) Indoor visit--A personal visit between a resident and one or more personal visitors that occurs in-person in a dedicated indoor space.

(9) Open window visit--A personal visit between a resident and a personal visitor during which the resident and personal visitor are separated by an open window.

(10) Outbreak--One or more laboratory confirmed cases of COVID-19 identified in either a resident or paid or unpaid staff.

(11) Outdoor visit--A personal visit between a resident and one or more personal visitors that occurs in-person in a dedicated outdoor space.

(12) Persons providing critical assistance--Providers of essential services, persons with legal authority to enter, and family members or friends of residents at the end of life, and designated essential caregivers.

(13) Persons with legal authority to enter--Law enforcement officers, representatives of the long-term care ombudsman's office, and government personnel performing their official duties.

(14) Physical distancing--Maintaining a minimum of six feet between persons, avoiding gathering in groups in accordance with state and local orders, and avoiding unnecessary physical contact.

(15) Plexiglass indoor visit--A personal visit between a resident and one or more personal visitors, during which the resident and the personal visitor are both inside the facility but within a booth separated by a plexiglass barrier.

(16) PPE--Personal protective equipment.

(17) Providers of essential services--Contract doctors or nurses, home health and hospice workers, health care professionals, contract professionals, and clergy members and spiritual counselors, whose services are necessary to ensure resident health and safety.

(18) Salon services visit--A personal visit between a resident and a salon services visitor.

(19) Salon services visitor--A barber, beautician, or cosmetologist providing hair care or personal grooming services to a resident.

(20) Unknown COVID-19 status--The status of a person who is a new admission or readmission, has spent one or more nights away from the facility, has had known exposure or close contact with a person who is COVID-19 positive, or who is exhibiting symptoms of COVID-19 while awaiting test results.

(21) Vehicle parade--A personal visit between a resident and one or more
personal visitors, during which the resident remains outdoors on the facility’s property and a personal visitor drives past in a vehicle.

(b) Visitors, except for essential caregivers, may be any age. Visitors under the age of two are exempt from all requirements related to wearing masks described in this section.

(c) An assisted living facility must screen all visitors prior to allowing them to enter the facility in accordance with subsection (d) of this section, except emergency services personnel entering the facility or facility campus in an emergency. Visitor screenings must be documented in a log kept at the entrance to the facility, which must include the name of each person screened, the date and time of the screening, and the results of the screening. The visitor screening log may contain protected health information and must be protected in accordance with applicable state and federal law.

(d) Visitors who meet any of the following screening criteria must leave the facility and reschedule the visit:

   (1) fever, defined as a temperature of 100.4 Fahrenheit and above, or signs or symptoms of a respiratory infection, such as cough, shortness of breath, or sore throat;

   (2) other signs or symptoms of COVID-19, including chills, new or worsening cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea;

   (3) any other signs and symptoms as outlined by the CDC in Symptoms of Coronavirus at cdc.gov;

   (4) contact in the last 14 days with someone who has a confirmed diagnosis of COVID-19, is under investigation for COVID-19, or is ill with a respiratory illness, regardless of whether the person is fully vaccinated; or

   (5) has tested positive for COVID-19 in the last 10 days.

(e) An assisted living facility must allow persons providing critical assistance, including essential caregivers, and persons with legal authority to enter to enter the facility if they pass the screening subsection (d) of this section.

(f) A person providing critical assistance who has had contact with a person with COVID-19 positive or COVID-19 unknown status, but does not meet the CDC definition of close contact or unprotected exposure, must not be denied entry to the facility unless the person providing critical assistance does not pass the screening criteria described in subsection (d)(1) - (3) and (5) of this section, or
any other screening criteria based on CDC guidance.

(g) If the facility has offered a complete series of a one- or two-dose COVID-19 vaccine to residents and staff and documented each resident’s choice to vaccinate or not vaccinate, the facility must allow essential caregiver visits, end-of-life visits, indoor visits, and outdoor visits as required in this subsection. If a facility fails to comply with the requirements of this subsection, HHSC may take action in accordance with Subchapter H of this chapter (relating to Enforcement).

(1) A facility may not require a visitor to provide documentation of a COVID-19 negative test or COVID-19 vaccination status as a condition of visitation or to enter the facility.

(2) The following requirements apply to essential caregiver visits.

(A) There may be up to two permanently designated essential caregiver visitors per resident.

(B) Up to two essential caregivers may visit a resident at the same time.

(C) The visit may occur outdoors, in the resident’s bedroom, or in another area in the facility that limits the visitor movement through the facility and interaction with other residents and staff.

(D) Essential caregiver visitors do not have to maintain physical distancing between themselves and the resident they are visiting but must maintain physical distancing between themselves and all other residents and staff.

(E) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(F) The facility must develop and enforce essential caregiver visitation policies and procedures, which include:

   (i) a written agreement that the essential caregiver understands and agrees to follow the applicable policies, procedures, and requirements;

   (ii) training each essential caregiver on proper PPE usage and infection control measures, hand hygiene, and cough and sneeze etiquette;

   (iii) a requirement that the essential caregiver must wear a facemask or face covering and any other appropriate PPE recommended by CDC guidance and the facility’s policy while in the facility;
(iv) expectations regarding using only designated entrances and exits as directed, if applicable; and

(v) limiting visitation to the area designated by the facility in accordance with subparagraph (C) of this paragraph.

(G) An assisted living facility must:

(i) inform the essential caregiver of applicable policies, procedures, and requirements;

(ii) approve the essential caregiver’s facemask or face covering and any other appropriate PPE recommended by CDC guidance and the facility’s policy, or provide an approved facemask or face covering and other appropriate PPE;

(iii) maintain documentation of the essential caregiver’s agreement to follow the applicable policies, procedures, and requirements;

(iv) maintain documentation of the essential caregiver’s training as required in subparagraph (F)(ii) of this paragraph;

(v) maintain documentation of the identity of each essential caregiver in the resident’s records and verify the identity of the essential caregiver at the time of each visit; and

(vi) maintain a record of each essential caregiver visit, including:

(I) the date and time of the arrival and departure of the essential caregiver visitor;

(II) the name of the essential caregiver visitor;

(III) the name of the resident being visited; and

(IV) attestation that the identity of the essential caregiver visitor was confirmed; and

(vii) prevent visitation by the essential caregiver visitor if the essential caregiver visitor has signs and symptoms of COVID-19 or an active COVID-19 infection.

(H) The facility may cancel the essential caregiver visit if the essential caregiver fails to comply with the facility’s policy regarding essential caregiver visits or applicable requirements in this section.
(3) To permit indoor visitation an assisted living facility must:

(A) have separate areas, which include enclosed rooms such as bedrooms, or activities rooms, units, wings, halls, or buildings, designated for COVID-19 positive, COVID-19 negative, and unknown COVID-19 status resident cohorts; and

(B) ensure separate staff are designated to work with only one resident cohort and the designation does not change from one day to another.

(4) An assisted living facility must provide instructional signage throughout the facility and proper visitor education regarding:

(A) the signs and symptoms of COVID-19;

(B) infection control precautions; and

(C) other applicable facility practices (e.g., use of facemasks and other appropriate PPE, specified entries and exits, routes to designated visitation areas, and hand hygiene).

(5) The following limits apply to all visitation allowed under this subsection.

(A) Visitation appointments must be scheduled to allow time for cleaning and sanitization of the visitation area between visits.

(B) Except as provided in subparagraph (C) of this paragraph, indoor visits and outdoor visits are permitted only for residents who are COVID-19 negative.

(C) Essential caregiver visits and end-of-life visits are permitted for residents who have COVID-19 negative, COVID-19 positive, or unknown COVID-19 status.

(D) A resident may choose to have close or personal contact with their visitor during the visit. The visitor must maintain physical distancing between themselves and all other persons in the facility.

(E) Visits are permitted where adequate space is available as necessary to ensure physical distancing between visitation groups and safe infection prevention and control measures, including the resident’s room. The facility must limit the movement of the visitor through the facility to ensure interaction with other persons in the facility is minimized.

(F) The visitor must wear a facemask or face covering over both the mouth and nose throughout the visit.
(G) The facility must encourage the resident to wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit. The resident may remove their facemask or face covering to eat or drink during the visit.

(H) A facility must ensure equal access by all residents to visitors and essential caregivers.

(I) Cleaning and disinfecting the visitation area, furniture, and all other items must be performed, per CDC guidance, before and after each visit.

(J) A facility must ensure a comfortable and safe outdoor visitation area for outdoor visits, considering outside air temperature and ventilation.

(K) A facility must provide hand washing stations, or hand sanitizer, to the visitor and resident before and after visits.

(L) The visitor and the resident must practice hand hygiene before and after the visit.

(h) If the facility has not offered a complete series of a one- or two-dose COVID-19 vaccine to residents, the facility must allow limited personal visitation as described in this subsection upon meeting the qualifications described in paragraph (3) of this subsection. These criteria are not required for a closed window visit, an end-of-life visit, or an essential caregiver visit as defined in subsection (a)(1), (4), and (6) of this section. If a facility fails to comply with the requirements of this subsection, HHSC may take action in accordance with Subchapter H of this chapter (relating to Enforcement).

(1) A facility may not require a visitor to provide documentation of a COVID-19 negative test or COVID-19 vaccination status as a condition of visitation or to enter the facility.

(2) The following requirements apply to essential caregiver visits.

(A) There may be up to two permanently designated essential caregivers per resident.

(B) Only one essential caregiver visitor at a time may visit a resident.

(C) The visit may occur outdoors, in the resident’s bedroom, or in another area in the facility that limits visitor movement through the facility and interaction with other residents and staff.

(D) Essential caregiver visitors do not have to maintain physical distancing between themselves and the resident they are visiting but must maintain physical distancing between themselves and all other residents and
staff.

(E) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(F) The facility must develop and enforce essential caregiver visitation policies and procedures, which include:

(i) a written agreement that the essential caregiver understands and agrees to follow the applicable policies, procedures, and requirements;

(ii) training each essential caregiver on proper PPE usage and infection control measures, hand hygiene, and cough and sneeze etiquette;

(iii) a requirement that the essential caregiver must wear a facemask or face covering and any other appropriate PPE recommended by CDC guidance and the facility’s policy while in the facility;

(iv) expectations regarding using only designated entrances and exits as directed, if applicable; and

(v) limiting visitation to the area designated by the facility in accordance with subparagraph (C) of this paragraph.

(G) An assisted living facility must:

(i) inform the essential caregiver visitor of applicable policies, procedures, and requirements;

(ii) approve the essential caregiver visitor’s facemask or face covering and any other appropriate PPE recommended by CDC guidance and the facility’s policy, or provide an approved facemask or face covering and other appropriate PPE;

(iii) maintain documentation of the essential caregiver’s agreement to follow the applicable policies, procedures, and requirements;

(iv) maintain documentation of the essential caregiver’s training as required in subparagraph (F)(ii) of this paragraph;

(v) maintain documentation of the identity of each essential caregiver visitor in the resident’s records and verify the identity of the essential caregiver visitor at the time of each visit;

(vi) maintain a record of each essential caregiver visit, including:
(I) the date and time of the arrival and departure of the essential caregiver visitor;

(II) the name of the essential caregiver visitor;

(III) the name of the resident being visited; and

(IV) attestation that the identity of the essential caregiver visitor was verified; and

(vii) prevent visitation by the essential caregiver visitor if the essential caregiver has signs and symptoms of COVID-19 or active COVID-19 infection.

(H) The facility may cancel the essential caregiver visit if the essential caregiver fails to comply with the facility’s policy regarding essential caregiver visits or applicable requirements in this section.

(3) To allow limited personal visitation in accordance with paragraph (8) of this subsection, a facility must submit a completed HHSC Long-term Care Regulation (LTCR) form 2196, COVID-19 Status Attestation form, including a facility map indicating which areas accommodate COVID-19 negative, COVID-19 positive, and unknown COVID-19 status residents, to the Regional Director in the LTCR Region where the facility is located. A facility with previous approval for visitation does not have to submit Form 2196 and a facility map, unless the previous visitation approval has been withdrawn, rescinded, or cancelled. To receive a facility visitation designation, an assisted living facility must demonstrate that:

(A) there are separate areas, which include enclosed rooms such as bedrooms or activities rooms, units, wings, halls, or buildings designated for resident cohorts who are COVID-19 positive, COVID-19 negative or unknown COVID-19 status;

(B) separate dedicated staff are working exclusively in the separate areas, units, wings, halls, or buildings for residents who are COVID-19 positive, COVID-19 negative or unknown COVID-19 status;

(C) there have been no confirmed COVID-19 cases for at least 14 consecutive days in staff working in the area, unit, wing, hall, or building that accommodates residents who are COVID-19 negative;

(D) there have been no facility-acquired COVID-19 confirmed cases for at least 14 consecutive days in residents in the COVID-19 negative area, unit, wing, hall, or building;
(E) staff are designated to work with only one resident cohort and the designation does not change from one day to another;

(F) evidence upon HHSC request of daily screening for staff and residents, if a testing strategy is not used; and

(G) if an assisted living facility has had previous cases of COVID-19 in staff or residents in the area, unit, wing, hall, or building that accommodates residents who are COVID-19 negative, LTCR may conduct a verification survey to confirm the following:

   (i) all staff and residents in the COVID-19 negative area, unit, wing, hall, or building have fully recovered;

   (ii) the assisted living facility has adequate staffing to continue care for all residents and administer visits permitted by this section; and

   (iii) the assisted living facility is in compliance with infection control requirements and emergency rules related to COVID-19.

(4) A small assisted living facility that cannot provide separate areas, including enclosed rooms such as bedrooms or activities rooms, units, wings, halls, or buildings for residents who are COVID-19 positive, COVID-19 negative, or unknown COVID-19 status must demonstrate:

   (A) there have been no confirmed COVID-19 cases for at least 14 consecutive days in staff;

   (B) there have been no facility-acquired COVID-19 confirmed cases for at least 14 consecutive days in residents; and

   (C) if an assisted living facility has had previous cases of COVID-19 in staff or residents, LTCR may conduct a verification survey and confirm the following:

      (i) all staff and residents have fully recovered;

      (ii) the assisted living facility has adequate staffing to continue care for all residents and administer visits permitted by this section; and

      (iii) the assisted living facility is in compliance with infection control requirements and emergency rules related to COVID-19.

(5) An assisted living facility that does not meet the criteria in paragraphs (3) or (4) of this subsection to receive a visitation designation, must:
(A) permit closed window visits and visits by persons providing critical assistance, including essential caregiver visits and end-of-life visits;

(B) develop and implement a plan describing the steps the facility intends to take in order to meet the criteria; and

(C) submit the plan to the Regional Director in the LTCR Region where the facility is located within five business days of submitting the form or of receiving notification from HHSC that the facility was not approved for visitation designation.

(6) An assisted living facility may request exemption from requirements of this section that a facility with a visitation designation allow certain personal visits. Facilities may not request, and HHSC will not approve, an exemption from closed window visits or visits by persons providing critical assistance, including essential caregivers and end-of-life visits. If the assisted living facility determines it is unable to meet one or more of the other visitation requirements of this section, the facility must request exemption from that requirement and explain its inability to meet the visitation requirement on the COVID-19 Status Attestation Form. HHSC will notify the assisted living facility if a temporary exemption for a specific visit type is granted and the time period for exemption.

(7) An assisted living facility must provide instructional signage throughout the facility and proper visitor education regarding:

(A) the signs and symptoms of COVID-19 signs;

(B) infection control precautions; and

(C) other applicable facility practices (e.g., use of facemask or other appropriate PPE, specified entries and exits, routes to designated visitation areas, and hand hygiene).

(8) Except if approved by HHSC for an exemption under paragraph (6) of this subsection, an assisted living facility with a facility visitation designation must allow outdoor visits, open window visits, vehicle parades, and plexiglass indoor visits involving residents and personal visitors. The following requirements apply to all visitation required under this subsection, and other visitation types as specified:

(A) Open window visits, vehicle parades, outdoor visits, and plexiglass indoor visits are permitted as can be accommodated by the facility only for residents who are COVID-19 negative.

(B) Closed window visits, end-of-life visits, and essential caregiver visits are permitted for residents who are COVID-19 negative, COVID-19 positive, or unknown COVID-19 status as can be accommodated by the facility.
(C) Physical contact between residents and visitors is prohibited, except for essential caregiver visits and end-of-life visits.

(D) Visits are permitted only where adequate space is available that meets the criteria and when adequate staff are available to comply with this section. Essential caregiver visits and end-of-life visits can take place in the resident’s room or other area of the facility separated from other residents. The facility must limit the movement of the visitor through the facility to ensure interaction with other residents is minimized.

(E) The visitor must wear a facemask or face covering over both the mouth and nose throughout the visit, except visitors participating in a vehicle parade or closed window visit.

(F) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(G) The facility must remind personal visitors and residents about physical distancing of at least six feet and face mask or face covering requirements either verbally or with a notice posted visible to personal visitors or handed to them. The facility must limit the number of visitors and residents in the visitation area as needed to ensure physical distancing is maintained. Essential caregiver and end-of-life visitors do not have to maintain physical distancing between themselves and the resident they are visiting, but they must maintain physical distancing between themselves and all other residents, staff, and other visitors.

(H) Cleaning and disinfecting the visitation area, furniture, and all other items must be performed, per CDC guidance, before and after each visit. The facility must schedule visits as necessary to allow time for sanitization between visits.

(I) The facility must ensure a comfortable and safe outdoor visiting area for outdoor visits, open window visits, and vehicle parades, considering outside air temperatures, weather conditions, and ventilation.

(J) For outdoor visits, the facility must designate an outdoor area for visitation that is separated from residents and limits the ability of the visitor to interact with residents.

(K) A facility must provide hand washing stations or hand sanitizer to the visitor and resident before and after visits, except visitors participating in a vehicle parade or closed window visit.

(L) The visitor and the resident must practice hand hygiene before and after the visit, except visitors participating in a vehicle parade or closed window visit.
(9) The following requirements apply to vehicle parades.

(A) Visitors must remain in their vehicles throughout the parade.

(B) The facility must encourage physical distancing of at least six feet between residents throughout the parade.

(C) The facility must prohibit residents from being closer than 10 feet to the vehicles for safety reasons.

(D) The facility must encourage residents to wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the parade.

(10) The following requirements apply to plexiglass indoor visits.

(A) The plexiglass barrier must be installed in an area where it does not impede a means of egress, does not impede or interfere with any fire safety equipment or system, and minimizes access to the rest of the facility and contact between personal visitors and other residents.

(B) Prior to using the booth, the facility must submit for approval a photo of the plexiglass visitation booth and its location in the facility to the Life Safety Code Program Manager in the LTCR Region in which the facility is located and must receive approval from HHSC.

(C) The visit must be supervised by facility staff for the duration of the visit.

(D) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(E) The visitor must wear a facemask or face covering over both the mouth and nose throughout the visit.

(F) The facility shall limit the number of visitors and residents in the visitation area as needed.

(i) A facility may allow a salon services visitor to enter the facility to provide services to a resident only if:

(1) the salon services visitor passes the screening described in subsection (d) of this section;

(2) the salon services visitor agrees to comply with the most current version of the Minimum Standard Health Protocols – Checklist for Cosmetology Salons/Hair Salons, located on website: open.texas.gov; and
(3) the requirements of subsection (j) of this section are met.

(j) The following requirements apply to salon services visits.

(1) A salon services visit may be permitted for all residents with COVID-19 negative status.

(2) The visit may occur outdoors, in the resident’s bedroom, or in another area in the facility that limits visitor movement through the facility and interaction with other persons in the facility.

(3) Salon services visitors do not have to maintain physical distancing between themselves and each resident they are visiting, but they must maintain physical distancing between themselves and all other persons in the facility.

(4) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(5) The facility must develop and enforce salon services visitation policies and procedures, which include:

   (A) a testing strategy for salon services visitors;

   (B) a written agreement that the salon services visitor understands and agrees to follow the applicable policies, procedures, and requirements;

   (C) training each salon services visitor on proper PPE usage and infection control measures, hand hygiene, and cough and sneeze etiquette;

   (D) the salon services visitor must wear a facemask and any other appropriate PPE recommended by CDC guidance and the facility’s policy while in the facility.

   (E) expectations regarding using only designated entrances and exits as directed; and

   (F) limiting visitation to the area designated by the facility in accordance with paragraph (2) of this subsection.

(6) The assisted living facility must:

   (A) inform the salon services visitor of applicable policies, procedures, and requirements;

   (B) approve the visitor’s facemask or provide an approved facemask;

   (C) maintain documentation of the salon services visitor’s
agreement to follow the applicable policies, procedures and requirements;

(D) maintain documentation of the salon services visitor’s training as required in paragraph (5)(C) of this subsection;

(E) document the identity of each salon services visitor in the facility’s records and verify the identity of the salon services visitor; and

(F) maintain a record of each salon services visit, including:

(i) the date and time of the arrival and departure of the salon services visitor;

(ii) the name of the salon services visitor;

(iii) the name of the resident being visited; and

(iv) attestation that the identity of the salon services visitor was confirmed; and

(G) prevent visitation by the salon services visitor if the resident has an active COVID-19 infection.

(7) The facility may cancel the salon services visit if the salon services visitor fails to comply with the facility’s policy regarding salon services visits or applicable requirements in this section.

(k) If, at any time after facility visitation designation is approved by HHSC, the area, unit, wing, hall, or building accommodating residents who are COVID-19 negative, or facility-wide for small assisted living facilities that received visitation designation in accordance with subsection (h)(4) of this section, experiences an outbreak of COVID-19, the facility must notify the Regional Director in the LTCR Region where the facility is located that the area, unit, wing, hall, building or facility no longer meets visitation criteria, and all visit types authorized under the facility’s visitation designation, including outdoor visits, open window visits, vehicle parades, and indoor plexiglass visits, must be cancelled until the area, unit, wing, hall, building or facility meets the criteria described in subsection (h)(3) or (4) of this section.

(l) If an assisted living fails to comply with the requirements of this section, HHSC may rescind the visitation designation and may impose licensure remedies in accordance with Subchapter H of this chapter (relating to Enforcement).

(m) If an executive order or other direction is issued by the Governor of Texas, the President of the United States, or another applicable authority, that is more restrictive than this rule or any minimum standard relating to a facility, the
facility must comply with the executive order or other direction.
1.0 Subject and Purpose

As part of the continued reopening of the State of Texas, the Health and Human Services Commission (HHSC) has published expanded Assisted Living Facility (ALF) emergency rules. The new rules allow for less stringent visitation guidelines once a facility has offered a complete series of COVID vaccines to residents and staff and documented each resident’s choice to vaccinate, or not to vaccinate. The new rules also allow for more stringent visitation if a facility has NOT yet made this offer to residents and staff.

In addition, this PL serves as a reminder that the ALF mitigation rules in 26 TAC §553.2001 are still in place.

2.0 Facility Visitation Requirements

2.1 Facilities that have offered vaccines

The new visitation rules provide flexibility for ALFs that have offered a complete series of a one- or two-dose COVID-19 vaccine to residents and staff and documented each resident’s choice to vaccinate or not vaccinate. Such facilities must allow essential caregiver visits, end-of-life visits, indoor visits, and outdoor visits. “Offer” in this context means to administer, arrange, or give information about the COVID-19 vaccine. If this is done, the facility can follow the less restrictive rules, as long as documentation is maintained.

The new requirements include the following:

- No attestation form for visitation is required.
- A resident may choose to have close or personal contact with their visitor during the visit.
- Schedule visitation appointments to allow time for cleaning and sanitization of the visitation area between visits.
- A facility may not require a visitor to provide documentation of COVID-19 negative test or COVID-19 vaccination status as a condition of visitation or to enter a facility.
- There may be up to two permanently designated essential caregivers per
resident, and up to two designated essential caregivers may visit at a time.

2.2 Facilities that have NOT have offered vaccines

If the facility has **NOT** offered a complete series of a one- or two-dose COVID-19 vaccine to residents, the facility must allow limited personal visitation including, but not limited to, the following requirements:

- Scheduling visitation appointments to allow time for cleaning and sanitization of the visitation area between visits.
- A facility may not require a visitor to provide documentation of COVID-19 negative test or COVID-19 vaccination status as a condition of visitation or to enter a facility.
- There may be up to two permanently designated essential caregivers per resident and only **one** designated essential caregiver may visit at a time.
- Submit LTCR Form 2196 to the Regional Director where the facility is located. If approved, the facility must allow for outdoor visits, open window visits, vehicle parades, and plexiglass indoor visits involving residents and personal visitors. See Section 3.0 for the link to LTCR Form 2196
- A facility must receive an approved visitation designation from HHSC before it can begin permitting outdoor visits, indoor plexiglass open window visits, and vehicle parades. The facility must demonstrate it meets the requirements in 26 TAC §553.2003(g).

2.3 Requirements regardless of offering vaccine series

In all circumstances, regardless of the facility offering or not offering the series of vaccines, these requirements apply:

- The facility must screen all visitors according the requirements in the rule. Visitors who meet any of the screening criteria must leave the facility and reschedule the visit.
- The essential caregiver does not have to maintain physical distance between themselves and the resident they are visiting but must maintain physical distancing between themselves and all other residents and staff. In addition, the facility must develop and enforce essential caregiver visitation policies and procedures, which are detailed in the emergency rule.

In addition, the facility must provide instructional signage throughout the facility and proper visitor education regarding the following:

- signs and symptoms of COVID-19
- infection control precautions
- other applicable facility practices (e.g. use of facemasks and other
appropriate PPE; specified entries and exits, routes to designated visitation and hand hygiene).

3.0 Mitigation Rules in 26 TAC §553.2001

An ALF must have a COVID-19 response plan that includes designated space for:

- residents with negative COVID-19 status
- residents with unknown COVID-19 status
- COVID-19 positive residents, when the facility can care for a resident at this level or until arrangements can be made to transfer the resident to a higher level of care.

4.0 Resources

LTCR FORM 2196: Expansion of Reopening Visitation Status Attestation Form for ALF

Section 1: Facility Information

Instructions: Submit Form 2196 to your Regional Director to request designation as a visitation facility. You must wait for approval prior to implementing new expansion of reopening visitation protocols.

<table>
<thead>
<tr>
<th>Facility Type:</th>
<th>Facility Name:</th>
<th>Facility #/ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name:</td>
<td>Contact #:</td>
<td></td>
</tr>
<tr>
<td>Contact's Email:</td>
<td></td>
<td></td>
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<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility's County:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visitation Designation requested:</td>
<td>List each wing, unit, area, or building for which you are requesting visitation designation below.</td>
<td></td>
</tr>
</tbody>
</table>
Indicate type of visitation:

☐ Indoor plexiglass booth/barrier visitation only (only select if requesting an exemption for outdoor visitation types)

☐ Outdoor visitation, vehicle parades and open window visits only (only select if requesting an exemption for indoor plexiglass visits)

☐ Indoor plexiglass booth/barrier and outdoor visitation

If requesting an exemption (indoor plexiglass visitation only or outdoor visitation only), an ALF must complete Section 2 and Section 5 of this form.

If requesting indoor plexiglass booth/barrier visitation, please attach pictures of the existing booth, the location of the booth/barrier in the facility, and the building map that indicates where in the facility the booth/barrier is located.

Note: there may be more stringent restrictions from local authorities that prohibit visitation to a facility. The facility must follow the more stringent guidelines.

If the ALF has NOT offered a complete series of a one- or two-dose COVID vaccine to residents, complete Sections 2 and 3.

Note: All ALFs must offer visitation, per state guidance. Complete Section 2 if your facility meets the visitation designation criteria. Complete Section 3 if your facility does not meet visitation designation criteria. Visitation criteria from 26 TAC §533.2003(g) are listed in Section 7 for your reference. All ALFs must complete Section 6, the signature section, if applicable.

SECTION 2:
I hereby attest that:

☐ There have been no confirmed COVID-19 cases in facility staff for at least 14 consecutive days in the specified areas, wings, units or buildings.

☐ There are no active or facility-acquired COVID-19
cases in residents in the specified areas, wings, units or buildings.

☐ I have attached a facility map indicating which areas, wings, units or buildings accommodate COVID-19 negative, COVID-19 positive and unknown COVID-19 status residents.

☐ There is no local order prohibiting visitation in this facility. I hereby further attest that either:

☐ There have been no confirmed COVID-19 cases in facility staff and/or residents in facility staff and/or residents in the specified areas, wings, units or buildings of the facility

OR

☐ There have been previous cases of COVID-19 in facility staff and/or residents in the specified areas, wings, units or buildings of the facility, and:

(A) all staff and/or residents in the specified areas, wings, units or buildings have fully recovered,

(B) the facility has adequate staffing to continue care for all residents and visits permitted in expansion of reopening visitation, and

(C) the facility is in compliance with infection control requirements and emergency rules related to COVID-19.

I understand that HHSC may verify this attestation through an onsite visit.
SECTION 3:
I hereby attest that:

☐ I have attached a facility map indicating which areas, wings, units, or buildings accommodate COVID-19 negative, COVID-19 positive, and unknown COVID-19 status residents.

☐ The facility does not currently meet the criteria for visitation designation.

and

☐ The facility is permitting closed window visits, end-of-life visits, and essential caregiver visits.

and

☐ There is no local order prohibiting visitation in this facility.

I further attest that:

☐ The facility has developed and implemented a plan to meet the visitation designation criteria as defined in 26 TAC §533.2003(g) and the plan is included with this form.

or

☐ The facility will submit a plan to meet the visitation designation criteria defined in 26 TAC §553.2003(g) within 5 business days of submitting this form.

SECTION 4: ALF unable to offer visitation because of local order
I hereby attest that:

☐ There is a local order prohibiting visitation in this facility. and

☐ Once the local order is no longer in effect, I will resubmit LTCR Form 2196 and request visitation designation.

I hereby further attest that:

I have included a copy of the local order or the website where the local order can be viewed.
SECTION 5: ALF unable to offer both indoor plexiglass and outdoor visitation

An ALF facility may request an exemption for outdoor visits, indoor plexiglass visits, open window visits, or vehicle parades. If your facility is unable to offer outdoor visits, indoor plexiglass visits, open window visits or vehicle parades, please provide an explanation as to why the facility is unable to meet the visitation requirements specified in 26 TAC §553.2003 (g)(6) and submit the explanation to this form. The visitation criteria are located in Section 7 for your reference. HHSC will review the rationale to determine if an exemption can be approved and will notify the ALF if an exemption is approved or denied, and whether the exemption is temporary or long-term, dependent upon the situation.

SECTION 6: Signature and HHSC Review

Name and title of ALF administrator/manager providing attestation:

Signature:

Date:

Email the form (and any applicable pictures, facility maps, and attachments) to the LTCR regional director in the LTCR region where the facility is located.

Approved by/date:

Denied, Reason for denial/date:

Note: there may be more stringent restrictions from local authorities that prohibit visitation to a facility. The facility must follow the more stringent guidelines.
(g) If the facility has not offered a complete series of a one- or two-dose COVID-19 vaccine to residents, the facility must allow limited personal visitation as described in this subsection upon meeting the qualifications described in paragraph (3) of this subsection. These criteria are not required for a closed window visit, an end-of-life visit, or an essential caregiver visit as defined in subsection (a)(1), (a)(4), and (a)(6) of this section. If a facility fails to comply with the requirements of this subsection, HHSC may take action in accordance with Subchapter H of this chapter (relating to Enforcement).

(1) A facility may not require a visitor to provide documentation of a COVID-19 negative test or COVID-19 vaccination status as a condition of visitation or to enter the facility.

(2) The following requirements apply to essential caregiver visits.

(A) There may be up to two permanently designated essential caregivers per resident.

(B) Only one essential caregiver visitor at a time may visit a resident.

(C) The visit may occur outdoors, in the resident’s bedroom, or in another area in the facility that limits visitor movement through the facility and interaction with other residents and staff.

(D) Essential caregiver visitors do not have to maintain physical distancing between themselves and the resident they are visiting but must maintain physical distancing between themselves and all other residents and staff.

(E) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(F) The facility must develop and enforce essential caregiver visitation policies and procedures, which include:

   (i) a written agreement that the essential caregiver understands and agrees to follow the applicable policies, procedures, and requirements;

   (ii) training each essential caregiver on proper PPE usage and infection control measures, hand hygiene, and cough and sneeze etiquette;

   (iii) a requirement that the essential caregiver must wear a facemask or face covering and any other appropriate PPE.
recommended by CDC guidance and the facility’s policy while in the facility;

(iv) expectations regarding using only designated entrances and exits as directed, if applicable; and

(v) limiting visitation to the area designated by the facility in accordance with paragraph (C) of this subsection.

(G) An assisted living facility must:

(i) inform the essential caregiver visitor of applicable policies, procedures, and requirements;

(ii) approve the essential caregiver visitor’s facemask or face covering and any other appropriate PPE recommended by CDC guidance and the facility’s policy, or provide an approved facemask or face covering and other appropriate PPE;

(iii) maintain documentation of the essential caregiver’s agreement to follow the applicable policies, procedures, and requirements;

(iv) maintain documentation of the essential caregiver’s training as required in paragraph (F)(ii) of this subsection;

(v) maintain documentation of the identity of each essential caregiver visitor in the resident’s records and verify the identity of the essential caregiver visitor at the time of each visit;

(vi) maintain a record of each essential caregiver visit, including:

(I) the date and time of the arrival and departure of the essential caregiver visitor;

(II) the name of the essential caregiver visitor; (III) the name of the resident being visited; and (IV) attestation that the identity of the essential caregiver visitor was verified; and

(vii) prevent visitation by the essential caregiver visitor if the essential caregiver has signs and symptoms of COVID-19 or active COVID-19 infection.

(H) The facility may cancel the essential caregiver visit if the essential caregiver fails to comply with the facility’s policy regarding essential
To allow limited personal visitation in accordance with paragraph (8) of this subsection, a facility must submit a completed Long-term Care Regulation (LTCR) Form 2196, COVID-19 Status Attestation form, including a facility map indicating which areas accommodate COVID-19 negative, COVID-19 positive, and unknown COVID-19 status residents, to the Regional Director in the LTCR Region where the facility is located. A facility with previous approval for visitation does not have to submit Form 2196 and a facility map, unless the previous visitation approval has been withdrawn, rescinded, or cancelled. To receive a facility visitation designation, an assisted living facility must demonstrate that:

(A) there are separate areas, which include enclosed rooms such as bedrooms or activities rooms, units, wings, halls, or buildings designated for resident cohorts who are COVID-19 positive, COVID-19 negative or unknown COVID-19 status;

(B) separate dedicated staff are working exclusively in the separate areas, units, wings, halls, or buildings for residents who are COVID-19 positive, COVID-19 negative or unknown COVID-19 status;

(C) there have been no confirmed COVID-19 cases for at least 14 consecutive days in staff working in the area, unit, wing, hall, or building that accommodates residents who are COVID-19 negative;

(D) there have been no facility-acquired COVID-19 confirmed cases for at least 14 consecutive days in residents in the COVID-19 negative area, unit, wing, hall, or building;

(E) staff are designated to work with only one resident cohort and the designation does not change from one day to another;

(F) evidence upon HHSC request of daily screening for staff and residents, if a testing strategy is not used; and

(G) if an assisted living facility has had previous cases of COVID-19 in staff or residents in the area, unit, wing, hall, or building, which accommodates residents who are COVID-19 negative, HHSC LTCR may conduct a verification survey to confirm the following:

(i) all staff and residents in the COVID-19 negative area, unit, wing, hall, or building have fully recovered;

(ii) the assisted living facility has adequate staffing to continue
care for all residents and administer visits permitted by this section; and

(iii) the assisted living facility is in compliance with infection control requirements and emergency rules related to COVID-19.

(4) A small assisted living facility that cannot provide separate areas, including enclosed rooms such as bedrooms or activities rooms, units, wings, halls, or buildings for residents who are COVID-19 positive, COVID-19 negative or unknown COVID-19 status must demonstrate:

(A) there have been no confirmed COVID-19 cases for at least 14 consecutive days in staff;

(B) there have been no facility-acquired COVID-19 confirmed cases for at least 14 consecutive days in residents; and

(C) if an assisted living facility has had previous cases of COVID-19 in staff or residents, HHSC LTCR may conduct a verification survey and confirm the following:

(i) all staff and residents have fully recovered;

(ii) the assisted living facility has adequate staffing to continue care for all residents and administer visits permitted by this section; and

(iii) the assisted living facility is in compliance with infection control requirements and emergency rules related to COVID-19.

(5) An assisted living facility that does not meet the criteria in paragraphs (3) or (4) of this subsection to receive a visitation designation, must:

(A) permit closed window visits and visits by persons providing critical assistance, including essential caregiver visits and end-of-life visits;

(B) develop and implement a plan describing the steps the facility intends to take in order to meet the criteria; and

(C) submit the plan to the Regional Director in the LTCR Region where the facility is located within five business days of submitting the form or of receiving notification from HHSC that the facility was not approved for visitation designation.

(6) An assisted living facility may request exemption from requirements of
this section that a facility with a visitation designation allow certain personal visits. Facilities may not request, and HHSC will not approve, an exemption from closed window visits or visits by persons providing critical assistance, including essential caregivers and end-of-life visits. If the assisted living facility determines it is unable to meet one or more of the other visitation requirements of this section, the facility must request exemption from that requirement and explain its inability to meet the visitation requirement on the COVID-19 Status Attestation Form. HHSC will notify the assisted living facility if a temporary exemption for a specific visit type is granted and the time period for exemption.

(7) An assisted living facility must provide instructional signage throughout the facility and proper visitor education regarding:

(A) the signs and symptoms of COVID-19 signs; (B) infection control precautions; and

(C) other applicable facility practices (e.g., use of facemask or other appropriate PPE, specified entries and exits, routes to designated visitation areas, hand hygiene).

(8) Except if approved by HHSC for an exemption under paragraph (6) of this subsection, an assisted living facility with a facility visitation designation must allow outdoor visits, open window visits, vehicle parades, and plexiglass indoor visits involving residents and personal visitors. The following requirements apply to all visitation required under this subsection, and other visitation types as specified:

(A) Open window visits, vehicle parades, outdoor visits, and plexiglass indoor visits are permitted as can be accommodated by the facility only for residents who are COVID-19 negative.

(B) Closed window visits, end-of-life visits, and essential caregiver visits are permitted for residents who are COVID-19 negative, COVID-19 positive, or unknown COVID-19 status as can be accommodated by the facility.

(C) Physical contact between residents and visitors is prohibited, except for essential caregiver visits and end-of-life visits.

(D) Visits are permitted only where adequate space is available that meets the criteria and when adequate staff are available to comply with this section. Essential caregiver visits and end-of-life visits can take place in the resident’s room or other area of the facility separated
from other residents. The facility must limit the movement of the visitor through the facility to ensure interaction with other residents is minimized.

(E) The visitor must wear a facemask or face covering over both the mouth and nose throughout the visit, except visitors participating in a vehicle parade or closed window visit.

(F) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(G) The facility must remind personal visitors and residents about physical distancing of at least six feet and face mask or face covering requirements either verbally or with a notice posted visible to personal visitors or handed to them. The facility must limit the number of visitors and residents in the visitation area as needed to ensure physical distancing is maintained. Essential caregiver and end-of-life visitors do not have to maintain physical distancing between themselves and the resident they are visiting, but they must maintain physical distancing between themselves and all other residents, staff, and other visitors.

(H) Cleaning and disinfecting of the visitation area, furniture, and all other items must be performed, per CDC guidance, before and after each visit. The facility must schedule visits as necessary to allow time for sanitization between visits.

(I) The facility must ensure a comfortable and safe outdoor visiting area for outdoor visits, open window visits, and vehicle parades, considering outside air temperatures, weather conditions, and ventilation.

(J) For outdoor visits, the facility must designate an outdoor area for visitation that is separated from residents and limits the ability of the visitor to interact with residents.

(K) A facility must provide hand washing stations or hand sanitizer to the visitor and resident before and after visits, except visitors participating in a vehicle parade or closed window visit.

(L) The visitor and the resident must practice hand hygiene before and after the visit, except visitors participating in a vehicle parade or closed window visit.

(9) The following requirements apply to vehicle parades.

(A) Visitors must remain in their vehicles throughout the parade.
(B) The facility must encourage physical distancing of at least six feet between residents throughout the parade.

(C) The facility must prohibit residents from being closer than 10 feet to the vehicles for safety reasons.

(D) The facility must encourage residents to wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the parade.

    The following requirements apply to plexiglass indoor visits.

(E) The plexiglass barrier must be installed in an area where it does not impede a means of egress, does not impede or interfere with any fire safety equipment or system, and minimizes access to the rest of the facility and contact between personal visitors and other residents.

(F) Prior to using the booth, the facility must submit for approval a photo of the plexiglass visitation booth and its location in the facility to the Life Safety Code Program Manager in the LTCR Region in which the facility is located and must receive approval from HHSC.

(G) The visit must be supervised by facility staff for the duration of the visit.

(H) The resident must wear a facemask or face covering over both the mouth and nose, if tolerated, throughout the visit.

(I) The visitor must wear a facemask or face covering over both the mouth and nose throughout the visit.

(J) The facility shall limit the number of visitors and residents in the visitation area as needed.
Attachment 09 26 TAC §553.2004 ALF COVID-19 Vaccination Data Reporting and Communication System Enrollment

Revised ALF COVID-19 Vaccination Data Reporting Rule and Emergency Communication System (texas.gov)

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 553 LICENSING STANDARDS FOR ASSISTED LIVING FACILITIES
SUBCHAPTER K COVID-19 EMERGENCY RULE


(a) An assisted living facility manager and one additional designee must enroll in an emergency communication system in accordance with instructions from the Texas Health and Human Services Commission (HHSC)

(b) An assisted living facility must respond to requests for information received through the emergency communication system in the format established by HHSC.

(c) Based on state law and federal guidance, HHSC finds COVID-19 to be a health and safety risk and, therefore, requires an assisted living facility to, within 24 hours of completing a round of vaccinations, accurately report COVID-19 vaccination data for staff and residents to HHSC in the format established by HHSC. <added>

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(a) Based on state law and federal guidance, the Texas Health and Human Services Commission (HHSC) finds COVID-19 to be a health and safety risk and requires an assisted living facility to take the following measures

(b) Within 24 hours of completing a round of vaccinations, an assisted living facility must accurately report COVID-19 vaccination data for staff and residents to HHSC in the format established by HHSC. <deleted>
Attachment 10 Long-term Regulation Provider
Letter PL 2020-37 (Revised)
PL 20-37 revised 11.20 (texas.gov)

Reporting Guidance for
Long-term Care Providers

Date Revised: November 19,
2020

1.0 Subject and Purpose

This letter outlines provider reporting responsibilities related to COVID-19 positive cases and deaths (COVID-19 and non-COVID-19 related). This letter and attachment also consolidate reporting requirements in a more user-friendly manner. This letter has been revised to include information for ALF and ICF providers offering point-of-care testing for COVID-19.

2.0 Policy Details & Provider Responsibilities

ALF Related Conditions COVID-19 Reporting Responsibilities

All ALFs shall:

- Report the first confirmed case of COVID-19 in staff or residents, as well as the first confirmed case of COVID-19 after a facility has been without new cases for 14 days or more, to CII through TULIP or by calling 1-800-458-9858 within 24 hours of the confirmed positive result.

- Complete Form 3613-A Provider Investigation Report and submit within five days from the day a confirmed case is reported to CII. The provider investigation report can be submitted:
  - via TULIP
  - by email at ciiprovider@hhsc.state.tx.us; or
  - by fax at 877-438-5827

- Report all confirmed COVID-19 cases immediately to the health authority with jurisdiction over the facility. If there is no local health authority, report to DSHS directly

- ALFs offering point-of-care testing related to COVID-19 must report data for all testing completed, for each individual tested. Reporting is to be made within 24 hours of results being known or determined, on a daily basis. The following steps outline what is needed to begin reporting in order to meet state and federal requirements.

- Report all resident deaths, serious injury of a resident, or any threat to a
resident’s health or safety resulting from a disaster or emergency to CII via TULIP or 1-800-458-9858 within 24 hours and complete form 3613-A provider investigation report within working days 5 days.

- If the death might have resulted from abuse, neglect, or exploitation, additional reporting requirements might apply.
1.0 Subject and Purpose

An ALF must have a written process for transferring a resident with an active COVID-19 infection to another facility or higher level of care if the ALF is unable to provide appropriate care. As part of the transfer process, an ALF must have a written agreement with an alternate facility to temporarily admit residents who have COVID-19 if the alternate facility has the available capacity and can provide the level of care required. An ALF must have at least one back-up plan established in the event the designated receiving facility is not capable of accepting residents when requested.

2.0 Policy Details & Provider Responsibilities

An ALF caring for a resident with COVID-19 must have a designated space to isolate the resident from all other residents and dedicated staff to provide care for all COVID positive residents. Meeting these requirements may be challenging, especially for small ALFs. Additionally, an ALF may have the appropriate isolation space and dedicated staff to care for residents with COVID-19, but if a resident’s condition changes so that he or she requires transfer to a higher level of care, the ALF must take prompt action to affect a transfer. Therefore, all ALFs must have a transfer process and agreements with other facilities should this situation arise.

3.0 The process for transferring a resident with an active COVID-19 infection

The transfer process must include the facility's policies and procedures for the following:

- Isolate a resident requiring transfer away from other residents and implement all applicable infection control precautions until the resident can be
• Have staff monitor the resident for worsening symptoms or a change in condition that would require a call to 911, including warning signs of respiratory distress. Subsection 2.2 lists the most common emergency warning signs of respiratory distress.

• Make arrangements with the receiving facility to temporarily admit the resident until the resident is cleared to return to their home facility.
• Work with the receiving facility to ensure continuity of care, including filling any prescriptions as necessary and making the receiving facility aware of any scheduled medical appointments, and coordinate the transfer of any other relevant medical information.

• Provide the receiving facility with a copy of the resident's service plan.

• Ensure that all items that the resident will need at the receiving facility are securely packed and that they are transferred along with the resident.

• Provide transportation to the receiving facility or arrange appropriate transportation according to the resident's condition and preference.

• Inform the following persons that the facility is transferring the resident and include the date of transfer and anticipated length of stay:
  o the resident, the resident's legally authorized representative, and any emergency contact(s);
  o the resident’s primary care physician or medical team, as applicable; and
  o any home and community support services agency or health care professional who provides care for the resident in the facility.

2.1 Emergency warning signs of respiratory distress

Seek emergency medical care or call 911 immediately if a resident suddenly starts showing any one of these signs:
  o Trouble breathing
  o Persistent pain or pressure in the chest
  o New confusion
  o Inability to wake or stay awake
  o Bluish lips or face

This is not an exhaustive list of symptoms of respiratory distress. Call a medical provider or 911 for any other symptoms that are severe or concerning.

3.0 Background/History

To protect residents in ALFs, HHSC has adopted emergency rule 26 TAC §553.2001 that requires ALF providers to include in their COVID-19 response plan a protocol that describes how the facility will transfer a COVID-19 positive resident to another facility or to a higher level of care, as applicable, capable of providing the necessary level of care, if the facility cannot provide the care required.
Attachment 12 Long-Term Care Regulation Provider Letter PL 20-50


Influenza (Flu) Vaccine Guidance During COVID-19

Date Issued: November 17, 2020

1.0 Subject and Purpose

This letter provides a brief overview of the Adult Influenza Vaccine Initiative and guidance on the administration of the influenza vaccine to residents and staff with and without COVID-19. This document also informs facilities when an individual should receive the influenza vaccine, even if the facility is not the vaccine administrator.

2.0 Policy Details & Provider Responsibilities

2.1 The Adult Influenza Vaccine Initiative

DSHS is providing a one-time-only allocation of adult influenza vaccine doses through the Adult Influenza Vaccine Initiative to target high risk populations disproportionately affected by or at risk for COVID-19. These populations include residents and staff of long-term care facilities, who are also at risk for contracting the influenza virus.

This initiative includes training and education provided to staff and access to an automated vaccine ordering and reporting system, all at no additional cost to providers.

Providers enrolled in this initiative must register and report doses administered in the Texas Immunization Registry (ImmTrac2).

Provider enrollment process:

1. Complete enrollment and obtain your ImmTrac2 Organization Code.
2. Complete Module 10 of the CDC “You Call the Shots” Training.
3. Complete the Adult Influenza Vaccine Initiative Provider Agreement form.
4. Agree to screen for patient eligibility and maintain screening records.
5. Agree to maintain vaccine safety and inventory.

2.2 Vaccination of Persons with Confirmed or Suspected COVID-19

In general, the annual influenza vaccination should be deferred for persons with suspected or confirmed COVID-19 until the criteria for the discontinuation of transmission-based precautions have been met. While
mild illness is not a contraindication to vaccination, vaccination visits for those who have not met all criteria to discontinue isolation should be postponed in order to avoid potentially exposing healthcare personnel and others to the virus that causes COVID-19.

There are additional considerations when administering the influenza vaccine to residents in long-term care facilities. In the long-term care setting, healthcare personnel are already entering residents’ rooms to provide care and administering the influenza vaccine should not result in additional exposures. According to CDC’s Pandemic Guidance for Vaccines:

- Symptomatic residents with confirmed COVID-19: Consider deferring vaccination until at least 10 days have passed since symptoms’ onset, and at least 24 hours have passed since resolution of fever without the use of fever-reducing medications, and other symptoms have improved.

- Residents with asymptomatic or pre-symptomatic confirmed COVID-19 AND residents who have had close contact with a person with COVID-19 in the past 14 days may be vaccinated. If there are concerns that post-vaccination symptoms may be mistaken for COVID-19 symptoms and cause diagnostic confusion, consider deferring vaccination until quarantine or isolation has ended.

Follow CDC Infection Prevention and Control Guidance to prevent the spread of COVID-19 in health care settings during vaccine administration procedures.

2.3 Vaccination of persons without COVID-19 and persons with no known exposure to COVID-19

Routine annual influenza vaccination is recommended for all persons at least 6 months or older who consent to receiving the vaccine and who do not have contraindications. Follow normal vaccination requirements and procedures for staff and residents without COVID-19.

2.4 People who SHOULD NOT get the flu vaccine

People with severe, life-threatening allergies to influenza vaccine or any ingredient in the vaccine should NOT receive the influenza vaccine. Such ingredients might include gelatin and antibiotics. See Special Considerations Regarding Egg Allergy for more information about egg allergies and influenza vaccine.

2.5 People who should talk to their health care provider before getting the flu vaccine

If a resident or staff have one of the following conditions, consult a healthcare provider before administering the vaccine.

- Allergy to eggs or any of the ingredients in the vaccine. See Special Considerations Regarding Egg Allergy for more information about egg allergies and flu vaccine.
• History of Guillain-Barré Syndrome (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get a flu vaccine.

If the person is not feeling well, discuss symptoms with healthcare provider.

3.0 Background/History

CDC recommends getting a flu vaccine by September or October. However, getting vaccinated any time during the flu season can help protect staff and residents and reduce the spread of influenza in the long-term care settings. Staff and residents who meet the eligibility criteria to get vaccinated are encouraged to do so. They also have the right to refuse the influenza vaccine.

Due to the COVID-19 pandemic, reducing the spread of respiratory illnesses, such as the flu, is especially important during this flu season.

Protective measures used for COVID-19 such as physical distancing, use of face masks, and frequent handwashing should be maintained and adhered to as we progress through influenza season.
Guidance for Activities, Dining, and Volunteers

Date Issued: November 20, 2020

Subject and Purpose

This provider letter outlines provider responsibilities for resident activities, including communal dining and holiday-related activities. This provider letter also gives specific stipulations on the use of volunteers and guidance on protocol for residents who leave a facility. This guidance can be used as a general reference through the duration of the public health emergency, the COVID-19 pandemic.

Policy Details & Provider Responsibilities

Facilities can offer facility-coordinated group activities and communal dining services, as well as allow volunteers to enter the facility. Volunteers must adhere to infection control principles, screening requirements, and testing requirements, where applicable, in accordance with the emergency rules. Additionally, facilities must assist residents in making any decision to leave the facility.

Infection Control and Prevention Principles

The CDC, CMS, and HHSC outline principles of COVID-19 infection control and prevention. These guidelines apply to all group activities, communal dining, and anyone who enters the facility as a staff member, visitor, volunteer, or provider of an essential service. These infection prevention and control measures include the following:

• All persons who enter the facility are screened for signs and symptoms of COVID-19;

• Frequent hand hygiene (use of alcohol-based hand rub is preferred when hands are not visibly dirty);

• Use of face covering or facemask (facemask necessary for all visitors; resident may wear a facemask or cloth facial covering as tolerated);

• Maintenance of physical distancing of at least six feet per program guidance and as applicable for the task or situation;

• Instructional signage posted throughout the facility with specified entries, exits, and routes to designated areas, including spaces for visitation, along with specific parts of the facility dedicated to resident cohorts based on COVID-19 status;
• Frequent cleaning and disinfection of shared areas;

• Education on COVID-19 signs and symptoms, infection control precautions, and other applicable facility practices;

• Appropriate use of personal protective equipment (PPE); and

• Effective cohorting of residents within separate areas based on COVID-19 status (negative, positive, and unknown).

Facilities must operationalize Infection Control and Prevention Principles and should consider all available resources when planning group activities and utilizing volunteers.

Screening

Each provider must screen all residents, staff, and anyone else who enters the facility, for the following criteria, before entering the facility:

• fever defined as a temperature of 100.4 Fahrenheit and above;

• signs or symptoms of COVID-19, including chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea;

• additional signs and symptoms as outlined by the Centers for Disease Control and Prevention (CDC) in Symptoms of Coronavirus at cdc.gov;

• contact in the last 14 days, unless to provide critical assistance, with someone who has a confirmed diagnosis of COVID-19, is under investigation for COVID-19, or is ill with a respiratory illness; and

• has a positive COVID-19 test result from a test performed in the last 10 days.

Anyone who does not pass screening must immediately leave the facility campus.

Facility-Coordinated Group Activities

Facility-coordinated group activities, including holiday-related group activities, are limited to residents who are COVID-19 negative and residents who have recovered from COVID-19 according to the CDC’s criteria for the discontinuation of transmission-based precautions. Residents with an active COVID-19 infection and residents with unknown COVID-19 status must be excluded from participating in group activities.

Facilities can utilize volunteers as essential workers, or contract with other persons or entities ("activity contractors"), to host or assist with facility-coordinated group activities, including holiday-related group activities. Volunteers and activity
contractors entering the facility must adhere to the Infection Control and Prevention Principles. Section 2.5 outlines other requirements related to the utilization of volunteers.

Governor Abbott’s Executive Order No. GA-30 limits the amount of people allowed for group activities to 10 people. For long-term care facilities, this limit applies to the people providing a group activity (volunteers and activity contractors), not the number of residents attending the activity. Additionally, the limit does not apply to religious services held at a facility. However, infection control and prevention principles must be followed in all cases, including maintaining social distancing.

While the 10-person limit does not apply to facility residents, the facility must limit the number of residents participating in any given activity to allow for physical distancing between all activity participants, adherence to the infection control guidelines, and ensure the safety of the residents. The facility can limit the number of people participating in an activity based on the status of COVID-19 infections in the facility.

The facility must limit participation in group activities to residents and those individuals who entered into an agreement with the facility to host or otherwise assist in that facility-coordinated activity (volunteers and activity contractors). Resident visitors, including essential caregivers, cannot participate in group activities unless they are hosting or assisting in the specific facility-coordinated activity as a volunteer. Visitors, including essential caregivers, hosting or assisting a facility-coordinated activity would be considered a volunteer or essential worker and would have to meet the requirements for volunteers as described in this provider letter.

Dining

Communal Dining

Residents can participate in communal dining. However, communal dining is limited to residents who are COVID-19 negative and residents who have recovered from COVID-19 according to the CDC’s criteria for the discontinuation of transmission-based precautions. The Infection Control and Prevention Principles, including physical distancing of at least 6 feet between residents, still apply. The number of residents permitted for any dining activity or in any dining space will depend on the specifics of the facility and space available to allow for physical distancing between all residents. Facilities can consider additional limitations on dining based on the status of COVID-19 infections in the facility.

Food-Delivered by Essential Caregiver Visitors

An essential caregiver can personally bring outside food and drink to a resident during a visit. Essential caregivers are not required to maintain a distance of 6 feet between themselves and the resident they are visiting. A resident can eat or drink during an essential caregiver visit. However, essential caregivers cannot eat or
drink during the visit with a resident because essential caregivers are required to wear a facemask over their nose and mouth throughout the entire visit.

Food Delivered by Other Visitors

Visitors other than essential caregivers can bring outside food and drink for a resident during a visit but must drop off the meal or food item in a designated delivery area, as determined by the facility. A resident can eat or drink during a visit. However, a visitor cannot eat or drink during the visit because visitors must wear a facemask over their nose and mouth throughout the entire visit.

Food Delivered by Other Persons

A resident can receive outside meals or food items delivered by persons other than a visitor. Facilities must designate an outside area for food and other items to be delivered. Facility staff must bring the delivered food from the designated outside area to the resident. Facilities should refer to CDC guidance for handling deliveries.

Volunteers

Facilities can use volunteers as essential workers to provide supplemental tasks to the facility (e.g., monitoring visits between residents and family members, escorting essential caregivers, assisting with cleaning and sanitizing). Volunteers who enter a facility to provide supplemental tasks must receive training on infection prevention and control standards and all other training provided to volunteers prior to the COVID-19 public health emergency (such as identifying and preventing abuse, neglect, and exploitation). The facility can use people who volunteered at the facility before the COVID-19 public health emergency, but the facility must provide training on COVID-19 infection prevention and control standards. The facility cannot rely on volunteers in lieu of paid staff to fill required staff positions and perform direct care services.

Facilities also can use volunteers to host or assist with facility-coordinated group activities (e.g., high school choir, bingo with residents, book club). Volunteers who only enter a facility to host or assist with facility-coordinated group activities must receive training on infection prevention and control standards. A volunteer cannot eat or drink while assisting with group activities or communal dining because volunteers must wear a facemask over their nose and mouth at all times.

Volunteers must pass all screening requirements, as outlined above, and must be overseen by facility staff. Volunteers must also adhere to the same PPE requirements as staff. Volunteer testing requirements are described in section 2.6.

Facilities should execute a written agreement with all volunteers documenting training requirements and facility policies regarding infection prevention and control standards.

Testing for COVID-19

ALFs can develop a testing strategy for staff, volunteers, and other individuals performing supplemental tasks or facility-coordinated activities who regularly come-
to the facility under this arrangement. Volunteers, and other individuals performing supplemental tasks or facility-coordinated activities under this arrangement, are considered staff. To determine testing frequency, facilities should consider factors such as the frequency of activities, frequency of volunteer visits, county positivity rate, and other factors specific to their facility.

Unless the resident is symptomatic, routine testing of residents in an ALF is not recommended. Each ALF must screen residents at least twice a day.

Volunteers, and other individuals performing supplemental tasks or facility-coordinated activities, who tests positive for COVID-19 or develops signs and symptoms of COVID-19 within 48 hours of visiting the facility is considered an outbreak in the facility. According to the CDC, for a resident, visitor, or staff with confirmed COVID-19 who developed symptoms, the exposure window is considered to be 2 days before symptom onset. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test. ALFs should consult with their local health department for assistance with determining the date of exposure.

Residents Who Leave the Facility

Residents who live in an ALF have the right to participate in activities of social, religious, or community groups. Facilities must educate the resident on the risks associated with different activities. If a resident makes an informed decision to leave the facility, the facility must educate the resident (and resident’s family if possible) about infection control and prevention procedures, including:

- wearing a facemask or face covering, if tolerated for the resident;
- performing hand hygiene;
- cough and sneeze etiquette;
- physical distancing (maintaining at least six feet of distance between themselves and others);
- being aware of others who potentially could have COVID-19 or are confirmed to have COVID-19; and
- reporting to the facility any contact with another person who potentially has COVID-19 or is confirmed to have COVID-19.

For residents who leave a facility to go out into the community, the facility will have to determine whether the resident meets any of the criteria for “unknown COVID-19 status,” which include.
• spending one or more nights away from the facility;
• having exposure or close contact with a person who is COVID-19 positive;
and
• having exposure or close contact with a person who is exhibiting symptoms of COVID-19 while awaiting test results.

If the resident meets any of these criteria, the resident will need to be placed in a 14-day quarantine upon return to the facility.

A resident who leaves the facility, is not gone overnight, and did not have contact with others who potentially has COVID-19 or is confirmed to have COVID-19, does not have to be quarantined upon returning to the facility. This is regardless of a resident’s means of transportation.

If a resident returns on the same day, the facility should discuss with the resident (or their visit companion) what activities occurred while the resident was outside the facility, using the following questions as a guide:

• Were you in any crowded spaces whether that be in public or at a large household gathering?
• Were you in any situation where you were unable to maintain a physical distance of at least 6 feet from someone who was not wearing a facemask, (excluding mealtimes) when you were in out in public or visiting with others in a household?
• Did you encounter anyone who tested positive for COVID-19 within the last 14 days or who does not yet meet CDC end of isolation criteria?
• Did you encounter anyone who was exhibiting any symptoms related to COVID-19 whether that be in public or at a household gathering?

A “yes” to any of these questions should be further investigated. Ask the resident or their visit companion the following questions to help determine if exposure occurred:

• If you attended a gathering at a family member or friend’s household, how many others attended? Was the gathering mostly indoors or mostly outdoors? Did attendees maintain physical distancing, wear facemasks, or practice other infection control measures such as proper hand hygiene?

• If you came in close contact with someone at a household gathering who was not wearing a face mask or practicing other infection control procedures, how long did that close contact occur?

• Did attendees at the household gathering maintain physical distancing during mealtimes, when they were unable to wear a facemask?
If the facility determines that a resident who left the facility and returned the same day requires a 14-day quarantine, the facility must document the decision and its rationale.

As a reminder, facilities must include in their infection prevention and control plans protocols for expanding quarantine areas as needed to accommodate an increase in unknown COVID-19 status residents. See the ALF COVID-19 Response Plan for guidance related to using shared rooms for unknown COVID-19 residents, if necessary.

Background/History

Facility coordinated group activities and communal dining, as well as the use of volunteers, has been restricted for long-term care residents during the COVID-19 pandemic. These types of activity and socialization are essential to resident well-being as the pandemic continues. This guidance aims to achieve a balance between the safety and well-being of residents and staff in long-term care facilities, while also preventing the potential spread of COVID-19 in the facility. <deleted>
1.0 Subject and Purpose

This provider letter has been revised to update the link for the BinaxNOW training for ALF staff who will be administering the COVID-19 BinaxNOW tests. This letter describes the process to request distribution of a limited number of free BinaxNOW COVID-19 point of care (POC) antigen test kits under limited circumstances to certain ALFs. The limitations in place are designed to help the Texas Health and Human Services Commission (HHSC) and the Texas Division of Emergency Management (TDEM) prioritize requests.

This initiative is new and unrelated to the antigen machines or the Centers for Medicare and Medicaid Services (CMS) distributions of BinaxNOW COVID-19 test kits.

2.0 Policy Details & Provider Responsibilities

To request consideration for the free BinaxNOW POC antigen COVID-19 test kits, an ALF must complete the Attestation for Free Test Kits (LTCR Form 2198) template applicable to ALF providers. An ALF provider must submit the completed attestation to the HHSC Regional Director or designee for the region in which the ALF is located.

The Regional Director or designee will elevate the completed attestation form to the State Operations Center in TDEM. Staff from HHSC Long-term Care Regulation (LTCR) and the TDEM will review the completed attestation form for accuracy and completeness. Staff may require and request documentation from the ALF to support the attestation.

2.1 Eligibility

The attestation criteria require an ALF to:

- be located in a county where the COVID-19 positivity rate is greater than 10% and in a rural area where there are limited free test sites available;
- have a current Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver or a CLIA laboratory certificate;
- only use the test kits to test essential caregivers;
- administer the test only by ALF staff who successfully complete training.
provided by Abbott Laboratories or who are clinicians with appropriate education and training;

- follow all reporting requirements associated with the use of the Binax cards;
- report test results appropriately;
- not be part of a large corporation; and
- continue to seek out community resources to secure testing.

The term essential caregiver means a family member or other outside caregiver, including a friend, volunteer, private personal caregiver or court appointed guardian, who is at least 18 years old and has been properly designated to provide regular care and support to the resident. The definition of essential caregiver does not include other persons providing critical assistance to the resident, such as contract doctors, clinical professionals, etc.

Typically, the term large corporation means 20 or more facilities or agencies in the State of Texas.

If an ALF does not meet the free kit criteria in the attestation but would like to request consideration, the ALF must describe the circumstances warranting consideration in the appropriate section of the attestation template. HHSC and TDEM will evaluate the request on a case-by-case basis.

2.2 CLIA Waivers

An ALF must have a current CLIA Certificate of Waiver or a CLIA laboratory certificate before it can receive and administer the free BinaxNOW COVID-19 tests. To obtain a CLIA Certificate of Waiver for the free BinaxNOW COVID-19 tests, complete Form CMS-116 available on the CMS CLIA website or on the HHSC Health Care Facilities Regulation - Laboratories webpage found under the Application header. Email the form to the regional CLIA licensing group via the HHSC HCF Regulation – Laboratories webpage.

ALFs that have existing CLIA Certificates of Waivers and are using a waived COVID-19 test are not required to update their CLIA Certificates of Waiver. As defined by CLIA, waived tests are categorized as “simple laboratory examinations and procedures that have an insignificant risk of an erroneous result.” The Food and Drug Administration determines which tests meet these criteria when it reviews a manufacturer’s application for a test system waiver.

For more specific guidance on the Certificate of Waiver application process, refer to HHSC COVID-19 provider letters and frequently asked questions (FAQs) applicable ALFs.

2.3 Reporting COVID-19 Test Results

ALFs performing the BinaxNOW COVID-19 testing authorized in this provider letter must report test results (positive, negative, or indeterminate) for each tested essential caregiver.
If an essential caregiver tests positive but is not allowed exposure to a resident or client, then the ALF would not report it as exposure. The ALF would still need to report the test results.

See provider letter 20-37, Reporting Guidance for Long-term Care Providers, for reporting instructions.

For more specific guidance on the reporting requirements, refer to HHSC COVID-19 Texas Administrative Code rules, provider letters and FAQs applicable to ALFs.

3.0 Background/History

In October 2020, the State of Texas began receiving a limited supply of BinaxNOW COVID-19 POC antigen test kits to distribute to providers under limited circumstances.

4.0 Resources

LTCR Form 2198, Attestation for Free Test Kits
Attachment 14 Long-Term Care Regulation Provider Letter PL 20-46 (Revised)

PL 20-46 (Revised): Reporting Guidance for Long-Term Care Providers – Point-of-Care Antigen Testing (texas.gov)

Reporting Guidance for Long-Term Care Providers – Point-of-Care Antigen Testing

Date Revised: November 30, 2020

1.0 Subject and Purpose

This provider letter outlines responsibilities related to reporting COVID-19 test results for providers conducting point-of-care (POC) antigen tests within their facilities. This letter is not intended for use by ALFs who do not conduct COVID-19 POC tests within their facility. ALFs who do not conduct COVID-19 POC tests within their facility can refer to PL 20-37.

2.0 Policy Details & Provider Responsibilities

ALFs conducting a COVID-19 POC antigen test within their facilities must apply for a CLIA waiver and comply with all applicable reporting requirements. The following sections describe each requirement.

2.1 CLIA Waivers

ALFs purchasing or receiving POC antigen test kits for COVID-19 will need to obtain a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver before any testing can be conducted. Additionally, ALFs without a CLIA Certificate of Waiver are encouraged to apply so that they may participate in any future testing initiatives should they occur. ALFs can apply for a CLIA waiver by filling out Form CMS-116 and sending it to the regional CLIA licensing group for the zone where the ALF is located.

2.2 Reporting COVID-19 Test Results:

ALFs offering POC antigen testing related to COVID-19 must report data for all testing completed, for all test results (positive, negative or indeterminate), and for each individual tested (residents and staff). A facility must report the test results within 24 hours of the results being known or determined, on a daily basis. For days that a ALF does not conduct any tests, the ALF would not have to submit a report.

2.2.1 Reporting to NHSN

Reporting antigen test results through the National Healthcare Safety Network (NHSN) is optional for ALFs.
The Texas Department of State Health Services (DSHS) receives test result data from NHSN, which means that facilities fulfill the state requirement to report test result data to DSHS by reporting test result data to NHSN. However, NHSN does not report to local health departments; facilities reporting test result data to NHSN must still report test data to their local health department. Reporting antigen test results through NHSN requires Level-3 SAMS access. Providers must report antigen test results to DSHS while awaiting approval for Level-3 SAMS access in NHSN.

ALFs choosing to report test data through the NHSN should follow the 5-step Enrollment for Long-term Care Facilities instructions before applying for Level-3 SAMS Access.

Applying for Level-3 SAMS access: To submit antigen test result data to NHSN, employees responsible for reporting must complete the Secure Access Management Services (SAMS) identity verification process to be migrated to a level-3 SAMS access in NHSN. The identity verification process is available at this link: https://www.cdc.gov/nhsn/ltc/covid19/sams-access.html. Each employee who submits testing data must complete the process to be migrated to a level-3 SAMS access.

2.2.2 Reporting to DSHS

The following steps outline what is needed to begin reporting to DSHS. Reporting test result data to DSHS is required for all facilities that do not report test result data through NHSN. Once you have CLIA or a CLIA waiver:

1. Register here: https://www.dshs.state.tx.us/coronavirus/forms/registerlab.aspx
2. Submit the online registration webform.
3. Complete DSHS onboarding process.
4. Submit required testing data to DSHS.

DSHS is considering alternative solutions for registering and onboarding that would create a more simplified, streamlined method for uploading electronic lab results. Facilities that have made every attempt to register with DSHS but are unable to complete the registration must keep all test-result documentation until the ALF is able to submit the testing data. Once the ALF successfully registers via the DSHS reporting system (or alternative method created by DSHS), the ALF will then submit all previous testing result data.

Facilities can contact DSHS at COVID-19ELR@dshs.texas.gov with any questions related to registration or reporting through DSHS.

2.2.3 Reporting to the Local Health Department
All facilities conducting COVID-19 antigen tests must report test result data to their local health department (LHD) or to the DSHS Region if there is not a local health department.

5. Locate the LHD or DSHS Region for the area in which the ALF is located: [https://www.dshs.texas.gov/regions/2019-nCoV-Local-Health-Entities/](https://www.dshs.texas.gov/regions/2019-nCoV-Local-Health-Entities/)

6. The LHD or DSHS region will inform providers of any required reporting forms and processes.

7. The required data is submitted to the LHD or DSHS Region for the area in which the facility is located, using the forms and processes indicated.

2.2.4 Reporting Confirmed Cases & Additional Reporting Information for all ALF Providers

In addition to reporting requirements related to COVID-19 POC antigen test results, ALFs must adhere to the reporting requirements outlined in PL 20-37.

3.0 Background/History

CMS began shipping POC antigen test kits to NFs with a CLIA waiver or CLIA certificate in July 2020. ALFs have also received POC antigen test kits, and therefore a CLIA waiver is also required. POC antigen tests quickly detect fragments of proteins found on or within the virus by testing samples collected from the nasal cavity using swabs.
COVID-19 Vaccination Reporting

1.0 Subject and Purpose

This letter was revised to include the link to the vaccination data survey and to clarify that facilities are to report vaccinations administered by a facility or a pharmacy partner. To assist the Texas Department of State Health Services, the Texas Department of Emergency Management, and the Office of the Governor in ensuring the vaccination of long-term care provider staff and residents who choose to be vaccinated, HHSC is requiring NFs and ALFs to report vaccinations.

2.0 Policy Details & Provider Responsibilities

In accordance with emergency rules, facilities must report the following data to HHSC within 24 hours of completing a round of vaccinations:

- Aggregate numbers of staff, including employees, contractors, and volunteers, who received their first dose of a two-dose COVID-19 vaccine or their only dose of a single-dose COVID-19 vaccine when available;
- Aggregate numbers of staff, including employees, contractors, and volunteers, who received their second dose of a two-dose COVID-19 vaccine;
- Aggregate numbers of residents who received their first dose of a two dose COVID-19 vaccine or their only dose of a single-dose COVID-19 vaccine when available; and
- Aggregate numbers of residents, who received their second dose of a two-dose COVID-19 vaccine.

2.1 Reporting Guidance

- **Method:** HHSC has developed a Survey Monkey tool to collect this information. HHSC sent out an alert containing the survey link on January 12 and the link is posted on the NF and ALF provider portals under the COVID-19 resources accordion. You can also access the survey at [https://www.surveymonkey.com/r/SRDM2GY](https://www.surveymonkey.com/r/SRDM2GY).
- **Multiple provider types/locations:** Submit a separate survey for each provider type and building. For example, a single building that includes a NF and an ALF would submit separate surveys for each type. A provider that owns multiple licenses would submit separate surveys for each license.
• **Frequency:** Complete the survey only when you have information to report, i.e., when a round of vaccines is administered to staff or residents. On days when no vaccines are administered, you do not need to complete the survey. *Note: If reporting vaccination rounds that occurred previously, complete a separate survey by date for each separate round.*

• **First report:** If a round of vaccinations was administered between your last report to HHSC and the effective date of this letter, submit a report to capture those vaccinations.

• **Parameters:** Reports are for a given round of vaccinations administered by the facility or a pharmacy partner. Do not provide cumulative numbers. In other words, do not include totals from previous reports in a new report. Only report vaccinations occurring onsite at the facility; do not include vaccinations that occurred at an off-site pharmacy, doctor’s office, local mass vaccination clinic, etc.

• **Item-by-item guidance:**
  
  o **Questions 1–4:** Demographic information required includes the name of the provider, the physical address of the building, the license number, and the provider type. Do not use a mailing address or corporate address.

  o **Question 5:** Check all that apply. Some facilities have directly received the vaccine and are storing it at the facility, while others have partnered with another entity that receives and stores the vaccine (such as a pharmacy). Some facilities use facility staff to administer the vaccine, while others have partnered with another entity to administer the vaccine. If the facility neither stores or administers vaccine, check none of the above.

  o **Question 6:** Facilities that indicated that they received vaccines directly on question #3 must indicate how many individual doses of COVID-19 vaccine they received. *Note: Do NOT report the number of vials.*

  o **Questions 7–8:** Indicate which round of vaccinations you are reporting and the date on which the vaccines were administered. *Note: If reporting vaccination rounds that occurred previously, complete a separate survey by date for each separate round.*

  o **Question 9:** Report the number of staff vaccinated on the date and round being reported. Include provider employees as well as contractors, volunteers, and others under the provider’s control. Report the number of residents vaccinated on the date and round being reported. Enter only the number; do not enter personally identifiable information.
2.2 Reporting of Data

Providers must report the vaccination data to HHSC within 24 hours of completing a round of vaccinations. HHSC may initiate status calls to providers who are not reporting vaccinations to assess provider needs.

2.3 Training

HHSC will provide training on this letter during regularly scheduled COVID-19 Q&A webinars. We will also provide a stand-alone webinar. We will send alerts notifying providers of dates, times, and registration links for these webinars. The webinars will be recorded, and recordings posted to the HHSC website.

3.0 Background/History

Accurate reporting will assist the State of Texas in ensuring full deployment of COVID-19 vaccines during the public health emergency. Future revisions to this letter will include direction on responding to special situations, such as changes of ownership and new licenses.
Attachment 16 Long-Term Care Regulation Provider Letter PL 2021-04

Provider Letter 2021-04 HHSC COVID Reporting (texas.gov)

HHSC COVID-19 Reporting Process

1.0 Subject and Purpose

This letter clarifies the triggering events and process for providers to report positive COVID-19 cases to the Texas Health and Human Services Commission (HHSC). The process is described, along with all other federal and state COVID-19 reporting requirements, in PL 2020-37.

2.0 Policy Details & Provider Responsibilities

ALFs are required to report to HHSC Complaint and Incident Intake (CII) within 24 hours of:

- a facility’s first positive case of COVID-19 in a resident or staff member, or
- a new positive case of COVID-19 in a resident or staff member after a facility has been without a new case of COVID-19 in a resident or staff member for 14 days or longer.

Do not report COVID-19 positive cases to HHSC CII outside of the two reportable events listed above. A facility must not report any additional COVID-19 positive cases to HHSC CII after the first positive case has been reported, unless the facility has been COVID-19 free for 14 days. Additionally, the reportable events listed above do not include a resident who was admitted to the facility with an active COVID-19 infection or a resident who developed COVID-19 within 14 days of being admitted to the facility. A decision tree is attached to this provider letter.

HHSC LTCR Regional Offices may contact facilities to request information related to COVID-19 cases. Reporting to a LTCR Regional Office is not related to reporting COVID-19 positive cases to HHSC CII.

Please note that the triggering events for each federal and state COVID-19 reporting requirement might differ. Refer to PL 2020-37 and PL 2020-46 for other federal and state COVID-19 reporting requirements.

If a facility has a new reportable COVID-19 positive case, and has not reported a COVID-19 positive case to HHSC within the past 14 days, the facility must:

- report the case to HHSC CII using one of these three methods: the Texas Unified Licensure Information Portal (TULIP), by email to ciicomplaints@hhsc.state.tx.us or by calling 1-800-458-9858 within 24 hours of the confirmed positive result; and
- complete and submit Form 3613-A Provider Investigation Report within five days from the day a confirmed case is reported to CII. The provider investigation report
can be submitted via TULIP, by email to ciprovider@hhsc.state.tx.us, or by fax to 877-438-5827.
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