



TEXAS

Health and Human Services

COVID-19 RESPONSE FOR LONG-TERM CARE FACILITIES

Abstract

This document provides guidance to Long-Term Care Facilities on Response Actions in the event of a COVID-19 exposure.

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I. Purpose:

The purpose of this document is to provide Long-Term Care facilities (LTCFs) with response guidance in the event of a positive COVID-19 case associated with the facility.

II. Goals:

- Rapid identification of COVID-19 situation in a LTCF
- 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 LTCF COVID-19 event

III. Summary:

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.

IV. Description of a Nursing Facility:

A nursing facility (NF) provides institutional care to people whose medical condition regularly requires the skills of licensed nurses. NF services are available to people who receive Medicaid assistance or those who wish to private pay for their care. The NF must provide for the needs of each resident, including room and board, social services, over-the-counter medications, medical supplies and equipment, and personal needs items.

A skilled nursing facility (SNF) is a special facility or part of a hospital that provides medically necessary professional services from nurses, physical and occupational therapists, speech pathologists and audiologists. SNFs provide round-the-clock assistance with health care and activities of daily living. SNFs are used for short-term rehabilitative stays after a resident is released from a hospital.

A hospital-based SNF is located in a hospital and provides skilled nursing care and rehabilitation services for people who have been discharged from that hospital but who are unable to return home right away. They do not accept general admissions.

V. LTCFs and COVID-19

Environment:

A NF is typically a mix of semi-private and private resident bedrooms; the majority of the bedrooms are semi-private, housing two to four people. The bedrooms usually do not have physical barriers like walls or partitions separating the space allotted for each resident inside the room. Rules require a minimum of 100 square feet for a private (one person) bedroom, 80 square feet per person in multiple occupant rooms, and a minimum dimension of 10 feet. Many of the common areas in a NF are intended for use by groups of people. These areas include dining and living room spaces, activity and therapy areas, and common bathing units, which are provided at a ratio of one tub or shower for every 20 residents.

Impact of environment on COVID-19 response:

A typical NF is not physically designed to effectively support social distancing measures, while at the same time housing numerous residents who might require quarantine measures including isolation. The limitations of the physical environment mean many of the protective measures required to limit potential exposure and spread must be accomplished by staff who are already working under extreme conditions. NF rooms can promote social distancing in a variety of ways. For example, dining and activities can take place in resident rooms and when able, residents can participate in medication passes while remaining in their doorways. Current Centers for Medicare and Medicaid Services (CMS) and state guidance for NFs state communal activities, including dining, should be canceled, and no more than 10 people, maintaining at least 6 feet of separation, be in a room at any time. Meals can be served in the dining room for residents who require assistance with feeding if social distancing is practiced.

Facility Demographics:

NFs are located in metropolitan, urban and rural locales. Each locale has specific characteristics that impact workforce availability, health care system support, and interactions with public health, emergency care, and

jurisdictional administration. There are currently 1,211 free-standing NFs and nine Maintain Patient Care hospital-based SNF units in Texas.

Impact of facility demographics on COVID-19 response:

NFs in more densely populated locations are likely to experience higher risk for exposure among staff and visitors. As a result, facilities in metropolitan and urban areas have a higher risk of infection and face more challenges controlling spread when there is infection. They are also more likely to face staffing shortages because of competitive job markets. NFs in more rural locations have less health care system support, might not have local health authorities, and have smaller staffing pools making it harder to cover shortages that result from suspected exposure. Facilities in rural areas might also be more challenged to find equipment, such as PPE and ventilators, necessary to care for COVID-19 positive residents.

Facility Considerations:

Facilities might have small, medium or large bed capacity within buildings differing in age, size, available space and equipment. Available services also differ by facility, impacting the level of available care; ventilator support might not be present, and the types of health care providers on-site will also vary.

Impact of facility considerations on COVID-19 response:

There are NFs with limited, or no isolation rooms available. Statewide, there are approximately 30 NFs equipped to care for residents on ventilators. Bed capacity (along with staff and PPE availability) also impacts the number of residents for which each facility can care. COVID-19 positive residents will increase the staff and resources required to provide care further limiting the number of residents for which a facility can care.

Resident Demographics:

All NF residents must meet medical necessity to reside in a NF. While all have medical needs, each resident is unique and might require rehabilitation services, minimal supportive care or significant medical care. Resident conditions will vary physically and mentally impacting mobility and intellectual capacity.

Impact of resident demographics on COVID -19 response:

All NF residents are in need of care from medical professionals who are in increasingly short supply as the pandemic continues. Also, the subpopulation of residents with dementia and Alzheimer's disease are often unable to express when they experience symptoms and could unknowingly (and without staff knowing) spread the virus if infected. This population is also less likely to understand why social distancing and quarantine are necessary and can present challenging behaviors when staff attempt to enforce such restrictions. Other subpopulations require specialized medical care, including specialized diets, ventilator care, gastronomy (feeding) tubes and wound care for pressure sores. These specialized needs require a combination of skilled and non-skilled caregivers. Having COVID-19 infections in a facility will increase the demands on and for staff.

NF Staffing Considerations:

The NF workforce includes medical professionals and direct care staff including: registered nurses (RNs), licensed vocational nurses (LVNs), certified nurse aides (CNAs), medication aides, respiratory therapists, facility support staff and other skilled and non-skilled workers. Rules require NFs to provide nursing services at a ratio of not less than one licensed nurse for every 20 residents, or a minimum of 0.4 licensed-care hours per resident per day.

Impact of NF staffing considerations on COVID-19 response:

Many NF residents' daily activities such as dining, bathing, grooming and ambulating require partial or total assistance from facility staff. Caring for someone with COVID-19 requires additional time and resources, including PPE, that maintain infection control and protect other residents and staff. As staff are exposed, become symptomatic or test positive for COVID-19, the available workforce will decline making it even more challenging for NFs to provide care. Additionally, NFs don't normally have a physician on-site. Typically, there is an RN and several LVNs and CNAs on staff. Staffing shortages resulting from possible exposure could lead to NFs refusing to admit residents because they won't have the ability to provide care. It is also common for NF staff to work in more than one NF, so if an employee is exposed, it is likely they will expose residents and staff in more than one NF, making it difficult to contain spread. An NF should follow CMS guidance (released April 2, 2020) related to NF staffing.

Visitors:

During routine NF operations, visitors including family members, volunteers, consultants, external providers and contractors routinely enter facilities. Many perform essential services necessary for facility function, or in the case of service providers such as hospice and dialysis staff, they provide services critical to resident care. It is important to note current CMS and state guidance to NFs requires they limit visitors to only those who are providing critical assistance.

Impact of visitors on COVID-19 response:

Despite efforts to screen visitors prior to allowing them to enter the facility, every person allowed inside the building increases the risk of infection. Some people will present as asymptomatic during screening but will have COVID-19 and unknowingly spread the virus. Some visitors will not follow standard precautions including proper hand-washing, use of hand sanitizer, use of PPE, isolation protocols, and limiting the number of areas in the building that they access, all of which increase the risk of infection for residents and staff.

VI. To Do's for Nursing Facilities:

- Review resident isolation/quarantine plans with staff.
- Review handwashing, surface cleaning and other environmental hygiene precautions with staff.
- Report every confirmed COVID-19 case to the local health department or DSHS and HHSC.
- Obtain and properly use PPE.
- Comply with all CMS and CDC guidance related to infection control (NF's need to frequently monitor CDC and CMS guidance as it is being updated frequently. This will ensure the NF is operating off the most current guidance).
- For the duration of the state of emergency, all NF personnel should wear a facemask while they are in the facility.
- Actively screen, monitor and surveil everyone who comes into the facility.
- To avoid transmission within facilities, NFs should use separate staffing teams for COVID-19-positive residents to the best of their ability, and work with state and local leaders to designate separate facilities or units within a facility to separate COVID-19-negative residents from COVID-19-positive residents and people with unknown COVID-19 status.
- Quarantine residents with exposure or symptoms.
- Isolate residents with positive cases.
- Clean and sanitize the facility when there is a positive case.
- Coordinate resident diagnoses and symptoms with transferring and receiving hospitals and other NFs.

- Communicate with residents, staff and family when there is exposure, suspected and confirmed cases in the facility.
- Keep an up-to-date list of all staff who work in other facilities.
- Require staff self-monitoring on days they work and on days they don't work.
- Require staff to report via phone prior to reporting for work if they have known exposure or symptoms.
- Post a list of state contacts where it is visible on all shifts.

VII. S.P.I.C.E.

Recognizing notification of a potential COVID-19 situation in a facility can result in disorientation, questions and confusion; this document suggests NFs focus on the following five basic actions (S.P.I.C.E.) to anchor activities:

- **S**urveillance – monitor for symptoms: fever, cough, shortness of breath and difficulty breathing for each resident at least once each shift
- **P**rotection/PPE – protection of workforce and residents through soap/water; hand sanitizer; facemask; If coughing or potential splash precautions are needed, wear a gown and face/eye shields. Refer to DSHS guidance
- **I**solate – residents with suspected and confirmed cases need to be isolated
- **C**ommunicate – call local health department/authority or DSHS and HHSC
- **E**valuate – infection control processes, spread of infection and mitigation efforts, staffing availability

S.P.I.C.E. is not meant to be all-encompassing. It is suggested to assist initial actions and be a reminder of necessary activities.

VIII. HHSC Long-term Care Regulatory Activities with NFs that have Positive COVID-19 Cases

For every report of a positive COVID-19 test (resident or staff) in a NF, the following will happen:

- Verify the NF is prohibiting non-essential visitors.
- Generate a priority 1 intake (must be investigated within 24 hours) for 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 suspected or positive for COVID-19.
- Determine the number of staff suspected or positive for COVID-19.
- Review facility isolation precautions and determine how residents are isolated in the facility (dedicated wing, private room) to ensure compliance with requirements.
- Determine if facilities have sufficient amounts of PPE.
- Determine if facilities 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 control or quarantine order.
- Ensure the control/quarantine orders are followed.
- Perform a call-down to all other facilities in the county when staff at one facility test positive for COVID-19.
- Determine if facilities are following rules and regulations related to admission and discharge and are readmitting residents when appropriate.
- Determine if staff, residents, and families are notified of positive COVID-19 cases in the facility.
- Track facilities by program type and number of positive and suspected cases.
- Track hospitalizations of COVID-19-positive NF residents.
- Track deaths of COVID-19-positive NF residents.
- Maintain communication with facilities after investigations are complete to obtain updates.

IX. Facility Activities Required for LTC COVID-19 Response

In Advance (actions focused on response)

- Review/create cohort plans for patients
- Review Health Care Associated Infection (HAI) plan
- Determine/review who is responsible for specific facility plans
- Identify desired applicable waivers
- Develop Communication Plan (external and internal)
- Conduct supply/resource evaluation
- Enact patient/staff/visitor screening

Immediate (0-24 hours)

- Activate patient Isolation/facility cohort plan
- Supply PPE to care for positive patients
- Screen patients for signs and symptoms
- Screen staff for signs and symptoms

- Enact HAI procedures
- Conduct decontamination
- Confirm case definitions
- Identify health care worker (HCW) outside activities
- Activate patient transport (patients out) protocols
- Establish contact with receiving agencies (hospitals, other facilities)
- Identify lead at facility and determine stakeholders involved external to facility
- Engage with community partners (public health, health care, organizational leadership, local/state administrators)
- Review/establish testing plan
- Activate all communication plans
- Determine need for facility restrictions/lock-down
- Supply resource evaluations
- Maintain patient care

Extended (24-72 hours)

- Supply PPE for HCWs, staff
- Screen patients for signs and symptoms
- Continue specialized HAI procedures
- Activate patient transport (patients out/in) protocols
- Establish contact with transporting/receiving agencies (hospitals, other facilities)
- Engage with external partners
- Testing
- Determine need for facility restrictions/lock-down
- Consider occupational medicine needs
- Maintain patient care

Long Term (72 hours plus)

- Screen patient for signs and symptoms
- Continue decontamination procedures
- Activate patient transport (patients in) protocols
- Establish contact with transporting/receiving agencies (hospitals, other facilities)
- Lift of facility restrictions
- Consider occupational medicine needs
- Maintain patient care

X. State\Regional\Local Support

Texas Health and Human Services Commission (HHSC) will serve as the lead state agency in the state's response to an LTC COVID-19 event. HHSC actions will include:

- Development of testing recommendations, in consultation with Texas Department of State Health Services (DSHS)
- Ensuring appropriate/assistance with patient movement
- Providing subject matter experts (SME): LTC, HAI, epidemiology
- Coordination of HHSC, DSHS, emergency management and local actions

Texas COVID-19 Assistance Team - LTC

In addition to the activities of Section VI of this response and those above, HHSC will coordinate formation of a Texas COVID-19 Assistance Team – LTC (TCAT-LTC). This team will include representatives from HHSC, DSHS, local health department (as applicable) and emergency management (as applicable.) The purpose of this team is to assist LTCFs with management of a COVID-19 event through provision of subject matter expertise, resource request management and support to facility actions through initial response activities. The TCAT-LTC will remain available for a maximum of 48 hours from activation. State and local entities will provide SMEs and continued assistance after TCAT-LTC deactivation.

ATTACHMENT 1: Immediate Response Guidelines

IMMEDIATE ACTIONS (0-24 hours)

FACILITY ACTIONS

REVIEW *SPICE* ACTIVITIES

Prevent further disease spread

- Determine number of residents potentially infected
- Determine number of staff potentially infected
- Invoke isolation precautions/plans
- Determine who has been tested
- If applicable, invoke quarantine or control order
- Identify if exposed staff are working in other facilities

Protect from infection

- Enact PPE plans
- Determine PPE supplies
- Screen residents/visitors
- Contact other facilities where exposed might have visited/worked
- Consult with your local health department (LHD) regarding testing
- Limit staff in contact with infected or exposed

Care for infected

- Isolate infected
- Identify cohorts (exposed, infected)
- Determine level of required care
- Determine if hospitalization and transport are required
- Notify local health care/EMS
- Track signs/symptoms

Other

- Contact LHD/DSHS regional office/health authority (HA)
- Ensure all relevant regulations/rules are followed
- Notify families, staff, residents of situation
- Track tested, suspected, positive, isolated, quarantined, hospitalized, and deaths
- Activate emergency response command structure
- Identify specific points of contact (POCs) for communication with HHSC, local government, clinical staff, and press
- Maintain central database of external contacts and phone numbers

HHSC ACTIONS

Prevent further disease spread

- Conduct Priority 1 Intake investigation
- Review facility Infection Control Practices
- Determine if staff work at other facilities

Protect Others from infection

- Review Isolation precautions/plans
- Determine if facility has sufficient PPE
- Determine if facility has enacted screening for residents/staff
- Determine if Quarantine Order is in effect
- Ensure contact of other facilities where exposed are working

Care for infected

- Ensure appropriate isolation and quarantine
- Ensure timely patient care
- Ensure clinical support

Other

- Review all relevant rules/regulations with facility
- Track tested, suspected, positive, isolated, quarantined, hospitalized, and deaths
- Identify POCs and maintain communication
- Contact DSHS to review response activities

EXTERNAL ACTIONS

Texas COVID-19 Assistance Team - NF

- Testing
- Patient Movement
- Emergency Management
- HAI
- LHD
- Resource Requests

ATTACHMENT 2: SPICE Graphic

SPICE

for COVID-19

Surveillance

- Sign and Symptoms
- Temperature Checks
- Residents/Staff/Visitors
- Testing

Protection/Personal Protective Equipment

- Clinical Staff
- Support Staff
- Patient
- Supply/Burn-rate

Isolate

- Patient(s) isolated
- Staff Isolated
- Others Isolated

Communicate

- Administrator Contact #:
- Local Health Department #:
- Department of State Health Services #:
- HHSC (TCAT)#:
- Hospital Contact #:

Evaluate

- Review 0-24-hour checklist
- Prevent delay of critical actions
- Communication plan

ATTACHMENT 3: Interim Guidance for Prevention, Management, and Reporting of Coronavirus Disease 2019 (COVID-19) Outbreaks in Long-Term Care Facilities and Other Communal Living Settings

Purpose

This document is intended to provide guidance to long-term care facilities (LTCFs) including nursing homes, skilled nursing facilities, long-term acute care hospitals; and other communal living settings such as assisted living, group homes, and other institutions for the prevention, management, and reporting of Coronavirus Disease 2019 (COVID-19) outbreaks.

Prompt recognition and immediate isolation of suspected cases is critical to prevent outbreaks in residential facilities.

Background

Because of their congregate nature and residents served (older adults often with underlying medical conditions), nursing home populations are at the highest risk of serious illness caused by COVID-19. Every effort must be made to prevent the introduction and spread of disease within these facilities. People at high risk for developing severe COVID-19 include those who are 65 or older, immunocompromised (including cancer treatment), and have other high-risk conditions such as chronic lung disease, moderate to severe asthma and heart conditions. People of any age with severe obesity or certain underlying medical conditions, particularly if not well controlled, such as diabetes, renal failure, or liver disease might also be at risk.

COVID-19 is most likely to be introduced into a facility by ill health care personnel (HCP) or visitors. Long-term care facilities should implement aggressive visitor restrictions and enforce sick leave policies for ill HCP. Facilities must take the extreme action of restricting visitors except in compassionate care, such as end-of-life situations. Facilities must also restrict entry of non-essential personnel, and essential personnel should be screened for fever and symptoms before they enter the facility and begin their shift.

Immediate Prevention Measures

Visitor restriction – On March 13, 2020, the Centers for Medicare and Medicaid Services (CMS) released a memorandum directing all nursing homes to restrict visitors except those medically necessary. This is an important measure to prevent the introduction of the virus that causes COVID-19 into LTCFs. The Texas Department of State Health Services (DSHS) recommends all LTCFs restrict visitation except in end-of-life care.

End-of-life care is the care given to people who have stopped treatment for their disease and are near the end of life.

1. For people allowed in the facility (in end-of-life situations when death is imminent), provide instruction before visitors enter the facility and residents' rooms on hand hygiene, limiting surfaces touched, and use of personal protective equipment (PPE) according to current facility policy while in the resident's room. Screen visitors and exclude those with fever and/or symptoms. Decisions about visitation during an end-of-life situation should be made on a case-by-case basis.
2. Visitors who are allowed in the facility must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility.
3. Facilities should communicate through multiple channels to inform people and non-essential health care personnel of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls and recorded messages for receiving calls.
4. In lieu of visits, facilities should consider offering alternative means of communication for people who would otherwise visit.
5. When visitation is necessary or allowable (in end-of-life scenarios), facilities should make efforts to allow for safe visitation for residents and loved ones.
 - a. Remind visitors to refrain from physical contact with residents and others while in the facility. Practice social distancing by not shaking hands or hugging and remaining 6 feet apart.
 - b. If possible (pending design of building), create dedicated visiting areas near the entrance to the facility where residents can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.

Advise visitors, and any person who entered the facility (hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms happen, advise them to self-isolate at home and immediately notify the facility of the date they were in the facility, the people they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the people of reported contact and take all necessary actions based on findings.

Restrict non-essential personnel – Review and revise how the facility interacts with vendors and delivery personnel, agency staff, EMS personnel and equipment, transportation providers (when taking residents to offsite appointments, etc.), and other non-health care providers (food delivery,

etc.). This should include taking necessary actions to prevent any potential transmission. For example, do not have supply vendors bring supplies inside the facility. Instead, have vendors drop off supplies at a dedicated location, such as a loading dock.

Restrict non-essential personnel including volunteers and non-essential consultant personnel (barbers, delivery personnel) from entering the building.

Essential services such as dialysis, interdisciplinary hospice care, organ procurement, or home health personnel should still be permitted to enter the facility provided they are wearing all appropriate PPE and undergo the same fever and symptom screening process as facility staff. Facilities can allow entry of these essential visitors after screening.

Surveyors should not be restricted. CMS and state survey agencies are 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 14 days, but because they were wearing PPE effectively per the Centers for Disease Control and Prevention (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 still not enter, such as if they have a fever or any additional signs or symptoms of illness.

Active screening – The CDC and CMS recommend LTCFs screen all staff entering the facility at the beginning of their shift for fever and symptoms consistent with COVID-19. Actively take their temperature and document absence of or shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home. DSHS has created a template screening log for facility staff that is available on the DSHS website at <https://dshs.texas.gov/coronavirus/>. Facilities should also screen any visitors who are permitted to enter the building, including visiting health care providers. Maintain a log of all visitors who enter the building that at minimum includes name, current contact information, and fever and presence/absence of symptoms.

Education – Share the latest information about COVID-19 and review CDC's [Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\) or Persons Under Investigation for COVID-19 in Healthcare Settings](#).

Educate residents and families about COVID-19, actions the facility is taking to protect them and their loved ones (including visitor restrictions) and actions residents and families can take to protect themselves in the facility. Educate and train HCP and reinforce sick leave policies and adherence to infection prevention and control measures, including hand hygiene and

selection and use of PPE. Have HCP demonstrate competency with putting on and removing PPE. Remind HCP not to report to work when ill. Educate facility-based and consultant personnel (wound care, podiatry, barber) and volunteers. Including consultants is important because they often provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.

Coordinate with your long-term care ombudsman to assist with education to residents and family members. To request help from an ombudsman statewide, call 1-800-252-2412 or email lrc.ombudsman@hhsc.state.tx.us.

Provide Supplies for Recommended Infection Prevention and Control Practices

- Hand hygiene supplies:
 - Put alcohol-based hand sanitizer with 60–95 percent alcohol in every resident room (ideally inside and outside of the room) and other resident care and common areas (outside dining hall, in therapy gym).
 - Make sure sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory hygiene and cough etiquette:
 - Make tissues and facemasks available for coughing people.
 - Consider designating staff to steward those supplies and encourage appropriate use by residents, visitors and staff.
- Make necessary Personal Protective Equipment (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. Facilities should have supplies of:
 - Facemasks
 - Respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP)
 - Gowns
 - Gloves
 - Eye protection (face shield or goggles).
- Consider implementing a respiratory protection program compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training and fit testing.
- Environmental cleaning and disinfection:

- Make sure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- 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 SARS-CoV-2.

Control Measures for Residents

Most of the actions that can be taken to prevent or control COVID-19 outbreaks in LTCFs are not new and include increasing hand hygiene compliance among staff, residents and their families through education and on the spot coaching; and providing facemasks and hand hygiene supplies at the entrance to the facility. Additional critical control measures are listed below:

Monitoring - Ask residents to report if they feel feverish or have symptoms of respiratory infection. Actively monitor all residents upon admission and at least daily for fever and respiratory symptoms (including shortness of breath, new or change in cough, and sore throat). If the resident has fever or symptoms, implement recommended infection prevention and control (IPC) measures.

Isolation - Once a case of COVID-19 is identified in the facility, immediate action must be taken to isolate the case away from other residents. Symptoms of COVID-19 can vary in severity. Initially, symptoms can be mild and not require transfer to a hospital if the facility can follow the infection prevention and control practices recommended by CDC. Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should be placed in a private room with their own bathroom.

If a resident requires a higher level of care or the facility cannot fully implement all recommended precautions, the resident should be transferred to another facility capable of implementation. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer. While awaiting transfer, symptomatic residents should wear a facemask (if tolerated) and be separated from others (kept in their room with the door closed). Appropriate PPE should be used by health care personnel when encountering the resident.

Any roommates should be moved and monitored for fever and symptoms twice daily for 14 days. Room-sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.

Create a plan for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units.

If the case is transferred to a higher level of care, perform a final, full clean of the room, and use an EPA-registered disinfectant that has qualified under EPA's emerging viral pathogens program for use against COVID-19. These products can be found on EPA's List N <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>.

Source control - Ill residents should wear a surgical mask when health care or other essential personnel enter the resident's room. If the resident cannot tolerate a surgical mask, personnel who enter the room must wear N95 respirators, if available and staff are fit-tested. If they are not available or staff are not trained or fit-tested, facemasks should be worn. Respiratory protection should be worn in addition to gown, gloves and face shield. Ensure staff have been appropriately trained and fit-tested before using N95 respirators.

Social distancing - Remind residents to practice social distancing and perform frequent hand hygiene. Social distancing means avoiding unnecessary physical contact and keeping a distance of at least 6 feet from other people. Cancel communal dining and all group activities, such as internal and external activities.

Resident education - Provide education to residents and any visitors regarding the importance of handwashing. Assist residents in performing hand hygiene if they are unable to do so themselves. Education should also be provided to residents to cover their coughs and sneezes with a tissue, then throw the tissue away in the trash and wash their hands.

Control Measures for Staff

Hand hygiene - Reinforce the importance of hand hygiene among all facility staff, including any contract staff. Facilities can increase the frequency of hand hygiene audits and implement short in-service sessions on the proper technique for hand hygiene.

Ensure that supplies for performing hand hygiene are readily available and easily accessible by staff. Advise staff not to keep hand sanitizer bottles in their pockets. This practice causes hands and sanitizer bottles to become contaminated. Instead, consider keeping alcohol-based hand rub (ABHR) bottles in easily accessible areas, and mounting ABHR to the sides of carts (dining tray carts, wound care carts, medication carts, etc.).

Personal protective equipment (PPE) - Ensure the facility maintains an adequate supply of PPE and that all required PPE is easily accessible to staff entering resident rooms. For COVID-19 patients, CDC recommends staff

adhere to standard and transmission-based precautions. If the facility does not have a supply of N95 respirators, or does not have any fit-tested staff, facemasks must be worn. Follow the CDC [Interim Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings](#), which includes detailed information regarding recommended PPE.

Consider designating staff to steward these supplies and encourage appropriate use by staff and residents.

Dedicated staff/COVID-19 response teams - Facilities can consider establishing COVID-19 care teams to dedicate to the care of positive cases. These teams should be fit-tested for N95 respirators and prepared to provide an advanced level of care for cases if necessary, or until cases can be transferred to a higher level of care. COVID-19 care teams can be implemented if not all staff can be trained and fit-tested for N95 respirators, or if supplies of N95 respirators are insufficient to equip the entire staff.

Sick leave - Facilities should review and potentially revise their sick leave policies. Staff who are ill should not come to work, and sick leave policies should not penalize staff with loss of status, wages or benefits.

Work exclusion – Staff who are confirmed to have COVID-19 must stay at home and cannot be released from home-isolation until at least seven days after symptom onset, and at least 72 hours after they have been fever-free without the use of fever-reducing medications and free of symptoms. Facility occupational health or infection prevention programs should work with the local/regional health department and recovered employees to decide when it is safe for them to return to work.

Upon returning to work, health care personnel will:

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

Environmental cleaning and disinfection – Increase environmental cleaning. Clean and disinfect all frequently touched surfaces such as doorknobs/handles, elevator buttons, bathroom surfaces/fixtures, 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.

<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>.

Reporting COVID-19

All confirmed cases of COVID-19 must be reported to the local health department (LHD), or public health region (PHR) in jurisdictions where the PHR serves as the LHD. If you suspect your facility is experiencing an outbreak of COVID-19, immediately notify your local health authority by phone.

You can 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 local health department to complete the COVID-19 Case Report form if and when necessary.

Outbreak Management

If an outbreak of COVID-19 is suspected or identified in your facility, strict measures must be put in place to halt disease transmission.

Outbreak definitions – A confirmed outbreak of COVID-19 is defined as one or more laboratory confirmed cases of COVID-19 identified in either a resident or paid/unpaid staff. All confirmed outbreaks will be reported to the LHD or PHR immediately.

A suspected outbreak is defined as one or more cases of respiratory illness within a one-week period without a positive test for COVID-19. Use the suspected outbreak definition if your facility is awaiting test results from either a resident or paid/unpaid staff. You can reach out to your local health authority for assistance during this period; but are not required to report suspected outbreaks. If you suspect a resident or staff member might have COVID-19, do not wait for test results to implement outbreak control measures.

If you have two or more residents or staff with similar symptoms, report to your local health authority as you would for any other cluster of illness. Maintain a low threshold of suspicion for COVID-19 as early symptoms can

be non-specific and include atypical presentations such as diarrhea, nausea, and vomiting, among others.

Implement universal use of facemask for HCP while inside the facility. Follow the CDC's guidance for optimizing the supply of PPE when deciding how long staff should wear one facemask (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>). Masks should be discarded upon exit, and a new mask should be worn upon reentry.

Note that homemade facemasks should only be used when all other options have been entirely exhausted and should only be used as source control. These masks are not considered protective.

Consider having HCP wear all recommended PPE for COVID-19 (gown, gloves, eye protection, a facemask or N95 respirator) for the care of all residents, regardless of presence of symptoms. Implement protocols for extended use of eye protection and facemasks. Refer to [DSHS' website](#) for strategies for optimizing the supply of PPE.

Restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room, residents should wear a facemask, perform hand hygiene, limit their movement in the facility, and keep a distance of 6 feet between themselves and other residents.

Implement protocols for cohorting positive COVID-19 cases with dedicated HCP. These HCP should be appropriately trained and fit-tested for N95 masks if at all possible. If staff cannot be fit-tested for N95 respirators, they should NOT use them and use facemasks instead. Consider designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 cases.

Movement and monitoring decisions for HCP with exposure to COVID-19 should be made in consultation with local public health authorities. To learn more, refer to the CDC [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 \(COVID-19\)](#).

Maintain a line list of all confirmed and suspected COVID-19 cases within your facility. Include details such as name, date of birth, age, sex, whether staff or resident, room number or job description, date of symptom onset, fever, symptoms, and others. If your facility does not already have a line list template, you can find one on the DSHS website at <https://dshs.texas.gov/coronavirus/>.

Glossary of Acronyms in Alphabetical Order

1. ABHR – Alcohol-based hand rub
2. AIIR – Airborne infection isolation room
3. CDC – The Centers for Disease Control and Prevention
4. CMS – The Centers for Medicare and Medicaid Services
5. CNA – Certified nursing aide
6. DSHS – Texas Department of State Health Services
7. EMS – Emergency medical services
8. EPA – Environmental Protection Agency
9. HA – Health authority
10. HAI – Health care associated infection
11. HCP – Health care personnel
12. HCW – Healthcare worker
13. HHSC – Texas Health and Human Service Commission
14. IPC – Infection prevention and control
15. LHA – Local health authority
16. LHD – Local health department
17. LTC – Long-term care
18. LTCF – Long-term care facility
19. LTCR – Long-term Care Regulatory
20. LVN – Licensed vocational nurse
21. NF – Nursing facility
22. OSHA – Occupational Safety and Health Administration
23. POC – Point of contact
24. PPE – Personal protective equipment

25. RN – Registered nurse

26. SME – Subject matter expert

27. TCAT – Texas COVID-19 Assistance Team

ATTACHMENT 4: Extended Response Guidelines (To Be Developed)
ATTACHMENT 5: Recovery Guidelines (To Be Developed)