COLORADO
Department of Public Health & Environment

COVID-19 GUIDANCE

Residential Care Facility (RCF) Comprehensive Mitigation Guidance Document

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Summary of Recent Changes

Updates as of 3/22/2021:

- Quarantine of residents post vaccination
- Quarantine of staff post vaccination
- Outbreak testing results and response
- Visitation

Scope

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

Background

Since early 2019, a new respiratory disease, coronavirus-19 (COVID-19) has been spreading globally and within the United States. This disease is caused by the virus SARS-CoV-2. The Colorado Department of Public Health and Environment (CDPHE) continues to monitor the situation closely. Updated case counts are available on the CDPHE website: Coronavirus Disease 2019 (COVID-19) in Colorado.

Residents of RCFs, which are often older people and/or those with underlying health conditions, are at especially high risk for developing serious illness associated with COVID-19. Healthcare personnel and close contacts of people with COVID-19 are also at elevated risk for exposure. Respiratory illnesses have the potential to spread easily in these settings due to the communal nature of the environment. Rapid response is key to limiting transmission in the facility. Ensure infection control measures remain in place consistently, taking immediate action if even a single case (staff or resident) is suspected.

Definitions

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

COVID-Naive

- COVID-Naive refers to persons who are not vaccinated or only partially vaccinated whose COVID-19 status is unknown, recently negative, or 90-days post infection (a COVID-19 positive test more than 90 days ago).

Fully Vaccinated

- Refers to a person who is ≥2 weeks following receipt of the second dose in a 2- dose vaccine series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.

Healthcare Personnel (HCP)

- HCP refers to all persons, paid and unpaid, working in healthcare settings engaged in resident care activities, including: resident assessment for triage, entering examination rooms or resident rooms to provide care or clean and disinfect the environment, obtaining clinical specimens, handling soiled medical supplies or equipment, and coming in contact with potentially contaminated environmental surfaces.

Isolation

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

Outbreak Definition

- Outbreaks have been standardized across outbreak settings. An outbreak in a residential setting is defined as two or more confirmed cases of COVID-19 among residents and/or staff in a facility with onset in a 14 day period OR one confirmed case and two or more probable cases of COVID-19 among residents and/or staff in a facility with onset in a 14 day period. Of note: Colorado COVID-19 Case and Outbreak Definitions for residential settings was updated on 12/7/2020 to include staff.

Outbreak Testing

- Upon notification of a single positive COVID-19 (staff or resident), the facility must implement facility-wide testing (outbreak testing) of **ALL** staff and residents to identify additional asymptomatic, pre-symptomatic, or symptomatic infections.

POD

- POD Refers to a hall, wing, unit, neighborhood, etc., that is a group assignment in which the same staff and residents are assigned consistently and across multiple shifts in order to limit the number of individuals interacting. It is best practice to enforce POD designation for care activities, communal dining, and group activities, consistently and according to the social distancing calculator, however, not to exceed 10 residents per POD. The smaller the POD size, the easier it will be to prevent transmission.

Quarantine

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

Residential Care Facilities (RCF)

- RCF refers to: skilled nursing facilities, assisted living residences, intermediate care facilities and group homes.

Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting of high-frequency touched surfaces in the facility often, designated visitation areas after each visit, and shared medical equipment
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO20-38-NH)

Preparation

Steps that facilities can take to prepare for COVID-19

1. Review the facility emergency plan.
2. Establish relationships with key healthcare and public health partners.
3. Communicate about COVID-19 with your residents and resident families, including actions taken to protect the residents from COVID-19.
4. Communicate about COVID-19 with your staff, including changes to policies and procedures.
5. Reinforce sick leave policies and restrict ill HCP from work and those reporting a high risk exposure (e.g., household contact with COVID-19 or caring for a COVID-19 positive resident without proper use of a mask and/or eye protection).
6. Screen residents and HCP for symptoms and signs of infection at least daily, and more frequently if illness is suspected. (See Surveillance and Monitoring, below)
7. Designate residents and staff to a POD to limit movement in the facility and the number of persons interacting with residents and each other.
8. Conduct an inventory of available PPE and ensure adequate supply.
9. Ensure proper use of recommended personal protective equipment (PPE).
10. Ensure proper hand hygiene and respiratory etiquette, making sure that supplies are available in residential care areas, throughout the facility, and at entrances.
11. Ensure adequate supplies and procedures for environmental cleaning and disinfection.
12. Facilities should assign at least one individual (full-time) with training in IPC to provide on-site management of their COVID-19 prevention and response activities.
13. Remain vigilant for COVID-19 among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death. Consider CDC's training modules for front-line staff.
14. Monitor the two-week average test positivity rate ("Colorado Covid Dial") to determine the frequency for surveillance testing and the level of communal dining and group activities allowed within their facility.
15. Create a plan for testing residents and healthcare personnel for COVID-19 in accordance with the Sixth Amended PHO 20-20.

Key Information about COVID-19

- **Agent**
  - SARS-CoV-2
- **Incubation Period**
  - Range 2 to 14 days
- **Transmission/Communicability**
  - The virus is thought to spread mainly from person-to-person.
  - Between people who are in close contact with one another (within about 6 feet).
  - Through respiratory droplets produced when an infected person talks, coughs, or sneezes.
  - These droplets can land in the eyes, mouths, or noses of people who are nearby or possibly be inhaled into the lungs.

    - It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- **Symptoms**
    - Symptoms associated with COVID-19 include: Fever (measured at >100.0°F or subjective), chills, cough, shortness or breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose. Consider also rhinorrhea, diarrhea, nausea or vomiting.

Reporting Requirements

Public Health

- COVID-19 (SARS-CoV-2) is a communicable disease in Colorado requiring both the ordering provider and laboratory to report positive results. Whoever performs the test is obligated to report the results to public health. Therefore, for specimens that are sent out to a lab for testing, your facility is responsible for reporting positive results. **Your facility is exempt from this rule only if you are currently participating in state funded surveillance and outbreak testing via your assigned laboratory.**
    - Polymerase chain reaction (PCR) tests are currently the most effective test available for detecting COVID-19 infection and why Sixth Amended PHO 20-20 requires all residential care facilities to utilize PCR testing for surveillance and outbreak testing. CDPHE has provided testing resources for all CO residential care facilities to conduct the required surveillance and outbreak testing. Facilities may choose at their own expense to utilize a lab other than the one provided by CDPHE. All PCR results (negative and positive) will be reported to CDPHE directly by the performing laboratory on behalf of the facility.
- POC antigen tests can be performed by the facility in addition to the required PCR testing but not as a replacement. According to Public Health Order 20-33, the facility assumes reporting responsibilities for all POC testing results (negative, positive, and inconclusive) as they are the acting laboratory.
    - Facilities performing POC testing must report results to CDPHE directly and include name, date of birth, sex, ethnicity, and complete home address and personal phone number for each person tested. **For additional reporting questions, email the team in PHIRR** cdphe_covidreporting@state.co.us.
        - Facility address is appropriate for residents, however, personal home address should be listed for staff.
    - Of note: Reporting of COVID-19 results to CDPHE (as outlined above) does not fulfill NHSN reporting requirements or outbreak reporting requirements.
- Any suspected or confirmed case **or** outbreak (e.g., one or more cases) of COVID-19 among residents or staff shall immediately be reported to the local or state public health agency using the COVID-19 Outbreak report form. Facilities can send this form

to their local public health agency OR to CDPHE by securely emailing the completed form to cdphe_covid_outbreak@state.co.us. Facilities may also contact CDPHE at 303-692-2700 (8:30 - 5:00, Monday - Friday) or 303-370-9395 (after-hours, holidays and weekends).

- Additionally, facilities should promptly notify public health for any of the following: Suspected or confirmed case of influenza in a resident or HCP (may indicate co-circulation); a resident with severe respiratory infection resulting in hospitalization or death; or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of one another.

EMResource

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

NHSN

- CMS nursing homes must report COVID-19 cases, facility staffing, supply information and both positive and negative COVID-19 point of care antigen test results to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module at least weekly (test results as completed).
  - CDC's NHSN provides long-term care facilities with a customized system to track infections and prevention process measures in a systematic way. Nursing homes can report into the four pathways of the LTCF COVID-19 Module including:
    - Resident impact and facility capacity
    - Staff and personnel impact
    - Supplies and personal protective equipment
    - Ventilator capacity and supplies
  - Weekly data submission to NHSN will meet the CMS COVID-19 reporting requirements.

Surveillance and Monitoring

Surveillance for Respiratory Illness in Residents during COVID-19

- Routinely monitor residents for symptoms and actively take their temperature and other vital signs, including pulse oximetry daily. **Increase monitoring of all residents to two times daily (at a minimum) if there is an outbreak of COVID-19 in the facility (suspected or confirmed).**
- Ensure residents have been educated on the signs and symptoms of COVID-19 and how to report if they develop illness.
- Residents with the following symptoms should be considered for potential COVID-19:
  - Cough
  - Shortness of breath, difficulty breathing, or signs of new hypoxemia

    - Fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)
    - Other symptoms in the setting of a suspected or confirmed COVID-19 outbreak (e.g., rhinorrhea, diarrhea, nausea or vomiting)
    - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include changes in cognition, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0˚F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- Residents should ***also*** be assessed for other etiologies (e.g. influenza, RSV, etc.) according to clinical suspicion and considering local circulation of respiratory viruses.

Surveillance for Respiratory Illness in Staff during COVID-19

- Facilities should have a process in place to ensure all staff (including consultant and ancillary personnel) are screened at the beginning of their shift for fever or respiratory symptoms. A sample form can be found here.
    - Screening should ask about close contact with a person infected with COVID-19 and any ill household member.
- Discourage staff from working in multiple facilities as this can increase the risk of transmission and an outbreak amongst multiple facilities. If such limitations cannot be maintained, keep a record of other healthcare facilities where your staff are working and ask about exposure to facilities with recognized COVID-19 cases.
- As part of routine practice, ask staff to regularly monitor themselves for fever and symptoms of respiratory infection and how to report illness promptly.
- Remind staff to stay home when they are ill or if they are COVID-naive and a high-risk exposure to COVID-19 has occurred (e.g., household contact tests positive or providing care to a COVID-positive resident without proper PPE).

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

- When SARS-CoV-2 and Influenza viruses are found to be co-circulating based upon local public health surveillance data and/or testing at local healthcare facilities, facilities should implement the following:
    - Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for COVID-19 and test for both viruses (COVID-19 and influenza).
    - Because some of the symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two infections based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in the current room, pending results of viral testing.

They should not be placed in a room with new roommates nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by SARS-CoV-2 (PCR) testing.
    - Facilities should promptly contact public health for consultation and further investigation if co-circulating illness is suspected.
    - Additional CDC guidance for influenza can be found here. The CDPHE guidelines for influenza outbreaks in long-term care facilities can be found here.
- CDPHE provides a basic tracking tool: Line List Template to Monitor Residents and Staff. Collection of additional variables may be recommended in the setting of a suspected or confirmed COVID-19 outbreak.

Infection Prevention

Consistent application of prevention and response measures help reduce the risk of transmission and severe disease from COVID-19. The more infection control measures we can maintain, the more effective we will be at preventing transmission.

Infection Prevention and Rapid Response

- Infection prevention and control recommendations have been consolidated into the following checklist: COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities.
    - **Prevention measures**, which should already be implemented to protect residents from possible COVID-19 infection, and
    - **Rapid response measures** that should be implemented immediately when even a single case of respiratory illness is identified in a resident or during suspected or confirmed outbreaks of COVID-19.
    - Do not wait for illness to occur before implementing prevention measures as these are intended to prevent infection from occurring and/or spreading in the facility. A delay in implementation could result in increased spread of infection.
- Provide written infection prevention policies and procedures that are available, current, and based on evidence-based guidelines (e.g. CDC, CMS, or CDPHE).
- Require training before individuals are allowed to perform their duties and at least annually as a refresher or sooner if there are recognized lapses in adherence.
- Ensure that a process is in place to monitor staff adherence to recommended infection prevention practices, including at minimum:
    - Hand hygiene (HH) observations
    - PPE use, to include proper glove use
    - Shared medical equipment cleaning and disinfection
    - Isolation precautions and cohorting
    - Environmental decontamination, to include isolation rooms
    - Surveillance

- Provide feedback on performance and adherence to individuals and maintain documentation of these efforts.
- Visit CDC's website for Infection Control Guidance and Strategies to Prevent Spread of COVID-19 in LTCFs: Healthcare Facilities (CDC).
- CMS has additional guidance:
    - Guidance for Infection Control and Prevention of Coronavirus Disease 2019(COVID-19) in nursing homes (CMS)
    - Nursing home guidance (CMS)
    - 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios

Infection Prevention and Control Post COVID-19 Vaccination

- COVID-19 vaccines will be an important tool to help slow/stop the pandemic but it is going to take time. **Even after vaccination, everyone should continue to follow all the current guidance to protect themselves and others from COVID-19.** All of CDC's and CDPHE's guidance should be followed until the guidance is updated. Including:
    - Proper mask use (covering both the nose and the mouth)
    - Social distancing of at least 6 feet
    - Current isolation and quarantine guidance
    - Surveillance and testing requirements
    - Proper hand hygiene
- Because there is a lack of information on transmission reduction following vaccination and the duration of protection, vaccinated HCP should continue to follow all current infection prevention and control recommendations to protect themselves and others from SARS-CoV-2 infection.
- Guidance for Managing Healthcare Personnel (CDP) Post COVID-19 Vaccination can be found here.
- Additional guidance for COVID-19 vaccination, infection control and testing in residential care facilities can be found here.
- Additional guidance for Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination can be found here
    - Quarantine guidance has been updated for fully vaccinated HCP with higher-risk exposures who are asymptomatic. Asymptomatic HCP no longer need to be restricted from work for 14 days following their exposure unless HCP has underlying immunocompromising conditions (organ transplantation, cancer treatment).
    - Fully vaccinated residents should continue to quarantine following prolonged close contact with someone with SARS CoV-2 infection.

Strategies to Optimize the Supply of PPE

- CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent.
- When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to HCP before they carry out patient care

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

- For PPE resource requests, facilities should notify their local public health agency or refer to Concept of Operations (CONOPS) for Coronavirus Disease (COVID-19) Personal Protection Equipment Shortage (CDPHE).
- CDPHE FAQ for Personal Protective Equipment can be found here.

Universal Source Control

- **CDC Recommendations**
  - CDC recommends that everyone entering the facility wear a mask or cloth face covering at all times while in the building, regardless of symptoms. The mask must cover both the nose and mouth to be effective.
  - Respirators or masks with exhalation valves protect the wearer from COVID-19, but may not prevent the virus from spreading to others (that is, they may not be effective for source control) as the exhalation valve allows unfiltered air from the wearer to escape. If only a respirator with an exhalation valve is available and source control is needed, cover the exhalation valve with a surgical mask, procedure mask, or a cloth face covering that does not interfere with the respirator fit.
  - It is important to remember that masks do not negate the need for social distancing. Maintaining social distances and ensuring proper mask use (covering both the nose and the mouth) support and increase successful source control.
- **All Staff**
  - All staff that comes into close proximity with residents (including contractors and ancillary staff) should wear a medical facemask or respirator (not a cloth mask) at all times that covers both their nose and mouth while they are in the facility.
  - Surgical masks and respirators are recommended for staff as they offer both source control and protection for the wearer against exposure to splashes and sprays. Cloth face coverings are not personal protective equipment (PPE) and should NOT be worn by staff if more than source control is required.
  - Ensure staff are wearing a mask upon arrival to the facility. This can be a cloth mask but must be changed to a surgical mask or respirator after the screening process is complete and before proceeding into the facility.
  - Some staff that do not come in contact with residents or other staff (e.g., clerical personnel) might wear a cloth face covering for source control while in the facility.
- **All Residents (if tolerated)**
  - All residents should wear a cloth face covering or facemask (if tolerated) when they leave their room or when others (e.g., staff, visitors, etc.) enter their room.
  - Residents leaving the facility should wear a cloth face covering or facemask while out of the facility and until they return to the facility (if tolerated).

Ensure residents are educated on how to safely remove their masks (should they need to do so) while out of the facility.

- **All Visitors**
  - All visitors entering the facility should, ideally, be wearing their own cloth face covering or facemask upon arrival and wear it at all times while in the facility.

Respiratory Illness Identified (Isolation and Quarantine)

What to do When a Resident with Respiratory Illness is Identified

- **Isolate Symptomatic Residents Promptly**
  - Do not wait for confirmation of a diagnosis to implement infection control precautions.
  - Residents with symptoms should be immediately isolated (preferably in a private room) and tested for COVID-19. **Note that prompt response and COVID-19 testing is necessary to limit transmission and should not wait for results of other virus testing.**
  - Place a facemask over the resident's nose and mouth (if tolerated) until the resident can be properly isolated. In times of PPE shortages, consider the use of tissues, a cloth face covering, or other barriers to cover the resident's mouth and nose. Ensure that residents have access to a trash receptacle to dispose of used tissues and a method for hand hygiene.
  - If symptomatic residents need to leave their room (e.g., for medical care), the resident should wear a facemask, cloth face covering, or use tissues as source control when they are outside of their room or affected unit. Prioritize medical facemasks for staff.
  - Avoid transferring residents with symptoms of respiratory illness to unaffected units or other facilities unless medically necessary. If such a transfer must occur, place the resident in a private room with the door closed.
  - Per CDC guidance, residents with known or suspected COVID-19 in the residential care setting do not need to be placed into an airborne infection isolation room (AIIR) (Preparing for COVID-19: Long-term Care Facilities, Nursing Homes (CDC)).
  - Only essential personnel should enter the room. Implement staffing policies to minimize the number of staff who enter the room. Consider having designated staff care for ill residents and/or bundle care activities to limit the number of interactions.
- **Quarantine and Management of Exposed Roommates**
  - If roommates are being moved, ensure they are moved to a private room and quarantined for 14 days with the use of transmission-based precautions in the event exposure has occurred and they may have incubating infection. Moving the roommate to a private room promptly can prevent exposure and limit ongoing transmission.

    - If roommates cannot be moved, ensure at least 6-feet separation between residents and utilize curtains or other physical dividers for separation, ensuring the roommate is quarantined for 14 days from their last exposure with the use of transmission-based precautions.
    - It is important to note that when roommates are not separated, potential exposure risks remain until the resident with COVID-19 meets the discontinuation of isolation criteria, extending the quarantine period for the non-COVID roommate. The quarantine period should begin again after the last potential exposure to COVID-19.
- **Quarantine of Residents Post Vaccination**
    - Guidance for residential care facilities regarding vaccinations and quarantine for exposed residents has not changed. Continue with current recommendations for quarantine (full 14 days regardless of vaccination status) for exposed roommates.
    - Fully vaccinated residents in residential care facilities should continue to quarantine following prolonged close contact with someone with SARS CoV-2 infection. This is due to limited information about vaccine effectiveness in this population, the higher risk of severe disease and death, and challenges with physical distancing in residential care settings.

What to do When Staff with Symptoms is Identified

- **Management of Staff with Symptoms**
    - If staff develop a fever or symptoms of respiratory infection while at work, they should immediately inform their supervisor and leave the workplace. It is assumed that staff are already wearing a facemask given the universal masking requirements. Ensure staff keep their mask on until they have left the building and are isolated.
        - Staff with symptoms should be isolated at home and tested for COVID-19 through their usual healthcare provider, alternate testing site, at the workplace (preferably outside the facility), or as part of a public health response.
        - Facilities should ensure that staff who have signs or symptoms of COVID-19 are prohibited from entering the building until the return to work criteria are met.
        - Consult occupational health/infection prevention or other appropriate administrative personnel on decisions about further evaluation and return to work. See also the section “Return of HCP to Work after Confirmed or Suspected COVID-19,” below. Consult public health as necessary.
- **Staff with Potential Exposure to COVID-19**
    - COVID-naive staff should avoid working when quarantined for an exposure to COVID-19.
    - CDC has guidance to assist with assessment of risk and application of work restrictions for asymptomatic staff with potential exposure to residents,

visitors, or other staff with confirmed COVID-19: Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 (CDC).
    - The feasibility and utility of performing contact tracing of exposed staff and application of work restrictions depends upon the degree of community transmission of SARS-CoV-2 and the resources available for contact tracing.
    - CDCs updated guidance has been simplified to focus on exposures that are believed to result in higher risk for HCP (e.g., prolonged exposure to patients with COVID-19 when HCP's eyes, nose, or mouth are not covered). Other exposures not included as higher risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touches their eyes, nose, or mouth. The specific factors associated with these exposures should be evaluated on a case by case basis; interventions, including restriction from work, can be applied if the risk for transmission is deemed substantial.
        - Prolonged" refers to a cumulative time period of 15 or more minutes during a 24-hour period, which aligns with the time period used in the guidance for community exposures and contact tracing. Although this definition can be used to guide decisions about work restriction, appropriate follow-up, and contact tracing, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For the purposes of this guidance, any duration should be considered prolonged if the exposure occurs during performance of an aerosol generating procedure.
- **Management of HCP Post COVID-19 Vaccination**
    - Guidance for managing HCP post COVID-19 vaccination can be found here.
    - Fully vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure. Work restrictions for the following fully vaccinated HCP populations with higher-risk exposure should still be considered for:
        - HCP who have underlying immunocompromising conditions (i.e., organ transplant, cancer treatment) which might impact level or protection provided by the COVID-19 vaccine.
    - Employers may consider allowing COVID-naive exposed and asymptomatic workers to continue working as a last resort following CDC's critical worker guidance.
- **Staff with Alternate Diagnosis**
    - If staff have COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. However, if concurrent COVID-19 infection is suspected based on association with a suspected or confirmed outbreak, return to work criteria should follow the strategies above.
    - After returning to work, staff should follow return to work practices and work restrictions as outlined by CDC.

- **Return to Work After Travel**
    - With ongoing transmission of COVID-19 (and new variants) within the United States and in destinations throughout the world, staff may have been exposed during their travels (domestic and/or international) and may pose a risk to other staff and residents. Facilities are encouraged to have processes in place that assess staff risk and their return to work status after travel. CDC travel recommendations can be found here.

Management of Variant Cases

- Generally, there is no difference between variant and non-variant cases with respect to determining who is a contact or who should quarantine.
    - All identified variant contacts should quarantine for 14 days; no variant contacts should be allowed to test out of or otherwise shorten quarantine.
- Contact public health if a variant case or exposure (suspected or confirmed) is identified.

Case Management

Management In Facility

- Residents with milder illness may be treated in the facility if felt to be medically appropriate by their healthcare provider. For more information about clinical management and treatment, see: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) (CDC).

Acute Care Management

- Transfer of residents to an acute care facility could be considered in the following circumstances:
    - If a resident requires a higher level of care due to medical necessity.
    - If the facility is not able to implement or maintain recommended precautions to appropriately care for and protect other residents, transfer to another facility should be considered in consultation with public health and the accepting facility.

Transport

- When transporting residents who require hospitalization, residents should wear a facemask over their nose and mouth to contain secretions. **Ensure transport personnel and the receiving hospital are informed of COVID-19 suspicion or diagnosis before arrival. This will allow the transport service and healthcare facility the opportunity to properly prepare.**

Testing Requirements

COVID-19 can spread rapidly within congregate settings, including residential care settings. Because asymptomatic or presymptomatic residents and staff likely play an important role in transmission in this high risk population, additional prevention measures merit consideration, including using expanded testing to guide isolation and cohorting strategies. Testing large numbers of residents and staff with rapid turn-around times will enable the cohorting of residents in locations designated for care of residents with COVID-19 infection, either in separate spaces within individual residential care settings or in separate Facilities.

Facilities must comply with the current version of Public Health Order 20-20 pertaining to facility testing and visitation, along with the Guidance for Indoor Visitation in Residential Care Facilities and should continue to apply CDC guidance for infection prevention in residential care settings as required. Residential care settings must develop a policy for implementing surveillance testing within their Facility and routinely evaluate and update the policy as updated guidance is released. Individual Facilities may enact stricter requirements based on their local conditions, but may not waive any of these requirements. The term residential care settings includes nursing homes, skilled nursing facilities, assisted living residences, group homes and intermediate care facilities.

Goals

- Employ on-going repeat surveillance testing of all residents and staff in order to identify and mitigate the spread of COVID-19
- Improve COVID-19 outbreak response in residential care settings to prevent transmission and thereby minimize cases and deaths
- Implement strategies for cohorting residents according to COVID-19 status to prevent transmission and conserve personal protective equipment
- Decrease the strain on local healthcare systems

Advantages of Expanded Testing within Residential Care Settings

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

Surveillance Testing Criteria (Frequency and Type)

- All Facilities must implement COVID-19 ongoing surveillance testing, and outbreak testing as needed, for all staff and residents. As the most effective test for detecting infection with COVID-19 at this time is polymerase chain reaction (PCR) tests,

Facilities are required to utilize PCR testing for all testing requirements outlined in the Fifth Amended Public Health Order. Facilities may use additional testing modalities at their discretion for more frequent or expanded testing.

- All Facilities must at a minimum implement weekly surveillance testing for all staff, if at any time the county the Facility is located in reaches a two-week test positivity rate of 10% (using the Colorado COVID-19 dashboard) or greater, the Facility should increase testing to twice weekly. Facilities should remain at the higher testing frequency until the two-week positivity rate returns to a rate of less than 10% for two consecutive weeks.
- Additionally, Facilities shall implement weekly surveillance testing for all residents who have left the Facility premises to interact with individuals outside of the Facility in the last 14 days. Facilities may choose to expand testing beyond these minimum requirements, such as testing all residents on a weekly basis.
- Providers of health care or ancillary non-medical services for residents of the Facility must either participate in the Facility's surveillance testing, or bring to the Facility evidence of negative PCR test results within the preceding week.
- Types of tests allowed:
    - Ongoing surveillance testing, and outbreak testing when needed, shall be conducted utilizing a PCR test; however, as needed, other types of tests may be approved by CDPHE.
        - It is recommended that antigen tests be reserved and used with symptomatic individuals to test for the presence of COVID-19.
        - If the Facility is utilizing rapid antigen tests for expansion of these testing requirements and timeframes, and encounters a negative result among symptomatic residents or staff, the facility must conduct a PCR test to confirm the results. POC testing should be used to isolate in a private room but facilities should not make cohorting decisions until PCR confirmation.
- CDPHE will provide testing supplies for all Facilities to implement surveillance and outbreak testing, or Facilities may choose to procure their own resource for PCR testing supplies and test processing that meets or exceeds the testing timeframes for performing and processing the testing services provided by CDPHE.
    - Facilities shall provide all information required to enable processing of the tests by the provider and/or testing lab, including but not limited to each staff or resident's full name, personal phone number, home address, date of birth, sex and identification of each individual as either a staff or resident. Please do not provide the facility address or phone number for staff members' specimens.
    - Facilities must follow all CDPHE reporting requirements and guidance related to testing.
    - Facilities utilizing other resources and labs for supplies and processing of tests must demonstrate that all requirements set out within these guidelines are met.

- Facilities should request the extra personal protective equipment needed to safely collect specimens from residents and staff through the State Laboratory using this form.

Individuals Subject to Testing

Residential care settings must arrange and facilitate the testing of all staff and residents as specified below:

- For the purposes of surveillance testing, "Residents" are those individuals residing in the facility who have left the Facility premises to interact with individuals outside of the Facility in the last 14 days.
- Facility "Staff" are defined as employees, consultants, contractors, volunteers, students, caregivers, and others who provide care and services to residents.
- Providers of health care or ancillary non-medical services for residents of the Facility must either participate in the Facility's surveillance testing, or bring to the Facility evidence of negative PCR test results within the preceding week.
    - Ancillary non-medical services include services such as those provided by hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists not employed by the Facility, but who enter the building to provide services to residents. Ancillary service providers must either participate in the Facility's surveillance testing or provide proof of COVID-19 PCR testing in accordance with these requirements.
    - Providers of health care services include those individuals providing medical services (such as podiatrists, dentists, physical or occupational therapists, or hospice nurses), not employed by the Facility, but who enter the building to provide care or services to residents. Health care service providers must either participate in the Facility's surveillance testing or provide proof of COVID-19 PCR testing in accordance with these requirements.
    - Service repair technicians, delivery persons and suppliers (e.g. oxygen delivery suppliers) are not included in required facility testing but should follow core infection prevention practices to prevent COVID-19 including screening for illness prior to admission.
- For outbreak testing, the Facility must utilize PCR tests. All staff and residents who have not tested positive for COVID-19 in the last 90 days must be tested whenever outbreak testing has been initiated. Outbreak testing will occur every 3 to 4 days initially, the ongoing frequency will be determined in conjunction with the CDPHE infection prevention consultation team and the results of the most recent round of outbreak testing. Staff and residents who have previously tested positive for COVID-19 should not get tested or need to quarantine for 90 days as long as they do not develop symptoms consistent with COVID-19. Those that develop symptoms again within 90 days should be tested if no other cause for their symptoms has been identified. Residents should resume routine COVID-19 surveillance testing once 90 days has elapsed since the previous positive test.

- Facilities must have procedures in place to address residents, staff, and others who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met.
    - Staff and residents (or resident guardians/representatives) may exercise their right to decline COVID-19 testing. Facilities must have written infection control policies and procedures in place to address staff and residents who refuse COVID-19 testing.
    - Staff refusing testing shall be excluded from the Facility for 14 days following each round of refused testing. If one or more persons is identified as having COVID-19 (indicating an outbreak in the facility), the staff should continue to be excluded from the facility for an additional 14 days or until the outbreak is resolved, whichever is longer.
    - If a resident refuses testing during an outbreak they shall be quarantined until the outbreak is resolved, and staff shall care for the individual using full personal protective equipment (PPE) effective against COVID-19.
- Facilities may not restrict Ombudsman, Adult Protective Services workers or Emergency Medical Services workers from entering their building for any reason, including the absence of proof of testing.

Testing Documentation

- If testing is conducted by a testing source other than the facility, the staff must provide proof of negative COVID-19 testing to the residential care setting in accordance with the weekly frequency for such testing as required.
    - If the residential care setting does not receive staff test results directly, the Facility must require all tested staff to notify the Facility of the test results the same day the results are received. Written documentation of test results must be provided to the Facility upon receipt by the staff.
- Residential care settings must document all staff testing, including the name of the individual, time, and date of the test.
- Residential care settings must keep copies of all staff and resident testing documentation on site and readily available for review by state and local public health officials.

Outbreak Testing: Positive Case Identification

- Upon notification of a single positive COVID-19 (staff or resident), the facility must implement facility-wide testing (outbreak testing) of ALL staff and residents to identify additional asymptomatic, pre-symptomatic, or symptomatic infections.
- Residential care settings must immediately report an outbreak of COVID-19.
- Facilities should complete this form and send it via secure email to the local public health agency, or the Colorado Department of Public Health and Environment, (cdphe_covid_outbreak@state.co.us).

Implement Outbreak Testing

- When you have one or more positive tests identified in a resident or a staff member, the facility moves to outbreak testing and follows additional response measures. After the positive test(s) do the following next steps:
    - Initiate outbreak testing
    - Perform round 1 of outbreak testing, include all staff and residents, except those who have tested positive in the last 3 months and remain asymptomatic.
    - Testing must be initiated, specimens collected and sent to the testing laboratory within 48 hours of identifying the positive test result.
    - The results for each round of testing will determine the next step in responding to the outbreak.

Outbreak Testing Results and Response (See decision tree at the end of this document)

- **Facilities that identify no positives in residents or staff**
    - Move to OB Exit Testing
    - Testing frequency is every 7 days until the outbreak is closed.
    - If a new positive is identified, the facility increases frequency to every 3-4 days and follows OB testing protocol.
    - Facilities may resume or continue admissions (regardless of resident COVID-19 status) communal dining and group activities and indoor visitation.
- **Facilities that identify positive residents only**
    - Continue to follow OB testing protocol
    - Testing frequency is every 3-4 days
    - Facility should stop indoor visitation, admissions of COVID naive, communal dining and group activities.
- **Facilities that identify positive staff and residents**
    - Continue to follow OB testing protocol
    - Testing frequency is every 3-4 days
    - Facility should stop indoor visitation, admissions of COVID naive, communal dining and group activities.
- **Facilities that identify positive staff only**
    - Continue to follow OB testing protocol
    - Testing frequency is every 7 days
    - Facilities may resume or continue admissions (regardless of resident COVID-19 status) communal dining and group activities and indoor visitation.
- **Outbreak Exit Testing**
    - Outbreak exit testing is done when a round of testing identifies no positive residents or staff.
    - Facilities may continue admissions including COVID naive, communal dining and group activities. Indoor visitation may resume if stopped.
    - Frequency of testing is at least 7 days from the previous round of testing.
    - All staff and residents are included.

- If at any point a round of testing identifies a new positive, the facility returns to OB testing.

Testing Preparation and Response

- Facility leadership should anticipate asymptomatic and pre-symptomatic residents and HCP with COVID-19 and be prepared to respond rapidly and mitigate potential staffing shortages.
  - Facility leadership should ensure continued testing of all previously negative residents and staff as outlined above, until no new positives are identified.
  - Immediately perform viral PCR testing of any resident or staff member who subsequently develops signs or symptoms consistent with COVID-19.
    - POC testing can be used (in addition to the required PCR testing but not as a replacement) to assist with prompt identification of COVID-19 if a resident develops symptoms.
  - Facilities should work with public health to coordinate initial expanded testing and repeat testing in response to an outbreak and if viral testing capacity is limited.
- Postmortem testing for COVID-19 should be completed following undiagnosed deaths suspected to be due to COVID-19 (e.g., during an outbreak of COVID-19).
- See the following guidance for expanded testing:
  - Testing Guidance for Nursing Homes (CDC)
  - Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes (CDC)

Testing Previous Positives

- CDPHE does not recommend repeat testing of persons who previously tested positive for COVID-19 within 90 days.
- Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset at levels where infectiousness is unlikely.
- To date, reinfection appears to be uncommon during the initial 90 days after symptom onset of the preceding infection (Annex: Quarantine of Persons Recovered from Laboratory-diagnosed SARS-CoV-2 Infection with Subsequent Re-Exposure). Thus, for persons recovered from SARS-CoV-2 infection, a positive PCR without new symptoms during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.
- If such a person remains *asymptomatic* during this 90-day period, then any re-testing is unlikely to yield useful information, even if the person had close contact with an infected person.
- If such a person becomes symptomatic during this 90-day period and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the person may warrant evaluation for SARS-CoV-2 reinfection in consultation with an infectious disease or infection control expert.

- Quarantine may be warranted during this evaluation, particularly if symptoms developed after close contact with an infected person.
- Serologic testing should not be used to establish the presence or absence of SARS-CoV-2 infection or reinfection. See Duration of Isolation and Precautions for Adults with COVID-19.

Refusal to Test

- Facilities must have written infection control policies and procedures in place to address staff and residents who refuse COVID-19 testing.
  - Staff and residents (or resident representatives) may exercise their right to decline COVID-19 testing, however, they must be offered testing. Facilities cannot decline on behalf of the resident.
  - Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met.
  - If outbreak testing has been triggered (identification of a positive resident or staff member) and an asymptomatic staff member refuses testing, the staff member should be restricted from the facility building for 14 days following each round of refused testing or until the procedures for outbreak testing have been completed (e.g., outbreak resolved).
  - Symptomatic residents that refuse testing should be placed on transmission based precautions in a private room until symptom based criteria for the discontinuation of isolation precautions have been met.
  - Asymptomatic residents that refuse testing should be quarantined and staff shall use PPE effective against COVID-19 until the outbreak resolves (e.g., no cases are identified and 14 days has passed since the last positive case).

Point of Care (POC) Antigen Testing

Antigen tests are available as point-of-care (POC) diagnostics for SARS-CoV-2, offering a rapid turnaround time. Although specificity for SARS-CoV-2 is similar to RT-PCR, it has a lower sensitivity. Considerations for use are outlined below:

- POC tests can be used in addition to the required PCR testing (outlined above) but not as a replacement. POC testing **DOES NOT** meet the testing requirements.
- In order for a facility to conduct POC testing, the facility must have a CLIA Certificate of Waiver. Information on obtaining a CLIA Certificate of Waiver can be found here.
- Facilities should be aware of the FDA EUA for antigen tests and potential implication for the Clinical laboratory improvement Amendments (CLIA) certificate of waiver when used in asymptomatic individuals and persons >5 days from symptoms.
- Considerations for interpreting antigen test results in nursing homes can be found here.
- Facilities that choose to use POC testing need to report results (negative and positive) to CDPHE as the performing laboratory (as outlined above in Reporting).

Specimen Collection

- Follow guidance from CDC regarding which specimens to obtain for COVID-19 testing (e.g., nasopharyngeal or anterior nares specimens). There are multiple acceptable upper respiratory specimens.
- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 resident, CDC recommends:
    - Specimen collection should be performed in a private area, such as an examination or a private room with the door closed.
    - HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection (e.g., goggles or face shield), gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors and roommates should not be present for specimen collection.
- In the RCF setting, consider the following options for appropriate specimen collection activities:
    - Collect the specimen outdoors (if weather allows and is feasible given resident status).
    - Collect the specimen in the resident's room with the door closed.
        - If the resident has roommates, move the roommate to another location while the specimen is being collected, if possible.
        - If roommates cannot be moved, ensure at least 6 feet separation between residents, and use curtains or other physical dividers for seperation.
    - Consider self-collection of anterior nares specimens for residents who are able to do so. Staff should still wear appropriate PPE, maintain social distances, and guide the resident on proper collection.
- Clean and disinfect procedure room surfaces promptly in accordance with CDC guidance additional guidance for infection prevention during sample collection can be found here.

Discontinuation of Isolation (Residents and Staff)

Discontinuation of Isolation for Residents

- Residents with mild to moderate illness who are **not** severely immunocompromised:
    - At least 10 days have passed since symptoms first appeared and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved.
    - Note: For residents who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may

be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

- Residents with severe to critical illness or who are severely immunocompromised:
    - At least 20 days have passed since symptoms first appeared and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved.
    - Note: For severely immunocompromised residents who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.
- If transmission-based precautions were started based on assessment observations (empirically) for a symptomatic resident and there is no suspected or confirmed COVID-19 outbreak in the facility, the decision to discontinue empiric precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 patient can be made based upon having negative results from at least one PCR.
    - **If a higher level of clinical suspicion for COVID-19 exists, maintain transmission-based precautions and perform a second PCR test**≥24 hours apart**.**
    - **If a patient suspected of having COVID-19 is never tested, the decision to discontinue transmission-based precautions can be made based upon using the symptom-based strategy described above.**
- In some instances, a test-based strategy could be considered for discontinuing isolation earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach.
    - *Test-based criteria for residents who are symptomatic:*
        - Resolution of fever without the use of fever-reducing medications and
        - Symptoms (e.g., cough, shortness of breath) have improved, and
        - Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).
    - *Test-based criteria for patients who are not symptomatic:*
        - Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).
- Additionally, all residents should remain in their rooms as much as possible, making sure residents remain safe and considering resident well-being and mental health.
- For more information, see Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance

Return to Work Criteria for HCP After Confirmed or Suspected COVID-19

- Staff with mild to moderate illness who are not severely immunocompromised:
  - At least 10 days have passed since symptoms first appeared and
  - At least 24 hours have passed since last fever without the use of fever-reducing medications and
  - Symptoms (e.g., cough, shortness of breath) have improved.
  - Note: Staff who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.
- Staff with severe to critical illness or who are severely immunocompromised:
  - At least 20 days have passed since symptoms first appeared
  - At least 24 hours have passed since last fever without the use of fever-reducing medications and
  - Symptoms (e.g., cough, shortness of breath) have improved
  - Note: Staff who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.
- In some instances, a test-based strategy could be considered for discontinuing isolation earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach.
  - *Test-based criteria for HCP who are symptomatic:*
    - Resolution of fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved, and
    - Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).
  - *Test-based criteria for HCP who are not symptomatic:*
    - Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

Communal Dining/Group Activities

- Facilities should use the Colorado COVID-19 Dial to determine the level of communal dining and group activities allowed within their facility. A table which assists facilities in determining their current level (e.g., red, yellow, green) can also be found in the COVID-19 LTCF Checklist.
- Residents should be restricted from participating in communal dining and group activities if:
  - Resident has symptoms of an illness, including signs and symptoms of COVID-19

    - Newly admitted residents and those returning from an overnight stay outside the facility who require a 14 day observation period to assess for COVID-19 symptoms.
    - Any resident requiring transmission-based isolation precautions for any condition (e.g. flu, C. diff etc.).
    - Any facility experiencing an outbreak amongst the residents should stop all communal dining and group activities until cleared by public health to resume such activities.
        - Of note: An outbreak amongst staff only may not impact communal dining and group activities if infection control measures are maintained, outbreak testing requirements have been implemented and positive staff have been excluded from the facility.
- When communal dining and group activities resume, facilities should designate **PODs**, that is a group assignment in which the same staff and residents are assigned consistently and across multiple shifts in order to limit the number of individuals interacting. It is best practice to enforce POD designation for care activities, communal dining, and group activities, consistently and according to the social distancing calculator, however, not to exceed 10 residents per POD. The smaller the POD size, the easier it will be to prevent transmission.
- Residents should wear face coverings and maintain social distances while moving throughout the facility. HCP should ensure (and assist) residents with hand hygiene prior to participating in group activities, prior to eating, and when returning to their room (at a minimum).

Admissions

COVID-Recovered Admissions

- Hospitalized residents with a history of COVID-19 can be admitted to the facility if transmission-based precautions have been discontinued in the hospital based on the above test-based or non-test-based strategies.
    - If the resident's symptoms are resolved, and they are within 90 days of their infection, no further restrictions (e.g., isolation or quarantine) are necessary and the resident can be admitted into the general population, unless resident activities are restricted due to an ongoing potential or confirmed outbreak in the facility.
    - If the resident has recovered, is within 90 days of their positive test, and met the above test-based or non-test-based strategies but has persistent symptoms from COVID-19 (e.g., persistent cough or above baseline), they can still be admitted to the facility and with the general population but they should be placed in a single room and restricted to their room to the extent possible until all symptoms are completely resolved or at baseline. Ensure the residents remain safe and consider resident well-being and mental health.
        - Ensure the resident wears a cloth face covering or facemask (if tolerated) that covers both the nose and mouth if leaving their room

and during care activities until all symptoms are completely resolved or at baseline.

COVID-Positive Admissions

- Residents with COVID-19 that have **not** met criteria for discontinuation of transmission-based precautions should go to a facility with adequate personal protective equipment supplies and an ability to adhere to infection prevention and control recommendations for the care of COVID-19-positive patients.
- Preferably, the patient would be placed at a facility that has already cared for COVID-19 cases, in a specific area designated to care for COVID-19 residents.
- It is recommended that facilities develop and maintain a COVID-19-positive area for rapid movement of residents who develop COVID-19 and/or for the admissions of residents with COVID-19. These areas should be designed to separate residents with COVID-19 from residents without COVID-19 and include physical separation, separate resident populations, separate staff, separate equipment, and adequate PPE.
- Consultation with public health is advised during the creation of a COVID-19-positive area. Guidance for preparing a COVID-19-positive area can be found here.

COVID-Naive Admissions

- During a suspected or confirmed COVID-19 outbreak, the facility should halt new admissions of COVID-naive residents until the outbreak has been resolved. It may be possible to admit COVID-naive residents to the facility if an unaffected area can clearly be established; however, consultation with public health is recommended.
- When an outbreak is not occurring, facilities should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.
    - For admission of residents who are COVID-naive , admit to a private room and consider admission to a separate wing/unit or floor (private room in an observation area) in order to observe for 14 days.
    - All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Follow strategies to optimize the supply of PPE when supplies are limited. Of note: facilities cannot implement extended use of gowns for these observation units.
    - Testing at the end of this period could be considered to increase certainty that the resident is not infected.
    - If the newly admitted resident develops respiratory illness or develops symptoms compatible with COVID19, follow the infection prevention recommendations for isolation and transmission-based precautions (Standard, Contact, and Droplet Precautions, including eye protection).
- Quarantine is not necessary following medical appointments as these are assumed to have occurred in a controlled environment in which proper infection control measures were maintained; however, these residents will need to participate in surveillance testing as outlined in the PHO.

- Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. In addition, residents with a negative test prior to admission should be managed the same as residents with unknown COVID-19 status, including transmission-based precautions during an observation period. The rationale is that a negative test does not rule out incubating disease that might develop during the observation period.

COVID-Vaccinated Admissions

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

Visitation

While COVID-19 continues to present a substantially increased risk of mortality among older adults and individuals with underlying medical conditions in the state of Colorado, social isolation of individuals in nursing homes, group homes, assisted living communities, intermediate care facilities, and other congregate settings impose substantial physical and mental health consequences for these residents. The following guidance outlines the revised requirements for visitation in residential care facilities serving older adults and people with disabilities, to align with CMS guidance to include the impact of COVID-19 vaccination. The use of electronic communication and outdoor visitation is preferred, even when the resident and visitor are fully vaccinated. Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.

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

Key points

- Outdoor visitation should be preferred over indoor visitation whenever possible.
- Compassionate care visits must be allowed at all times, even during an outbreak.
- If the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask (covering both their nose and mouth) and cleaning their hands before and after contact.
- Indoor visitation should be allowed for all residents except:
    - Unvaccinated residents whenever the facility's COVID-19 county prior week test positivity rate is more than 10% and fewer than 70% of residents in the facility are fully vaccinated.
    - Vaccinated and unvaccinated residents with confirmed or suspected COVID-19 infection, until they have met the criteria to discontinue Transmission-Based Precautions.

- Vaccinated and unvaccinated residents in quarantine until they have met the criteria to discontinue Transmission-Based Precautions.

General Visitation Guidance

The following guidance outlines requirements for all indoor and outdoor visitation, as well as circumstances when visitation should be limited. Visitation can be conducted through different means based on a facility's structure and residents' needs such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. For all visitation, the facility shall:

- Have adequate staffing and personal protective equipment (PPE), as reported into EMResource. The facility may cease visitation if it does not have necessary staff or PPE to perform infection control practices. **The facility must contact CDPHE (residentialcarestriketeam@state.co.us) if it wishes to cease visitation due to a lack of staffing or PPE.**
- Require visitors to schedule an appointment for the visit to ensure the facility can safely accommodate the number of people and have enough staff to monitor compliance with required infection prevention activities.
- Appropriately schedule visits so that staff have sufficient time to ensure rooms and/or surfaces can be properly cleaned and disinfected according to manufacturer's instructions between each visit.
- Require visitors to remain in their cars or outside the building until their scheduled visit time.
- Require visitors to wear a well-fitting mask or respirator (without an exhalation valve) which covers their nose and mouth during the entirety of the visit.
    - Residents should wear a well-fitting mask or respirator (without an exhalation valve) which covers their nose and mouth unless it is medically contraindicated.
- Deny entry to visitors who do not pass screening or who refuse to comply with any of the indoor visitation requirements set forth in this guidance.
- Cease visitation for visitors and residents who do not adhere to the core principles of COVID-19 infection prevention during the visit.
- Consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors and to allow the facility to maintain proper infection control procedures with additional people in the building.

Who May Visit

All residential care facilities, including those which do not meet the criteria for indoor visitation, must allow entry and may not deny entrance for the following services:

- **Essential health care service providers**
    - This includes but is not limited to physicians, hospice, and home health staff of all disciplines, along with other types of both medical and nonmedical health care and services.
    - Essential health care services providers must be screened and tested in accordance with the surveillance and outbreak testing prescribed in the Sixth Amended PHO 20-20
    - Essential health care service providers must either produce a negative COVID-19 test within the prescribed testing frequency the

facility is following or submit to facility testing.

- **Religious exercise**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Adult Protective Services**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Long Term Care Ombudsman**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Designated Support Persons**
  - Support service providers must be screened and may be offered testing in accordance with the surveillance and outbreak testing prescribed in the Sixth Amended PHO 20-20
- **Compassionate Care Visits should be permitted at all times**
  - Screening is required.
- **Emergency medical service personnel**
  - Neither screening nor testing is required.
  - Emergency medical and service personnel shall not be delayed from response or access in relation to responding and carrying out their duties.
- **Ancillary non-medical services**
  - Includes hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists.
  - Ancillary services must be provided in the resident's room or in a separate room that is appropriately disinfected between uses.
  - Must wear appropriate PPE and follow appropriate infection control measures prior to, during, and after each resident encounter.
  - Comply with the policy and procedures regarding infection control, and abide by all other precautions and restrictions imposed on their profession that would be required in any setting.

Visitation Restrictions

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

- The resident participating in the visit has symptoms of COVID-19 or an active COVID-19 infection.
- The resident participating in the visit is on transmission-based precautions (e.g., COVID-19 isolation, droplet or contact precautions). This includes residents on observation following admission.
- Statewide restrictions are implemented due to increased cases of COVID-19.
- If the facility's COVID-19 county positivity rate is more than 10% and fewer than 70% of residents in the facility are fully vaccinated, indoor visitation for unvaccinated residents should be limited to compassionate care visits only.
  - The facility shall utilize the COVID-19 Colorado Dial Dashboard to determine their county's average one-week positivity rate.
- Residents with confirmed COVID-19 infection should refrain from visitation, whether vaccinated or unvaccinated, until they have met the criteria to discontinue Transmission-Based Precautions.

- Residents in quarantine, whether vaccinated or unvaccinated, should refrain from visitation until they have met criteria for release from quarantine.

Prior to Implementing Visitation

The facility shall:

- Notify residents' families and friends that general visitation is occurring in the facility. The notification should include:
    - Requirements, expectations and limitations of visitation.
    - Instructions for self-screening along with information about when the results of the screening would require a cancellation of the visit.
    - Information on minimizing the spread of COVID-19, including instructions for how to properly wear a **mask**. For the purposes of facility visitation, masks with exhalation valves cannot be worn by visitors, residents, or staff members as they cannot prevent the spread of respiratory droplets to others.
    - Instructions for physical distancing and requirements for wearing a mask.
    - Instructions for scheduling visits, arriving, checking in for the visit, and screening with staff prior to entry.

Outdoor Visitation

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

- The designated meeting area should be isolated. The facility should ensure that residents not participating in visits continue to have access to separate outdoor space.
    - The meeting area should be monitored to ensure it remains separated from the facility population and from facility staff.
- The number of visitors should be determined by using the outdoor social distancing calculator, which will provide the allowable number based on the square footage of the area that will be designated for outside visits.
    - The allowable number of persons (resident, staff, and visitors) is either the calculated number or eight, whichever is smaller.
    - Any codes, regulations, or ordinances requiring a smaller number of people must be followed.
    - This number of maximum visitors allowed must be documented in the visitation plan.
- Furniture used for external visits should be appropriately disinfected between visits.

Indoor Visitation

Facilities should allow indoor visitation at all times and for all residents, regardless of vaccination status. Ensuring the following:

- The facility should restrict the total number of visitors according to the size of the facility in order to maintain core principles of infection prevention as well as the number of visitors allowed per resident at one time. CDPHE recommends allowing no more than two visitors per resident per room.
- Visitors are not required to show proof of COVID-19 vaccination or a negative COVID-19 test at the time of the visit. Visitor vaccination is preferred, but it should NOT be a condition for visitation.
- Facilities may choose to offer rapid testing of visitors; however, it cannot be a contingency for visitation. Facilities should deny entry to visitors who test positive.
    - Facilities should have a process in place to respond to positive results. Should a potential visitor test positive, the visitor's positive test will not impact the facility's outbreak status even if the visitor has been in the facility during the prior 14 days. The visitor could be counted towards the facility's outbreak status if an epidemiological link is identified.
    - If the facility arranges, suggests, or performs COVID-19 testing for visitors, the test results must be obtained in a reasonable amount of time and visitation cannot be denied as a result of prolonged turnaround time.
- All visitors must be screened for COVID-19 symptoms, and facilities should limit visitor movement in the facility by following these procedures:
    - Greet visitors at a designated area at the entrance of the facility where a staff member must:
        - Perform temperature check and symptom screening.
        - Document the visitor's contact information and the results of the screening. This example form may be used to document the information.
        - Deny entry to visitors who have a positive test or display symptoms during the screening.
        - Ensure the visitor has a face mask that does not have an exhalation valve, and ensure the mask covers the visitor's nose and mouth.
        - Have the visitor clean their hands with alcohol-based hand sanitizer.
        - Escort the visitor to the designated visitation area.
- Indoor visitation should occur in dedicated visitation spaces and private rooms that allow for appropriate physical distancing according to the distancing space calculator, proper ventilation (open windows, etc.), and cleaning and disinfection between visitors.
    - If the room is shared, the resident's roommate must be fully vaccinated and the facility shall obtain the consent of the roommate and/or the roommate's POA that visitation may occur in the room.

        - Visitors must not access the roommate's living area or have contact with the roommate's environment.
        - If the room is shared, ensure visits do not overlap. This is to limit the number of visitors in a resident's room at any given time.
    - In-room visits do not require staff supervision.
- Residents that are fully vaccinated may have limited physical contact with screened visitors (e.g., hugging and/or hand holding) within resident rooms. Both the resident and their visitor should wear a well-fitting face mask and perform hand hygiene before and after contact. Visitors should still physically distance from other residents and staff in the facility.
- Internal group gatherings, such as dining and group activities, should be restricted in these areas during visitation to prevent potential exposure to other residents.
- For smaller facilities, such as those in residential home-like structures and/or those with limited room ventilation systems, indoor visitation must be limited to one visitor for one resident at a time with no congregating of individuals or groups of residents or visitors in the area being used for indoor visitation.

Visitation During an Outbreak

Visitation can still occur when there is an outbreak under certain circumstances. When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation, until at least one round of facility-wide testing is completed. **Residents in isolation or quarantine are not eligible for visitation until discontinuation of transmission based precautions**. Visitation can resume based on the following criteria:

- If the first round of outbreak testing reveals no additional COVID-19 cases, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend indoor visitation in the affected unit until the facility meets the criteria to discontinue outbreak testing. The facility may continue with outdoor visitation for all residents with a negative COVID-19 test after the first round of outbreak testing.
- If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend indoor visitation for all residents (vaccinated and unvaccinated) until the facility meets the criteria to discontinue outbreak testing. The facility may continue with outdoor visitation for all residents with a negative COVID-19 test after the first round of outbreak testing.
- Both indoor and outdoor visitation must be stopped if any round of outbreak testing results in any of the following:
    - COVID-19 transmission outside the original pod or neighborhood.
    - Greater than 10% of the resident population is impacted.
    - COVID-19 transmission that continues in a resident population for greater than 4 weeks.
- In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility.

Note: compassionate care visits and visits required under federal disability rights law should be allowed <u>at all times</u>, for any resident (vaccinated or unvaccinated)

regardless of the above scenarios.

Visitation: Miscellaneous Considerations

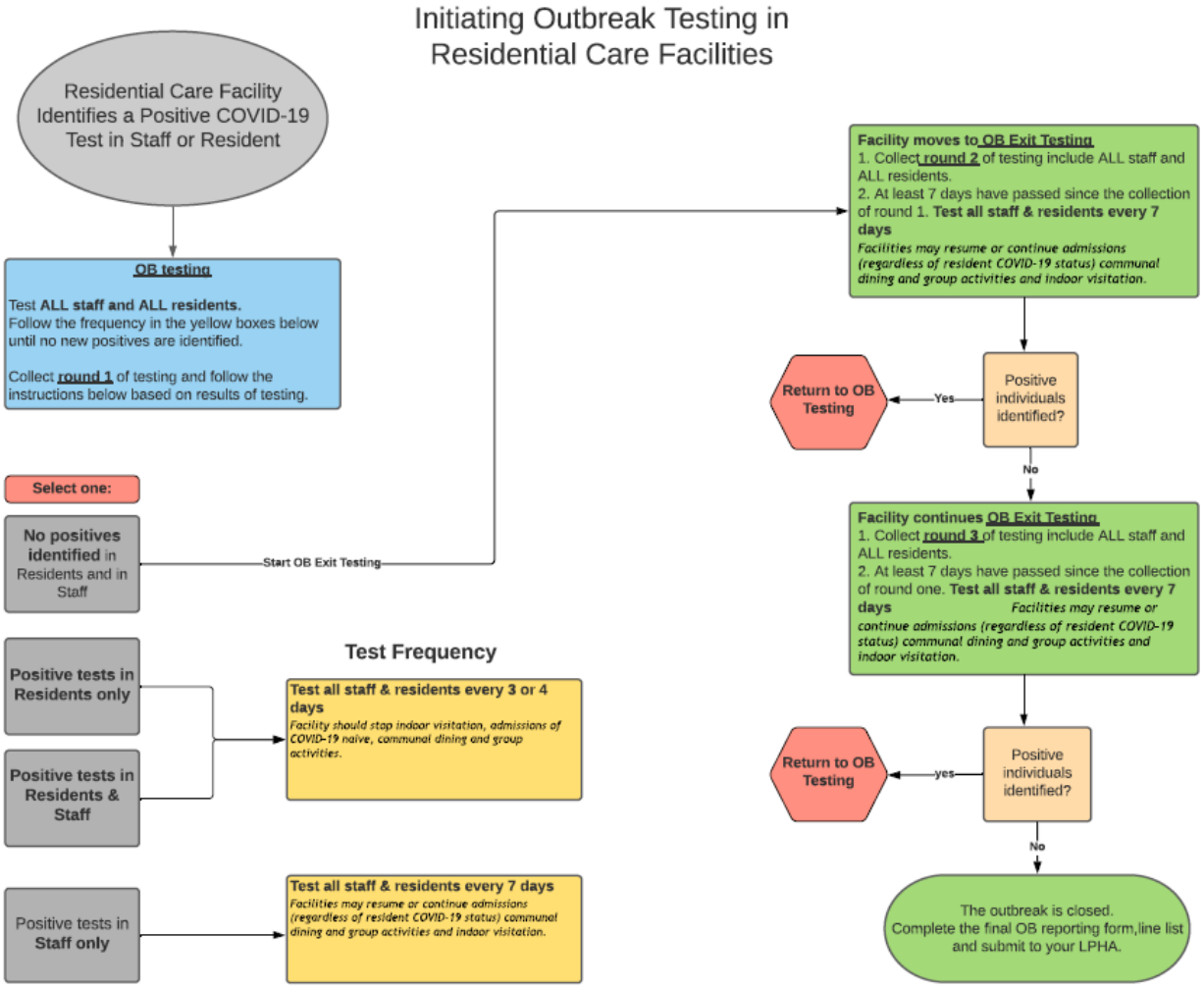
- With pre-notice and facility permission, pets may accompany a visitor for a visit with a single resident. Pets can aid in the transmission of COVID-19 and therefore the pet must be kept away from other staff and residents during the visit (inside or outside). The facility should have policies and procedures regarding the safety and parameters for pet visitation, including criteria for vaccinations and infection control.
- Visitors who are unable to comply with the required infection control measures for visitation, including mask use, will be denied entry for visitation.
- Remind visitors that they should refrain from visiting for at least 14 days if they have been in close contact with anyone who has tested positive for or has symptoms consistent with COVID-19. Visitors should alert the facility if they develop fever or other symptoms consistent with COVID-19, or if they are diagnosed with COVID-19 in the 14 days following visitation. Promptly notify public health if such notification occurs.
- Unvaccinated residents who have recovered from COVID-19 (no longer on transmission-based precautions) within the past 90 days of their infection (i.e., positive test) can also participate in private indoor visitation in the residents' room.

Communication

- Communicate with staff, residents, and families about suspected or confirmed COVID-19 cases/outbreaks, steps the facility is taking in response to the cases/outbreak, and visitation.
- Ensure outbreaks are reported to public health (as outlined above).
- Confirmed outbreaks will be publicly reported by facility name on the CDPHE website: https://covid19.colorado.gov/outbreak-data.

Attachment Image 1

Testing Decision Tree


Initiating Outbreak Testing in Residential Care Facilities
Residential Care Facility Identifies a Positive COVID-19 Test in Staff or Resident
OB testing
Test ALL staff and ALL residents.
Follow the frequency in the yellow boxes below until no new positives are identified.
Collect round 1 of testing and follow the instructions below based on results of testing.
Select one:
No positives identified in Residents and in Staff
Start OB Exit Testing
Facility moves to OB Exit Testing
1. Collect round 2 of testing include ALL staff and ALL residents.
2. At least 7 days have passed since the collection of round 1. Test all staff & residents every 7 days
Facilities may resume or continue admissions (regardless of resident COVID-19 status) communal dining and group activities and indoor visitation.
Positive individuals identified?
Yes
Return to OB Testing
No
Facility continues OB Exit Testing
1. Collect round 3 of testing include ALL staff and ALL residents.
2. At least 7 days have passed since the collection of round one. Test all staff & residents every 7 days
Facilities may resume or continue admissions (regardless of resident COVID-19 status) communal dining and group activities and indoor visitation.
Positive individuals identified?
yes
Return to OB Testing
No
The outbreak is closed.
Complete the final OB reporting form,line list and submit to your LPHA.
Test Frequency
Positive tests in Residents only
Positive tests in Residents & Staff
Test all staff & residents every 3 or 4 days
Facility should stop indoor visitation, admissions of COVID-19 naive, communal dining and group activities.
Positive tests in Staff only
Test all staff & residents every 7 days
Facilities may resume or continue admissions (regardless of resident COVID-19 status) communal dining and group activities and indoor visitation.