



# TEXAS

## Health and Human Services

### COVID-19 RESPONSE FOR NURSING FACILITIES

#### Abstract

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

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## POINTS OF CONTACT FOR THIS DOCUMENT

### Texas Health and Human Services Commission Regulatory Services Division

Michelle Dionne-Vahalik, DNP, RN  
Associate Commissioner, LCTR  
To activate SWAT assistance  
[Michelle.dionne-vahalik@hhsc.state.tx.us](mailto:Michelle.dionne-vahalik@hhsc.state.tx.us)  
Phone: 512-962-3260

Renee Blanch-Haley, BSN, RN  
Director of Field Operations, LCTR  
Survey Operations  
[Renee.Blanch-Haley@hhsc.state.tx.us](mailto:Renee.Blanch-Haley@hhsc.state.tx.us)  
Phone: 512-571-2163

Cecilia Cavuto  
Nursing Facility, Policy Manager  
Contact for Policy and Rule  
[Cecilia.Cavuto@hhsc.state.tx.us](mailto:Cecilia.Cavuto@hhsc.state.tx.us)  
Phone: 512-650-6401

Michael Gayle, PT  
Director of the Quality Monitoring Program  
Nursing Facility Technical Assistance and Infection Control Best Practice  
[Michael.Gayle01@hhsc.state.tx.us](mailto:Michael.Gayle01@hhsc.state.tx.us)  
Phone: 512-318-6902

## TABLE OF CHANGES

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## I. Purpose:

The purpose of this document is to provide nursing facilities (NFs) 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 NF
- 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 NF COVID-19 event

## III. Summary:

Residents of NFs 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, resulting in potentially rapid spread among a highly vulnerable population.

This document provides NFs 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 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. NFs 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.

NFs 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 that communal activities, including dining, should be canceled, and no more than 10 people, maintaining at least 6 feet of separation, can 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 affect workforce availability, health care system support, and interactions with public health, emergency care, and

jurisdictional administration. Texas currently has 1,220 NFs and nine Maintain Patient Care hospital-based SNF units.

*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, these facilities have a higher risk of infection and face more challenges controlling spread when infection occurs. 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 personal protective equipment (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, affecting 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, approximately 30 NFs are equipped to care for residents on ventilators. Bed capacity (along with staff and PPE availability) also affects the number of residents for which each facility can provide care. COVID-19 positive residents will increase the staff and resources required to provide care, further limiting the number of residents that a facility can serve.

*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, affecting mobility and intellectual capacity.



### *Impact of resident demographics on COVID -19 response*

All NF residents require 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 is made up of 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, to 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 cannot 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 he or she will expose residents and staff in more than one NF, making it difficult to contain spread. A 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 regularly enter facilities. Many perform services essential 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 and only if these essential visitors are properly screened.

### *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 such as 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 increases the risk of infection for residents and staff.

## VI. To Do's for Nursing Facilities:

- Review the CDC's [Key Strategies to Prepare for COVID-19 in Long-term Care 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 to HHSC.
- Obtain and properly use PPE.
- Comply with all CMS and CDC guidance related to infection control. (NFs need to frequently monitor CDC and CMS guidance, as it is being updated often.)
- For the duration of the state of emergency, all NF personnel should wear a facemask while 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, as well as 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 a positive case occurs.
- Coordinate resident diagnoses and symptoms with transferring and receiving hospitals and other NFs.
- Communicate with residents, staff, and family when exposure, suspected, or confirmed cases occur 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.
- Follow the guidance beginning on page 25 of this document to determine when staff can return to work after recovering from an illness.
- Post a list of state contacts where it is visible on all shifts. **The list should at least include phone numbers for the local health authority or DSHS office and the regional HHSC LTCR office.**
- Follow physician's plan for immediate care of any resident with a positive case. Orders can include increased assessment frequency, increased monitoring of fluid intake and output, supportive care, a treatment plan, and what to do in case of a change in the resident's status.
- Inform the resident of treatment or supportive care plans; residents have the right to participate in care planning.
- Work with the local health authority (LHA) or DSHS to determine a COVID-19 testing strategy for residents and health care workers (HCW).

## 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, or difficulty breathing – for each resident at least once each shift.
- **P**rotection/PPE – Protect 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 Long-term Care Regulatory to report confirmed cases.
- **E**valuate – Infection control processes, spread of infection and mitigation efforts, and staffing availability need to be assessed.

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, HHSC will take the following steps:

- Verify the NF is prohibiting non-essential visitors.
- Generate a priority 1 intake (must be investigated within 24 hours).
- 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 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 tests 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.

## 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 resident
- Screen residents for signs and symptoms
- Screen staff for signs and symptoms
- Enact HAI procedures
- Clean and disinfect facility
- 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
- Work with the local health department or DSHS to activate testing strategy

### Extended (24-72 hours)

- Supply PPE for HCWs, staff
- Screen residents for signs and symptoms
- Continue specialized HAI procedures
- Activate patient transport (residents 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

- Work with your LHD or DSHS to establish a resident recovery plan, including when a resident is considered recovered and next steps for care.

#### Long Term (72 hours plus)

- Screen patient for signs and symptoms
- Continue cleaning and disinfecting procedures
- Activate transport (residents in) protocols
- Establish contact with transporting/receiving agencies (hospitals, other facilities)
- Lift of facility restrictions/lockdown
- 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:

- Developing recommendations in consultation with 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.)

This team will assist NFs with management of a COVID-19 event by providing subject matter expertise, resource request management, and other 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.

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

## 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
- Work with the local health department or DSHS to activate testing strategy

##### Create an isolation wing/unit

- Identify a separate, well-ventilated area to use as an isolation area. This NF area should be an isolated wing, unit, or floor that provides meaningful separation between COVID-19 positive residents and the space where the facility cares for residents who are COVID-19 negative or untested and asymptomatic. A curtain or a moveable screen does not provide meaningful separation.
- When possible, use an area with an entrance separated from the rest of building. The isolation space should be separated so the essential NF personnel maintaining the building or providing services to residents in the isolation space are not required to go through areas where negative or asymptomatic residents are receiving care.
- Provide handwashing areas as needed, including inside and outside of the entrance to isolation area when possible.
- Use a private bedroom with its own bathroom for each resident when possible.
- Use a semi-private bedroom and cohort COVID-19 positive residents if necessary.
- House a resident in the same bedroom for their entire stay when possible.
- Limit resident transport and movement to medically essential purposes only.
- Use dedicated HCW and staff for the isolation area,
- Minimize traffic in and out of the isolation area,
- Provide dedicated areas within the isolation area for HCW and staff use, including break rooms, medication rooms, and supply rooms.

- Provide adequate staff with training, skills, and competencies for COVID-19 care.
- Provide dedicated and adequate PPE, supplies and equipment for use in the isolation area.
- Train HCW and staff on proper use and maintenance of PPE per CDC guidance.
- Use dedicated staff to provide meal service and cleaning in the isolation area.
- Transfer all of a resident's personal belongings to the new bedroom in the isolation area, and ensure all belongings are disinfected before they are moved out of the isolation area.

#### HCW/staff leaving and entering isolation wing/unit

- Directly after entering the isolation area and prior to donning PPE, perform hand hygiene
- Put on proper PPE
- Perform hand hygiene before and after performing resident care
- Directly before exiting the isolation area, remove PPE
- Perform hand hygiene
- Exit isolation area, and directly after leaving the isolation area, perform hygiene

#### Protect from infection

- **Enact PPE plans**
- Determine PPE supplies
- Screen residents/essential visitors
- Contact other facilities where exposed might have visited/worked
- Consult with local health department (LHD) or DSHS 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
- **Work with your LHD or DSHS to establish a resident recovery plan, including when a resident is considered recovered and next steps for care.**

#### Other

- Contact LHD/DSHS regional office/health authority (HA)
- Ensure all relevant regulations/rules are followed
- Notify families, staff, residents
- 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

#### Creating a voluntary isolation NF

- Identify NF location to use as an isolation facility
- Identify service and supply vendors and notify them of anticipated operations start date. Example: Transportation, Oxygen Supply, Laundry, Hospice Agencies, ESRDs
- Arrange for PPE supplies and HCW/staff training.
- Discharge current residents to other NFs in the area if needed, working with residents and families, guardians, and local LTC Ombudsman.
- Standard discharge requirements apply, and a resident's rights are still protected. If current residents do not want to move to another NF, they are not required to move, and the facility should take all actions necessary to protect them from possible COVID-19 exposure.
- Follow steps for establishing an isolation wing or unit if residents do not want to move.
- When residents move, transfer all personal belongings to limit the risk of contamination.
- Work with the LHD or DSHS to test residents per the testing strategy prior to moving them to other NFs.
- Staffing considerations:
  - Provide additional training specific to caring for persons with COVID-19
  - Provide additional PPE training
  - Provide meals to all employees to limit items brought into the facility and to limit them exiting the facility
  - Provide showers and changing area for the start and end of each shift
  - Increase housekeeping and laundry to accommodate increased needs in a COVID-19 positive environment
  - Use an off-site location for interviewing, and orientation of additional employees
  - Conduct twice daily COVID-19 conference calls 7 days a week to hear staff concerns and provide immediate support

## 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 local 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

### **S**urveillance

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

### **P**rotection/Personal Protective Equipment

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

### **I**solate

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

### **C**ommunicate

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

### **E**valuate

- 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 provides guidance to nursing facilities (NFs), 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 staff. 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 to 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 facilities to restrict visitors except those deemed medically necessary.

This is an important measure to prevent the introduction of the virus that causes COVID-19 into NFs. DSHS recommends all NFs restrict all non-essential 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 whose death is imminent.

1. For people allowed in the facility (in end-of-life situations when death is imminent), instruct visitors before they enter the facility and residents' rooms on hand hygiene, limiting surfaces touched, and use of 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 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 NFs 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. 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 Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) 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 health care personnel (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](mailto: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 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
  - N95 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 NFs are not new and include increasing hand hygiene compliance among staff, residents, and their families through education and on the spot coaching, as well as 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 three times daily for fever and respiratory symptoms (including shortness of breath, new or change in cough, sore throat, and oxygen saturation).** 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](#).

**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.

Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments.

If COVID-19 is identified in the facility, restrict all residents to their rooms and have HCP wear [all recommended PPE](#) for care of all residents (regardless of symptoms) on the affected unit (or facility-wide, depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use, including putting it on and taking it off.

**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** - Educate 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.

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

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

#### 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 Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) 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.

**Minimize staff movement between facilities** - Facilities should minimize the movement of staff between facilities whenever possible.

**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.

**Staff return to work** – After being diagnosed with COVID-19, an employee can return to work per CDC guidance.

After the employee returns to work, both the provider and the employee must take all necessary measures to ensure the safety of everyone in the facility, including wearing a facemask at all times while in the facility, being restricted from contact with patients who have a weakened immune system, and adhering to all infection control procedures, including hand hygiene, respiratory hygiene, and cough etiquette.

Note: If the employee was diagnosed with a different illness (e.g., influenza) and was never tested for COVID-19, base their return to work on

the criteria associated with that diagnosis.

**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.

#### 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 on the [DSHS Local Health Entities](#) website.

Work with your local health department to complete the COVID-19 Case Report form if and when necessary.

Long-term care facilities are also required to notify HHSC Long-term Care Regulatory of any confirmed cases in either residents or staff.

[You can find information about reporting to HHSC on the Complaint and Incident Intake website.](#)

[In addition, CMS now requires NF providers to report to the CDC all confirmed COVID-19 cases and persons under investigation for COVID-19 among residents and staff.](#)

[CMS also requires NFs to keep all residents' and their representatives up to date on the conditions inside the facility, such as when new cases of COVID-19 occur.](#)

## 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, as well as to HHSC.

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 are required to report suspected outbreaks to your local health department, local health authority or DSHS pending COVID-19 test results. 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. 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' [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, gender, 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.

## 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



## List of Referenced Resources

### CDC

[Cleaning and Disinfecting Your Facility](#)

[Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings \(Interim Guidance\)](#)

[Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings - Includes PPE Recommendations](#)

[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 \(COVID-19\)](#)

[Key Strategies to Prepare for COVID-19 in Long-term Care Facilities](#)

[Strategies for Optimizing the Supply of Facemasks](#)

[CDC Guidance on the Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19](#)

### CMS

[QSO 20-14 Guidance for Infection Control and Prevention of Coronavirus Disease 2019 \(COVID-19\) in Nursing Homes](#)

[QSO 20-26 Upcoming Requirements for Notification of Confirmed COVID-19 \(or COVID-19 Persons under Investigation\) Among Residents and Staff in Nursing Homes](#)

### EPA

[List N: Disinfectants for Use Against SARS-CoV-2](#)

### DSHS

[DSHS COVID-19 LTC Facility Staff Symptom Monitoring Log](#)

[DSHS Local Health Entities](#)

[Information on PPE](#)

[Line List Template](#)

[Strategies for Optimizing the Supply of PPE](#)

HHS

[The Difference Between Isolation and Quarantine](#)

HHSC

[CII – Reporting to HHSC](#)

[LTCR Regional Contact Information](#)

OOG

[Governor Abbot's Executive Order GA-16](#)

## Long-Term Care Facilities Coronavirus Disease 2019 (COVID-19) Symptom Monitoring Log

## Long-Term Care Facilities Coronavirus Disease 2019 (COVID-19) Symptom Monitoring Log

Instructions:

Screen all healthcare personnel (HCP) at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. Mark the symptoms below with 'Y' for Yes and 'N' for No. Don't leave any spaces blank. If any HCP are ill, have them put on a facemask and leave the workplace. As part of a routine practice, ask HCP to regularly monitor themselves for fever and symptoms of respiratory infection.

[illegible]

ATTACHMENT 5 – Tracking Line List – Click [HERE](#) for Source Document

[illegible]

ATTACHMENT 6: Extended Response Guidelines (To Be Developed)  
ATTACHMENT 7: Recovery Guidelines (To Be Developed)