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**Infection Control COVID-19**

**Policy Statement**

[facility name’s] Infection Control Program (ICP), includes policies and procedures to assist in preventing transmission of COVID-19 into the [facility name] campus. In the event a transmission occurs, prompt detection and effective triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among additional residents, employees, and visitors. [facility name] recognizes its high-risk population and, as such, the actions listed below will be implemented, and [facility name] will further coordinate the ICP and Emergency Preparedness (EP) plans to address COVID-19. These policies and practices are based on Infection Prevention and Control recommendations from the Centers for Disease Control (CDC), Illinois Department of Public Health (IDPH) and requirements implemented by the Centers for Medicare & Medicaid Services (CMS). This information is based on the information available about coronavirus disease 2019 (COVID-19) related to disease severity, transmission efficiency, and shedding duration. According to the CDC, their guidance is applicable to all U.S. healthcare settings and subject to change as more information becomes available.

This policy incorporates all guidelines related to the prevention and detection of COVID-19.

**Definitions:**

**Acute Respiratory Illness** is an illness characterized by any two of the following signs and symptoms that are new or worsening from baseline.

* Fever (greater than 100 degrees Fahrenheit or 37.8 degrees Celsius or more than two degrees above the resident’s baseline)
* Couth (productive or nonproductive)
* Runny nose or nasal congestion
* Sore throat
* Muscle aches
* Shortness of breath or difficulty breathing, which may manifest as increased fatigue
* Low oxygen saturation in the blood (normal levels are between 95-100% but may vary for people with certain medical conditions)

**Close Contact:** Being within 6 feet for a cumulative total of 15 or more minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

**Cohorting** is the practice of grouping residents infected with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. During outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission.

**Empiric Transmission Based Precautions:** Measures of infection prevention and control used in addition to standard precautions. Empiric transmission-based precautions are used when a patient or resident has a known or suspected infection with a pathogen that requires additional measures of precaution.

**Facemask:** OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as ‘medical procedure masks’”. Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Healthcare Personnel (HCP)***:* For the purposes of this document HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to residents or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in resident care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting.

**Higher-Risk Exposure:** HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and:

* The HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask.
* The HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask.
* The HCP was not wearing all recommended PPE (gown, gloves, eye protection, respirator) while present in the room for all aerosol generating procedures. dure.

**Immunocompromised: For the purposes of this document, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the** [Use of COVID-19 Vaccines in the United States](https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html) **document from the CDC.**

* **Other factors, such as end-stage renal disease, may pose a much lower degree of immunocompromise. However, people in this category should still consider continuing to use source control while in a healthcare setting.**
* **Ultimately, the degree of immunocompromise for the HCP is determined by the treating provider, and preventative actions are tailored to each individual and situation.**

**Illness Severity Criteria (Adapted from the NIH COVID-19 Treatment Guidelines):**

* **Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 without shortness of breath, dyspnea, or abnormal chest imaging.**
* **Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) at or less than 94% on room air at sea level.**
* **Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fracture of inspired oxygen (PaO2/Fi02) <300 mmHg, or lung infiltrates >50%.**
* **Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.**

**Isolation**means the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectiousfrom those who are not infected to prevent spread of the communicable disease.

**Nursing Home-Onset SARS-CoV-2 Infections:** refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:

* When a resident with known COVID-19 is admitted directly into transmission-based precautions, or
* When a resident known to have close contact with someone with COVID-19 is admitted directly into transmission-based precautions and develops COVID-19 before transmission-based precautions are discontinued.

**Outbreak:** Acute respiratory illness (ARI) or viral respiratory diseases (including COVID-19, Influenza, Respiratory Syncytial Virus or RSV, parainfluenza, human metapneumovirus, respiratory adenovirus, rhino/enterovirus, or other viral respiratory diseases meeting the outbreak definition).

* Three or more residents and/or staff in a building, within 72 hours of each other have an ARI, positive point of care test or laboratory-positive test for a single virus, and at least one of the cases is a resident.
* After 14 days without additional cases, respiratory outbreaks can be finalized and considered over. A new outbreak occurred if additional cases are identified after 14 days have passed.

**Personal protective equipment (PPE**) are protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. This includes but is not limited to gloves, gowns, goggles, facemasks, or respirators.

**Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are approved by CDC/NIOSH, including those intended for use in healthcare.

**Standard precautions** are infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infections agents.

**Source Control:** Use of respirators, well-fitting facemasks, or well-fitting cloth masks to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on children under the age of 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing one safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control.

**Transmission based precautions** are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission.

**Up to Date with COVID-19 Vaccines**: Up to date refers to the current CDC recommendations for receipt of COVID-19 vaccines. Current guidance on vaccine recommendations can be located on the [Staying Up to Date with COVID-19 Vaccines](https://www.cdc.gov/covid/vaccines/stay-up-to-date.html) document from the CDC.

**Routine Infection Prevention and Control Practices During the COVID-19 Pandemic:**

**[Enter facility name]** will encourage all healthcare providers, residents/tenants and visitors to remain up to date with COVID-19 vaccines, including education on the importance of vaccination and offering or assisting with coordinating vaccine administration as appropriate.

**Ensure adequate resources including personal protective equipment (PPE), alcohol-based hand sanitizer (ABHS), and testing supplies. Providers should have plans for increasing resource supplies when necessary such as an influx of symptomatic individuals and monitoring supply availability and access.**

**A visual alert will be posted at the entrance and in strategic locations throughout the building. These alerts will instruct individuals on current IPC recommendations such as when to use source control and performing hand hygiene.**

**Implementing use of source control based on individual symptoms, outbreaks in the health care setting, and increased prevalence of respiratory viruses in the community.**

**In consultation with building engineers, explore options to improve ventilation including opening windows during appropriate weather, providing portable air cleaners or purifiers, limiting box fan usage, ensuring the HVAC system is properly maintained including use of at least a MERV-13 filter.**

**Develop plans to provide rapid detection of respiratory viruses and treatments including establishing relationships with pharmacies to ensure adequate viral respiratory treatment and prophylaxis availability. Providers should consult with medical directors to consider establishing standing orders for testing, treatment, and chemoprophylaxis.**

**Establishing a process to make everyone entering the building aware of recommended actions to prevent transmission to others if they have any of the following criteria:**

* **A positive viral test for SARS-CoV-2**
* **Symptoms of COVID-19 including:**
	+ Fever or chills
	+ Cough
	+ Shortness of breath or difficulty breathing
	+ Fatigue
	+ Muscle or body aches
	+ Headache
	+ New loss of taste or smell
	+ Sore throat
	+ Congestion or runny nose
	+ Nausea or vomiting
	+ Diarrhea
* **Close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for HCP).**
* **Defer visits if possible until healthcare criteria have been met for discontinuing quarantine or isolation. If you must visit, report above criteria to the [enter title/name]** for additional directions.
* Staff will report the above symptoms to **[enter title/name]** for further directions.
* **[enter title/name]** will provide guidance to the individual reporting any of the above criteria to minimize COVID-19 transmission including:
	+ Following guidance described in the close contact/higher-risk exposure section of this policy.
	+ Those with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation; this time period is longer than what is recommended in the community.
	+ Individuals who had close contact or were in a higher-risk situation (such as large event). It is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria in the above section.

**Vaccination:**

All residents/tenants and staff will be screened upon admission/hire for COVID-19 vaccination status. If the resident/tenant or staff is not up to date (as defined by the CDC and referenced under the definition section of this policy), the resident/tenant, their representative (as appropriate) or staff member will be provided education on the benefits, risks and potential adverse effects of the COVID-19 vaccines. Upon review of the educational items provided to the resident or staff, they will be given an opportunity to consent or decline COVID-19 vaccination, in coordination with the attending physician or medical director.

Anytime the FDA authorizes, and CDC approves use of additional COVID-19 vaccines and/or doses, education will be provided to all residents/tenants (or their representatives as appropriate) and staff members who are not up to date on the COVID-19 vaccine(s), and an updated consent/declination will be completed.

If available and able, COVID-19 vaccines will be administered by the provider. If the COVID-19 vaccines are not available/able to be administered by the provider:

* Resident/tenant’s will be assisted with setting up an appointment and transportation to/from a vaccine provider for receipt of the vaccine.
* Staff members will be provided information on locations that are able to administer the vaccine and assisted as much as possible to obtain vaccination.

All resident/tenant and staff vaccination status’ will be documented either in the resident/tenant’s medical record or in the staff’s medical file.

For nursing home providers, vaccination status will be reported to the CDC’s NHSN Reporting Modules as required by CMS.

**Source Control:**

The use of universal source control including well-fitting facemasks or respirators covering a person’s mouth and nose will be based on several factors outlined below.

* **[Enter Provider Name]** guidelines for universal source control include:
	+ **[enter provider specific guidelines here]**
* Individuals who have suspected or confirmed COVID-19 or other respiratory illness/symptoms must wear source control at all times when in the building.
* When levels of respiratory virus are increasing in the community, visitors and HCP are recommended to wear a facemask at all times. In addition, residents may be encouraged to wear a mask whenever leaving their room. Data may be obtained from the [IDPH Seasonal Respiratory Illness Dashboard](https://dph.illinois.gov/topics-services/diseases-and-conditions/respiratory-disease/surveillance/respiratory-disease-report.html).
* Health care settings can implement broader use of source control at their discretion.
* Individuals who had close-contact or a higher-risk exposure to someone with COVID-19 must wear source control at all times when in the building for 10-days following the close-contact or higher-risk exposure.
* Individuals may choose to wear source control at any point based on their individual preference.
* Acceptable forms of source control based on individual preference include a well-fitting face mask or a respirator with higher-level protection that is not visibly soiled.
* When not used for high-risk procedures or when caring for a resident/tenant in transmission-based precautions source control can be utilized for an entire shift.

**PPE Use for Healthcare Providers:**

All healthcare providers will utilize standard precautions for all patient-care encounters according to policies and procedures.

If a resident/tenant is suspected or confirmed to have COVID-19 healthcare providers will utilize transmission-based precautions including an N95 or higher-level respirator, gloves, isolation gown, and eye protection, under conventional strategies which include removal or disinfection of all PPE following each resident encounter, or as otherwise directed in infection control policies and procedures.

**Testing:**

Testing for COVID-19 will be completed according to CDC recommendations. Tests will be performed according to the FDA Emergency Use Authorization or FDA approval for the COVID-19 testing device or kit and the manufacturer’s recommendations.

Admission:

* Pre-admission testing is at the discretion of the provider.
* When utilized, providers should test residents:
	+ The initial test will be conducted on the day of admission.
	+ If the initial test is negative, a 2nd test is completed 48 hours following the first.
	+ If the second test is negative, a 3rd test is completed 48 hours following the second.
* Residents/tenants who leave the building for 24 hours or longer will be tested in accordance with admission testing as appropriate.

Symptomatic:

* Testing will be conducted as soon as possible, regardless of their vaccination status, on any healthcare provider or resident/tenant that has symptoms consistent with COVID-19.
* Healthcare providers and residents/tenants will be isolated as indicated in the isolation section later in this policy and isolation/return to work criteria will be followed.
* A point of care (POC)/Flu A&B rapid antigen test should be completed when a resident develops symptoms. If the POC test is negative, a follow up PCR test should be conducted. Providers can consider sending a multiplex broad respiratory PCR panel if both COVID-19 and influenza are negative on POC testing. If PCR testing is also negative for COVID-19 and Influenza, a subset of isolates should be sent for a multiplex broad respiratory PCR. These specimens can be sent to any laboratory that performs multiplex testing or, with prior health department approval, specimens can be sent to the Illinois Department of Public Health, where testing will be done free of charge.

Close Contact (resident/tenant) or High-Risk Exposure (healthcare provider):

* Residents/Tenants that have been exposed to an individual with COVID-19 as defined in close contact or high-risk exposure in this policy must be tested with a series of 3 tests.
	+ The initial test should be conducted immediately, but not earlier than 24 hours following the exposure.
	+ If the initial test is negative, a 2nd test is completed 48 hours following the first.
	+ If the second test is negative, a 3rd test is completed 48 hours following the second.
* HCP exposed to COVID-19 (or other ARI) and are asymptomatic should wear source control from the day of first exposure through the 5th day after last exposure, monitor for development of signs and symptoms for 5 days after their last exposure.
	+ Work restrictions are generally not necessary.
	+ Testing should be completed as noted above.

Testing on Individuals with Previous COVID-19 Infection:

Testing is generally not recommended on individuals who have recovered from COVID-19 infection within the last 30 days.

Testing should be considered for individuals who have recovered from COVID-19 infection within the last 31-90 days, however, it is recommended to test these individuals with an antigen test instead of a nucleic acid amplification test (NAAT) due to individuals testing positive on a NAAT test but not being infectious during this period.

Residents/tenants Who Refuse Testing:

**[enter facility name]** will educate residents/tenants who refuse to be tested for COVID-19 on the importance of being tested based on the circumstances. If the resident/tenant continues to refuse to be tested the resident/tenant will **[input procedures for residents/tenants that refuse testing.].**

Outbreak:

A single case of COVID-19 identified in a resident/tenant or healthcare provider will trigger an outbreak investigation. If **[enter facility name]** is able to identify close-contacts (resident/tenant) or higher-risk exposures (healthcare provider) to the newly identified case of COVID-19, testing should be conducted according to the previous section (close contact or high-risk exposure).

If healthcare transmission is identified or **[enter facility name]** is unable to contact trace, broad based testing strategies should be implemented. Broad based testing could begin with individual units or departments. If additional cases of COVID-19 are identified or ongoing cases identified despite initial mitigation measures, testing should be expanded. Broad based testing occurs every 3-7 days for all residents and healthcare providers until no further new cases are identified for a 14-day period.

If additional cases are identified during contact tracing, consideration will be given to shifting to broad-based testing strategies if not already implemented.

Outbreaks must be reported to the following:

* All providers must report outbreaks of all ARI to the local health department (LHD) via [RedCap Outbreak Reporting Tool](https://redcap.dph.illinois.gov/surveys/?s=JR9K8FXNETK8H3XN).
* Providers licensed by IDPH must report all outbreaks of ARI to the Office of Healthcare Regulations (OHCR) by submitting a [long-term care incident report](https://dph.illinois.gov/content/dam/soi/en/web/idph/forms/topics-services/health-care-regulation/complaints/LTC-incident-reporting-form-7.2022.pdf) via the [OHCR Portal](https://llcs.dph.illinois.gov/s/facility-lookup?language=en_US) or via email.
* All CMS certified providers must report cases and vaccination data to the [National Healthcare Safety Network](https://www.cdc.gov/nhsn/ltc/index.html) (CDC).

Upon recognition of a confirmed or suspected outbreak of respiratory illness, consideration should be made to temporarily halting new admissions until infection prevention staff are able to consult with the local health department. If the outbreak is confined to a specific unit, wing, or floor, admissions may be allowed to areas not affected by the outbreak if they have staffing, space and supplies to safely admit residents. A pause of new admissions to the affected areas may be considered, but admissions and readmissions should be facilitated whenever safely possible.

**Employee Return to Work Criteria**

Staff should be given support and flexibility to encourage them to stay home from work. To the extent possible, logistical barriers and financial hardship should be reduced.

The following criteria is used to determine when healthcare personnel with SARS-CoV-2 infection can return to work.

HCP with **mild to moderate ARI** who are not moderately to severely immunocompromised could return to work after the following criteria have been met:

* At least 3 days have passed since symptom onset, at least 24 hours have passed with no fever (without the use of fever-reducing medicines), symptoms are improving, and they feel well enough to return to work.
	+ If a positive test result is noted, but the HCP is asymptomatic throughout the infection, they should not return to work until at least 3 days have passed since their first positive test.
	+ Symptom onset or positive test is day, making the first return to work day 4.
* Upon return to work, the HCP shall wear a facemask in all areas of the building, including patient care and common areas for at least 7 days after symptom onset or the positive test (if asymptomatic), if not already wearing a facemask as source control.
* Consider reassigning or excluding these HCP from care of patients at highest risk of severe disease, including those with moderate or severe immunocompromising conditions, for 7-10 days after symptom onset or resolution, whichever is longer.

HCP with **severe to critical illnesses** or who are moderately to severely immunocompromised could return to work after the following criteria have been met:

* Should refer to the individual provider’s occupational medicine, infection prevention, or policy before returning to work as these individuals may shed viruses for longer periods. You may consider consulting with infectious disease specialists or other experts and/or using a test-based strategy in making this determination.

**Recommended Infection Prevention and Control Practices for Residents/tenants with Suspected or Confirmed COVID-19**

Close Contact:

In general, residents/tenants who are asymptomatic that have been in close contact with an individual with COVID-19 do not require isolation with transmission-based precautions. However, **[enter facility name]** may determine that isolation with transmission-based precautions are necessary on a case-by-case basis which will be documented in the resident/tenant’s medical record. Circumstances that may warrant isolation include but are not limited to:

* The resident/tenant is unable to wear source control as recommended for 10 days following close contact.
* The resident/tenant refuses to be tested for COVID-19 as recommended.
* The resident/tenant is moderately to severely immunocompromised.
* The resident/tenant resides on a unit with other residents/tenants who are immunocompromised.
* The resident/tenant is residing on a unit experiencing ongoing COVID-19 transmission that is not controlled with initial interventions.

If a resident/tenant is placed in empiric transmission-based precautions because of close contact, the resident/tenant can be removed from transmission-based precautions:

* After day 7 following close contact (the day of close contact is day 0), if the resident/tenant remains asymptomatic and all testing is negative.
* After day 10 following close contact (the day of close contact is day 0), if the resident/tenant remains asymptomatic and testing is not completed.

Symptomatic/Confirmed COVID-19:

Residents/tenants with symptoms consistent with COVID-19 or have tested positive for COVID-19 should ideally be placed in a single-person room, including a dedicated bathroom, with the room door closed (if safe to do so). Transmission-based precautions must be implemented, including additional use of PPE as identified in this policy.

Nursing home providers could consider designating entire units within the building or cohorting, with dedicated healthcare providers, to care for residents. If implemented, cohorting should consist of:

* An area for residents who are COVID-19 positive.
* An area for residents who are symptomatic consistent with symptoms of COVID-19, but testing results are pending.
* An area for residents who are in empiric transmission-based precautions for close contact exposures.
* An area for residents who have not been in close contact and are asymptomatic.

Nursing homes that are unable to cohort residents in single rooms are encouraged to cohort residents with similar communicable diseases, including consideration for MDROs.

In circumstances of either a really low or high number of COVID-19 cases are identified or staffing shortages are present, dedicated units may not be feasible, and COVID-19 positive residents may reside in their own room, ideally without a roommate.

Care for symptomatic or positive residents/tenants include:

* Limiting movement outside of their room and only for medically essential purposes.
* Communicating COVID-19 status to all other departments/healthcare entities that the resident/tenant may receive care from.
* Aerosol-generating procedures should be performed cautiously and avoided if appropriate alternatives exist. If necessary:
	+ These procedures should be completed in an airborne infection isolation room (AIIR), if possible.
	+ The number of healthcare providers present during the procedure should be limited to only those essential for the treatment and procedure support.
	+ Visitors should not be present during the procedure.

Discontinuing Transmission-Based Precautions for Symptomatic Residents/Tenants:

Residents/tenants who have symptoms consistent with COVID-19 should remain in isolation with transmission-based precautions until the diagnosis of COVID-19 is excluded. In general, a negative result from one antigen test would be sufficient to discontinue isolation, however, if there is a higher level of clinical suspicion for COVID-19 infection, despite the negative result:

* Consideration for continuing transmission-based precautions and confirming the first test with a NAAT test or a second negative antigen test taken 48 hours after the first.
* If the first was a NAAT test, a second NAAT test could be collected confirming the results of the first.

If a symptomatic resident/tenant was not tested for COVID-19, **[enter facility name]** will have the resident/tenant remain in isolation until they meet criteria to discontinue isolation for a confirmed COVID-19 case.

Empiric Use of Transmission-Based Precautions in an Outbreak:

In the event of ongoing transmission that is not controlled with initial interventions, strong consideration will be given to the use of empiric transmission-based precautions for residents/tenants and work restriction of healthcare providers with high-risk exposures.

Discontinuing Transmission-Based Precautions for Confirmed COVID-19 Cases:

Residents/tenants who are asymptomatic and are not moderately to severely immunocompromised:

* At least 10 days have passed since the date of their first positive test.

Residents/tenants with mild to moderate illness who are not moderately to severely immunocompromised:

* At least 10 days have passed since symptoms first appeared.
* At least 24 hours have passed since their last fever without the use of fever-reducing medications, and
* Symptoms have improved.

Residents/tenants with severe to critical illness and who are not moderately to severely immunocompromised: (this includes individuals who were hospitalized)

* At least 10 days and up to 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 have improved.
* The test-based strategy as described below for moderately to severely immunocompromised residents/tenants can be used to inform the duration of isolation.

Residents/tenants who are moderately to severely immunocompromised:

* Use of test-based strategy:
	+ Resolution of fever without the use of fever-reducing medications (if symptoms present), and
	+ Symptoms have improved (if symptoms present), and
	+ Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) using an antigen or NAAT.
* Consultation (if available) with an infectious disease specialist.

**Environmental Infection Control**

Residents/tenants in isolation with transmission-based precautions will have their own dedicated medical equipment. If medical equipment is unable to be dedicated, it will be cleaned and disinfected according to manufacturer’s instructions before use on another resident/tenant.

An EPA-registered disinfectant in accordance with [List N](https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) on the EPA website will be used following a thorough cleaning of the item(s). The disinfectant will be applied as directed by the contact kill times located on the product’s label.

Management of laundry, food service utensils, and medical waste will be in accordance with the Isolation Precautions or Transmission-Based Precautions policy and procedure.

Once the transmission-based precautions have been discontinued or the resident/tenant has discharged, healthcare providers shall refrain from entering the room without appropriate PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles from the room. The room and all equipment shall be appropriately cleaned and disinfected before it is returned to reuse.

**Visitation**

Visitation for residents/tenants will occur at all times, regardless of COVID-19 activity in the building or the community. Visitors should defer non-urgent visitation if they have tested positive for COVID-19 in the last 10 days, have symptoms consistent with COVID-19, or have been in close contact with someone who has COVID-19 in the last 10 days.

Visitors will receive education about the core infection prevention and control principles as outlined in this policy and procedures.

Outdoor visitation generally poses a lower risk of transmission of COVID-19. Outdoor visitation may occur in established areas, weather permitting. Visitors should adhere to the core principles of infection prevention, despite outdoor visitation.

Indoor visitation:

Indoor visitation must be allowed at all times, for all residents, as permitted in the Federal Regulations for nursing homes and the State Rules for non-Medicare participating providers. Indoor visitation must be conducted in a manner that adheres to the core principles of infection prevention and does not pose an increased risk to other residents/tenants.

Source control during indoor visitation will be followed as outlined in the source control section of this policy and procedures.

While not recommended, residents in transmission-based precautions may still receive visitors. The resident and the visitor should be counseled prior to the visit on the increased risk for infection transmission and the visitor will be instructed on key principles of infection control including the use of PPE during the visit and instructions for the safety of staff and other residents following the visit.

When the building is completing an outbreak investigation, all visitors should be notified of COVID-19 being identified in the building and additional mitigation measures they can take to reduce the spread of COVID-19.

Visitors can be asked to test for COVID-19 prior to their visit, however, testing cannot be utilized as a condition of visitation. Visitors may also be asked about their vaccination status, however, vaccination status and/or proof of vaccination status also cannot be used as a condition of visitation.

Representatives from state and federal agencies including but not limited to the Department of Public Health, Long-Term Care Ombudsman, Protection & Advocacy Agencies, and CMS will be allowed access to the building at all times. Residents may visit with these officials during their visits. If residents do not want these representatives to visit, they must indicate this at the time of the visit to the representative. If a resident is on transmission-based precautions, these representatives are still allowed to visit and will be notified that these residents are in transmission-based precautions with directions on how to visit the residents with the required PPE.

**Communal Dining, Activities and Resident Outings**

If an outbreak is limited to specific areas in the building, consider limiting potential interactions between residents on outbreak-impacted units. When possible, maintain physical distancing of at least six feet and maintain a reduced capacity in the space along with improving ventilation. If initial interventions fail, limit group activities and communal dining. Consider limiting the use of communal areas where residents or HCP might congregate across multiple units or buildings. Residents with active ARI should not participate in resident activities involving other residents, therapy, or communal dining.

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. The safest approach for everyone, particularly those at high risk for severe illness, is to wear a face covering or mask while in communal areas of the building.

Resident/tenants have the right to leave the building as they choose. Residents (tenants as applicable) and the individual accompanying them should be educated to follow all recommended infection prevention practices such as wearing a face covering or mask especially for those at high risk for severe illness and when community transmission is high, performing hand hygiene and encouraging those around them to do the same.

Upon return to the building, the provider should take the following actions:

* Screen residents/tenants upon return for signs or symptoms of COVID-19, documentation by exception standards will be used such as if a resident/tenant develops symptoms consistent with COVID-19.
	+ If the resident/tenant or family member reports possible close contact to an individual with COVID-19 while outside of the building, **[enter facility name]** will follow procedures for residents with close contact as outlined in this policy.
	+ If the resident/tenant develops signs or symptoms of COVID-19 after the outing, **[enter facility name]** will follow procedures for symptomatic residents/tenants as outlined in this policy.

In most circumstances, quarantine is not recommended for residents/tenants who leave the building for less than 24 hours except in certain situations as described in the empiric transmission-based precautions section of this policy. Residents who leave the building for 24 hours or longer will be managed as a new admission.

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