Iowa Guidance on Phased Easing of Restrictions for Long-Term Care Facilities

Updated September 2, 2020

Beginning March 13, 2020, Iowa long-term care facilities began implementing guidance from the Centers for Medicare and Medicaid Services (CMS) that outlined recommended restrictions to normal operations in an attempt to mitigate the entry and spread of COVID-19. This guidance has been further supported by additional Iowa agencies, such as, the Iowa Department of Inspections and Appeals (DIA) and the Iowa Department of Public Health (IDPH).

While public health mitigation efforts remain critically important, especially in long-term care settings where residents may be more vulnerable to virus exposure, the state acknowledges that it is equally important to consider the quality of life and dignity of the residents of long-term care facilities. Based on recent guidance from CMS, the state has collaborated with long-term care associations on how to responsibly ease restrictions in long-term care facilities while COVID-19 remains in communities across the state. This guidance is based on currently available best-practice recommendations and evidence and may be updated and adjusted as additional information becomes available and response efforts evolve.

The guidance below is specifically targeted at long-term care facilities (e.g., nursing homes). Other facilities or congregate care settings, such as assisted living or residential care facilities, may choose to follow an independently developed framework for easing restrictions. Guidance from the Centers for Disease Control (CDC) for COVID-19 mitigation strategies for assisted living congregate settings is found at:

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html

Phase 1

Phase 1 is designed for vigilant infection control during periods of heightened virus spread in the community and potential for healthcare system limitations, which may include factors such as staffing, hospital capacity, Personal Protective Equipment (PPE), and testing.

Consideration	Mitigation Steps
Visitation	Visitation generally prohibited, except for: ● Closed-window visits via telephone with the visitor standing outside the closed facility window. ● Outdoor visits, open-window visits, and dedicated chat box visits. Outdoor visits, open-window visits, and dedicated chat box visits are allowed only at facilities that are not in an outbreak status, and only for residents that are asymptomatic and not confirmed COVID-19 positive. ● Indoor compassionate care situations are restricted to end-of-life and psycho-social needs; these visits are under limited and controlled conditions, coordinated by the facility, in consideration of social distancing and universal source control. Window visits, dedicated chat boxes, and outdoor visits are preferred. These limited and controlled visits may be included in the facility's temporary visitation policy and are not mandated; but rather at the discretion of the facility. Facility responsibilities: ● Facility should consider a supervised approach to ensure the visit complies with facility expectations. ● All visitors must be screened immediately prior to visitation and additional precautions are required, including social distancing (visitors and residents maintain six feet of separation) and hand hygiene must be used before and after visits. All visitors must wear a cloth face covering or facemask for the duration of their visit. The facility must provide a face mask to the visitor, in the event they do not have one, to ensure universal source control. Residents are encouraged to wear a facemask or face covering for all visits. ● All visits should be by appointment only, a limited number of visitors at the facility allowed at a time(inclusive of visitors in outdoor, chatbox, and compassionate care visits), and a limit to the number of visitors to a resident at a time (e.g. no more than 2 visitors per resident). ● Facilities should maintain a log of visitors in case an individual becomes ill and case investigation and contact tracing are necessary.

	● Visitation areas and contact surfaces (e.g. chairs, tables, etc) should be sanitized between uses. Facility should have policies in place for virtual visitation, whenever possible, to include: ● Access to communication with friends, family, and their spiritual community. ● Access to the Long-Term Care Ombudsman.
Essential/Non-Essential Healthcare Personnel	● Restricted entry of non-essential healthcare personnel. Non-essential personnel may be allowed into the building following an infection control risk analysis by the facility. ● All healthcare personnel are screened upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE as determined by the task; and at a minimum wearing a face mask for the duration of their visit.
Medical Trips Outside the Facility	● Telemedicine should be utilized whenever possible. ● Residents that go out of the facility for scheduled health care visits (e.g. dialysis, podiatry, opthamologist): o Screen residents for COVID-19 symptoms when leaving the facility for an appointment and within one-hour of returning to the facility. o Continue daily resident screening each shift thereafter. o Work with dialysis centers when COVID-19 cases are identified in the facility to determine close contacts among long term care residents. o The resident must wear a cloth face covering or facemask when they leave their room and during transport. o The facility must share the resident's COVID-19 status with the transportation service and medical facility. o Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. o Transportation equipment shall be sanitized between transports.
Communal Dining	● Communal dining not recommended but must be limited (for COVID-19 negative or asymptomatic residents only). ● Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). ● No more than 10 individuals in a dining area at one time. ● If staff assistance is required, appropriate hand hygiene must occur between residents.
Screening	● Resident screening each shift. It should be clearly documented in the facility policies when shift screenings should occur and how it is

	tracked. It is not required that residents be woken up if asleep during an overnight shift as long as residents are evaluated at least twice in a 24 hour period. ● Staff screening at the beginning and end of each shift.
Universal Source Control & Personal Protective Equipment (PPE)	**Universal Source Control Recommendation:** All facility staff, regardless of their position should wear a cloth face covering or face mask while in the facility in common areas or in resident rooms. This can be done in accordance with COVID-19: Strategies for Optimizing the Supply of PPE ○ Strict adherence to extended and reuse guidance ○ Strict adherence to meticulous hand hygiene ○ Discard face mask or wash face covering at the end of each shift **Personal Protective Equipment:** All HCP wear appropriate PPE when interacting with residents who are suspected or confirmed to have an infectious disease, including COVID-19. Proper selection and use of PPE is based on the pathogen, the nature of the patient interaction, and potential exposure to blood, body fluid and/or infectious material. ○ Isolation Precautions ○ Protecting Healthcare Personnel ○ Using Personal Protective Equipment
Cohorting & Dedicated Staff*	● Dedicated space in facility and dedicated staff for cohorting and managing care for residents who are symptomatic or testing positive with COVID-19. ● Plan to manage new admissions and readmissions with an unknown COVID- 19 status. ● Plan to safely manage residents who routinely attend outside medically necessary appointments (e.g., dialysis). ● New admissions or readmissions from a hospital setting should quarantine for 14 days.
Group Activities	● Limit group activities, but some activities may be conducted in facilities not currently experiencing an outbreak (for COVID-19 negative or asymptomatic residents only) with social distancing, hand hygiene, and use of a cloth face covering or facemask. These activities may be indoor or outdoor. Activities that require or encourage residents to handle the same object are prohibited. Limit the size of the group to no more than ten. ● Facilities should maintain a record of participants, dates, and type of activity for reference in the event that someone becomes ill and case investigation and contact tracing are needed. ● Engagement through technology is preferred to minimize opportunity for exposure.

	● Facilities should have policies in place to engage virtually, where possible, in activities that improve quality of life (e.g. church service, art classes, concerts, etc.).
Testing	● Facility shall report progress towards completion of baseline testing for staff and residents, as described in Appendix A. ● Staff and residents shall be tested if any symptoms are detected or if a positive case of COVID-19 has been identified, as described in Appendix A. ● See Appendix B & C for additional guidance on testing supplies.
Survey Activity	● Investigation of complaints alleging there is an immediate serious threat to the residents' health and safety (known as Immediate Jeopardy). ● Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings. ● Focused infection control surveys. ● Initial survey to certify that the provider has met the required conditions to participate in the Medicare. ● Any other survey as authorized or required by CMS. State based priorities, such as hot spots.

Phase 2

Facility may decide to initiate Phase 2 upon alignment with the following metrics:

- Facility is not currently experiencing an outbreak.
    - Outbreak is defined as three COVID-19 positive residents within the same 14 day period.
    - Outbreaks are considered closed when it has been more than 28 days since the last identified resident case.
- 14 days since last positive or suspected case identified. (See Appendix A regarding testing recommendations that should be completed prior to moving to Phase 2.)
- Adequate staffing levels.
- Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- Ability of local hospital to accept referrals/transfers.
- Capable of cohorting residents with dedicated staff in the case of suspected or positive cases.
- A downward trend in number of cases or the % positivity over the past 14 days in the county.
- Facility shall report their Phase status to the Regional Medical Coordination Center.
- Facilities may use discretion to be more restrictive in areas, where deemed appropriate through internal policies, even if they have moved to this Phase.

Consideration	Mitigation Steps
Visitation	Visitation generally prohibited, except for: ● All visitation activities described in Phase 1, in addition to the following expanded activities for Compassionate Care are allowed in Phase 2. ● Compassionate Care visits shall be limited as follows: • By appointment only as coordinated by the nursing home based on their ability to manage infection control practices and proper social distancing. • Only in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Note: each facility must determine their capacity to manage limited visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits. • Facilities may limit the number of visitors for each resident per week and per occurrence. • Preference should be given to outdoor, window, or dedicated chat box visits as described in Phase 1.

	Facility responsibilities: ● Facility should consider a supervised approach to ensure the visit complies with facility expectations. ● All visitors must be screened immediately prior to visitation and additional precautions are required, including social distancing (visitors and residents maintain six feet of separation) and hand hygiene must be used before and after visits. All visitors must wear a cloth face covering or facemask for the duration of their visit. The facility must provide a face mask to the visitor, in the event they do not have one, to ensure universal source control. Residents are encouraged to wear a facemask or face covering for all visits. ● All visits should be by appointment only, a limited number of visitors at the facility allowed at a time(inclusive of visitors in outdoor, chatbox, and compassionate care visits), and a limit to the number of visitors to a resident at a time (e.g. no more than 2 visitors per resident). ● Facilities should maintain a log of visitors in case an individual becomes ill and case investigation and contact tracing are necessary. ● Visitation areas and contact surfaces (e.g. chairs, tables, etc) should be sanitized between uses. Facility should have policies in place for virtual visitation, whenever possible, to include: ● Access to communication with friends, family, and their spiritual community. ● Access to the Long-Term Care Ombudsman.
Essential/Non-Essential Healthcare Personnel	● Limited entry of non-essential healthcare personnel based on risk analysis by the facility infection control team, including the entry of barbers and beauticians. All healthcare personnel are screened upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE as determined by the task; and at a minimum wearing a face mask for the duration of their visit.
Medical Trips Outside the Facility	● Telemedicine should be utilized whenever possible. ● Residents that go out of the facility for scheduled health care visits (e.g. dialysis, podiatry, opthamologist): o Screen residents for COVID-19 symptoms when leaving the facility for an appointment and within one-hour of returning to the facility. o Continue daily resident screening each shift thereafter. o Work with dialysis centers when COVID-19 cases are identified in the facility to determine close contacts among

	long term care residents. o The resident must wear a cloth face covering or facemask when they leave their room and during transport. o The facility must share the resident's COVID-19 status with the transportation service and medical facility. o Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. o Transportation equipment shall be sanitized between transports.
Communal Dining	● Communal dining limited. ● Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). ● Limit the number of individuals in a dining area at one time, not to exceed 50 percent of capacity unless that would be less than 10 people. ● If staff assistance is required, appropriate hand hygiene must occur between residents as well as use of appropriate PPE.
Screening	● Conduct resident screening each shift. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. It is not required that residents be woken up if asleep during an overnight shift as long as residents are evaluated at least twice in a 24 hour period. ● Conduct staff screening at the beginning and end of their shift.
Universal Source Control & PPE	**Universal Source Control Recommendation:** All facility staff, regardless of their position should wear a cloth face covering or face mask while in the facility in common areas or in resident rooms. This can be done in accordance with COVID-19: Strategies for Optimizing the Supply of PPE ○ Strict adherence to extended and reuse guidance ○ Strict adherence to meticulous hand hygiene ○ Discard face mask or wash face covering at the end of shift **Personal Protective Equipment:** All HCP wear appropriate PPE when interacting with residents who are suspected or confirmed to have an infectious disease, including COVID-19. Proper selection and use of PPE is based on the pathogen, the nature of the patient interaction, and potential exposure to blood, body fluid and/or infectious material. ○ Isolation Precautions ○ Protecting Healthcare Personnel ○ Using Personal Protective Equipment
Cohorting & Dedicated Staff*	● Must have a dedicated space in facility for cohorting with dedicated staff and managing care for residents who become symptomatic or

	test positive with COVID-19; ● A plan to manage new/readmissions with an unknown COVID- 19 status and residents who routinely attend outside medically necessary appointments (e.g., dialysis). ● New admissions or readmissions from a hospital setting should quarantine for 14 days.
Group Activities	● Limit group activities. ● Small group activities may occur with social distancing, hand hygiene, and use of a cloth face covering or facemask and no more than 10 people. ● Facilities must restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss). ● Activities may be indoors or outdoors.
Salons	● If barbers and beauticians are determined a low risk for entry, the following mitigation steps should be followed. • Salons may open so long as the beautician or barber is properly screened when entering the facility and must wear a face covering or mask for the duration of time in the facility. • The beautician or barber must remain in the salon area and avoid common areas of the facility. • Salons must limit the number of residents in the salon at one time to accommodate ongoing social distancing. • Staged appointments should be utilized to maintain distancing and allow for infection control. • Salons must properly sanitize equipment and salon chairs between each resident; and the beautician or barber must perform proper hand hygiene. • No hand-held dryers. • Salons must routinely sanitize high-touch areas. • Residents must wear a face mask during their salon visit.
Testing	● See guidance for testing in Appendix A. ● Facility shall report ongoing testing efforts to the Regional Medical Coordination Center as requested. ● See Appendix B & C for additional guidance on testing supplies.
Phase Regression	● A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through resident screening each shift, and staff screening before and after each shift, and leveraging the data points requested by the CDC as reported through the NHSN system. ● The facility will continue to progress through the different phases of adjusting restrictions until one staff or resident is confirmed positive for COVID-19 and another has symptoms, at which time, the facility

	will return to the Phase 1. ● If the facility must return to Phase 1, and 14 days have passed with no additional residents or staff testing positive for COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase 2 of the reopening process.
Survey Activity	● Investigation of complaints alleging Immediate Jeopardy OR actual harm to residents. ● Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings or actual harm. ● Focused infection control surveys. ● Initial certification surveys. ● Any other survey as authorized or required by CMS. ● State based priorities, such as hot spots.

Phase 3

Facilities may decide to initiate Phase 3 upon alignment with the following metrics:

- 14 days since entering Phase 2, and without a COVID-19 positive or suspected case identified.
- Adequate staffing levels.
- Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- Ability of local hospital to accept referrals/transfers.
- Capable of cohorting residents with dedicated staff in the case of suspected or positive cases.
- A downward trend in number of cases or the % positivity over the past 14 days in the county.
- Facility shall report their Phase status to the Regional Medical Coordination Center.
- Facilities may use discretion to be more restrictive in certain areas, where deemed appropriate through internal policies, even if they have moved to this Phase.

Consideration	Mitigation Steps
Visitation -	● All residents are eligible to have limited visitation. ● Each facility should develop a limited visitation policy which addresses the following, at minimum: • Visitation schedule, hours, and location. • Number of visitors and visits. • Infection control practices including proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors and social distancing. • Use of PPE. • By appointment only as coordinated by the nursing home based on their ability to manage infection control practices and proper social distancing. • Only in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Note: each facility must determine their capacity to manage limited visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits. • Facilities should limit the number of visitors for each resident per week and per occurrence. • Preference should be given to outdoor visitation opportunities like parking lot visits with distancing. ● All visitors are screened upon entry. ● Visitors unable to pass the screening or comply with infection

	control practices like masks should refrain from visiting. ● Types of visitation from Phase 1 and 2 may continue under limited controlled conditions coordinated by the facility in consideration of social distancing and universal source control (e.g., window visits).
Essential/Non-Essential Healthcare Personnel	● Limited entry of non-essential healthcare personnel to include barbers and beauticians. See salon guidance below for mitigation steps. ● All healthcare personnel are screened upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE as determined by the task; and at a minimum wearing a face mask for the duration of their visit.
Medical Trips Outside the Facility	● Telemedicine should be utilized whenever possible. ● Residents that go out of the facility for scheduled health care visits (e.g. dialysis, podiatry, opthamologist): o Screen residents for COVID-19 symptoms when leaving the facility for an appointment and within one-hour of returning to the facility. o Continue daily resident screening each shift thereafter. o Work with dialysis centers when COVID-19 cases are identified in the facility to determine close contacts among long term care residents. o The resident must wear a cloth face covering or facemask when they leave their room and during transport. o The facility must share the resident's COVID-19 status with the transportation service and medical facility. o Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. o Transportation equipment shall be sanitized between transports.
Communal Dining	● Modified Communal dining. ● Residents may eat in the same room with social distancing (limited number of people at tables to ensure space of at least 6 feet). ● If staff assistance is required, appropriate hand hygiene must occur between residents.
Screening	● Conduct resident screening daily. It should be clearly documented in the facility policies when daily screening should occur and how it is tracked. ● Conduct staff screening at the beginning and end of their shift.
Universal Source Control & PPE	**Universal Source Control Recommendation:** All facility staff, regardless of their position should wear a cloth face covering or face mask while in the facility in common areas or in resident

	rooms. This can be done in accordance with COVID-19: Strategies for Optimizing the Supply of PPE ○ Strict adherence to extended and reuse guidance ○ Strict adherence to meticulous hand hygiene ○ Discard face mask or wash face covering at the end of shift **Personal Protective Equipment:** All HCP wear appropriate PPE when interacting with residents who are suspected or confirmed to have an infectious disease, including COVID-19. Proper selection and use of PPE is based on the pathogen, the nature of the patient interaction, and potential exposure to blood, body fluid and/or infectious material. ○ Isolation Precautions ○ Protecting Healthcare Personnel ○ Using Personal Protective Equipment
Cohorting & Dedicated Staff*	● Dedicated space in facility for cohorting with dedicated staff and managing care for residents who become symptomatic or test positive with COVID-19; ● Plan to manage new/readmissions with an unknown COVID- 19 status and residents who routinely attend outside medically necessary appointments (e.g., dialysis). ● New admissions or readmissions from a hospital setting should quarantine for 14 days.
Group Activities	● Expanded group activities may occur with social distancing, hand hygiene, and use of a cloth face covering or facemask. ● Facilities should restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss).
Salons	● Salons may open so long as the beautician or barber is properly screened when entering the facility and must wear a face covering or mask for the duration of time in the facility. ● The beautician or barber must remain in the salon area and avoid common areas of the facility. ● Salons must limit the number of residents in the salon at one time to accommodate ongoing social distancing. ● Staged appointments should be utilized to maintain distancing and allow for infection control. ● Salons must properly sanitize equipment and salon chairs between each resident; and the beautician or barber must perform proper hand hygiene. ● No hand-held dryers. ● Salons must routinely sanitize high-touch areas. ● Residents must wear a face mask during their salon visit.

Testing	● See guidance for testing in Appendix A. ● Facility shall report ongoing testing efforts to the Regional Medical Coordination Center as requested. ● See Appendix B & C for additional guidance on testing supplies.
Phase Regression	● A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through daily resident screening and staff screening before and after each shift and leveraging the data points requested by the CDC as reported through the NHSN system. ● The facility will remain in Phase 3 until one staff or resident is confirmed positive for COVID-19 and another has symptoms, at which time, the facility will return to the Phase 1. ● If the facility must return to Phase 1, and 14 days have passed with no additional residents or staff testing positive for COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase 2 of the reopening process.
Survey Activity	● All complaint and revisit surveys required to identify and resolve any non-compliance with health and safety requirements ● Standard (recertification) surveys and revisits ● Focused infection control surveys ● Initial certification surveys ● Any other survey as authorized or required by CMS. ● State based priorities, such as hot spots.

*Many senior care communities include assisted living programs that are attached to nursing facilities or are a part of a continuing care retirement community or senior living campus and have commonly shared kitchen facilities. In the current public health mitigation environment, facilities should not routinely share direct care, dietary, or environmental services staff who may have contact with residents or tenants in other segments of the senior living operations. If there are identified cases of COVID-19 in other service delivery areas of the campus, there should be no sharing of staff between those care systems.

Appendix A: Testing Guidance

On May 18, 2020, The Centers for Medicare and Medicaid Services (CMS) issued QSO-20-30-NH, Nursing Home Reopening Recommendations for State and Local Officials. The document provides guidance for State Survey Agencies and other state officials to determine how nursing facilities may begin to lift restrictions placed to mitigate the spread of COVID-19. CMS indicates in this QSO that testing will be a critical part of a facility lifting restrictions on operations.

The state agrees that it is important for all facilities to participate in baseline testing for all residents and staff prior to consideration of lifting restrictions. Baseline testing is critical to understand how the virus may exist in facilities especially among those without symptoms, so that informed decisions can be made and appropriate steps are taken for containment. Comprehensive testing of all staff and residents is encouraged as a baseline regardless of whether a case has been identified or not. At minimum facilities should meet the following testing metrics prior to moving to Phase 2 and also follow this guidance any time a single positive case is identified in a facility:

- If there were one or more positive cases previously in residents, at a minimum, all residents with shared hallways/unit or staff should have been tested. Offering testing to all residents when a positive case is recognized is advised. Additionally weekly testing will be offered to a cohort in a facility experiencing an outbreak.
- All staff, including administrative, should be offered testing regardless of contact with residents that have tested positive for COVID-19.
- Staff declining testing should be treated as having a positive or unknown COVID-19 status and appropriate PPE should be used.

For Phase 2 and 3, the state encourages testing to continue as outlined in previous guidance for residents and staff that:

- Are currently symptomatic.
- Have had close contact with an individual, either at work or in the community that has tested positive for COVID-19.
- Staff that meet either of the above two bullets and decline testing should be treated as having a positive or unknown COVID-19 status and excluded or use recommended PPE as appropriate.

Additionally, the state will be engaging in sentinel testing in facilities across the state during Phase 2 and 3. Sentinel testing will be conducted on a weekly basis with a limited number of facilities and will include a prescribed number of staff, as determined by the Iowa Department of Public Health in collaboration with a facility. Sentinel testing will be based on factors such as:

- Virus activity in the community.
- Geographic representation.
- Availability of testing in the community.
- Findings from infection control surveys.
- Reporting of testing efforts and resources by the facility.

The state will work with local public health entities and facilities to access supplies or appropriate funding for baseline testing in Phase 1 as well as case-directed and sentinel testing in Phase 2 and 3. See Appendix B for additional information.

Facilities should report their baseline testing numbers (Phase 1) for residents and staff through their Regional Medical Coordination Centers (RMCC).

For ongoing testing efforts in Phase 2 and 3, facilities should report through their RMCC once reporting surveys are ready to accept data. Definitions for all requested data will be available as part of the RMCC reporting process.

Appendix B
Testing Supplies and PPE

	Contact	Information Needed
Baseline Testing	**State Hygienic Lab**	To order testing supply: http://www.shl.uiowa.edu/kitsquotesforms/clinicalkit.xml To submit specimens for testing: http://www.shl.uiowa.edu/results/COVID-19_Electronic_Test_Request_Form_User_Guide.pdf SHL courier will pick up specimens at your facility. To request a specimen pick up contact the SHL hotline 855-374-4692 before 11 am.
Ongoing Testing	**State Hygienic Lab**	Same as above. This includes offering testing in outbreak situations.
State Department of Public Health Sentinel Testing Requests	**State Hygienic Lab**	Same as above.
Personal Protective Equipment (if unable to procure independently)	**Local Emergency Operations Coordinators**	Be prepared to itemize the count of PPE needed, by type. https://www.homelandsecurity.iowa.gov/documents/county/COORD_Public_List.pdf

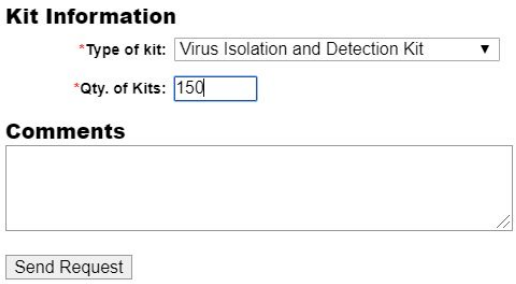
Appendix C
Guidance for long term care facilities to access COVID-19 testing at the State Hygienic Laboratory

The State Hygienic Laboratory will perform COVID-19 PCR testing for long term care facilities in accordance with the guidance outlined in this document. This testing will be performed at no cost to the long term care facility. Iowa long term care facilities are NOT required to conduct testing at the State Hygienic Laboratory. Each long term care facility should decide which laboratory they want to use. If Iowa long term care facilities choose to conduct testing at the State Hygienic Laboratory, the procedures outlined below should be followed.

Order Testing Supplies: Long term care facilities should order testing supplies directly by filling out the order form available at: http://www.shl.uiowa.edu/kitsquotesforms/clinicalkit.xml

- If the ordering long term care facility is not listed in the system, facilities can enter their information under the "Shipping Information" header.

- Ordering long term care facilities should select “Virus Isolation and Detection Kit” from the drop-down and type the number of testing kits they need into the “Qty. of Kits” field.



Order Tests: Long term care facilities without access to the State Hygienic Laboratory’s OpenELIS Web Portal should contact SHL (by calling 855-374-4692) to request facility registration.

Once registered, long term care facilities should submit all specimens using the electronic test request form. Instructions for using the electronic test request form are available at: http://www.shl.uiowa.edu/results/COVID-19_Electronic_Test_Request_Form_User_Guide.pdf.

Test Results: Long terms care facilities should log into the OpenELIS Web Portal to access resident and staff results.

Courier Service: To request a courier pick up of specimens from the long term care facility for delivery to the State Hygienic Laboratory call 855-374-4692.

Appendix D

Frequently Asked Questions re: Iowa Guidance on Phased Easing of Restrictions for Long-Term Care Facilities

Updated September 2, 2020

1. When does the 14 day clock begin for Phase 1.
   A: The 14 day clock began the day the Long Term Care guidance was released, June 4, 2020.

2. Does a facility have to do testing even if there has never been a confirmed COVID-19 positive case in the facility?
   A: Testing is not mandated at this time but it is expected that facilities, if choosing not to conduct comprehensive baseline testing, align with the below minimal efforts also outlined in Appendix A of the guidance.
   - **If there were one or more positive cases previously in residents, at a minimum, all residents with shared hallways/unit or staff should have been tested. Offering testing to all residents when a positive case is recognized is advised.**
   - **All staff, including administrative, should be offered testing regardless of contact with residents that have tested positive for COVID-19. (This is recommended even for facilities with no COVID-19 positive cases.)**
   - **Staff declining testing should be treated as having a positive or unknown COVID-19 status and appropriate PPE should be used.**

3. If a resident refuses testing for COVID-19, when should they be quarantined or required to wear PPE?
   A: If the resident has symptoms of COVID-19 (without alternate diagnosis) and refuses testing, the facility should assume the resident to be infected and respond accordingly (this includes isolation of the resident).

   If the resident does NOT have symptoms, is NOT a close contact of a case, and refuses testing for COVID-19, no additional measures are required of the resident.

   If the resident does NOT have symptoms and IS a close contact of a case, the resident should be quarantined for 14 days after their last exposure to the case (regardless of whether testing is needed).

4. If staff refuse testing, should they wear appropriate PPE?

A: If staff are symptomatic and refuse testing, staff should be isolated in accordance with the following guidance
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

If staff do NOT have symptoms and were exposed to COVID-19, staff should be quarantined in accordance with the following guidance
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

If staff do not have symptoms and were NOT exposed to COVID-19, staff should use PPE in accordance with the following guidance
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html without reuse or extended use strategies, while working with quarantine or isolated COVID-19 residents.

5. Is the IDPH going to determine sentinel surveillance sites? If yes, how will long term care facilities know they have been selected?
A: Yes, the Iowa Department of Public Health will be working with local public health agencies to target Long Term Care Facilities for sentinel surveillance. Public health will contact identified Long Term Care Facilities to request their participation in the sentinel surveillance program.

6. What is the Phase 2 and Phase 3 testing guidance for residents and staff?
A: In Phase 2 and 3, ongoing testing strategies are outlined in Appendix A and include testing for anyone meeting the below criteria:
    - **Are currently symptomatic.**
    - **Have had close contact with an individual, either at work or in the community, that has tested positive for COVID-19.**
    - **Staff that meet either of the above two bullets and decline testing should be treated as having a positive or unknown COVID-19 status and excluded or use recommended PPE as appropriate.**

7. Phase 1 and Phase 2 guidance directs newly admitted or readmitted residents to be quarantined. Should dedicated staff be assigned to these quarantined residents?
A: The guidance for admissions and readmissions has not changed and can be found more in detail at
www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

8. Please define isolation and quarantine?
A: Isolation refers to keeping persons who are sick away from others until they recover. Quarantine refers to keeping persons who had an exposure but are not yet sick away from others so that if they were to become sick, they could not infect anyone else. Both isolated and quarantined residents should be placed in a private room and cohorted with dedicated staff.

9. Can symptomatic residents that test positive for COVID-19 be cohorted with newly admitted/readmitted residents?
   A: Residents that test positive for COVID-19 should not be cohorted with newly admitted/readmitted residents. Ideally residents in the facility who develop symptoms consistent with COVID-19 would be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing.
   Guidance is available at:
   www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

10. Should residents wear masks when in the dining area and when not eating or drinking?
    A: Communal dining is not recommended in Phase 1 and limited in Phase 2. Residents should use face masks in any group setting, including during Phase 1 – 3. Residents should not wear facemasks when eating or drinking.

11. Under Phase 1 group activities, it does not specify the number of residents that can participate, what is that number? Also, should residents be encouraged NOT to handle the same objects in Phase 1?
    A: Group activities are generally not recommended in Phase 1.
    However, if a facility does choose to have group activities for COVID-19 negative or asymptomatic residents those should be limited to no more than 10 people. It is also recommended that residents avoid handling the same objects and practice frequent hand-washing.

12. Under Phases 1 and 2, it references a risk assessment analysis. Are there specific elements that IDPH and DIA want to see included in the risk assessment analysis for non-essential healthcare providers?
    A: It is recommended that infection control risk assessments for COVID-19 should be informed using CDC and CMS guidance on infection control practices (tools already leveraged by facilities). At minimum, facilities should consider virus activity in the community, appropriate screening of non-essential healthcare providers, access to PPE for recommended use, access to testing, and the ability to follow adequate hygiene measures.

13. Can employers make COVID-19 testing a condition of employment?
    A: Requiring COVID-19 testing is a facility decision, which should be made in consultation with legal counsel.

14. What will the turn-around-time be for testing?
    A: The State Hygienic Laboratory (state public health laboratory) understands that Long Term Care Facilities need quick turn-around-time and will do everything possible to provide it.

15. How should Long Term Care Facilities place an order for testing supplies needed for the phases of reopening?
A: No, facilities should use the online form to order supplies directly from the State Hygienic Lab at http://www.shl.uiowa.edu/kitsquotesforms/clinicalkit.xml.

The State Hygienic Lab will work to set up an account for each facility for ease of order and reporting. Additionally, facilities should reference http://www.shl.uiowa.edu/results/COVID-19_Electronic_Test_Request_Form_User_Guide.pdf for additional information and directions.

16. How should Long Term Care Facilities address concerns from residents' families who are comparing facility visitation restrictions with other facilities?
A: Long Term Care Facilities can share IDPH guidance with families. Long Term Care associations and providers may also want to consider assisting with creation of communications resources for their members.

17. How should Long Term Care Facilities monitor COVID-19 trends and positivity rates for their county?
A: County-specific COVID-19 trends and positivity rates are available at https://coronavirus.iowa.gov/pages/case-counts. For the information specific to the county of interest, the user will need to click that county on the map.

18. In Phase 2, how many residents should be seated at each table?
A: The guidance has been updated for Phase 2 and 3 to remove a number of residents at each table.

19. Does the threshold for regression of phases include new admissions already diagnosed with COVID at the time of admission?
A: The criteria for Phase regression does not include admissions of residents already diagnosed with COVID-19 or admissions of residents with an unknown COVID-19 status that are identified as COVID-19 positive during their 14 day quarantine status. All admissions should be appropriately quarantined and cohorted with dedicated staff.

20. Do new admissions and readmissions need to be cohorted and placed in a 14 day quarantine upon admission?
A: Yes. Regardless of COVID status, all new admissions and readmissions should still be cohorted and screened in accordance with the phased guidance.

21. Are facilities allowed to use plexiglass chat boxes for visits during Phase 1?
A: Yes. Under limited and controlled conditions, coordinated by the facility, in consideration of social distancing and universal source control, a plexiglass chat box visit is allowed. Note: these limited controlled visits may be included in the facility's temporary visitation policy and are not mandated; rather, these visits are allowed at the discretion of the facility. These visits should include screening all

visitors for symptoms of COVID-19, practicing social distancing, performing hand hygiene (e.g., use alcohol-based hand rub upon entry), and both residents and visitors wear a cloth face covering or facemask for the duration of their visit. We recommend facilities limit the number of individuals visiting with any one resident (e.g., two visitors for one resident visit). (Updated 06/26/2020).

22. What if I am wearing a cloth face mask and I have to go into an isolation or quarantine room?

A: Do not wear cloth face masks in isolation or quarantine rooms. If you are wearing a cloth mask, it should be doffed and a new procedure or surgical mask should be donned in addition to the other required PPE for patient care. Remember, N-95 respirators are recommended for aerosol generating procedures.

23. If I'm working in non-isolation and non-quarantine rooms, can I wear the same face mask on multiple shifts since it is breathable, not soiled, or damaged?

A: No. **A face mask should be used for a maximum of one shift in a clinical setting. Cloth masks should be laundered and face masks discarded. A face mask must be worn by a single wearer.**

24. Our facility is in Phase 3, but the county in which we are located is now in an upward trend of case positivity. Are we now required to regress to Phase 1 based on the increasing rate of positivity in the county?

A: No. The only conditions under which the facility is <u>required</u> to regress to Phase 1 is when there is one positive case in the facility (staff or resident), AND at least one other case (staff or resident) that is symptomatic for COVID-19. NOTE: If a county is experiencing community spread and increased case positivity, all staff should be acutely aware of their individual responsibility to practice mitigation strategies (social distancing, wearing masks, avoiding social gatherings to the extent possible, etc.) both while working and when in the community. Additionally, facilities may decide, on their own, to regress phases based on other facility-defined criteria, but they are not required to do so.

25. Should residents that leave the facility for medical visits (this includes emergency department visits that do not result in stays greater than 23 hours) or procedures that do not require hospitalization (i.e., colonoscopy) be placed in quarantine when they return to the facility?

A: No. Residents that leave the facility for medical visits (this includes emergency department visits that do not result in stays greater than 23 hours) or procedures that do not require hospitalization do not need to be placed in quarantine when they return to the facility. Telemedicine should be utilized whenever possible. Screen residents for COVID-19 symptoms when leaving the facility for an appointment and within one-hour of returning to the facility. Continue daily resident screening each shift thereafter. The resident must wear a cloth face covering or facemask when they leave their room and during transport. The facility must share the resident's COVID-19 status with the transportation service

and medical facility. Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. Transportation equipment shall be sanitized between transports.

Assisted Living Facility Questions

1. Can Assisted Living Facilities develop their own customized reopening plan?
   A: Yes. Assisted Living Facilities can develop and implement a plan that incorporates public health mitigation strategies appropriate for their facility (there is not a model plan that Assisted Living Facilities are required to follow).

2. Does the Iowa Guidance on Phased Easing of Restrictions for Long-Term Care Facilities issued June 4, 2020 negate the visitation restrictions imposed by DIA on March 18, 2020?
   A: Yes.

3. The guidance issued for LTC facilities issued on June 4, 2020 states "The guidance below is specifically targeted at long-term care facilities (e.g., nursing homes). Other facilities or congregate care settings, such as assisted living or residential care facilities, may choose to follow an independently developed framework for easing restrictions." Does that statement clearly allow assisted living programs to adopt their own phased approaches to reopening visitation without any structured guidance from DIA?
   A: Yes.

4. If programs are allowed to create their own approaches to the restoration of visitation, will DIA allow programs to determine when visitation restrictions need to be reinstated due to COVID cases within the AL program or within the community?
   A: Yes.

5. Will programs be allowed to delay lifting of restrictions now due to the same circumstances?
   A: Yes.

6. Will facilities be subject to adverse action by DIA for resident rights violations due to their reopening plans?
   A: See Question 3. Also, the ALP should base their Phased Easing of Restrictions on the Phased Easing of Restrictions for LTC, the ALPs Infection Control Risk Assessment, and CDC Guidelines.

7. How will complaints be handled?
   A: Currently, DIA will be conducting Remote Infection Control Surveys with the intent of conducting the onsite portion beginning July 6, 2020. Also, DIA is conducting onsite surveys for IJ level complaints. DIA will be announcing updates to their survey activity when the survey priorities change.

8. The Iowa reopening guidance provides a link to CDC guidance for assisted living facilities, will facilities be cited or otherwise face adverse action if they do not comply with each aspect of the CDC guidance?
   A: See Questions 2 and 4. **Further, ALPs are allowed to develop their own Phased Easing of Restrictions based on the needs of their own programs and tenants. However, they should base their Plan off of the Guidelines provided to LTC, CDC Guidelines, and their own Infection Control Risk Assessment**.

9. Is the same type of testing available to Assisted Living Facilities through the State Hygienic Laboratory?

   A: Baseline, phased, and sentinel testing is only available through the State Hygienic Laboratory for Long Term Care Facilities at this time. As testing capacity continues to expand, additional testing for Assisted Living Facilities may become available in the future. However, sick persons who meet SHL criteria can still use this resource.
   https://idph.iowa.gov/Portals/1/userfiles/61/covid19/COVID%2019%20Testing%20Framework%2005_27_20.pdf