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| <p>Original Release Date: August 13, 2020 Effective Date: August 14, 2020 Updated: October 21, 2020 Updated: March 19, 2021 Updated: May 6, 2021</p> | <p>Updated: July 28, 2021 Updated: August 6, 2021 Updated: October 20, 2021 Updated: December 3, 2021 Updated: January 18, 2022</p> |
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Updated Interim Guidance for Nursing Homes and Other Licensed Long-Term Care Facilities

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Applicability

This interim guidance provides guidelines for nursing homes and other long-term care (LTC) facilities regarding restrictions that were instituted to mitigate the spread of COVID-19. The guidance in this document is specifically intended for facilities as defined in the Nursing Home Care Act (210 ILCS 45), and also applies to Supportive Living Facilities, Assisted Living Facilities, Shared Housing Establishments, Sheltered Care Facilities, Specialized Mental Health Rehabilitation Facilities (SMHRF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), State-Operated Developmental Centers (SODC), Medically Complex/Developmentally Disabled Facilities (MC/DD), and Illinois Department of Veterans Affairs facilities.

Non-discrimination Statement

It is essential that health care institutions operate within an ethical framework and consistent with civil rights laws that prohibit discrimination in the delivery of health care. Specifically, in allocating health care resources or services during public health emergencies, health care institutions are prohibited from using factors including, but not limited to, race, ethnicity, sex, gender identity, national origin, sexual orientation, religious affiliation, age, and disability. For additional information, refer to: [Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 \(COVID-19\)](#).

Reason for Update

New Guidance released from the CDC and CMS

CDC has updated the guidance for [Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#) as well as [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#) and CMS [Nursing Home Visitation Frequently Asked Questions \(FAQs\)](#). **CDC has also transitioned to using “up to date” as the preferred description of an individual’s vaccination status, including any booster dose(s)(see definitions).**

Introduction/Background

“Older adults living in congregate settings are at high risk for infection by respiratory and other pathogens, such as SARS-CoV-2. Even as nursing homes and other long-term care facilities resume normal practices, they must sustain core infection prevention and control (IPC) practices and remain vigilant for SARS-CoV-2 infection among residents and health care personnel (HCP) in order to prevent spread and to protect residents and HCP from severe infections, hospitalizations, and death.”¹

This IDPH guidance document draws on currently available best practice recommendations. IDPH will revise and update this document as needed, based on accrued experience, new information, and future guidance from CMS and CDC.

The Core Principles of COVID-19 Infection Prevention

- Vaccination
- Source control (masks, face coverings, and other respiratory protection)
- Resident and staff testing
- Hand hygiene (use of alcohol-based hand rub is preferred)

¹ Centers for Disease Control and Prevention (CDC). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. September 10, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

- Physical distancing
- Appropriate use of personal protective equipment (PPE)
- Instructional signage throughout the facility and communication
- Infection prevention and control education and competency
- Cleaning and disinfecting high frequency touched surfaces and equipment
- Appropriate ventilation and engineering controls to improve air quality
- Effective cohorting

Continuing to take precautions to reduce the risk of transmission of COVID-19 remains vitally important. At this time, not all nursing home residents and staff are [up to date](#) on their COVID-19 vaccinations, making it possible for them to still become infected by visitors. In addition, individuals can spread COVID-19, including new variants, even if they are vaccinated. Having a strong IPC program is critical to protect both residents and health care personnel (HCP).

Use of Engineering Controls and Indoor Air Quality

When indoors, improving ventilation and increasing the number of times fresh or filtered air enters a room can help reduce viral particle concentration and have been proven to decrease COVID-19 transmission². “The lower the concentration, the less likely viral particles can be inhaled into the lungs (potentially lowering the inhaled dose); contact eyes, nose, and mouth; or fall out of the air to accumulate on surfaces.”³

Improving ventilation practices and interventions can reduce the airborne concentrations and reduce the risk that residents, visitors, and HCP come in contact with viral particles.

Approaches include:

- Increasing the introduction of outdoor air.
- Ensuring ventilation systems are operating properly as defined by [ASHRAE Standard 62.1](#)
- Optimizing the use of engineering controls to reduce or to eliminate exposures.
- Exploring options to improve ventilation delivery and indoor air quality in all shared spaces. The higher number of air exchanges per hour will result in better results with respect to purging airborne contaminants. Refer to the CDC suggested options for [Air Changes per Hour \(ACH\)](#).
- Using portable High-Efficiency Particulate Air (HEPA) fan/filtration systems to enhance air cleaning. HEPA filters need to have the appropriate CADR (Clean Air Delivery Rate) rating

² Efficacy of Portable Air Cleaners and Masking for Reducing Indoor Exposure to Simulated Exhaled SARS-CoV-2 Aerosols — United States, 2021 *Weekly* / July 9, 2021 / 70(27);972–976

³ Centers for Disease Control and Prevention (CDC) (June 2, 2021). Ventilation in Buildings, retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>

for the room size [e.g., a 300-ft² room with an 11-foot ceiling will require a portable air cleaner labeled for a room size of at least 415 ft² (300 × [11/8] = 415)]³. [CDC FAQ #5](#).

- The following resources provide evidence-based guidance:
 - [CDC Ventilation in Buildings](#) (June 2, 2021)
 - CDC/HICPAC [Guidelines for Environmental Infection Control in Health Care Facilities](#) (2003)
 - American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), which provides [COVID-19 technical resources](#) for health care settings.

Vaccinations - Updated

LTC facilities and state-operated congregate facilities must ensure that staff are vaccinated and tested in accordance with Executive Order 2021-22 ([COVID-19 EXECUTIVE ORDER NO. 87](#)) and the Illinois Administrative Codes applicable to each respective licensure found at this [link](#).

In addition, on November 5, 2021 CMS issued COVID-19 [vaccination requirements for health care staff in certified facilities](#). IDPH will enforce in compliance with [QSO-22-07-ALL, released on December 28, 2021](#)

Per CDC guidance, [up to date vaccination](#) , including booster doses for visitors, is always preferred and should be encouraged. The state has arrangements with specialized LTC pharmacies that will work with facilities to provide onsite vaccination clinics for residents as well as the family and friends of residents.

All LTC facilities have access to COVID-19 vaccinations, either through their local health department or specialized LTC pharmacy vaccine providers operating within Illinois. For LTC facilities with questions about obtaining COVID-19 vaccinations outside the city of Chicago, contact your local health department or email dphltctesting@illinois.gov.

Note: Chicago receives a direct federal allocation of vaccine and oversees their own LTC pharmacy provider network. Chicago facilities should contact the Chicago Department of Public Health to coordinate a COVID-19 vaccination clinic at covid19vaccine@cityofchicago.gov. For larger LTC facilities with the ability to accept, store, administer, and report COVID-19 vaccine doses administered to the Illinois vaccine registry (I-CARE), you may wish to enroll as a registered COVID-19 provider through the [I-CARE system](#).

Reporting of Staff and Resident COVID-19 Vaccinations and Testing

Facilities that are not required to report COVID-19 aggregate vaccination and testing data into the National Healthcare Safety Network (NHSN) shall report this data to IDPH weekly utilizing the online form at [LTC Weekly Reporting COVID-19 Vaccinations and Testing](#). The required information matches that submitted by CMS-certified facilities to NHSN.

Oral Antivirals and Other Therapeutics for Outpatient Management of Covid-19

Facilities interested in providing [Evusheld](#) (for pre-exposure prophylaxis), [Paxlovid](#) (for treatment), or [Molnupiravir](#) (for treatment) should complete the [COVID-19 Antiviral Survey](#). Please review the indications and safety profile for each of these therapies with your pharmacy and healthcare providers.

Antiviral Treatments

[Paxlovid](#) and [Molnupiravir](#) are oral antivirals that MUST be used within 5 days of symptom onset to prevent hospital admissions and death from Covid-19. [Molnupiravir](#) should only be used when other outpatient therapies are not available within the required timeframe.

Agents like [Remdesivir](#) are also available currently to help prevent hospital admissions and are given as an intravenous injection once a day for three days.

Monoclonal Antibodies

More information about mAb treatment is available from [IDPH](#), [CDC](#), [CMS](#), and from the [U.S. Department of Health and Human Services](#) (HHS).

- **Pre-exposure prophylaxis**

Pre-exposure prophylaxis agent [Evusheld](#) is a monoclonal antibody that is only for those who are not expected to mount a response to vaccination due to their immunosuppressed state or have a contraindication to receiving the vaccine. It is given as intramuscular injections every 6 months.

- **Treatment:** Persons who are older or who have chronic respiratory, cardiac, or renal disease, obesity, immunosuppressive disease, diabetes, and other medical conditions or factors, including race and ethnicity associated with increased risk of severe COVID-19 disease, may benefit from mAb treatment, **regardless of vaccination status**.

Treatment with monoclonal antibodies (mAb) may reduce the risk of severe COVID-19 disease and hospitalization. **As soon as a resident is diagnosed with COVID-19 or determined to be a close contact of someone with COVID-19, contact the resident's provider and the pharmacy to assess whether monoclonal antibodies should be administered and the type of mAb available.**

Please consider circulating variants and whether the available mAb will be effective active against them. If monoclonal antibodies cannot be administered on site, then it is important to be able to transport residents to locations for the one-time infusion or injection treatments. The links below have information on mAb treatment, and effectiveness against circulating strains.

- **Post-exposure Prophylaxis**

Monoclonal antibody treatment may also be used to prevent the development of COVID-19 for close contacts who are at high risk for progression to severe COVID-19, including hospitalization or death, in those who are not fully vaccinated or who are not expected to develop immunity from vaccination (for example, people with immunocompromising conditions, including those taking immunosuppressive medications). **During supply shortages, treatment should be prioritized over PEP.**

Monoclonal Antibody Allocation and distribution process

Long-term care facilities should contact their usual pharmacy provider for more information on residents receiving monoclonal antibodies or oral therapeutics or visit the [IDPH therapeutic locator webpage](#) to identify other locations where these therapeutics are available.

In the situation of an urgent need for mAb (i.e., positive residents and contacts) by a facility that does not usually provide Covid-19 therapeutics, use the [matchmaker function](#) to locate doses nearest to you or email IDPH at dph.mabtherapy@illinois.gov.

- **New providers or sites** for mAb administration, may register as a new site through [this link](#).
- **Current mAb providers** can submit requests for monoclonal antibody treatment [here](#).

Source Control and Physical Distancing Recommendations - Updated

The safest practice is for residents and visitors to wear source control and physically distance, particularly if either are at risk for severe disease or are unvaccinated.

Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a health care setting. HCP must wear, at a minimum, a well-fitted face mask while working. Other PPE may be required; see the section on Universal PPE for HCP.

In accordance with Governor Pritzker's August 4, 2021 Executive Order Number 18 ([COVID-19 Executive Order No. 85](#)), "all nursing homes and long-term care facilities in Illinois must continue to follow the guidance issued by the CDC and IDPH that requires the use of face coverings in congregate facilities for those over the age of 2 and able to medically tolerate a face covering, regardless of vaccination status." Face coverings may be removed temporarily while actively eating or drinking while maintaining 6 feet of distance from others.

Universal PPE for HCP

- **If a resident is suspected or confirmed to have COVID-19, or is an unvaccinated resident identified to be a close contact**, HCP must wear an N95 respirator, eye protection, gown, and gloves.

- If a resident is identified to be a close contact and is vaccinated, HCP must wear PPE according to community transmission levels listed below.
- **For those residents not suspected to have COVID-19, HCP should use community transmission levels to determine the appropriate PPE to wear.**
 - **When community transmission levels are *substantial or high***
HCP must wear a well-fitted mask and eye protection **while present in patient care areas.**
 - HCP are not required to wear eye protection for COVID-19 when working in non-patient care areas (e.g., offices, main kitchens, maintenance areas) when there are substantial or high community COVID-19 transmission levels. HCP should wear eye protection when entering the patient care areas.
 - **When community transmission levels are *low-to-moderate***
HCP must wear a well-fitted face mask.
- **For COVID-19 specimen collection:** HCP must wear an N95 respirator, eye protection, gown, and gloves.
- **Guidance for CPAP/BIPAP for asymptomatic residents,** who are not suspected to have COVID-19 (regardless of vaccination status).
 - In areas with **substantial-to-high community transmission levels,** HCP must wear an N95 respirator and eye protection.
 - In areas **with moderate-to-low community transmission levels,** HCP must wear a well-fitted face mask.

Continued Monitoring of Essential Measures - Updated

Facilities should continue to monitor essential criteria to ensure they can provide safe care and respond to outbreak situations.

Case Status in the Community: Focus on County Level COVID-19 Transmission

How to implement several of the IPC measures (e.g., use of source control, screening testing) depends on levels of COVID-19 transmission in the community.

KEY POINTS

- **Facilities must use the [CDC COVID-19 Data Tracker](#).**
- **Facilities must carefully monitor the color-coding, which depicts county community transmission levels.**
- Facilities must contact their local health department with questions pertaining to community transmission levels.

Community transmission levels dictate facility testing of unvaccinated HCP, PPE use, and facility response to a positive case(s).

- **The facility must test unvaccinated staff** at a minimum of weekly in accordance with [COVID-19 EXECUTIVE ORDER NO. 87](#), or more frequently according to the community transmission level or if required by local health departments. See Table: Testing Intervals of Unvaccinated HCP by Community Transmission Level (below).
- **Facilities must monitor their community transmission level every other week (e.g., first and third Monday of every month) and adjust the frequency of staff testing accordingly.**
- **If the community transmission level increases**, the facility must test staff at the frequency shown in the table below as soon as the criteria for the higher activity level are met.
- **If the community transmission level decreases**, the facility must continue testing staff at the higher frequency until the level of community transmission has remained at the lower level for at least two weeks before reducing testing frequency as shown in the table below.
- **For HCPs who work infrequently (less than weekly)**, test within 72 hours of the next scheduled shift.
- Local health departments may have more stringent testing requirements.

Table 1: Testing Intervals of Unvaccinated HCP by Community Transmission Level

| Community Transmission Level | Minimum Testing Frequency of Unvaccinated Staff* |
|------------------------------|---|
| LOW | Per Illinois COVID-19 Executive Order No. 87 testing is required at a minimum of weekly |
| MODERATE | Once a week |
| SUBSTANTIAL | Twice a week |
| HIGH | Twice a week |

*Vaccinated staff do not need to be routinely tested.

Case status in the facility

A facility must continue to test and to monitor for new facility-onset and facility-associated cases and, if found, must implement facility-wide testing per testing plan.

Staffing level

IDPH does not support staff working while ill. However, should shortages occur, facilities should utilize mitigation strategies as defined by CDC.⁴ Refer to CDC website [Mitigation Strategies for Staffing Shortages](#). Please see page 13 for additional discussion.

⁴ Centers for Disease Control and Prevention. Strategies to Mitigate Healthcare Personnel Staffing Shortages, March 10, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

Hand hygiene

The facility must train and validate competencies of all staff on hand hygiene. Everyone entering the facility must perform hand hygiene.⁵

Cleaning and disinfection supplies

Ensure that any disinfectants used in the facility are included on the U.S. Environmental Protection Agency (EPA) "[List N](#)"⁶ as effective against coronavirus (COVID-19). Cleaning and disinfectant products should be readily available for use at the point-of-care.

PPE supply

- **Conventional** (normal operations without shortages),
- **contingency capacity** (measures used temporarily during periods of anticipated PPE shortages), and
- **crisis capacity** (strategies implemented during periods of shortages even though they do not meet U.S. standards of care).

The supply and availability of NIOSH-approved respirators and other PPE has increased significantly. **Health care facilities should not be using crisis capacity strategies at this time.**

Facilities that extend the use of N95 respirators, face masks, and eye protection are operating at a contingency level of PPE utilization. If respirators, face masks, or gowns are reused, the facility is operating at a crisis level. Based upon availability, facilities should not be operating at a crisis level for PPE utilization⁷. Utilize CDC [PPE optimization strategies](#).

Universal screening

- Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following criteria so that they can be properly managed:
 - 1) a positive viral test for SARS-CoV-2,
 - 2) symptoms of COVID-19, or
 - 3) persons who meet criteria for quarantine, isolation, or exclusion from work.
- Options could include (but are not limited to): individual screening on arrival at the facility or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

⁵ Centers for Medicare and Medicaid Services Nursing Home Visitation - COVID-19 (REVISED) April 27, 2021. <https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf>

⁶ U.S. Environmental Protection Agency (EPA) <https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19>

⁷ Centers for Disease Control and Prevention (CDC). Optimizing Supply of PPE and Other Equipment during Shortages <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html>

- **Health care personnel (HCP)**, should report any of the above criteria, regardless of vaccination status. Symptomatic HCP should be restricted from work until they have been evaluated.
- **Visitors** meeting any of the above criteria should be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively⁸. **Visitors must follow the quarantine and isolation guidance for LTC residents; the shortened CDC time periods for the general public do not apply. This means that a visitor must be in isolation for 10 full days after a positive test, or 14 days of quarantine if a close contact of a COVID-19 positive individual, regardless of vaccination status.**

Testing Plan and Response Strategy

The facility must have a written COVID-19 testing plan and response strategy in place based on contingencies informed by the CDC⁹ and, as applicable, CMS requirements.¹⁰ The testing plan must specify the method(s) and locations of testing (laboratory and/or point-of-care). The testing plan should include:

- **A policy for addressing residents and staff that refuse testing.**
- **Timely reporting of test results** to IDPH and the certified local health department.
- **Provisions for designating resident care areas** with dedicated staff if residents test positive for COVID-19 (COVID-19 unit).
- **Visitor testing:** While not required, facilities in counties with substantial or high levels of community transmission are encouraged to offer testing to visitors, if feasible. If facilities do not offer testing, they should encourage visitors to be tested on their own before coming to the facility (e.g., within 2–3 days).
- **Visitor vaccination information:** Facilities may ask about a visitor’s vaccination status; however, visitors are not required to be tested or vaccinated (or show proof of such) as a condition of visitation.
- **Provisions for the facility to submit the testing and response plan** to IDPH, CMS, or local health department personnel upon request.
- **Arrangements with a laboratory** to conduct tests to meet these requirements. Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48

⁸ Centers for Disease Control and Prevention (CDC). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. September 10, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html> ; <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

¹⁰ <https://www.federalregister.gov/documents/2020/09/02/2020-19150/medicare-and-medicaid- programs-clinical-laboratory-improvement-amendments-clia-and-patient>

hours) should be selected to rapidly inform infection prevention initiatives to prevent and to limit transmission. A list of private labs available to provide testing in LTC facilities can be [found here](#).

- **Provisions for point-of-care testing, if applicable.** Although a laboratory RT-PCR test remains the gold standard for testing, point-of-care (POC) antigen testing is acceptable. For a facility to conduct these tests with their own staff and equipment, the facility must have at a minimum, a CLIA Certificate of Waiver.

Newly Identified Positive Case in an HCP or Resident – Updated **(Table 3 in Appendix A summarizes this information)**

Because of the risk of unrecognized infections among HCP or residents, a single new case of COVID-19 in any HCP or resident should be evaluated as a potential outbreak.

- Increase monitoring and screening of all residents and HCP for signs and symptoms of COVID-19 from daily to each shift to more rapidly detect those with new symptoms.
- **Determine which approach to use for the outbreak investigation.** Facilities have the option to choose either a contact tracing/unit (or department)-based approach or a broad-based approach
 - Either contact tracing or broad-based approaches are recommended by the CDC for outbreak investigations in long-term care facilities. In order to assure that all potential close contacts are tested, IDPH will require, at a minimum, a unit-based approach in addition to contact tracing.
 - It is up to the facility to determine which approach to use. If the facility has the resources and experience to investigate the outbreak at a unit-level (e.g., unit, floor, or other specific area(s) of the facility), and identify higher risk exposures and close contacts, they can choose the unit-level approach. Otherwise, the facility should use a broad-based approach.
 - A broad-based approach is required in situations where all potential contacts cannot be identified, are too numerous to manage, or when contact tracing fails to halt transmission.
- LTC facilities responding to COVID-19 cases must always notify and follow the recommendations of the local health department.

Unit (or department level)-based approach

This is a more focused approach and starts the outbreak investigation on the unit or department where the positive COVID-19 case was identified (affected unit).

- If the unit-based approach is used, the facility must test all residents and HCP on the unit (or department) where the HCP worked or the resident resided immediately (but not earlier than **24 hours** after exposure), regardless of vaccination status. Continue to test every 3-7 days until there are no more positive cases for 14 days.
- There is no need to test individuals who have had COVID-19 in the prior 90 days if they remain asymptomatic.
- Perform contact tracing on the unit or department where the new case was identified, by investigating to determine if, during the prior 48 hours, there were any higher risk exposures to other HCP or close contacts with residents.
- Also determine if there were any higher risk exposures of HCP or close contacts of residents beyond the affected unit (e.g., other units, departments).
- Those identified to be higher risk exposures or close contacts must be tested every 3-7 days until there are no more positive cases for 14 days.
- While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility.
- Visitors should be made aware of the potential risk of visiting during an outbreak and adhere to the core principles of infection prevention and control.
- If residents or their representative would like to have a visit during an outbreak, they should wear a well-fitting mask during the visit, regardless of vaccination status. Visits should ideally occur outdoors or in the resident's room, unless it is a shared room and the resident's roommate is unvaccinated or immunocompromised (regardless of vaccination status).
- Once the initial tests are completed and the results are obtained, the facility must **determine if the outbreak investigation should be expanded** to other areas of the facility.
- When the positive case is a staff member who rotates on multiple units, facilities must determine which units may be affected based upon the infectious period of 48 hours prior to symptoms onset or the positive test. Multiple units may need to be tested. **If more than one unit is indicated, follow the broad-based approach below.**
- In general, individuals who have had a COVID-19 infection within the past 90 days are exempt from testing unless they become symptomatic.

Broad-based Approach

This approach is broad from the start or onset and requires testing of all residents and HCP regardless of vaccination status when a single case of COVID-19 is identified in the facility. **If using the broad-based approach and not completing contact tracing, the facility must quarantine all unvaccinated residents.**⁸

- Conduct facility-wide testing of all residents and HCP immediately (but not earlier than **24 hours** after exposure), regardless of vaccination status.
- While it is safer for visitors not to enter the facility during an outbreak, visitors must still be allowed in the facility.
- Visitors should be made aware of the potential risk of visiting during an outbreak and adhere to the core principles of infection prevention and control.

- If residents or their representative would like to have a visit during an outbreak, they should wear a well-fitting mask during the visit, regardless of vaccination status, and visits should ideally occur outdoors or in the resident room.
- **Continue to test every 3-7 days until there are no more positive cases for 14 days.**
- There is no need to test individuals who have had COVID-19 in the prior 90 days if they remain asymptomatic.

Management of HCP with higher risk exposures or COVID-19 infections – Updated
([CDC Guidance Managing Health Care Personnel with COVID-19 Infection or Exposure](#))
(See Tables 4 & 5 in Appendix A for Details)

The specific factors associated with these exposures should be evaluated on a case-by-case basis to determine if a higher-risk exposure occurred; interventions, including restriction from work, **have been updated to enhance protection for HCP, residents, and visitors and to address concerns about potential impacts on the healthcare system given a surge of COVID-19 infections.** Updates to CDC guidance are found at CDC ([evaluating an exposure](#)).¹¹

If conventional strategies cannot be sustained during a surge in cases, facilities may consider implementing contingency strategies, then crisis strategies, in an incremental manner. Facilities are best positioned to evaluate their own needs as to whether conventional, contingency, or crisis strategies are most appropriate at a given time. **IDPH generally does not support HCP working while ill, as sickness presenteeism, or working while ill, increases risk of errors and COVID-19 transmission.¹² If a facility is allowing HCP who are positive to work, they must be willing and well enough to work.**

Notes: This guidance is for HCP and does not apply to residents or the general public.

- HCP who are moderately to severely immunocompromised regardless of vaccination status might be at increased risk for infection. Facilities should consult with their local health department for any work restrictions that may be required after a higher risk exposure.
- HCP who have had prolonged, continued close contact with someone with COVID-19 in the home, regardless of vaccination status, must test immediately, but not earlier than **24 hours**, between days 5-7, and weekly for two weeks after the last exposure date.
- Facilities must notify the local health department **and the IDPH Office of Health Care Regulation** if they are moving to crisis staffing. **For reporting of crisis status, facilities should report to OHCR in the same manner used to report serious incidents or accidents.**

¹² Kinman G, Grant C. Presenteeism during the COVID-19 pandemic: risks and solutions. *Occup Med (Lond)*. 2021;71(6-7):243-244. doi:10.1093/occmed/kqaa193

Mitigation Strategies for Staffing Shortages – Reminder - updated
(This section was published in previous editions, and has been updated)
(Definitions for vaccination status are at the end of this document)
(CDC strategies to mitigate staffing shortages)

IDPH does not support staff working while ill. HCPs should be asymptomatic and well enough to work, as sickness presenteeism, or working while ill, increases risk of errors and transmission.¹² **Mitigation strategies listed below are intended to be used in the order that they appear.**

Contingency Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are anticipated, health care facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and to prepare for mitigating this problem. **Crisis level staffing mitigation strategies are discussed in a separate section below.** Contingency mitigation strategies include:

- Attempt to hire additional staff; rotate staff; offer overtime, bonus, or hazard pay to support patient care activities.
- Contact staffing agencies to identify additional health care personnel (staff) to work in the facility. Be aware of Illinois-specific emergency waivers or changes to licensure requirements or renewals for select categories of staff.
- Determine if there are alternate care sites with adequate staffing to care for patients with COVID-19 (e.g., sister facilities in same network or other COVID-19 designated facilities where residents could be transferred to for care).
- Reach out to Illinois Helps for staffing assistance (<https://illinoishelps.net/>).
- As appropriate, consider requesting that staff postpone elective time off from work.
- **If shortages continue despite other mitigation strategies, consider allowing asymptomatic staff with higher risk exposures to return to work (Table 5). If HCP develop symptoms at any point, they should immediately isolate and undergo testing and evaluation to determine if they have COVID-19.**

- Consider allowing staff with COVID-19 infection who are asymptomatic or have mild to moderate (but improving) symptoms, and no fever within 24 hours, to return to work with a shortened, 5-day isolation period (Table 4). **HCP should wear an N95 respirator at work until 10 full days after they developed symptoms or had a positive test.**
- **Facilities should prioritize job duties for HCP who have COVID-19 and are returning to work sooner under shortened isolation guidelines.**

Care Strategies

- Bundle care activities or determine if tasks could be postponed, offered every other day, or on an alternate schedule (e.g., showers given every other day unless necessary to maintain skin integrity). Resume routine care activities as soon as staffing allows.
- Reassign staff who work in non-clinical areas to support patient care activities. Facilities will need to ensure these staff have received appropriate orientation, appropriate and adequate PPE, and training to work in areas that are new to them.

NOTE: Document all attempts to augment staffing needs (date, time, and effort made)

Crisis Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are occurring, health care facilities and employers (in collaboration with their local health department, human resources, and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to designated health care facilities, or alternate care sites with adequate staffing.
- The facility has activated its contingency staffing plan and has exhausted all options to address staffing needs, triggering a crisis level of staffing.
- The facility has exhausted all options to cohort COVID-19-positive residents internally or transfer positive residents to COVID-19 care sites.
- **If shortages continue despite other mitigation strategies, consider allowing asymptomatic HCP with higher risk exposures to return to work (Table 5). **If HCP develop symptoms at any point, they should immediately isolate and undergo testing and evaluation to determine if they have COVID-19.****
- Consider allowing HCP with COVID-19 infection who are asymptomatic or have mild to moderate (but improving) symptoms, and no fever within 24 hours, to return to work with a

shortened isolation period (Table 4). **HCP should wear an N95 respirator until 10 full days after they developed symptoms or had a positive test.**

- **Facilities should prioritize job duties for HCP who have COVID-19 and are returning to work sooner under shortened isolation guidelines.**

Additional information is available: *Strategies to Mitigate Health Care Personnel Staffing Shortages* can be found at the following CDC website: <https://www.cdc.gov/coronavirus/2019-ncov/Staff/mitigating-staff-shortages.html>

Management of Residents

Residents with **Confirmed** COVID-19

- Resident placement
 - Single room
 - Door closed (if safe to do so)
- Designate a separate area or unit as a COVID-19 unit
- Isolate using transmission-based precautions
- Monitor the resident every four hours
- Use dedicated medical equipment
- Dedicate HCP to the COVID-19 unit (including environmental services or housekeeping staff)
- Staff wear full PPE (N95 respirator, gown, gloves, eye protection)
- Visitation - Updated
 - While not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors and visits from ombudsmen. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting mask.
 - Before visiting residents, who are on TBP, visitors and ombudsmen should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors and ombudsmen must wear PPE as indicated by the type of transmission-based precaution. For COVID-19 this includes a well-fitting mask (for visitors), gown, gloves, and eye protection if providing direct care.
 - Visitors and ombudsmen should adhere to the core principles of infection prevention and control, which includes hand hygiene, well-fitting face covering, appropriate physical distancing and PPE.
 - Facilities should offer well-fitting mask or other appropriate PPE.^{13,14} Visitors should not wear facility provided N95s, however they may wear their own.
 - Counsel visitors about risks of COVID-19.
- Communal dining – Dining for persons confirmed to have COVID-19 is not allowed in communal areas. Dining should occur in the resident room.
- Group activities - resident should not participate in group activities until recovered.
- Transmission-based precautions (TBP).
 - Symptom-based strategy is preferred over testing strategy.
 - Mild-to-moderate illness.

- A minimum of 10 days since symptoms first appeared or first diagnostic test.
- Fever free for 24 hours without fever-reducing medications.
- Symptoms improving (e.g., shortness of breath, cough).
- Severe-to-critical illness or moderate-to-severely immunocompromised.
 - A minimum of 10 days (or up to 20 days) since symptoms first appeared.
 - Fever free for 24 hours without fever-reducing medications.
 - Symptoms improving (e.g., shortness of breath, cough).
 - Consider consultation with infectious disease expert.
- Environmental cleaning
 - Routine cleaning and disinfection of surfaces and equipment.
 - After discharge, leave the room empty (do not occupy or enter) for a period of one hour (60 minutes). Environmental services or housekeeping must not enter to terminally clean the room before 60 minutes has elapsed, unless they are wearing full PPE. After 60 minutes, they can enter wearing appropriate PPE for the terminal cleaning.

Residents Suspected to have COVID-19 -

- Test symptomatic residents regardless of vaccination status.
- Patient placement
 - Single room (if feasible)
 - Door closed (if safe to do so)
 - Private bathroom if possible
- Isolate using transmission-based precautions until results of tests are known.
- Monitor residents at least daily.
- Use dedicated medical equipment.
- Staff wear full PPE (N95 respirator, gown, gloves, eye protection).
- Visitation-Updated
 - While not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting mask (if tolerated). Before visiting a resident, who is on TBP, visitors should be made aware of the potential risk of visiting and the precautions necessary in order to visit the resident.
 - Visitors should adhere to the core principles of infection prevention, which includes hand hygiene, well-fitting face covering, and appropriate social distancing and PPE.
 - Facilities should offer a well-fitting mask or other appropriate PPE.¹²
 - Visitors must wear PPE as indicated by the type of transmission-based precaution. For COVID-19 this includes a well-fitting mask, gown, gloves, and eye protection if providing direct care.
- Communal dining – Dining for persons suspected of having COVID-19 is not allowed in communal areas. Dining must occur in the resident room.
- Group activities – resident must not participate in group activities until recovered.
- Routine cleaning and disinfection of surfaces and equipment.

- After discharge, leave the room empty for a period of 60 minutes. HCP must not enter to remove equipment or terminally clean the room for at least 60 minutes after discharge, unless they are wearing full PPE. After 60 minutes, they can enter wearing appropriate PPE for the terminal cleaning.
- If limited single rooms are available, or if numerous residents are simultaneously identified to have COVID-19 exposures or symptoms concerning for COVID-19, residents should remain in their current location, draw a privacy curtain between beds, and wait for **test results**.

Resident identified as a Close Contact of someone with COVID-19 (e.g., roommates or other close contacts) - Updated

- **Testing is not recommended for residents who have had COVID-19 in the last 90 days if they remain asymptomatic.**
- **Regardless of vaccination status**, a resident should have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than **24 hours** after the exposure) and, if negative, again 5–7 days after the exposure.
- Isolation, quarantine, and PPE requirements for residents identified to be a close contact of a positive COVID-19 case.
 - If the resident is **symptomatic**, regardless of vaccination status, isolate using transmission-based precautions and test as above. HCP should wear full PPE — treat as suspected COVID-19 case (see above guidance).
 - If the resident is **asymptomatic and vaccinated**, no need to quarantine or restrict the resident to their room, but the resident should wear source control for 14 days post exposure.
 - If the resident is **asymptomatic and unvaccinated**, quarantine for 14 days even if testing negative. HCP should wear full PPE.
 - If the resident is asymptomatic and **has had COVID-19 within last 90 days**, there is no need to quarantine; resident should wear source control for 14 days post exposure.
 - If the resident is **moderate-to-severely immunocompromised**, consider quarantine. Consult with the resident’s health care provider to determine if quarantine is necessary.
- Visitation
 - Visitors should be counseled on the risks of COVID-19.
 - **Unvaccinated residents identified to have had a close contact with a resident in quarantine** are allowed indoor visits in their room only. Both the resident and the visitor should wear source control and maintain physical distancing.
 - **Vaccinated residents identified to have had a close contact** can participate in indoor visits in their rooms, in common areas, or in designated visitation spaces. Outdoor visits are also allowed. Both the resident and the visitor should wear source control and maintain physical distancing for both indoor and outdoor visits.
- Dining
 - **Unvaccinated residents identified to have had a close contact** who are in quarantine must not participate in communal dining and should dine in their room.

- **Vaccinated residents identified to have had a close contact** may participate in communal dining but should wear source control to and from the dining hall and when not eating or drinking.
- Group activities
 - **Unvaccinated residents identified to have had a close contact** with a resident in quarantine must not participate in group activities.
 - **Vaccinated residents identified to have had a close contact** may participate in group activities but should wear source control during the activity.

New Admissions or Readmissions

- Hospitalized residents with confirmed COVID-19 must complete transmission-based precautions (isolation) requirements (minimum of 10 days or up to 20 days if immunocompromised or severe illness).
- Because of the risk of unrecognized COVID-19 infections among residents, facilities must conduct testing at the time of admission to the facility (if not done in the past 72 hours).
- **New Admissions or Readmissions – see Table 2 below**
 - When **community transmission levels are substantial or high**, asymptomatic new admissions and readmissions, regardless of vaccination status, must be tested **on admission** if not tested in the past 72 hours. ***If negative, test again 5 – 7 days after admission.***
 - If **community transmission levels are low-to-moderate**, asymptomatic new admissions and readmissions ***do not need to be tested on admission.***
- PCR testing is the preferred testing method; however, POC antigen testing is acceptable.
- **New admissions or readmissions that are unvaccinated** need to quarantine for 14 days and complete the testing listed above.
- **New admissions or readmissions that are fully vaccinated** do not need to quarantine if they remain asymptomatic but must complete testing listed above.
- **Visitation** – follow the same guidance as residents who are close contacts.
- **Facilities in an outbreak** may admit new residents if they have met the following criteria:
 - Have adequate HCP to provide care to all current residents and new admissions,
 - Are not in crisis staffing, have adequate PPE inventory to meet the care needs of all residents (those currently residing in the building and new admissions), and have appropriate room placement for residents.
 - **Facilities involved in an outbreak must consider the criteria listed above, the extent of the outbreak, and consult with their local health department before accepting new admissions.**

Residents who leave the facility - see table below

Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident, and any individual accompanying the resident, to wear a well-fitting mask, physically distance, and perform frequent hand hygiene, and to encourage those around them to do the same.

- Screen residents upon return for signs or symptoms of COVID-19.
 - If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, test the resident for COVID-19, regardless of vaccination status. Place the resident in quarantine and follow the guidance for “Resident Identified as a Close Contact of Someone with COVID-19 (above)”.
 - If the resident develops signs or symptoms of COVID-19 after the outing, test the resident for COVID-19, regardless of vaccination status, and follow the guidance for “Residents Suspected of Having COVID-19 (above)”.
- Quarantine is not recommended for **unvaccinated residents** who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and **do not** have close contact with someone with COVID-19.
- Residents who leave the facility for 24 hours or longer should generally be managed as described in **New Admissions and Readmissions**.

| Table 2: New Admission/Readmissions and Residents who Leave the Facility | | | |
|---|---|---|---|
| Resident vaccination status | Is quarantine of resident necessary? | Is testing of the resident necessary? | |
| | | Low-to-moderate community transmission | Substantial-to-high community transmission |
| Unvaccinated resident out for less than 24 hours | No | No | No |
| Unvaccinated resident out for 24 hours or more | Yes | No | Yes, test as readmission |
| Vaccinated resident out for less than 24 hours | No | No | No |
| Vaccinated resident out for 24 hours or more | No | No | Yes, test as readmission |

Visitation

Residents have the right to receive visitors of their choosing at the time of their choosing, and in a manner that does not impose on the rights of another resident, such as a clinical necessity or

safety restriction (see 42 CFR § 483.10(f)(4)(v)). Nursing homes must facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated below. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR § 483.10(f) (4), and the facility would be subject to citation and enforcement actions.

Adherence to the core principles of infection prevention and control is an evidence-based way to reduce the risk of COVID-19 transmission. **Residents have the right to make choices about aspects of their lives in the facility that are significant to their wellbeing. Therefore, if a resident receives a visitor in their room and the visit occurs in a manner that does not place other residents at risk, residents must be allowed to receive visitors in the manner they choose.**

- Facilities must allow indoor visitation at all times and for all residents as required under the CMS visitation rules ([QSO-20-39-NH](#)).
- Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of infection prevention and control and does not increase COVID-19 infection risk to other residents.
- The safest practice is for residents and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated.
- **Nursing homes may take additional measures to make visitation safer, while ensuring visitation can still occur. This includes requiring that, during visits, residents and visitors wear masks that are well-fitting, and preferably those with better protection, such as surgical masks or KN95s. While not required, facilities may offer visitors surgical masks or KN95s to replace a cloth face covering or mask.**
- **Visitors who are unwilling or unable to adhere to the core principles of COVID-19 infection prevention and control should not be permitted to visit or should be asked to leave.**
- If a resident's roommate is unvaccinated or immunocompromised (regardless of vaccination status), visits should not be conducted in the resident's room, if possible.
- If the county COVID-19 community level of transmission is substantial-to-high, all residents and visitors, regardless of vaccination status, should wear face coverings or masks and physically distance at all times.
- **Illinois Executive Order 2020-21 ([COVID-19 EXECUTIVE ORDER NO. 87](#)), requires residents to wear face coverings while indoors in public areas and visitors to wear source control at all times while in the building. In addition, it states that face coverings may be removed temporarily while actively eating or drinking when persons can consistently maintain 6 feet of distance.**
- Visitors, regardless of vaccination status, should wear source control and physically distance themselves from other residents or HCP.
- Touch-based communication may be necessary for residents with combined hearing and vision impairment, but increased use of touch-based communication may necessitate higher

levels of hand hygiene, respiratory protection, and/or other protections that may be appropriate in such situations.

- Visitation may occur in the following locations:
 - Resident room (no roommates **present unless moving roommate is not possible**)
 - Multipurpose rooms
 - Dining areas
 - Designated visitation rooms
 - Outdoors

Indoor Visitation During an Outbreak - updated

- While it is safer for visitors not to enter the facility during an outbreak, visitors must still be allowed in the facility.
- Visitors should be made aware of the potential risk of visiting during an outbreak and adhere to the core principles of infection prevention.
- If residents or their representative would like to have a visit during an outbreak, they should wear well-fitting masks during visits, regardless of vaccination status.
- Visits should occur in resident rooms rather than public areas on the affected unit(s).
- Local health departments may provide further guidance or direction to a facility to reduce the risk of COVID-19 transmission during an outbreak.
- **There may be times when the scope and severity of an outbreak warrants the health department to recommend a pause or limitations on visitation as a temporary, short-term intervention (e.g. 14 days). We expect these situations to be extremely rare and only occur after the facility has been working with the local health department to manage and prevent escalation of the outbreak. We also expect that if the outbreak is severe enough to warrant pausing visitation, it would also warrant a pause on accepting new admissions (as long as there is adequate alternative access to care for hospital discharges).¹² Facilities must document the outbreak control measures taken, including consultations with the local health department, that preceded the decision to limit visitation.**

Compassionate Care Visits

While end-of-life situations have been used as examples of compassionate care situations, the term “compassionate care situations” does not exclusively refer to end-of-life circumstances.

Compassionate care visits and visits required under federal disability rights law should be allowed at all times regardless of a resident’s vaccination status, the community transmission levels, or an outbreak.

¹² CMS Nursing Home Frequently Asked Questions. <https://www.cms.gov/files/document/nursing-home-visitation-faq-1223.pdf>

Federal Disability Rights Laws and Protection and Advocacy Personnel

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs Section 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000).

Additionally, each facility must comply with federal disability rights laws, such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

Essential Caregivers

Refer to the [IDPH Essential Caregiver Guidance for Long-term Care Facilities Guidance](#)

Communal Dining and Group activities – Updated

Communal Dining

- Residents must wear a mask to and from dining hall or activity room.
- Consistent with Illinois Executive Order 2020-21 ([COVID-19 EXECUTIVE ORDER NO. 87](#)), residents, regardless of vaccination status or community transmission levels, should wear source control in public areas of the facility when not actively eating or drinking.
- **Unvaccinated residents must** maintain 6 feet distance from other residents and HCP.

Live Music, Vocal Performances and Sing-alongs, or Worship Services

- **Outdoor performances are preferred**
 - **Residents**, regardless of vaccination status, are not required to wear source control when outdoors. Unvaccinated residents should physically distance from other residents and visitors when outdoors.
 - **Performers are not** required to wear source control while performing outdoors provided they can maintain 6-9 feet of distance from the audience. If this is not possible, source control must be worn.
 - **Performing groups** with more than five performers must perform outdoors. Facilities should not allow indoor performances of large groups.
 - Instruments should be fitted with bell covers consisting of a minimum of two layers of dense fabric. Bell covers should be made of a non-stretchy material with a MERV-13 rating (Minimum Efficiency Reporting Value).
 - Performers who play wind instruments can use face coverings with a slit.
 - **Communion.** Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.

- **Indoor Performances and Sing-alongs or Worship services** are allowed using the following guidance.
 - Illinois Executive Order 2020-21 (COVID-19 [EXECUTIVE ORDER NO. 87](#)) requires residents, visitors, and HCP to follow CDC guidance and wear source control while indoors in public areas of the facility.
 - **Vaccinated** residents do not have to physically distance from one another when wearing source control as long as they do not have symptoms of COVID-19.
 - **Unvaccinated** residents should physically distance from one another.
 - Individuals (e.g., clergy, pastors, etc.) conducting the worship service, regardless of vaccination status, are required to wear source control and maintain a physical distance of 6-9 feet from the audience or congregation.
 - Instruments should be fitted with bell covers consisting of a minimum of two layers of dense fabric. Bell covers should be made of a non-stretchy material with a MERV-13 rating to protect against bacteria and virus particles.
 - Individuals who play wind instruments can use face coverings with a slit.
 - **Communion.** Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.
 - If required, individuals providing pastoral care visits must wear source control and other PPE (e.g., eye protection, gown and gloves).

Group outings beyond the facility grounds may be considered provided all the above precautions are observed, along with precautions listed below for trips that are not medically necessary.

- Outdoor outings, such as a stroll in the park, are strongly preferable to outings to indoor destinations, weather permitting.
- Avoid mass events like festivals, fairs, and parades.
- Avoid other locations where it may be difficult to maintain 6-foot separation.

Beauty salons and barber shops

To operate facility-based beauty salons and barber shops:

- Allow services in beauty salons and barber shops only for residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- All residents must wear source control to and from and in the beauty salon.
- **The beautician or barber**, regardless of vaccination status, must wear source control at all times while in the beauty salon.
- Hand-held blow dryers are now allowed to be used in salons.
- Observe restrictions and precautions in [Personal Care Services Guidelines for Restore Illinois](#), except if IDPH guidelines in this document are more stringent, the IDPH guidance applies.

Assisted living facilities and other similar arrangements

For Assisted Living Facilities (ALF), Shared Housing Establishments (SHE), Sheltered Care Facilities, and Supportive Living Facilities (SLF), visits can be in common areas or in residents' apartments, following guidance listed above.

State-Authorized Personnel. IDPH grants authorization for entry to state-authorized personnel. They should **not** be classified as visitors. All such individuals must promptly notify facility staff upon arrival, follow all screening protocols established by the facility, and wear appropriate source control while onsite. State-authorized personnel are required to bring their own PPE and sufficient additional PPE for donning and doffing while entering and exiting COVID-19 units. State-authorized personnel will follow the COVID-19 rules and policies set forth by their respective state agencies. (For additional guidance, see this IDPH guidance document: "[Access to Hospital Patients and Residents of Long-Term Care Facilities by Essential State-Authorized Personnel](#)", April 17, 2020). Failure to allow entry of state-authorized personnel may lead to penalties and sanctions pursuant to applicable state and federal law.

Long-Term Care Ombudsman

As stated in previous [CMS guidance QSO-20-28-NH](#), regulations at 42 CFR § 483.10(f)(4)(i)(C) require that Medicare and Medicaid-certified nursing homes provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident

Representatives of the Office of the State Long-Term Care Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If the resident or the Ombudsman program requests alternative communication in lieu of an in-person visit, facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by state law.

Surveyors

Federal and state surveyors must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19. Consistent with [QSO-20-39-NH](#), LTC facilities are not permitted to restrict access to surveyors based on vaccination status, nor ask a surveyor for proof of his or her vaccination status as a condition of entry. Surveyors must adhere to the core principles of COVID-19 infection prevention.

Health Care Workers and Other Service Providers

Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, emergency medical services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy, etc., must be

permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or showing signs or symptoms of COVID-19 after being screened. Note that EMS personnel do not need to be screened so they can attend to an emergency without delay. These personnel should adhere to the core principles of COVID-19 infection prevention and must comply with CMS COVID-19 testing requirements.

Definitions - updated

Contingency staffing

Staffing shortages are imminent, and if action is not taken will interrupt care functions. Contingency strategies are used to mitigate staffing shortages.

Crisis staffing

Staffing shortages already exist, and crisis strategies are used in order to continue to provide resident care.

Facility-onset case: Following the definition from [CMS \(QSO-20-30-NH\)](#): "A COVID-19 case that originated in the facility; not a case where the facility admitted an individual from a hospital or other congregate care setting with known COVID-19 positive status, or an individual with unknown COVID-19 status that became COVID-19 positive within 14 days after admission."

Facility-associated case of COVID-19 infection in a staff member: A staff member who worked at the facility for any length of time two calendar days before the onset of symptoms (for a symptomatic person) or two calendar days before the positive sample was obtained (for an asymptomatic person) until the day that the positive staff member was excluded from work. (CDC [Contact Tracing for COVID-19](#)).

Higher-risk Exposure: HCP who had prolonged close contact* with a patient, visitor, or HCP with confirmed COVID-19, and

- HCP was not wearing a respirator when caring for a person with known COVID-19
- HCP was wearing a surgical or procedure mask, and the individual later identified to have COVID-19 was not wearing a face covering or mask
- HCP was not wearing eye protection if the individual with COVID-19 was not wearing a face covering or mask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure

*Prolonged close contact is within 6 feet for 15 minutes or longer during a 24-hour period, or for any duration during an aerosol generating procedure.

Source Control (e.g., Cloth Face Covering, Face Mask, or Respirator): Source control refers to the use of a well-fitting face covering, face masks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control offers varying levels of protection for the wearer against exposure to infectious droplets and particles produced by infected people.

- o Resident Source Control = cloth face covering, surgical mask, or procedure mask.
- o HCP Source Control = surgical mask, procedure mask, or respirator, as applicable.

Staff: (CDC) also known as healthcare personnel (HCP) or healthcare worker (HCW): include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

State-authorized personnel: State-authorized personnel include, but are not limited to, representatives of the Office of the State Long-Term Care Ombudsman Program, the Office of State Guardian, IDPH Office of Health Care Regulation, and the Legal Advocacy Service; and community-service providers, social-service organizations, prime agencies, or third parties serving as agents of the state for purposes of providing telemedicine, transitional services to community-based living, and any other supports related to existing consent decrees and court mandated actions, including, but not limited to, the prime agencies and sub-contractors of the Comprehensive Program serving the Williams and Colbert Consent Decree Class Members.

Vaccination status

- o **Boosted:** Have received all COVID-19 vaccine doses, including a booster dose.
- o **Up to date:** An individual has received the primary series of COVID-19 vaccine (either two doses or one dose, depending on the vaccine), and has received all additional and booster doses for which they are eligible as recommended by the CDC. ([CDC up to date recommendations for COVID-19 vaccines](#))
- o **Not Up to date:** An individual has not received all COVID-19 vaccinations for which they are eligible, as outlined under "up to date".
- o **Fully Vaccinated ("Vaccinated"):** Two weeks have passed since an individual received the second dose of a two-dose primary series, or one dose of a single dose vaccine. These individuals have NOT received a booster dose.
- o **Unvaccinated:** have NOT received all primary COVID-19 vaccine doses.

APPENDIX A: SUMMARY TABLES

| Testing Trigger | Staff (HCP) | Residents |
|--|--|---|
| Symptomatic individual identified. | All staff with signs or symptoms must be tested, regardless of vaccination status. | All residents with signs or symptoms must be tested, regardless of vaccination status. |
| Higher-risk exposure or close contact with an individual who tested positive for COVID-19 that occurs within the facility. | Follow testing requirements listed in Table 5: Work Exclusions & Restrictions for Asymptomatic HCP with Exposures | Asymptomatic residents with prolonged close contact with someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen), unless within 90 days of COVID-19 infection. Test immediately, but not earlier than 24 hours post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule. |
| Higher risk exposure or close contact with individual positive with COVID-19 that occurs outside the facility. | Follow testing requirements listed in Table 5: Work Exclusions & Restrictions for Asymptomatic HCP with Exposures | Asymptomatic residents with prolonged close contact with someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen), unless within 90 days of COVID-19 infection. Test immediately, but not earlier than 24 hours post-exposure. If negative, test again between day 5-7 post-exposure. |
| New admissions, readmissions, or those out of the facility for more than 24 hours. Testing is not required for individuals who are within 90 days of a COVID-19 infection. | | If community transmission levels are substantial or high , regardless of vaccination status, must be tested on admission if not tested in the past 72 hours. If negative, test again 5 – 7 days after admission. PCR testing is preferred. If community transmission levels are low-to-moderate , do not need to be tested on admission. |

| Vaccination Status | Conventional | | Contingency | | Crisis (Must notify LHD and OHCR) ² | |
|---|-------------------------|--|----------------|---|--|--|
| | Work Exclusion | Required Testing | Work Exclusion | Required Testing | Work Exclusion | Required Testing |
| Boosted, Vaccinated and Unvaccinated | 10 days off (ideal) | No testing required to return to work | 5 days off | May return after 5 days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. Must have one negative test¹ completed within 48 hours before work shift begins or rapid antigen test prior to shift. | Allowed to work except, should have duties prioritized | No additional testing required to work |
| | OR 7 days off | May return to work after 7 days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. Must have one negative test¹ completed within 48 hours before work shift begins or rapid antigen test prior to shift | | | | |
| ¹ Either an antigen test or NAAT can be used as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection. ² LHD – Local Health Department, OHCR = IDPH Office of Health Care Regulation | | | | | | |

APPENDIX A: SUMMARY TABLES

Table 5: Work Exclusions & Restrictions for *Asymptomatic HCP with Exposures - New*

| Vaccination Status | Conventional | | Contingency | | Crisis (Must notify LHD and OHCR) | |
|--|--|--|---|--|---|--|
| | Work Exclusion | Required Testing | Work Exclusion | Required Testing | Work Exclusion | Required Testing |
| <p>Boosted HCP have received all COVID-19 vaccine doses, including booster dose(s)</p> <p>Screen for symptoms twice per shift</p> | <p>Allowed to work with testing</p> <p>Must be asymptomatic</p> | <p>Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, must additionally test weekly for two weeks after the last exposure date.</p> | <p>Allowed to work</p> <p>Must be asymptomatic</p> | <p>No additional testing required to work but include HCP in outbreak testing completed every 3-7 days, unless within 90 days of COVID-19 infection</p> | <p>Allowed to work</p> <p>Must be asymptomatic</p> | <p>No additional testing required to work but include HCP in outbreak testing completed every 3-7 days, unless within 90 days of COVID-19 infection.</p> |
| <p>Vaccinated or Unvaccinated</p> <p>Vaccinated HCP have received all primary COVID-19 vaccine doses but not the booster.</p> <p>Unvaccinated HCP have NOT received all primary COVID-19 vaccine doses.</p> <p>Screen for symptoms twice per shift</p> | <p>10 days off (ideal)</p> <p>OR</p> <p>7 days off</p> <p>Must be asymptomatic</p> | <p>If excluded from work for 10 days, no testing is required to return to work.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection, must additionally test weekly for two weeks after the last exposure date.</p> <p>May return after 7 days with one negative test*</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work following testing cadence noted above under 10 days off.</p> | <p>Allowed to work with negative testing*</p> <p>Must be asymptomatic</p> | <p>Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection., must additionally test weekly for two weeks after the last exposure date.</p> | <p>Allowed to work with negative testing*</p> <p>Must be asymptomatic</p> | <p>Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 for two weeks after the last exposure date.</p> |
| <p>NOTE: Asymptomatic Exposed HCP must complete required testing listed above and should be included in the facility's routine testing for unvaccinated HCP and outbreak testing every 3-7 days until there are no more positive results for 14 days.</p> | | | | | | |
| <p>* Negative test result must be within 48 hours of returning to work. Either an antigen test or NAAT can be used, as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection.</p> | | | | | | |
| <p>* For calculating day of test: 1) for infection consider day of symptomatic onset or first positive test if asymptomatic, as day 0 2) for exposure consider day of exposure as day 0</p> | | | | | | |