State of Illinois
Illinois Department of Public Health

# COVID-19

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## Updated Interim Guidance for Nursing Homes and Other Long-Term Care Facilities Incorporating COVID-19 Vaccination

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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 the 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), located at: https://coronavirus.illinois.gov/sfc/servlet.shepherd/document/download/069t000000AiOFZAA3?operationContext=S1

**Reason for Update – New COVID-19 Vaccinations**

Safe and effective COVID-19 vaccines received Emergency Use Authorization from the Food and Drug Administration in December 2020. Since then, more than 300,000 COVID-19 vaccinations have been administered to residents and staff at nearly 1,600 long-term care facilities in Illinois through the work of the Federal Pharmacy Partnership Program, Illinois Department of Public Health (IDPH), and local health departments. Similar programs ensuring the vulnerable residents of long-term care facilities receive COVID-19 vaccinations have been offered in every state.

Encouraged by the decline of COVID-19 cases across the country, and the availability of vaccines, the Centers for Medicare and Medicaid Services (CMS), in conjunction with the Centers for Disease Control and Prevention (CDC), released expanded nursing home visitation guidance on March 10, 2021 (QSO-20-39-NH revised). Separation from family and other loved ones has taken a physical and emotional toll on residents, and the revised guidance is a step towards reducing that burden.

Continuing to take precautions to reduce the risk of transmission of COVID-19, however, remains vitally important. At this time, not all nursing home residents and staff are fully vaccinated making it possible for them to still become infected by visitors. In addition, the CDC and public health experts are evaluating if individuals can spread COVID-19, including new variants, even if they are vaccinated.

Therefore, the CDC still recommends maintaining the infection prevention practices that reduce the spread of COVID-19, such as wearing a face mask, performing hand hygiene, and maintaining 6 feet of physical distance from others.

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.

## Definitions

***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 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, found at: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact)

***Fully Vaccinated (New):*** The vaccination status of a person who is ≥two weeks following receipt of the second dose in a valid two-dose series, or ≥two weeks following receipt of one dose of a single-dose vaccine.

***Higher-risk Exposure (New):*** An exposure of a staff member to a person with COVID-19 in any of the following circumstances:

1. Staff member not wearing either face mask or respirator.

2. Staff member not wearing eye protection, if staff member was not wearing either face mask or cloth face covering.

3. Staff member not wearing full personal protective equipment (PPE) (gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure.

***Round of Testing (New):*** The first round of testing refers to having one test performed for all residents and staff, which should be completed within three days.

***Staff:*** (CDC) "[Staff] 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, Office of Health Care Regulation, and the Legal Advocacy Service; and community-service providers 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.

## Continued Monitoring of Essential Measures

Facilities are no longer required to attest to meeting eligibility criteria; however, facilities should continue to monitor criteria to ensure they can provide safe care and respond to outbreak situations. The CMS Reopening Phases No Longer Apply.

**Case status in the community:**
The state is divided into 11 geographic Illinois COVID-19 regions for the purpose of monitoring and mitigating resurgence of COVID-19. Indicators are calculated daily for each region and compared to pre-established threshold values for: (a) test positivity rate; and (b) a composite metric of COVID-19 hospital admissions and hospital resource capacity.[1]

Note: If health metrics indicate resurgence of COVID-19 within one of the 11 defined Illinois COVID-19 regions, then IDPH will consider mitigation options for various settings within that region from a tiered menu. See the end of this document for details.

**Case status in the facility:**
A facility must continue to test and to monitor new facility-onset and facility-associated cases and implement facility-wide testing per testing plan.

**Staffing level:**
The facility has sufficient staffing that it is not operating with a contingency or crisis staffing strategy, as defined by CDC.[2] Refer to Mitigation Strategies for Staffing Shortages section below.

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[1] https://www.dph.illinois.gov/regionmetrics

[2] https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

**Hand hygiene:**
All staff are trained in proper hand hygiene.[3] Everyone entering the facility must perform hand hygiene upon entry.

**Cleaning and disinfection supplies:**
Ensure that disinfectants are included on the U.S. Environmental Protection Agency (EPA) "List N"[4] as effective against coronavirus (COVID-19**.** Cleaning and disinfecting 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 PPE shortages), and
- **crisis capacity** (strategies implemented during periods of shortages even though they do not meet U.S. standards of care).

Facilities can consider crisis capacity strategies when the supply is not able to meet the facility's current or anticipated utilization rate. CDC's optimization strategies for PPE offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted. KN95 masks are not considered NIOSH-approved N95 respirators and are considered a crisis level strategy option.

As specified in the guidance for PPE, a NIOSH-approved N95 equivalent or higher-level respirator is recommended when caring for suspected or confirmed patients with COVID-19.[5] Facilities would be considered in crisis capacity, if their supply of N95s does not meet the anticipated demand as calculated by the CDC Burn Rate Calculator available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

**As PPE availability returns to normal, health care facilities should promptly resume standard practices.[6]**

The facility may operate at contingency PPE capacity. If the facility has sufficient PPE, it is not operating at crisis capacity, as defined by CDC.[7] All staff must wear appropriate PPE when indicated. Also refer to the PPE Capacity Categories section below.

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3 https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

4 https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19

5 https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ ; https://www.cms.gov/files/document/qso-20-39-nh.pdf

6 https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/

7 https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Everyone entering the facility must wear a face mask or respirator, as appropriate, and additional PPE, as appropriate, except during breaks in designated break areas. All residents must wear a cloth face mask or face covering if possible when outside of their rooms and when staff enter their rooms:

- If, due to a medical condition or disability, a resident cannot tolerate or is unable to remove a cloth face covering, then a face shield may be substituted as a second-best alternative.

- If, due to a medical condition or disability, a staff member cannot tolerate a face mask, and the staff member requests a reasonable accommodation under the Americans with Disabilities Act or the Illinois Human Rights Act, then the employer will determine whether such an accommodation can be provided while fully protecting the health and safety of that employee, other staff members, and residents of the facility, and without causing an undue hardship to the employer.

**Universal screening:** (no longer needs to be verbal screening by staff) The facility must have a written policy that states where, when, how, and by whom screening will be performed and recorded. The facility must use a checklist-based screening protocol, recorded in written or electronic format, for each person entering the facility, including all staff, visitors, and other persons. The facility must deny access if any findings are positive. The facility must retain screening records according to the facility's record retention policy, but not for less than 30 days. Screening must check for each of these exclusion criteria:

- measured body temperature of 100.0 degrees Fahrenheit or more;[8]
- symptoms of COVID-19, as listed by CDC;[9]
- diagnosis of COVID-19 before completing the appropriate period of isolation;[10] or
- those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status).[11]

All residents are to be screened for elevated body temperature, pulse oxygen level, and symptoms of COVID-19, as listed by CDC, at least daily.

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[8] https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
[9] https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html
[10] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
[11] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

## Testing Plan and Response Strategy

A written COVID-19 testing plan and response strategy is in place, based on contingencies informed by the CDC[12] and, as applicable, CMS requirements.[13]

- The testing plan must specify the method(s) and locations of testing (laboratory and/or point-of-care).
- The testing plan includes:
    - Initial testing of all residents and staff ("facility-wide baseline testing"), if this has not been done previously during the COVID-19 pandemic.
    - Immediate testing of residents or staff with signs/symptoms of COVID-19.
    - A policy for addressing residents and staff that refuse testing in each of the following situations: (a) symptomatic, or (b) asymptomatic.
    - Timely reporting of testing results to IDPH and the certified local health department in accordance with applicable regulations; records are retained according to the facility's record retention policy.
    - Provisions for designating resident care areas with dedicated staff if residents become symptomatic ("PUI unit") or test positive for COVID-19 (COVID-19 unit).[14] [15]
    - The facility must submit its testing and response plan to IDPH, CMS, or local health department personnel upon request.
- **Response to a positive test**: If there is an outbreak, a single facility-onset COVID-19 infection in a resident, or a single new case of facility-associated COVID-19 infection in a staff member, the first round of testing of all previously negative residents and staff occurs.

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[12] https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html ; https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
[13] https://www.federalregister.gov/documents/2020/09/02/2020-19150/medicare-and-medicaid- programs-clinical-laboratory-improvement-amendments-clia-and-patient
[14] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
[15] https://www.cdc.gov/coronavirus/2019-ncov/community/community-mitigation.html

- Repeated retesting continues, generally every 3 to 7 days, until no new cases of COVID-19 infection are identified among residents or staff for a period of at least 14 days. Thereafter, retesting of staff occurs at the minimum testing frequency required by CMS.[16]

- Asymptomatic persons with a history of a positive COVID-19 test generally should not be retested within 90 days. Follow current CDC guidance if the interval for testing changes.

- When the positive case is identified in an HCP and the individual rotates on multiple units, facilities must determine which units are affected based upon the infectious period: 48 hours prior to the positive test and whether an exposure occurred (15 min. cumulative exposure in 24 hours (Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2 | CDC).

- If a facility has had no new cases within the past 14 days, then serial testing of staff occurs, and the minimum testing frequency is based on county positivity rates (based on CMS data)[11] and CMS requirements (see CMS chart below).[17]

| Community COVID-19 Activity | County Positivity Rate in the Past Week | Minimum Testing Frequency |
|---|---|---|
| **Low** | **<5%** | **Once a month** |
| **Medium** | **5% -10%** | **Once a week*** |
| **High** | **>10%** | **Twice a week*** |

***This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.**

- However, if the local health department endorses a higher frequency of testing for staff at facilities within its jurisdiction, based on other factors for COVID-19 transmission,[18] then facilities in that jurisdiction must test staff at the higher frequency.

- Periodic retesting of staff can be done on a fractional basis (for example, 50% of the staff on each testing occasion), provided that all staff are tested at the target frequency. A positive finding still must trigger immediate, facility-wide testing.

[16] https://www.federalregister.gov/documents/2020/09/02/2020-19150/medicare-and-medicaid- programs-clinical-laboratory-improvement-amendments-clia-and-patient
[17] https://www.cms.gov/files/document/qso-20-38-nh.pdf
[18] https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

**Mitigation Strategies for Staffing Shortages**

IDPH does not support staff working while ill. Mitigation strategies listed below are intended to be used in the order that they appear. *Fully vaccinated health care personnel (HCP) with higher-risk exposures who are asymptomatic do not need to be restricted from work following their exposure.*

**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. These 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 (HCP) to work in the facility. Be aware of Illinois-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.

- 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, request HCP postpone elective time off from work.

- Allow *asymptomatic HCP who are not fully vaccinated and have had a higher-risk exposure* but are not known to be infected to shorten their duration of work restriction.

**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.

- Shift HCP who work in other areas to support patient care activities. Facilities will need to ensure these HCP 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 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.

- Allow *asymptomatic HCP who are not fully vaccinated and have had a higher-risk exposure* to continue to work onsite throughout their 14-day post-exposure period. If permitted to work, these HCP should be monitored for symptoms as described above.

- If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others, such as in telemedicine services; or provide direct care only for patients with confirmed or suspected COVID-19, preferably in a cohort setting.

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

## Vaccinated Health Care Personnel (New)

IDPH recommends following CDC guidance for return to work and work restrictions specific for HCP who have been vaccinated against COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

## Newly Admitted or Readmitted Residents (New)

- Residents who are **not fully vaccinated** must quarantine for 14 days upon admission or readmission to the facility in transmission-based precautions.

- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility if they are **fully vaccinated or within 90 days of confirmed COVID-19 infection** and have not had prolonged close contact with someone with COVID-19 infection in the prior 14 days.

## Visitation (New)

### General Visitation Guidance - Required Visitation

This section aligns with the newly released revised CMS Nursing Home COVID-19 Visitation Guidance.[19]

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f) (4) (v). A nursing home 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.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through closed windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described below.

CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection prevention, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated.

However, we acknowledge the toll that separation and isolation have taken. We also acknowledge there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. **Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting cloth face mask or face covering and performing hand-hygiene before and after.** Regardless, visitors should physically distance from other residents and staff in the facility.

According to the new CMS guidance, visitation should be person-centered; consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. Nursing homes should enable visits to be conducted with an adequate degree of privacy. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission.

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[19] https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

**Core Principles of COVID-19 Infection Prevention**

- **Screening** of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status).

- **Hand hygiene** (use of alcohol-based hand rub is preferred to soap and water).

- **Face covering** or mask (covering mouth and nose).

- **Social distancing** at least 6 feet between persons.

- **Instructional signage** throughout the facility and visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of cloth face mask or face covering, specified entries, exits and routes to designated areas, hand hygiene).

- **Cleaning and disinfecting** high touch surfaces in the facility often, and designated visitation areas after each visit.

- Appropriate staff use of **PPE**.

- **Effective cohorting** of residents (e.g., separate areas dedicated to COVID-19 care).

- **Resident and staff testing** as required.

**Visits may occur**:
- Outdoors
- In dedicated indoor visitation spaces
- In private rooms
- In shared rooms provided that only one resident can have visitors at a time in-room without roommate present if possible, and core principles of infection control are maintained.

Lastly, the facility should develop a short, easy-to-read fact sheet on visitation policy for residents and visitors. This fact sheet should include emphasis that outdoor visits are strongly preferable to indoor visits, weather permitting. The facility should distribute the fact sheet to residents and post it on the facility's website. The facility should also make printed copies available at the visitors' lobby. Visitors are required to comply with the facility's visitation policy. If a visitor refuses to follow the facility's policy during the visit, then staff may end the visit.

**Outdoor Visitation**

To conduct outdoor visitation, the facility must formulate a written visitation policy. This policy must balance clinical and safety considerations of infection control with the resident's right to receive visitors [42 CFR § 483.10(f)(4)]. The facility should develop a short, easy-to-read fact sheet on visitation policy for residents and visitors, distribute to residents, and post on the facility's website. Visitors are required to comply with the facility's visitation policy. If a visitor refuses to follow the facility's policy during the visit, then staff may end the visit.

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitor are fully vaccinated against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status) may hinder outdoor visits.

For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents (open on at least two sides), if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to.

The outdoor visitation must address the following points:

- Designate outdoor space for visitation.
  - Visits may take place under a canopy or tent without walls.

- Measure the designated outdoor space and determine the number of residents and visitors that can be accommodated at one time in that area with at least 6-foot separation between residents and their visitors
  - Consider marking the ground to show how visitors can place themselves with at least 6-foot separation.
  - Post maximum number of residents and visitors that can occupy the area.
  - Post signage to cue 6-foot separation, face covering, and hand hygiene.

    - Set up dispensers for alcohol-based hand rub.

- Designate outdoor visitation hours when staff for screening and supervision of visitors will be available.

- The facility may limit the number of visitors per resident at one time.

- Create an appointment schedule with time slots for each visitation area.
    - Schedule visits by appointment only; specify start, end time, and location for each visit.
    - Limit sign-ups to the allowed number of visitors in each time slot and visitation area.
    - If demand for appointment slots exceeds availability, set limits on the number of slots per week or per day for each resident.

- Pre-screen visitors either by phone using its checklist-based screening protocol (see section on Universal Screening above) or through electronic screening methods, required less than 24 hours in advance; re-screen with the same protocol on arrival, as for all other persons entering the facility, including temperature check. (Facilities cannot require viral testing of visitors as unless they offer point-of-care testing at no charge).

- Maintain a record of all visitors with contact information, for potential contact tracing.
    - Record date and time of visit, name, address, telephone, and, if available, email address.
    - Make records available to IDPH and local health department for inspection and, as needed, for contact tracing; retain at least 30 days.

- Notify all visitors upon arrival that if they develop symptoms of COVID-19 within three days after visiting, they must immediately notify the facility.

- Ensure infection control practices are utilized, including that visitors keep at least a 6-foot separation between themselves and the resident, that the visitor continually wears a cloth face mask or face covering, and that the visitor practices proper hand hygiene.

- If feasible, the facility may construct an outdoor conversation booth for residents unable or unwilling to wear a cloth face mask or face covering.
    - The conversation booth is constructed as a three-sided box with transparent walls at least 3 feet higher than the seated height of the occupant and the visitor.
    - The resident sits inside the box and the visitor sits opposite the front wall.

- Between visits clean and disinfect seating and frequently touched surfaces in the visitation area.

- The long-term care facility must submit its outdoor visitation policy upon request to IDPH or the certified local health department.

**Indoor Visitation**

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times).

These scenarios include limiting indoor visitation for:

- unvaccinated residents, if the nursing home's COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated;
- residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated, until they have met the criteria to discontinue transmission-based precautions; or
- residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

**Facilities should consider:**

- The number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space).
- If necessary, facilities should consider scheduling visits for a specific length of time to help ensure all residents are able to receive visitors.
- During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area.
- CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection prevention, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated.

**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, with 6-foot separation and cloth face covering or masking by visitors and residents.

**Indoor Visitation During an Outbreak:**

- While outbreaks increase the risk of COVID-19 transmission, a facility should **not** restrict visitation for **all** residents when there is evidence the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility.

- Facilities should continue to adhere to CMS regulations and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.

- When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed.

**Visitation can resume based on the following criteria:**

- If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases.

- However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. For example, if the first round of outbreak testing reveals two or more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

- If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

While the above scenarios describe how visitation can continue after one round of outbreak testing, **facilities should continue all necessary rounds of outbreak testing**. In other words, this guidance provides information on how visitation can occur during an outbreak but **does not change any expectations for testing and adherence to infection prevention and control practices.** If subsequent rounds of outbreak testing identify one or more additional COVID-19 cases in other areas/units of the facility, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

**NOTE:** In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings. Lastly, facilities should continue to consult with their local health departments when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.

The facility then notifies residents, their families or guardians, the long-term care ombudsman of relevant operational changes. Facilities should meet this requirement by using multiple communication channels, such as email listservs, social media, website postings, recorded telephone messages, and/or paper notification. Facilities should post signage about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

## 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 situations.

**Examples** of other types of compassionate care situations include, but are not limited to:

- A resident who was living with their family before recently being admitted to a nursing home is struggling with the change in environment and lack of physical family support.
- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident who used to talk and interact with others is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had a resident who used to talk and interact with others is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations would be consistent with the intent of "compassionate care situations." Also, in addition to family members, compassionate care visits can be conducted by any individual who can meet the resident's needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included.

**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 county's COVID-19 positivity rate, or an outbreak.**

## 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 and follow all screening protocols established by the facility. 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.]

### Long-Term Care Ombudsman

As stated in previous CMS guidance QSO-20-28-NH (revised), regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid- certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. During this Public Health Emergency, in-person access may be limited due to infection control concerns and/or transmission of COVID-19, such as the scenarios stated above for limiting indoor visitation; however, in-person access may not be limited without reasonable cause.

We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If in-person access is deemed inadvisable (e.g., the ombudsman has signs or symptoms of COVID-19), 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 (New)

Federal and state surveyors are not required to be vaccinated and must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19. Surveyors should also adhere to the core principles of COVID-19 infection prevention.

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 428 CFR § 483.10(b), F550.

- For concerns related to a facility limiting visitors without a reasonable clinical and safety cause, surveyors should investigate for non-compliance at 42 CFR § 483.10(f)(4), F563.

- For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at 42 CFR §§ 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.

- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance at 42 CFR § 483.80(a), F880.

**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).

**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. We 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.

**Essential Caregivers**

Refer to the IDPH Essential Caregiver Guidance for Long-term Care Facilities Guidance [https://www.dph.illinois.gov/covid19/community-guidance/essential-caregiver-guidance-long-term-care-facilities](https://www.dph.illinois.gov/covid19/community-guidance/essential-caregiver-guidance-long-term-care-facilities)

**Activities**

Whenever visitation is suspended for residents in an area (e.g., a unit) affected by outbreak, suspension of social activities and communal dining should also be considered.

**Communal Dining**

While adhering to the core principles of infection prevention, communal dining may occur.

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Limit number of residents in dining area to the maximum allowed by 6-foot separation. Serve diners in shifts as needed. (Previous limitation to 25% capacity has been eliminated)
- Organize residents to enter the dining room one at a time and to take tables starting in the back and then filling in toward the front. After the meal, exit one at a time in reverse order, starting from the front (last in, first out).
- Residents should wear a cloth face mask or face covering in the dining area when not eating or drinking.
- Maintain at least 6-foot separation between diners.
- Staff must perform hand hygiene and change PPE as appropriate in between assisting residents.
- Clean and disinfect surfaces between shifts of diners.

**Group Activities**

Small-group activities. Group activities may be considered for activities that improve the quality of life for residents. To conduct activities:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Outdoor activities, such as a stroll on facility grounds, are encouraged. Provide hand sanitizer stations.
- Use a sign-up process as needed to allow for 6-foot separation of residents within the activity area (room capacity). (Previous limitation to 10 residents no longer applies).
- Avoid crowding on ingress and egress.
- Maintain 6-foot separation, wear a cloth face mask or face covering, and hand hygiene
- Sanitize items used in activity between users: game pieces, craft tools, etc.

- Avoid activities that involve multiple residents handling the same object (e.g., ball toss).

- For live music, avoid vocal performances and sing-alongs. Limit performances to instruments that can be played while wearing a face mask or face covering.

- Worship services should avoid singing, chanting, and group recitation.

- 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.

- The beautician or barber is subject to the same infection control requirements as staff, including, but not limited to:
  - Testing for COVID-19 with the same frequency as for staff.
  - Screening for elevated temperature and COVID-19 symptoms.
  - Wearing a cloth face mask or face covering, performing hand hygiene, and maintaining social distancing, except from a resident receiving service.

- The beautician or barber must remain in the salon area throughout their time in the facility. Services may not be provided in residents' rooms.

- Do not use hand-held blow dryers.

- Observe restrictions and precautions in Personal Care Services Guidelines for Restore Illinois https://dceocovid19resources.com/assets/Restore-Illinois/businessguidelines4/personalcare.pdf

- Where IDPH guidelines in this document are more stringent, the IDPH guidance applies.

## Trips Outside of the Building

For trips away from the facility:

- Share the resident's COVID-19 status with transport staff, any attendant persons, and with the appointment destination.

- Screen the transport staff, patient, and any attendant persons for elevated temperature and COVID-19 symptoms before entry into vehicle.

- Limit occupancy in vehicle based upon ability to maintain 6-foot separation.

- Driver must wear a cloth face mask or face covering and use additional PPE as indicated by CDC guidelines; resident must wear a cloth face covering or face mask.

- Assist resident in performing hand hygiene on departure from facility and upon return to facility.

- Disinfect transport equipment and commonly touched surfaces, including vehicle handles and seatbelts, before and after transport.

- Maintain social distancing, wear a cloth face mask or face covering, and hand hygiene throughout time spent at the destination.

**Upon return of a resident from a trip outside the facility:**

- **Unvaccinated residents** should be observed and monitored closely for development of symptoms during the following 14-day period following the outing. Decisions on whether to place such residents into transmission-based precautions, should be made by assessing the potential for exposure while away using the IDPH Risk Assessment: http://dph.illinois.gov/sites/default/files/COVID-19_LTC_FacilityRiskAssessment.pdf

- **Unvaccinated residents** that spend overnight out of building should be placed in transmission-based precautions for 14 days.

- **Fully vaccinated** inpatients and residents are not required to quarantine.

- Residents **within 90 days of confirmed COVID-19 infection** do not need to quarantine

## IDPH Procedure for Applying Tiered Mitigation

**Illinois Regional Metrics Leading to Tiered Mitigation.**
If health metrics indicate resurgence of COVID-19 within one of the 11 defined Illinois COVID-19 regions, then IDPH will consider mitigation options within that region from a tiered menu. If sustained increases in health metrics continue unabated despite initial measures, further mitigations may be added from additional tiers. Actions for long-term care facilities by tier are shown in the following table:

| Mitigation | Tier 1 | Tier 2 | Tier 3 |
|---|---|---|---|
| Visitation | Suspend indoor visits. Continue outdoor visits. | Same as Tier 1 | Suspend all visits except for EC or compassionate care. |
| Communal Dining | Continue | Continue | Suspend |
| Group Activities | Continue without outside leaders or off-site outings. | Same as Tier 1, plus limit to 10 participants. | Suspend |
| Barber and Beauty Shop | Suspend | Suspend | Suspend |

If resurgence metrics exceed threshold within one of the 11 Illinois COVID-19 regions and mitigation measures are applied to long-term care facilities in that region, then LTC facilities must wait at least 14 days after metrics return to their target ranges before reversing tiered mitigation.

Mitigation options from a tiered menu may also be considered under other circumstances:

- A facility may voluntarily apply mitigation measures, if deemed necessary, in accordance with the facility's internal policies for infection control.

- IDPH or the local health department may direct a facility to apply temporary mitigation measures pending correction of deficiencies in its infection control program that are identified in a regulatory survey.

If tiered mitigation measures are applied, then the facility must notify residents, their families or guardians, the long-term care ombudsman, and the local health department of relevant operational changes.

In the event of a conflict between this guidance document and any previously issued interim guidance from IDPH, this guidance takes precedence.

Questions about reopening may be directed to DPH.LTCreopening@illinois.gov.