COLORADO
Department of Public Health & Environment

COVID-19 GUIDANCE

Residential Care Facility (RCF) Comprehensive Mitigation Guidance

Table of Contents (Clickable)

Summary of Recent Changes

11/16/2021

- **Updated visitation content to align with changes to CMS requirements on 11/12 that removed visitation restrictions.**

11/8/2021

- Reorganized and created new section titles to align with CDC's current guidance.
- Updated the link to the Eighth Amended PHO 20-20
- Updated language in the definition of Close Contact.
- Added "Voter Assistance Personnel" to the Essential Health Care Service Providers definition.
- Added links to training resources in several sections throughout the document.
- Added a definition of Cloth Mask.
- Updated guidance with a link to the CDC Data Tracker.
- Added clarifying language to the Outbreak Testing section.
- Added "unknown vaccination status" to Unvaccinated, Partially Vaccinated, and Individuals With an Unknown Vaccination Status section.
- Outlined requirements for the individual responsible for the Infection Prevention Program.
- Added a link to the CDPHE Respiratory Protection Toolkit.
- Added a Source Control and Physical Distancing Table.
- Added a comprehensive Testing Table.
- Updated clarifying language in the LTC Testing Decision Tree.

11/29/2021

- Added clarifying language in the visitor section of the Source Control and Physical Distancing table which specifies allowances for removing masks and not following physical distancing requirements in areas of low to moderate community transmission.

COVID-19 in Residential Care Facilities

Scope

The purpose of this document is to provide guidance to residential care facilities (RCF) when a resident or health care personnel (HCP) is suspected or confirmed to have COVID-19 and to provide recommendations to prevent transmission of COVID-19 within the facility. These recommendations are specific for RCFs. Guidance provided in this document is based on currently available information at the time it was drafted and is subject to change. Updated case counts are available on the CDPHE website: Coronavirus Disease 2019 (COVID-19) in Colorado.

RCFs (skilled nursing facilities, assisted living residences, group homes, and intermediate care facilities) are licensed by the Colorado Department of Public Health and Environment (CDPHE). Some of these facilities are also federally certified by the Centers for Medicare and Medicaid Services (CMS). **In instances where state and federal guidance do not align, federally certified facilities are required to follow the more conservative guidance.**

Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), residential care facility populations are at high risk of being affected by respiratory pathogens like SARS-CoV-2 and other pathogens, including multidrug-resistant organisms (e.g., carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and health care personnel (HCP). Even as residential care facilities resume more normal practices and begin relaxing restrictions, **residential care facilities must sustain core IPC practices and remain vigilant for COVID-19 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.**

The information in this document applies regardless of vaccination status and level of vaccine coverage in the facility unless specifically stated.

Key Information about COVID-19

- **Agent**
  - SARS-CoV-2
- **Incubation Period**
  - Range 2 to 14 days
- **Transmission/Communicability**
  - The virus is thought to spread mainly from person-to-person.

- Between people who are in close contact with one another (within about 6 feet).
- Through respiratory droplets produced when an infected person talks, coughs, or sneezes.
- These droplets can land in the eyes, mouths, or noses of people who are nearby or possibly be inhaled into the lungs.
- There is evidence that the virus can also be spread via airborne transmission, when smaller droplets and particles containing the virus remain suspended in the air for minutes to hours.
- It is possible for individuals who are asymptomatic, presymptomatic and symptomatic to spread illness to other individuals.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.

- **Symptoms**
  - Symptoms associated with COVID-19 include: Fever (measured at >100.0°F or subjective), chills, cough, shortness or breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose. Consider also diarrhea, nausea or vomiting.

- **Personal Protective Equipment**
  - HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions, Transmission-Based Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
  - Additional information about using PPE is available in Protecting Healthcare Personnel | HAI | CDC

Definitions

For the purpose of this document, definitions are as follows:

Adult Day Services Centers

- Adult Day Services Centers (ADSCs) are professional care settings where community-dwelling adults receive social or health services for some part of the day. ADSCs often serve adults aged 65 years or older who may require supervised care and adults (of any age) living with dementia, cognitive decline, or disability. ADSCs are designed to provide a safe, community-based group setting where specific needs are addressed and individualized therapeutic, social, or health services are delivered.

Aerosol Generating Procedures (AGPs)

- Procedures that could generate infectious aerosols should be performed cautiously and avoided if appropriate alternatives exist.
- AGPs should take place in an airborne infection isolation room (AIIR), if possible.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.

Ancillary Non-Medical Services

- Ancillary non-medical services are such as those provided by hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists not employed by the facility, but who enter the building to provide services to residents. Ancillary service providers must either participate in the facility's surveillance testing or provide proof of SARS CoV-2 **lab-based** PCR testing in accordance with these requirements.

Close Contact

- Anyone who had prolonged close contact (within six feet for at least 15 minutes over a 24-hour period) should be considered potentially exposed. The use of a facemask for source control and adherence to other recommended infection prevention and control (IPC) measures (e.g., hand hygiene) by the provider help to reduce the risk of transmission or severe illness. The following should be considered when determining which patients are at higher risk for transmission and might be prioritized for evaluation and testing:
    - Facemask use by the patient – Mirroring the risk assessment guidance for health care personnel, patients not wearing a facemask would likely be at higher risk for infection compared to those that were wearing a facemask.
    - Type of interaction that occurred between the patient and infected provider – An interaction involving manipulation or prolonged close contact with the patient's eyes, nose, or mouth (e.g. dental cleaning) likely poses a higher risk of transmission to the patient compared to other interactions (e.g., physical contact, feeding, incontinent care, assistance with activities of daily living).
    - PPE used by infected HCP – HCP wearing a facemask (or respirator) and face shield that extends down below the chin might have had better source control than wearing only a facemask. Note that respirators with exhalation valves might not provide source control.
    - Current status of patient – Is the patient currently admitted to a hospital or long-term care facility? These individuals, if infected, can be at higher risk for severe illness and have the potential to expose large numbers of individuals at risk for severe disease.
    - Additional information can be found here.

Cloth Mask

- Cloth masks refer to textile (cloth) covers that are intended primarily for source control. They are not personal protective equipment (PPE) appropriate for use by

health care personnel. Guidance on design, use, and maintenance of cloth masks is available at CDC's website.

Core Infection Prevention Principles

- Instructional signage throughout the facility and proper visitor education on COVID-19, including the signs and symptoms, infection control precautions, and other applicable facility practices (e.g., use of face covering or mask; specified entries, exits and routes to designated areas; hand hygiene).
- Screening of all who enter the facility for signs and symptoms consistent with COVID-19, including a temperature check and questions about risk (e.g., close contact with someone with COVID-19 infection in the prior 14 days).
- Denying entry to those with signs or symptoms of COVID-19 or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the vaccination status).
- Hand hygiene (use of 60-95% alcohol-based hand rub is preferred).
- Universal face coverings or masks (covering both mouth and nose) for all individuals (HCP, residents, and visitors), regardless of vaccination status.
- Physical distancing of at least six feet between persons.
- Increased cleaning and disinfecting of high-frequency touched surfaces throughout the facility, including designated visitation areas and shared medical equipment.
- Appropriate HCP use of Personal Protective Equipment (PPE) including when caring for a suspected or confirmed COVID-19 resident regardless of HCP vaccination status.
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care).
- Resident and HCP testing as required per the Eighth Amended PHO 20-20 and this document.

Community Transmission

- Several of the IPC measures (e.g., use of source control, screening testing) are influenced by levels of SARS-CoV-2 transmission in the community. Two different indicators in CDC's COVID-19 Data Tracker are used to determine the level of SARS-CoV-2 transmission for the county where the health care facility is located. If the two indicators suggest different transmission levels, the higher level is selected.

Essential Health Care Service Providers

- Essential Health Care Service Providers (not staff) include but are not limited to physicians, hospice, and home health staff of all disciplines, along with other types of both medical and nonmedical health care and services, such as voter assistance personnel. They must be screened and tested in accordance with the surveillance and outbreak testing prescribed in the Eighth Amended PHO 20-20 and this document.

Face mask

- OSHA defines face masks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Face masks may also be referred to as 'medical procedure masks'." Face Masks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to

protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Fully Vaccinated

- "Fully vaccinated" refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose vaccine series or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons, and has provided verification of vaccination status to the facility.

Health Care Personnel (HCP)

- Includes staff and essential service providers and providers of healthcare.
- In general HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to residents or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Isolation

- Isolation is for someone who has developed illness (i.e., COVID-19 like symptoms) or who has tested positive for SARS CoV-2. Individuals with COVID-19 are infectious and can transmit COVID-19 to others. Individuals who have illness and/or who test positive for SARS CoV-2, the virus that causes COVID-19 should remain in isolation until at least 10 days have passed since their illness began or from the date of test if asymptomatic. For more information go to CDC: COVID-19: Quarantine vs. Isolation. Required personal protection equipment needed to care for someone in isolation can be found here.

Medical Appointments

- Medical appointments (e.g., clinic visits, emergency department, outpatient surgical procedures, dialysis) are medical visits that are assumed to have occurred in a controlled environment in which proper infection control measures were maintained.

Outbreak Definition

- Outbreaks have been standardized across outbreak settings. An outbreak in a residential setting is defined as:
    - Two or more confirmed cases of COVID-19 among residents and/or HCP in a facility with onset in a 14-day period
      [OR]

    - One confirmed case and two or more probable cases of COVID-19 among residents and/or HCP in a facility with onset in a 14-day period.
- When **determining** if an outbreak has occurred in a facility, to assess whether disease transmission occurred in the facility:
    - Exclude residents with a diagnosis of COVID-19 known at time of admission to the facility.
    - Exclude residents who test positive for COVID-19 in the 14 days after admission AND are in observation for signs/symptoms of COVID-19 and following appropriate Transmission-Based Precautions to prevent transmission to others in the facility.

Outbreak Testing

An outbreak investigation is initiated when a new single positive COVID-19 case occurs among residents or HCP. To swiftly detect cases, facility should implement the following:

- Upon notification of a single positive COVID-19 case (HCP or resident), the facility must immediately conduct facility-wide testing (outbreak testing) of **ALL** HCP and **ALL** residents (regardless of vaccination status) to identify additional asymptomatic, pre-symptomatic, or symptomatic infections. Outbreak testing specimens must be collected immediately from all individuals (who have not already tested positive utilizing a lab-based PCR test in the previous 90 days) and received by the testing lab within 48 hours of identifying the COVID-19 positive HCP or resident. If testing does not identify any additional positive cases, the facility may resume surveillance testing and no additional outbreak testing and/or restrictions are necessary. If testing identifies additional cases and the facility meets the Outbreak Definition, the facility must continue outbreak testing following the Decision Tree within this document.

Personal Protective Equipment (PPE)

- PPE Information is available:
    - Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC
    - Personal Protective Equipment: Questions and Answers | CDC
    - Optimizing Personal Protective Equipment (PPE) Supplies (cdc.gov)

Physical Distancing

- Physical distancing refers to maintaining a physical distance of at least 6 feet whenever possible and is an important strategy to prevent COVID-19 transmission.

Providers of Health Care Services

- Providers of health care services include those individuals providing medical services (such as podiatrists, dentists, physical or occupational therapists, or hospice nurses), not employed by the facility, but who enter the building to provide care or services to residents. Health care service providers must either participate in the facility's

surveillance testing or provide proof of SARS CoV-2 PCR testing in accordance with these requirements.

Quarantine

- Quarantine is for someone who was possibly exposed to COVID-19 and needs to stay away from others for a certain period of time to determine whether they develop infection. This is to limit transmission in the event the exposed individual develops COVID-19. Because the incubation period for SARS CoV-2 is 2-14 days, individuals should remain in quarantine until 14 days have passed since their last possible exposure. Testing during this time will not rule out incubating disease and therefore cannot be used to shorten quarantine. Required personal protection equipment needed to care for someone in isolation can be found here.
    - Of note: The options to shorten quarantine that CDC published do not apply to high-risk settings such as residential care facilities. The quarantine period for residential settings will remain 14 days after exposure.

Residential Care Facilities (RCF)

- Residential Care Facilities (RCF) are skilled nursing facilities, assisted living residences, intermediate care facilities, and group homes. This does not include non-residential settings such as Adult Day Services.

Respirator

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

Service Repair Technicians, Delivery Persons, and Suppliers

- Service repair technicians, delivery persons, and suppliers (e.g., oxygen delivery suppliers) are not included in required facility testing but should follow core infection prevention practices to prevent COVID-19 including screening for illness prior to admission.

Source Control

- Source control refers to the use of well-fitting cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Cloth masks, face masks and respirators should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing a cloth mask, facemask, or respirator safely or anyone who is unconscious, incapacitated or otherwise unable to remove their cloth mask, facemask, or respirator without assistance. Face shields alone are not recommended for source control. See source control and physical distancing table.

Staff

- Staff are defined as employees (e.g., nurses, licensed independent practitioners, students and trainees, therapists, environmental services) whether employed, contracted, consulting, or volunteer.

Unvaccinated, Partially Vaccinated, and Individuals With an Unknown Vaccination Status

- These include persons who do not yet meet the definition of fully vaccinated, including persons who have never received a vaccine (unvaccinated) and persons who have received one or two doses, but have not yet met the complete criteria for full vaccination (partially vaccinated). This also includes individuals whose vaccination status is unknown for the purpose of this document. These populations are treated the same for disease control purposes.

Vaccine Breakthrough Case

- Vaccine breakthrough case refers to a person who tests positive for SARS-CoV-2 (regardless of symptoms) and ≥2 weeks has passed following receipt of the second dose in a 2-dose vaccine series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons. Vaccine breakthrough cases are treated the same as all individuals who test positive for SARS CoV-2.

Visitor

- A visitor does not meet the criteria of staff. Visitors may include musicians and other performers that provide group activities to more than one resident at a time or a family member or friend visiting one resident. Visitors do not typically participate in orientation or training programs. Visitors are not included in surveillance and outbreak testing nor are they offered vaccination. See visitation section for more information.

Volunteer

- Volunteers are unpaid staff members who provide routine services, generally have a recurrent role within the facility, and have received structured training and orientation on resident rights and infection prevention practices. Volunteers generally are 18 and older and have an ongoing relationship with a contract, role, and/or schedule. Volunteers are not infrequent visitors (e.g., Girl Scout troops, musicians, individuals seeking community service hours). Volunteers should be treated as staff and should be included in surveillance and outbreak testing and offered vaccination (e.g., influenza, COVID-19).

Infection Prevention and Control Program (IPC)

For All Facility Types

- Assign at least one individual with training in IPC to provide on-site management of COVID-19 prevention and response activities and general infection prevention duties.
- **The designated person must:**

- Complete the RCF IP Training Program annually using CO.TRAIN. If you have difficulties accessing this training, please contact: cdphe_project_firstline@state.co.us
- Be well informed of current infection prevention requirements (e.g., attending technical assistance calls, understanding this document, reading state guidance, and reviewing current CDC recommendations for facility type).
- Be responsible for contacting public health to notify of reportable conditions and/or outbreaks in their facility.
- Make sure COVID-19 lab testing is completed based on current requirements, have the ability to access testing results, and implement interventions appropriately based on the results.
- Ensure the facility has adequate supplies and personal protective equipment to follow infection prevention requirements listed in this document.
- Ensure facility staff receive appropriate training.

Nursing Facilities

- In addition to the requirements for all facility types, individuals responsible for the IPC Program in a Nursing Facility should complete CDC's online training modules or complete/have documentation of other comparable infection prevention training education.

- Facilities with 99 or fewer residents should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment. Facilities with 100 or more residents or those that provide onsite ventilator or hemodialysis services should assign someone full-time to this role.

Provide Necessary Supplies to Adhere to Recommended IPC Practices

Ensure HCP have access to all supplies necessary to adhere to recommended infection prevention and control practices:

Hand Hygiene Supplies

- Project Firstline training resources related to hand hygiene can be found here.
  - Put FDA-approved alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside the dining hall, in the therapy gym).
  - Unless hands are visibly soiled, performing hand hygiene using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands.
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.

Personal Protective Equipment (PPE)

- Find Project Firstline training resources related to PPE.
- Ensure Proper Use, Handling, and Implementation of Personal Protective Equipment
    - Information is available:
        - Information is available:
            - Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC
            - Personal Protective Equipment: Questions and Answers | CDC
            - Optimizing Personal Protective Equipment (PPE) Supplies (cdc.gov)
    - Employers should select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration (OSHA) PPE standards (29 CFR 1910 Subpart I).
    - Facilities should have supplies of face masks, N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles that cover the front and sides of the face).
        - Make necessary PPE available in areas where resident care is provided.
    - Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard (29 CFR 1910.134) for employees if not already in place. The program should include medical evaluations, training, and fit testing.
    - Respiratory Protection Toolkit
        - Respiratory Protection Toolkit Document
        - Respiratory Protection Toolkit Slide Presentation
    - Perform and maintain an inventory of PPE in the facility including: face masks, respirators (if available and the facility has a respiratory protection program with trained medically cleared, and fit-tested providers) gowns, gloves, and eye protection (i.e., face shield or goggles that covers the front and sides of the face).
        - Consider designating HCP responsible for stewarding those supplies,monitoring and providing timely feedback, and promoting appropriate use by HCP.
        - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.
        - For PPE resource requests, facilities should notify their local public health agency or refer to the Concept of Operations (CONOPS) for Coronavirus Disease (COVID-19) Personal Protection Equipment Shortage (CDPHE).
    - N95 respirators should be prioritized for use as PPE versus source control.
    - For more on PPE, to include CDCs Optimization Strategies and how to implement them safely, go to CDPHE PPE FAQ.

Environmental Cleaning and Disinfection

- Find Project Firstline training resources related to cleaning and disinfection.
- Develop a schedule for regular cleaning and disinfection of frequently touched surfaces in resident rooms and common areas.
    - Shared equipment (e.g., thermometers, pulse ox, blood pressure cuffs, resident lifts) should be cleaned and disinfected according to manufacturer instructions in between residents.
    - Equipment utilized to care for individuals on transmission-based precautions should be disposable or dedicated to an individual resident whenever possible. If disposable or dedicated equipment is not possible, all equipment must be cleaned and disinfected before it is moved to another area and prior to use on additional residents.
    - Ensure HCP are appropriately trained on use and follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).
- Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
    - All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.
    - Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Once the patient has been discharged or transferred, the door to the room should remain closed and HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles According to the CDC, waiting enough time to clear 99% of SARS-CoV-2 particles is appropriate for healthcare and other spaces. The amount of time that takes (see Table B.1) will vary from one room to another depending upon a variety of factors. If the number of air exchanges is unknown, waiting at least two hours after the patient has been discharged or transferred will be sufficient for most rooms. Do not use a fan to move air away from

the room to other parts of the building, or to bring air from a window into the room. That will cause the air in the room to disperse to nearby areas. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

Education

Educate residents, health care personnel, and visitors about SARS-CoV-2, current precautions being taken in the facility, and actions they should take to protect themselves.

- Regularly review CDC's Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic for current information and ensure HCP and residents are updated when this guidance changes.
- Educate and train HCP about practices to prevent spread of SARS-CoV-2, including reminding them not to report to work when ill.
- Training should include facility-based and consultant personnel (e.g. rehabilitation therapy, wound care, podiatry, barber), ombudsman, and volunteers who provide care of services in the facility. Including consultants is important since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of SARS-CoV-2.
- CDC has created training resources for front-line HCP that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
- Educate residents and families through educational sessions and written materials on topics including information about SARS-CoV-2, actions the facility is taking to protect them and their loved ones from SARS-CoV-2 , and actions they should take to protect themselves and others in the facility, emphasizing when they should wear source control, physically distance and perform hand hygiene.

Notify HCP, Residents, and Families about Outbreaks

- Notify HCP, residents, and families promptly about identification of SARS-CoV-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions.

Report SARS-CoV-2 Infections, Facility Staffing, Testing, and Supply Information to Public Health Authorities

- Notify public health promptly about any of the following:
    - ≥ 1 residents or HCP with suspected or confirmed SARS-CoV-2 infection
    - Resident with severe respiratory infection resulting in hospitalization or death

- ≥ 3 residents or HCP with acute illness compatible with COVID-19 with onset within a 72-hour period

Reporting Test Results to Public Health

- COVID-19 (SARS-CoV-2 positive lab testing) is a reportable communicable disease in Colorado requiring both the ordering provider and laboratory to report SARS-CoV-2 test results. Your facility is responsible for reporting all results (positive, negative, and inconclusive) for specimens that are collected and tested by your facility (e.g., rapid point-of-care tests) as described below. Additionally, your facility is responsible for reporting positive results from laboratory-based testing directly to CDPHE. **Your facility is exempt from reporting lab-based PCR results only if you are currently participating in state-funded surveillance and outbreak testing via your assigned laboratory. For additional questions about reporting SARS-CoV-2 results, please email the team in PHIRR:** cdphe_covidreporting@state.co.us.
- Facilities performing POC testing must report all SARS-CoV-2 results (positive, negative, and inconclusive) to CDPHE directly.
- All tests, whether submitted to a laboratory or conducted as a point of care test, MUST include all of the required information necessary for the provider and testing lab to process the tests and should include:
    - Full name of the individual being tested.
    - Date of birth.
    - Sex.
    - Ethnicity and race.
    - Complete street address (only residents may utilize the facility address—the address should be where the individual resides).
    - Phone number (only residents may use the facility phone number).
    - Collection date
    - Specimen type
- Any suspected or confirmed case **or** outbreak (e.g., one or more cases) of COVID-19 among residents or HCP shall immediately be reported to the local or state public health agency using the COVID-19 Outbreak report form.
    - Facilities can send this form to their local public health agency OR to CDPHE by securely emailing the completed form to cdphe_covid_outbreak@state.co.us. Facilities may also contact CDPHE at 303-692-2700 (8:30 - 5:00, Monday - Friday) or 303-370-9395 (after hours, holidays, and weekends).
    - Additionally, facilities should promptly notify public health for any of the following: Suspected or confirmed case of influenza in a resident or HCP (may indicate co-circulation); a resident with severe respiratory infection resulting in hospitalization or death; or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of one another.

Reporting to NHSN

- The state of Colorado does not currently require RCF's to report information to the CDC's National Healthcare Safety Network. Facilities regulated by CMS may have

additional requirements including weekly case counts and number of vaccinated residents and health care workers.

- Facilities that report their POC testing data to NHSN do not need to report the testing information to additional sources including CDPHE. Reported POC test information will be imported from NHSN to CDPHE's disease reporting database on behalf of your facility.

EMResource

- ALL residential care facilities should report COVID-19 information weekly using CDPHE EMResource. Residential care facilities must update or change the information in EMResource for all questions on a weekly basis. EMResource collects situational awareness information that may include, but is not limited to: bed capacity, staffing levels, PPE quantity, resident vaccination data, and flu vaccination data.

Vaccination

Receiving a COVID-19 (SARS CoV-2) vaccination is critical to protect both staff and residents against COVID-19. Each facility must establish and maintain a COVID-19 mitigation and vaccination plan that promotes vaccine confidence and acceptance and must continue to offer vaccinations to all consenting staff and residents. The Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility provides resources, including information on preparing for vaccination, vaccination safety monitoring and reporting, frequently asked questions, and printable tools.

Facilities must continue to offer vaccination to both residents and staff. The 8th amended PHO 20-20 required each facility that has a population that is eligible for a booster dose shall complete a COVID-19 booster dose clinic for current eligible residents and staff by October 25, 2021. Residents and staff that are eligible for a booster dose after October 25, 2021 may be vaccinated through the facilities laid out in their ongoing vaccination plans.

After COVID-19 vaccination, employees and residents might have some side effects. It is normal for these to occur. Common side effects include pain, redness, and swelling in the arm where they received the vaccination, as well as fever, chills, tiredness, headache, nausea, and muscle pain. To minimize the effect of post-vaccination signs and symptoms on employees and the workplace consult the following CDC tool.

Ongoing Vaccination Plans

Each facility shall submit to CDPHE a plan which details how the facility ensures vaccinations are offered and provided to all consenting staff and residents. A template for this plan is available on the CDPHE webpage. Minimally, this information must include:

- How the facility assesses and addresses the vaccination status of new staff and residents;
- The identification of designated staff who coordinate vaccination information, administration and tracking of the vaccination status of staff and residents on an ongoing basis,
- Ongoing measures to promote vaccine confidence and acceptance, and;
- The vaccination status of all current staff and residents.
- Submission of this information may be completed utilizing this form and must be submitted via email to residentialcarestriketeam@state.co.us. It was due Monday, June 14, 2021 and must be kept current by the facility and be presented for review during health facility inspections.

Required Vaccination of Health Care Personnel

- Facilities must follow Chapter 2 regulations, specifically Part 12, for staff vaccination.

Source Control and Physical Distancing Measures

Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. Universal use of source control is required for all HCP regardless of their role within the facility. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission or who have:

- Not been fully vaccinated
- Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze)
- Had close contact (residents and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection for 14 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission
- Moderate to severe immunocompromise
- Otherwise had source control and physical distancing recommended by public health authorities

Project Firstline training resources related to source control can be found here.

Encourage Physical Distancing

- In situations when unvaccinated residents could be in the same space (e.g., dining rooms, dialysis treatment room, activity rooms), arrange seating so that residents can sit at least 6 feet apart, especially in counties with substantial or high transmission.

This might require limiting the number of residents in treatment areas, or participating in group activities.

Optimize the Use of Engineering Controls and Indoor Air Quality

Project Firstline training resources related to ventilation can be found here.

- Optimize the use of engineering controls to reduce or eliminate exposures whenever possible.
- Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in all shared spaces.
    - Guidance on ensuring that ventilation systems are operating properly are available in the following resources:
        - Guidelines for Environmental Infection Control in Health-Care Facilities
        - American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities which also provides COVID-19 technical resources for healthcare facilities.
        - Outdoor Visitation: Patients and their visitors should follow the source control and physical distancing recommendations included in the Source Control and Physical Distancing Measures table below.

Source Control and Physical Distancing Measures

Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission.

Universal source control is required for all HCP and visitors who enter the facility regardless of the work they are performing or tasks they may be participating in.

Facilities should utilize the CDC COVID Data Tracker to determine SARS-CO-V2 levels of community transmission.

Individual requiring source control:	What type of **source control** may be used:	When should **source control** be worn and/or changed:	**Physical Distance** Requirements:

HCP in areas of low to moderate transmission	• A NIOSH-approved N95 or equivalent or higher-level respirator or • A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) • A well-fitting facemask. • **Cloth masks should not be utilized for HCPs.**	**Universal use of source control is required for all HCP** regardless of their role within the facility. • When used solely for source control, any of the options listed could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. • If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved N95 or equivalent or higher-level respirator during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned.	Physically distance from others when feasible and will not interfere with provision of care. HCP should be reminded to distance from others when in break rooms, meeting rooms and other non-clinical areas.

HCP in areas of substantial to high transmission	In addition to the requirements listed for **low to moderate transmission** counties, facilities in counties with **substantial or high transmission** should also **use universal PPE as described below for all resident care** if SARS-CoV-2 is **not** suspected: **Add the following PPE:** ● NIOSH-approved N95 or equivalent or higher-level respirators should be used for: ○ All aerosol-generating procedures (refer to which procedures are considered aerosol generating procedures in healthcare settings?) ○ Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. ● Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all	● Following all aerosol generating procedures, respiratory protection should be doffed and disposed of. ● Any time PPE is removed it should be replaced or disinfected according to manufacturer instructions for use.	Physically distance when feasible and will not interfere with provision of care. HCP should be reminded to distance from others when inbreak rooms, meeting rooms and other non-clinical areas.

	patient care encounters.		
Residents in a community with low to moderate transmission	• A well-fitting facemask or cloth mask.	Consideration could be given to allowing fully vaccinated residents to not use source control when in communal areas of the facility; however, residents at increased risk for severe disease should still consider continuing to practice physical distancing and use of source control. **Indoor or Outdoor Visitation** • Residents should wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated. ○ If the resident and all their visitor(s) are fully vaccinated, the resident and visitor can choose not to wear source control and to have physical contact.	Residents at increased risk of severe disease should still consider continuing to practice physical distancing. • In situations when unvaccinated residents could be in the same space as others (e.g., waiting rooms, dining rooms, activity rooms, rehab areas, dialysis treatment rooms), arrange seating so that residents can sit at least 6 feet apart, especially in counties with substantial or high transmission. This might require scheduling appointments to limit the number of residents in waiting rooms, treatment areas, or participating in group activities. All residents should physically distance themselves from others when participating in indoor and outdoor

			visitation. ● If residents and all their visitor(s) are fully vaccinated, they can choose to have physical contact.
Residents in a community with substantial to high transmission	● A well-fitting facemask or cloth mask.	● Residents should wear source control when outside of their room, participating in visitation and out in the community.	All residents should physically distance themselves from others when participating in indoor and outdoor visitation, this recommendation should continue until the community transmission rate returns to low to moderate.
Visitors regardless of the level of community transmission.	● Well-fitting cloth mask ● A well-fitting facemask. ● A well-fitting respirator	Everyone who enters the facility is required to wear a face covering that covers both their nose and mouth at all times. Individuals who are unable to wear appropriate source control must be excluded from inside the facility. ● Visitors should wear source control when around residents or HCP, regardless of vaccination status.	Visitors should physically distance themselves from others while in the facility. Visitors should visit with residents in single-person rooms; in multi-person rooms; or designated visitation areas when only the resident they are visiting with is present. When the level of community has low to moderate transmission The following may added: Visitors should physically distance themselves from the resident they are visiting unless the resident and all of their visitors are fully

			vaccinated, then they can choose to have physical contact with one another.

Evaluating and Managing Personnel, Residents and Visitors

Refer to CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for more information.

- HCP should not work while acutely ill, **even if SARS-CoV-2 testing is negative**, in order to minimize the risk of transmission of other infectious pathogens, including respiratory pathogens such as influenza.
    - Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Guidance on when HCP with SARS-CoV-2 infection could return to work, and on work restrictions for HCP with higher-risk exposures, is in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
- Ensure everyone is aware of recommended IPC practices in the facility.
    - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations.
- Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed:
    - 1) a positive viral test for SARS-CoV-2,
    - 2) symptoms of COVID-19, or
    - 3) who meets criteria for quarantine 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.
- Healthcare personnel (HCP), even if fully vaccinated, should report any of the 3 above criteria to occupational health or another point of contact designated by the facility. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- Visitors meeting any of the 3 above criteria should generally be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively is available from CMS.
- Residents meeting any of the 3 above criteria should be managed as described in New Infection in Healthcare Personnel or Resident

- Unvaccinated HCP, residents and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.

Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with Confirmed SARS-CoV-2 Infection

- Determine the location of the COVID-19 care unit and create a staffing plan.
- The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with SARS-CoV-2 infection.
- Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. If possible, HCP should avoid working on both the COVID-19 care unit and other units during the same shift.
    - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the cohort residents with SARS-CoV-2 infection.
    - Ideally, environmental services (EVS) staff should be dedicated to this unit, but to the extent possible, EVS staff should avoid working on both the COVID-19 care unit and other units during the same shift.
    - To the extent possible, HCP dedicated to the COVID-19 care unit (e.g., NAs and nurses) will also be performing cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N into the room and wipe down high-touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.
- Guidance addressing placement, duration, and recommended PPE when caring for residents with SARS-CoV-2 infection is described in Section: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident (Isolate)

Evaluate Residents at Least Daily

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection.
- Actively monitor all residents upon admission and at least daily for fever (temperature ≥100.0˚F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in Section: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident (Isolate)
    - Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0˚F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection.
    - Because some of the symptoms are similar, it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections, based on symptoms alone. Consider testing for pathogens other than

SARS-CoV-2 and initiating appropriate infection prevention precautions for symptomatic older adults.
    - Refer to CDC resources for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of residents with SARS-CoV-2 infection is described in the Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19).

Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection (Quarantine)

- **Unvaccinated residents** who have had **close contact** with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).
- **Fully vaccinated residents** who have had **close contact** with someone with SARS-CoV-2 infection should wear source control and be tested as described in the testing section. Fully vaccinated residents and residents with SARS-CoV-2 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by public health. Additional potential exceptions are described here
- Guidance addressing quarantine and testing during an outbreak is described in Section: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident.

New Admissions and Residents Who Leave the Facility

Create a Plan for Managing New Admissions and Readmissions

- Residents with confirmed SARS-CoV-2 infection who have not met criteria to discontinue Transmission-Based Precautions should be placed in the designated COVID-19 care unit, regardless of vaccination status.
- In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.
- Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which unvaccinated residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission.
- Fully vaccinated residents and residents within 90 days of a SARS-CoV-2 infection do not need to be placed in quarantine.

Guidance addressing recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection.

Create a Plan for Residents who Leave the Facility

- Residents who leave the facility should be reminded to follow recommended IPC practices (e.g., source control, physical distancing, and hand hygiene) and to encourage those around them to do the same.
- Individuals accompanying residents (e.g., transport personnel, family members) should also be educated about these IPC practices and should assist the resident with adherence.
- For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.
- In most circumstances, 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 SARS-CoV-2 infection.
- Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.

Guidance addressing placement, duration, and recommended PPE when caring for residents with SARS-CoV-2 infection is described in Section: New Infection in Healthcare Personnel or Resident

Respond to a Newly Identified SARS-CoV-2-Infected Healthcare Personnel or Resident (Isolate)

Because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak.

- Following the outbreak testing Decision Tree is the most conservative measure to mitigate additional spread of COVID-19 within the facility and should be followed by most facilities.

- Increase monitoring of all residents from daily to three times per day, to more rapidly detect those with new symptoms.

HCP and Residents with Symptoms of COVID-19

- Symptomatic HCP, regardless of vaccination status, should be restricted from work pending evaluation for SARS-CoV-2 infection.
- Symptomatic residents, regardless of vaccination status, should be restricted to their rooms and cared for by HCP using a NIOSH-approved N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face) gloves, and a gown pending evaluation for SARS-CoV-2 infection.

Perform Contact Tracing to Identify any HCP who have had a Higher-Risk Exposure or Residents who may have had Close Contact with the Individual with SARS-CoV-2 Infection

- All HCP who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested as described in the testing section.
    - Restriction from work, quarantine, and testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic. Potential exceptions are described here and here.

Unvaccinated residents who are close contacts and HCP with higher-risk exposures

- Unvaccinated residents who are close contacts should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection.

Fully vaccinated residents who are close contacts and HCP with higher-risk exposures

- Fully vaccinated residents who are close contacts should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection.
    - For guidance about work restriction for fully vaccinated HCP who have higher-risk exposures, refer to Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2.
- If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection.
- A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
- If the outbreak investigation is broadened to either a facility-wide or group-level approach, follow recommendations below for alternative approaches to individual contact tracing.
- **Alternative, broad-based approach**
    - If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility).
        - Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.

- Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but not earlier than two days after the exposure, if known) and, if negative, again five to seven days later.

Unvaccinated Residents and HCP

- Unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.
  - Close contacts, if known, should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection.
  - For guidance about work restriction for unvaccinated HCP who are identified to have had higher-risk exposures, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.

Fully Vaccinated Residents and HCP

- Fully vaccinated residents should be tested as described in the testing section; they do not need to be restricted to their rooms or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.
- For guidance about work restriction for fully vaccinated HCP who have higher-risk exposures, refer to Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2.
- In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated residents and work restriction of fully vaccinated HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
- If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days and no further testing is indicated.
- If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days based on the outbreak testing table, in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days.

Indoor visitation during an outbreak response

- In addition to this guidance, CMS regulated facilities should follow guidance from CMS about visitation, following whichever guidance is stricter.
- Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility.
- Whether unvaccinated residents are known to be close contacts or are identified as a part of a broad-based outbreak response but not known to be close contacts, indoor visitation should ideally occur only in the resident's room, the resident and their

visitors should wear well-fitting source control (if tolerated) and physically distance (if possible).

- Source control and physical distancing recommendations should also be followed for vaccinated residents.
- Outdoor visitation is allowed, but residents should wear well-fitting source control (if tolerated), maintain physical distancing from others, and not linger in common spaces when moving from their rooms to the outdoors.

Testing Table

Who to Test	Considerations	Testing Recommendations
Individuals With Symptoms		
• Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**	• Symptomatic HCP should be restricted from work until return to work criteria has been met. • Symptomatic residents should be restricted to their rooms, with the door closed (if safe) and cared for by HCP using a NIOSH-approved N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and a gown pending evaluation for SARS-CoV-2 infection. Extended-use of respirators may be considered for respiratory protection, consult CDC Strategies for Optimizing the Supply of PPE for additional information.	• Test as soon as possible with a rapid POC test. **Do not** make cohorting decisions until the lab-based testing result is available. • At the same time that the rapid POC test is collected, also collect a lab-based PCR test.
HCP With a Higher-Risk Exposure to Someone with SARS-CoV-2 *In general HCP with community exposures should be restricted from work if they have a community exposure for which quarantine is recommended (e.g. living with someone with SARS-CoV-2).*		
• **Asymptomatic fully vaccinated HCP** with a higher-risk exposure. • Include Ancillary Non-Medical Service Providers	• In general fully vaccinated HCP with higher-risk exposures do not require work exclusion. • Work exclusions may be required if directed by public health.	• **Approximately the same time each day,** test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test. • Daily rapid testing should continue for 14 days

		AND • Complete lab-based PCR testing immediately after the close contact has been identified (but not earlier than 2 days after the exposure) and, if negative, again 5-7 days after the exposure.
• **Asymptomatic HCP who are not fully vaccinated** with a higher-risk exposure • Include Ancillary Non-Medical Service Providers	• In general HCP should be excluded from work for 14 days following a higher-risk exposure.	• Test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test, at the beginning of every shift. **AND** • Complete lab-based PCR testing immediately after the close contact has been identified (but not earlier than 2 days after the exposure) and, if negative, again 5-7 days after the exposure.
Residents with Close Contact to Someone with SARS-CoV-2		
• **Asymptomatic Residents** who are not fully vaccinated and AND	• **Residents** should be placed in **quarantine for 14 days** after their exposure, **even if viral testing is negative.** • HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). Extended-use of respirators may be considered for respiratory	• **Approximately the same time each day,** test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test. • Daily rapid testing

• Had **close contact** to someone with SARS-CoV-2 infection OR • Have **left the facility (overnight - generally 24 hours or longer)** in the past 14 days	protection, consult CDC Strategies for Optimizing the Supply of PPE for additional information.	should continue for 14 days *(e.g. The date the resident returns to the facility is counted as day 1)*. **AND** • Complete lab-based PCR testing immediately after the close contact has been identified (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure.
• **Asymptomatic Residents** who are **fully vaccinated** and had close contact with someone with SARS-CoV-2 infection OR • Have **left the facility (overnight - generally 24 hours or longer)** in the past 14 days	• **Fully vaccinated residents**: • Should wear source control for 14 days following the close contact. • Do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by public health.	• Complete lab-based PCR testing immediately after the close contact has been identified (but not earlier than 2 days after the exposure) and, if negative, again 5-7 days after the exposure.

Recommendations Following Travel

State, local, and territorial governments may have travel restrictions in place, including testing requirements, stay-at-home orders, and quarantine requirements upon arrival. For up-to-date information and travel guidance, check the state or territorial and local health department where you are, along your route, and where you are going. Prepare to be flexible during your trip as restrictions and policies may change during your travel. Follow all state, local, and territorial travel restrictions.

<table>
<tr><td colspan="3">For additional information:
https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html#travel-restrictions</td></tr>
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- **HCP who are not fully vaccinated**
- Include Ancillary Non-Medical Service Providers

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After Travel

- HCP should be restricted from work for 14 days, whether or not they get tested. Even if they test negative.

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- Get tested with a lab based PCR test 3-5 days after travel
- Self-monitor for COVID-19 symptoms; isolate and get tested if you develop symptoms.

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- **HCP who are fully vaccinated or have recovered from COVID-19 in the past 3 months.**
- Include Ancillary Non-Medical Service Providers

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After Travel

- Self-monitor for COVID-19 symptoms; isolate and get tested if you develop symptoms.

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- Follow testing guidance for individuals with symptoms.

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<tr><td colspan="3">Individuals who have Recovered from SARS-CoV-2 Infection in the Last 90 Days</td></tr>
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- Residents and HCP who have recovered from SARS-CoV-2 infection in the last 90 days (and remain asymptomatic) regardless of their vaccination status
- Include Ancillary Non-Medical Service Providers

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- HCP and Residents who have recovered from SARS-CoV-2 in the past 90 days, should wear source control, they do not need to be quarantined,
- Residents do not need to be restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by public health.

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- Testing is not recommended for people who have had SARS-CoV-2 infection in the past 90 days if they remain asymptomatic.

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Routine Surveillance Testing		
Individual facility surveillance testing frequency is determined based on the county's level of SARS-CoV-2 transmission. Two different indicators in CDC's COVID-19 Data Tracker are used to determine the level of SARS-CoV-2 transmission for the county where the health care facility is located. If the two indicators suggest different transmission levels, the higher level should be utilized. Surveillance testing should occur based on the level of community transmission as indicated below:		
Person Being Tested	**Community Transmission Level**	**Testing Recommendation**
HCP who are not fully vaccinated: ● Include Ancillary Non-Medical Service Providers *Exclude asymptomatic HCP who tested positive in the past 90 days.	● Counties with **moderate community** transmission	● Test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test, at the beginning of every shift. **AND** ● Complete **once weekly lab-based PCR testing.** ○ If HCP work infrequently at the facility, they should be tested within 3 days before their shift (including day of the shift).
HCP who are not fully vaccinated: ● Include Ancillary Non-Medical Service Providers *Exclude asymptomatic HCP who tested positive in the past 90 days.	● Counties with **substantial to high community** transmission	● Test for SARS CoV-2, the virus that causes COVID-19 using a **rapid molecular or antigen test**, at the beginning of every shift. **AND** ● Complete **twice weekly lab-based PCR testing.** ○ If HCP work infrequently at the facility, they should be

		tested within 3 days before their shift (including day of the shift).
HCP who are not fully vaccinated: ● Include Ancillary Non-Medical Service Providers *Exclude asymptomatic HCP who tested positive in the past 90 days.	● Counties with **low community transmission**, surveillance testing is not required for asymptomatic individuals.	● No routine surveillance testing is required
Asymptomatic HCP who are fully vaccinated: ● Include Ancillary Non-Medical Service Providers	● Unless they develop symptoms, have a known close-contact or a higher-risk exposure.	● For testing recommendations consult the appropriate category in the testing table.
Outbreak Testing		
When one or more positive tests are identified in a resident or HCP (regardless of vaccination status), the facility moves to outbreak testing and follows additional response measures outlined below.		
Asymptomatic HCP and Residents who are fully vaccinated: ● Include Ancillary Non-Medical Service Providers	● HCP who test positive, regardless of vaccination status, should be excluded from work and instructed to isolate at home. ● HCP should self-report positive results to any additional employer(s) so that disease control measures can be implemented if necessary.	● Complete twice weekly **lab-based** PCR testing. ○ If HCP work infrequently at the facility, they should be tested within 3 days before their shift (including day of the shift).
HCP who are not fully vaccinated:	● HCP who test positive, regardless of vaccination status, should be excluded from work and instructed to isolate at home.	● Test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen

• Include Ancillary Non-Medical Service Providers	• HCP should self-report positive results to any additional employer(s) so that disease control measures can be implemented if necessary.	test, at the beginning of every shift. **AND** • Complete twice weekly **lab-based** PCR testing. ○ If HCP work infrequently at the facility, they should be tested within 3 days before their shift (including day of the shift).
Residents who are not fully vaccinated regardless if they have left the facility.	• Residents who test positive should be isolated in a private room and cared for using PPE effective against SARS CoV-2, the virus that causes COVID-19. • Residents should not be cohorted with other positive residents until lab-based PCR confirmation is received.	• Approximately the same time each day, test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test. **AND** • Complete twice weekly **lab-based** PCR testing. ○ If HCP work infrequently at the facility, they should be tested within 3 days before their shift (including day of the shift).
Continue to follow this testing frequency until no new positives are identified. When no additional positives are identified, move to "Outbreak Exit Testing". Refer to "Decision Tree" for testing frequency.		
• Regardless of the reason tested, all individuals who test positive with a rapid test should have a second sample collected **immediately** and sent for **lab-based** PCR testing. • Notify public health immediately of any positive results.		

Monoclonal Antibody Therapy for Residents with a Positive Test

Monoclonal antibodies are approved for treatment of residents who are diagnosed with COVID-19 and have a high risk of progression of disease, but are not yet ill enough to require hospital admission. Treatment with monoclonal antibodies has the potential to alleviate symptoms and limit progression to severe disease in residents with mild to moderate COVID-19.

- All residents who are diagnosed with COVID-19 by a PCR or antigen test for SARS CoV-2 and are not hospitalized should be evaluated by a health care provider to determine if they are eligible for monoclonal antibody therapy.
- A health care provider should be consulted immediately after the positive test result is received, as there is only a 10-day window to initiate monoclonal antibody therapy after the onset of symptoms (or documentation of a positive test in residents without symptoms).
- IV administration is the preferred route for monoclonal antibody therapy. However, one monoclonal antibody product is approved for subcutaneous (SQ) administration, and inability to obtain IV access or provide IV infusions should not disqualify a patient from receiving monoclonal antibody therapy.
- Vaccinated residents who test positive for SARS CoV-2 are eligible for monoclonal antibody therapy.
- For more information about monoclonal antibody therapy, please consult the NIH Treatment Guidelines.
- For more information on specific monoclonal antibody medications, please consult the FDA fact sheets for REGEN-COV and sotrovimab.
- For Colorado specific information on monoclonal antibody medications, consult the CDPHE COVID-19 Treatments webpage.

Recommended Infection Prevention and Control (IPC) Practices when Caring for a Resident with Suspected or Confirmed SARS-CoV-2 Infection

The IPC recommendations described below also apply to residents with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic residents who have met the criteria for Transmission-Based Precautions (quarantine) based on close contact with someone with SARS-CoV-2 infection. However, these residents should NOT be cohorted with residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through lab-based testing.

Note: In general, the following residents who are asymptomatic do not require use of Transmission-Based Precautions (quarantine) for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection:

- Fully vaccinated residents

- Residents who have had SARS-CoV-2 infection in the last 90 days

However, there may be circumstances when Transmission-Based Precautions (quarantine) for these residents might be recommended (e.g., patient is moderately to severely immunocompromised, if the initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result). In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated residents on affected units and work restriction of fully vaccinated HCP with higher-risk exposures. In addition, there might be other circumstances for which public health recommends these and additional precautions.

Resident Placement

- Place a resident with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). The resident should have a dedicated bathroom.
- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for residents with SARS-CoV-2 infection. Dedicated means that HCP are assigned to care only for these residents during their shifts.
- Only residents with the same respiratory pathogen should be housed in the same room.
- Limit transport and movement of the resident outside of the room to medically essential purposes.
- Communicate information about residents with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility and to other healthcare facilities.

Personal Protective Equipment

- HCP who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
- Additional information about using PPE is available in Protecting Healthcare Personnel | HAI | CDC
- Extended-use of respirators may be considered for respiratory protection, consult CDC Strategies for Optimizing the Supply of PPE for additional information.
    - When practicing extended use of N95 respirators over the course of a shift, considerations should include 1) the ability of the N95 respirator to retain its fit, 2) contamination concerns, 3) practical considerations (e.g., meal breaks), and 4) comfort of the user. N95 respirators should be discarded immediately after being removed. If removed for a meal break, the respirator should be discarded and a new respirator put on after the break.

Aerosol Generating Procedures (AGPs)

- Procedures that could generate infectious aerosols should be performed cautiously and avoided if appropriate alternatives exist.
- AGPs should take place in an airborne infection isolation room (AIIR), if possible.

- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.
- Following AGPs PPE worn for respiratory protection should be removed and disposed of and new PPE donned prior to continuing patient care activities.

Visitation While Infectious

- For the safety of the visitor, in general, residents should be encouraged to limit in-person visitation while they are infectious. Visitation guidance for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from CMS.
    - Counsel residents and their visitor(s) about the risks of an in-person visit.
    - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
- Facilities should provide instruction, before visitors enter the resident's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Visitors should be instructed to only visit the resident room. They should minimize their time spent in other locations in the facility.

Duration of Transmission-Based Precautions

- A symptom-based strategy for discontinuing Transmission-Based Precautions is preferred in most clinical situations.

Criteria for the Symptom-Based Strategy

- Patients with mild to moderate illness who are not moderately to severely immunocompromised:
    - At least 10 days have passed since symptoms first appeared and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved
- Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised:
    - At least 10 days have passed since the date of their first positive viral diagnostic test.
- Patients with severe to critical illness or who are moderately to severely immunocompromised:
    - At least 10 days and up to 20 days have passed since symptoms first appeared and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved
    - Consider consultation with infection control experts

- A test-based strategy could be considered for some residents (e.g., those who are moderately to severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the patient being infectious for more than 20 days. Limitations of the test-based strategy are described elsewhere.

Criteria for the Test-Based Strategy

Residents who are Symptomatic:

- Resolution of fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved, and
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized laboratory-based NAAT to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

Residents who are not Symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized laboratory-based NAAT to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with suspected SARS-CoV-2 infection can be made based upon having negative results from at least one respiratory specimen tested using an FDA-authorized COVID-19 viral test.

- If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.
- If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made using the symptom-based strategy described above.

Environmental Infection Control

- Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
    - All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to

frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed. Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2.

- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles [more information (to include important footnotes on its application) on clearance rates under differing ventilation conditions is available]. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

When SARS-CoV-2 and Influenza Viruses are Co-circulating

- When SARS-CoV-2 and influenza viruses are found to be co-circulating based upon local public health surveillance data and/or testing at local health care facilities, facilities should implement the following:
    - Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for SARS CoV-2, the virus that causes COVID-19 and test for both viruses (SARS CoV-2 and influenza).
    - Because some of the symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two infections based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in the current room, pending results of viral testing. **They should not be placed in the COVID-19 care unit unless influenza is ruled out and they are confirmed to have COVID-19 by SARS-CoV-2 (PCR) testing.**
    - Facilities should promptly contact public health for consultation and further investigation if co-circulating viruses are suspected.
    - Additional CDC guidance for influenza can be found here. The CDPHE guidelines for influenza outbreaks in long-term care facilities can be found here.
- CDPHE provides a basic tracking tool: Line List Template to Monitor Residents and Health Care Personnel. Collection of additional variables may be recommended in the setting of a suspected or confirmed COVID-19 outbreak.

Testing

Public Health Order 20-20 requires facilities to participate in surveillance and outbreak testing as described in this guidance document.

All facilities must implement routine surveillance and outbreak testing for SARS CoV-2, the virus that causes COVID-19 utilizing laboratory based PCR testing AND rapid point of care testing as outlined in the testing table within this document. Facilities should have a process in place that ensures and maintains the required documentation (e.g. vaccination record or a copy of negative **lab-based** PCR test results) necessary to meet the requirements outlined in this document .

- Facilities may not restrict Ombudsman, Adult Protective Services workers, Voter Assistance Personnel, or Emergency Medical Services workers from entering their building for any reason, including the absence of proof of testing and/or vaccination.

CDPHE will provide testing supplies and lab resources for all facilities required to implement surveillance and outbreak testing as described in this guidance document. If a facility chooses not to use the testing lab provided by CDPHE (CDPHE, CSU, Mako), they must notify the Residential Care Strike Team at the following email: residentialcarestriketeam@state.co.us to ensure that the contracted lab meets the requirements necessary to perform or facilitate whole genome sequencing on all positive specimens to identify current and emerging variants.

- Providers of health care or ancillary non-medical services for residents of the facility must do one of the following:
    - Participate in the facility outbreak and/or surveillance testing.
    - Provide a copy of a negative PCR lab report for SARS CoV-2 collected within the required time period indicated in the testing table
      AND
      Complete a rapid POC test, prior to entering the facility if indicated in the testing table.

Individuals Who Refuse Testing When Indicated

Facilities must have procedures in place to address residents, HCP, and others who refuse testing. HCP and residents (or resident guardians/representatives) may exercise their right to decline SARS CoV-2 (COVID-19) testing. Facilities must have written infection control policies and procedures in place to address HCP and residents who refuse SARS CoV-2 (COVID-19) testing.

- HCP who have symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return-to-work criteria are met.
- Asymptomatic HCP that refuse testing should be restricted from the facility for 14 days following each round of refused testing or until the procedures for outbreak testing have been completed (e.g., outbreak resolved).
- Residents who refuse testing regardless of symptoms, should be restricted to their rooms, with the door closed (if safe) and cared for by HCP using a NIOSH-approved N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face) gloves, and a gown pending evaluation for SARS-CoV-2 infection.
- Symptomatic residents may be released from isolation as indicated in this section.
- Asymptomatic residents who refuse testing should be quarantined for 14 days following each round of refused testing or until the the procedures for outbreak testing have been completed (e.g. outbreak resolved)

Testing Frequency

Individual facility surveillance testing frequency is determined based on the county's level of SARS-CoV-2 transmission found in CDC's COVID-19 Data Tracker. If the two indicators suggest different transmission levels, the higher level should be utilized. Consult the testing table to determine the frequency of testing required.

The facility should test all HCP and residents at the frequency indicated in the testing table within this document.

- If HCP work infrequently at the facility, they should be tested within 3 days before their shift (including day of the shift).

After the positive test(s), take the following steps:

- Initiate outbreak testing. Perform round 1 of outbreak testing (See decision tree), including all HCP and residents regardless of vaccination status, except those who have tested positive in the previous 90 days and remain asymptomatic. Testing must be initiated **immediately**. Specimens must be sent to the testing laboratory as soon as possible but not greater than 48 hours after identifying the positive test result. This is to promptly identify other asymptomatic, presymptomatic, and symptomatic infections.
    - The results for each round of testing will determine the next step in responding to the outbreak, as outlined in the Outbreak Testing Results and Response section.
    - Conduct contact tracing to identify residents that are close contacts and HCP and with high risk exposures and quarantine accordingly.
    - Facilities must immediately report an outbreak of COVID-19 (suspected or confirmed) to public health. Review reporting within this document for additional information.

Outbreak (OB) Testing Results and Response (See decision tree)

- **Facilities that Identify No Positives in Residents or HCPs**
    - Initiate OB Exit Testing.
        - Facilities must ensure testing of ALL HCP and residents except those who have tested positive in the previous 90 days in order to initiate OB Exit Testing.
    - **Lab-based** PCR testing frequency decreases to every 7 days until the outbreak is closed.
        - Daily rapid testing continues for HCP and residents who are not fully vaccinated.
    - Facilities may resume or continue admissions, communal dining, and group activities, for all residents regardless of vaccination status.
- **Facilities that Identify a Positive Resident or HCP**
    - Continue to follow OB testing protocol.
    - Lab-based PCR testing frequency is every 3-4 days.
    - Facilities should stop admissions, communal dining, and group activities for unvaccinated persons.
- **Discordant Results**
    - When discordant results are identified between POC antigen tests and lab-based PCR, Facilities should consult the CDC tool Considerations for

Interpreting Antigen Test Results in Nursing Homes and the associated webpage to determine appropriate next steps.
    - When discordant results are identified between POC NAAT (molecular tests) and lab-based PCR, Facilities should also consult the CDC tool Considerations for Interpreting Antigen Test Results in Nursing Homes and the associated webpage to determine appropriate next steps. Facilities should substitute the POC NAAT (molecular test) results in the algorithm anywhere the antigen testing is mentioned.
    - CDPHE requires the collection of a confirmatory lab-based PCR test immediately following a positive POC antigen or POC NAAT (molecular test), however there may be rare exceptions when this is not possible. If more than 48 hours separate the two specimen collections, or if there have been opportunities for new exposures, a laboratory-based NAAT (molecular test should be considered a separate test – not a confirmation of the earlier test. If a facility identifies more than one discordant test result in a 24 hr period, the facility should contact the CDPHE IP team to assist with determining isolation and quarantine recommendations. To contact the team email cdphe_covid_infection_prevention@state.co.us or call 303-692-2700.

- **Outbreak Exit Testing**
    - Outbreak exit testing is intended for facilities who have met outbreak criteria; it begins when a round of lab-based PCR testing identifies no positive residents or HCP. This is the first round of OB exit testing. Facilities must ensure and document testing of ALL eligible HCP and residents (i.e., individuals who have not tested PCR positive in the previous 90 days) in order to initiate OB Exit Testing.
    - A minimum of 7 days have passed since the collection date of the last positive lab-based PCR test and two additional rounds of **lab-based** PCR testing identify no positive residents or HCP.
    - If at any point a positive resident or HCP is identified during a round of lab-based PCR testing, the facility returns to OB testing.
    - Facilities may resume or continue admissions (regardless of resident COVID-19 status), communal dining and group activities, and indoor visitation.
    - All other testing should continue based on the testing table in this document.
- Additional information for CMS regulated facilities, to include next steps in responding and visitation during an outbreak, can be found in the Visitation During an Outbreak section.

Testing Previous Positives

- CDPHE does not recommend repeat testing of persons who previously tested positive for SARS CoV-2, the virus that causes COVID-19 utilizing a laboratory-based PCR test in the past 90 days. **Repeated testing of any positive individual cannot be used to release someone from isolation or resolve an outbreak.** For adults who have recovered from COVID-19 infection, a positive lab-based SARS-CoV-2 test result without new symptoms during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.

- Serologic testing should not be used to establish the presence or absence of COVID-19 infection or reinfection. See Duration of Isolation and Precautions for Adults with COVID-19.

Point of Care (POC) Rapid Testing

Rapid tests are available as point-of-care (POC) diagnostics for SARS-CoV-2, offering a rapid turnaround time. Tests are available as antigen or molecular tests; they often have a lower sensitivity but similar specificity to **lab-based** PCR testing. Rapid tests can play an important role in disease mitigation including: testing symptomatic individuals, those who have had a testing a close contact or high-risk exposure and testing asymptomatic individuals as part of an outbreak response.

Considerations for Use

- POC tests supplement but cannot replace the required **lab-based** PCR testing. The facility must have a CLIA Certificate of Waiver. Information on obtaining a CLIA Certificate of Waiver can be found here.
- The facility should be familiar with the instructions for use of the specific test being utilized, including the FDA EUA for tests.
- Considerations for interpreting rapid antigen or molecular test results in residential care facilities can be found here.
- POC testing results need to be reported (positive, negative, and inconclusive) to CDPHE as the performing laboratory (as outlined below in Reporting Test Results to Public Health).

Specimen Collection

- The type of specimen collected when testing for current or past infection with SARS-CoV-2 is based on the test being performed and its manufacturer's instructions for use. Some of the specimen types will not be appropriate for all tests.
- CDC interim guidelines for collecting and handling of clinical specimens for COVID-19 testing should be followed.

Communal Dining/Group Activities/Facility Outings

Facilities may participate in communal dining, group activities and facility outings as outlined below:

- Documented proof of vaccination status is required and must be maintained by the facility for all staff, residents and any visitors participating in group activities, communal dining or facility outings.
- Residents with symptoms of illness, including signs and symptoms of COVID-19, or those that require isolation or quarantine (regardless of the reason) should be excluded from participating in communal dining, group activities, and facility outings.

- Facilities that are conducting outbreak testing related to the identification of one or more positive COVID-19 cases should follow the OB testing guidance and decision tree to determine when communal dining and group activities should be stopped, or resumed.
- Pets other than ADA service animals should not be included in communal dining or group activities. See visitation for individual pet visits.
- Hand hygiene should occur before and after all communal dining, group activities, and outings.
- It may not be possible to social distance from others while riding in shared transportation required for facility outings. This should be considered prior to allowing unvaccinated residents to participate in such activity. If residents are sharing transportation to/from an activity, all individuals in the vehicle should wear masks and vehicle ventilation should be increased.
- Residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces. They should be encouraged and assisted with adherence to all recommended infection prevention and control measures, including source control, physical distancing, and hand hygiene.

Communal Meals, Group Activities and Facility Outings

- **Fully Vaccinated Residents**
  - Should wear masks at all times when outside of their room, including while participating in group activities and facility outings. While participating in group activities, residents should socially distance themselves from other residents and HCP. Refer to the Source Control Table for examples of when source control may no longer be necessary in facilities with low levels of community based transmission.
  - Food and drink should not be consumed during group activities and facility outings unless food and drink are consumed outdoors and residents are physically distanced from others.
  - Should wear a mask while ambulating to the communal dining area. Fully vaccinated residents may share a table with other fully vaccinated residents without source control or physical distancing during the meal.
  - May choose to participate in facility outings using a mask and social distancing.
- **Residents Not Fully Vaccinated**
  - Should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated or when the facility has implemented outbreak testing see decision tree.
  - Should wear masks at all times when outside of their room and until seated at a table to consume a meal.
  - Meals should be consumed while socially distanced from other residents or in the resident's room.
  - Unvaccinated residents should wear masks and physically distance themselves from others.

    - Food and drink should not be consumed during facility outings unless food and drink are consumed outdoors and socially distanced from other residents and HCP.
- **Fully Vaccinated Visitors**
    - Fully vaccinated visitors (e.g., family members, musicians, entertainers) may participate in group activities, facility outings, and communal meals. Visitors must provide proof of vaccination.
    - Visitors who are unable to provide proof of vaccination are restricted from participating in group activities, facility outings, and communal dining and should follow visitation guidance.
    - If a visitor is participating in activities (e.g. communal dining, group activities and facility outings) reserved for only those that are fully vaccinated, the visitor must share a copy of their vaccination record with the facility prior to the visit. The facility is required to maintain a copy of such records.
    - Visitors are required to wear a well-fitting mask that covers both their nose and mouth at all times while in the facility and when participating in activities, facility outings and communal meals.

Visitation

Facilities should allow for visitation at all times and for all residents. Visitation should be person-centered; consider the residents' physical, mental, and psychosocial well-being; and support their quality of life and follow all infection control core principles included in this guidance. The facility must be in compliance with all public health orders as part of the implementation for this guidance. Residential care providers must routinely evaluate and update their visitation policies and procedures as guidance, facility resources, and the degree of community spread changes.

Outdoor visitation is preferred even when the resident and visitor are fully vaccinated, as these visits generally pose a lower risk of transmission due to increased space and airflow. Visits should be held outdoors whenever possible. However, poor weather conditions or an individual resident's health status may preclude the possibility of an outdoor visit. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as courtyards, patios, or parking lots, including the use of tents, if available. For all visitation the following shall occur:

Notification and Screening of Visitors

- Send letters or emails to families and post signs at entrances reminding them of the importance of getting vaccinated, recommendations for source control and physical distancing and any other facility instructions related to visitation, including not to visit if they have any symptoms or meet quarantine criteria.
- All visitors must be screened for COVID-19 symptoms, regardless of vaccination status, and facilities should limit visitor movement in the facility by following these procedures:

    - Greet visitors at a designated area at the entrance of the facility where a staff member must:
        - Perform temperature check and symptom screening.
        - Document the visitor's contact information and the results of the screening. This example form may be used to document the information.
        - Deny entry to visitors who:
            - Have a positive test
            - Display symptoms during the screening
            - Currently meet criteria for quarantine
        - Ensure the visitor has a face mask and ensure the mask covers the visitor's nose and mouth.
        - Have the visitor clean their hands with alcohol-based hand sanitizer.
        - Escort the visitor to the designated visitation area.
        - If the resident's roommate is unvaccinated or immunocompromised (regardless of vaccination status), then the visit should not occur in the resident's room.
        - Indoor visitation for unvaccinated residents and visitors should occur in dedicated visitation spaces that allow for appropriate physical distancing, increased ventilation (open windows, etc.), cleaning and disinfection between visitors.

- Visitors should alert the facility if they develop fever or other symptoms consistent with COVID-19, or if they are diagnosed with COVID-19 in the 14 days following visitation. Promptly notify public health if such notification occurs.

Source Control During Visitation

- Residents and visitors should wear source control during visitation as outlined in the Source Control and Physical Distancing Measures table above.

Number of Visitors Allowed Per Visit

- 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 COVID-19 infection prevention and does not increase the risk to other residents. Facilities should ensure that physical distancing can still be maintained during peak visitation. Also, facilities should avoid large gatherings (e.g. parties, events) where large numbers of visitors are in the same space at the same time and physical distancing cannot be maintained.
- The facility should restrict the total number of visitors (according to the size of the facility in order to maintain core principles of infection prevention) as well as the number of visitors allowed per resident at one time. CDPHE generally recommends allowing no more than two visitors per resident per room.

Visitor Vaccination

- Visitors are not required to be vaccinated or show proof of SARS CoV-2 (COVID-19) vaccination unless they are participating in activities requiring vaccination. To participate in these activities, the facility must:

    - Ensure visitors are aware of this requirement when scheduling their visit.
    - The facility must maintain documentation of the visitor vaccination status as outlined in the group activities section.

Visitor Testing

- Facilities may choose to offer rapid testing of visitors; however, it cannot be a contingency for visitation. Facilities should deny entry to visitors who test positive.
    - Facilities should have a process in place to respond to positive results. Should a potential visitor test positive, the visitor's positive test will not impact the facility's outbreak status even if the visitor has been in the facility during the prior 14 days. The visitor could be counted towards the facility's outbreak status if an epidemiological link is identified.
    - If the facility arranges, suggests, or performs SARS CoV-2 testing for visitors, the test results must be obtained in a reasonable amount of time and visitation cannot be denied as a result of prolonged turnaround time.
- Residents who are fully vaccinated and those who are within three months of a prior COVID-19 infection may have private in-room visits with unvaccinated visitors. Both the resident and their visitor should wear a well-fitting face mask and perform hand hygiene before and after limited physical contact (e.g., hugging and/or hand-holding).
    - Visitors should still physically distance themselves from other residents and HCP in the facility.
    - If the room is shared, the resident's roommate must be fully vaccinated and the facility shall obtain the consent of the roommate and/or the roommate's POA that visitation may occur in the room.
    - Visitors must not access the roommate's living area or have contact with the roommate's environment.
    - If the room is shared, ensure visits do not overlap. This is to limit the number of visitors in a resident's room at any given time.
    - In-room visits with unvaccinated visitors do not require staff supervision, but do require staff to escort the unvaccinated visitor to and from the room.
- The allowable number of persons (resident, HCP, and visitors) will depend on the size of the space and should allow for social distance of at least six feet for residents and visitors who are unvaccinated.

Any codes, regulations, or ordinances requiring a smaller number of people must be followed.

    - The number of maximum visitors allowed must be documented in the visitation plan.
- Furniture used for external visits should be appropriately disinfected between visits.

Who May Visit

All residential care facilities must allow entry and may not deny entrance for the following services.

Essential Health Care Service Providers

These include but are not limited to physicians, hospice, and home health staff of all disciplines, along with other types of both medical and nonmedical health care and services.

  - Essential health care services providers must be screened and tested in accordance with the surveillance and outbreak testing prescribed in the Eighth Amended PHO 20-20.
  - Essential health care service providers must either produce a negative SARS CoV-2 (COVID-19) test within the prescribed testing frequency as indicated in the testing table or submit to facility testing.
- **Religious Exercise**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Adult Protective Services**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Long Term Care Ombudsman**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Voter Support Personnel**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Designated Support Persons**
  - Support service providers must be screened and may be offered testing in accordance with the surveillance and outbreak testing prescribed in the Eighth Amended PHO 20-20.
- **Compassionate Care Visits Should be Permitted at All Times**
  - Screening is required.
- **Emergency Medical Service Personnel**
  - Neither screening nor testing is required.
  - Emergency medical and service personnel shall not be delayed from response or access in relation to responding and carrying out their duties.
- **Ancillary Non-Medical Services**
  - Includes hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists.
  - Ancillary services must be provided in the resident's room or in a separate room that is appropriately disinfected between uses.
  - Must wear appropriate PPE and follow appropriate infection control measures prior to, during, and after each resident encounter.

- Comply with the policy and procedures regarding infection control, and abide by all other precautions and restrictions imposed on their profession that would be required in any setting.

Visitation: Animal Visitation

- With pre-notice and facility permission, pets may accompany a visitor for a visit with a single resident. Pets can aid in the transmission of COVID-19 and therefore the pet must be kept away from other HCP and residents during the visit (inside or outside). The facility should have policies and procedures regarding the safety and parameters for pet visitation, including criteria for vaccinations and infection control.

Strategies for Memory Care or Facilities Serving People with Developmental Disabilities

COVID-19 Care Area in Memory Care

- Because isolation amongst memory care residents or individuals with developmental disabilities can be challenging, facilities should consider additional measures to prevent COVID-19 from entering the facility and rapidly responding once illness is identified.

Limit Health Care Personnel Movement as Much as Possible

- If possible, HCP should avoid working on both the COVID-19 care unit and other units during the same shift.
  - Assign dedicated health care providers (HCP) to work only with individuals who have tested positive for SARS CoV-2, the virus that causes COVID-19.
- To prevent dietary staff from entering the unit and/or resident rooms, consider having dietary staff deliver meals or meal carts to the unit and allow the designated HCP to deliver the meal trays to the residents.
- To prevent housekeeping staff from entering the unit and/or resident rooms, consider having the designated HCP place bagged laundry in a hamper outside the unit or resident room to allow housekeeping staff to collect these items. A similar practice can be used when returning clean linens back to the unit.
- Consider having the designated HCP clean and disinfect common areas and high touch surfaces more frequently to limit the frequency of environmental staff in the unit or resident room.
- Discourage HCP from visiting other units and from interacting with other HCP outside of their designated unit.

Miscellaneous Considerations for Memory Care Residents

- To the extent possible, consider cohorting residents to the smallest area/unit possible, depending on the facility layout.
- Consider closing fire doors or placing temporary barriers at the end of hallways or neighborhoods while allowing for Life Safety Requirements. This consideration is an attempt to limit the movement of residents interacting with each other by limiting movement throughout the facility.

- Consider re-arranging furniture to provide places for residents to sit that are spaced at least six feet apart.
- Activities should be provided in a cohorted neighborhood or POD while maintaining physical distance.
- If activities or dining occur in common spaces shared by multiple neighborhoods, consider staggering the times when residents in cohorted neighborhoods will access the common space so that two neighborhoods are not in the shared space at the same time.
- Consider alternate activities that residents can participate in while in their rooms (hallway Bingo, television, music, arts, making their own masks, etc.).
- If space allows, consider designating a location to care for residents with confirmed COVID-19, separating them from other residents promptly to mitigate spread.

Strategies for Small Residential Settings (13 or Fewer Residents)

These strategies have been developed to meet the needs of small assisted living residences, intermediate care facilities (ICFs), and group homes typically operating in single-family homes which typically have 13 or fewer residents. These settings operate similarly to a single family residence due to the smaller spaces and congregate setting between residents and HCP and therefore may need to consider additional strategies when trying to implement IPC recommendations.

Dining

- If it is not always possible to stop communal dining (e.g., during outbreak testing when new positive residents are being identified) due to space constraints or if the resident requires assistance (as outlined in their care plan), dining should be limited to 2 residents at a time in order to maintain social distances.
- Unvaccinated residents should remain at least 6 feet away from each other during meal times. Four (4) foot tables can only seat one resident in this case. The facility may consider adding an additional four foot table to accommodate additional residents during meals, but should adhere to residents remaining at least 6 feet away from each other. Consider scheduling times and locations for meals to allow for social distancing for unvaccinated residents.
- Maintain physical distances of at least 6 feet for unvaccinated residents and HCP at all times and while residents are entering and leaving the dining room.
- Keep hand sanitizer on each table for use before and after mealtime.
- Disinfect all surfaces in between each resident.
- Consider using disposable plates, napkins, and silverware.
- Follow recommendations for source control in the table within the RCF Comprehensive Guidance document, which includes recommendations for source control for HCP, residents and visitors.
- Unvaccinated residents should wear masks that cover their nose and mouth when entering and leaving the dining room and anytime they are out of their room.

Feeding Sick Residents

- Stay separated: The person who is sick should eat (or be fed) in their room, if possible.
- Sick residents should not participate in communal meals or group activities.
- It is strongly recommended to stop all communal dining and group activities within the home while an ill resident resides there. If you have no other option to care for residents, limit meals and activities to no more than two people in a shared room at the same time and provide as much space between individuals as possible.
- Handle any dishes, cups/glasses, or silverware used by the person who is sick with gloves. Wash them with soap and hot water or in a dishwasher.
- Clean hands after taking off gloves or handling used items.
- Do not share dishes, cups/glasses, silverware, towels, bedding, or electronics (like a cell phone) with the person who is sick.

Self-Isolation

- The sick person, their roommates, and close contacts within the house need to self-isolate and limit their use of shared spaces as much as possible until public health determines your outbreak is over.
- A mask helps prevent a person who is sick from spreading the virus to others. It keeps respiratory droplets contained and prevents them from reaching other people.

Bedrooms and Bathrooms

- If possible, have the person who is sick use a separate bedroom and bathroom and keep the door closed as much as possible. If possible, have the person who is sick stay in their own “sick room” or area and away from others. Try to keep yourself and others at least 6 feet away from the sick person.
- If a sick person must share a bedroom, make sure the room has good airflow. Open the window to increase air circulation if possible. Caution should be utilized if considering the use of an individual room fan; consult CDPHE’s COVID-19 Ventilation Guidance for more information. Improving ventilation within a room or home helps remove respiratory droplets from the air and works to dilute the amount of virus present. Space beds in a shared room at least 6 feet from one another; consider placing heads of beds at opposite ends of the room.
- Disinfect shared bathrooms after each use and leave the exhaust fan running. Wear a mask and wait as long as possible after the sick person has used the bathroom before coming in to clean and use the bathroom.
- If a sick person is using a separate bedroom and bathroom: Only clean the area around the person who is sick when needed, such as when the area is soiled. This will help limit your contact with the sick person.

Avoid Sharing Personal Items

- Everyone should avoid placing toothbrushes directly on counter surfaces. Totes can be used for personal items so they do not touch the bathroom countertop.

Washing and Drying Laundry Items

- Do not shake dirty laundry or hold it close to you.

- Wear disposable gloves while handling dirty laundry.
- Dirty laundry from a person who is sick can be washed with other people's items.
- Wash items according to the label instructions. Use the warmest water setting you can.
- Remove gloves and wash hands right away.
- Dry laundry completely on hot or high if possible.
- Wash hands after putting clothes in the dryer.
- Clean and disinfect clothes hampers. Wash

Decision Tree