COVID-19 RESPONSE FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS

This document provides guidance to Intermediate Care Facilities on Response Actions in the event of a COVID-19 exposure.

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TEXAS
Health and Human Services

Contents

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TABLE OF CHANGES

Document Version	Date	Change	Comments
2.0	05/06/2020	Additions to pages 5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 25, guidance in attachments 4, 5, 6, 7, 8, 9 and 10 added, and contents reorganized for clarity	
2.1	06/02/2020	Entire document revised for accessibility, style and HHSC branding. Additions to pages 9, 10, 13, 14, 15, 24, 25, 27, 28, 29, 30, 31, 32, 33, 35, 36, 37, 51, 54, 55, 56 and guidance in attachment 7, 8, 9 and 10 added.	
2.2	06/15/2020	Additions to pages 9, 13, 18, 30, 31, 32, 33, 57, 59, and 60. Link to the WHO visual tools added as well as additional CDC resources.	
2.3	12/22/2020	Table of Contents updated and reorganized. Expansion of Reopening Visitation Requirements added. Additions to pages 6, 10, 13, 14, 15, 18, 19, 22, 25, 29, 30, 31, 33, 34, 36, 37, 38, 42-50, 51-54, 56, 59, 62, 64, 65, 68, 69, 70, 71, 72 and 74.	
3.0	04/01/2021	Additions/changes to pages 11, 14, 15, 25, 26, 28, 30, 31, 35, 38, 39, 40, 44-54, 60, 76, 78. Attachment 11 (pg. 76) added.	Revised Expansion of Reopening Visitation Requirements section
3.1	7/28/2021	8, 9, 13, 14, 15, 16, 18, 19, 24, 25, 26, 27, 29, 30, 37, 55, 56, 75	Revised for new mitigation rules
3.2	10/05/2021	Updated State/Regional/Local Support and changes to CDC quarantine guidance. Added CMS QSO 21-21 information. Changes to pages 11, 17, 31, 32, 57, 58, 59, and 74.	Edited to include current information for testing, vaccination, funding and general resources as well as changes to CDC quarantine guidance and CMS QSO 21-21.
3.3	10/26/2021	Changes to pages 44-46	Edited to include revised COVID-19 Expansion of Reopening Visitation Emergency Rules for ICFs/IID
3.4	12/07/2021	Changes to pages 15, 16, 25, 26, 31, 35	Edited to include revised ICF COVID-19 Provider Response Mitigation Rules for ICFs/IID

Document Version	Date	Change	Comments
3.5	1/7/2022	Changes to pages 6, 31, 38, 39, 40, 51, 71, and 72	Changes made to reflect the most updated CDC guidance.
3.6	1/14/2022	Left additions from 1/7/2022 updated and made additional changes to pages 18-19, 32, 39-40, 41-42, 47-48, 53, 73, 74, and 75.	Changes made to reflect the most updated guidance regarding staffing shortages, testing supplies and consolidation of group homes.

1. Purpose

This document provides Intermediate Care Facilities for People with an Intellectual Disability or Related Conditions (ICFs) with guidance in the event of a positive COVID-19 case associated with the facility. Additionally, included in this document is information regarding emergency rules, visitation and mitigation expectations.

Individuals of ICFs are more susceptible to COVID-19 infection and the detrimental impact of the virus than the general population. In addition to the susceptibility of individuals, an ICF environment presents challenges to infection control and the ability to contain an outbreak, partly due to individuals living in close proximity to others, which could result in potentially rapid spread among a highly vulnerable population.

2. Goals

- Rapid identification of COVID-19 situation in an ICF
- Prevention of spread within the facility
- Protection of individuals, staff and visitors
- Provision of care for an infected individual(s)
- Recovery from an in-house ICF COVID-19 event
- Visitation rules and guidance
- Mitigation guidance

3. To Do's for Intermediate Care Facilities:

- Review the CDC's [Key Strategies to Prepare for COVID-19 in Long-term Care Facilities](#).
- Review the CDC's [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#).
- Review the CDC's [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#).
- Review the CDC's [Guidance for Group Homes for Individuals with Disabilities](#)
- Review the CDC's [Guidance for Direct Service Providers.](#)
- Review the CDC's [Guidance for Direct Service Providers, Caregivers, Parents, and People with Developmental and Behavioral Disorders.](#)
- Review the CDC's [Quarantine vs. Isolation.](#)
- Review HHSC's [Helping Individuals with Intellectual Disabilities and Related Conditions Prevent the Spread of COVID-19.](#)
- Review HHSC's [Expansion of Reopening Visitation](#)
- Review the WHO's [Visual Tools.](#)
- Review [CMS blanket (1135) waivers,](#) which include:
  - Individual Care and Program Requirements
    - staffing flexibilities;
    - suspension of community outings;
    - suspend mandatory training requirements; and
    - modification of adult training programs and active treatment
  - Physical Environment and LSC
    - inspection, testing, and maintenance of systems and equipment;
    - individual bedroom outside window or door;
    - ABHR dispensers;
    - fire drills; and
    - temporary construction, including temporary walls or barriers between individuals

Note: Temporary walls or barriers or plastic sheeting must not impede or obstruct the means of egress, fire safety components, or fire safety systems (e.g., corridors, exit doors, smoke barrier doors, fire alarm pulls, fire sprinklers, smoke detectors, fire alarm panels, or fire extinguishers).

- Review individual [isolation and quarantine](#) plans with staff.
- Review handwashing, surface-cleaning, and other environmental hygiene precautions with staff.
- Develop a staffing contingency plan in case a large number of staff must self-quarantine or isolate because of potential exposure, being suspected of, or positive for COVID-19.
- Report all confirmed COVID-19 cases to the local health department (LHD) with jurisdiction over the facility. In instances where there is no local health authority, report to DSHS directly.
- Report the first case in either an individual or employee and the first case that occurs in either an individual or employee after the ICF has been without COVID-19 infection for 14

days or more to [HHSC Complaint and Incident Intake (CII)](). Report the incident within 24 hours of receiving the COVID-19 positive test result.

- Obtain and properly use PPE.
- Review the [CDC's LTC Webinar Series](), including:
  - Clean Hands;
  - Closely Monitor Individuals;
  - Keep COVID-19 Out;
  - PPE Lessons; and
  - Sparkling Surfaces
- Utilize the ASPR TRACIE [workforce virtual toolkit.]()
- Comply with all CMS and CDC guidance related to infection control. ICFs need to frequently monitor CDC and CMS guidance as it is being updated often. This will ensure the ICF is operating off the most current guidance.
- For the duration of the state of emergency, all ICF personnel should wear a facemask while in the facility. Staff who are have been appropriately trained and fit-tested can use N95 respirators. Staff who are caring for individuals with COVID-19 or caring for individuals in a building with widespread COVID-19 infection, should wear an N95 respirator and all suggested PPE. See guidance in the section related to [PPE use when caring for individuals with COVID-19]().
- If N95 or other respirators are used, review [OSHA's Respiratory Protection Training Videos]().
- Actively screen everyone who comes into the facility.
- To avoid transmission within facilities, ICFs to the best of their ability should use separate staffing teams for COVID-19-positive individuals and designate separate ICFs or units within an ICF to separate COVID-19-negative individuals from COVID-19-positive individuals and people with unknown COVID-19 status.
- [Quarantine]() individuals as per CDC guidance.
- [Isolate]() individuals with positive cases.
- [Clean and disinfect]() the facility if there is a positive case.
- Coordinate individual diagnoses and symptoms with transferring and receiving hospitals and other ICFs.
- Communicate with individuals, staff, and family when there is exposure to or suspected or confirmed cases in the facility.
- Keep an up-to-date list of all staff who work in other facilities. The list does not have to include the names or locations of the other facilities, just whether the staff member works at other facilities.
- Minimize the movement of staff between facilities as much as possible.
- Require staff self-monitoring on days they work. Ask staff to self-monitor on days they don't work.
- Require staff to report via phone prior to reporting for work if they have known exposure or symptoms.
- Follow the guidance beginning on page 38 of this document to determine when staff can return to work after recovering from an illness.

- Post a list of state contacts where it is visible on all shifts. The list should at least include phone numbers for the local health authority or DSHS office and the regional HHSC LTCR office.
- Follow physician's plan for immediate care of any individual with a positive case. Orders can include increased assessment frequency, increased monitoring of fluid intake and output, supportive care, a treatment plan, and what to do in case of a change in the individual's status.
- Inform the individual of treatment or supportive healthcare plans; individuals have the right to participate in their own care.
- Upon the first positive test result of an ICF staff member or individual, consider testing of all ICF staff and individuals.
- If needed, request deployment of the TCAT-ICF team.

4. S.P.I.C.E.

Recognizing a potential COVID-19 situation in a facility can result in disorientation, questions, and confusion; this document suggests ICFs focus on the following five basic actions (S.P.I.C.E.) to anchor activities:

- **S**urveillance – Monitor for symptoms – fever, cough, shortness of breath, or difficulty breathing – for each individual at least once a day.
- **P**rotection/PPE – Protect workforce and individuals through soap/water and hand sanitizer per CDC guidance. If coughing or potential splash precautions are needed, wear a gown and face/eye shields. Refer to DSHS guidance. Keep a two-week supply of PPE on hand as per HHSC emergency rules.
- **I**solate – Individuals with suspected and confirmed cases need to be isolated. Ensure cohorting is set up by potential infection status.
- **C**ommunicate – Call local health department/authority and/or DSHS and HHSC Long-term Care Regulation to report confirmed cases. Have contact information available for people such as: facility management, staff, local health department, the hospital, etc.
- **E**valuate – Infection control processes, spread of infection and mitigation efforts, and staffing availability need to be assessed. Prevent delay of critical actions and ensure there is a plan for communication.

S.P.I.C.E. is not meant to be all-encompassing. It is suggested to assist initial actions and be a reminder of necessary activities.

5. HHSC Long-term Care Regulation Activities with ICFs that have Positive COVID-19 Cases

For a report of a positive COVID-19 test (individual or staff) in an ICF, HHSC will take the following steps:

- Generate a priority 1 intake (must be investigated within 24 hours).
- Conduct a focused review of facility infection control processes.
- Communicate with the local health department/local health authority and DSHS.
- Determine the number of individuals suspected or positive for COVID-19.
- Determine the number of staff suspected or positive for COVID-19.
- Review facility isolation precautions and determine how individuals are isolated in the facility to ensure compliance with requirements.
- Determine that all staff suspected or positive for COVID-19 have been sent home and the facility knows to coordinate any return to work with the local health department.
- Determine if facilities have sufficient PPE.
- Determine if facilities are screening individuals and staff, and at what frequency.
- Determine if others (contract staff, family members) are also being tested per facility policy.
- Determine if there is a control or quarantine order.
- Ensure the control/quarantine orders are followed.
- Perform a call-down to all other facilities in the county when staff at one facility tests positive for COVID-19.
- Determine if facilities are following rules and regulations related to admission and discharge and are readmitting individuals when appropriate.
- Determine if staff, individuals, and families are notified of positive COVID-19 cases in the facility.
- Track facilities by program type and number of positive and suspected cases.
- Track hospitalizations of COVID-19 positive ICF individuals.
- Track deaths of COVID-19 positive ICF individuals.
- Maintain communication with facilities after investigations are complete.

6. Facility Activities Required for LTC COVID-19 Response

In Advance (actions focused on response)

- Review the CDC information in Section 3 of this document.
- Review the HHSC information in Section 3 of this document.
- Review the WHO information in Section 3 of this document.

Immediate (0-24 hours)

- Activate individual isolation/facility cohort plan, including establishing a unit, wing, or group of rooms for any positive individuals.
- Supply PPE to care for individuals positive for COVID-19. See attachment 5 about donning (putting on) and doffing (taking off) PPE, and attachment 4 about optimizing the use of facemasks and do's and don'ts for facemask use.
- Screen individuals for signs and symptoms at least once a day per HHSC guidance.
- Screen staff for signs and symptoms at least at the beginning of their shift.
- Clean and disinfect facility.
- Confirm case definitions.
- Identify DSP outside activities.
- Activate individual transport protocols (for transporting individuals out).
- Establish contact with receiving agencies (hospitals, other facilities).
- Identify lead at facility and determine stakeholders involved external to facility.
- Engage with community partners (public health, health care, organizational leadership, local/state administrators).
- Review/establish testing plan.
- Activate all communication plans.
- Determine need for facility restrictions/lock-down.
- Evaluate supply resources.
- Maintain individual care.
- Report all confirmed COVID-19 cases to HHS and the local health department (LHD) with jurisdiction over the facility. In instances where there is no local health authority, report to DSHS directly.
- Report the first case in either an individual or employee and the first case that occurs in either an individual or employee after the facility has been without COVID-19 infection for 14 days or more to HHSC CII. Report the incident within 24 hours of receiving the COVID-19 positive test result.
- If needed, request deployment of the Rapid Assessment Quick Response Force.

Extended (24-72 hours)

- Supply PPE for staff.
- Screen individuals for signs and symptoms at least once a day per HHSC guidance.
- Screen staff for signs and symptoms at least at the beginning of their shift.

- Continue specialized infection control procedures.
- Activate individual transport protocols (for transporting individuals out/in).
- Establish contact with transporting/receiving agencies (hospitals, other facilities).
- Engage with external partners.
- Continue testing.
- Determine need for facility restrictions/lock-down.
- Consider additional healthcare needs.
- Maintain individual care.
- Establish an individual recovery plan, including when an individual is considered recovered and next steps for care.

Long Term (72 hours plus)

- Screen individual for signs and symptoms at least once a day per HHSC guidance.
- Screen staff for signs and symptoms at least at the beginning of their shift.
- [Continue cleaning and disinfecting procedures.](#)
- Activate transport (individuals in) protocols.
- Establish contact with transporting/receiving agencies (hospitals, other facilities).
- Lift of facility restrictions/lock-down.
- Consider additional healthcare needs.
- Maintain individual care.

7. State\Regional\Local Support

Federal [COVID-19 Local Fiscal Recovery Funds](#) are being distributed to Texas cities and counties. HHSC urges LTCR providers that need COVID-19 resources to:

- Contact your city, county or [regional advisory council](#) to find out if resources or funds will be available for health care staffing support, testing services, resident or site assessment, and disinfecting services as these resources are no longer available through HHSC;

- Call 844-90-TEXAS to ask for a Mobile Vaccination Team to come out to your facility;

- Contact DSHS to [become a COVID-19 vaccinator](#) or to [ask for COVID-19 vaccine;](#)

[BinaxNOW COVID-19 POC Antigen Test Kits]

[All long-term care providers can now request free BinaxNOW COVID-19 POC antigen test kits. The requested test kits can now be used to test any individuals, including residents, staff, and visitors.]

[To request consideration for the free BinaxNOW POC antigen COVID-19 test kits, an NF, ALF, ICF/IID, HCS program provider, or HCSSA must complete the Attestation for Free Test Kits, [LTCR Form 2198](#). An NF, ALF, ICF/IID, or HCS program provider must submit the completed attestation to the HHSC Regional Director or designee for the region in which the provider is located.]

[The Regional Director or designee will elevate the completed attestation form to the State Operations Center in TDEM. Staff from HHSC Long-term Care Regulation (LTCR) and the TDEM will review the completed attestation form for accuracy and completeness. Staff may require and request documentation from the provider to support the attestation.]

[The attestation criteria require a NF, ALF, ICF/IID, HCS, and HCSSA program to:

- have a current Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver or a CLIA laboratory certificate;
- administer the test only by provider staff who successfully complete training provided by [Abbott Laboratories](#) or who are clinicians with appropriate education and training;
- follow all reporting requirements associated with the use of the Binax cards; and
- report test results appropriately.]

[Any provider that meets the requirements listed above is eligible to request free BinaxNOW COVID-19 POC antigen test kits].

[A provider must have a current CLIA Certificate of Waiver or a CLIA laboratory certificate before it can receive and administer the free BinaxNOW COVID-19 tests. To obtain a CLIA Certificate of

Waiver for the free BinaxNOW COVID-19 tests, complete Form CMS-116 available on the CMS CLIA website or on the HHSC Health Care Facilities Regulation - Laboratories webpage found under the Application header. Email the form to the regional CLIA licensing group via the HHSC HCF Regulation – Laboratories webpage.]

[Providers that have existing CLIA Certificates of Waivers and are using a waived COVID-19 test are not required to update their CLIA Certificates of Waiver. As defined by CLIA, waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." The Food and Drug Administration determines which tests meet these criteria when it reviews a manufacturer's application for a test system waiver.]

[This information can be found in PL 2020-49 (PDF).]

[Additional Resources]

[Long-term care providers can request:

- COVID-19 mobile vaccine clinics for residents and staff
- BinaxNow testing kits. Read PL 2020-49 for details.
- PPE (providers should exhaust all other options before request)
- Facility cleaning and disinfection
- Healthcare-associated infection and epidemiological support]

[To Request Support:

To initiate a request for COVID-19 support described above, contact the HHSC LTCR Regional Director in the region where the facility is located.

HHSC LTCR staff are responsible for initiating a State of Texas Assistance Request on behalf of the long-term care provider.

This information can be found at this alert on the ICF Provider Portal.]

8. ICFs and COVID-19

ICF/IIDs provide residential and habilitation services to people with intellectual disabilities or a related condition.

Environment

A small ICF home is often integrated into the community and is typical of other residences in the community. These residential settings include a mix of semi-private and private individual bedrooms; many of the bedrooms are shared, accommodating two to three people. The bedrooms usually do not have physical barriers like walls or partitions separating the space allotted for each individual inside the room.

Rules require a minimum of 80 square feet for a private (one person) bedroom, 60 square feet per person in multiple occupant rooms, and a minimum dimension of 8 feet for a private room and 10 feet for a shared room. The common areas in an ICF are intended for use by the individuals of the facility. These areas include dining and living room spaces, activity areas, and common bathing units, which are provided at a ratio of one tub or shower for every 8 individuals.

A large ICF might be made up several cottages similar to a small ICF home, a larger building more similar in design to a nursing facility, or both. A large ICF is also typically a mix of semi-private and private individual bedrooms; many of the bedrooms are semi-private, accommodating two to three people. The bedrooms usually do not have physical barriers like walls or partitions separating the space allotted for each individual inside the room.

Rules require a minimum of 80 square feet for a private (one person) bedroom, 60 square feet per person in multiple occupant rooms, and a minimum dimension of 8 feet. Many of the common areas in a large ICF are intended for use by groups of people. These areas include dining and living room spaces, activity and therapy areas, and common bathing units, which are provided at a ratio of one tub or shower for every 15 individuals.

Impact of environment on COVID-19 response:

The relatively small size of a typical ICF residence makes it challenging for providers to effectively support physical distancing measures or accommodate quarantine or isolation measures. A single shared kitchen can pose infection control challenges when both individuals and staff access the kitchen throughout the day.

While adhering to the core principles of COVID-19 infection prevention and following CDC guidance, communal activities and dining can occur. Additionally, group activities can be facilitated for individuals who have fully recovered from COVID-19, as well as for those not in isolation for observation or with suspected or confirmed COVID-19 status. Facilities can offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with

alterations to adhere to the guidelines for preventing transmission. Group activities for individuals that adhere to the following criteria are acceptable:

- Limit the number of people in an area of the facility participating in an activity to a number that will ensure physical distance is maintained when not all participants are vaccinated.
- Individuals who are fully vaccinated may have close contact and do not have to physically distance according to CDC guidance.
- Staff and individuals perform appropriate hand hygiene before and after each activity.
- Clean and sanitize the activity area and all items used before and after each activity.

Facilities should consider additional limitations based on status of COVID-19 infections in the facility.

Facility Demographics

ICFs are located in metropolitan, urban, and rural locales. Each locale has specific characteristics that impact workforce availability, health care system support, and interactions with public health, emergency care, and jurisdictional administration. Texas currently has 786 community ICFs and 13 State Supported Living Centers (SSLCs).

Impact of facility demographics on COVID-19 response:

ICFs in more densely populated locations are likely to experience higher risk for exposure among staff and visitors. As a result, facilities in metropolitan and urban areas have a higher risk of infection and face more challenges controlling spread when infection occurs. ICFs in more rural locations have less health care system support, might not have local health authorities, and have smaller staffing pools, making it harder to cover shortages that result from suspected exposure. Facilities in both metropolitan and rural areas are likely to face staffing shortages because of competitive job markets and have challenges finding PPE.

Facility Considerations

Facilities have small or large bed capacity and differ in age, size, available space, and equipment. Available services also differ by facility, affecting the level of available care; ventilator support might not be present, and the types of health care providers available or on-site will also vary.

Impact of facility considerations on COVID-19 response:

Most ICFs have limited or no isolation rooms available. Most small ICFs are not equipped to care for individual with fragile medical conditions. Bed capacity along with staff and PPE availability also affects the number of individuals for which each facility can provide care. COVID-19 positive

individuals will increase the staff and resources required to provide care further limiting the number of individuals for which a facility can care.

Individual Demographics

All ICF individuals must have an intellectual disability (IDD) or related condition. While all have an IDD or related condition, each individual is unique and might require habilitation services, minimal supportive care, or significant medical care. Individuals' conditions will vary physically and mentally, impacting mobility and intellectual capacity.

Impact of individual demographics on COVID-19 response:

In addition to having an IDD or related condition, many ICF individuals need care from medical professionals who are in increasingly short supply as the pandemic continues. Also, the population of individuals with IDD and related conditions are often unable to express when they experience symptoms and could unknowingly (and without staff knowing) spread the virus if infected. This population is also less likely to understand why physical distancing and quarantine are necessary and can present challenging behaviors when staff attempt to enforce such restrictions. Having COVID-19 infections in a facility will increase the demands on and for staff.

ICF Staffing Considerations

The ICF workforce includes qualified intellectual disability professionals (QIDPs), house managers, medical professionals, and direct care staff including: registered nurses (RNs), licensed vocational nurses (LVNs), facility support staff and other skilled and non-skilled workers. Rules require ICFs to provide nursing services as needed, and most small ICFs use contract medical providers rather than staff providers to do so.

Impact of ICF staffing considerations on COVID-19 response:

Many ICF individual's daily activities, such as dining, bathing, grooming, and ambulating, require partial or total assistance from facility staff. Caring for someone with COVID-19 requires additional time and resources, including PPE, to maintain infection control and protect other individuals and staff. As staff are exposed, become symptomatic, or test positive for COVID-19, the available workforce will decline, making it even more challenging for ICFs to provide care.

Additionally, ICFs don't normally have a physician on-site. Typically, direct care staff are in the facility and health care professionals are available by phone. Staffing shortages resulting from possible exposure could lead to ICFs refusing to admit individuals because they won't have the ability to provide care. It is also common for ICF staff to work in more than one ICF, so if an employee is exposed, it is likely they will expose individuals and staff in more than one ICF, making it difficult to contain spread.

Impact of Visitors

During routine ICF operations, visitors including family members, volunteers, consultants, external providers, and contractors routinely enter facilities. Many perform essential services necessary for facility function.

Impact of visitors on COVID-19 response:

Despite efforts to screen visitors prior to allowing them to enter the facility, every person allowed inside the building increases the risk of infection. Some people will present as asymptomatic during screening but will have COVID-19 and unknowingly spread the virus. Some visitors will not follow standard precautions including proper hand-washing, use of hand sanitizer, use of PPE, isolation protocols, and limiting the number of areas in the building that they access, all of which increase the risk of infection for individuals and staff.

ATTACHMENT 1: Immediate Response Guidelines (0-24 hours)

FACILITY ACTIONS

REVIEW ***S.P.I.C.E.*** ACTIVITIES

Prevent further disease spread:

- Determine number of individuals potentially infected.
- Determine number of staff potentially infected.
- Invoke isolation precautions/plans.
- Determine who has been tested.
- If applicable, invoke quarantine or control order.
- Identify if exposed staff are working in other facilities. Staff movement between facilities should continue to be limited as much as possible.
- Report all confirmed COVID-19 cases to the local health department (LHD) with jurisdiction over the facility. In instances where there is no local health authority, report to DSHS directly.
- Report the first case in either an individual or employee and the first case that occurs in either an individual or employee after the facility has been without COVID-19 infection for 14 days or more to HHSC CII. Report the incident within 24 hours of receiving the COVID-19 positive test result.

Protect from infection:

- Enact PPE plans;
- Determine PPE supplies;
- Screen individuals/essential visitors;
- Contact other facilities where exposed individuals might have visited/worked;
- Consult with LHD or DSHS regarding testing; and
- Limit staff in contact with infected or exposed individuals.

Care for individuals who are infected:

- Isolate individuals who are infected and identify cohorts (exposed, infected);
- Determine level of required care;
- Determine if hospitalization and transport are required;
- Notify local health care/EMS;
- Track signs/symptoms;
- Establish an individual recovery plan, including when an individual is considered recovered and next steps for care; and
- Upon the first positive test result of an ICF staff member or individual, consider testing of all ICF staff and individuals.

Other:

- Contact HHSC, LHD/DSHS regional office/health authority (HA);
- Ensure all relevant regulations/rules are followed;
- Notify families, staff, individuals;
- Track tested, suspected, positive, isolated, quarantined, hospitalized, and deaths;
- Activate emergency response command structure;
- Identify specific points of contact (POCs) for communication with HHSC, local government, clinical staff, and press; and
- Maintain central database of external contacts and phone numbers.

HHSC ACTIONS

Prevent further disease spread:

- Conduct Priority 1 intake investigation;
- Review facility infection control practices; and
- Determine if staff work at other facilities.

Protect others from infection:

- Review isolation precautions/plans;
- Determine if facility has sufficient PPE;
- Determine if facility has enacted screening for individuals/staff;
- Determine if local quarantine order is in effect; and
- Ensure contact of other facilities where exposed individuals are working.

Care for individuals who are infected:

- Ensure appropriate isolation and quarantine;
- Ensure timely individual care; and
- Ensure clinical support.

Other:

- Review all relevant rules/regulations with facility;
- Track tested, suspected, positive, isolated, quarantined, hospitalized, and deaths;
- Identify POCs and maintain communication; and
- Contact DSHS to review response activities.

ATTACHMENT 2: Interim Guidance for Prevention, Management, and Reporting of COVID-19 Outbreaks in Long- Term Care Facilities

Purpose

This document provides guidance to ICFs for the prevention, management, and reporting of COVID-19 outbreaks. Prompt recognition and immediate isolation of suspected cases is critical to prevent outbreaks in residential facilities.

Background

Because of their congregate nature and individuals served (adults with IDD or a related condition, often with underlying medical conditions), ICF populations are one of the most at risk of serious illness caused by COVID-19. Every effort must be made to prevent the introduction and spread of disease within these facilities.

People at high risk for developing severe COVID-19 include those who are 65 or older, immunocompromised (including cancer treatment), or have other high-risk conditions such as chronic lung disease, moderate to severe asthma, and heart conditions. People of any age with severe obesity or certain underlying medical conditions, particularly if not well-controlled, such as diabetes, renal failure, or liver disease, might also be at risk.

COVID-19 is most likely to be introduced into a facility by ill DSP or visitors. ICFs should implement visitor restrictions, as per CDC guidance and HHSC rule, and strictly enforce sick leave policies for ill DSP.

Immediate Prevention Measures

Supplies for Recommended Infection Prevention and Control Practices

- Hand hygiene supplies:
  - Put alcohol-based hand sanitizer with 60–95 percent alcohol in every individual room (ideally inside and outside of the room) and other individual care and common areas (outside dining room, in living room); and
  - Make sure sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory hygiene and cough etiquette:

  - Make tissues and facemasks available for people who are coughing; and
  - Consider designating staff to steward those supplies and encourage appropriate use by individuals, essential visitors, and staff.

- Make necessary PPE available in areas where individual care is provided. Put a trash can near the exit inside the individual room to make it easy for staff to discard PPE prior to

exiting the room or before providing care for another individual in the same room. Facilities should have supplies of:

- o Facemasks;
- o N95 respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested DSP);
- o Gowns;
- o Gloves; and
- o Eye protection (face shield or goggles).

- See guidance in the section related to [PPE use when caring for individuals with COVID-19](#).
- Consider implementing a respiratory protection program compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training and fit testing.
- Ensure environmental cleaning and disinfection.
- Make sure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning and disinfection of high-touch surfaces and shared individual care equipment:

  - o Refer to [List N](#) on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against COVID-19;
  - o [Clean and disinfect](#) all high-touch surfaces frequently including items like doorknobs, light switches, handrails, countertops, remote controls, bathroom surfaces/fixtures;
  - o Workstations include items like computers, chairs, keypads, common-use items (pens, pads, phones) - clean and disinfect frequently; and
  - o Equipment includes items like blood pressure cuffs, hoyer lifts, adaptive equipment, wheelchairs and other shared equipment used for individual care - clean and disinfect after each use.

Screening and Education

HHSC Screening criteria – A person must be screened in accordance with the following:

1. Experiencing COVID-19 symptoms and any additional signs and symptoms as outlined by the CDC in Symptoms of Coronavirus at cdc.gov:
   - fever (100.4 and above as measured with a thermometer);
   - chills;
   - new or worsening cough, sore throat, shortness of breath, or difficulty breathing;
   - fatigue, muscle, or body aches;
   - headache;
   - new loss of taste or smell;
   - congestion or runny nose;
   - nausea or vomiting; and
   - diarrhea.
2. Having had unprotected contact, regardless of vaccination status, in the last 14 days with someone who:

- has a confirmed diagnosis of COVID-19;
- is under investigation for COVID-19; or
- is ill with a respiratory illness.

3. Testing positive for COVID-19 in the last 10 days.

Active screening – HHSC [COVID-19 rules](#) require an ICF to screen all staff prior to entering the facility at the beginning of their shift in accordance with HHSC guidance. Actively take their temperature and document absence of or shortness of breath, new or worsening in cough, and sore throat. If they are ill, immediately send them home to self-isolate. For the SSLCs, HHSC recognizes that documenting the absence of symptoms on all staff daily might pose a challenge and will educate surveyors accordingly.

DSHS has created a [screening log template](#) for facility. Facilities should also screen any essential visitors who are permitted to enter the building, including health care providers. Maintain a log of all visitors who enter the building that at minimum includes name and current contact information and documents the results of the screening.

A provider must screen individuals according to HHSC guidance:

- upon admission or readmission, and
- at least once a day.

Education – Share the latest information about COVID-19 and review CDC guidance. Educate individuals and families about COVID-19, actions the facility is taking to protect them and their loved ones (including visitor restrictions) and actions individuals and families can take to protect themselves in the facility. Educate and train DSP and reinforce sick leave policies and adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE. Have DSPs demonstrate competency with putting on and removing PPE. Remind DSPs not to report to work when ill.

Educate consultant personnel (therapists of different disciplines, behavior support specialists, etc.). Including consultants is important because they often provide care in multiple facilities and can be exposed to, or serve as, a source of pathogen transmission.

Non-essential personnel – Review and revise how the facility interacts with vendors and delivery personnel, agency staff, EMS personnel and equipment, transportation providers (when taking individuals to offsite appointments, etc.), and other non-health care providers (food delivery, etc.). This should include taking necessary actions to prevent any potential transmission. For example, do not have supply vendors bring supplies inside the facility. Instead, have vendors drop off supplies at a dedicated location, such as a front or back patio.

Essential services such as therapists of different disciplines, behavior support staff, or direct support professionals should still be permitted to enter the facility provided they are wearing all appropriate PPE, per [CDC guidance,](#) and undergo the same fever and symptom screening process as facility staff. Facilities can allow entry of these essential staff only after screening.

HHSC surveyors should not be restricted. HHSC surveyors are conducting surveys and investigations remotely, by regional offsite review, or through the use of telecommunications to the extent practicable, as well as limiting surveys and investigations to essential activities only. CMS and state survey agencies are constantly evaluating their surveyors to ensure they don't pose a transmission risk when entering a facility. For example, surveyors might have been in a facility with COVID-19 cases in the previous 14 days, but because they were wearing PPE effectively per CDC guidelines, they pose a low risk to transmission in the next facility and must be allowed to enter. However, there are circumstances under which surveyors should still not enter, such as if they have a fever or any additional signs or symptoms of illness.

9. Control Measures

Control Measures for Individuals

Most of the actions to prevent or control COVID-19 outbreaks in ICFs are not new, and include: increasing hand hygiene compliance among staff, individuals, and essential visitors through education and on-the-spot coaching; and providing hand hygiene supplies at the entrance to the facility. Additional critical control measures are described below.

Monitoring

Ask individuals to report if they feel feverish or have symptoms of respiratory infection and COVID-19. Actively monitor all individuals upon admission and at least three times daily for fever and respiratory symptoms and COVID-19 (including shortness of breath, new or worsening cough, and sore throat). If the individual has fever or symptoms, implement recommended infection prevention and control measures. For the SSLCs, HHSC recognizes that daily fever checks for every individual might pose a challenge and will educate surveyors accordingly.

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:

- Fever or chills
- New or worsening cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Isolation

If a case of COVID-19 is identified in the facility, immediate action must be taken to isolate the individual who is positive for COVID-19 away from other individuals.

Symptoms of COVID-19 can vary in severity. Initially, symptoms can be mild and not require transfer to a hospital if the facility can follow the infection prevention and control practices recommended by the CDC. Individuals with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room but should be placed in a private room with their own bathroom if possible.

If an individual requires a higher level of care or the facility cannot fully implement all recommended precautions, the individual should be transferred to another facility capable of implementation. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer. While awaiting transfer, symptomatic individuals should wear a facemask (if tolerated) and be separated from others (kept in their room with the door closed). Appropriate PPE should be used by staff when encountering the individual.

Any roommates should be moved and monitored for fever and symptoms three times a day (once each shift) per CDC guidance. Room-sharing might be necessary if there are multiple individuals with known or suspected COVID-19 in the facility. As roommates of symptomatic individuals might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about individual placement.

Create a plan for cohorting individuals with symptoms of respiratory infection and COVID-19, including dedicating DSP to work only on affected units. Per the COVID-19 rules and as part of the facility infection control plan, individuals must be cohorted only with other individuals who have the same COVID-19 status (positive, negative or unknown) and there should be designated staff for each cohort. Staff should not work with more than one cohort per shift or from day to day unless it's required to provide necessary staffing coverage.

If the individual is transferred to a higher level of care, perform a final, full clean of the room, and use an EPA-registered disinfectant that has qualified under EPA's emerging viral pathogens program for use against COVID-19. These products can be found on EPA's List N.

See attachment 10 for actions to consider when isolating an individual with COVID-19.

Source control

The facility must create and implement infection prevention and control policies. The facility may use CDC, CMS, and DSHS guidance to create infection prevention and control policies. The CDC recommends that all individuals who are ill should wear a facemask at all times as tolerated, except for when they are eating or drinking, taking medications, or performing personal hygiene like bathing or oral care. If the individual cannot tolerate a surgical mask, personnel who enter the room must wear N95 respirators, if available and staff are fit-tested. If they are not available or staff are not trained or fit-tested, facemasks should be worn. Respiratory protection should be worn in addition to gown, gloves, and face shield.

Ensure staff have been appropriately trained and fit-tested before using N95 masks. See guidance in the section related to PPE use when caring for individuals with COVID-19.

If COVID-19 is identified in the facility, have DSP wear all recommended PPE for care of all individuals (regardless of symptoms) on the affected unit (or facility-wide, depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. DSP should be trained on PPE use, including putting it on and taking it off.

The CDC also recommends that, in general, fully vaccinated staff should continue to wear source control while at work. However, fully vaccinated staff could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If unvaccinated staff are present, everyone should wear source control and unvaccinated staff should physically distance from others.

Physical Distancing

As per the most updated CDC guidance:

- If all individuals are fully vaccinated, then they may choose to have close contact and do not have to physically distance from other fully vaccinated people.

- If unvaccinated individuals are present in the residence or participating in an activity, then unvaccinated individuals should physically distance from others.

Quarantine

The CDC guidance recommends that individuals be restricted to their bedroom if they are confirmed or suspected of having COVID-19. It does not recommend restricting individuals to their bedroom if they are not confirmed or suspected of having COVID-19. Except those who are fully vaccinated or fully recovered from COVID-19, if an individual is a new admission or readmission, leaves the ICF overnight and returns, has had known exposure or close contact with a person who is COVID-19 positive, or who is exhibiting symptoms of COVID-19 while awaiting test results, the individual is considered to have unknown COVID-19 status. An individual who has not been fully vaccinated against COVID-19 and is considered to have unknown COVID-19 status should be kept away from others while they are under observation. The individual should be monitored for signs and symptoms of COVID-19.

[For new admissions or readmissions who are unvaccinated, quarantine for 14 days is recommended if:]

- The individual has not recovered from COVID-19 within the last 90 days, or

- Has had close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with confirmed COVID-19 or area.

Quarantine is no longer recommended for individuals who are being admitted to an ICF if they are full vaccinated and asymptomatic.]

Individuals with unknown COVID-19 status must be quarantined per CDC guidance. For individuals who **have not been fully vaccinated against COVID-19**, the CDC still endorses a 14-day quarantine period. It offers two alternatives and guidance to reducing quarantine time. Local public health authorities make the final decisions about how long quarantine should last, based on local conditions and needs. CDC's two alternatives are:

- Alternative #1 - Quarantine can end after Day 10 without testing if the person has no symptoms as determined by daily monitoring.

- Alternative #2 - Quarantine can end after Day 7 if the person tests negative and has no symptoms as determined by daily monitoring. The test must occur on Day 5 or later. Quarantine cannot be discontinued earlier than after Day 7.

Guidance includes the following information:

- Persons can discontinue quarantine at either alternative described above only if the following criteria are also met:

  o No COVID-19 symptoms were detected by daily symptom monitoring during the entirety of quarantine up to the time at which quarantine is discontinued; and

  o Daily symptom monitoring continues through Day 14; and

  o Persons are counseled about the need to adhere strictly through Day 14 to all mitigation strategies, such as wearing a mask, avoiding crowds, practicing physical distancing, and practicing hand and cough hygiene. They should be advised that if any symptoms develop, they should immediately self-isolate and contact their healthcare provider to report this change in clinical status.

- Testing under Alternative #2 above should be considered only if it will have no impact on community diagnostic testing. Testing of persons seeking evaluation for an actual infection must be prioritized.

- Persons can continue to be quarantined for 14 days without testing per existing recommendations. This option is maximally effective.

Both alternatives raise the risk of being a less effective than the 14-day quarantine as currently recommended. However, the specific risks are as follows:

- For Alternative #1, the residual post-quarantine transmission risk is estimated to be about 1% with an upper limit of about 10%; and

- For Alternative #2, the residual post-quarantine transmission risk is estimated to be about 5% with an upper limit of about 12%.

See Attachment 10 for actions to consider when separating an individual who might have been exposed to COVID-19, including individuals whose status is unknown, and when the individual visits common areas.

CDC guidance has changed related to quarantine for individual **who are considered fully vaccinated against COVID-19**. The CDC describes fully vaccinated individuals as an individual >2 weeks following receipt of the second dose in a 2-dose series, or >2 weeks following receipt of one dose of a single-dose vaccine. Quarantine is no longer recommended for asymptomatic

fully vaccinated individuals who were exposed to COVID-19 or those individuals who have had COVID-19 infection in the prior 90 days.

CDC Guidance changed related to quarantine for **COVID-19 recovered individuals**. The CDC indicates that people who have tested positive and have subsequently recovered for COVID-19 do not need to quarantine or get tested again for up to 90 days as long as they remain asymptomatic. Therefore, if a individual has recovered from COVID-19 within the previous 90 days, he or she does not have to be quarantined. The individual can return to the non-quarantine area of the facility (e.g., cold zone or COVID-19 negative cohort area) upon admission, readmission, or return to the facility.

The facility still needs to consider what additional precautions it should take for such individuals, such as whether staff will wear full PPE when caring for individuals who have recently recovered from COVID-19. The facility also can quarantine these individuals out of an abundance of caution if it has reasonable health and safety concerns. Additionally, as the individual approaches 90 days since illness onset, the facility should consider recent actions or interactions of the individual, such as participation in high-risk activities or contact with persons who are confirmed or suspected of having COVID-19. This will help the facility determine the need for quarantine, as the 90-day timeframe is not an absolute guarantee against transmission and long-term care individuals are a high-risk population.

The CDC acknowledges that there is still uncertainty on contagiousness and susceptibility to reinfection with COVID-19. At this time, the CDC cannot say for certain that there is no chance of reinfection in the 90-day post recovery period. However, the CDC maintains that the risk of transmission in recovered persons is outweighed by the personal and societal benefits of avoiding unnecessary quarantine.

If a recovered individual experiences COVID-19 symptoms at any point during the 90-day post recovery period, he or she would need to be tested, quarantined, or isolated, depending on test result, as well as evaluated by an attending physician to determine whether it is a case of reinfection with COVID-19 or another illness.

Reminder: There may be circumstances when Transmission-Based Precautions (quarantine) for these individuals might be recommended (e.g., individual is moderately to severely immunocompromised, if the initial diagnosis of COVID-19 might have been based on a false positive test result).

Please see the CDC's [When to Quarantine](#) and [Reinfection](#) for more information.

Bathing, Showering, and Hygiene

Individuals with active signs and symptoms of respiratory illness [and COVID-19](#) should remain in their bedroom while being evaluated and treated. However, care and services for other individuals should continue with appropriate precautions.

Ideally, individuals with COVID-19 should be accommodated in a private bedroom with a private bathroom if at all possible. If a private bathroom is not available, the ICF should at least designate a bathroom that is separate from the ones used for individuals who do *not* have COVID-19.

Alternately, the ICF could use other strategies for ensuring individual safety while delivering care, including staggering schedules for individual showering or bathing. for individuals with COVID-19 so there would be less overlap with individuals who do not have COVID-19.

ICFs should continue to follow existing CDC recommendations for cleaning and disinfection of equipment and surfaces in shared spaces, like bathrooms or equipment that must be shared between individuals, **between every individual use**, using the appropriate EPA-approved products for COVID-19 prevention.

DSPs should also be able to wear and maintain safe use of all recommended PPE while assisting individuals with personal hygiene. Some PPE, including respirators and facemasks, could be compromised if they get wet.

Individuals who can bathe independently - If an individual is able to bathe independently, they should continue to do so.

Individuals who need assistance to bathe - If an individual needs assistance with bathing and:

- the individual has COVID-19 and is symptomatic or asymptomatic, DSP must also be able to wear and maintain safe use of all recommended PPE while assisting individuals with personal hygiene; or
- the individual has recovered from COVID-19, per the test-based or non-test-based strategy (or otherwise), OR the individual has consistently tested negative and is asymptomatic, follow established policies and procedures for other care that requires close contact for bathing and showering.

Cleaning and disinfecting the bathing or shower area - If individuals with COVID-19 have access to a private bathroom or only share a bathroom with other individuals who have the same COVID-19 status, the ICF should clean and sanitize the bathroom frequently.

If the bathroom is shared by both individuals who have COVID-19 and those who don't, clean and disinfect the area **between every individual use**.

Individual education - Educate individuals and any essential visitors regarding the importance of handwashing. Assist individuals in performing hand hygiene if they are unable to do so themselves. Education should also be provided to individuals to cover their coughs and sneezes with a tissue, then throw the tissue away in the trash and wash their hands. If individuals are unable to understand or perform the appropriate hygiene, DSPs should assist as necessary.

Recovery

Establish an individual recovery plan, including when an individual is considered recovered and next steps for care. A recovery plan is the guidance for determining when to discontinue transmission-based precautions and continued are of an individual. The recovery plan may be different depending on whether a test-based or non-test-based strategy is used. Criteria should include:

- Discontinuation of transmission-based precautions without testing.
- Discontinuation of transmission-based precautions with testing.
- Whether using a testing-based strategy for discontinuation of transmission-based precautions is preferred.

Discontinuation of Transmission-Based Precautions for Individuals with COVID-19

The decision to [discontinue transmission-based precautions for individuals with confirmed COVID-19 infection](#) should be made using a symptom-based strategy as described below. The time period since symptoms first appeared depends on the individual's severity of illness, and if they are severely immunocompromised. A test-based strategy is no longer recommended, except as noted below.

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions

Individuals with mild to moderate illness who are not 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

Individuals with severe to critical illness or who are severely immunocompromised:

- At least 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

Test-Based Strategy for Discontinuing Transmission-Based Precautions.

In some instances, a test-based strategy could be considered for discontinuing transmission-based precautions earlier than if the symptom-based strategy were used. A test-based strategy could also be considered for some individuals (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist about the individual being infectious for more than 20 days.

The criteria for the test-based strategy are:

Individuals 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 PCR tests at least 24 hours apart

Individuals who are not symptomatic:

- Results are negative from at least two consecutive PCR tests at least 24 hours apart

Control Measures for Staff

Active screening

The CDC and CMS recommend ICFs screen all staff prior to entering the facility at the beginning of their shift in in accordance with HHSC guidance. Actively take their temperature and document shortness of breath, new or worsening cough, and sore throat. If they are ill, immediately send them home to self-isolate. For the SSLCs, HHSC recognizes that documenting the absence of symptoms on all staff daily might pose a challenge and will educate surveyors accordingly.

Staffing contingency plan

Develop a staffing contingency plan in case a large number of staff must self-quarantine or isolate because of potential exposure, being suspected of, or positive for COVID-19. ICFs must:

- have sufficient direct care staff to manage and supervise individuals in accordance with their individual program plans - 42 CFR §483.430(d)(1);
- have an active program for the prevention, control, and investigation of infection and communicable diseases - 42 CFR §483.470(l)(1); and
- develop and maintain an emergency preparedness plan that is based on a facility-based and community-based risk assessment, utilizing an all-hazards approach, and includes emerging infectious disease - 42 CFR §483.475(a).

Hand Hygiene and PPE

Hand hygiene - Reinforce the importance of hand hygiene among all facility staff, including any contract staff. Facilities can increase the frequency of hand hygiene audits and implement short in-service sessions on the proper technique for hand hygiene.

Ensure that supplies for performing hand hygiene are readily available and easily accessible by staff. Advise staff not to keep hand sanitizer bottles in their pockets. This practice causes hands and sanitizer bottles to become contaminated. Instead, consider keeping alcohol-based hand rub (ABHR) bottles in easily accessible areas and in different rooms throughout the facility.

PPE - Ensure the facility maintains an adequate supply of PPE and that all required PPE is easily accessible to staff entering individual rooms. For individuals with COVID-19, CDC recommends staff adhere to standard and transmission-based precautions. If the facility does not have a supply of N95 respirators, or does not have any fit-tested staff, facemasks should be worn for droplet protection. Follow the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings, which includes detailed information regarding recommended PPE.

Consider designating staff to steward these supplies and encourage appropriate use by staff and individuals.

PPE and Infection Control Education and Training - Ensure staff are educated and trained on which PPE they should use, proper procedure for donning (putting on) and doffing (taking off) PPE, and how to determine if the PPE is contaminated or damaged.

ICFs must identify whether the following concerns exist and specifically address them through education and training:

- Improper use of PPE:
    - lack of understanding of proper use of each type of PPE;
    - lack of fit-testing (see PPE Use When Caring for Individuals with COVID-19); and/or
    - lack of user seal check.
- Improper donning and doffing procedures:
    - lack of understanding of appropriate donning and doffing sequence;
    - safety and quality control measures; and/or
    - lack of appropriate donning and doffing locations.
- Cross contamination:
    - lack of understanding of cold, warm, and hot zones within a facility;
    - cold zone - area with no COVID-19 infection present;
    - warm zones - area used to monitor individuals suspected of COVID-19 infection; and/or
    - hot zones - area where COVID-19 infection is present.

If the ICF is following the CDC's or DSHS' guidance for optimizing the supply of PPE, inform staff of the expectations specific to the type of PPE they are using. PPE education and training for staff should include at least the following information:

- PPE – simple, easy to understand training that includes:
    - use of PPE in an ICF *without* a known positive case of COVID-19;
    - use of PPE in an ICF *with* a suspected or positive case of COVID-19;
    - donning and doffing sequence and procedures;
    - procedures, if any, for optimizing the use of PPE;
    - procedures for determining if the PPE is contaminated or soiled; and
    - procedures for disposal of PPE (contaminated or uncontaminated).
- Infection Control – simple, easy to understand training that includes:

- o Concept of infection control zones including:
    - cold - clean or uncontaminated area;
    - warm - potentially contaminated area;
    - hot - contaminated area; and/or
    - understanding of how cross contamination occurs.
- o Protocols, policies, and procedures for use during:
    - monitoring for COVID-19;
    - suspected COVID-19; and
    - confirmed COVID-19.

Note: See attachment 5 about donning (putting on) and doffing (taking off) PPE, and attachment 4 about optimizing the use of facemasks and do's and don'ts for facemask use.

Dedicated staff/COVID-19 response teams - Staff caring for individuals in a COVID-19 positive or unknown COVID-19 status cohort area should be fit-tested for N95 respirators and prepared to provide an advanced level of care for cases if necessary, or until individuals with COVID-19 can be transferred to a higher level of care. COVID-19 care teams can be implemented if not all staff can be trained and fit-tested for N95 masks, or if supplies of them are insufficient to equip the entire staff. See guidance in the section related to PPE use when caring for individuals with COVID-19.

Restrict staff movement between facilities -. The facility must develop and implement a policy regarding staff working with other long-term care (LTC) providers that limits the sharing of staff with other LTC providers and facilities, unless required in order to maintain adequate staffing at a facility.

Sick leave - Facilities should review and potentially revise their sick leave policies. Staff who are ill should not come to work. Sick leave policies that do not penalize staff with loss of status, wages, or benefits will encourage staff who are ill to stay home.

Work exclusion – Staff who are confirmed or suspected to have COVID-19 must stay at home. See below for guidance on when they may return to work.

[Quarantine Options for Staff]

[The criteria for when an employee can return to work depends on whether the employee has symptoms of COVID-19 or has been diagnosed with COVID-19 and is in isolation, or whether the employee has been exposed to COVID-19 and requires quarantine.]

[Follow the CDC's Potential Exposure at Work/Return to Work Criteria when an employee has confirmed or probable COVID-19 and requires isolation.]

[To determine whether an employee had potential exposure at work to someone with confirmed COVID-19 and must be excluded from work and quarantined, read the CDC's Potential Exposure at Work risk assessment tool.]

[Per the latest CDC guidance, DSP who have received all COVID-19 vaccine doses, including a booster dose, do not have to be restricted from work, as long as they have a negative antigen or PCR test on days 2 and days 5-7 after the exposure (day 0).]

[All other DSP who are not boosted (vaccinated or unvaccinated, including those within 90 days of prior infection) must quarantine for:

- at least 10 days since the date of exposure (day 0) when the DSP remains asymptomatic; OR

- at least 7 days since the date of exposure (day 0) when the DSP remains asymptomatic and the DSP tests negative via antigen or PCR test. The DSP should be tested within 48 hours prior to returning to work (in anticipation of testing delays).]

[The provider must determine what steps are necessary to protect the health and safety of the individual in quarantine, as well as the health and safety of other employees and individuals. If an employee returns to work following a reduced quarantine period, facilities can require the employee to wear full PPE regardless of where the individual works in the ICF, or limit work activities. Facilities can utilize other precautions or restrictions to minimize the risk of viral transmission.]

Return to Work Criteria for DSP with COVID-19

Symptom-based strategy for determining when DSP can return to work

DSP with mild to moderate illness who are not severely immunocompromised can return to work:

- [At least 7 days if a negative antigen or PCR test is obtained within 48 hours prior to returning to work have passed since symptoms first appear (or 10 days if testing is not performed or if a positive test at day 5-7)] **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.

[DSP with severe to critical illness and are *not* moderately to severely immunocompromised can return to work:
- In general, when 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 there is an improvement of symptoms.
- The test-based strategy as described for moderately to severely immunocompromised DSP can be used to inform the duration of isolation.]

[DSP who are moderately to severely immunocompromised may test positive beyond 20 days after symptom onset or, for those who are asymptomatic throughout their infection, the date of their first positive viral test]:

- [Use of a test-based strategy as described in Interim Guidance for Managing Healthcare Personnel can be used to inform the duration of isolation.
- Consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.]

Test-Based Strategy for Discontinuing Transmission-Based Precautions

In some instances, a test-based strategy could be considered for discontinuing transmission-based precautions earlier than if the symptom-based strategy were used. A test-based strategy could also be considered for some DSP (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist about the DSP being infectious for more than 20 days.

The criteria for the test-based strategy are:

DSP 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 PCR tests at least 24 hours apart

DSP who are not symptomatic:

- Results are negative from at least two consecutive PCR tests at least 24 hours apart

Note: If the employee was diagnosed with a different illness (e.g., influenza) and was never tested for COVID-19, base their return to work on the criteria associated with that diagnosis.

[Boosted Staff (Asymptomatic)]

[DSP are considered "boosted" if they have received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC. At this time, boosted staff with higher-risk exposures who are asymptomatic do not need to be restricted from work, as long as they test negative immediately (but not earlier than 24 hours after the exposure, and, if negative again 5-7 days after exposure.]

[Higher-risk exposure refers to exposure of an individual's eyes, nose, or mouth to material potentially containing COVID-19, particularly if present in the room for an aerosol-generating procedure. This can occur when staff do not wear adequate personal protective equipment during care or interaction with an individual.]

[Work restrictions for staff with higher-risk exposures should still be considered for:
- Staff who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment).
  - These conditions might impact the level of protection provided by the COVID-19 vaccine. However, data on which immunocompromising conditions might affect response to the COVID-19 vaccine and the magnitude of risk are not available.
- Staff who have traveled.

- o DSP with [travel](#) or [community](#) exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with COVID-19 in the community (e.g., household contacts) should be managed as described [for higher-risk occupational exposures](#).]

[Fully vaccinated and boosted people who do not quarantine should still watch for symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19, including testing for COVID-19, if indicated.]

Reporting COVID-19

All ICFs are required to report to HHSC CII within 24 hours of:

- A facility's *first* positive case of COVID-19 in staff or individuals, or
- A new positive case of COVID-19 after a facility has been without new cases for 14 days or more.

Do not report COVID-19 positive cases to HHSC CII outside of the two reportable events listed above. A facility must not report any additional COVID-19 positive cases to HHSC CII after the first positive case has been reported, unless the facility has been COVID-19 free for 14 days. Additionally, the reportable events listed above do not include a individual who was admitted to the facility with an active COVID-19 infection or a individual who developed COVID-19 within 14 days of being admitted to the facility. A decision tree can be found on [Attachment 11](#).

If a facility has a new reportable COVID-19 positive case, and has not reported a COVID-19 positive case to HHSC within the past 14 days, the facility must:

- report the case to HHSC CII using one of these three methods:
    - o the Texas Unified Licensure Information Portal (TULIP),
    - o by email to ciicomplaints@hhs.texas.gov or
    - o by calling 1-800-458- 9858 within 24 hours of the confirmed positive result; and
- complete and submit Form 3613-A Provider Investigation Report within five days from the day a confirmed case is reported to CII. The provider investigation report can be submitted:
    - o via TULIP
    - o by email to ciiprovider@hhs.texas.gov; or
    - o by fax to 877-438-5827

- Report all confirmed COVID-19 cases immediately to the health authority with jurisdiction over the facility. If there is no local health authority, report to DSHS directly.

- Report all significant incidents or changes in the client's condition to the client's parents or guardians (including but not limited to serious illness), no later than 24 hours after the incident.

- ICFs offering point-of-care testing related to COVID-19 must report data for all testing completed, for each individual tested. Reporting is to be made within 24 hours of results being known or determined, on a daily basis. The following steps outline what is needed to begin reporting in order to meet state and federal requirements.
  Once you have CLIA or a CLIA waiver:

  o Register here: https://www.dshs.texas.gov/coronavirus/lab-reporting.aspx.
  o Submit the online registration webform.
  o Complete DSHS onboarding process.
  o Submit required testing data to DSHS.
  o Locate your local health department or DSHS Region at https://dshs.texas.gov/regions/2019-nCoV- Local-Health- Entities/.
  o The LHD or DSHS region will provide the input forms and process for you. The required data elements are submitted to your Local Health Department or DSHS Region using the forms and process they provided.
  o The required data is submitted to the LHD or DSHS Region for the area in which the facility is located, using the forms and processes indicated.
- Report all deaths (COVID-19 and non-COVID-19) that occur in an ICF/IID within one hour to CII. See:
  - PL 17-02 (licensed facilities).
  - PL 17-03 (non-licensed facilities).
  - If the death might have resulted from abuse, neglect, or exploitation, additional reporting requirements might apply.

You can find contact information for your local/regional health department on the DSHS Local Health Entities website.

HHSC LTCR Regional Offices may contact facilities to request information related to COVID-19 cases. Reporting to a LTCR Regional Office is not related to reporting COVID-19 positive cases to HHSC CII.

Outbreak Management

If an outbreak of COVID-19 is suspected or identified in your facility, strict measures must be put in place to halt disease transmission.

Outbreak definitions – A confirmed outbreak of COVID-19 is defined as one or more laboratory confirmed cases of COVID-19 identified in either an individual or paid/unpaid staff. All confirmed outbreaks will be reported to the LHD or PHR immediately, or DSHS when a LHD or PHR are not available in that region.

A suspected outbreak is defined as one or more cases of respiratory illness within a one-week period without a positive test for COVID-19. Use the suspected outbreak definition if your facility is awaiting test results from either an individual or paid/unpaid staff. You can contact your local

health authority for assistance during this period but are not required to report suspected outbreaks. If you suspect an individual or staff member might have COVID-19, do not wait for test results to implement outbreak control measures.

If you have two or more individuals or staff with similar symptoms, report to your local health authority (or DSHS when there is no local health authority) as you would for any other cluster of illness.

For Individuals: Facility-onset COVID-19 infections must originate in the facility more than 14 days after admission to be considered an outbreak.

- For example, a current individual (who is past their 14-day post admission period) that tests positive IS considered outbreak.

This definition does not include individuals who were known to have COVID-19 infection upon admission and were placed on transmission-based precautions. Nor does the definition include individuals who were placed on transmission-based precautions upon admission and developed COVID-19 infection within 14 days after admission. These exceptions would not constitute outbreak criteria.

For DSP: A recent positive COVID-19 test would be considered an outbreak for the facility, if the DSP was at work during their infectious period.

Based on the CDC definition of close contact, if the infected DSP was at the facility any time during the two days before their positive test result, or two days before symptom onset, then they were at the facility during their infectious period and that would be considered an outbreak.

However, if the DSP tests positive, but has not been at the facility for more than two days before their positive test result, or two days before symptom onset, then that does not qualify as an outbreak.

Maintain a low threshold of suspicion for COVID-19, as early symptoms can be non-specific and include atypical presentations such as diarrhea, nausea, and vomiting, among others.

Implement universal use of facemasks for DSP while inside the facility. Follow the CDC's [guidance for optimizing the supply of facemasks](#) when deciding how long staff should wear one facemask. Masks should be discarded upon exit, and a new mask should be worn upon reentry.

Note that homemade facemasks should only be used when all other options have been entirely exhausted and should only be used as source control. These masks are not considered protective.

Consider having DSP wear all recommended PPE for COVID-19 (gown, gloves, eye protection, a facemask or N95) for the care of all individuals, regardless of presence of symptoms. Implement protocols for extended use of eye protection and facemasks. Refer to DSHS' [strategies for optimizing the supply of PPE](#).

Implement protocols for cohorting positive COVID-19 cases with dedicated DSP. These DSP should be appropriately trained and fit-tested for N95 masks if at all possible. If staff cannot be fit-tested for N95s, they should NOT use them and use facemasks instead. Consider designating entire units within the facility, with dedicated DSP, to care for known or suspected COVID-19 cases. See guidance in section related to [PPE use when caring for individuals with COVID-19](#).

Movement and monitoring decisions for DSP with exposure to COVID-19 should be made in consultation with local public health authorities. To learn more, refer to the CDC's [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19](#).

Maintain a line list of all confirmed and suspected COVID-19 cases within your facility. Include details such as name, date of birth, age, gender, whether staff or individual, room number (shared or private) or job description, date of symptom onset, fever, symptoms, and others. If your facility does not already have a [line list template](#), you can find one on the DSHS website.

PPE Use When Caring for Individuals with COVID-19

DSP should wear an N95 respirator and all suggested PPE when caring for individuals with COVID-19. If there is widespread COVID-19 infection in the building, staff should wear an N95 respirator and all suggested PPE when caring for individuals.

Per the CDC, "all suggested PPE" includes:

- N95 respirator;
- eye protection;
- gloves; and
- gown.

Cloth gowns - Follow manufacturer's recommendations for cleaning and laundering, including the number of times the gown can be laundered and re-worn. This might differ by manufacturer and type of cloth gown. Immediately remove the gown to be laundered if it becomes soiled.

Certain types of gowns, sometimes called Level 1 or "minimal risk" gowns, do not provide protection from splashes/sprays of blood or body fluids, depending on the material the gown is made of. For these situations:

- Use a disposable, impervious isolation gown when a splash, spray, or cough might be expected.
- If an ICF does not have disposable, impervious isolation gowns, use a disposable plastic apron over the cloth gown in these situations.

The ICF also should train staff on how to correctly don/doff any cloth or other alternative isolation gown; include a competency check.

Review the CDC's [Strategies for Optimizing the Supply of Isolation Gowns](#) for more information.

N95 respirator fit testing - Under serious outbreak conditions in which respirator supplies are severely limited, DSP may not have the opportunity to be fit-tested on a respirator before using it. ICFs should make every effort to ensure DSPs who need to use tight-fitting respirators are fit-tested to identify the right respirator for the DSP. Under serious outbreak conditions, there may be limited availability of respirators or fit-test kits.

If ICFs cannot fit-test DSPs for N95 respirators, they should follow the NIOSH guidance for respirator use in a serious outbreak.

While it is not ideal, even without fit-testing, a respirator will provide better protection than a facemask or using no respirator at all. ICFs should assist the DSP in choosing a respirator that fits best.

Even if DSPs begin using respirators without proper fit-testing, ICFs should make every effort to perform fit-testing as respirator supplies allow. ICFs should always perform fit-testing for workers who cannot successfully seal check their own respirators.

DSPs should review the following OSHA Respiratory Protection Training Videos:

- Respiratory Protection for Healthcare Workers;
- The Differences Between Respirators and Surgical Masks;
- Respirator Safety: Donning & Doffing;
- Respirator Types;
- Respirator Fit Testing;
- Maintenance and Care of Respirators;
- Medical Evaluations;
- Respiratory Protection Training Requirements;
- Voluntary Use of Respirators; and
- Counterfeit and Altered Respirators: The Importance of NIOSH Certification.

Review attachment 7, the "Three Key Factors Required for a Respirator to be Effective" infographic.

ICFs should document that the DSP has reviewed the OSHA respiratory protection training videos.

User Seal Check - DSPs wearing tight-fitting respiratory protection should perform a user seal check each time they put on their respirator. A fit test ensures that the respirator fits and provides a secure seal. A user seal check ensures that it's being worn right each time.

DSPs can either perform a positive-pressure or negative-pressure seal check:

- A positive-pressure check is accomplished by covering the respirator surface on a filtering facepiece (N95) and trying to breathe out. Cover the surface using your hands. If slight pressure builds up, that means air isn't leaking around the edges of the respirator.

- A negative-pressure check is accomplished by covering the respirator surface on a filtering facepiece N95) and trying to breathe in. Cover the surface using your hands. If no air enters, the seal is tight.

The seal check method may vary by manufacturer and model and will be described in the user instructions. DSPs should follow the PPE manufacturer's instructions and recommendations for the proper use, donning, doffing, and user seal check of the N95 respirator.

Review attachment 6, the "User Seal Check" infographic.

[Staffing Shortages]

[HHSC LTCR offers emergency staff for providers facing severe critical shortages because existing staff is unable to work due to being infected with COVID-19. Emergency staffing is only approved for providers that can't provide necessary care to residents or individuals due to COVID-19 related staffing shortages. Emergency staffing is temporary while providers obtain alternative staffing resources or until existing staff can return to work.]

[Providers may only request emergency staffing from HHSC if all the strategies from the Staffing Contingency Checklist have been exhausted. If a provider has implemented or attempted each item in the Staffing Contingency and still does not have adequate staff to meet critical staffing levels, the provider must contact the Regional Director for their LTCR Region to request emergency staffing.]

[LTCR may request documentation to support that all mitigation strategies have been exhausted and that all other checklist items have been exhausted before facilities and providers are provided emergency staff.]

[LTCR may perform an on-site survey to confirm that all mitigation strategies have been exhausted and that all other checklist items have been exhausted before providers are provided emergency staff.]

[This is only available on an emergency basis, as staff are available, and as a temporary measure. Not all requests for emergency staffing will be fulfilled. Requests are prioritized by level of need.]

[HHSC published Provider Letter 2022-02 which allows providers to request emergency staffing resources.]

[Providers may request emergency staff from HHSC in an emergency as a one-time option to alleviate staffing crisis due to the impact of Omicron variant on staffing resources.]

[To complete a one-time request for emergency staff from HHSC, HCS providers should follow all steps located in PL 2022-02.]

[Facility Consolidations (due to Staffing]

[The following is guidance regarding temporary closures:

- If the licensed provider is going to be temporarily closed for an extended period of time, contact LTCR Licensing and Credentialing at LTC_ALF_ICF_Licensing@hhs.texas.gov

- If the licensed provider is going to be closed for short period of time (i.e. 24/48 hours, weekend), contact the regional office (Regional Director and Program Manager).

- If two licensed ICF/IID providers are consolidating facilities and the this will place the provider over capacity at the facility they are consolidation to, contact LTCR Survey Operations at ltcrsurveyoperation@hhs.texas.gov. This section is responsible for approving the temporary increase in licensed capacity. This information will be provided to LTCR Licensing and Credentialing.]

[When consolidation ends:

- Contact the regional office (Regional Director and Program Manager); and

- Contact LTCR Survey Operations at ltcrsurveyoperation@hhs.texas.gov.]

10. Expansion of Reopening Visitation

ICFs are required to allow indoor visits, outdoor visits, end-of-life visits, and visits of persons providing critical assistance, including essential caregivers for individuals.

Any reference to "indoor visits" and "outdoor visits" refer to visits between an individual and a personal visitor. Essential caregiver and end-of-life visits can also occur indoors or outdoors but are referred to as essential caregiver visits or end-of-life visits.

As a reminder, an ICF is required to screen all visitors for signs or symptoms of COVID-19. A visitor may not participate in a visit if the visitor has signs and symptoms of COVID-19 or active COVID-19 infection.

Visitation Requirements

The following applies to all visitations.

An ICF must:

- develop and enforce policies and procedures that ensure infection control practices, including whether the visitor and the individual must wear a face mask, face covering, or appropriate PPE;
- ensure equal access by all individuals to personal visitors, end-of-life visitors, and essential caregivers;
- allow visitors of any age;
- ensure a comfortable and safe outdoor visitation area for outdoor visits, considering outside air temperature and ventilation;
- inform visitors of the facility's infection control policies and procedures related to visitation;
- limit the movement of the visitor through the facility to ensure interaction with other persons in the facility is minimized; and
- provide hand-washing stations, or hand sanitizer, to the visitor and individual before and after visits.

Visitation must be facilitated to allow time for cleaning and sanitization of the visitation area between visits and to ensure infection prevention and control measures are followed. An ICF can allow both scheduled and unscheduled visits but should not require scheduled visits in such a way as to prohibit or limit visitation for individuals.

The individual and his or her personal visitor may have close or personal contact in accordance with CDC guidance. For essential caregiver requirements, see Essential Caregiver Visits.

Visits are permitted where adequate space is available, including in the individual's room, to ensure physical distancing between visitation groups and safe infection prevention and control measures.

The visitor and the individual must practice hand hygiene before and after the visit.

Essential Caregiver Visits

An essential caregiver visit is defined as a personal visit between an individual and a designated essential caregiver, permitted in all facilities for all individuals with any COVID-19 status.

An ICF must allow essential caregiver visits. The following requirements apply to essential caregiver visits:

- Up to two essential caregivers can be designated per individual and up to two essential caregivers can visit each individual at the same time.
- An essential caregiver visit is not allowed if the visitor has signs or symptoms of COVID-19 or an active COVID-19 infection.
- Essential caregiver visits can occur outdoors, in the individual's bedroom, or in another area in the facility that limits visitor movement through the facility and interaction with other individuals.
- Essential caregivers do not have to maintain physical distancing between themselves and the individual they are visiting but must maintain physical distancing between themselves and other persons in the facility.
- An ICF is not required to maintain a separate record of the essential caregiver visit or verify the identity of the essential caregiver at each visit.

An ICF must:

- develop and enforce essential caregiver visitation policies and procedures, including:
  - a written agreement that the essential caregiver understands and agrees to follow the applicable policies, procedures, and requirements;
  - training each designated essential caregiver on infection control measures, hand hygiene, and cough and sneeze etiquette;
  - expectations regarding using only designated entrances and exits as directed, if applicable; and
  - limiting visitation to the area designated by the facility;
- inform the essential caregiver of applicable policies, procedures, and requirements;
- maintain documentation of the essential caregiver's agreement to follow the applicable policies, procedures, and requirements;
- maintain documentation of the essential caregiver's training on infection control measures, hand hygiene, and cough and sneeze etiquette;
- maintain documentation of the identity of each essential caregiver in the individual's records; and
- prevent visitation by the essential caregiver if the essential caregiver has signs and symptoms of COVID-19 or an active COVID-19 infection.

Salon Services Visits

An ICF is not required to maintain a separate record of the salon services visit or verify the identity of the salon services visitor at each visit.

An ICF may allow salon services visits. The following requirements apply to salon services visits:

- The salon services visitor passes screening for COVID-19 symptoms.
- The salon services visitor agrees to comply with the most current version of the Minimum Standard Health Protocols – Checklist for Cosmetology Salons/Hair Salons, located on open.texas.gov.
- A salon services visit may be permitted for all individuals with COVID-19 negative status.
- The visit may occur outdoors, in the individual's bedroom, or in another area in the facility that limits visitor movement through the facility and interaction with other persons in the facility.
- Salon services visitors do not have to maintain physical distancing between themselves and each individual they are visiting, but they must maintain physical distancing between themselves and all other persons in the facility.
- The intermediate care facility must develop and enforce salon services visitation policies and procedures, which include:
  - a written agreement that the salon services visitor understands and agrees to follow the applicable policies, procedures, and requirements;
  - training each salon services visor on infection control measures, hand hygiene, and cough and sneeze etiquette;
  - expectations regarding using only designated entrances and exits, as directed; and
  - limiting visitation to the area designated by the facility.

The ICF must:

- inform the salon services visitor of applicable policies, procedures, and requirements;
- maintain documentation of the salon services visitor's agreement to follow the applicable policies, procedures and requirements;
- maintain documentation of the salon services visitor's training on infections control measures, hand hygiene, and cough and sneeze etiquette;
- document the identity of each salon services visitor in the facility's records; and
- cancel the salon services visit if the salon services visitor fails to comply with the facility's policy regarding salon services visits or applicable requirements in this section.

11. Holiday Visitations & Other Considerations

Bringing Food During Visitation

Visitors are not prohibited from bringing in outside food for an individual.

Individuals may eat or drink during the visit.

Visitors can bring outside food for an individual. An ICF facilitates indoor and outdoor visitation between personal visitors and individuals according to CDC guidance.

The facility should refer to CDC guidance on Food Safety for food brought in from the outside for an individual.

The CDC provides the following about food safety:

- The risk of infection by the virus from food products, food packaging, or bags is thought to be very low.

- Currently, no cases of COVID-19 have been identified where infection was thought to have occurred by touching food, food packaging, or shopping bags.

- Do NOT use disinfectants designed for hard surfaces, such as bleach or ammonia, on food packaged in cardboard or plastic wrap.

- After handling food packages and before eating food, always wash your hands with soap and water for at least 20 seconds. If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.

Visitors may bring items, including food, for an individual during a visit.

For essential caregivers, the facility informs the essential caregiver of the necessary infection control and food safety protocols for delivered items. The essential caregiver can deliver the items directly to the individual.

The CDC shared information on Food and COVID-19 that reviewed risks from food or packaging and handling packaged food and produce.

Facility Activities and Outings

ICFs planning facility-coordinated group activities, including holiday meals, should ensure the following:

- Perform hand hygiene before and after activity

- Clean and sanitize the activity area and all items used before and after each activity

Individuals have the right to make the informed decision to leave the facility for a holiday activity.

As per the most updated CDC guidance:

- If all individuals participating in the communal dining or group activity are fully vaccinated, then they may choose to have close contact and do not have to physically distance from other fully vaccinated people.
- If unvaccinated individuals are present, then unvaccinated individuals should physically distance from others.

[Per CMS and CDC, the safest approach is for everyone, regardless of vaccination status, to wear a face covering or mask while in communal areas of the facility.]

Quarantining Specifics when Leaving the Home

An individual who leaves the facility, who is not gone overnight and who did not have contact with others who may potentially have COVID-19 or are confirmed to have COVID-19, does not have to be quarantined upon returning to the facility.

Quarantine is no longer recommended for individuals who leave the facility and return when they have been fully vaccinated against COVID-19.

According to the CDC's When to Quarantine, anyone who has surpassed their 90-day post recovery period after having had COVID-19 should still quarantine if exposed to the virus or symptomatic, until or if they become fully vaccinated. The 90-day timeframe is not an absolute guarantee against transmission and long-term care individuals are a high-risk population.

Packages and Receivable Items (i.e., gifts)

Individuals may receive items, including food, flowers, and packages, from family members or persons other than a scheduled visitor. For items delivered outside of a personal visit, facilities should designate an outside area for food and other items to be delivered.

Facility staff would retrieve the items, bring them inside, and disinfect them prior to delivering the items to the individuals. Facilities should follow CDC guidance for appropriate disinfecting guidelines, depending on what the items are.

For handling non-food items, the CDC recommends hand washing after handling items delivered or after handling mail.

Per the CDC, although COVID-19 can survive for a short period on some surfaces, it is unlikely to be spread from domestic or international mail, products, or packaging.

It may be possible to get COVID-19 by touching an object that has the virus on it and then touching your mouth, nose, or eyes, but this is not thought to be the main way the virus spreads.

Individuals have a right to privacy with their mail per federal and state rule.

12. COVID-19 Vaccinations

Reporting

In accordance with [emergency rules at 26 TAC §551.48](#), ICF facilities except SSLCs must report the following data to HHSC within 24 hours of completing a round of vaccinations:

- Aggregate numbers of staff – including employees, contractors, and volunteers – who received their first dose of a two-dose COVID-19 vaccine or their only dose of a single-dose COVID-19 vaccine;

- Aggregate numbers of staff – including employees, contractors, and volunteers – who received their second dose of a two-dose COVID-19 vaccine;

- Aggregate numbers of individuals who received their first dose of a two- dose COVID-19 vaccine or their only dose of a single-dose COVID-19 vaccine; and

- Aggregate numbers of individuals who received their second dose of a two-dose COVID-19 vaccine.

- Aggregate numbers of individuals and staff who received their COVID-19 booster vaccine.

Reporting Guidance

Method: HHSC has developed a Survey Monkey tool to collect this information. HHSC issued an alert containing the survey link on February 12, and the link to the ICF survey is posted on the ICF provider portal under the COVID-19 resource accordion. You can access the ICF survey at https://www.surveymonkey.com/r/95FQ52S.

Multiple locations: Submit a separate survey for each license number. For example, a provider that owns multiple licenses would submit separate surveys for each license.

Frequency: Complete the survey only when you have information to report, i.e., when a round of vaccines is administered to staff or individuals. On days when no vaccines are administered, you do not need to complete the survey. *Note: If reporting vaccination rounds that occurred previously, complete a separate survey by date for each previous separate round.*

First report: If a round of vaccinations was administered before the effective date of this letter, submit a report to capture those vaccinations.

Parameters: Reports are for a given round of vaccinations administered by the facility or a pharmacy partner. Do not provide cumulative numbers. In other words, do not include totals from previous reports in a new report. Report all vaccinations, including those that occurred at an off-site pharmacy, doctor's office, local mass vaccination clinic, etc.

CMS QSO 21-21

As per CMS QSO 21-21, effective May 21, 2021, CMS added new requirements at 42 CFR §483.460(a)(4) directing each ICF/IID to develop policies and procedures to educate clients, their representatives, and staff on the benefits and risks and potential side effects of the COVID-19 vaccine. Further, the ICF/IID must offer the vaccine unless it is medically contraindicated, or the client or staff member has already been immunized. In this context, offer means that the ICF must facilitate the provision of the COVID-19 vaccine to individuals and staff members who choose to receive it. The facility can administer the vaccine itself or take individuals and staff to an external vaccine provider. Additionally, the facility must maintain appropriate documentation to reflect the provision of the required COVID-19 vaccine education and offering, and whether the client and staff member received the vaccine or did not receive it due to medical contraindications or refusal.

Surveyors should expect to see documentation of the facility offering the vaccine to individuals and staff as required by HHCS ICF COVID-19 emergency rules as of March 23, 2021. ICFs are only expected to document the CMS QSO 21-21 required education and offering of the vaccine to individuals and staff members as of the effective date of the rule, May 21, 2021.
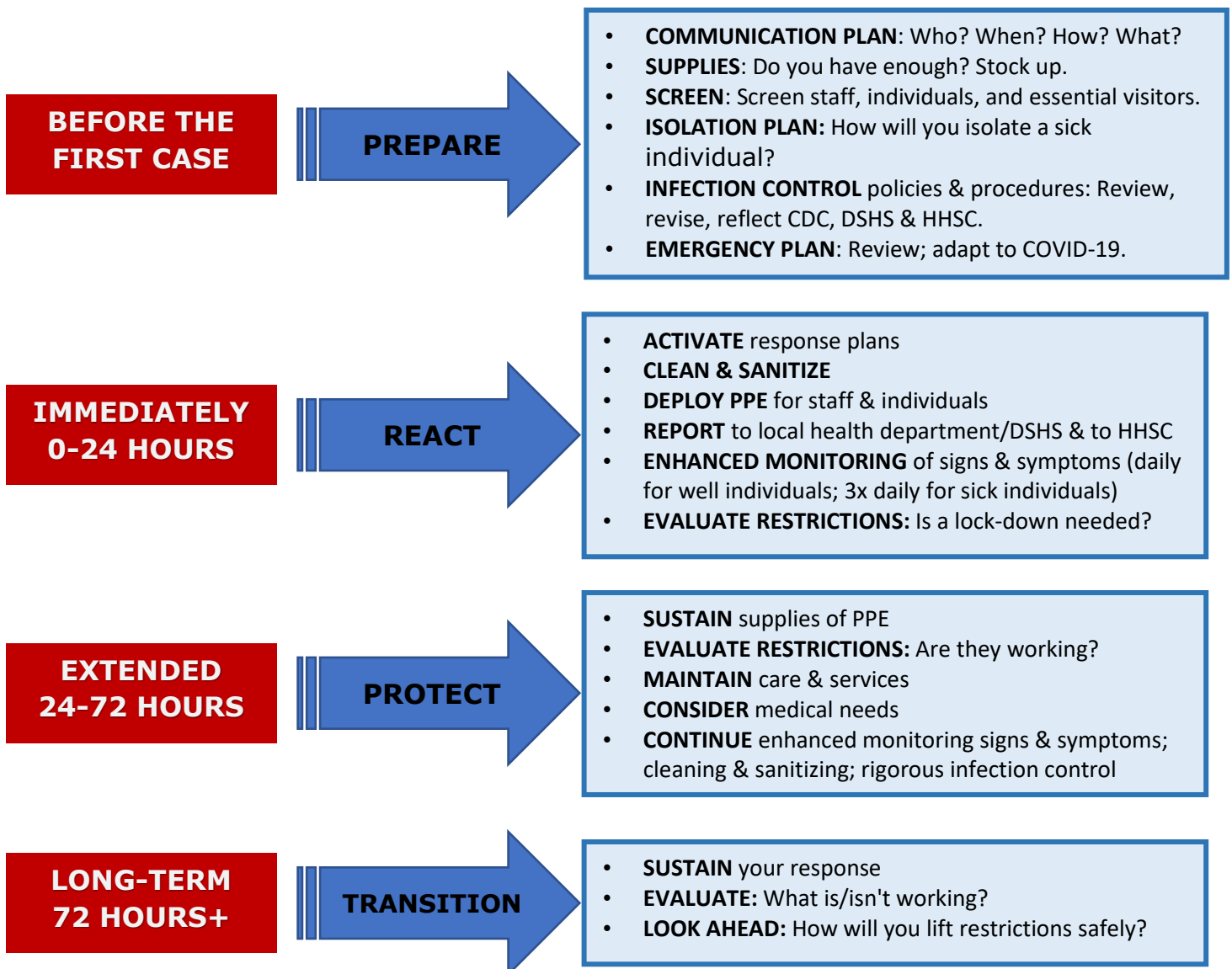
Noncompliance related to the new requirements for educating and offering COVID-19 vaccination to clients and staff will be cited at W-tags 500-507.

ATTACHMENT 3: Facility Actions for COVID-19 Response - Infographic

Activities Required for COVID-19 Response

People who live in long-term care facilities are at higher risk for severe illness. There are actions that an ICF provider can take to identify a COVID-19 situation, help prevent the spread within facility, and care for individuals who have COVID-19.

BEFORE THE FIRST CASE → **PREPARE**

- **COMMUNICATION PLAN**: Who? When? How? What?
- **SUPPLIES**: Do you have enough? Stock up.
- **SCREEN**: Screen staff, individuals, and essential visitors.
- **ISOLATION PLAN:** How will you isolate a sick individual?
- **INFECTION CONTROL** policies & procedures: Review, revise, reflect CDC, DSHS & HHSC.
- **EMERGENCY PLAN**: Review; adapt to COVID-19.

IMMEDIATELY 0-24 HOURS → **REACT**

- **ACTIVATE** response plans
- **CLEAN & SANITIZE**
- **DEPLOY PPE** for staff & individuals
- **REPORT** to local health department/DSHS & to HHSC
- **ENHANCED MONITORING** of signs & symptoms (daily for well individuals; 3x daily for sick individuals)
- **EVALUATE RESTRICTIONS**: Is a lock-down needed?

EXTENDED 24-72 HOURS → **PROTECT**

- **SUSTAIN** supplies of PPE
- **EVALUATE RESTRICTIONS**: Are they working?
- **MAINTAIN** care & services
- **CONSIDER** medical needs
- **CONTINUE** enhanced monitoring signs & symptoms; cleaning & sanitizing; rigorous infection control

LONG-TERM 72 HOURS+ → **TRANSITION**

- **SUSTAIN** your response
- **EVALUATE**: What is/isn't working?
- **LOOK AHEAD**: How will you lift restrictions safely?

ATTACHMENT 4: CDC Guidance - Optimization of Facemasks Infographic and Do's and Don'ts for Facemask Use Infographic

EXTENDED USE

The practice of wearing the same facemask for repeated close contact with several different residents, without removing the facemask between resident encounters.

ADJUST facemask

- Staff should take care not to touch their facemask.
- If staff touch or adjust their facemask, they must immediately perform hand hygiene.

REMOVE facemask

- Staff should leave the resident care area if they need to remove the facemask.

STORE facemask

- Carefully fold so the outer surface is held inward and against itself to reduce contact with the outer surface during storage.
- Folded facemask can be stored between uses in a clean sealable paper bag or breathable container.

DISCARD facemask

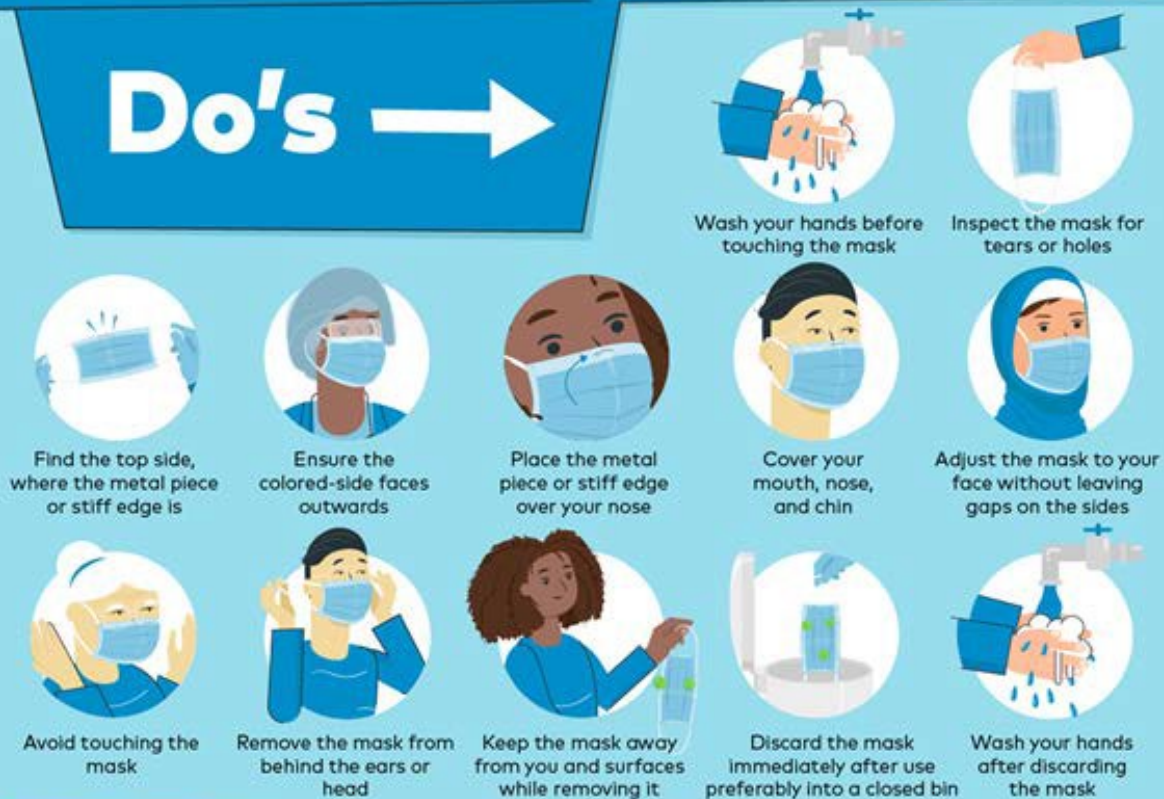- Remove and discard if facemask is soiled, damaged, or hard to breathe through.

Example of a damaged facemask.
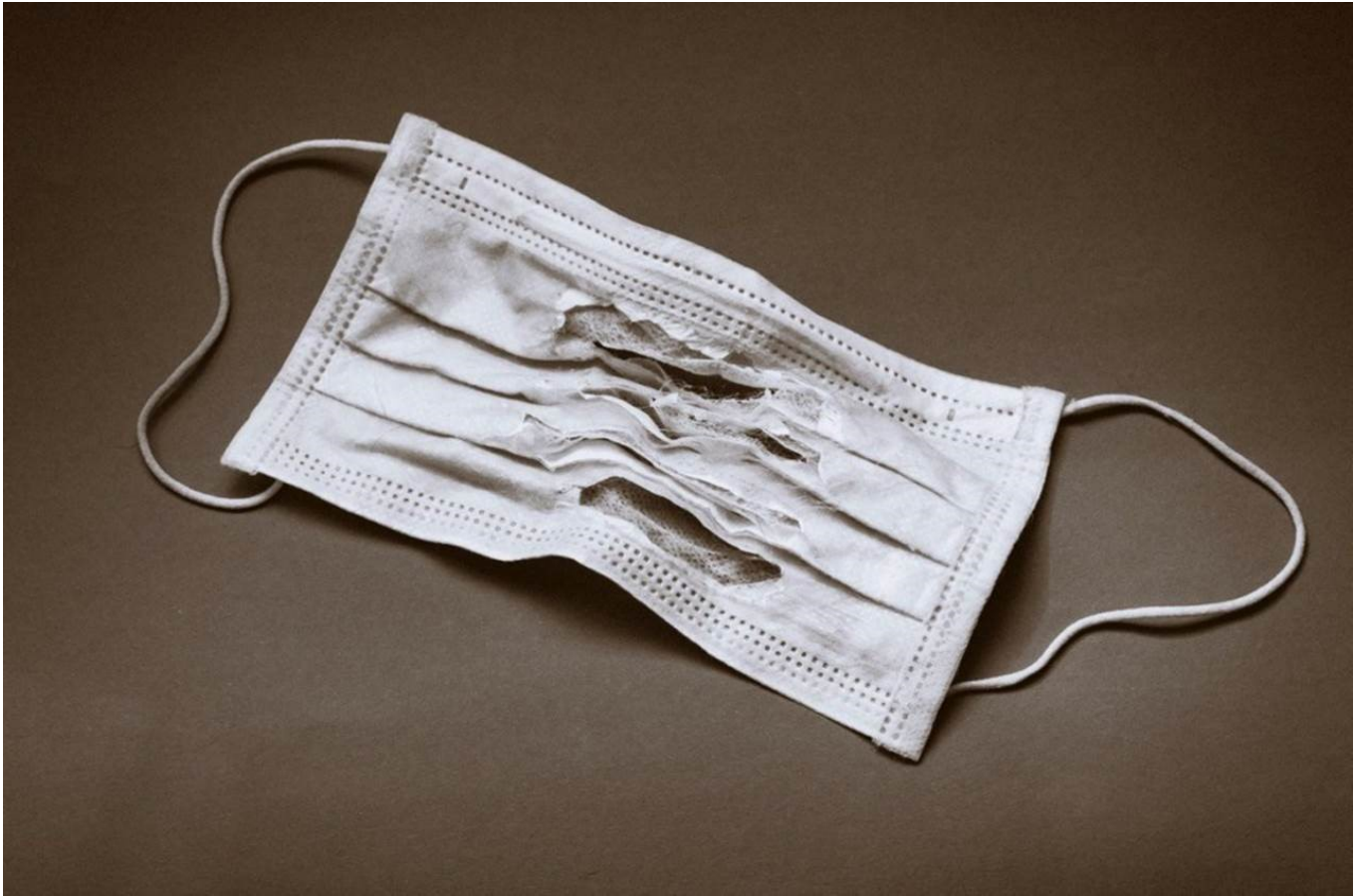
# ATTACHMENT 5: PPE Donning and Doffing Infographic

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist
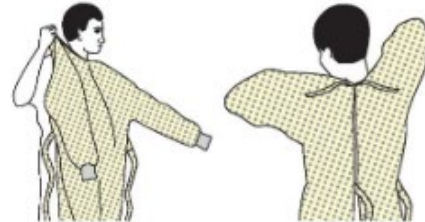
2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

CDC

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container
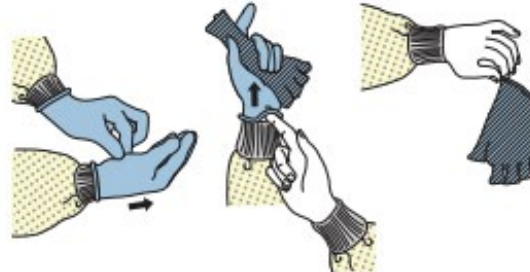
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE
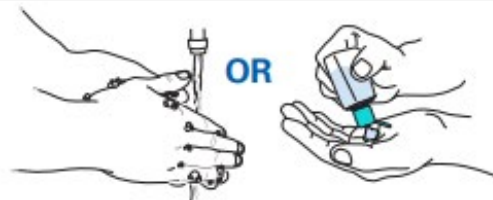
OR

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE
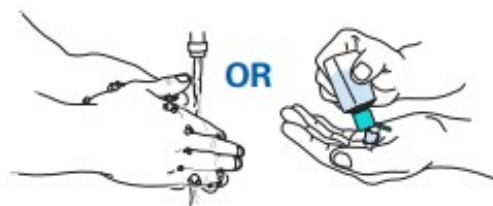
OR

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

ATTACHMENT 6: User Seal Check – Infographic

Filtering out Confusion:
Frequently Asked Questions about Respiratory Protection

User Seal Check

Over 3 million United States employees in approximately 1.3 million workplaces are required to wear respiratory protection. The Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires an annual fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace.[1] Once a fit test has been done to determine the best respirator model and size for a particular user, **a user seal check** should be done every time the respirator is to be worn to ensure an adequate seal is achieved.

What is a User Seal Check?

A user seal check is a procedure conducted by the respirator wearer to determine if the respirator is being properly worn. The user seal check can either be a positive pressure or negative pressure check.

During a **positive pressure user seal check**, the respirator user **exhales** gently while blocking the paths for air to exit the facepiece. A successful check is when the facepiece is slightly pressurized before increased pressure causes outward leakage.

During a **negative pressure user seal check**, the respirator user **inhales** sharply while blocking the paths for air to enter the facepiece. A successful check is when the facepiece collapses slightly under the negative pressure that is created with this procedure.

A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual.

How do I do a User Seal Check while Wearing a Filtering Facepiece Respirator?

Not every respirator can be checked using both positive and negative pressure. Refer to the manufacturer's instructions for conducting user seal checks on any specific respirator. This information can be found on the box or individual respirator packaging.

The following positive and negative user seal check procedures for filtering facepiece respirators are provided as examples of how to perform these procedures.

CDC NIOSH
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

How to do a positive pressure user seal check

Once the particulate respirator is properly donned, place your hands over the facepiece, covering as much surface area as possible. Exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure is being built up inside the facepiece without any evidence of outward leakage of air at the seal. Examples of such evidence would be the feeling of air movement on your face along the seal of the facepiece, fogging of your glasses, or a lack of pressure being built up inside the facepiece.

If the particulate respirator has an exhalation valve, then performing a positive pressure check may be impossible. In such cases, a negative pressure check should be performed.

How to do a negative pressure user seal check

Negative pressure seal checks are typically conducted on particulate respirators that have exhalation valves. To conduct a negative pressure user seal check, cover the filter surface with your hands as much as possible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece.

In the case of either type of seal check, if air leaks around the nose, use both hands to readjust the nosepiece by placing your fingertips at the top of the metal nose clip. Slide your fingertips down both sides of the metal strip to more efficiently mold the nose area to the shape of your nose. Readjust the straps along the sides of your head until a proper seal is achieved.[2]

If you cannot achieve a proper seal due to air leakage, you may need to be fit tested for a different respirator model or size.

Can a user seal check be considered a substitute for a fit testing?

No. The user seal check does not have the sensitivity and specificity to replace either fit test methods, qualitative or quantitative, that are accepted by OSHA (29 CFR 1910.134). A user should only wear respirator models with which they have achieved a successful fit test within the last year. NIOSH data suggests that the added care from performing a user seal check leads to higher quality donnings (e.g., reduces the chances of a donning with a poor fit).[3]

Where can I Find More Information?

This information and more is available on the NIOSH Respirator Trusted-Source webpage.

References
1. OSHA [1998]. Respiratory Protection. 29 CFR 1910.134. Final rule. Fed Register 63:1152-1300.
2. NIOSH [2010]. How to properly put on and take off a disposable respirator. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 2010-133. https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf
3. Viscusi DJ, Bergman MS, Zhuang Z, and Shaffer RE [2012]. Evaluation of the benefits of the user seal check on N95 filtering facepiece respirator fit. J Occup and Environl Hyg. 9(6):408-416.
Photos courtesy of NIOSH

ATTACHMENT 7: Three Key Factors Required for a Respirator to be Effective - Infographic


Three Key Factors Required for a Respirator to be Effective

Correct*

Incorrect

① The respirator must be put on correctly and worn during the exposure.

② The respirator must fit snugly against the user's face to ensure that there are no gaps between the user's skin and respirator seal.

③ The respirator filter must capture more than 95% of the particles from the air that passes through it.
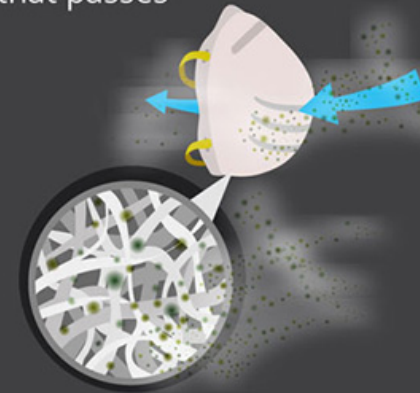
*If your respirator has a metal bar or a molded nose cushion, it should rest over the nose and not the chin area.

CDC NIOSH

ATTACHMENT 8: Isolation Planning in ICF Homes

PRIOR TO COVID-19 Diagnosis

The time to begin planning is BEFORE a resident is diagnosed with COVID-19.

WHERE will you isolate a COVID + individual?
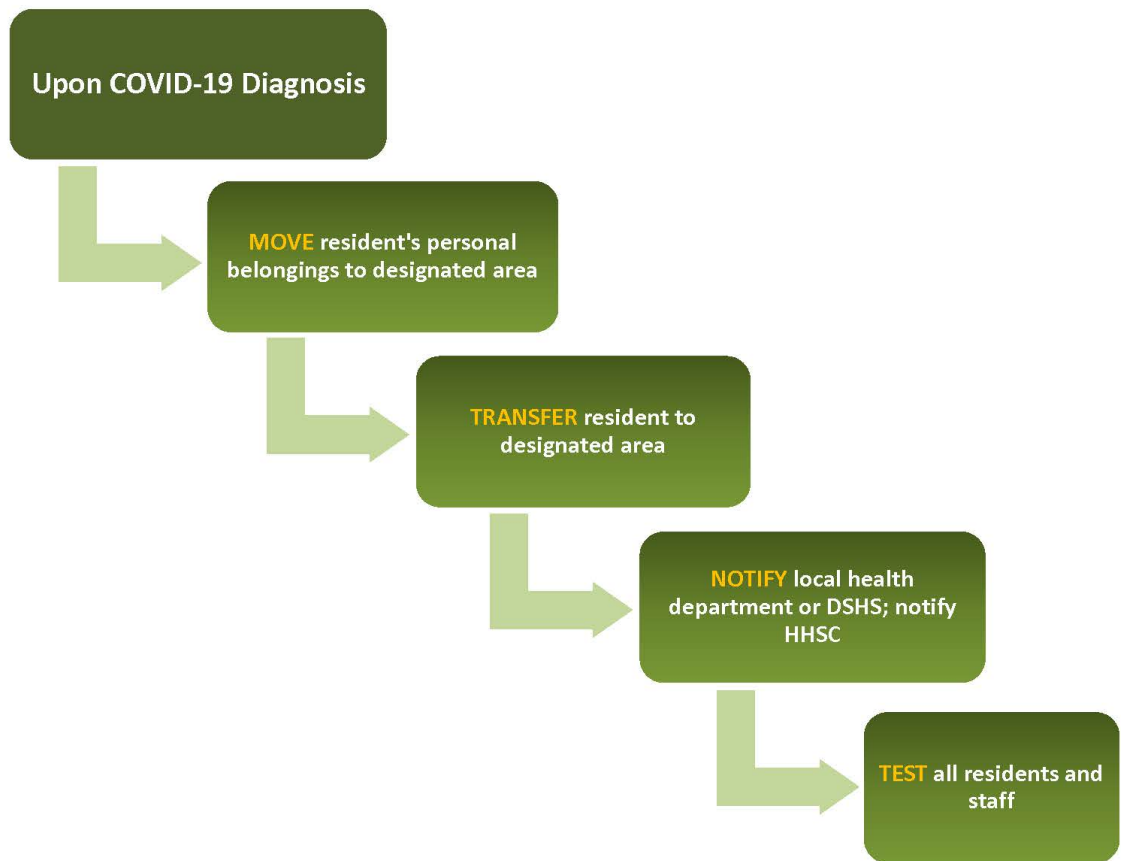
- Is there a room you can repurpose?
- Can you make an arrangement with another ICF?

WHO will provide care?

- Can you dedicate certain staff to provide care?
- Keep staff who provide care to resident with COVID-19 from working at other ICFs if possible.

HOW will you ensure infection control?

- Train staff on infection control.
- Provide hygiene supplies and PPE.

Upon COVID-19 Diagnosis

MOVE resident's personal belongings to designated area

TRANSFER resident to designated area

NOTIFY local health department or DSHS; notify HHSC

TEST all residents and staff

After Recovery

CLEAN & DISINFECT
resident's personal belongings

TRANSFER
resident & belongings out of isolation

MONITOR
resident for signs/ symptoms

CLEAN & DISINFECT
isolation room

ATTACHMENT 9: Quarantine[1] Vs. Isolation

COVID-19: Quarantine vs. Isolation

QUARANTINE keeps someone who was in close contact with someone who has COVID-19 away from others.

If you had close contact with a person who has COVID-19

- Stay home until 14 days after your last contact.

- Check your temperature twice a day and watch for symptoms of COVID-19.

- If possible, stay away from people who are at higher-risk for getting very sick from COVID-19.

ISOLATION keeps someone who is sick or tested positive for COVID-19 without symptoms away from others, even in their own home.

If you are sick and think or know you have COVID-19

- Stay home until after
  - At least 10 days since symptoms first appeared **and**
  - At least 24 hours with no fever without fever-reducing medication **and**
  - Symptoms have improved

If you tested positive for COVID-19 but do not have symptoms

- Stay home until after
  - 10 days have passed since your positive test

If you live with others, stay in a specific "sick room" or area and away from other people or animals, including pets. Use a separate bathroom, if available.

cdc.gov/coronavirus

CS317422-A   7/20/2020 7AM

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[1] See quarantine section for more information regarding quarantine recommendations

ATTACHMENT 10: Things to Consider
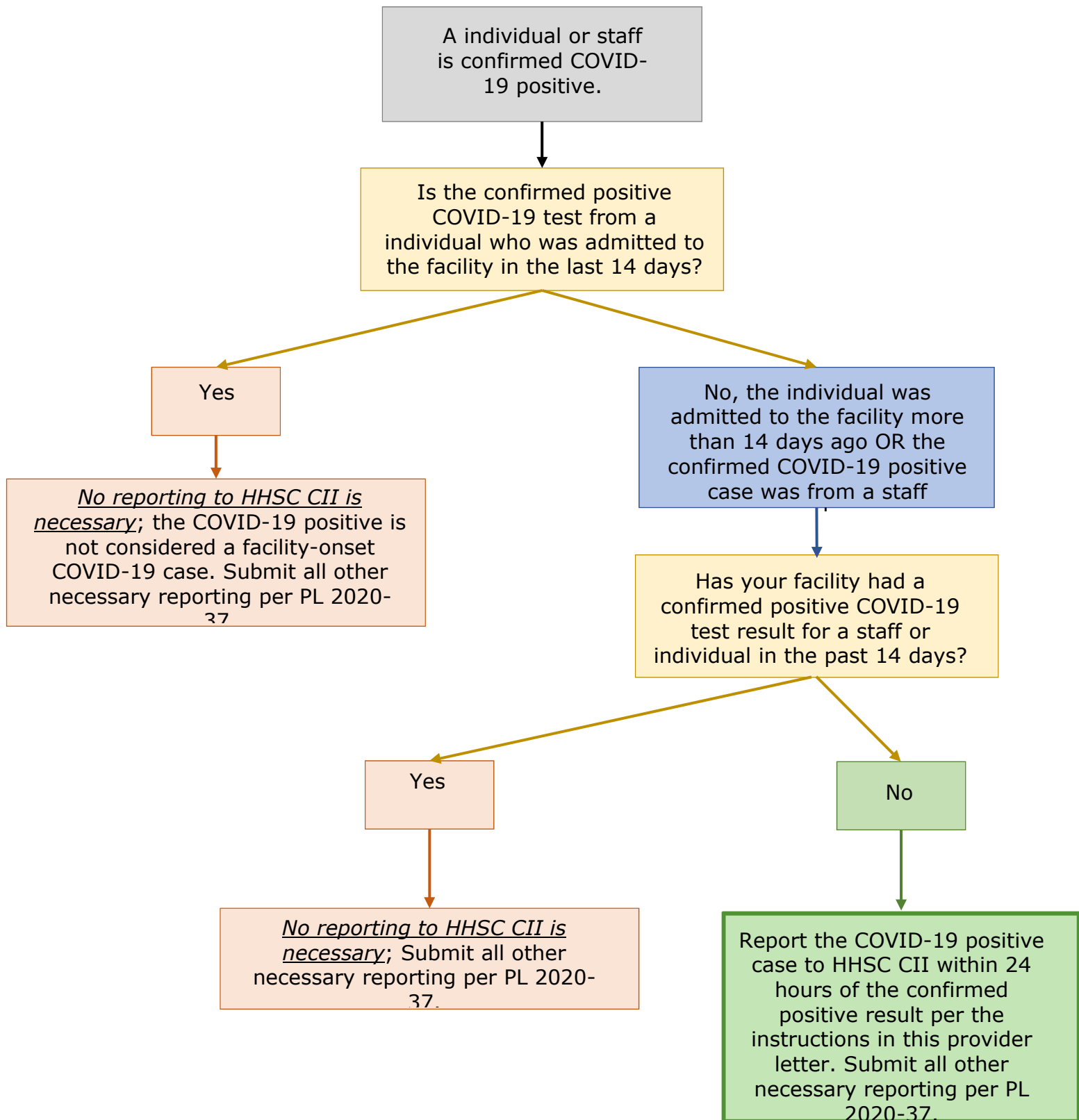
Things to Consider when Isolating an Individual with COVID-19	**Things to Consider for the Quarantine of an Individual who is not fully vaccinated and who HAS been exposed to COVID-19, including Individuals whose status is unknown**	**Things to Consider when an Individual in Quarantine Visits Common Areas of the home**
• Isolate in a private bedroom with the use of a private bathroom if possible; • Consider whether other rooms in the ICF can be used as a bedroom during an isolation emergency; • Consider whether a bathroom can be reserved only for the use of the individual with COVID-19, possibly the one closest to the bedroom; • Consider cohorting (accommodating in same bedroom) with another individual who also has COVID-19; • Do *not* cohort with another individual who does not have COVID-19 or whose status is unknown; • Maintain at least 6 feet distance between individual's beds, or more if possible, for individuals who are cohorting in the same room; • Increase cleaning and disinfection of the bedroom, including commonly touched surfaces and equipment; • Increase cleaning and disinfection of the bathroom, including after each use by the individual with COVID-19 if a bathroom cannot be dedicated only for use by the individual with COVID-19; • Keep the bedroom door closed when at all possible; • Have everyone with COVID-19 wear a facemask always, as tolerated; and • Educate individuals about hand hygiene, covering coughs and sneezes, and properly discarding used tissues.	• Consider whether other rooms in the ICF could be used as a bedroom; • Consider whether a bathroom can be reserved only for the use of the individual being quarantined, possibly the one closest to the bedroom; • Consider cohorting an individual who might have been exposed with another individual who also has been exposed; • Consider cohorting an individual whose status is unknown with another individual whose status is unknown; • Do *not* cohort with an individual who has COVID-19; • Maintain at least 6 feet distance between individuals' beds, or more if possible, for individuals who are cohorting in the same room; • Increase cleaning and disinfection of the bedroom, including commonly touched surfaces and equipment; • Increase cleaning and disinfection of the bathroom, including after each use by the individual being quarantined if a bathroom cannot be dedicated only for that individual's use; • Have everyone who has been exposed to COVID-19 or whose status is unknown wear a facemask or cloth face covering always when they are not in their bedroom, as tolerated; and • Educate individuals about hand hygiene, covering coughs and sneezes, and properly discarding used tissues.	• Can the individual visit the common areas and still be separate from other individuals who are not under quarantine? • Can at least 6 feet of distance be maintained between the individual under quarantine and the other individuals? • Are all individuals, including the individual in quarantine, wearing a facemask or cloth face covering when out of their bedrooms? • Are all individuals practicing hand hygiene, covering coughs and sneezes, and properly discarding used tissues? • Is the facility frequently cleaning and disinfecting high-touch surfaces and equipment? • Is the facility monitoring for signs and symptoms at least three times a day (once per shift)? • Does the facility have a plan for what to do if the individual starts having signs or symptoms of respiratory illness?

ATTACHMENT 11: COVID-19 Reporting Decision Tree

A individual or staff is confirmed COVID-19 positive.

↓

Is the confirmed positive COVID-19 test from a individual who was admitted to the facility in the last 14 days?

Yes → *No reporting to HHSC CII is necessary*; the COVID-19 positive is not considered a facility-onset COVID-19 case. Submit all other necessary reporting per PL 2020-37

No, the individual was admitted to the facility more than 14 days ago OR the confirmed COVID-19 positive case was from a staff

↓

Has your facility had a confirmed positive COVID-19 test result for a staff or individual in the past 14 days?

Yes → *No reporting to HHSC CII is necessary*; Submit all other necessary reporting per PL 2020-37.

No → Report the COVID-19 positive case to HHSC CII within 24 hours of the confirmed positive result per the instructions in this provider letter. Submit all other necessary reporting per PL 2020-37.

[Attachment 12: Comparing Symptoms of COVID-19 Infection, Flu, and Seasonal Allergies]

Those who present with a symptom or symptoms that are consistent with allergies and COVID-19 will need to be evaluated on a case-by-case basis. COVID-19, influenza, and seasonal allergies cause many of the same signs and symptoms. However, there are some differences.

Symptom or sign	COVID-19	Influenza (Flu)	Seasonal Allergy
Cough	Often (dry)	Often	Sometimes
Fever	Often	Often	Rare
Muscle aches	Often	Often	Rare
Itchy nose, eyes, mouth or inner ear	Rare	Sometimes	Often
Sneezing	Rare	Rare	Often
Sore throat and stuffy nose	Often	Often	Rare
Diarrhea	Sometimes	Sometimes (in children)	Rare
Vomiting	Sometimes	Sometimes (in children)	Rare
Change in or loss of taste or smell	Often	Sometimes	Rare]

[Attachment 13: Work Restrictions for DSP with COVID-19 Infection and Exposures]

Work Restrictions for DSP with *COVID-19 Infection*			
Vaccination Status	**Conventional**	**Contingency** (when staffing shortages are anticipated)	**Crisis** (when staffing shortages occur)
Boosted*, Vaccinated, or Unvaccinated	10 days OR 7 days with a negative test#, if asymptomatic or mildly symptomatic (with improving symptoms)	5 days with/without negative test, if asymptomatic or mildly symptomatic (with improving symptoms)	No work restrictions, with prioritization considerations (e.g. asymptomatic or mildly symptomatic)
Work Restrictions for Asymptomatic DSP with *Exposure to COVID-19*			
Boosted	No work restrictions, with negative test on days 2+ and 5-7	No work restrictions	No work restrictions
Fully vaccinated or Unvaccinated, within 90 days of prior infection	10 days or 7 days with a negative test	No work restrictions with negative tests on days 1+, 2, 3 and 5-7	No work restrictions (test if possible)

*DSP are considered "boosted" if they have received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC.

#Negative test result within 48 hours before returning to work

+Calculating day of test: 1) *for those with infection* consider date of first positive test if asymptomatic OR date of symptom onset as day 0; 2) *for those with exposure* consider day of exposure as day 0

(Table adapted by HHSC LTCR. Read original CDC table [here](.).)

ATTACHMENT 12: List of Referenced Resources

ASPR TRACIE

COVID-19 Workforce Virtual Toolkit

CDC

CDC LTC Webinar Series:

- Clean Hands
- Closely Monitor Individuals
- Keep COVID-19 Out
- PPE Lessons
- Sparkling Surfaces
- Cleaning and Disinfecting Your Facility

[Ending Isolation and Precautions for People with COVID-19: Interim Guidance]

Food and COVID-19

Guidance for Direct Service Providers

Guidance for Direct Service Providers, Caregivers, Parents, and People with Developmental and Behavioral Disorders

Guidance for Group Homes for Individuals with Disabilities

Interim Infection Prevention and Control Recommendations for Individuals with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings

[Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2]

Key Strategies to Prepare for COVID-19 in Long-term Care Facilities

Preparing for COVID-19: Long-term Care Facilities

Quarantine vs. Isolation

Severity of Illness

[Science Brief: Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing]

Strategies for Optimizing the Supply of Facemasks

Strategies for Optimizing the Supply of Isolation Gowns

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Strategies to Optimize the Supply of PPE and Equipment

Symptoms of COVID-19

CMS

1135 Waivers

QSO 20-23 Guidance for Infection Control and Prevention of COVID-19 in Intermediate Care Facilities for Individuals with Intellectual Disabilities

QSO 21-07 COVID-19 Infection Control for Psychiatric and Intermediate Care Facilities for Individuals with Intellectual Disabilities

QSO 21-14 ICF/IID & PRTF Visitation at ICF/IIDs and PRTFs – COVID-19 (Revised)

DSHS

DSHS COVID-19 LTC Facility Staff Symptom Monitoring Log

DSHS Local Health Entities

Information on PPE

Screening Log Template

Strategies for Optimizing the Supply of PPE

EPA

List N: Disinfectants for Use Against COVID-19

HHSC

CII – Reporting to HHSC

LTCR Regional Contact Information

PL 2020-18 Guidance on COVID-19 Response in Intermediate Care Facilities

PL 2020-37 Reporting Guidance for Long-term Care Providers

PL 2021-04 HHSC COVID-19 Reporting Process

PL 2021-05 COVID-19 Vaccination Reporting

PL 2021-21 COVID-19 Response - Expansion of Reopening Visitation (Replaces PL 2021-10)

PL 2021-29 End of Temporary Suspension of Certain LTCR Requirements During COVID-19 Outbreak

NIOSH

Proper N95 Respirator Use for Respiratory Protection Preparedness - includes respirator use during a serious outbreak condition

User Seal Check - N95 respirator

OOG

Governor Abbott's Executive Orders

OSHA

OSHA Respiratory Protection Training Videos, including:

- Respiratory Protection for Healthcare Workers
- The Differences Between Respirators and Surgical Masks
- Respirator Safety: Donning & Doffing
- Respirator Types
- Respirator Fit Testing
- Maintenance and Care of Respirators
- Medical Evaluations
- Respiratory Protection Training Requirements
- Voluntary Use of Respirators
- Counterfeit and Altered Respirators: The Importance of NIOSH Certification
- OSHA Respiratory Protection Standard (29 CFR §1910.134)

U.S. HHS

The Difference Between Isolation and Quarantine

WHO

- Visual Tools

ATTACHMENT 13: Glossary of Acronyms in Alphabetical Order

1. ABHR – Alcohol-based hand rub
2. AIIR – Airborne infection isolation room
3. CDC – The Centers for Disease Control and Prevention
4. CMS – The Centers for Medicare and Medicaid Services
5. CNA – Certified nursing aide
6. DSHS – Texas Department of State Health Services
7. DSP – Direct Support Staff
8. EMS – Emergency medical services
9. EPA – Environmental Protection Agency
10. HA – Health authority
11. HHSC – Texas Health and Human Service Commission
12. IPC – Infection prevention and control
13. ICF- Intermediate Care Facility
14. IDD – Intellectual or Developmental Disability
15. LHA – Local health authority
16. LHD – Local health department
17. LTC – Long-term care
18. LTCR – Long-term Care Regulation
19. LVN – Licensed vocational nurse
20. OSHA – Occupational Safety and Health Administration
21. POC – Point of contact
22. PPE – Personal protective equipment
23. QIDP – Qualified Intellectual Disability Professional
24. RN – Registered nurse
25. SME – Subject Matter Expert
26. SSLC – State Supported Living Center
27. TCAT – Texas COVID-19 Assistance Team
28. W.H.O – World Health Organization