

PENNSYLVANIA DEPARTMENT OF HEALTH

2021 – PAHAN – 568 – 04-30-ADV

ADVISORY: Core Infection Prevention and Control Measures for Long-term Care Facilities

This document has been archived. Please refer to [PA-HAN-598](#) for updated information on the topic.



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FROM:	Alison Beam, JD, Acting Secretary of Health
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HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL; **EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS:** PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF

This advisory provides guidance on core infection prevention and control measures for long-term care facilities (LTCF) during the COVID-19 pandemic. The guidance supplements general guidance for all healthcare facilities given in [PA-HAN-563](#).

Additional guidance for LTCFs, which can be more conservative than what is recommended for other healthcare settings, is necessary due to the increased risk of transmission and increased risk of severe health outcomes related to COVID-19 in this setting.

If you have additional questions about this guidance, please contact DOH at 1-877-PA- HEALTH (1-877-724-3258) or your local health department.

This guidance is specific for long-term care facilities (LTCFs) but may also be applicable to other congregate and residential settings. This guidance supplements recommendations for all healthcare facilities given in [PA-HAN-563](#). Additional guidance for LTCFs in response to an exposure to, or a case of COVID-19 is given in [PA-HAN-567](#). If you have questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

Even as LTCFs resume more normal practices and begin relaxing restrictions, facilities must sustain core infection prevention and control (IPC) practices and remain vigilant for SARS-CoV-2 infection among residents and healthcare personnel (HCP) in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.

Nursing homes must follow Centers for Medicare and Medicaid Services (CMS) core principles of COVID-19 infection prevention (e.g., in [QSO-20-39-NH](#)). These are consistent with principles provided by the Centers for Disease Control and Prevention ([CDC](#)) and the Department of Health. For additional information to outline the facility's response to a new suspected, probable, or confirmed case of COVID-19 in a facility staff or resident, or when a resident has been exposed to COVID-19, refer to guidance provided in [PA-HAN-567](#).

Core prevention measures for COVID-19 in long-term care facilities in Pennsylvania include:

1. Infection prevention and control program
2. Vaccinate residents and HCP against SARS-CoV-2
3. Implement universal source control and eye protection
4. Implement physical distancing measures
5. Implement source control and physical distancing options for fully vaccinated persons
6. Have a plan for visitation
7. Evaluate and manage HCP
8. Identify a COVID Care Unit dedicated to monitor and care for residents with confirmed SARS-CoV-2 infection
9. Evaluate residents at least daily
10. Create a plan for testing residents and HCP for SARS-CoV-2
11. Create a staffing plan

1. INFECTION PREVENTION AND CONTROL PROGRAM

a. Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program

- We recommend, but do not require, that this be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the [IPC risk assessment](#).
- CDC has created an [online training course](#) that can orient individuals to this role in nursing homes.

b. Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices

- Hand Hygiene Supplies:
 - Put FDA-approved alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
 - Unless hands are visibly soiled, performing hand hygiene using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are an effective method of cleaning hands.
 - Use the Department's [Alcohol-based Hand Rub Memo](#) to inform your facility's policy and educate staff.
 - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Personal Protective Equipment (PPE):
 - Employers should select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration ([OSHA](#)) [PPE standards \(29 CFR 1910 Subpart I\)](#).
 - In certain facility types, Department mandates regarding PPE may apply. Facilities must follow Department mandates, which presently include provision of an N95 or higher-level respirator for HCP providing direct patient care to COVID-19 positive and

suspected cases. For long-term care facilities, reference the [August 17, 2020 Secretary's Order](#).

- Facilities should have supplies of facemasks, N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles).
- Implement a [respiratory protection program](#) that is compliant with the OSHA respiratory protection standard ([29 CFR 1910.134](#)) for employees if not already in place. The program should include medical evaluations, training, and fit testing.
- Perform and maintain an inventory of PPE in the facility.
 - Monitor daily PPE use to identify when supplies will run low; use the [PPE burn rate calculator](#) or other tools, such as the [PPE Preservation Planning Toolkit](#).
 - During PPE shortages, refer to the Department's website to [submit a resource request](#).
 - Use the Supplies and PPE pathway in the [National Healthcare Safety Network \(NHSN\) LTCF COVID-19 Module](#) to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of [CDC PPE optimization strategies](#)). Even if you submit a request to the Department, NHSN data assist with nationwide tracking.
- Make necessary PPE available in areas where resident care is provided.
 - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback, promoting appropriate use by staff.
- Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
- Follow [CDC PPE optimization strategies](#), which offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted.
- Environmental Cleaning and Disinfection:
 - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas.
 - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
 - Use an EPA-registered disinfectant from [List N: Disinfectants for coronavirus \(COVID-19\)](#) on the EPA website to disinfect surfaces that might be contaminated with SARS-CoV-2.
 - Ensure HCP are appropriately trained on its use and follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).

c. Ensure Proper Use and Handling of PPE

- The [Order of the Secretary of Health](#) directing long-term care facilities to implement measures for use and distribution of PPE includes provisions for the development of policies and procedures. In addition to those, facilities should have policies and procedures addressing:
 - Which PPE is required in which situations (e.g., residents with suspected or confirmed SARS-CoV-2 infection, residents placed in quarantine);
 - Recommended sequence for safely donning and doffing PPE.
- Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.
- Bundle care activities to minimize the number of HCP entries into a room.
- Facilities should continue to aim for conventional capacity while the supply of PPE is deemed to be adequate.

d. Monitor Hand Hygiene, PPE Use, and Adherence to Core Prevention Measures

- Establish a policy or written schedule for hand hygiene, PPE, environmental cleaning, and other IPC audits.
- Utilize the Department [Hand Hygiene Audit Toolkit](#) which can also be used to conduct other types of IPC audits.

- Track audit data and share with frontline staff, as this has been shown to motivate staff and increase awareness among staff and residents.

e. Educate Residents, Healthcare Personnel, and Visitors about SARS-CoV-2, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves

- Provide culturally and linguistically tailored information about SARS-CoV-2 infection, including the signs and symptoms that could signal infection.
- Provide information about strategies for [managing stress and anxiety](#).
- Regularly review [PA-HAN-563](#) or its successor for current information and ensure staff and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., rehabilitation therapy, wound care, podiatry, barber), ombudsman, and volunteers who provide care or services in the facility. Including consultants is important since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of SARS-CoV-2.
 - Educate HCP about any new policies or procedures.
 - **Reinforce sick leave policies and remind HCP not to report to work when ill.**
 - Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of PPE. Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.
 - CDC has created [training resources](#) for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
 - As part of facility-wide education efforts, encourage all HCP to sign up to receive infection prevention and control text messages on their mobile phones through [PA Project Firstline](#).
- Educate residents and families through educational sessions and written materials on topics including information about SARS-CoV-2, actions the facility is taking to protect them and their loved ones, any visitor restrictions that are in place, and actions they should take to protect themselves in the facility, emphasizing the importance of source control, physical distancing and hand hygiene.
- Have a plan and mechanism to regularly communicate with residents, families, and HCP, including if cases of SARS-CoV-2 infection are identified among residents or HCP. Refer to [PA-HAN-567](#) for additional guidance on outbreak response.

f. Notify HCP, residents, and families about outbreaks, and report SARS-CoV-2 infection, facility staffing, testing, and supply information to public health

- Notify the local health department promptly about any of the following:
 - ≥ 1 resident(s) or HCP with suspected or confirmed SARS-CoV-2 infection,
 - Resident with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with acute illness compatible with COVID-19 with onset within a 72-hour period
- Notify HCP, residents, and families promptly about identification of SARS-CoV-2 in the facility and maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions.
- Report SARS-CoV-2 infections, facility staffing and supply information, and [point-of-care testing](#) data to the [NHSN LTCF COVID-19 Module](#) weekly. CDC's NHSN provides LTCFs with a secure reporting platform to track infections and prevention process measures in a systematic way.
- Weekly data submission to NHSN will meet CMS [COVID-19 reporting requirements](#).
- Continue to follow all reporting requirements as outlined by the Secretary of Health.

2. VACCINATE RESIDENTS AND HCP AGAINST SARS-COV-2

- Receiving a COVID-19 vaccination is an important step to prevent getting sick with COVID-19. CDC continues to stress the importance of getting vaccinated when it is offered to you.
- The [Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility](#) provides resources including information on preparing for vaccination, vaccination safety monitoring and reporting, frequently asked questions, and printable tools.
- Weekly vaccination numbers of nursing home residents and HCP can be reported into the [NHSN LTCF Weekly HCP & Resident COVID-19 Vaccination Reporting module](#).
- Guidance on adjustment to IPC recommendations following vaccination is available in [PA-HAN-599](#) for residents and in [PA-HAN-560](#) for HCP.

3. IMPLEMENT UNIVERSAL SOURCE CONTROL AND EYE PROTECTION

- Source control refers to use of **well-fitting** cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. In addition to providing source control, these devices also offer varying levels of protection against exposure to infectious droplets and particles produced by infected people. Fit-tested respirators are most protective for the wearer. Ensuring a proper fit is important to optimize both the source control and protection offered. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19.
- **Universal Source Control for Residents:** If tolerated, residents should wear a well-fitting form of source control upon arrival and throughout their stay in the facility. Residents may remove their source control when in their rooms but should put it back on when around others (e.g., HCP or visitors enter the room) and whenever they leave their room, including when in common areas or when outside of the facility. [More information on options to improve fit is available from CDC](#).
 - Source control should not be placed on anyone who cannot wear a mask safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask or who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Universal Source Control for HCP:** HCP should wear well-fitting source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.
 - In general, fully vaccinated HCP should continue to practice source control while at work. However, fully vaccinated HCP could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If unvaccinated HCP are present, everyone should wear source control.
 - To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or well-fitting facemask throughout their entire work shift when the respirator or facemask is used for source control.
 - HCP should remove their respirator or facemask, perform hand hygiene, and put on their community source control (i.e., mask), when leaving the facility at the end of their shift.
 - Visitors and others who enter the facility (e.g., contractors, people making deliveries), if permitted into the facility, should wear a well-fitting form of source control while in the facility.
- **Universal Eye Protection for HCP:** HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection.

In areas with moderate to substantial community transmission if SARS-CoV-2 infection is **not** suspected in a resident (based on symptom and exposure history):

- HCP should follow [Standard Precautions](#) (and any other precautions such as contact or droplet, if required based on the diagnosis).
- HCP should use N95 respirators or equivalent or higher-level respirators should be used for all [aerosol generating procedures](#).
- HCP should wear eye protection during all patient care encounters to ensure the eyes are also protected from exposure to respiratory secretions.

HCP working in areas with minimal to no community transmission should continue to adhere to [Standard](#) and [Transmission-Based Precautions](#) based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other PPE. If not otherwise wearing a respirator, universal masking for source control is indicated.

4. IMPLEMENT PHYSICAL DISTANCING MEASURES

- Although most care activities require close physical contact between residents and HCP, when possible, maintaining physical distance between people (at least 6 feet) is an important strategy to prevent SARS-CoV-2 transmission.

5. IMPLEMENT SOURCE CONTROL AND PHYSICAL DISTANCING OPTIONS FOR FULLY VACCINATED PERSONS

Options to forgo source control and physical distancing in a LTCF exist for situations where all present meet the criteria as fully vaccinated. Determining the vaccination status of patients/residents/HCP at the time of the activity might be challenging. When determining vaccination status, the privacy of the resident or HCP should be maintained (e.g., not asked in front of other residents or HCP). For example, when planning for group activities or communal dining, facilities might consider having residents sign up in advance so their vaccination status can be confirmed and seating and staffing assigned as appropriate. **If vaccination status cannot be determined, the safest practice is for all participants to follow all recommended infection prevention and control practices including maintaining physical distancing and wearing source control.**

- In general, fully vaccinated HCP should continue to practice physical distancing while at work. However, fully vaccinated HCP could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If unvaccinated persons are present, everyone should wear source control and unvaccinated HCP should physically distance from others.
- The following activities can be considered for residents who do not have current suspected or confirmed SARS-CoV-2 infection, including those who have fully recovered, and residents who have not had [close contact](#) with a person with SARS-CoV-2 infection.
 - Communal dining and group activities at the facility
 - If all residents and HCP participating in the activity or communal dining are fully vaccinated, then residents may choose to have close contact and to not wear source control.
 - If activities and communal dining involve individuals who are not fully vaccinated, all residents should wear source control (if tolerated and during non-eating times) and perform frequent hand hygiene. Those residents who are not fully vaccinated should also practice physical distancing.
 - Social excursions outside the facility
 - Residents and their families should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces.
 - They should practice physical distancing, wear source control (if tolerated), and

perform frequent hand hygiene.

- If fully vaccinated residents are visiting friends or family in their homes, they should follow the source control and physical distancing [recommendations for visiting with others in private settings](#).
- They should inform the facility if they have close contact with a person with SARS-CoV-2 infection while outside the facility. Additional guidance is available in [PA-HAN-567](#).

6. HAVE A PLAN FOR VISITATION

- Have a facility plan for managing visitation, including use of restrictions when necessary.
- While facilities are encouraged to facilitate in-person visits whenever possible, the [CMS visitation memo](#) describes situations requiring temporary restriction of indoor visitors, except for compassionate care reasons. Please refer to [CMS visitation memo](#), [PA Interim Guidance for Skilled Nursing Facilities during COVID-19](#), and [PA-HAN-567](#) for more details.
- Send letters or emails to families reminding them not to visit when ill or if they have had close contact with someone with SARS-CoV-2 infection in the prior 14 days. An example letter can be found [here](#).
- Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry. Assessment should include:
 - [Symptoms](#) of COVID-19;
 - Fever of 100.0 °F or higher or report feeling feverish;
 - [Close contact](#) to someone with COVID-19 during the prior 14 days;
 - Undergoing evaluation for COVID-19 (such as pending viral test) due to exposure or close contact to a person with COVID-19;
 - Diagnosis of COVID-19 in the prior 10 days;
 - A request for visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.
- Visitors should be counseled about recommended infection prevention and control practices that should be used during the visit (e.g., facility policies for source control or physical distancing).
- Facilities should have a plan to manage visitation and visitor flow.
 - Visitors, regardless of their vaccination status, should physically distance (maintaining at least 6 feet between people) from other patients/residents, visitors that are not part of their group, and HCP in the facility, except as described in the scenarios below.
- Facilities might need to limit the total number of visitors in the facility at one time in order to maintain recommended infection control precautions. Facilities might also need to limit the number of visitors per patient/resident at one time to maintain any required physical distancing.
- Location of visitation if occurring indoors:
 - If the patient/resident is in a single-person room, visitation could occur in their room.
 - Visits for patients/residents who share a room should ideally not be conducted in the patient/resident's room.
 - If in-room visitation must occur (e.g., patient/resident is unable to leave the room), an unvaccinated roommate should not be present during the visit. If neither patient/resident is able to leave the room, facilities should attempt to enable in-room visitation while maintaining [recommended infection prevention and control practices](#), including physical distancing and source control.
 - If visitation is occurring in a designated area in the facility, facilities could consider scheduling visits so that multiple visits are not occurring simultaneously, to the extent possible. If simultaneous visits do occur, everyone in the designated area should wear source control and physical distancing should be maintained between different visitation groups regardless of vaccination status.
- When both the resident and all visitors are fully vaccinated, and while alone in the patient/resident's room or the designated visitation room, patients/residents and their visitor(s) can choose to have close contact (including touch) and to not wear source control.

- When visitation is restricted:
 - Send letters or emails to families advising them of the restrictions.
 - Facilitate and encourage alternative methods for visitation (e.g., video conferencing) and communication with the resident.

7. EVALUATE AND MANAGE HEALTHCARE PERSONNEL

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Create an inventory of all volunteers and HCP who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
- Establish a process to ensure HCP (including consultant personnel and ancillary staff such as environmental and dietary services) entering the facility are assessed for symptoms of COVID-19 or close contact outside the facility to others with SARS-CoV-2 infection and that they are practicing source control.
 - Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, HCP report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not had close contact with others with SARS-CoV-2 infection during the prior 14 days.
 - Fever in this setting is defined as a measured temperature $\geq 100.0^{\circ}\text{F}$ or a report of subjective fever (i.e., feeling feverish). People might not notice symptoms of fever at this level, so a measured temperature should be used if the HCP feels well.
- HCP who report symptoms should be excluded from work and should notify occupational health services to arrange for further evaluation. In addition, asymptomatic HCP who report close contact with others with SARS-CoV-2 infection might need to be excluded from work.
 - If HCP develop fever (Temperature $\geq 100.0^{\circ}\text{F}$) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace.
- Have a plan for how to respond to HCP with SARS-CoV-2 infection who worked while ill (e.g., identifying exposed residents and co-workers and initiating an outbreak investigation in the unit or area of the building where they worked).
- Information about when non-essential HCP should have limited entry into facilities can be found in the [CMS Re-opening Memo](#).
- Information about when HCP with suspected or confirmed SARS-CoV-2 infection may return to work is provided in [PA-HAN-553](#).
- Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in [PA-HAN-560](#).

8. IDENTIFY A COVID-19 CARE UNIT DEDICATED TO MONITOR AND CARE FOR RESIDENTS WITH CONFIRMED SARS-COV-2 INFECTION

- Determine the location of the COVID Care Unit and create a staffing plan.
 - Doing this before residents or HCP with SARS-CoV-2 infection are identified in the facility will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit.
 - Facilities that have already identified cases of SARS-CoV-2 infection among residents but have not developed a COVID Care Unit should work to create one unless the proportion of residents with SARS-CoV-2 infection makes this impossible (e.g., the majority of residents in the facility are already infected).
- The location of the COVID Care Unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to

cohort residents with SARS-CoV-2 infection. The COVID Care Unit should have dedicated entrance and exit points such that HCP not working in that unit do not need to pass through.

- Identify HCP who will be assigned to work only on the COVID Care Unit when it is in use. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. If possible, HCP should avoid working on both the COVID Care Unit and other units during the same shift.
 - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
 - Ideally, environmental services (EVS) should be dedicated to this unit, but to the extent possible, EVS should avoid working on both the COVID Care Unit and other units during the same shift.
 - To the extent possible, HCP dedicated to the COVID Care Unit (e.g., NAs and nurses) will also be performing cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from [List N](#) into the room and wipe down high-touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.
- HCP working on the COVID Care Unit should have access to a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
 - Ensure HCP practice source control measures and physical distancing in the break room and other common areas (i.e., other than while eating, HCP wear a respirator or source control and sit at least 6 feet apart while on break).
 - Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).

9. EVALUATE RESIDENTS AT LEAST DAILY

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever (temperature $\geq 100.0^{\circ}\text{F}$) and [symptoms consistent with COVID-19](#). Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions as described in [PA-HAN-567](#).

10. CREATE A PLAN FOR TESTING RESIDENTS AND HEALTHCARE PERSONNEL FOR SARS-COV-2

- Guidance addressing when to test residents and HCP for SARS-CoV-2 and how to interpret results of antigen tests is available at the following links:
 - CDC: [Testing Guidelines for Nursing Homes and Guidance on SARS-CoV-2 Testing and Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#)
 - [PA-HAN-547](#) Point-of-Care Antigen Testing for SARS-CoV-2 in Long-term Care Facilities
 - [PA-HAN-567](#) Response to an Outbreak and Residents with Exposure to COVID-19 for Long-term Care Facilities
- The plan should align with state and federal requirements for testing residents and HCP for SARS-CoV-2 and address:
 - Triggers for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, a resident or HCP with SARS-CoV-2 in the facility, routine testing)
 - Fully vaccinated HCP may be exempt from expanded screening testing. However, vaccinated HCP should have a viral test if the HCP is symptomatic, has a higher-risk exposure or is working in a facility experiencing an outbreak.
 - Access to tests capable of detecting the virus and an arrangement with laboratories to process tests or capacity to conduct and process point-of care tests onsite. A laboratory must have a current PA laboratory permit or waiver (for point-of-care testing)

- and be approved to perform COVID-19 testing. A facility may verify licensure and approval by emailing RA-DHPACLIA@pa.gov.
- Process for and capacity to perform SARS-CoV-2 testing of all residents and HCP
- Training for HCP on how to collect and process specimens correctly, including correct use of PPE.
- A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until [symptom-based criteria](#) are met for a symptomatic resident who refuses testing)
- A plan to respond to results of the testing; for additional information see [PA-HAN-567](#).
- For requests for testing support, please visit the [Department webpage for nursing homes](#).
- Additional information about testing of residents and HCP is available:
 - [Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings](#), which includes considerations for health departments and nursing homes for facility-wide testing
 - [Interim Final Rule \(IFC\), CMS-3401-IFC](#), Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool

11. CREATE A STAFFING PLAN

Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these before shortages occur, including providing [resources](#) to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are described in [PA-HAN-560](#).

Ideally, residents with different levels of COVID-19 exposure (e.g. positive residents in isolation, residents in quarantine for close contact, residents in quarantine following admission, residents with no known exposure) would be cared for by HCP that do not care for residents in other risk categories. This is not possible in many LTCFs.

Prioritize dedicated staff for COVID Care Unit where residents with COVID-19 infection are being housed. Identify HCP who will be assigned to work only on the COVID Care Unit when it is in use. At a minimum this should include the primary NAs and nurses assigned to care for these residents. If possible, HCP should avoid working on both the COVID Care Unit and other units during the same shift. HCP working on the COVID Care Unit should have access to a restroom, break room, and work area that are separate from HCP working in other areas of the facility.

Second, if possible, prioritize dedicated HCP for units or residents with known exposure to COVID-19. If HCP must move between units (for example, specialized therapy staff), schedule their resident visits such that the residents at lowest risk of having COVID-19 (e.g., those with no known exposure) are visited earlier in the day, with residents at highest risk of COVID-19 (e.g., those in quarantine) at the end of the day. If the facility is using extended use of PPE as an optimization strategy, HCP moving between units should follow all infection prevention and control measures including removing gloves and gowns and performing hand hygiene between units. Respirators and eye protection can be worn continuously as part of PPE optimization strategies.

The facility staffing plan should outline ways to assure that most HCP work on only one unit, or a consistent set of units. The fewer HCP that work in multiple units, the fewer residents will be exposed if an HCP become infectious.

DEFINITIONS

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency

medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Fully vaccinated refers to a person who is:

- ≥ 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; there is currently no post-vaccination time limit on fully vaccinated status
- This guidance applies to COVID-19 vaccines currently authorized for emergency use by the Food and Drug Administration. Considerations for applying this guidance to vaccines that are not FDA-authorized include whether the vaccine product has received emergency approval from the World Health Organization or authorization from a national regulatory agency.

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

Minimal to no community transmission of SARS-CoV-2: For the purposes of this guidance, a county positivity rate less than 5% is considered minimal to no community transmission. Facilities can use rates published by [CMS](#) or [PA DOH](#), but must use the same source every week as defined in their policy.

Moderate to sustained community transmission: For the purposes of this guidance, a county positivity rate of 5% or more is considered moderate to sustained community transmission. Facilities can use rates published by [CMS](#) or [PA DOH](#), but must use the same source every week as defined in their policy.

If you have questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877- 724-3258) or your local health department.

Categories of Health Alert messages:

Health Alert: conveys the highest level of importance; warrants immediate action or attention.

Health Advisory: provides important information for a specific incident or situation; may not require immediate action.

Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of April 30, 2021 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.