



This document has been archived. Please refer to [PA-HAN-663](#) for updated information on the topic.

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TO:	Health Alert Network
FROM:	Keara Klinepeter, Acting Secretary of Health
SUBJECT:	UPDATE: Core Infection Prevention and Control Measures for Long-term Care Facilities
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This transmission is a “Health Update”: provides updated information regarding an incident or situation; unlikely to require immediate action.

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 HAN provides guidance on core infection prevention and control measures for long-term care facilities (LTCF) during the COVID-19 pandemic and incorporates updates made by CDC on February 2, 2022. The guidance supplements general guidance for all healthcare facilities given in [PA-HAN-624](#).

This update includes:

- For instances where the term “fully vaccinated” was previously used to guide infection prevention and control measures, a person must instead be “up to date” with all recommended COVID-19 vaccine doses.
- Even if they have met community criteria to discontinue isolation or quarantine per [PA-HAN 619](#) (typically 5 days), visitors **should not visit** if they have not met the same criteria used to discontinue isolation and quarantine for residents (typically 10 days).
- HCP should not work while acutely ill, even if SARS-CoV-2 testing is negative, in order to minimize the risk of transmission of other infectious pathogens, including respiratory pathogens such as influenza.

This guidance replaces PA-HAN-609. Additions are written in red. 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. The guidance in this HAN applies to skilled nursing facilities (SNFs), personal care homes (PCHs), assisted living facilities (ALFs), and intermediate care facilities (ICFs) **except regarding visitation**. This visitation guidance only applies only to SNFs. Other facility types should seek guidance from their licensing agency for visitation. This guidance supplements recommendations for all healthcare facilities given in [PA-HAN-624](#). Additional guidance for LTCFs in response to an exposure to, or a case of COVID-19 is given in [PA-HAN-627](#) or its successor. 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](#)).

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, physical distancing, and eye protection
4. Have a plan for visitation
5. Evaluate and manage HCP
6. Identify a COVID Care Unit dedicated to monitor and care for residents with confirmed SARS-CoV-2 infection
7. Evaluate residents at least daily
8. Create a plan for testing residents and HCP for SARS-CoV-2
9. 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-624](#) 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 or its successor 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.

- Submit data at least once per week to the each of the 4 surveillance reporting pathways within the [NHSN LTCF COVID-19 Module](#). Data submission to NHSN will meet CMS [COVID-19 reporting requirements](#).
- Submit positive and negative COVID-19 viral test results performed at the LTCF into the [point-of-care testing](#) reporting tool within NHSN or PA-NEDSS within 24 hours of test completion as described in [PA HAN 534](#). CDC's NHSN provides LTCFs with a secure reporting platform to track infections, equipment and staffing shortages, lab results performed at the LTCF and COVID-19 vaccination rates in a systematic way.
- Continue to follow all reporting requirements as outlined by the Secretary of Health.

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

- Remaining **up to date** with all recommended COVID-19 vaccine doses is critical to protect both staff and residents against SARS-CoV-2 infection. Current COVID-19 vaccine recommendations are available in the [Interim Clinical Considerations for Use of COVID-19 Vaccines](#).
- 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.
- Per CMS requirements, submit the number of nursing home residents and HCP who received any doses of the COVID-19 vaccination into the [NHSN LTCF Weekly HCP & Resident COVID-](#)

3. IMPLEMENT UNIVERSAL SOURCE CONTROL, PHYSICAL DISTANCING AND EYE PROTECTION

Refer to [PA-HAN-624](#) for details regarding source control, physical distancing and eye protection measures recommended for HCP and residents.

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. For residents **who are up to date with all recommended COVID-19 vaccine doses** and not restricted to their room following an exposure to COVID-19, source control is a critical mitigation measure. If a resident is not able to maintain adequate well-fitting source control, consider limiting the resident to their room.

4. HAVE A PLAN FOR VISITATION

The guidance in this HAN applies to SNFs, PCHs, ALFs, and ICFs **except regarding visitation**. This visitation guidance only applies only to SNFs. Other facility types should seek guidance from their licensing agency for visitation.

- Have a facility plan for managing visitation, including use of restrictions when necessary.
- Visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention as outlined in [QSO-20-39-NH](#). Please refer to [CMS visitation memo](#), [PA Interim Guidance for Skilled Nursing Facilities during COVID-19](#), and [PA-HAN-627](#) or its successor for more details.
- **Send letters or emails to families and post signs at entrances reminding them of the: 1) importance of remaining up to date with all recommended COVID-19 vaccine doses; 2) recommendations for source control and physical distancing; and 3) any other facility instructions related to visitation.** An example letter can be found [here](#).
- **Even if they have met community criteria to discontinue isolation or quarantine per PA-HAN 619 or its successor, visitors should not visit if they have any of the following and have not met the same criteria used to discontinue isolation and quarantine for residents.** 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:

- Diagnosis of COVID-19 in the prior 10 days;
- 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 **10 days**;
- Undergoing evaluation for COVID-19 (such as pending viral test) due to exposure or close contact to a person with COVID-19;
- A request for visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within **10 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 wear face coverings or masks and physically distance (maintaining at least 6 feet between people) when around other patients/residents, visitors that are not part of their group, and HCP in the facility.
- 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), a roommate who is **not up to date with all recommended COVID-19 vaccine doses** or who is immunocompromised (regardless of vaccination status) 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.
- Patients/residents and their visitor(s) can choose to have close contact (including touch) and to not wear source control if:
 - Resident and all visitors are **up to date with all recommended COVID-19 vaccine doses**; and
 - Resident is not moderately or severely immunocompromised; and
 - The visit takes place in patient/resident's room or the designated visitation room
- **Facilitate and encourage alternative methods for visitation (e.g., video conferencing) and communication with the resident.**

Additional information about visitation for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from CMS.

5. EVALUATE AND MANAGE HEALTHCARE PERSONNEL

- **HCP should not work while acutely ill, even if SARS-CoV-2 testing is negative, in order to minimize the risk of transmission of other infectious pathogens, including respiratory pathogens such as influenza.**
 - **If an alternative diagnosis has been established through laboratory testing, may use return to work criteria for that diagnosis.**
 - **Otherwise, HCP should follow their facility's return to work policy for respiratory illness.**
- 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 HCP with suspected or confirmed SARS-CoV-2 infection may return to work is provided in [PA-HAN 622](#).
- Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in [PA-HAN 621](#).

6. 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).

7. EVALUATE RESIDENTS AT LEAST DAILY

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 **or an acute respiratory infection**.
- Actively monitor all residents upon admission and at least daily for fever (temperature $\geq 100.0^{\circ}\text{F}$) 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-627](#) or its successor.
 - Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures $>99.0^{\circ}\text{F}$ might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection.
 - Because some of the [symptoms are similar](#), it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections, based on symptoms alone. [Consider testing for pathogens](#) other than SARS-CoV-2 and initiating appropriate infection prevention precautions for symptomatic older adults.
 - Refer to CDC [resources](#) for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of patients with SARS-CoV-2 infection is described in the [Management of Patients with Confirmed 2019-nCoV | CDC](#).

8. 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:
 - [PA-HAN-624](#) Interim Infection Prevention and Control Recommendations for Healthcare Settings during the COVID-19 Pandemic
 - [PA-HAN-547](#) Point-of-Care Antigen Testing for SARS-CoV-2 in Long-term Care Facilities
 - [PA-HAN-627](#) Response to an Outbreak and Residents with Exposure to COVID-19 for Long-term Care Facilities
 - [PA-HAN-621](#) Work Restrictions for Healthcare Personnel with Exposure to COVID-19
- 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)
 - HCP **up to date with all recommended COVID-19 vaccine doses** may be exempt from expanded screening testing. However, these 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-627](#) or its successor.
- 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
 - [QSO-20-38-NH REVISED](#), 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

9. 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 621](#) and [PA-HAN 622](#).

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 as described in Section 6.

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

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal protective equipment (PPE) appropriate for use by healthcare personnel as the degree to which**

cloth masks protect the wearer might vary. Guidance on design, use, and maintenance of cloth masks is [available](#).

Close contact: Being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

Facemask: OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy.”

Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

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).

Healthcare settings: Places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the CDC [Interim Clinical Considerations for Use of COVID-19 Vaccines](#).

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise and not clearly affect decisions about need for or duration of Transmission-Based Precautions if the individual had close contact with someone with SARS-CoV-2 infection. However, people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility, **even if they are up to date with all recommended COVID-19 vaccine doses.**
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

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

Source control: Use of well-fitting cloth masks, **well-fitting** 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. Source control 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.

Up to date: In general, being up to date on COVID-19 vaccination includes receiving all vaccines according to the recommendations provided by CDC. This includes a primary series of vaccine, booster doses, and any recommended third doses for immunocompromised people. For specifics, refer to [CDC guidance](#).

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 February 15, 2022 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.