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Updated Interim Guidance for Nursing Homes and Other Long-Term Care Facilities

Corresponding Emergency Rules will be Promulgated

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Applicability

This interim guidance provides guidelines for nursing homes and other long-term care (LTC) facilities regarding restrictions that were instituted to mitigate the spread of COVID-19. The guidance in this document is specifically intended for facilities as defined in the Nursing Home Care Act (210 ILCS 45), and also applies to Supportive Living Facilities, Assisted Living Facilities, Shared Housing Establishments, Sheltered Care Facilities, Specialized Mental Health Rehabilitation Facilities (SMHRF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), State-Operated Developmental Centers (SODC), Medically Complex/Developmentally Disabled Facilities (MC/DD), and Illinois Department of Veterans Affairs facilities.

Non-discrimination Statement

It is essential that health care institutions operate within an ethical framework and consistent with civil rights laws that prohibit discrimination in the delivery of health care. Specifically, in allocating health care resources or services during public health emergencies, health care institutions are prohibited from using factors including, but not limited to, race, ethnicity, sex, gender identity, national origin, sexual orientation, religious affiliation, age, and disability. For additional information, refer to: Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 (COVID-19).

Reason for Update
New Guidance released from the CDC and CMS

This interim guidance incorporates the September 10, 2021 recommendations for nursing homes and other long-term care (LTC) facilities from the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) to prevent the spread of SARS-CoV-2.

Introduction/Background

Older adults living in congregate settings are at high risk for infection by respiratory and other pathogens, such as SARS-CoV-2. Even as nursing homes and other long-term care facilities resume normal practices, they must sustain core infection prevention and control (IPC) practices and remain vigilant for SARS-CoV-2 infection among residents and health care personnel (HCP) in order to prevent spread and to protect residents and HCP from severe infections, hospitalizations, and death."[1]

[1] Centers for Disease Control and Prevention (CDC). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. September 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

The Core Principles of COVID-19 Infection Prevention have been updated to reflect recent advances in the prevention of COVID-19, including the availability of effective, U.S. Department of Food and Drug Administration (FDA)-approved vaccines, and increased knowledge about the transmission of the SARS-CoV-2 virus.

Core Principles of COVID-19 Infection Prevention

- Vaccination
- Source control (masks, face coverings, and other respiratory protection)
- Resident and staff testing
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Physical distancing
- Appropriate use of personal protective equipment (PPE)
- Instructional signage throughout the facility and communication
- Infection prevention and control education and competency
- Cleaning and disinfecting high frequency touched surfaces and equipment
- Appropriate ventilation
- Effective cohorting

Continuing to take precautions to reduce the risk of transmission of COVID-19 remains vitally important. At this time, not all nursing home residents and staff are fully vaccinated making it possible for them to still become infected by visitors. In addition, the CDC and public health experts are evaluating if individuals can spread COVID-19, including new variants, even if they are vaccinated. Having a strong IPC program is critical to protect both residents and health care personnel (HCP).

This IDPH guidance document draws on currently available best practice recommendations. IDPH will revise and update this document as needed, based on accrued experience, new information, and future guidance from CMS and CDC.

Vaccinations – Updated

LTC facilities and State-operated congregate facilities must ensure that staff are vaccinated and tested in accordance with Executive Order 2021-22 and the Illinois Administrative Codes applicable to each respective licensure found at link.

Testing is not required of HCP within 90 days of a prior COVID-19 infection, if the staff member remains asymptomatic.

Vaccination for visitors is always preferred and should be encouraged. The state has arrangements with specialized LTC pharmacies that will work with facilities to provide onsite vaccination clinics for the family and friends of residents.

All LTC facilities have access to COVID-19 vaccinations, either through their local health department or specialized LTC pharmacy vaccine providers operating within Illinois. For LTC facilities with questions about obtaining COVID-19 vaccinations outside of the city of Chicago, please contact your local health department or email dphltctesting@illinois.gov.

Note Chicago receives a direct federal allocation of vaccine and oversees their own LTC pharmacy provider network. Chicago facilities should contact the Chicago Department of Public Health to coordinate a COVID-19 vaccination clinic at covid19vaccine@cityofchicago.gov .

For larger LTC facilities with the ability to accept, store, administer, and report COVID-19 vaccine doses administered to the Illinois vaccine registry (I-CARE), you may wish to enroll as a registered COVID-19 provider through the I-CARE system.

Reporting of Staff and Resident COVID-19 Vaccinations and Testing - New

Facilities that are not required to report COVID-19 aggregate vaccination and testing data into the National Healthcare Safety Network (NHSN) shall report this data to the Department weekly utilizing the online form at LTC Weekly Reporting COVID-19 Vaccinations and Testing.

The required information matches that submitted by CMS-certified facilities to NHSN.

Monoclonal Antibody Therapy – New

Treatment with monoclonal antibodies (mAb) may reduce the risk of severe COVID-19 disease and hospitalization. **As soon as a resident is diagnosed with COVID-19 or determined to be a close contact of someone with COVID-19, contact the resident's provider and the pharmacy to assess whether monoclonal antibodies should be administered.**

Treatment: Persons who are older or who have chronic respiratory, cardiac, or renal disease, obesity, immunosuppressive disease, diabetes, and other medical conditions or factors, including race and ethnicity associated with increased risk of severe COVID-19 disease, may benefit from mAb treatment**, regardless of vaccination status**.

Post-exposure prophylaxis: Monoclonal antibody treatment may also be used to prevent the development of COVID-19 for close contacts who are at high risk for progression to severe COVID-19, including hospitalization or death, and are not fully vaccinated or who are not expected to develop immunity from vaccination (for example, people with immunocompromising conditions, including those taking immunosuppressive medications).

More information about mAb treatment is available from IDPH, CDC, CMS, and from the U.S. Department of Health and Human Services (HHS).

Allocation and distribution process

Long-term care facilities should contact your usual pharmacy provider for more information on residents receiving monoclonal antibodies.

New providers or sites for mAb administration, please provide initial account information to AmeriSource Bergen through this link**.**

Current mAb providers can submit requests for monoclonal antibody treatment to the State here.

Source control and physical distancing recommendations - Updated

The safest practice is for residents and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated.

Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a health care setting. HCP must wear at a minimum a well fitted face mask while working. Other PPE may be required; see the section on Universal PPE for HCP.

In accordance with Governor Pritzker's August 4, 2021 Executive Order Number 18 (COVID-19 Executive Order No. 85), "all nursing homes and long-term care facilities in Illinois must continue to follow the guidance issued by the CDC and IDPH that requires the use of face coverings in congregate facilities for those over the age of 2 and able to medically tolerate a face covering, regardless of vaccination status."

Universal PPE for HCP – New

- **If a resident is suspected or confirmed to have COVID-19, or is an unvaccinated resident identified to be a close contact,** HCP must wear an N95 respirator, eye protection, gown, and gloves.

- If a resident is identified to be a close contact and is vaccinated, HCP must wear PPE according to community transmission levels listed below.

- **For those residents not suspected to have COVID-19, HCP should use community transmission levels to determine the appropriate PPE to wear**

    - **When community transmission levels are *substantial or high***

HCP must wear a well-fitted face mask and eye protection.
  - **HCP working in non-patient care areas** are not required to wear eye protection with substantial or high community transmission levels, except when entering the patient care areas (e.g., dietary aide, maintenance, etc.).

- **When community transmission levels are *low-to-moderate***
  HCP must wear a well-fitted face mask.

- **For COVID-19 specimen collection**: HCP must wear N95 respirator, eye protection, gown, and gloves

- **Guidance for CPAP/BIPAP for asymptomatic residents**, who are not suspected to have COVID-19 (regardless of vaccination status).
  - In areas with **substantial-to-high community transmission levels,** HCP must wear N95 respirator and eye protection.
  - In areas **with moderate-to-low community transmission levels**, HCP must wear a well-fitted face mask.

Continued Monitoring of Essential Measures - Updated

Facilities should continue to monitor essential criteria to ensure they can provide safe care and respond to outbreak situations.

Case Status in the Community: New Focus on County Level COVID-19 Transmission
How to implement several of the IPC measures (e.g., vaccination, use of source control, screening testing) depends on levels of SARS-CoV-2 transmission in the community.

KEY POINTS:
County test positivity rates for COVID-19 are no longer available on the CMS website.

- **Facilities must use the CDC COVID-19 Data Tracker.**
- **Facilities must carefully monitor the color-coding, which depicts county community transmission levels.**
- Facilities must contact their local health department with questions pertaining to community transmission levels.

Factors CDC uses to calculate the COVID-19 county level of community transmission.
The CDC uses two different indicators (identified in the table below) to determine the level of SARS-CoV-2 transmission for the county where the LTC facility is located**.** If the two indicators suggest different transmission levels, CDC will use the higher level to determine community transmission risk. Facilities do not need to calculate county community transmission levels.

Table 1: Determining County Level of Community Transmission

	LOW	MODERATE	SUBSTANTIAL	HIGH
New cases per 100,000 persons in the past 7 days*	<10	10-49.99	50-99.99	>100
Percentage of positive NAATS tests during the past 7 days*	<5%	5-7.99%	8-9.99%	>10.0%

*See footnotes from CDC guidance: https://covid.cdc.gov/covid-data-tracker/#county-view

Community transmission levels dictate facility testing of unvaccinated HCP, PPE use, and facility response to a positive case(s).

- **The facility must test unvaccinated staff** according to the community transmission level or more frequently if required by local or state authorities. See Table: Routine Testing Intervals by County COVID-19 Level of Community Transmission (below).

- **Facilities must monitor their community transmission level every other week (e.g., first and third Monday of every month) and adjust the frequency of staff testing accordingly.**

- **If the community transmission level increases** to a higher level of activity, the facility must begin testing staff at the frequency shown in the table below as soon as the criteria for the higher activity level are met.
- **If the community transmission level decreases**, the facility must continue testing staff at the higher frequency until the level of community transmission has remained at the lower level for at least two weeks before reducing testing frequency as shown in the table below.

- **For HCPs who work infrequently (less than weekly)**, test within 72 hours of the next scheduled shift.

- The local health department may have a more stringent testing requirements that facilities must follow.

Table 2: Testing Intervals of Unvaccinated HCP by Community Transmission Level

Community Transmission Level	Minimum Testing Frequency of Unvaccinated Staff*
LOW	Per Illinois COVID-19 Executive Order No. 85 testing is required at a minimum of weekly
MODERATE	Once a week
SUBSTANTIAL	Twice a week
HIGH	Twice a week

*Vaccinated staff do not need to be routinely tested. Testing is not required of HCP within 90 days of a prior COVID-19 infection, if the staff member remains asymptomatic.

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

Staffing level
IDPH does not support staff working while ill. However, should shortages occur, facilities should utilize mitigation strategies as defined by CDC.[2] Refer to CDC website "Mitigation Strategies for Staffing Shortages."

Hand hygiene
The facility must train and validate competencies of all staff on hand hygiene. Everyone entering the facility must perform hand hygiene.[3]

Cleaning and disinfection supplies
Ensure that any disinfectants used in the facility are included on the U.S. Environmental Protection Agency (EPA) "List N"[4] as effective against coronavirus (COVID-19)**.** Cleaning and disinfecting products should be readily available for use at the point of care.

PPE supply
- **Conventional** (normal operations without shortages),
- **Contingency capacity** (measures used temporarily during periods of anticipated PPE shortages), and
- **Crisis capacity** (strategies implemented during periods of shortages even though they do not meet U.S. standards of care).

The supply and availability of NIOSH-approved respirators and other PPE has increased significantly. **Health care facilities should not be using crisis capacity strategies at this time**.

Facilities that extend the use of N95 respirators, face masks, and eye protection are operating at a contingency level of PPE utilization. If PPE is reused, the facility is operating at a crisis level. Based upon availability, facilities should not be operating at a crisis level for PPE utilization[5]. Utilize CDC PPE optimization strategies

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[2] Centers for Disease Control and Prevention. Strategies to Mitigate Healthcare Personnel Staffing Shortages, March 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

[3] Centers for Medicare and Medicaid Services Nursing Home Visitation - COVID-19 (REVISED) April 27, 2021. https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

[4] U.S. Environmental Protection Agency (EPA) https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19

[5] Centers for Disease Control and Prevention (CDC). Optimizing Supply of PPE and Other Equipment during Shortages https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html

Universal screening

- Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following criteria so that they can be properly managed:
    - 1) a positive viral test for SARS-CoV-2,
    - 2) symptoms of COVID-19, or
    - 3) person who meets criteria for quarantine, isolation, or exclusion from work.

- Options could include (but are not limited to): individual screening on arrival at the facility or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

- **Health care personnel (HCP),** even if fully vaccinated, should report any of the above criteria. Symptomatic HCP should be restricted from work until they have been evaluated.

- **Visitors** meeting any of the above criteria should generally be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively[6].

Testing Plan and Response Strategy - Updated
(Appendix A has a table summarizing this information)

The facility must have a written COVID-19 testing plan and response strategy in place based on contingencies informed by the CDC[7] and, as applicable, CMS requirements.[8] The testing plan must specify the method(s) and locations of testing (laboratory and/or point-of-care). The testing plan should include:

- **A policy for addressing residents and staff that refuse testing.**

- **Timely reporting of testing results** to IDPH and the certified local health department.

- **Provisions for designating resident care areas** with dedicated staff if residents test positive for COVID-19 (COVID-19 unit).

- **The facility must submit its testing and response plan** to IDPH, CMS, or local health department personnel upon request.

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[6] Centers for Disease Control and Prevention (CDC). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. September 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

[7] https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html ; https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

[8] https://www.federalregister.gov/documents/2020/09/02/2020-19150/medicare-and-medicaid- programs-clinical-laboratory-improvement-amendments-clia-and-patient

- **Facilities should have arrangements with a laboratory** to conduct tests to meet these requirements. Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48 hours) should be selected to rapidly inform infection prevention initiatives to prevent and to limit transmission. A list of private labs available to provide testing in LTC facilities can be found here.

- Although a laboratory RT-PCR test remains the gold standard for testing, point-of-care (POC) antigen testing is acceptable. For a facility to conduct these tests with their own staff and equipment, the facility must have, at a minimum, a CLIA Certificate of Waiver**.**

Newly Identified Positive Case in an HCP or Resident – Updated

Because of the risk of unrecognized infections among HCP or residents, a single new case of COVID-19 in any HCP or resident should be evaluated as a potential outbreak.

- Increase monitoring and screening of all residents and HCP for signs and symptoms of COVID-19 from daily to each shift, to more rapidly detect those with new symptoms.

- **Determine which approach to use for the outbreak investigation.** Facilities have the option to choose either a Unit (or department)-based approach or a broad-based approach

    - Either contact tracing or broad-based approaches are recommended by the CDC for outbreak investigations in long-term care facilities. In order to assure that all potential close contacts are tested, IDPH will require at a minimum a unit-based approach in addition to contact tracing.

    - It is up to the facility to determine which approach to use. If the facility has the resources and experience to investigate the outbreak at a unit-level [e.g., unit, floor, or other specific area(s) of the facility], and identify higher risk exposures and close contacts, they can choose the unit-level approach. Otherwise, the facility should use a broad-based approach.

    - A broad-based approach is required in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.

- LTC facilities responding to COVID-19 cases must always notify and follow the recommendations of the local health department.

Unit (or department level)-based approach
This is a more focused approach and starts the outbreak investigation on the unit or department where the positive COVID-19 case was identified (affected unit).

- If the unit-based approach is used, the facility must test all residents and HCP on the unit (or department) where the HCP worked or the resident resided immediately (but not earlier than two days after exposure), regardless of vaccination status. Continue to test every 3-7 days until there are no more positive cases for 14 days.

- There is no need to test individuals who have had COVID-19 in the prior 90 days if they remain asymptomatic. PCR testing is preferred, but POC antigen tests are also acceptable.

- Perform contact tracing on the unit or department where the new case was identified, by investigating to determine if during the prior 48 hours there were any higher risk exposures to other HCP or close contacts with residents.

- Also determine if there were any higher risk exposures of HCP or close contacts of residents beyond the affected unit (e.g., other units, departments).

- Those identified to be higher risk exposures or close contacts must be tested every 3-7 days until there are no more positive cases for 14 days.

- **Pause all visitation** (except compassionate care, end-of-life, essential caregivers) on the affected unit until the first round of testing is performed and results are obtained.

- Once the initial tests are completed and the results are obtained, the facility must **determine if the outbreak investigation should be expanded** to other areas of the facility.

- When the positive case is a staff member who rotates on multiple units, facilities must determine which units may be affected based upon the infectious period or 48 hours prior to the positive test. Multiple units may need to be tested. **If more than one unit is indicated, follow the broad-based approach below.**

- In general, individuals who have had a COVID-19 infection within the past 90 days are exempt from testing unless they become symptomatic.

Broad-based Approach

This approach is broad from the start or onset and requires testing of all residents and HCP regardless of vaccination status when a single case of COVID-19 is identified in the facility.

- Conduct facility-wide testing of all residents and HCP immediately (but not earlier than two days after exposure), regardless of vaccination status.

- **Pause all visitation** (except compassionate care, end-of-life, essential caregivers) until the first round of testing is performed and results are obtained.
- **Continue to test every 3-7 days until there are no more positive cases for 14 days.**

- In general, individuals who have had a COVID-19 infection within the past 90 days are exempt from testing unless they become symptomatic.

HCP Higher-risk Exposure – Updated

The specific factors associated with these exposures should be evaluated on a case-by-case basis to determine if a higher-risk exposure occurred; interventions, including restriction from work, can be applied if the risk for transmission is deemed substantial (evaluating an exposure).[9]

Testing of HCP with higher risk exposures is conducted in addition to the routine serial testing of unvaccinated HCP required by CMS and the COVID-19 Executive Order No. 85.

- **Unvaccinated HCP** should be excluded from work for 14 days after their last exposure and have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than two days after the exposure) and, if negative, again 5–7 days after the exposure. The HCP should be referred to their health care provider for possible post-exposure prophylaxis with monoclonal antibodies.

- **Fully vaccinated asymptomatic HCP** should have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than two days after the exposure) and, if negative, again 5–7 days after the exposure. Work restriction is not necessary unless the HCP develops symptoms or tests positive for COVID-19.

- **Asymptomatic HCP who have recovered from COVID-19 in the past 90 days,** do not need to be restricted from work or have testing performed following exposure to a confirmed or probable COVID-19 case if they remain asymptomatic.

- HCP who are **moderately to severely immunocompromised** might be at increased risk for infection. Facilities should consult with their local health department for any work restrictions that may be required after a higher risk exposure.

- **Note:** Fully vaccinated HCP with **prolonged, continued exposure in the home** (e.g. children, spouse or other household member positive for COVID-19 who cannot be isolated from others in the home) must test at least two days after first exposure, between days 5-7, and weekly for two weeks after the last exposure date.

[9] Centers for Disease Control and Prevention (CDC). Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

- Restriction from work, quarantine, and testing is not recommended for people who have had COVID-19 in the last 90 days if they remain asymptomatic.

Management of Residents – Updated

Residents with ***Confirmed* COVID-19**

- Resident placement
  - Single room
  - Door closed (if safe to do so)
- Designate a separate area or unit as a COVID-19 unit
- Isolate using transmission-based precautions
- Monitor the resident every four hours
- Use dedicated medical equipment
- Dedicate HCP to the COVID-19 unit (including environmental services or housekeeping staff)
- Staff wear full PPE (N95 respirator, gown, gloves, eye protection)
- Visitation - Updated
  - Indoor and outdoor visits -generally not allowed except facilities must allow compassionate care, end-of-life visits, and visits from ombudsman/guardians
  - Counsel visitors about risks of COVID-19
- Communal dining - not allowed in communal areas. Dining should occur in resident room.
- Group activities - resident should not participate in group activities until recovered.
- Transmission-based precautions (TBP)
  - Symptom-based strategy is preferred over testing strategy
  - Mild-to-moderate illness
    - A minimum of 10 days since symptoms first appeared or first diagnostic test
    - Fever free for 24 hours without fever-reducing medications
    - Symptoms improving (e.g., shortness of breath, cough)
  - Severe-to-critical illness or moderate-to-severely immunocompromised
    - A minimum of 10 days (or up to 20 days) since symptoms first appeared
    - Fever free for 24 hours without fever-reducing medications
    - Symptoms improving (e.g., shortness of breath, cough)
    - Consider consultation with infectious disease expert
- Environmental cleaning
  - Routine cleaning and disinfection of surfaces and equipment.
  - After discharge, leave the room empty (do not occupy or enter) for a period of one hour (60 minutes). Environmental services or housekeeping must not enter to terminally clean the room before 60 minutes has elapsed, unless they are wearing full PPE. After 60 minutes, they can wear a well-fitted face mask.

Residents ***Suspected* to have COVID-19 - Updated**

- Test symptomatic residents regardless of vaccination status
- Patient placement

  - Single room (if feasible)
  - Door closed (if safe to do so)
  - Private bathroom if possible
- Isolate using transmission-based precautions until results of tests are known
- Evaluate residents at least daily
- Use dedicated medical equipment
- Staff wear full PPE (N95 respirator, gown, gloves, eye protection)
- Visitation-Updated
  - Indoor and outdoor visits - generally not allowed except facilities must allow compassionate care, end-of-life visits, and visits from ombudsman/guardians
  - Counsel visitors about the risks of COVID-19
- Communal dining – not allowed in communal areas. Dining must occur in resident room.
- Group activities – resident must not participate in group activities until recovered.
- Routine cleaning and disinfection of surfaces and equipment.
- After discharge, leave the room empty for a period of 60 minutes. Environmental services or housekeeping must not enter to terminally clean the room before 60 minutes has elapsed, unless they are wearing full PPE. After 60 minutes, they can wear a well-fitted face mask.
- If limited single rooms are available, or if numerous residents are simultaneously identified to have COVID-19 exposures or symptoms concerning for COVID-19, residents should remain in their current location, draw privacy curtain between beds, and wait for ***test results.***

Resident identified as a *Close Contact* of someone with COVID-19 (e.g., roommates or other close contacts) - Updated

- **Restriction from quarantine, and testing is not recommended for people who have had COVID-19 in the last 90 days if they remain asymptomatic.**
- **Regardless of vaccination status**, should have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than two days after the exposure) and, if negative, again 5–7 days after the exposure.
- Isolation, quarantine, and PPE requirements for residents identified to be a close contact of a positive COVID-19 case.
  - If the resident is ***symptomatic,*** regardless of vaccination status isolate using transmission-based precautions and test as above. HCP should wear full PPE — treat as suspected COVID-19 case (see above guidance).
  - If resident is ***asymptomatic and fully vaccinated,*** no need to quarantine or restrict resident to their rooms, but resident should wear source control for 14 days post exposure.
  - If the resident is ***asymptomatic and unvaccinated***, quarantine for 14 days even if testing negative. HCP should wear full PPE.
  - If the resident is asymptomatic and **has had COVID-19 within last 90 days,** no need to quarantine; resident should wear source control for 14 days post exposure.
  - If the resident **is moderate-to-severely immunocompromised,** consider quarantine. Consult with resident's health care provider to determine if quarantine is necessary.

- Visitation
  - ***Unvaccinated residents identified to have had a close contact that are in quarantine*** are allowed indoor visits in their room only. Both the resident and the visitor should wear source control and maintain physical distancing.
  - ***Vaccinated residents identified to have had a close contact*** can participate in indoor visits in their rooms, in common areas, or in designated visitation spaces. Outdoor visits are allowed. Both the resident and the visitor should wear source control and maintain physical distancing for both indoor and outdoor visits.
- Dining
  - ***Unvaccinated residents identified to have had a close contact*** that are in quarantine must not participate in communal dining and should dine in their room.
  - ***Vaccinated residents identified to have had a close contact*** may participate in communal dining but should wear source control to and from the dining hall and when not eating or drinking.
- Group activities
  - ***Unvaccinated residents identified to have had a close contact*** that are in quarantine must not participate in group activities.
  - ***Vaccinated residents identified to have had a close contact*** may participate in group activities but should wear source control during the activity.

New Admissions or Readmissions – Updated

- Hospitalized residents with confirmed COVID-19 must complete transmission-based precautions (isolation) requirements (minimum of 10 days or up to 20 days if immunocompromised or severe illness).

- Because of the risk of unrecognized COVID-19 infections among residents, facilities must conduct testing at the time of admission to the facility (if not done in the past 72 hours). See testing requirements listed below.

- **New Admissions or Readmissions**
  - When **community transmission levels are substantial or high**, asymptomatic new admissions and readmissions, regardless of vaccination status, must be tested ***on admission*** if not tested in the past 72 hours. ***If negative, test again 5 – 7 days after admission***.

  - If **community transmission levels are low-to-moderate**, asymptomatic new admissions and readmissions ***do not need to be tested on admission***.

- PCR testing is the preferred testing method. If unable to perform PCR testing, POC antigen testing is acceptable.
- **New admissions or readmissions that are unvaccinated** need to quarantine for 14 days and complete testing listed above.

- **New admissions or readmissions that are fully vaccinated** do not need to quarantine as long as they remain asymptomatic but must complete testing listed above.

- **Visitation** – follow the same guidance as residents who are close contacts.

- **Facilities in an outbreak** may admit new residents if they have met the following criteria: have adequate staffing (HCP) to provide care to all residents (current residents and new admissions), are not in crisis staffing, have adequate PPE inventory to meet the care needs of all residents (those currently residing in the building and new admissions), and have appropriate room placement for residents. **Facilities in outbreak must consider the criteria listed above, the extent of the outbreak, and must consult with their local health department before accepting new admissions.**

Residents who leave the facility – Updated

- Remind residents to follow core infection control measures when out of the building (e.g., hand hygiene, source control in crowded settings, physical distancing when feasible, etc.)

- Quarantine is not recommended for **unvaccinated residents** who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and **do not** have close contact with someone with COVID-19.

- Residents who leave the facility for 24 hours or longer should generally be managed as described in New Admissions and Readmissions.

Table 4: New Admission/Readmissions & Residents who Leave the Facility

Resident vaccination status	Is quarantine of resident necessary?	Is testing of the resident necessary?	
		Low-to-moderate community transmission	Substantial-to-high community transmission
Unvaccinated resident out for less than 24 hours	No	No	No
Unvaccinated resident out for 24 hours or more	Yes	No	Yes, test as readmission
Vaccinated resident out for less than 24 hours	No	No	No
Vaccinated resident out for 24 hours or more	No	No	Yes, test as readmission

Visitation - Updated

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f)(4)(v). A nursing home must facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated below. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR § 483.10(f) (4), and the facility would be subject to citation and enforcement actions**.**

- **The safest practice is for residents and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated.**
- If the resident and their visitor(s) are fully vaccinated, they can choose not to wear source control and have physical touch while in the resident's room or apartment.
- **Illinois Executive Order Number 18 (COVID-19 EXECUTIVE ORDER NO. 85), requires residents and visitors to wear source control while indoors in all areas of the facility other than their room(s) or apartments.**
- Visitors, regardless of vaccination status, should wear source control and physically distance themselves from other residents or HCP.
- Touch-based communication may be necessary for residents with combined hearing and vision impairment, but increased use of touch-based communication may necessitate higher levels of hand hygiene, respiratory protection, and/or other protections that may be appropriate in such situations.
- Visitation may occur in the following locations:
  - Resident room (no roommates)
  - Multipurpose rooms
  - Designated visitation rooms
  - Outdoors

Indoor Visitation During an Outbreak

- When a new case of COVID-19 among residents or staff is identified, a facility must test using a unit-based or broad-based (facility-wide) approach.
- During the first round of testing, on the unit or facility-wide, **pause visitation** until testing is complete and the results are obtained.
- Compassionate care, end-of-life, essential caregivers, and ombudsmen/guardian visits should be allowed during this time with appropriate PPE.

Compassionate Care Visits

While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations.

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

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

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

Compassionate care visits and visits required under federal disability rights law should be allowed at all times regardless of a resident's vaccination status, the community transmission levels, or an outbreak.

Federal Disability Rights Laws and Protection and Advocacy Personnel

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs Section 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000).

Additionally, each facility must comply with federal disability rights laws, such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

Essential Caregivers

Refer to the IDPH Essential Caregiver Guidance for Long-term Care Facilities Guidance

Communal Dining and Group activities – Updated

Communal Dining

- Residents must wear a mask to and from dining hall or activity room.
- Consistent with the Illinois-COVID-19 Executive Order No. 85 residents, regardless of vaccination status or community transmission levels should wear source control when not eating or drinking unless they are in their own room or apartment.

Live Music, Vocal Performances and Sing-alongs, or Worship Services

- **Outdoor performances are preferred**
  - **Residents** regardless of vaccination status are not required to wear source control when outdoors. Unvaccinated residents should physically distance from one another when outdoors.
  - **Performers are not** required to wear source control while performing outdoors but must maintain at least 6-9 feet from audience. If unable to maintain 6-9 feet separation, the performer must wear source control.
  - **Performing groups** with more than five performers must perform outdoors. Facilities should not allow indoor performances of large groups.
  - Instruments should be fitted with bell covers consisting of a minimum of two layers of dense fabric. Bell covers should be made of a non-stretchy material with a MERV-13 rating (Minimum Efficiency Reporting Value) to protect against bacteria and virus particles.
  - Performers who play wind instruments can use face coverings with a slit.
  - **Communion.** Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.

- **Indoor Performances and Sing-alongs or Worship services** are allowed using the following guidance.
  - Illinois Executive Order Number 18 (COVID-19 EXECUTIVE ORDER NO. 85), requires residents, visitors, and HCP to wear source control while indoors in all areas of the facility other than their room(s) or apartments.
  - **Vaccinated** residents do not have to physically distance from one another.
  - **Unvaccinated** residents should physically distance from one another.
  - Individuals (e.g., clergy, pastors, etc.), conducting the worship service, regardless of vaccination status, are required to wear source control and maintain a physical distance of 6-9 feet from the audience or congregation.
  - Instruments should be fitted with bell covers consisting of a minimum of two layers of dense fabric. Bell covers should be made of a non-stretchy material with a MERV-13 rating to protect against bacteria and virus particles.
  - Individuals who play wind instruments can use face coverings with a slit.
  - **Communion.** Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.

- If required, individuals providing pastoral care visits must wear source control and other PPE (e.g., eye protection, gown and gloves).
- **Communion.** Individual serving packets of wafer and juice/wine are preferred. Do not share or pass communion articles among residents.

Group outings beyond the facility grounds may be considered provided all the above precautions are observed, along with precautions listed below for trips that are not medically necessary.

- Outdoor outings, such as a stroll in the park, are strongly preferable to outings to indoor destinations, weather permitting.
- Avoid mass events like festivals, fairs, and parades.
- Avoid other locations where it may be difficult to maintain 6-foot separation.

Beauty salons and barber shops

To operate facility-based beauty salons and barber shops:

- Allow services in beauty salons and barber shops only for residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- All residents must wear source control to and from and in the beauty salon.
- **The beautician or barber**, regardless of vaccination status, must wear source control at all times while in the beauty salon.
- Hand-held blow dryers are now allowed to be used in salons.
- Observe restrictions and precautions in Personal Care Services Guidelines for Restore Illinois except if IDPH guidelines in this document are more stringent, the IDPH guidance applies.

Assisted living facilities and other similar arrangements

For Assisted Living Facilities (ALF), Shared Housing Establishments (SHE), Sheltered Care Facilities, and Supportive Living Facilities (SLF), visits can be in common areas or in residents' apartments, following guidance listed above.

State-Authorized Personnel. IDPH grants authorization for entry to state-authorized personnel. They should **not** be classified as visitors. All such individuals must promptly notify facility staff upon arrival, follow all screening protocols established by the facility, and wear appropriate source control while onsite. State-authorized personnel are required to bring their own PPE and sufficient additional PPE for donning and doffing while entering and exiting COVID-19 units. State-authorized personnel will follow the COVID-19 rules and policies set forth by their respective state agencies. (For additional guidance, see this IDPH guidance document: "Access to Hospital Patients and Residents of Long-Term Care Facilities by Essential State-Authorized Personnel," April 17, 2020). Failure to allow entry by state-authorized personnel may lead to penalties and sanctions pursuant to applicable state and federal law.

Long-Term Care Ombudsman

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

Representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If in-person access is deemed inadvisable (e.g., the ombudsman has signs or symptoms of COVID-19), facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by state law.

Surveyors

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

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

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

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

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

Health Care Workers and Other Service Providers

Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, emergency medical services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy, etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or showing signs or symptoms of COVID-19 after being screened. Note

that EMS personnel do not need to be screened so they can attend to an emergency without delay. These personnel should adhere to the core principles of COVID-19 infection prevention and must comply with CMS COVID-19 testing requirements.

Definitions

Facility-onset case: Following the definition from CMS (QSO-20-30-NH): "A COVID-19 case that originated in the facility; not a case where the facility admitted an individual from a hospital with known COVID-19 positive status, or an individual with unknown COVID-19 status that became COVID-19 positive within 14 days after admission."

Facility-associated case of COVID-19 infection in a staff member: "A staff member who worked at the facility for any length of time two calendar days before the onset of symptoms (for a symptomatic person) or two calendar days before the positive sample was obtained (for an asymptomatic person) until the day that the positive staff member was excluded from work." (CDC Contact Tracing for COVID-19, found at: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact).

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

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

- Staff member not wearing a respirator or face mask.
- Staff not wearing eye protection if the person with COVID-19 was not wearing a cloth mask or face mask.
- Staff member not wearing full personal protective equipment (PPE) (gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure.

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

State-authorized personnel: State-authorized personnel include, but are not limited to, representatives of the Office of the State Long-Term Care Ombudsman Program, the Office of State Guardian, IDPH Office of Health Care Regulation, and the Legal Advocacy Service; and

community-service providers, social-service organizations, prime agencies, or third parties serving as agents of the state for purposes of providing telemedicine, transitional services to community-based living, and any other supports related to existing consent decrees and court mandated actions, including, but not limited to, the prime agencies and sub-contractors of the Comprehensive Program serving the Williams and Colbert Consent Decree Class Members.

Source Control (e.g., Cloth Face Covering, Face Mask, or Respirator): Source control refers to the use of a well-fitting face covering, face masks, 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 offers varying levels of protection for the wearer against exposure to infectious droplets and particles produced by infected people.

o Resident Source Control = cloth face covering, surgical mask, or procedure mask.
o HCP Source Control = surgical mask, procedure mask, or respirator, as applicable.

Appendix A: COVID-19 Testing Summary (New)		
Testing Trigger	**Staff (HCP)**	**Residents**
Symptomatic individual identified.	Vaccinated and unvaccinated staff with signs or symptoms must be tested.	Vaccinated and unvaccinated residents with signs or symptoms must be tested.
Higher risk exposure or close contact with individual who tested positive for COVID-19 **that occurs within the facility**	Asymptomatic HCP with higher-risk exposure to someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection. Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule	Asymptomatic residents with prolonged close contact with someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection. Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule
Higher risk exposure or close contact with individual positive with COVID-19 **that occurs outside the facility**	Asymptomatic HCP with higher-risk exposure to someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection. Test two days post-exposure. If negative, test again between day 5-7 post-exposure. **Note:** Fully vaccinated HCP with prolonged, continued exposure in the home must test at two days, between days 5-7, and weekly for two weeks after the last exposure date.	Asymptomatic residents with prolonged close contact with someone with COVID-19, regardless of vaccination status, must have a series of two tests (PCR or POC antigen) for SARS-CoV-2 infection. Test two days post-exposure. If negative, test again between day 5-7 post-exposure
New admissions, readmissions or those out of the facility for more than 24 hours.		If **community transmission levels are substantial or high**, regardless of vaccination status, must be tested on admission if not tested in the past 72 hours. If negative, test again 5 – 7 days after admission. PCR testing is preferred. If **community transmission levels are low to moderate**, do not need to be tested on admission.

Appendix A: COVID-19 Testing Summary Continued (New)		
Testing Trigger	**Testing Trigger**	**Testing Trigger**
Newly identified COVID-19 positive HCP or resident in a facility. If the facility has the ability to investigate the outbreak at a unit-level (e.g., unit, floor, or other specific area(s) of the facility), and identify higher risk exposures and close contacts, they can choose the unit-level approach. Otherwise, the facility should use a broad-based approach.	**Unit approach:** Test all HCP on the unit (or department) where the case was identified immediately (but not earlier than two days after exposure), regardless of vaccination status, Continue to test every 3-7 days until there are no more positive cases for 14 days. No need to test individuals who have had COVID-19 in the prior 90 days. Identify any asymptomatic higher risk exposures in HCP and close contacts in residents not on that unit. Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule. **Broad-based approach**; Test **all** HCP facility-wide immediately (but not earlier than two days after exposure) regardless of vaccination status. Continue to test every 3-7 days until there are no more positive cases for 14 days.. No need to test individuals who have had COVID-19 in the prior 90 days.	**Unit approach:** Test all residents on the unit (or department) where the case was identified immediately (but not earlier than two days after exposure), regardless of vaccination status Continue to test every 3-7 days until there are no more positive cases for 14 days. No need to test individuals who have had COVID-19 in the prior 90 days. Identify any asymptomatic higher risk exposures in HCP and close contacts in residents not on that unit. Test two days post-exposure. If negative, test again between day 5-7 post-exposure or may incorporate into the unit-based or broad-based testing schedule. **Broad-based approach**; Test **all** residents facility-wide immediately (but not earlier than two days after exposure), regardless of vaccination status. Continue to test every 3-7 days until there are no more positive cases for 14 days.. No need to test individuals who have had COVID-19 in the prior 90 days.
Routine testing	Follow Table 2: Testing Intervals of Unvaccinated HCP by Community Transmission Level	Not generally recommended.